Department of Health and Social Services

MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986

Code of Practice

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PREFACE

This Code of Practice was prepared in accordance with Article 111 of the Mental Health (Northern Ireland) Order 1986 by the Department of Health and Social Services after consulting the Mental Health Commission for Northern Ireland and such other bodies as appeared to the Department to be concerned.

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1. INTRODUCTION

Purpose of the Code

1.1 Article 111 of the Mental Health (Northern Ireland) Order 1986 (referred to throughout the Code as 'the Order') requires the Department of Health and Social Services (the Department) to prepare, and from time to time revise, a Code of Practice to be published for the guidance of Health and Social Services Boards, Board staff and others in respect of various matters dealt with in the Order. Article 111(1) defines the purpose of the Code as being:

> " (a) for the guidance of medical practitioners, Boards, staff of hospitals and approved social workers in relation to the admission of patients to hospitals and the reception of patients into guardianship under this Order; and
>
> (b) for the guidance of medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder."

Article 111(2) states:

"The code shall, in particular, specify forms of medical treatment in addition to any specified by regulations made for the purposes of Article 63 which in the opinion of the Department give rise to special concern and which should accordingly not be given by a medical practitioner unless the patient has consented to the treatment .....".

Article 63 provides that the Department may by regulation specify forms of treatment requiring both the patient's consent and a second medical opinion.

1.2 The Order does not impose a legal duty to comply with the Code but the fact that the Code had not been followed could be referred to in evidence in legal proceedings.

1.3 As required by the Order, the Department will keep the Code under review and will revise it as appropriate in the light of experience.

Scope of the Code

1.4 The scope of the Code is prescribed by the provisions of Article 111 of the Order and the guidance it contains does not extend beyond the matters specified in that Article. The Code is intended to be complementary to the Order, which should always be referred to for its precise terms; and to the Guide to the Order published by the Department in 1986 (referred to throughout the Code as 'the Guide').

1.5 The Code does not purport to be all-embracing. Its intention is to provide guidance in straightforward language on matters of day to day practice which it would not be appropriate to deal with in primary or secondary legislation. It offers advice on what is generally agreed to be good professional practice in relation to the procedures laid down in the Order. The Department hopes that this will enable members of different professional groups to work together on practical issues that may straddle professional boundaries. It is not concerned with questions of professional judgment which are more appropriately dealt with in clinical and other text books. The Code applies to all patients including those under 18 years. Where specific guidance in respect of younger patients is considered appropriate this is provided.

References

1.6 Appropriate provisions of the Order and corresponding sections of the Guide are referred to throughout the Code by Article and paragraph numbers respectively. All professionals concerned with the operation of the Order should be familiar with the provisions of the Order and sections of the Guide relative to their duties and responsibilities. Other legislative provisions referred to in the text are identified. All references to legislative provisions are listed in the Index of Statutory References.

1.7 References to "Forms" are references to the forms prescribed by Regulation 7 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 as amended by the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms)(Amendment) Regulations (Northern Ireland) 1992. A complete set of the forms is also contained in Appendix 1 to the Guide.

Principles

1.8 The Code must be read with regard to the broad principles that people suffering from mental disorder should:

- be treated and cared for in such a way as to maintain their dignity;
- receive respect for and consideration of their individual qualities and background - social, cultural, and religious;
- have their needs taken fully into account notwithstanding the fact that, within available resources, it may not always be practicable to meet them;
- receive any necessary treatment or care with the least degree of control and segregation consistent with their safety and the safety of others;
- be discharged from any form of constraint or control to which they are subject under the Order immediately this is no longer necessary;
- be treated or cared for in such a way as to promote their self-determination and encourage personal responsibility to the greatest possible degree consistent with their needs, wishes and abilities.

1.9 This means, in particular, that all individuals should be as fully involved as practicable, consistent with their needs and wishes, in the formulation and delivery of their care and treatment. They should be informed about the nature, purpose and likely outcome of any proposed treatment. This applies equally to young patients and to patients who are receiving care or treatment on a compulsory basis. Where physical difficulties such as hearing impairment impede such involvement, reasonable steps should be taken to attempt to overcome them. It means that patients should have their legal rights drawn to their attention, consistent with their capacity to understand them. Where they cannot understand, their rights should be explained to their carers, relatives or friends as appropriate. Finally, it means that, when treatment or care is provided in conditions of security, patients should be subject only to the level of security appropriate to their individual needs and only for so long as it is required.

Definitions

1.10 The Order makes provision with respect to the detention, guardianship, care and treatment of patients suffering from mental disorder. "Mental disorder" and related expressions are defined in Article 3 for the purposes of the Order. The definitions are not meant to delimit psychiatric practice outside the terms of the Order. For example, the exclusions in Article 3(2) mean that a person cannot be compulsorily admitted to hospital under the terms of the Order by reason only of personality disorder (paragraph 14 of the Guide) but that does not mean that someone with personality disorder may not be offered hospital admission for assessment and treatment on a voluntary basis.

1.11 It is not obligatory for the expression "mental disorder" to be used in psychiatric practice only in accordance with the legal definition. To avoid confusion, however, it is generally better to use some other term for conditions which fall outside this definition.

1.12 "Mental disorder" is defined in Article 3 as meaning "mental illness, mental handicap and any other disorder or disability of mind". "Mental illness" and "mental handicap" are then defined individually. The great majority of cases to which the Order applies will fall into one or other of these categories. There may occasionally be a case to which the Order should apply and which falls within the general definition, but which may not exactly fit the definition of either "mental illness" or "mental handicap". An example would be a person who had sustained brain damage in adult life causing a disability similar to that defined within "severe mental handicap" and who satisfied the other criteria of the Order. In such a case, the apparent severe mental handicap is not strictly speaking "a state of arrested or incomplete development of mind". The effect of including "any other disorder or disability of mind" in the general definition of "mental disorder" is to avoid semantic difficulties of this kind when cases, which properly and necessarily fall within the terms of the Order, are being considered. This does not mean that all patients with brain damage should be treated or managed within a particular regime. Brain damage does not always cause intellectual impairment: it can result in various forms of mental disturbance. The nature of the mental disorder will determine the appropriate regime of treatment or management.

1.13 The definitions of "severe mental handicap" and "severe mental impairment" include the term "severe impairment of intelligence and social functioning". That is not meant to restrict these definitions to persons whose intelligence level as measured by psychological tests falls below a particular figure. Assessment should take into account the total impairment both of intelligence and of social functioning.

1.14 The English and Scottish legislation contain definitions of "mental disorder" which are broadly compatible, but not identical, with those in the Order and with each other. The definition in the Mental Health Act 1983 includes "psychopathic disorder"; the Mental Health (Scotland) Act 1984 does not define "mental illness" in detail.

1.15 Article 2 of the Order defines "patient" as a person suffering or appearing to be suffering from mental disorder. The word "patient" should be given the same interpretation in the Code.

Expressions used in the Code

1.16 Medical practitioners appointed by the Mental Health Commission for the purposes of Part II of the Order and Part IV of the Order are commonly known as Part II and Part IV doctors respectively and are referred to as such throughout the Code.

1.17 The responsible medical officer (RMO) is the Part II doctor in charge of the patient's assessment or treatment (or who provides certain medical recommendations required by the Order for the purposes of guardianship).

1.18 Approved social workers (ASWs) are social workers specially trained in dealing with persons who are suffering from mental disorder and appointed by a Board to act as an ASW for the purposes of the Order.

1.19 The glossary defines some of the expressions and words used in the Code.

1.20 Solely to facilitate drafting, the male gender has been used throughout the Code, but the guidance it contains in its references to patients, professional staff and others applies equally to both males and females.

2. COMPULSORY ADMISSION TO HOSPITAL FOR ASSESSMENT

Introduction

2.1 Part II of the Order sets out the circumstances in which, and the procedures through which, mentally disordered persons can be compulsorily admitted to and detained in hospital. It does not, however, deal with admissions through the Courts or transfers from prisons or remand centres, which are covered in Part III.

2.2 The Order makes a very clear distinction between admission to hospital for assessment and detention in hospital for treatment. The distinction is emphasised by the fact that where the assessment is not followed by detention for treatment the assessment period can be disregarded for certain purposes (Article 10 and paragraph 45 of the Guide).

2.3 The admission for assessment procedure is initiated by the applicant with the support of a medical recommendation. The procedure is laid down in Articles 4 to 8 of the Order and explained in paragraphs 18 to 24 of the Guide. Detention for treatment is initiated by a Part II doctor on completion of the assessment process, and the criteria are stringent. The procedure is laid down in Articles 12 and 13 of the Order and explained in paragraphs 46 to 50 of the Guide.

Application for admission for assessment

2.4 The application, founded on a medical recommendation, is central to the admission for assessment procedure. Applications and medical recommendations must be made on the appropriate prescribed forms, and care must be taken to ensure that these are completed correctly. While inaccuracies may be subsequently corrected, any significant irregularity in the documentation may invalidate the authority to admit the patient (Article 11). The scrutiny and amendment of documents is dealt with in paragraphs 2.52 to 2.56 of the Code.

2.5 It is good practice for the professionals involved in the application for admission to be present at the same time (although it may be advantageous for each to interview the patient separately). Everyone involved should be aware of the need to provide mutual support. They should also, where there is a risk of the patient causing serious physical harm, consider calling for police assistance and should know how to use that assistance to minimise the risk of violence.

2.6 Good communication with the patient is essential. In particular:

- where the patient has difficulty either in hearing or speaking, or does not speak English, the assistance of staff with specialist communication skills, such as professional interpreters, should be considered;

- the potential disadvantages of a patient's relative being asked to interpret should be borne in mind;

- where the patient is still unwilling or unable to communicate adequately (despite assistance from interpreters) the decision to proceed will have to be based on whatever information can be obtained from other sources;

- it is not desirable for a patient to be interviewed through a closed door or window except where this is necessary to avoid serious risk to other people. Where there is no immediate risk of physical danger to the patient or to others, powers in the Order to secure access (Article 129) should be considered;

- where the patient is under the effects of sedative medication, or the short-term effects of drugs or alcohol, the interview should be postponed, unless it is not possible because of the patient's disturbed behaviour and the urgency of the case. If it is not realistic to wait, the decision to proceed with the application will have to be based on whatever information can be obtained from all reliable sources;

- the patient should ordinarily be given the opportunity of being interviewed in private, but, if there is a risk of physical violence, the doctor and the applicant can insist on another person being present. If the patient would like another person (for example a friend) to be with him during the interview and any subsequent action which may be taken, he should be assisted in securing that person's attendance unless the urgency of the case or some other proper reason makes it inappropriate to do so .

Choice of applicant

2.7 Application for admission to hospital for assessment may be made by:

- the patient's nearest relative (Article 5(1)(a));
- an ASW (Article 5(1)(b)); or
- a person appointed by the County Court to act as the nearest relative (Article 36).

The nearest relative

2.8 The nearest relative is defined in Article 32 of the Order by reference to a list of relationships in paragraph (1) of that Article, a caring relative taking priority over a non-caring relative (whatever his position on the list). Guidance on how the nearest relative is determined is set out in paragraphs 110 to 112 of the Guide and on the back of the application form (Form 1). He has an important part to play in the application to admit to hospital even if he is not the applicant. He is normally the person who is closest to the patient and will usually be aware of the circumstances surrounding the possible need for admission.

2.9 The doctor should ensure that the nearest relative is aware that he can ask for an ASW to consider making the application. Where the nearest relative is proposing to act as the applicant, the professionals involved in the case should offer him any assistance or advice required. That advice should include such elements of the guidance for ASWs in paragraphs 2.13 to 2.20 of the Code as are appropriate. The nearest relative should also be made aware of the relevant form (Form 1) and how it should be completed. Alternatives to compulsory admission, such as voluntary admission, guardianship, or continuing medical, nursing and social work help outside hospital, should be discussed with him.

2.10 There will, of course, be occasions when the nearest relative does not wish, or is unable, to make the application. Applying for admission at a time of crisis can be a stressful experience. On occasions an application by the nearest relative may be regarded by the patient as rejection by his family. Where the nearest relative is reluctant to initiate the application procedure, the doctor should consult the ASW and explain, to the nearest relative, the ASW's power to make an application.

2.11 ASWs are qualified to address these relationship and procedural issues. Their role is described more fully below. It is envisaged that, in many cases, the nearest relative will continue to play a significant part in the application process, even where the ASW acts as applicant. However, a nearest relative should not be forced to make an application for admission under the Order because of a delay in obtaining the services of an ASW.

2.12 Boards should aim to provide a 24 hour ASW service. They should issue guidance to ASWs on:

- what amounts to a "request" to consider application from the nearest relative;
- how to respond to repeated requests where the condition of the patient has not changed significantly;
- how to respond to a request made on behalf of a nearest relative by a GP or other professional whether employed in the statutory or voluntary sector.

ASW responsibilities

2.13 Article 40 of the Order places a duty on the ASW to make an application where he is satisfied that an application ought to be made and that it is necessary or proper for the application to be made by him. The practical guidance in this part of the Code applies where the ASW is acting under Article 40 but is generally applicable where he is considering an application at the request of the nearest relative.

2.14 To satisfy himself that it is necessary and proper for an application to be made the ASW should interview the patient in person. At the start of the interview he should identify himself to the patient and to members of the family and other professionals present; explain in clear terms his role and the purpose of his visit; and check that the other professionals have explained their roles. ASWs should at all times carry documents identifying themselves as ASWs.

2.15 Paragraph 120 of the Guide gives details of certain requirements in the interview. The general guidance given in paragraph 2.5 of the Code should also be observed.

2.16 The ASW must attempt to identify the patient's nearest relative and ensure that his statutory obligations to the nearest relative are fulfilled. In addition, the ASW should where possible -

a. ascertain the nearest relative's views about the patient's needs and his (the relative's) own needs in relation to the patient; and

b. inform the nearest relative of the reasons for considering an application for admission under the Order and the effects of making such an application.

2.17 If the nearest relative objects to an application being made and the ASW wishes to proceed with the application, he must consult a second ASW before he makes the application (Article 5(4)). The second ASW should interview the patient and record his conclusions. If after consultation the first ASW decides to proceed, he must record the nearest relative's objection on the application for assessment. Alternatively he may apply to the County Court to have an acting nearest relative appointed on the grounds that the nearest relative has unreasonably objected to the making of an application (Article 36(3)(c)).

2.18 The ASW should take into account any wishes expressed to him by relatives of the patient and any other relevant circumstances when deciding whether or not to make an application (Article 40(1)(b)). It will be appropriate in certain cases to have regard to any views expressed by particularly close friends.

2.19 The ASW should consult the doctor in attendance and whenever possible other professionals who have been involved with the patient's care, for example home care staff, community psychiatric nurses (CPNs) or community mental handicap nurses (CMHNs).

2.20 When the ASW has decided whether or not he will make an application for admission, he should tell (giving the reason):

- the patient;
- the patient's nearest relative (whenever possible); and
- the doctor(s) involved in the assessment.

Indeed, since the application must be founded on a medical recommendation, it is good practice for both the doctor and the ASW to be present at the same time, although they may wish to interview the patient separately.

Medical recommendation

2.21 The doctor providing the medical recommendation must have examined the patient within the previous 2 days (Article 6). He should, if at all possible, be someone who already knows the patient, and normally the patient's own GP would be the first choice. A partner or locum is not barred from providing the recommendation. A doctor on the staff of the hospital to which the patient is to be admitted cannot provide the recommendation except in a case of urgent necessity (Article 6(c)).

2.22 The criteria for application and medical recommendation for admission for assessment are set out in Article 4(2) and (3) of the Order. Article 4(2) provides that an application may be made in respect of a patient on the grounds that -

> "(a) he is suffering from mental disorder of a nature or degree which warrants his detention in a hospital ....; and
>
> (b) failure to detain him would create a substantial likelihood of serious physical harm to himself or to other persons."

Article 4(3) of the Order provides that an application must be founded on a medical recommendation which includes -

> (a) a statement that, in the opinion of the recommending doctor, the grounds set out in Article 2(a) and (b) apply;

(b) the grounds, including a clinical description of the mental condition, for his opinion that the detention is warranted; and

(c) the evidence for his opinion that failure to detain the patient would create a substantial likelihood of serious physical harm.

Article 2(4) and paragraphs 23 and 24 of the Guide specify the evidence which can be used in determining that there is a substantial likelihood of serious physical harm to himself or to other persons. The assessment of a patient may legitimately involve consideration of any prognosis of future deterioration of the patient's mental health and the known history of his mental disorder. Some examples of what may be considered in assessing the nature of the serious physical harm are:

- uncontrolled over-activity likely to lead to exhaustion;

- gross neglect of hygiene and personal safety which would create a hazard to the patient or others;

- serious and protracted neglect of diet which would lead to malnutrition;

- disinhibited behaviour likely eventually to lead to serious physical harm to the patient, his family or other persons.

2.23 It will be seen that the doctor's responsibility goes beyond diagnostic assessment and includes assessment of the need for detention in hospital. In this he should co-operate with the applicant and consider both the need for detention and the possibility of alternative measures and how they might be taken. When the applicant is the nearest relative, the doctor should advise him that he can discuss the position with an ASW.

2.24 The doctor should specifically address the legal criteria for admission under the Order and set out in his recommendation those aspects of the patient's symptoms and behaviour which satisfy the criteria.

2.25 If an application for assessment is to be made the doctor should contact medical staff in the hospital to which the patient is to be admitted, to discuss any possible difficulties or uncertainties about admission, ensure that a bed will be available and advise of the anticipated time of arrival of the patient at the hospital.

The application

2.26 The application is made on Form 1 by the nearest relative or Form 2 by the ASW, and the doctor's medical recommendation is made on Form 3. As the application must be founded on and accompanied by a medical recommendation, it follows that the doctor should give Form 3 to the applicant. It is important that the correct forms are used and that they are properly completed. Otherwise the receiving hospital may be unable to accept the patient.

Alternatives to application for admission

2.27 Before making a recommendation or proceeding with an application the professionals involved should consider what is needed for the patient's care and protection and (where this applies) for the protection of others. All reasonable options should be considered. Where admission is necessary, generally speaking voluntary admission is to be preferred to compulsory admission under Part II of the Order. But compulsory admission should be considered where the patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that he will change his mind about voluntary admission, prior to his actual admission to hospital, with a resulting risk to health and safety.

2.28 If it is decided not to apply for admission, the professionals concerned should decide what action is needed to meet the patient's needs, including the possible provision of other health and social services, and should decide how to implement that action. Other professionals concerned with the patient's care should be fully involved in the taking of such decisions, notably the CPN or CMHN. The professionals should ensure that they, the patient, and (with the patient's consent) the nearest relative and any other closely connected relatives, have a clear understanding of any alternative arrangements and who will be responsible for ensuring that they are put in place. Such arrangements should be recorded in writing and copies made available to all those who need them, subject to the patient's right to confidentiality.

2.29 The ASW should discuss with the patient's nearest relative the reasons for not making an application. The ASW should advise the nearest relative of his rights to apply and suggest that he consult the doctor if he wishes to consider this alternative. Where the ASW has been acting at the request of the nearest relative he must give that relative a written statement of the reasons for not applying for the patient's admission (Article 40(4)). The statement should contain sufficient details to enable the nearest relative to understand the decision whilst at the same time preserving the patient's right to confidentiality. A copy of the statement should be retained by the ASW.

Disagreements

2.30 For an application for assessment to succeed there must be agreement between the applicant and the doctor. Where this is difficult to achieve, consultation with colleagues should be considered, including CPNs, CMHNs and other community care staff. Where there is an unresolved dispute about an application it is essential that the professionals do not abandon the patient and his family. They should explore and determine an alternative plan and ensure that the family is kept informed. Such a plan should identify a named professional who will have responsibility for ensuring its implementation. It should be recorded in writing and copies made available to all those who need them, subject to the needs of confidentiality.

Admission of children and young persons under the age of 18 years

2.31 Part II of the Order applies equally to children and young persons under the age of 18 years. There are, however, a number of issues of particular importance which should be considered when persons under the age of 18 years are admitted to hospital whether on a voluntary basis or on foot of an application for assessment.

2.32 Practice for this age group should be guided by the following principles:

- young people should be kept as fully informed as possible about their care and treatment; their views and wishes must always be taken into account;

- unless statute specifically overrides, young people should be regarded as having the right to make their own decisions (and in particular treatment decisions) when they have sufficient "under standing and intelligence";

- any intervention in the life of a young person, considered necessary by reason of their mental disorder, should be the least restrictive possible and result in the least possible segregation from family, friends, community and school.

2.33 The legal framework governing the admission to hospital (and treatment) of young people under the age of 18 years (and in particular those under the age of 16 years) is complex and it is the responsibility of all professionals and the Boards to ensure that there is sufficient guidance available to those responsible for the care of children and young people.

2.34 Whenever the admission to hospital (and care and treatment in hospital) of somebody under the age of 16 years is being considered, the following questions (amongst many others) need to be asked:

- who is legally responsible for decisions affecting the child, and who has the authority to make such decisions? Those assuming professional responsibility for the care of a child or young person should always request copies of any statutory orders (wardship, care order, custody order, guardianship order, access arrangements, etc) for reference on the ward;

- if the child is in the custody of parents who are separated, which parent has custody, or is the custody shared?;

- what is the capability of the child to make his own decisions in terms of emotional maturity, intellectual capacity and psychological state?

2.35 Parents or guardians may arrange for the admission of children under the age of 16 years to hospital as voluntary patients. Where a doctor concludes, however, that a child under the age of 16 years has the capacity to make such a decision for himself, the child should not be admitted against his will. Where a child is willing to be admitted, but his parents (or guardian) object, their views should be accorded serious consideration and given due weight. It should be remembered that recourse to law to stop such an admission could be sought. Anyone aged 16 to 18 years who is "capable of expressing his own wishes" can admit or discharge himself as a voluntary patient to or from hospital, irrespective of the wishes of his parents or guardian.

2.36 It is always preferable for children and young people admitted to hospital to be accommodated with others of their own age group in children's wards or adolescents' units, separate from adults. If, exceptionally, this is not practicable, discrete accommodation in an adult ward, with facilities appropriate to the needs of children and young people, offers the most satisfactory solution.

Conveyance to hospital

2.37 A duly made application for assessment is sufficient authority for the patient to be conveyed to hospital by the applicant, by a person authorised by him, or by the responsible Board if it is requested to do so by the applicant in a case of difficulty (Article 8(1)). The patient must be admitted to hospital within 2 days, or such longer period not exceeding 14 days as a Part II doctor may certify on Form 4 in exceptional circumstances (Article 8(1) and paragraph 26 of the Guide).

2.38 While being conveyed to hospital the patient is deemed to be in legal custody (Article 131(1)). Should the patient escape while being conveyed to hospital, he may be retaken, and conveyed to the hospital within the time permitted for his admission, by the person who had custody of him immediately before the escape, or any constable or ASW (Article 132(1)).

Conveyance by the nearest relative

2.39 Where the nearest relative is the applicant he should be advised that the assistance of an ASW in conveying the patient to hospital is available on request. Where the nearest relative as the applicant intends to exercise his authority himself, or to authorise some other person unfamiliar with admission procedures to convey the patient, the doctor and other professionals involved in the case should offer him any advice and assistance required. That advice should include the guidance for ASWs set out in the following paragraphs. Where the patient is to be conveyed to hospital by ambulance, the doctor should make the necessary arrangements and explain them to the nearest relative.

Conveyance by the ASW

2.40 Where an ASW is the applicant, has been asked by the nearest relative for assistance or has been appointed by the Board to exercise its duty in a case of difficulty to convey the patient to hospital, the ASW has a professional responsibility for ensuring that all the necessary arrangements are made for the patient's conveyance to hospital and that the patient is properly admitted to the hospital. In planning the patient's conveyance to hospital the ASW should, whilst ensuring that the legalities are observed, favour the most humane and least threatening mode of transport consistent with the needs and the safety of the patient and his escort. Where the decision is that the patient should be conveyed to hospital by ambulance the doctor will normally make the necessary arrangements.

2.41 The ASW is permitted to delegate the task of conveying the patient to another person (eg ambulance personnel or possibly the police). The ASW is, however, ultimately responsible for ensuring that the patient is conveyed in a lawful and humane manner and should be ready to give the necessary guidance to those asked to assist.

2.42 It will often be best to convey the patient by ambulance. The ASW will need to decide if he should accompany the patient. If the patient would prefer to be accompanied by another professional (perhaps better known to him) or by a responsible relative, the ASW may ask that person to escort the patient, provided he is satisfied that in doing so he is not increasing the risk of harm to the patient or others.

2.43 The patient should not be conveyed to hospital by car unless the ASW is satisfied the patient will not endanger himself or others on the journey. There should **always** be an escort for the patient other than the driver.

2.44 If the patient is likely to be violent or dangerous, the police should be asked to help. Such a patient should never be conveyed by private car. Where possible an ambulance should be used, or failing that, a police vehicle. Although the police may have to exercise their duty to protect persons or property while the patient is being conveyed, they should, where this is not inconsistent with their duty, comply with any directions or guidance given by the ASW.

2.45 The ASW should inform the receiving hospital, giving the likely time of arrival, to ensure that the patient is expected and that arrangements have been made for his acceptance and for receiving the admission documents.

2.46 The ASW must ensure that the admission documents arrive at the receiving hospital at the same time as the patient. If the ASW is not travelling in the same vehicle as the patient, the documents should be given to the person authorised to convey the patient with instructions for them to be presented on arrival at the hospital to the nurse in charge of the ward into which the patient is to be admitted.

2.47 If the ASW is not travelling with the patient, he should arrive at the hospital at the same time as the patient or as soon as possible afterwards. He should ensure that the admission documents have been delivered, that the admission of the patient is under way and that any relevant information in his possession is passed to appropriate personnel in the hospital. He should remain in the hospital until the patient has been medically examined.

2.48 Where a patient is admitted for assessment on the application of an ASW who has not consulted the patient's nearest relative, the ASW must inform the nearest relative as soon as is practicable (Article 5(5)). Where a patient who is subject to guardianship under the Order is admitted for assessment, the Board must inform the guardian as soon as is practicable (Article 8(3)).

2.49 A patient who has been sedated **for the purpose of being conveyed to hospital** should be accompanied by a nurse, doctor or ambulance person who is sufficiently skilled in resuscitation techniques and the observation of drowsy or comatose patients.

Role of the responsible Board

2.50 Under Article 8(1)(b) of the Order it is a Board's responsibility to convey a patient to hospital in a case of difficulty. To meet such cases Boards should, in conjunction with other authorities likely to be involved in conveying patients to hospital (eg the police), prepare joint guidance on policy and procedures including:

- a clear statement of the roles and obligations of each authority and its personnel;
- the form of any authorisation to be given by the ASW to others to convey the patient to hospital; and
- guidance to personnel as to their powers in relation to conveying patients to hospital.

Admission Procedures

2.51 A valid application for assessment constitutes authority for the patient not only to be conveyed to hospital but also to be detained there for the purposes of a medical examination (a report of which should be sent to the responsible Board) and of subsequent assessment (Articles 8(2) and 9). The essential procedures to be followed on the patient's arrival at hospital are:

- receipt and scrutiny of the application and medical recommendation;
- acceptance and medical examination of the patient;
- notification of the application and detention for assessment to the Board and the Mental Health Commission.

Proper procedures should be applied for the care of patients' property on admission to hospital.

Receipt and scrutiny of documents

2.52 General Managers are ultimately responsible for establishing the validity of a duly completed application for assessment as authority to detain a patient for medical examination and assessment. They should formally delegate this responsibility to officers who will receive the patient. Normally this duty will fall to the nurse in charge of the ward or unit.

2.53 Responsibility for receiving the patient and checking the application must be assumed by a first level nurse registered in the Register of Nurses, Midwives and Health Visitors in accordance with Regulation 3 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 (that is, a first level nurse trained in the nursing of persons suffering from mental illness or mental handicap).

2.54 The receiving officer should have delegated authority to ensure that the documents are in order. He should be familiar with the requirements of the Order and be able to refer to an authorised administrative officer in any case where there is doubt about the validity of the documents. Both the receiving officer and the administrative officer should understand what errors can properly be corrected in accordance with Article 11 of the Order (paragraph 2.62 of the Code). This subject is covered in paragraphs 34 to 44 of the Guide.

2.55 Medical recommendations should be examined at the same time as the application. They must be scrutinised to ensure that they show sufficient legal grounds for detention. The clinical description of the patient's mental condition should include a description of his symptoms and of his behaviour, not merely a diagnostic classification. The receiving officer should have ready access to a hospital doctor with delegated responsibility who is familiar with the requirements of the Order and be able to refer to the doctor in any case where there is uncertainty about the medical recommendation accompanying the application for assessment. The doctor making the recommendation will have been in touch with a hospital doctor to arrange for the patient's reception, and that hospital doctor should have advised the receiving officer that the patient is to be admitted and have explained the medical grounds for the recommendation. Ideally he should be the hospital doctor to whom the nurse can refer queries about the medical recommendation. If he will not be that doctor, he should brief colleagues to whom such reference may be made, in anticipation of the arrival at hospital of the patient and the documents. It would be advantageous, when contacting the hospital, for the doctor recommending admission to speak to the doctor who will examine the patient on arrival.

2.56 When the patient is being admitted on the application of an ASW, the person receiving the admission documents should check their accuracy with the ASW.

Medical examination on arrival

2.57 The patient must be medically examined immediately on arrival at the hospital by the RMO, another Part II doctor, or any other doctor on the staff of the hospital (Article 9). The examining doctor should preferably have discussed the case beforehand with the doctor who made the recommendation for admission. Failing this the examining doctor should seek all relevant information from the hospital doctor contacted by the doctor who made the recommendation. This should reduce the likelihood of disagreement on the need to admit the patient for assessment.

2.58 The examining doctor must report the result of his examination to the Board on Form 7 whether his opinion be that the patient should be detained in hospital for assessment, should remain in hospital on a voluntary basis or should not remain in hospital. The patient may be detained for up to 7 days on the opinion of the RMO or another Part II doctor. On the opinion of any other doctor the patient may be detained for a period of up to 48 hours during which he must be examined by the RMO or other Part II doctor who must report to the Board on Form 8. If the examining doctor forms the opinion that detention should continue the patient may be detained for up to 7 days from the date of the first examination. Either way the assessment period cannot exceed 7 days without a further examination. If within the 7 day period a Part II doctor examines the patient and reports to the Board on Form 9, the assessment period may be extended for a further 7 days after the expiration of the first 7 day period. In no circumstances can a patient be detained more than 14 days for assessment.

2.59 Where a patient has been admitted for assessment on the application of his nearest relative the responsible Board must arrange for a social worker to interview the patient and report on the patient's social circumstances to the RMO (Article 5(6)). The RMO should take the social worker's report into account when making his assessment. It is imperative therefore that the report should be available to the RMO as soon as possible within the assessment period.

2.60 The purpose of the application for admission is to permit a comprehensive assessment of the patient to be made in hospital and a decision as to the need for further detention for treatment to be taken on the strength of that assessment. There are obvious objections to anticipating the outcome of the assessment process. A decision to reject the application on examination of the patient on arrival should not, therefore, be taken lightly. Such a decision should only be taken on the judgment of a Part II doctor normally after consultation with, and, if possible the agreement of, the doctor who made the recommendation for admission. An examining doctor who is not a Part II doctor should, therefore, before taking such a decision, consult a Part II doctor. The examining doctor should arrange for the doctor who made the recommendation for admission and the applicant to be informed by letter where the patient is to be detained for assessment or to remain in hospital as a voluntary patient. Where the decision is that the patient should be discharged the examining doctor should immediately inform the doctor who made the application and the latter should, with the other professionals concerned, decide what action is needed to meet the patient's needs, including the possible provision of other health and social services, and decide how to implement that action.

Notifications to Board and Mental Health Commission

2.61 A valid application is authority for the responsible Board to detain the patient in hospital for assessment. Once the hospital has admitted a patient for examination a copy of the application (Form 1 or Form 2) and the medical recommendation (Form 3) should be forwarded to the Board which should immediately send copies to the Mental Health Commission. The examining doctor's report (Form 7) should also, whatever the outcome of his examination, be forwarded to the Board on completion and copied immediately by the Board to the Commission. Any subsequent reports relating to detention for assessment (Forms 8 or 9) should be forwarded on completion to the Board and immediately copied by the Board to the Commission, as should a report on Form 10 relating to detention for treatment (paragraph 2.63 of the Code).

Rectification of applications, recommendations and reports

2.62 Article 11 of the Order provides that an application for assessment, medical recommendation or examining doctor's report found within 14 days of admission to be incorrect or defective, may be corrected within the 14 days.

Where a medical recommendation or report is deemed insufficient to warrant detention the applicant should be informed. Article ll provides that in such circumstances the recommendation or report shall be disregarded but the application shall be deemed to be sufficient if a fresh recommendation or report complying with the provisions of the Order is furnished to the Board. The Mental Health Commission must be informed of any alterations made and sent a copy of any substitution furnished. The authorised administrative officer (paragraph 2.54 of the Code) should ensure that any such corrections are made as required by, and in accordance with, Article 11 of the Order (paragraphs 34 to 44 of the Guide).

Detention for treatment

2.63 The RMO, or another Part II doctor in the absence of the RMO, must examine the patient before the end of the initial 7 day assessment period. If the examining doctor decides that further detention is not necessary the patient will either remain in hospital voluntarily or be discharged. If the doctor decides that the patient should be detained for a further period, that period will commence after the expiry of the first period (Article 9(8)). The patient must be re-examined before the end of the second period. If the examining doctor is then of the opinion that the patient should be detained for treatment, and the criteria of Article 12(1) of the Order are satisfied, the doctor must report to the Board on Form 10 .

Detention of a voluntary patient already in hospital

2.64 Article 7 of the Order provides that an application for assessment may be made in respect of a hospital in-patient who is not liable to be detained under the Order, where it appears to a medical practitioner on the staff of the hospital that an application ought to be made. In effect this allows a patient to be held for up to 48 hours to allow the application to be made.

2.65 Where a doctor is of the opinion that an application for assessment ought to be made in respect of a patient already in hospital including a general hospital (but not an out-patient or someone attending an accident and emergency department) the doctor should, when appropriate, complete Form 5 recording his reasons. Use should only be made of this provision, and Form 5 should only be completed, where there is a possibility that the patient could seek to leave hospital before an application can be made. The Form should not be completed unless at the time there is a genuine intention on the part of the doctor that an application for assessment should be made (paragraph 2.70 of the Code). Once Form 5 has been completed the patient can be held in the hospital for up to 48 hours to permit that to be done. An application for assessment in respect of a voluntary patient may, of course, be made in the normal way without resort to Article 7 of the Order and completion of Form 5.

Nurse's holding power

2.66 A doctor may not always be immediately available when a voluntary patient, undergoing treatment for mental disorder, seeks to leave hospital and cannot be persuaded to stay. In such circumstances, an appropriately qualified nurse may exercise a holding power (provision for which is made in Article 7(3) of the Order) to detain the patient where the nurse is of the opinion that :

- an application for assessment ought to be made in respect of the patient; and

- it is not practicable to secure the immediate attendance of a doctor.

The holding power may be exercised by a first level nurse registered in the Register of Nurses, Midwives and Health Visitors in accordance with Regulation 3 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 (that is, a first level nurse trained in the nursing of persons suffering from mental illness or mental handicap).

2.67 A suitably qualified nurse should be on all wards where there is a possibility of the nurse's holding power being used. This is most likely to occur on acute admission wards and wards where there are severely disturbed patients. Hospital management should assess the potential for its use elsewhere in the hospital and ensure that appropriate arrangements are in place for a suitably qualified nurse to be available. Clear procedural guidelines should be available to all staff in these settings.

2.68 The decision to exercise the holding power is at the personal discretion of the nurse. He cannot be instructed to exercise this power by anyone else. Before using the power the nurse should assess:

a. the likely arrival time of the doctor as against the likely intention of the patient to leave. Most patients who express a wish to leave hospital can be persuaded to wait until a doctor arrives, to discuss the matter further. Where this is not possible the nurse must try to predict the impact of any delay upon the patient; and

b. the consequences of a patient leaving hospital immediately including the harm that might occur to the patient or others taking into account:

- what the patient says he will do and his known history;

- the likelihood of the patient committing suicide;

- the patient's current behaviour and in particular any changes from usual behaviour;

- the likelihood of the patient behaving in a violent manner;

- the availability of appropriate accommodation and support in the home;

- any recently received messages from relatives or friends;

- any recent disturbance on the ward (which may or may not have involved the patient);

- any relevant involvement of other patients;

- any relevant information from other members of the multidisciplinary team.

2.69 The nurse must record, on Form 6, his opinion that an application for assessment ought to be made. The reasons for invoking the holding power should be entered in the patient's nursing notes. The nurse's holding power starts once he has completed Form 6 and ends 6 hours later or on the earlier arrival of a hospital doctor empowered to report that an application for assessment should be made. Where the doctor is in attendance pursuant to the exercise of the nurse's holding power but is of the opinion that an application for assessment should not be made the patient cannot be held further, and Form 5 should not be completed.

Application for assessment in respect of a patient already in hospital

2.70 So far as possible the application procedures described in paragraphs 2.4 to 2.26 of the Code should be followed. Where practicable the patient's own GP should attend the hospital to give the medical recommendation on which the application would be founded. A doctor on the staff of the hospital in which it is intended the assessment should be carried out cannot give the recommendation except in a case of urgent necessity (Article 6(c)). The Order does not prohibit a doctor on the staff of another hospital from making the medical recommendation, but it is preferable for this to be done by the patient's own GP, or by another practitioner who has previous knowledge of the patient (Article 6(b)).

Documentation

2.71 Forms 6 and 5 should be delivered to the Board as soon as possible, and copied by the Board immediately on receipt to the Mental Health Commission.

Duty to give information to patients and nearest relatives

2.72 The Board must ensure that each detained patient and his nearest relative receive the information to which they are entitled under Article 27 of the Order at the time and in the manner specified in that Article (paragraphs 92 to 97 of the Guide).

3. RECEPTION INTO GUARDIANSHIP

Introduction

3.1 The purpose of guardianship is primarily to ensure the welfare (rather than the medical treatment) of a patient in a community setting where this cannot be achieved without the use of some or all of the powers vested by guardianship. It provides a less restrictive means of offering assistance to a person than, and should be considered as an alternative to, detention in hospital. It enables the establishment of an authoritative framework for working with a patient with a minimum of constraint to help him to achieve as independent a life as possible within the community. Arrangements for giving effect to guardianship should not be unnecessarily complicated. The objective should be simply to ensure that guardianship is used properly and in a positive and flexible manner.

3.2 Part II of the Order sets out the circumstances in which, and the procedures through which, certain mentally disordered persons aged 16 or over may be received into guardianship. Part II does not, however, deal with guardianship orders made by the Courts which are covered in Part III.

Components of effective guardianship

3.3 Where guardianship is used it should be part of an agreed comprehensive care plan drawn up by the professionals who are or who could be involved in the patient's care, and, where appropriate, the patient's nearest relative or other informal carer. The plan should identify the services needed by the patient, including as necessary his care arrangements, appropriate accommodation, his treatment and personal support requirements, and those who have responsibilities under the care plan. It should indicate which of the powers given by guardianship are necessary to achieve the plan. If none of the powers given by guardianship are considered necessary for achieving the patient's welfare, guardianship is inappropriate.

3.4 The following components are necessary for guardianship to be effective:

- a willingness by the guardian to "advocate" on behalf of the patient in relation to those agencies whose services are needed to carry out the care plan;
- readily available support from the Board for the guardian;
- an appropriate place of residence taking into account the patient's needs for support, care, treatment and protection;
- access to necessary day care, education and training facilities as appropriate;
- effective co-operation and communication between all persons concerned in implementing the care plan.

Where the patient is capable of understanding, it is also necessary that there should be a recognition by the patient of the "authority" of the guardian. There must be a willingness on the part of both parties to work together within the terms of the authority which is vested in the guardian by the Order.

Application for reception into guardianship

3.5 The application, founded on 2 medical recommendations and a recommendation by an ASW, is central to the reception into guardianship procedure. The procedure is laid down in Articles 18 to 21 of the Order and explained in paragraphs 74 to 80 of the Guide. Applications and recommendations must be made on the appropriate prescribed forms, and care must be taken to ensure that these are completed correctly.

Choice of applicant

3.6 Application for reception into guardianship may be made by:

- the patient's nearest relative (Article 19(1)(a));

- an ASW (Article 19(1)(b));

- a person appointed by a County Court to act as the nearest relative (Article 36).

The nearest relative

3.7 The nearest relative is defined in Article 32 of the Order by reference to a list of relationships in paragraph (1) of that Article, a caring relative taking priority over a non-caring relative (whatever his position on the list). He has an important part to play in the guardianship application even if he is not the applicant or the person named as the prospective guardian. He is normally the person who is closest to the patient and will usually be aware of the circumstances surrounding the possible need for guardianship. The patient may be required to live with the nearest relative whilst under guardianship.

3.8 Professionals involved in a case should offer to the nearest relative any advice or assistance required where he is proposing to act as the applicant and/or guardian. As applicant he should be made aware of the relevant form (Form 13) and how it should be completed. As prospective guardian he should be advised about the effect of guardianship and the extent and limitations of a guardian's powers (paragraphs 3.21 to 3.24 of the Code).

3.9 The Code envisages that the nearest relative will continue to play a significant part in the reception of patients into guardianship, even where the ASW acts as applicant, except where this is clearly not desirable, for example where the patient has been neglected or abused by the nearest relative. In no circumstances should pressure be brought to bear on the nearest relative to make a guardianship application, act as guardian or participate in the continuing care of the patient whilst the patient is subject to guardianship.

3.10 Where the nearest relative unreasonably objects to the making of a guardianship application the ASW should pursue the application. Alternatively he may apply to the County Court to have an acting nearest relative appointed.

ASW responsibilities

3. 11 ASWs have 2 distinct roles in the application process, and these must be carried out by 2 different ASWs .

3.12 Article 40 of the Order places a duty on the ASW to make a guardianship application where he is satisfied that an application ought to be made and that it is necessary or proper for the application to be made by him. The practical guidance in paragraphs 2.13 to 2.20 of the Code is equally applicable where the ASW is considering making a guardianship application pursuant to his duty under Article 40 and is generally applicable also where he is considering an application at the request of the nearest relative.

3.13 A guardianship application must be founded on a recommendation by an ASW other than the ASW applicant and on 2 medical recommendations. In making a recommendation the ASW has to be reasonably satisfied that reception into guardianship is in the interests of the welfare of the patient. This includes being sure that appropriate facilities are available to give effect to the powers of guardianship, such as a suitable place of residence or adequate arrangements for occupation, education or training.

Medical recommendations

3.14 Two medical recommendations are required and may be made jointly or separately (paragraphs 76 and 77 of the Guide). If the doctors examine the patient separately they must do so within 7 days of each other. Each must sign his recommendation within 2 days of carrying out the examination. One recommendation must be given by a Part II doctor. The other should, if at all possible, be made by the patient's own general practitioner or by a medical practitioner who already knows the patient. Neither recommendation can be made by the prospective guardian.

3.15 The criteria for guardianship application and medical recommendation are set out in Article 18(2) and (3) (a) of the Order. The medical criteria differ from those for application for admission to hospital for assessment in that the patient must be diagnosed as suffering from "mental illness or **severe** mental handicap".

The application

3.16 A guardianship application is made to the responsible Board. The application may name the responsible Board or any other willing person including the applicant as prospective guardian (Article 18(5) and (6)). The application is made on Form 13 by the nearest relative or on Form 14 by the ASW. The medical recommendations may be given jointly on Form 15 or separately on Form 16. The ASW' s recommendation is given on Form 17 . As the application must be founded on these recommendations Form 15 (or 2 separate Forms 16) and Form 17 must be completed before Form 13 or Form 14. It follows that the completed recommendation forms should be given to the applicant. The correct forms must be used and must be properly completed, if the Board is to be able to grant the application.

3.17 Where a patient is received into guardianship on the application of an ASW who has not consulted the patient's nearest relative, the ASW must inform the nearest relative as soon as is practicable (Article 19(6)).

Notifications to Mental Health Commission

3.18 Where a patient is received into guardianship the Board should forward a copy of the application and the recommendations on which it is founded to the Mental Health Commission (Article 22(5)) .

Rectification of guardianship applications and recommendations

3.19 Article 21 of the Order provides that a guardianship application or any recommendation on which it is founded, discovered within 14 days of acceptance by the Board to be incorrect or defective, may be corrected within the 14 days. Where a recommendation is deemed insufficient to warrant reception into guardianship the applicant should be informed. Article 21 provides that in such circumstances the recommendation shall be disregarded but that the application shall be deemed to be sufficient if a fresh recommendation complying with the provisions of the Order is furnished to the Board. The Mental Health Commission must be informed of any alterations made and sent a copy of any substitution furnished.

Role of the Board

3.20 The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 govern the exercise by guardians of their powers under the Order and impose duties on guardians and on the Boards in the interests of patients. In pursuance of its powers and duties under the Order and the Regulations each Board should prepare and publish a statement setting out its arrangements for:

- receiving, considering and scrutinising applications for guardianship. Such arrangements should ensure that applications are adequately, but **speedily**, considered;

- ensuring the suitability of any proposed private guardian (ie a guardian other than a Board);

- ensuring that private guardians understand and carry out their statutory powers and duties, including those prescribed in Regulation 4 requiring compliance with Board directions and notification to the Board of particulars relating to the patient;

- ensuring that each patient under guardianship receives, both orally and in writing as soon as practicable and commensurate with his understanding, the information to which he is entitled under Article 27 of the Order, including notification of the provision of the Order under which he is subject to guardianship and the effect of that provision; his rights to apply to the Mental Health Review Tribunal (the patient should also be advised that a named officer of the Board will give any necessary assistance to make such an application); and the effects of the provisions of the Order relating to discharge from guardianship and his right to make representations to the Commission (paragraphs 92 to 97 of the Guide);

- ensuring that each patient's nearest relative is furnished with a statement of his rights and powers under the Order and, subject to the patient's wishes, a copy of any written information given to the patient (paragraph 96 of the Guide);

- monitoring the progress of the guardianship including steps to be taken to fulfil the Board's statutory obligations in relation to guardianship. These statutory obligations include those prescribed in Regulation 5 relating to supervision of private guardians and to visits to patients under guardianship;

- maintaining detailed records relating to patients subject to guardianship;

- reviewing guardianship towards the end of each period;

- complying with the provisions of Article 24 of the Order for discharging patients from guardianship (guardianship should not simply be allowed to lapse when no longer appropriate);

- transferring guardianship from or to the Board, or from one person to another, in accordance with Articles 25 and 28 of the Order. Circumstances in which this would be appropriate are described in paragraphs 86 to 89, 99 and 102 to 105 of the Guide;

- notifying the Mental Health Commission of events prescribed in Regulation 5.

Where the Board is named, and appointed, as guardian it should nominate a professional officer to carry out its duties as guardian.

Powers of the guardian

3.21 Article 22 of the Order gives the guardian power -

> "to require the patient to reside at a place specified by the Board or person named as guardian". The patient may be taken to the specified place in furtherance of this requirement if he willingly complies or offers no resistance. However, this power does not provide the legal authority to detain a patient physically in such a place, nor does it authorise the removal of a patient against his will. If the patient is absent without leave from the specified place, he may be returned to it within 28 days by those authorised to do so under Article 29(2) and (3) of the Order;

> "to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training". If the patient refuses to attend the guardian is not authorised to use force to secure such attendance, nor does the Order enable medical treatment to be administered in the absence of the patient's consent;
>
> "to require access to the patient to be given at any place where the patient is residing to any medical practitioner, approved social worker or other person so specified". A refusal without reasonable cause to permit an authorised person to have access to the patient is an offence under Article 125 of the Order. Neither the guardian nor any authorised person can use force to secure entry".

If the patient consistently resists the exercise of the guardian's powers, it can be concluded that guardianship is not the most appropriate form of care for that person and guardianship should be discharged.

3.22 Guardianship does not restrict the patient's access to hospital services on a voluntary basis. Furthermore, guardianship can remain in force if the patient is admitted to hospital for assessment under Article 4 of the Order (paragraph 106 of the Guide). However, it ceases to have effect if the patient is detained for treatment under Article 12 of the Order. If guardianship is considered to be appropriate when the patient is discharged following detention for treatment, a fresh application for guardianship is required.

3.23 It is possible for a person subject to guardianship under Part II of the Order to be transferred into the guardianship of another Board or person approved by such Board (Article 28).

3.24 Where an adult is assessed as requiring residential care but due to mental incapacity is unable to make a decision as to whether he wishes to be placed in residential care, those who are responsible for his care should consider the applicability and appropriateness of guardianship for providing a framework within which decisions about his current and future care can be planned. Guardianship does not, however, confer powers to compel the admission of an unwilling person into residential care.

Alternatives to guardianship application

3.25 Before making a recommendation or guardianship application the professionals involved should consider all reasonable alternatives for providing for the patient's care and protection. The practical guidance in paragraphs 2.27 and 2.28 of the Code is equally applicable when guardianship is being contemplated.

4. PATIENTS CONCERNED IN CRIMINAL PROCEEDINGS OR UNDER SENTENCE

Introduction

4.1 Part III of the Order provides for the admission to hospital or placement under guardianship of persons concerned in criminal proceedings or under sentence. The Department's role and responsibilities under the provisions of Part III have been delegated to Boards by the Functions of Health and Social Services Boards (No. 1) Direction (Northern Ireland) 1973, as amended by the Functions of Health and Social Services Boards (No. 1) Direction (Northern Ireland) 1986.

4.2 People who are mentally disordered are particularly vulnerable when in custody. All professional staff should take this into account in dealing with accused or convicted prisoners, not forgetting the possibility of self-injury or suicide.

4.3 Those subject to criminal proceedings are entitled to any necessary psychiatric assessment and treatment. Although psychiatric treatment is available to persons in prison custody, there are limitations to the treatment which can be provided in prison, and a prison hospital or a prison psychiatric unit is not a hospital as defined in the Order.

4.4 Part III of the Order provides that in certain circumstances an accused person may, by order of a Court, be admitted to hospital on grounds of mental illness or severe mental impairment or placed under guardianship on grounds of mental illness or severe mental handicap. Part III also provides that in certain circumstances a person convicted of an offence, or on remand, may by direction of the Secretary of State for Northern Ireland be admitted to hospital on grounds of mental illness or severe mental impairment.

Hospital admissions ordered by a Court

4.5 A Court may order a person's admission to hospital under the following Articles of the Order:

i. **Article 42 - Remand for report on accused's mental condition.**

The Crown Court or a Magistrates' Court may remand to hospital a person, who has been accused of an offence, for a report on his mental condition. Before exercising the powers in Article 42 the Court must be satisfied that there is reason to suspect mental illness or severe mental impairment. Oral evidence by a Part II doctor is required. The remanded person must be admitted to hospital within 7 days of the date of the remand. Anyone so remanded has the status of a patient compulsorily detained in hospital, except that the right to give treatment without consent conveyed in Article 69 does not apply. He may be kept in hospital for up to 28 days, and thereafter may be further remanded by the Court for similar periods up to a maximum of 12 weeks.

ii. **Article 43 - Remand for treatment.**

The Crown Court may remand an accused person to hospital for treatment. Before exercising the powers in Article 43 the Court must be satisfied that the accused person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II doctor, and oral or written evidence by one other medical practitioner, is required. The remanded person must be admitted to hospital within 7 days of the date of the remand. Anyone so remanded has the status of a detained patient. He may be kept in hospital for up to 28 days, and thereafter may be further remanded by the Court for similar periods up to a maximum of 12 weeks.

iii. **Articles 44 and 47 - Hospital order and restriction order.**

The Crown Court or a Magistrates' Court may (by a hospital order) order the hospital admission of a person convicted of an imprisonable offence (Article 44(1)). A Magistrates' Court may also make a hospital order in respect of an accused person without conviction if it is satisfied that he committed the act of which he is accused (Article 44(4)). Either Court may in addition make an order restricting discharge from hospital (Article 47), either for a specified period or without limit of time. Before exercising the powers in Articles 44 and 47 the Court must be satisfied that the convicted or accused person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II doctor, and written or oral evidence by another medical practitioner, are required. The subject of a hospital order must be admitted to hospital within 28 days of the date of the order. The subject of a hospital order has the status of a detained patient. If there is a restriction order, the Secretary of State will exercise authority, through the Northern Ireland Office, over the patient's discharge or leave of absence from hospital and will require periodic reports on the patient from the RMO.

iv. Article 45 - Interim hospital order.

The Crown Court or a Magistrates' Court may (by an interim hospital order) order the hospital admission of a person convicted of an imprisonable offence, if it has reason to suppose but is not certain at the time that a hospital order under Article 44 is justified. Before exercising the power in Article 45 the Court must be satisfied that the convicted person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II doctor, and oral or written evidence by another medical practitioner, is required. The subject of an interim order must be admitted to hospital within 28 days of the date of the order. The effect of an interim order is similar to that of a hospital order, except that the Court specifies its duration, which must not exceed 12 weeks. The Court may renew an interim order on expiry for periods of up to 28 days, but the maximum period of an interim hospital order (with renewals) must not exceed 6 months. It may be superseded by a hospital order made under Article 44.

v. Article 49 - Unfitness to be tried.

Where the Crown Court decides that an accused person is unfit to be tried it will order that person to be admitted to hospital. The question of fitness to be tried is decided by a jury, or a judge in the case of a Diplock Court, and there is no specific requirement in the Order for medical evidence. Usually the Court will wish to hear medical evidence. Although there is no right under Article 49 for a Board to make representations to the Court concerning such cases, the appropriate Board should be prepared to offer advice to the Court if required. The subject of such an order must be admitted to hospital within 28 days of the date of the order. The effect of such an order is the same as that of a hospital order (Article 44) together with a restriction order made without limitation of time (Article 47).

vi. **Article 50 - Not guilty on the ground of insanity.**

Where the Crown Court finds that a person committed the offence with which he has been charged but was an insane person at the time, the Court will order his admission to hospital. Article 50 requires the Court to be given "evidence ..... that the person charged was an insane person at the time the offence was committed". It does not specify the nature of that evidence, but in practice the evidence will normally be given by at least one psychiatrist. Although there is no right under Article 50 for a Board to make representations to the Court concerning such cases, the appropriate Board should be prepared to offer advice to the Court if required. The subject of such an order must be admitted to hospital within 28 days of the date of the order. The effect of such an order is the same as that of a hospital order (Article 44) with a restriction order made without limit of time (Article 47).

Role of the responsible Board

4.6 In all cases, the decision as to whether the person in court should be admitted to hospital lies solely with the Court. However, a Court cannot remand a person to hospital for assessment or treatment, nor make a hospital order or interim hospital order, unless the Board which will be responsible for implementing the order has been given an opportunity to make representations to the Court in accordance with Articles 42(4), 43(3), 44(5) and 45(3) of the Order: the Department's statutory role in making representations has been delegated to the Boards, as explained in paragraph 4.1 of the Code. No similar opportunity is provided by the Order in respect of orders made under Articles 49 and 50 though the Court may invite the Board to make representations and Boards should, therefore, always be prepared for this eventuality.

4.7 Boards are responsible for securing admission when this is ordered by a Court. By availing itself of the opportunity to make representations to the Court the Board should be able to keep itself informed of what is happening and to satisfy the Court that proper arrangements can and will be made for the accused person's admission and care. Each Board should establish standard arrangements and procedures for making representations to a Court.

Boards' Designated Officers

4.8 Each Area General Manager should designate an officer (referred to hereafter as the Designated Officer) to take responsibility for making the Board's representations in Court and advance arrangements for admission (paragraphs 4.16 to 4.21 and 4.24 of the Code), and, if admission is ordered, for ensuring that the admission is properly effected within the time available. In performing these duties the Designated Officer should co-operate with administrative staff at Area and Unit level and with professional staff including consultant psychiatrists and the Director of Public Health, all of whom should be notified of the identity of the Designated Officer and be prepared to co-operate with him in any case where admission by order of a Court is a possibility. The Designated Officer's identity should also be given to the Northern Ireland Court Service for notification to the Courts as their point of contact with the Board, to the Northern Ireland Office and to the Department.

Duties of the doctor giving medical evidence to the Court

4.9 The doctor is required, without prejudging the case, to give impartial professional evidence about the accused person's mental condition; whether that condition satisfies the criteria required in any of the Articles in Part III of the Order listed in paragraph 4.5 of the Code; and what arrangements would be appropriate for the accused person's further care. He could also be asked for advice as to how those arrangements could be put into practice.

4.10 In order to carry out these duties the doctor must be familiar with the provisions of Part III of the Order, and particularly the criteria for application of the Articles referred to in paragraph 4.5 of the Code. He must be able to make an adequate assessment of the accused person's mental state. To do this he must have access to relevant reports, including details of the accused person's previous psychiatric history and treatment, documents relating to the alleged offence and any relevant reports by other professionals such as social workers. He must have access to and examine the accused person and form an opinion on the most suitable provision for his future management.

Medical assessment of the accused person

4.11 If assessment has to be carried out in prison, the doctor giving evidence should make arrangements to obtain information about observations on the accused person's mental state while in prison and about any treatment given, and to gain access to the accused person. The approach will normally be to the Senior Medical Officer in the prison, and, if another psychiatrist has attended the accused person there, the doctor should consult him about his findings and any treatment that has been given. Before carrying out the examination the doctor should identify himself to the accused person and explain at whose request he is preparing his report.

Arrangements for the accused person's hospital care

4.12 If he concludes that hospital admission would be a proper and suitable provision for the accused person, the examining doctor, before giving his evidence to the Court, should ascertain whether admission can be arranged and the accused person given the care he needs. To that end the examining doctor should identify the hospital to which the accused person should be admitted and the consultant who will be in charge of his treatment. If the examining doctor is to be that consultant, he should consult his professional and administrative colleagues, including the Designated Officer, to ensure that they are agreed that admission would be feasible. If another consultant is to be responsible for the accused person's hospital care the examining doctor should confirm that the consultant concerned is in a position to admit the patient and arrange for his proper management. Before giving this confirmation, that consultant should consult his professional and administrative colleagues, including the Designated Officer, to ensure that they are agreed that admission would be feasible.

4.13 It is **particularly** important that nursing staff understand what is proposed so that they can make adequate preparation for the admission. If the examining doctor is to be the consultant in charge of the accused person's treatment, it would normally be good practice for him to arrange for a nursing colleague also to assess the accused person's suitability for care in the hospital identified. If another consultant is to be responsible for the accused person's hospital care, that consultant should consult his nursing colleagues before advising the examining doctor on the feasibility of managing the accused person in his unit. The Designated Officer should be kept fully informed of the professionals' decisions and his agreement obtained to their conclusions.

4.14 If the accused person appears to need facilities that are not available in Northern Ireland, the examining doctor should confirm that other satisfactory arrangements can be made. This applies where psychiatric care is needed in conditions of security which can only be provided in a special hospital in Scotland or England (paragraphs 4.27 to 4.29 of the Code).

4.15 It is particularly important, where there is a possibility that the Court may find the accused person unfit to be tried or not guilty on the grounds of insanity, that any doctor giving evidence should ensure that the consultant likely to be responsible for the accused person's care and the Board's Designated Officer are notified at the earliest possible stage.

Boards' representations in Court

4.16 In those cases where Boards must be given an opportunity to make representations, the Court will notify the Board's Designated Officer of the circumstances of the case and the date of the hearing. There should be prior understanding about which Board to notify. Usually this will be the Board for the area in which the accused person resides and will be clear from his home address. Where there is any uncertainty, the accused person should be asked where he usually lives in order to obtain a decision. The principle is that the accused person's perception of where he is resident (either currently or, failing that, most recently) is the criterion. Where an accused person cannot identify a current or recent address, the Board for the area in which the alleged crime was committed should accept responsibility. If the Court notifies the wrong Board, that Board should promptly refer the matter back to the Court for redirection and at the same time inform the appropriate Board that this is being done. Exceptionally, where admission to a hospital which is administered by another Board is proposed, the latter Board should make the representations to the Court. In such circumstances the Designated Officer of each Board should agree the way forward and explain the position to the Court.

4.17 Any notification of a case by a Court to a Board should be referred to the Board's Designated Officer. The Board's standard procedures for making representations to the Court should be put into effect by the Designated Officer and followed in any case where there is a possibility that the Court may order admission to hospital.

4.18 The Board's representative must be able to advise the Court what arrangements would be made for the accused person's admission to hospital and subsequent care should the Court decide to order admission. He may be either the Designated Officer or another officer so authorised by the Designated Officer. Where a consultant psychiatrist employed by the Board is giving evidence, that consultant may be the authorised officer. This would, however, probably not be a suitable arrangement where he was giving evidence to the effect that hospital admission would not be appropriate. In such circumstances, the Designated Officer should attend in person or send an authorised deputy. In any event the Designated Officer should, before the date of the hearing, give the name of the Board's representative to the Clerk of the Court.

4.19 If a consultant psychiatrist acts as the Board's representative he **must** obtain the Designated Officer's assurance that the Board endorses his proposals. Likewise, if the Designated Officer or another officer acts in this capacity, he **must** ensure that he has the agreement of the professional staff concerned to any arrangements in regard to which he may express the Board's acceptance. In particular he must consult with the psychiatrist giving evidence to ensure that the representations made on the Board's behalf are compatible with the medical proposals for the accused person's further management.

Arrangements for Admission

4.20 An order by a Court for admission must be implemented within a fixed time: 7 days for admission under Article 42 or 43; 28 days under Article 44, 45, 49 or 50.

4.21 The Court has no power to designate the hospital to which the patient is to be admitted. That is a matter for the Board after an order is made, though normally it will have been determined before the order is made. The Designated Officer in each Board will be responsible for ensuring that arrangements for the patient's reception are made by the appropriate professional and administrative staff. It is essential that these are made in advance so that if admission is ordered the patient can be admitted within the appropriate fixed time.

Admissions directed by the Secretary of State

4.22 The Secretary of State may direct that a person in custody be admitted to hospital under the following Articles of the Order. In practice admission will be directed by the Northern Ireland Office exercising the powers of the Secretary of State.

i. **Articles 53 and 54 - Transfer directions.**

The Secretary of State may direct the hospital admission of a person serving a sentence of imprisonment (Article 53) or of certain other persons who are in custody, most commonly those on remand (Article 54). The Secretary of State may also, and in some cases must, direct that the person removed to hospital should be subject to restrictions (Article 55). Written reports by a Part II doctor and by one other medical practitioner are required. These must specify that the person to be transferred is suffering from mental illness or severe mental impairment and that the nature or degree of the disorder is such to warrant his detention in hospital for medical treatment. In practice these reports are commonly made by a consultant psychiatrist in attendance at the prison and by a prison medical officer. The subject of a transfer direction must be admitted to hospital within 14 days of the date of the direction. The subject of a transfer direction has the same status as a person who is subject to a hospital order, and a restriction direction made by the Secretary of State has the same effect as a restriction order made by a Court under Article 47 (paragraph 4.5 iii of the Code).

ii. **Article 52 - Persons ordered to be kept in custody during Her Majesty's pleasure.**

This Article is seldom used in practice. It applies to servicemen whom Courts Martial have found unfit to plead or not guilty by reason of insanity. Medical evidence as to the serviceman's mental state is heard by the Court Martial, and no further medical evidence is required when the powers in Article 52 are being exercised. The subject of a direction under this Article has the same status as a person who is subject to a hospital order together with a restriction order without limitation of time made by a Court under Articles 44 and 47 (paragraph 4.5 iii of the Code).

4.23 The Order makes no provision for Board representation where the Secretary of State is considering hospital admission. In practice the Northern Ireland Office will ensure that the appropriate Board is adequately consulted and that professional staff of the Board are given an opportunity to assess the patient. The guidance in paragraphs 4.6 to 4.21 of the Code on examining the patient, agreeing a course of action and making representations should be applied as appropriate.

Admission

4.24 Once a Part III admission has been ordered, the Board should receive immediate formal notification. Court orders are given by the Court to the person directed to convey the patient to the hospital, and a copy will be sent to the Board's Designated Officer. A transfer direction is sent by the Northern Ireland Office to the governor of the prison where the person to whom the direction applies is being held. The Northern Ireland Office will at the same time send a copy of the direction to the Board's Designated Officer. If received by any other Board employee the orders and transfer directions should immediately be brought to the attention of the Designated Officer. The latter should ensure that arrangements for admission are finalised promptly so that the patient can be conveyed to hospital within the specified time.

Conveyance to hospital

4.25 A Court order or transfer direction is sufficient authority for the patient to be conveyed to hospital. Most Part III admissions are of persons in custody. In these circumstances the Board's Designated Officer should ensure that consultations take place between staff in the prison and the receiving hospital at an early date on the timing of the move and on any other practical details. In the unlikely event of an ASW being directed by the Court to convey the patient to hospital, the ASW should follow the guidance in paragraphs 2.40 to 2.49 of the Code, as appropriate.

4.26 A Court order or transfer direction is also the authority to detain the patient. Boards should ensure that the original order or direction is received. This should be delivered with the patient to the receiving hospital.

Admissions to special hospitals

4.27 A patient ordered by a Court or ordered by the Secretary of State to be detained in hospital may require treatment in conditions of security which are not available in Northern Ireland. The special hospitals in Great Britain provide psychiatric care in conditions of extra security, and patients from Northern Ireland may be admitted to these hospitals, provided the relevant authority in Great Britain agrees to their admission.

4.28 A Northern Ireland Court can only order admission to a hospital within its jurisdiction. If admission to a special hospital is necessary, the Court will order the appropriate Board to admit the patient to hospital, and that Board must seek authority, from the Department of Health and Social Services or the Northern Ireland Office, for his transfer to a special hospital. The necessary arrangements for the move must, therefore, be put in hand before representations are made to the Court. It is of vital importance in such cases that the Court should be advised that the patient cannot be accommodated in a Northern Ireland hospital, that transfer to a special hospital will be required, and of the prospects and likely timing of such a transfer.

4.29 The arrangements for the removal of a patient to a special hospital in Great Britain are complex as several different agencies are involved. Before a special hospital authority agrees to the admission of a patient from Northern Ireland, it is usual for a consultant from the special hospital to visit and assess the patient. Formal authorisation for the patient's removal to Great Britain must be obtained from the Department of Health and Social Services or, if a restriction order is made, the Northern Ireland Office. The original Court order or transfer direction and the original authorisation for removal (which will be sent to the Board's Designated Officer by the Department or the Northern Ireland Office) must accompany the patient, when he is transferred. Specific guidance has been issued to psychiatrists on the transfer of patients to special hospitals.

Admissions from special hospitals

4.30 The special hospitals accept patients from Northern Ireland on the understanding that these patients will return to Northern Ireland when they no longer require to be managed in conditions of high security. Normally such a patient will return to the hospital from which he was originally transferred, or to which he was originally committed pursuant to an order of a Northern Ireland Court or the Secretary of State. Authority for the patient's transfer from the special hospital is given by the Home Secretary or by the Secretary of State for Scotland. Before it is given, the relevant authority in Great Britain will seek formal confirmation from the Department, or the Northern Ireland Office, that arrangements have been made for the patient's admission to a Northern Ireland hospital.

4.31 The first approach is usually made by the responsible consultant in the special hospital to the Northern Ireland consultant who will be the RMO on the patient's return. The latter in turn has the responsibility for ensuring that the patient can be suitably managed under his care, for advising his Board that this is so, and for agreeing the timing and details of the transfer. That requires, firstly, an assessment of the patient's condition and of the requirements for his management in hospital. It is common practice, though not an absolute requirement, for an assessment visit to be made to the special hospital by the Northern Ireland consultant concerned, and, when this is done, a nursing colleague should accompany the visiting consultant. On return the consultant should confirm his assessment in writing to the special hospital consultant and inform the Board of his conclusions. It is helpful for his report to be copied to the Director of Public Health and to the Department's medical adviser on mental health. If the consultant is reporting to the Board that the patient can be properly managed under his care, he should confirm that his nursing colleagues are in agreement with that view.

4.32 When a detained patient is transferred to Northern Ireland the receiving hospital must ensure that the original Court order or transfer direction and the original authorisation for removal to Northern Ireland are received.

Guardianship ordered by a Court

4.33 As a potentially useful alternative to hospital orders, Courts are empowered (Article 44) to make guardianship orders where the prescribed criteria, which are similar to those applying to a hospital order, are met and the Court, having regard to all the circumstances, considers reception into the guardianship of the Board, or of any other person, appropriate. Guardianship orders may be particularly suitable in helping to meet the needs of some offenders who could benefit from occupation, training and education in the community. The Court's decision will be based on oral evidence by a Part II doctor, written or oral evidence from another medical practitioner and written or oral evidence from an ASW.

4.34 Before making such an order the Court has to be satisfied that the Board or other person is willing to act as guardian. The Board will need to be satisfied with the arrangements, and, in considering the appropriateness of guardianship, it will be guided by the same principles as apply under Part II of the Order. Similarly the powers and duties conferred on the Board or private guardian and the provisions as to duration, renewal and discharge are those which apply to Part II guardianship applications except that the power to discharge is not available to the nearest relative.

5. TREATMENT AND CARE

Introduction

5.1 The guidance in this chapter deals with the treatment and care, under medical supervision, of all mentally disordered patients. Specific guidance is given on particular aspects of treatment and care for patients in hospital. Where the guidance applies only to patients detained under the provisions of the Order, that is made clear in the text.

5.2 **As defined in Article 2(2) of the Order medical treatment "includes nursing, and also includes care and training under medical supervision".** This acknowledges that modern psychiatric care is a team activity involving several disciplines, including psychiatry, clinical psychology, nursing, occupational therapy and social work. The team approach need not undermine the professional independence of the various team members who will have their own professional codes of practice. However, it is necessary to reconcile the need for team involvement in patient care with continuing medical responsibility for the patient's clinical management. That responsibility is recognised in the term "responsible medical officer" (RMO), the doctor, appointed for the purposes of Part II of the Order by the Mental Health Commission, who is in charge of the assessment or treatment of the patient.

Principles of treatment

5.3 All treatment should:

- **be primarily for the benefit of the patient.** Where possible the patient's willing participation should be obtained. The main aims should be, so far as is possible, to improve health and reduce handicap including social handicap;

- **protect the safety of the patient and other people.** In the course of treatment or in the interests of safety, restriction of liberty may be necessary but should never be used as a punishment and should only be used as a last resort to the minimum extent necessary;

- **respect the patient's dignity and rights.** No treatment should deprive a patient of food, shelter, water, warmth, a comfortable environment or confidentiality;

- **respect the patient's rights to privacy and freedom of choice.** Forms of treatment, such as psychological treatment techniques, group therapy and behaviour modification programmes, which may intrude on the patient's normal right to privacy and freedom of action, should be carefully planned and conducted by experienced and appropriately trained staff and should be kept under review;

- **respect the patient's rights to information.** Patients are entitled to information and an explanation about their condition, any treatment which is proposed, and their rights. This information should be conveyed at a suitable time and in a form which takes account of the patient's capacity to understand.

These principles apply to the treatment of all mentally disordered patients whether or not they are in hospital. In hospital practice they apply to both voluntary and detained patients including those admitted under Part III of the Order.

Treatment Plans

5.4 Treatment plans are essential in order to observe the principles which are set out above and to ensure that the different elements of patient care are co-ordinated as parts of an effective programme. Detailed programmes of treatment and care by members of individual disciplines should be developed in accordance with the overall treatment plan and recorded in their respective notes.

5.5 In hospital, consultants should initiate the formulation of treatment plans which should be prepared in consultation with their professional colleagues. The plan should be recorded in the patient's clinical notes. It should include a description of the immediate and long-term goals for the patient with a clear indication of the treatments proposed and the methods of treatment. The patient's progress and possible changes to the plan should be reviewed at regular intervals. Wherever possible the plan should be discussed with the patient who should be encouraged to say whether or not he agrees with the plan and to make his own contribution. In many cases it will be important to discuss the plan with the patient's close relatives, and the patient's consent to this being done must be obtained whenever possible in keeping with the professionals' duty of confidentiality to their patients, and their respective codes of ethics.

5.6 In the community, the doctor in charge of the patient's treatment should initiate the formulation of the treatment plan along similar lines. Where a patient is being treated in the community by a consultant that consultant should normally take the lead. In any event, in such cases, the respective roles and responsibilities of the consultant and the patient's GP should be clearly understood and agreed.

5.7 Treatment takes many forms. Some, such as psychological treatment techniques, can be intrusive and interfere with the patient's rights. Such techniques should only be used when authorised, as part of the patient's agreed treatment plan, by the RMO following a full discussion with the professional staff concerned with the patient. They should not be used without the patient's consent except in carefully justified circumstances. If consent is not or cannot be given the RMO should seek the advice of a suitably qualified person who is not a member of the clinical team responsible for the patient. This would normally be a clinical psychologist experienced in the use of the intended techniques although some members of other professions may have suitable expertise and experience. The RMO may delegate appropriate members of staff to use such treatments. Where he does so, it is his responsibility to ensure that they are carried out only by staff competent to do so. Professional line managers must ensure that members of staff have received relevant training and that they know who to turn to for advice when necessary.

Consent to treatment

5.8 The common law, as it relates to consent to treatment, applies to all patients whether voluntary or detained, except where statute (for example Part IV of the Order) specifically overrides it. Consent is the voluntary and continuing permission of the patient for a particular form of treatment to be given, based on an adequate knowledge of its nature, purpose, and likely effects. The assessment of the patient's ability to make a decision about his own treatment and the nature and extent of the information to be given in seeking consent are matters for clinical judgment, guided by current professional practice and subject to legal requirements. Permission given under duress is not "consent". Being mentally disordered does not preclude the ability to give consent. The treatment proposed should be explained to the patient as fully as possible, in terms appropriate to his ability to understand. An explanation should be given of the desired effect and outcome of the treatment as well as of the risk of developing significant and, in particular, disabling side-effects. The explanation may also include an account of the likely progress of the illness if the treatment is not given. It should be explained to the patient that he has a right to withdraw consent at any time.

5.9 Part IV of the Order imposes conditions on giving treatment with or without consent. Article 63 of the Order provides that, for specified forms of treatment, consent **and** a second opinion are required and applies to **all** patients (paragraphs 5.10 and 5.11 of the Code). The provision of treatment to certain **detained** patients is dealt with in a number of Articles which need to be read together. Article 64 provides that, for the treatments specified, consent **or** a second opinion is required (paragraphs 5.12 and 5.13), and Article 69 provides that treatment may be given in certain cases without either the patient's consent or a second opinion. Article 62 provides that the powers in Article 64 and 69 of the Order to treat detained patients without consent do not apply to those liable to be detained by virtue of Article 7(2), 7(3), 42, 129 or 130, liable to be detained by virtue of directions under Article 46(4), or conditionally discharged under Article 48(2), 78 or 79. In circumstances where there is no specific legislative provision the common law applies. Even when consent is not legally required, every attempt should be made to explain what is proposed and to obtain the patient's agreement.

Treatment requiring consent and a second opinion

5.10 Under **Article 63** of the Order psychosurgery (any surgical operation for destroying the functioning of brain tissue) requires consent **and** a second opinion. As specified by Regulation 6 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986, surgical implantation of hormones for the purposes of reducing male sexual drive also requires consent **and** a second opinion (paragraph 181 of the Guide).

5.11 The consent must be validated by a Part IV doctor (not being the RMO), and by 2 other persons (not being medical practitioners) appointed for the purpose by the Mental Health Commission (Article 63(2)(a) and paragraph 182 of the Guide). If they agree the consent is valid, they should complete Part I of Form 21. The Part IV doctor must also consider whether the proposed treatment is appropriate (paragraphs 183 and 184 of the Guide) and, if he is satisfied that it is, complete Part II of Form 21. The completed forms must be sent to the Mental Health Commission.

Treatment requiring consent or a second opinion

5.12 Article 64 of the Order applies to detained patients other than those excepted by Article 62 (paragraph 5.9 of the Code). Under Article 64 the administration of medicine 3 months or more after its first administration during any continuing period of liability for detention requires consent **or** a second opinion. As specified by Regulation 6 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 electro-convulsive therapy also requires consent **or** a second opinion. In the case of detained patients to whom Article 64 does not apply consent must be obtained.

5.13 In the case of consent given by a detained patient to which Article 64 applies, the consent must be validated by the RMO or a Part IV doctor (paragraph 187 of the Guide). Form 22 is used for this purpose. Where a valid consent is not or cannot be given, a second opinion must be obtained: in the case of electro-convulsive therapy from a Part IV doctor; and for the administration of medicine from either a Part II or Part IV doctor (paragraph 187 of the Guide). This is recorded on Form 23. The completed forms must be sent to the Mental Health Commission.

Treatment without consent

5.14 Article 69 of the Order applies to detained patients other than those excepted by Article 62 (paragraph 5.9 of the Code). Under Article 69 consent is not required for medical treatment (other than treatment falling within Articles 63 or 64) given to those patients for the mental disorder from which they are suffering, provided the treatment is given by or under the direction of the RMO. The exclusion of patients remanded under Article 42 should be noted. If a Court remands an accused person to hospital for assessment under that Article, no legal right to treat without consent is thereby conferred, and this will be relevant if a therapeutic trial of drugs is contemplated as part of the assessment process. In that case, unless the patient is willing to accept treatment, remand for treatment under Article 43 would be required.

5.15 For patients to whom Article 69 does not apply, including all patients not subject to detention, the legal position concerning treatment without consent derives from common law (which, of course, does not apply only or specifically to patients with mental disorder or treatment for mental disorder). Generally speaking consent is a legal pre-requisite of treatment except when the patient is incapable of giving consent because he is:

- a child with insufficient understanding and intelligence, in which case a parent or person having parental authority may consent;

- an adult suffering from mental handicap to a degree that renders him incapable of understanding;

- unconscious and in urgent need of treatment to preserve life, health or well-being (unless there is unequivocal and reliable evidence that the patient did not want that treatment) provided that the treatment has to be administered while the patient is still unconscious;

- suffering from a mental disorder leading to behaviour which is an immediate serious danger to himself or others, and the treatment is the minimum necessary to avert that danger but the provisions of the Order cannot be immediately invoked; or

- otherwise incapable and in need of medical care in circumstances in which he has not declared his unwillingness to be treated prior to the onset of the incapacitating condition.

5.16 In F v West Berkshire Health Authority and another (Mental Health Act Commission intervening) ([1989] 2 ALL ER 545), the House of Lords held that, in all cases involving the treatment of a person incapable of giving consent, the treatment must be "in the patient's best interest". It must be:

- necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health;

- in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question.

The standard of care required of the doctor concerned in all cases is that laid down in Bolam v Friern Hospital Management Committee ([1957] 1 WLR 582), namely, that he must act in accordance with a responsible and competent body of relevant professional opinion. Agreement of the nearest relative is desirable but not essential.

5.17 If repeated emergency drug treatment for mental disorder has to be given to a patient, without his consent, the responsible doctor should consider whether the patient's condition and the circumstances of the case might require that patient to be detained under the provisions of the Order.

5.18 In the above noted case, F v West Berkshire Health Authority and another (Mental Health Act Commission intervening), the House of Lords held that, as a matter of practice, sterilisation should not be performed on an adult who lacks the capacity to give consent without first obtaining the opinion of the High Court that the operation is, in the circumstances, in the best interests of the persons concerned. The Courts in Northern Ireland may apply that decision.

Consent by children and young persons under the age of 18 years

5.19 The guidance on admission to hospital of children and young persons under the age of 18 years applies also to the treatment of such patients (see paragraphs 2.31 to 2.36 of the Code) . When treatment is being planned the following questions (in addition to those listed in paragraph 2.34) need to be asked:

- where a parent refuses consent to treatment, how sound are the reasons and on what grounds are they made?

- how necessary is treatment for the child?

- how feasible would be treatment of a child under the age of 16 years living at home if there was no parental consent and no statutory orders?

5.20 The following guidance applies to young people who are not detained under the Act:

a. **Under 16**. Children under the age of 16 years who have 'sufficient understanding and intelligence' can take decisions about their own medical treatment in the same way as adults. Otherwise the permission of parents or guardians must be sought (save in emergencies when only the treatment necessary to end the emergency should be given). If the parents or guardians do not consent to treatment, consideration should be given to both the use of child care legislation and the Order before coming to a final conclusion as to what action should be taken. In complex cases wardship may be the preferable course to take for as long as wardship continues to exist.

b. The same principles concerning consent apply in respect of children under the age of 16 years in the care of a Board. The legal authority to authorise any treatment is vested in the Board where a child in care, by virtue of a Court order, does not have 'sufficient understanding and intelligence' to take his own treatment decisions. The Board's legal obligation to consult the child's parents depends upon how the child was brought into care. Wherever possible, his parents should be consulted. Where a child is a ward of court, the consent of the High Court must be sought. In an emergency consent may be obtained retrospectively (but this should be regarded as wholly exceptional).

c. **Young people aged 16 and 17**. Young people in this age group who have the capacity to make their own treatment decisions can do so in the same way as adults (Section 4 of the Age of Majority Act (Northern Ireland) 1969). Where such a young person does not have this capacity, the authorisation of either parent, guardian or care authority (whichever has the lawful authority in relation to the particular young person) must be obtained. The consent of the High Court must be obtained in the case of a ward of court.

5.21 The fact that a child or young person has been admitted as a voluntary patient by his parents or guardians should not lead professionals to assume that they have consented to any treatment regarded as 'necessary'. Consent should be sought for each aspect of the child's care and treatment as it arises. 'Blanket' consent forms must not be used.

Withdrawal of consent

5.22 A patient may withdraw consent at any time and where he does so the common law applies except where statute specifically overrides it. Article 66 of the Order provides that a patient may withdraw consent given by him in respect of treatment specifically requiring his consent under Article 63 or 64 of the Order before completion of the treatment. In such circumstances treatment must cease immediately:

- unless the RMO considers that its discontinuance would cause serious suffering to the patient (Article 68(2)); or

- until a second medical opinion is obtained in the case of a detained patient to whom Article 64 applies (paragraph 5.9 of the Code).

The patient should be kept informed of the intended course of action.

Urgent treatment

5.23 Urgent treatment may be given without the patient's consent if the circumstances make it impractical to obtain his consent and imperative to give treatment. In most cases the common law will apply (paragraph 5.15 of the Code). Article 68 of the Order makes provision for giving treatment covered by Articles 63 and 64 in cases of urgent necessity (paragraphs 193 and 194 of the Guide). Where a patient is given treatment under Article 68 the Mental Health Commission must be notified immediately by the RMO (Article 68(4) and paragraph 196 of the Guide).

Consent by relatives

5.24 Except for consent by a parent of an immature child (paragraphs 5.15 to 5.20 of the Code), consent by a patient's relative is not an acceptable legal alternative to consent by the patient. The fact that a relative may agree to treatment being given to the patient does not alter the requirements of the common law or of the Order.

Treatment for physical illness

5.25 It should be noted that the principles of common law apply not only to treatment for mental disorder but to medical or surgical treatment which may be required for mentally disordered patients.

Review of treatment

5.26 Where a patient is given treatment under Article 63 or 64, the RMO must report, in accordance with the provisions of Article 67 of the Order, to the Mental Health Commission on the treatment and the patient's condition (paragraphs 190 and 191 of the Guide). Article 67(3) of the Order provides that the Commission may at any time give notice to the RMO that a certificate authorising treatment under Article 63 or 64 shall no longer apply (paragraph 192 of the Guide). Thereafter the treatment may be continued only if the provisions of the appropriate Article have been complied with once again or, pending such compliance, if the RMO considers that the abrupt discontinuance of the treatment would cause serious suffering to the patient (Article 68(2)).

Conduct presenting particular problems of management

5.27 Hospital patients, both voluntary and detained, and patients outside hospital, may behave in such a way as to disturb, or be a risk to, others around them or those charged with their care. They may also be a danger to themselves. The guidance in the following paragraphs has general application but certain paragraphs apply specifically to hospital practice.

5.28 Behaviour giving rise to problems of management of patients can include:

- refusal to participate in treatment programmes;
- prolonged verbal abuse and threatening behaviour;
- destructive behaviour;
- self injurious behaviour;
- physical attack on others.

Causes of behaviour problems

5.29 Possible causes of behaviour problems include:

- type of mental disorder;
- boredom and lack of environmental stimulation;
- too much stimulation, noise and general disruption;
- overcrowding;
- an unsuitable mix of patients;
- antagonism, aggression or provocation on the part of others;
- low staffing levels;
- inappropriate attitudes on the part of staff.

General preventive measures

5.30 In addition to preventive measures documented in the individual care plan, much can be done to prevent behaviour problems by ensuring environmental factors giving rise to such problems are as far as possible eliminated and staff are adequately trained and supported. General measures which can be taken might include:

- monitoring the mix of patients;
- developing primary nursing (giving each patient an identified nurse who is responsible and accountable for his nursing care);
- giving each patient a defined personal space and secure locker for the safe keeping of possessions;
- organising the environment to provide quiet rooms, recreation rooms and visitors' rooms;
- consistent conformity to the individual care programme;
- keeping patients fully informed of what is happening and why;
- allowing patients opportunities to express their thoughts and feelings;
- ensuring that patients' complaints are dealt with quickly and fairly;
- ensuring, where appropriate, continuing contact with the community through access to a telephone and visitors;
- providing structured activities;
- encouraging energetic activities for younger patients.

Dealing with violence

5.31 Although much violence is preventable, it is inevitable that violent incidents will occur from time to time, and staff should be adequately prepared to deal with them. It is emphasised, however, that only the minimum degree of restraint which is necessary in the circumstances should be employed to contain the incident.

Restraint

5.32 Restraint may take many forms and may vary in degree from mild instruction to seclusion. The essence of restraint is to contain or limit a patient's freedom. The most common reasons for restraint are:

- physical assault;
- destructive behaviour;
- non-compliance with treatment;
- self harm or risk of physical injury by accident;
- extreme and prolonged over-activity likely to lead to physical exhaustion.

The basic principles which should underlie any methods which are aimed at reducing and eliminating unwanted behaviour are:

- by intervention, to reduce such behaviour;
- to review regularly any intervention as part of the patient's agreed treatment programme relating to his particular management problem.

Policy on physical restraint

5.33 Each Unit of Management should have a clear, written policy on the use of **all** forms of **physical** restraint, and, where appropriate, the recording, monitoring, reviewing and follow-up of the use of restraint. That policy should be made known to all staff. Physical restraint in the context of this guidance includes locked ward doors, time out and seclusion.

5.34 When physical restraint is used, a written report on the incident and the form of restraint used must be kept and submitted to line management.

5.35 All staff who are likely to be involved must be adequately trained in the use of the various forms of physical restraint. Appropriate training must be given by a qualified instructor.

5.36 Patients should not be deprived of appropriate day-time clothing during the day with the sole intention of restricting their freedom of movement nor should they be deprived of other aids necessary for their daily living in the absence of any danger to themselves or others, unless as part of a therapeutic programme.

5.37 Staff must try and get to know patients not only in order that the patient may gain confidence in them but also so that they can learn to recognise potential danger signs in patients and be able to diffuse the situation in time. They should have good communication skills and know when to intervene in certain potentially aggressive situations. Continuity of staffing is an important factor both in the development of professional skills and consistency in managing patients.

Procedural steps for physical restraint

5.38 In all cases where physical restraint is applied:

- assistance should be sought verbally or by call system;
- one member of the team should assume control of the incident;
- the patient should be approached where possible and encouraged to stop the behaviour, or to comply with a request;
- where possible an explanation should be given of the consequences of non compliance;
- other patients or people not involved should be asked to leave the area quietly.

5.39 Any attempt to restrain aggressive behaviour should, as far as the situation will allow, be non-physical such as verbal command or persuasion. Where non-physical methods have failed or the incident is of such significance as to warrant immediate action, physical restraint may be necessary.

Physical restraint should only be used as a last resort and never as a matter of course. It can be used in an emergency when there is the possibility that significant harm will occur if intervention is withheld.

5.40 Although the presence of a larger number of staff may avert the outbreak of violence, when actual physical restraint is imposed fewer but well briefed staff are likely to be more effective in controlling and restraining the patient.

5.41 The person or persons imposing physical restraint should:

- constantly explain the reason for action and enlist the patient's voluntary co-operation as soon as possible;
- make a visual check for weapons;
- nominate staff members to assist in control and allocate each a specific task;
- aim at restraining arms and legs to immobilise the patient simply and safely;
- avoid neck holds;
- avoid excess weight being placed on any area but particularly on the abdomen, chest or neck;
- not slap, kick or punch.

5.42 Each incident involving the use of physical restraint should be discussed, as soon as possible and preferably within 48 hours, by the professionals responsible for the patient's treatment and care. The discussion should be informal, allowing the staff involved in the incident to express their feelings and evaluate the incident. If necessary modification should be made to the patient's treatment plan.

Personal searches

5.43 Each Unit of Management should draw up policy and procedural guidance relating to searching patients and their belongings, and the recording of searches. This guidance should be checked by a legal adviser and made known to all staff who may be involved. Searches should only be carried out where there are lawful and necessary grounds for such action. The patient's consent should be obtained if possible. If it is not, the Unit General Manager or delegated senior staff should be consulted before more junior staff undertake a search. The nurse in charge of the ward should supervise staff undertaking the search.

5.44 The manner in which the search is conducted should ensure the greatest possible privacy and respect for the dignity of the patient. Only the minimum amount of force should be used, should the patient be difficult. Searches of a patient's person should only be done by a staff member of the same sex as the patient, unless urgent necessity dictates otherwise. If items belonging to the patient are removed, he should be told who has custody and responsibility for these items.

Locked ward doors on open wards

5.45 The management, security and safety of patients should, wherever practicable, be ensured by means of adequate staffing. Boards are responsible for trying to ensure that staffing is adequate to avoid the need for the practice of locking patients in wards or any other area solely for their containment.

5.46 The nurse in charge of the ward at any given time is responsible for the care and protection of the patients and staff and the maintenance of a safe environment. To maintain a safe environment he may find it necessary to lock ward doors, and there should be local detailed procedures for doing this. The nurse should:

- inform all staff of the reason why the action has been taken and how long it will last;

- inform the patient or patients whose behaviour has led to the locking of the ward door of the reason for taking such action;

- inform all other patients that they may leave on request at any time and ensure that someone is available to unlock the door;

- inform line management of the action taken;

- inform the consultant or his deputy of the action taken;

- keep a record of the action taken together with the reasons for the action;

- use the incident reporting procedures.

Time out

5.47 The Mental Health Commission has referred to "time out" as a behavioural procedure involving the removal of an individual from a rewarding to a non-rewarding situation for a short period of time as a consequence of behaviour which is specified as undesirable.

5.48 Time out is a planned therapeutic procedure and therefore should normally be part of the written treatment plan which should always specify the duration. It should be seen as one of a range of methods of managing difficult or disturbed patients and not as an immediate reaction to such behaviour. When time out is used, the course of the treatment should be regularly reviewed, the patient should be carefully monitored and a written record should be kept of observations.

Seclusion

5.49 The Mental Health Commission has referred to "seclusion" as the forcible denial of the company of other people by constraint within a closed environment. The patient is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other means of exit open to the patient himself. The room should have adequate heating, lighting, ventilation and bedding.

5.50 Seclusion is an emergency management procedure for the short term control of patients whose behaviour is seriously disturbed and should be used as a last resort, after all other reasonable steps to control the behaviour have been taken. The sole aim in using seclusion is to contain severely disturbed behaviour which is likely to cause harm to others. It should never be used where there is a risk that the patient may take his own life. The decision to use seclusion can be made in the first instance by a doctor, the nurse in charge of the ward or a senior nurse manager. Where the decision is taken by someone other than a doctor, arrangements must be made for a doctor to attend immediately.

5.51 A nurse should be available within sight and sound of the seclusion room throughout the period of the patient's seclusion. The frequency of observation should be decided on an individual basis, but a documented report must be made every 15 minutes. The aim of observation is to monitor the state of the patient and to ascertain whether seclusion can be terminated. A patient who has been sedated should be kept under constant review.

5.52 If seclusion needs to continue, a review should be made in the seclusion room, every 2 hours by 2 nurses and every 4 hours by a doctor.

Special accommodation of dangerous patients

5.53 A small number of mentally disordered patients present such problems of violent, criminal or severely anti-social conduct that special arrangements are needed for their safe accommodation in hospital. Some, but not all, will be detained by order of a Court or the Secretary of State under Part III of the Order. Conditions of high security for such patients are provided in the special hospitals in England and Scotland. For patients presenting similar problems but to a lesser degree special accommodation is provided in High Intensive Nursing Care Units (HINCUs) in major psychiatric and mental handicap hospitals in Northern Ireland. The guidance in this Chapter is generally applicable in HINCUs. However, extra measures including locked wards have to be accepted in the interests of safety.

GLOSSARY

Applicant, the	The patient's nearest relative or an Approved Social Worker, or a person appointed by the County Court to act as the nearest relative.
Approved Social Worker (ASW)	A social worker specially trained in dealing with persons suffering from mental disorder, and appointed by a Board to act as an ASW for the purposes of the Order.
Board	A Health and Social Services Board
Department, the	The Department of Health and Social Services.
Forms (numbered)	The forms which are required to be prescribed under the Order. They are prescribed under the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 (SR 1986 No 174) as amended, and are included also in the Guide.
Guide, the	"The Mental Health (NI) Order 1986 - A Guide" published by the Department in 1986 .
Medical treatment	Medical treatment is broadly defined to include nursing, and also care and training under medical supervision.
Mental disorder	This is defined in Article 3 of the Order, and discussed in paragraphs 8 to 14 of the Guide.
Mental Health Commission	The Mental Health Commission for Northern Ireland established under Article 85 of the Order to perform specified statutory functions.
Mental Health Review Tribunal	Appeal tribunal constituted in accordance with Article 70 of the Order.

Nearest relative	This is defined in Article 32 of the Order by reference to a list of relationships, a caring relative taking priority over a non-caring relative, whatever his position on the list. The list is also reproduced in the notes to the relevant prescribed forms.
Order, the	The Mental Health (Northern Ireland) Order 1986.
Part II/Part IV Doctor	A medical practitioner appointed by the Mental Health Commission for the purposes of these Parts of the Order.
Patient	A person suffering or appearing to be suffering from mental disorder. (NB A different meaning applies for the purposes of Part VIII of the Order).
Responsible Board	For a hospital patient, the Board administering the hospital. For guardianship, the Board for the area in which the patient resides.
Responsible Medical Officer (RMO)	The Part II doctor in charge of the patient's assessment or treatment (or who provides certain medical recommendations required by the Order for the purposes of guardianship).
Regulations	A number of regulations (also known as Statutory Rules) have been made under powers given in the Order. The most important, for the purposes of this Code, are the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986, as amended.

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DH Department of Health

Guidance for Restrictive Physical Interventions

How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder

July 2002

Valuing People:

A New Strategy for Learning Disability for the 21st Century

Foreword

“We welcome this guidance, which has been carefully developed over the past 2 years with considerable help from the health, social care and education sectors.

For the first time, guidance covers all areas of service that children and adults with learning disabilities and difficulties will use throughout their lives.

It is vitally important for all staff to have effective training and support in the use of restrictive physical interventions. People with learning disabilities have a right to be treated with respect, care and dignity especially when they are behaving in ways which maybe harmful to themselves or others and as a result require physical intervention from staff. By using this guidance staff will be helped to act appropriately and in a safe manner, so ensuring effective responses in difficult situations.

We would like to thank all those who have been involved in the production of this material, particularly Professor John Harris and his colleagues at the British Institute of Learning Disability. We are indebted to them for a great deal of hard work since the mid 90’s. We would also like to thank all those who responded so positively to the consultation process, including staff, service users and their families.

We hope that you will find this a useful document, which will bring benefits to the day to day lives of people with learning disabilities, their families and all staff who work with them.”

Jacqui Smith

Catherine M. Ashton.

Jacqui Smith

Cathy Ashton

Summary

This is the first time joint Guidance by the Department of Health and the Department for Education and Skills has been proposed on this topic. It is identified as an integral part of both "Valuing People White Paper: A New Strategy for Learning Disability for the 21st Century" and the National Minimum Standards for Care Homes for Younger Adults and Adult Placements. Physical intervention refers to direct physical contact between one person and another or to physical contact mediated by an instrument or device. This guidance is specifically concerned with restrictive physical interventions which involve the use of force to restrict movement or mobility or the use of force to disengage from dangerous or harmful physical contact initiated by pupils or service users. (Since the Guidance refers to both adults and children using a variety of different services, the generic term 'service user' is used throughout the guidance to refer to children or adults who are in receipt of health, education or social services.)

The Guidance is issued by the Department of Health under Section 7 of LASSA 1970. It meets the commitment given by the DfEE in Circular 10/98, (Section 550A of the Education Act 1996: The Use of Force to Control Or Restrain Pupils) to issue Guidance to help schools and Local Education Authorities plan their strategies for managing the behaviour of pupils with severe behavioural difficulties. It should be read in conjunction with the letter from the Head of DfES's Special Educational Needs Division to Chief Education Officers on Promoting Positive Handling Strategies for Pupils with Severe Behavioural Difficulties, dated April 24th 2001.

The purpose of the Guidance is to ensure that restrictive physical interventions (which employ force) are used as infrequently as possible, that they are used in the best interests of the service user, and that when they are used, everything possible is done to prevent injury and maintain the person's sense of dignity. Restrictive physical intervention should be seen as one part of a broader strategy to address the needs of children and adults whose behaviour poses a serious challenge to services.

This Guidance should be used by those responsible for commissioning, providing and regulating:

- health and social services for adults and children with a learning disability and/or Autistic Spectrum Disorder;
- educational provision catering for pupils with severe behavioural difficulties, for example, those with emotional and behavioural difficulties, autism and learning difficulties which can result in pupils displaying extreme behaviour.

It will also be useful to parents and those with parental responsibilities, independent advocates and service users.

The inappropriate use of restrictive physical intervention may give rise to criminal charges, action under civil law or prosecution under health and safety legislation. As a general rule, restrictive physical interventions should only be used when other strategies (which do not employ force) have been tried and found to be unsuccessful or, in an emergency, when the risks of not employing a restrictive intervention are outweighed by the risks of using force.

Restrictive physical intervention should employ the minimum reasonable force to prevent injury or avert serious damage to property. Section 550A of the Education Act 1996 allows staff of a school to use reasonable force in relation to a pupil for the purpose of preventing him/her:

- committing an offence;
- causing personal injury or damage to property;
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the schools or among any of its pupils.

Any restrictive intervention should employ the minimum degree of force needed to achieve these outcomes.

The use of restrictive physical interventions should be minimised by the adoption of fully documented risk assessment and preventative strategies whenever it is foreseeable that the use of force might be required. However, staff should be aware that, in an emergency, restrictive physical interventions are permissible if they are necessary to prevent injury or serious damage to property or, in school settings, if their use complies with Section 550A of the Education Act 1996.

Action

The following organisations should have a policy on the use of restrictive physical interventions:

- agencies which provide services for adults or children with a Learning Disability and or Autistic Spectrum Disorder;
- schools which make provision for pupils with Emotional and Behavioural Difficulties, Learning Difficulties and/or Autistic Spectrum Disorder.
- Local Education Authorities.

Policies should clearly describe both *good practice* in the use of restrictive physical interventions and *unacceptable* practices that might expose service users or staff to foreseeable risk of injury or psychological distress.

The use of a restrictive physical intervention, whether planned or unplanned should always be recorded in an incident book with numbered pages.

All staff who will be required to employ restrictive physical interventions will require specialised training and they should only employ methods of restrictive physical interventions for which they have received training. Trainers should be carefully selected with reference to the BILD Code of Practice and evidence of professional accreditation.

Implementation of this guidance will require the co-ordinated effort of commissioners, service providers, regulators, teachers and other professionals, care staff, and training organisations. It is important that good practice in the use of restrictive physical interventions is properly co-ordinated with other procedures designed to protect vulnerable children and adults.

Local Authorities are asked to read Appendix 1 which is available on the DH website (www.doh.gov.uk/learningdisabilities) and follow as Guidance under Section 7 of the Local Authority Social Services Act 1970.

Local Education Authorities and schools are asked to read this guidance which is available on the DfES website (www.dfes.gsi.gov.uk) and use it to assist the implementation of Section 550A of the Education Act 1996.

For health service commissioners and providers the Guidance indicates required outcomes. Any variation from this guidance will require demonstrable effectiveness when examined by the STHA.

Contents

1. Introduction

1.1 This guidance on the use of restrictive physical interventions in special schools, care and health settings, is issued jointly by the Department for Education and Skills/Department of Health. It stands as guidance under Section 7 of the Local Authority and Social Services Act 1970; and as advice to support the implementation of Section 550A of the Education Act 1996, in particular in special school settings catering for pupils with severe behavioural difficulties associated with learning difficulties and/or autistic spectrum disorders. Additionally, this guidance will have relevance for working with pupils with severe emotional and behavioural difficulties. Whilst the principles that underpin this guidance will have wider relevance and implications for children in mainstream schools (and LEAs may wish to bring the guidance to the attention of mainstream schools within their area), this guidance is not intended to cover all forms of extreme behaviours in all schools.

1.2 Many pupils for whom this guidance is intended use health and social care services both inside and outside the school setting, and many will continue to use health and social care services when they become adults and leave school. Consistency in approach is important, both to provide the most effective support for individual service users and to reduce the possibility of confusion or disagreements between staff employed by different agencies. This joint guidance is issued to help ensure that staff in schools and staff working in health and social care settings adopt consistent practices in the use of restrictive physical interventions, based upon a common set of principles. Where there is a clear justification for different practices being sanctioned in schools, compared with health and social care settings (for example, where different legislation applies), this is clearly indicated. In this guidance, the term 'service user' refers to adults and children who receive services in care establishments and/or educational settings.

1.3 The guidance will help staff in health and social services to address important outcomes for children and service users – rights, choice, independence and inclusion – described in the Learning Disability White Paper Valuing People and will contribute to the preparation of Joint Investment Plans.

1.4 Associated guidance on the care of adults with learning disability and/or autism can be found in the Department of Health guidance on the protection of vulnerable adults 'No Secrets' and in the report of the Task Force on Violence Against Social Care Staff 'A Safer Place: Combating Violence Against Social Care

Staff. The Mental Health Act (1983, under review) and its associated Code of Practice provides relevant guidance in respect of people who have been detained.

1.5 Guidance for all schools on the use of physical intervention for pupils in school can be found in DfEE Circular 10/98 "Section 550A Of The Education Act 1996: The Use Of Force To Control Or Restrain Pupils", and in guidance issued to Chief Education Officers on Positive Handling Strategies in the letter from DfES dated April 24th 2001 (see appendix 1). Additionally, to assist Local Education Authorities and schools in developing local policies and to help schools establish risk assessment procedures, DfES has commissioned the British Institute of Learning Disabilities (BILD) to produce model policies on the use of physical interventions, together with a risk assessment proforma for pupils who present challenging behaviours.

1.6 In care settings, good practice in the use of physical interventions described in this guidance will be monitored as part of the implementation of the Care Standards Act.

1.7 In the case of children in residential care, the general Guidance and Regulations issued in respect of the Children Act 1989 (Volume 4 Residential Care) addressed the use of physical action such as restraint and holding in the context of good order and discipline. The Children Act Guidance states that in residential care settings 'physical restraint should be used rarely and only to prevent a child harming himself or others or from damaging property' (para 1.82). Section 550A of the Education Act 1996 sets out circumstances in which reasonable force may be used by members of staff in schools. These are when it is reasonable to use force for the purpose of preventing a pupil:

- committing an offence;
- causing personal injury or damage to property;
- engaging in any behaviour prejudicial to the maintenance of good order and discipline in a school or among any of its pupils.

This Section does not apply to Colleges of Further and Higher Education.

1.8 Those concerned with, or responsible for, children in residential care, should read this document in conjunction with earlier Department of Health Guidance on Permissible Forms of Control in Children's Residential Care (1993).

1.9 Those concerned with or responsible for pupils with SEN in schools should read this guidance in conjunction with:

- section 550A of the Education Act 1996 and the associated guidance (DfEE Circular 10/98) 'Section 550A Of the Education Act 1996: The Use of Force To Control Or Restrain Pupils';

- the letter of 24th April 2001 from DfES to Chief Education Officers on Promoting Positive Handling Strategies for Pupils with Severe Behavioural Difficulties (see Appendix 1).

1.10 The book Physical Interventions: A Policy Framework (BILD 1996) provides additional advice and information on the use of physical interventions in different service settings.

1.11 This guidance has been prepared in the context of The Human Rights Act (1998) and The United Nations Convention on the Rights of the Child (ratified 1991). It is based on the presumption that every adult and child is entitled to:

- respect for his/her private life;
- the right not to be subjected to inhuman or degrading treatment;
- the right to liberty and security; and
- the right not to be discriminated against in his/her enjoyment of those rights.

1.12 All services should be designed to promote independence, choice and inclusion and to establish an environment that enables children and service users maximum opportunity for personal growth and emotional wellbeing.

1.13 Wherever possible, restrictive physical interventions should be used in a way that is sensitive to, and respects the cultural expectations of, children and service users and their attitudes towards physical contact.

1.14 Any restrictive physical Intervention should avoid contact that might be mis-interpreted as sexual.

1.15 Restrictive physical interventions should always be designed to achieve outcomes that reflect the best interests of the child or adult whose behaviour is of immediate concern and others affected by the behaviour requiring intervention. The decision to use a restrictive physical intervention must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing a restrictive physical intervention. A restrictive physical intervention must also only employ a reasonable amount of force – that is the minimum force needed to avert injury or damage to property, or (in schools) to prevent a breakdown of discipline – applied for the shortest period of time.

2. Who should read this guidance?

2.1 This guidance should be used by:

- Service commissioners in health and social care.
- Managers of health and social care services.
- LEAs.
- Governing bodies.
- Teachers and other staff working in schools catering for pupils with severe behavioural difficulties, for example, those with emotional and behavioural difficulties, autism and learning difficulties which can result in pupils displaying extreme behaviour.
- Staff working in health and social care services.
- Persons responsible for the operation of independent sector homes and hospitals.
- Registration and Inspection staff.
- Ofsted inspectors.
- Those who provide training for staff on the use of physical interventions.

Commissioning authorities will need to ensure that provider agencies follow this guidance. Registration and Inspection staff will monitor the implementation of this guidance within the terms of the Care Standards regulations.

2.2 The information in this guidance may also be helpful to:

- Parents and those with parental responsibilities.
- Independent advocates.
- Service users.
- Pupils
- Staff working in colleges catering for students with severe behavioural difficulties, for example, those with emotional and behavioural difficulties, autism and learning difficulties which can result in pupils displaying extreme behaviour.

3. Definitions

3.1 Different forms of physical intervention are summarised in the table below. It shows the difference between restrictive forms of intervention, which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact, and non-restrictive methods. Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment. The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice. For these reasons this guidance is specifically concerned with the use of restrictive physical interventions.

	Bodily contact	**Mechanical**	**Environmental change**
Non restrictive	Manual guidance to assist a person walking	Use of a protective helmet to prevent self injury	Removal of the cause of distress, for example, adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them hitting someone	Use of arm cuffs or splints to prevent self injury	Forcible seclusion or the use of locked doors

3.2 Restrictive physical interventions can be employed to achieve a number of different outcomes:

- to break away or disengage from dangerous or harmful physical contact initiated by a service user;
- to separate the person from a 'trigger', for example, removing one pupil who responds to another with physical aggression;
- to protect a child or service user from a dangerous situation – for example, the hazards of a busy road.

3.3 It is helpful to distinguish between:

- *planned intervention*, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment (see below) and recorded in care plans;
- *emergency or unplanned* use of force which occurs in response to unforeseen events.

3.4 The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled, and the nature of the harm they might cause. These judgements have to be made at the time, taking due account of all the circumstances, including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques deployed should be those with which the staff involved are familiar and able to use safely and are described in the child or service user's support plan. Where possible, there should be careful planning of responses to individual children and adults known to be at risk of self-harm, or of harming others.

3.5 The use of force is likely to be legally defensible when it is required to prevent:

- self-harming;
- injury to other children, service-users, staff or teachers;
- damage to property;
- an offence being committed; and
- in school settings, any behaviour prejudicial to the maintenance of good order and discipline within the school or among any of its pupils.

3.6 The use of force to restrict movement or mobility or to break away from dangerous or harmful physical contact initiated by a service user will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to children, service users, staff and others and pre-planning responses, where possible. Examples of physical intervention that might generally be considered low risk include:

- members of staff taking reasonable measures to hold a service user to prevent him or her from hitting someone;
- a specially designed "arm cuff" to prevent someone self-injuring (see para 7.4);
- accompanying a person who dislikes physical contact to a separate room where they can be alone for a few minutes while being continuously observed and supported.

3.7 Elevated levels of risk are associated with:

- the use of clothing or belts to restrict movement;
- holding someone who is lying on the floor or forcing them onto the floor;
- any procedure which restricts breathing or impedes the airways;

- seclusion, where an adult or child is forced to spend time alone in a room against their will;
- extending or flexing the joints or putting pressure on the joints;
- pressure on the neck chest abdomen or groin areas.

3.8 Planned physical intervention strategies should be:

- agreed in advance by a multidisciplinary or school team working in consultation with the child or service user, his or her carers or advocates and, in the case of a child, those with parental responsibility;
- described in writing and incorporated into other documentation which sets out a broader strategy for addressing the service user's behavioural difficulties;
- implemented under the supervision of an identified member of staff who has undertaken appropriate training provided by an organisation accredited by BILD;
- recorded in writing so that the method of physical intervention and the circumstances when it was employed can be monitored and, if necessary, investigated.

3.9 Where planned physical intervention strategies are in place, they should be one component of a broader approach to behaviour management, treatment or therapy.

3.10 Unplanned or emergency intervention may be necessary when a service user behaves in an unexpected way. In such circumstances, members of staff retain their duty of care to the service user and any response must be proportionate to the circumstances. Staff should use the minimum force necessary to prevent injury and maintain safety, consistent with appropriate training they have received.

3.11 To the extent that seclusion (where an adult or child is forced to spend time alone against their will) involves restricting a person's freedom of movement, it should also be considered a form of physical intervention. The use of seclusion for people detained under the Mental Health Act (1983;under review) is set out in the Code of Practice published in 1999.

3.12 The right to liberty and personal freedom is enshrined Article 5 of the Human Rights Act 1998 and is protected by the criminal and civil law. For these reasons the use of seclusion outside the Mental Health Act should only be considered in exceptional circumstances and should always be proportional to the risk presented by the child or service user.

3.13 Under the Children Act 1989 any practice or measure, such as 'time out' or seclusion, which prevents a child from leaving a room or building of his own free will, may be deemed a 'restriction of liberty'. Under this Act, restriction of liberty of children being looked after by a local authority or accommodated by NHS establishments is only permissible in very specific circumstances, for example when the child is placed in secure accommodation approved by the Secretary of State or where a court order is in operation.

3.14 In care settings, if seclusion is required other than in an emergency (for periods of longer than a few minutes or more frequently than once a week) then staff should seek advice regarding the use of statutory powers under mental health or child care legislation.

4. Legal considerations

The Human Rights Act 1998 sets out important principles regarding protection of individuals from abuse by state organisations or people working for those institutions. Implementation of this guidance will help to ensure that practice within services is consistent with this Act.

4.1 It is a criminal offence to use physical force, or to threaten to use force (for example, by raising a fist or issuing a verbal threat), unless the circumstances give rise to a 'lawful excuse' or justification for the use of force. Similarly, it is an offence to lock an adult or child in a room without recourse to the law (even if they are not aware that they locked in) except in an emergency when for example the use of a locked room as a temporary measure while seeking assistance would provide legal justification. The use of double or high door handles in classrooms or locking outside doors, as a safety measure and/or security precaution *when children are supervised by an adult* would be considered a reasonable measure to prevent a significant risk of harm within a school's duty of care to its pupils. Use of physical intervention may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned.

4.2 Under health and safety legislation, employers are responsible for the health safety and welfare of employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of physical interventions. Employers should also establish and monitor safe systems of work and ensure that employees are adequately trained. Employers should also ensure that all employees, including agency staff, have access to appropriate information about adults and children they are working with.

4.3 Schools owe a duty of care to their pupils. Providers of health and social care services owe a duty of care towards all service users. The duty of care requires that reasonable measures are taken to prevent harm. Therefore, the use of "high handles" that are beyond the reach of a child and the use locks or other security measures on outside doors to control visitor entry are permissible, if the child is supervised by an adult. It may be appropriate to employ restrictive physical intervention to prevent a significant risk of harm, for example:

- to prevent an adult or child running toward a busy road;
- to prevent an adult or child self-injuring;

- to prevent an adult or child injuring another person;
- to prevent an adult or child committing an offence.

4.4 Planned physical interventions should only be used as part of a holistic strategy when the risks of employing an intervention are judged to be lower than the risks of not doing so. The use of unplanned or emergency physical intervention is addressed in paragraph 3.10 above and in Section 9 below.

4.5 Any physical intervention should employ the minimum reasonable force to prevent injury or serious damage to property, to avert an offence being committed and, in school settings, to prevent a pupil engaging in extreme behaviour prejudicial to the maintenance of good order and discipline at school or among any of its pupils (see DfEE Circular 10/98 “Section 550A of the Education Act 1996: The Use of Force to Control or Restrain Pupils” for more details).

4.6 Records of incidents involving particular pupils and service users sometimes show that there are set patterns to their behaviour which, if unchecked, will lead to it becoming dangerous or exceptionally disruptive. In these circumstances, it might be necessary to use restrictive physical interventions at an early stage. (see Section 10 on Policies and Section 11 on Recording below).

5. Prevention

5.1 The use of restrictive physical interventions should be minimised by the adoption of primary and secondary preventative strategies.

Primary prevention is achieved by:

- ensuring that the number of staff deployed and their level of competence corresponds to the needs of children and service users and the likelihood that physical interventions will be needed. Staff should not be are left in vulnerable positions;
- helping children and service users to avoid situations which are known to provoke violent or aggressive behaviour, for example, settings where there are few options for individualised activities;
- care plans or, for school pupils, Positive Handling Plans, which are responsive to individual needs and include current information on risk assessment;
- creating opportunities for children and service users to engage in meaningful activities which include opportunities for choice and a sense of achievement;
- developing staff expertise in working with children and service users who present challenging behaviours;
- talking to children, service users, their families and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others. Some children or service users prefer withdrawal to a quiet area to an intervention which involves bodily contact.

Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing ‘defusion’ techniques to avert any further escalation.

Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of a restrictive physical intervention at an early stage in the sequence may, potentially, be justified if it is clear that:

- primary prevention has not been effective;

- the risks associated with not using a restrictive physical intervention are greater than the risks of using a restrictive physical intervention; and
- other appropriate methods, which do not involve restrictive physical interventions, have been tried without success.

5.2 All prevention strategies should be carefully selected and reviewed to ensure that they do not constrain opportunities or have an adverse effect on the welfare or the quality of life service users (including those in close proximity to the incident), unnecessarily. In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities which might provoke challenging behaviours compared with the impact on the person's overall quality of life if such activities are proscribed. This is likely to require a detailed risk assessment – see section 6 above.

5.3 Devices which are required for a therapeutic purpose, such as buggies, wheelchairs and standing frames (including any supporting harness) may also restrict movement. Such devices should never be provided for the purpose of preventing problem behaviour, although, in extreme circumstances, they might be used to manage risks as defined in section 6. A decision to use therapeutic devices to prevent problem behaviour (for example, strapping someone into a wheelchair) must be agreed by a multi-disciplinary team in consultation with service users, their families (and in the case of children, those with parental responsibility) and advocates, and recorded within an individual's care plan/ Positive Handling Plan.

5.4 Devices that are designed specifically to prevent problem behaviours should be considered a form of restrictive physical intervention, even if the service user does not resist the use of such devices. For example, arm splints or protective garments might be used to prevent self-injury. They should only be introduced after a multidisciplinary assessment which includes consultation with service users their families (and in the case of children, those with parental responsibility) and advocates. If used, they should be selected carefully to impose the least restriction of movement required to prevent harm while attempts should continue to be made to achieve the desired outcomes with less restrictive interventions. Such devices should only be used by teachers and carers who have received specific training in their usage. The rational for using any devices and the circumstances in which they may be used must be clearly recorded within an individual's care plan/ Positive Handling Plan.

6. Medication

6.1 In certain situations, the use of medication may be indicated as a method of managing extreme behaviour. Medication must only be administered upon medical advice and must only be used as a routine method of managing difficult behaviour where it is included within an individual’s care plan and agreed by a qualified medical practitioner. The use of medication should comply any regulations or national minimum standards issued under the Care Standards Act. Under their duty of care, staff should not give tranquillisers to service users who have contra- indications and any contra indications should always be recorded in their care plan. Except in an emergency, (see Section 9) where there is a significant risk of personal injury or a serious risk of an offence being committed, rapid tranquillisation should not be used as a method of gaining control over adults or children who display violent or aggressive behaviour. Even in an emergency, if force is required to administer a tranquilliser, the degree of force must be reasonable. For further information on managing medication in schools please see DfEE Circular 14/96 “Supporting Pupils with Medical Needs in School”.

7. Risk Assessment

7.1 When the use of a restrictive physical Intervention is sanctioned, it is important that appropriate steps are taken to minimise the risk to both staff and service users. Among the main risks to children and service users are that a physical intervention could:

- be used unnecessarily, that is when other less intrusive methods could achieve the desired outcome;
- cause injury;
- cause pain, distress or psychological trauma;
- become routine, rather than exceptional methods of management;
- increase the risk of abuse;
- undermine the dignity of the staff or service users or otherwise humiliate or degrade those involved;
- create distrust and undermine personal relationships.

7.2 The main risks to staff include the following:

- as a result of applying a physical intervention they suffer injury;
- as a result of applying a physical intervention they experience distress or psychological trauma;
- the legal justification for the use of a physical intervention is challenged in the courts;
- disciplinary action.

7.3 The main risks of not intervening include:

- staff may be in breach of the duty of care (see 4.3 above);
- children, service users, staff or other people will be injured or abused;
- serious damage to property will occur;
- the possibility of litigation in respect of these matters.

7.4 Whenever it is foreseeable that a service user might require a restrictive physical intervention, a risk assessment should be carried out which identifies the benefits and risks associated with the application of different intervention techniques with the person concerned (see BILD's risk assessment proforma). Where the use of self-harm prevention devices is indicated, staff should be fully trained in their usage. This should always be recorded and incorporated with individual care plans or Positive Handling Plans for school pupils (See DfES letter of April 24 2001 to Chief Education Officers on Promoting Positive Handling Strategies for Pupils with Severe Behavioural Difficulties) and other documents that describe a broader strategy for responding to behavioural difficulties. Where incidents are foreseeable, service users should only be exposed to restrictive physical intervention techniques which are described in their individual records/ Positive Handling Plans following a risk assessment.

8. Proactive use of restrictive physical interventions

8.1 In most circumstances, restrictive physical interventions will be used reactively. Occasionally, it may be considered in the best interests of the child or adult to accept the possible use of a restrictive physical intervention as part of a therapeutic or educational strategy that could not be introduced without accepting that reasonable force might be required. For example, the best way of helping a child to tolerate other children without becoming aggressive might be for an adult to ‘shadow’ the child and to adjust the level of any physical intervention needed according to the child’s behaviour. Similarly, staff might be sanctioned to use a restrictive physical intervention, if necessary, as part of an agreed strategy to help a person who is gradually learning to control their aggressive behaviour in public places. In both examples, the physical intervention is part of a broader educational or therapeutic strategy.

8.2 Where this approach is employed it is important to establish in writing a clear rationale for the anticipated use of the restrictive physical intervention and to have this endorsed by a multidisciplinary meeting which includes, wherever possible, family members (or those with parental responsibility) and an independent advocate. In schools, the possible use of restrictive physical interventions, as part of a broader educational or therapeutic strategy, will be included within the pupil’s Positive Handling Plan.

9. Emergency use of restrictive physical interventions

9.1 Emergency use of restrictive physical interventions may be required when service users behave in ways that have not been foreseen by a risk assessment. Research evidence[1] shows that injuries to staff and to service users are more likely to occur when physical interventions are used to manage unforeseen events and for this reason great care should be taken to avoid situations where unplanned physical interventions might be needed.

9.2 An effective risk assessment procedure together with well planned preventative strategies will help to keep emergency use of restrictive physical interventions to an absolute minimum. However, staff should be aware that, in an emergency, the use of force can be justified if it is reasonable to use it to prevent injury or serious damage to property and, in schools, to prevent a pupil engaging in any behaviour prejudicial to the maintenance of good order and discipline in the school or among any of its pupils.

9.3 Even in an emergency, the force used must be reasonable. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration. Before using restrictive physical intervention in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences which might have occurred without the use of a physical intervention.

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[1] Hill, J. and Spreat, S. (1987) – "Staff injury rates associated with the implementation of contingent restraint" Mental Retardation, 25, 3, 141-145
Spreat, S.; Lipinski, D.P.; Hill, J. and Halpin, M. (1986) – "Safety indices associated with the use of contingent restraint procedures." Applied Research in Mental Retardation, 7, 475-481

10. Policies

10.1 The starting point for establishing good practice in the use of restrictive physical interventions is the development of organisational policies which reflect current legislation and case law as well as government guidance, professional codes of practice and local circumstances, including the characteristics of the children or adults within particular services. Policies on physical interventions are expected to be developed in collaboration with local Adult Protection and Area Child Protection Committees.

10.2 Every agency included within the remit of this guidance is expected to have a policy on the use of restrictive physical interventions. The amount of detail needed will depend upon local circumstances but would be expected to cover the areas described in section 10.8 below. In general terms, policies will describe the context in which it is appropriate to use restrictive physical interventions.

10.3 Policies are expected to emphasise that restrictive physical interventions should always be used as part of a more general behaviour management strategy.

10.4 A school's Behaviour Policy and the related Physical Interventions Policy will set out the broad range of strategies staff are allowed to use when attempting to defuse an incident of extreme behaviour.

10.5 Individual Care Plans and, in schools, Positive Handling Plans (see DfES letter of April 24th 2001 to Chief Education Officers on Positive Handling Strategies for Pupils with Severe Behavioural Difficulties) are expected to set out, in detail, the specific strategies and techniques which should, if necessary, be used with each named service user who has been assessed as being at risk of needing restrictive physical interventions. Plans are also expected to list any specific techniques which it would not normally be appropriate to use (whether because the service user has experienced abuse in the past or for some other reason. See Section 6 on Risk Assessment)

10.6 The policy is expected to explain how service users, their families (and in the case of children, those with parental responsibility) and advocates participate in planning, monitoring and reviewing the use of restrictive physical interventions.

10.7 LEAs are also expected to develop their own policies on the use of restrictive physical interventions using this guidance as a framework. LEAs are also expected to inform schools when new pupils who are identified as being at risk of displaying extreme behaviour are due or likely to be placed there. Other important points of reference will be the letter from DfES to Chief Education Officers on Promoting Positive Handling Strategies for Pupils with Severe Behavioural Difficulties and the materials on policy development and implementation being produced by BILD.

10.8 Policies on restrictive physical interventions are expected to include reference to the following:

- Strategies for preventing the occurrence of behaviours which precipitate the use of a physical intervention.
- Strategies for 'de-escalation' or 'defusion' which can avert the need for a physical intervention.
- Procedures for post incident support and de-briefing for staff, children, service users and their families.
- The concept of reasonable force where 'reasonableness' is determined with reference to all the circumstances, including:
  - The seriousness of the incident.
  - The relative risks arising from using a physical intervention compared with using other strategies.
  - The age, cultural background, gender, stature and medical history of the child or service user concerned.
  - The application of gradually increasing or decreasing levels of force in response to the person's behaviour.
- The approach to risk assessment and risk management employed.
- The distinction between.
  - *seclusion* where an adult or child is forced to spend time alone against their will;
  - *time out* which involves restricting the service user's access to all positive reinforcements as part of the behavioural programme;
  - *withdrawal* which involves removing the person from a situation which causes anxiety or distress to a location where they can be continuously observed and supported until they are ready to resume their usual activities.
- The distinction between *planned* physical interventions (where incidents are foreseeable) and the use of force in *emergency* situations (which cannot reasonably be anticipated).
- First aid procedures to be employed and those responsible for implementation in the event of an injury or physical distress arising as a result of a physical intervention.

- Policies should clearly describe *unacceptable* practices that might expose service users or staff to foreseeable risk of injury of psychological distress.

10.9 Policies will need to recognise situations where breakaway or disengagement strategies, which involve minimal use of pain or discomfort, may be sanctioned as the least intrusive method which is consistent with the safety of staff and service users. Such methods will be based upon a risk assessment, will be fully documented and will employ only the minimum amount of force required.

10.10 Policies should include a clear statement about the safeguards needed to protect the rights of service users who need constant supervision. Children and service users who lack an awareness of danger may present a risk to themselves or others in public places and for this reason the use of locked doors may be considered. In these circumstances a court order should be obtained. This does not apply to the use of high or double handles in classrooms as a safety measure, or to locking or providing security on outside doors to control visitor entry, provided that children are supervised by an adult.

10.11 Employers and managers are responsible for ensuring that staff receive training, including updates and refresher courses, appropriate to their role and responsibilities within the service. There should be a policy on staff development and training which includes reference to training in the use of physical interventions.

10.12 Normally, only staff who been trained to an appropriate level should be sanctioned to use restrictive physical interventions. In schools, under Section 550A of the Education Act 1996, this will be a teacher or someone who, with the head's authority, has lawful control of pupils. However, in an emergency the use of force by other people can be justified if it is the only way to prevent injury or to prevent an offence being committed. In these circumstances, the use of force should be reasonable and proportionate and, whenever possible, it should reflect the person's previous training in the appropriate use of restrictive physical interventions.

10.13 Employers and managers wishing to engage trainers or training organisations should seek evidence to support the suitability of particular approaches. The BILD Code of Practice for Trainers in the Use of Physical Interventions is an important point of reference for trainers and service providers.

10.14 Policies should be reviewed, evaluated and amended at least every 12 months.

10.15 Agency policies on restrictive physical interventions should be explained to service users, including those who might be exposed to physical interventions. All those who experience physical interventions should be offered the opportunity to discuss the way in which staff have responded to their behaviour and to express their concerns and preferences about future management.

11. Recording

11.1 For schools: Clarifying the text of DfEE Circular 10/98, the DfES letter to Chief Education Officers dated April 24th 2001 describes the basic procedures and systems for recording incidents involving the use of restrictive physical interventions that schools are expected to follow. These should be taken as a minimum. The protocol described below, although designed for care settings, includes much which schools might consider drawing on.

11.2 For health and care settings: If it is foreseeable that a child or adult will require some form of restrictive physical intervention, for each service user, there must be a written protocol which includes:

- a description of behaviour sequences and settings which may require a physical intervention response;
- the results of an assessment to determine any contra indications for use of physical interventions;
- a risk assessment which balances the risk of using a restrictive physical intervention against the risk of not using a physical intervention;
- a record of the views of those with parental responsibility in the case of children and family members in the case of adults;
- a system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages (see 11.2 below);
- previous methods which have been tried without success;
- a description of the specific physical intervention techniques which are sanctioned, the dates on which they will be reviewed;
- a description of staff who are judged competent to use these methods with this person (see section 11 on Staff Training below);
- the ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

An up-to-date copy of this protocol must be included in the person's individual care plan.

11.3 The use of a restrictive physical intervention, whether planned or unplanned (emergency) should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. The written record should indicate:

- the names of the staff and service users involved;
- the reason for using a physical intervention (rather than another strategy);
- the type of physical intervention employed;
- the date and the duration of the physical intervention;
- whether the service user or anyone else experienced injury or distress and, if they did, what action was taken.

The views of the service user(s) involved in the incident should also be recorded.

11.4 The contents of the incident book should be reviewed on a half-termly basis and appropriate action taken.

11.5 Recording will be used for a number of different purposes:

- compliance with statutory requirements;
- monitoring of service users' welfare;
- monitoring staff performance and identifying training needs or outcomes;
- contributing to service audit and evaluation;
- updating medical records.

11.6 Services need to ensure that recording methods are in place to meet each of these requirements.

12. Post Incident Management

12 .1 Following an incident in which restrictive physical interventions are employed, both staff and service users should be given separate opportunities to talk about what happened in a calm and safe environment. Interviews should only take place when those involved have recovered their composure. Post incident interviews should be designed to discover exactly what happened and the effects on the participants. They should not be used to apportion blame or to punish those involved. If there is any reason to suspect that a service user or a member of staff has experienced injury or severe distress following the use of a physical intervention, they should receive prompt medical attention.

12.2 To help protect the interests of service users who are exposed to restrictive physical interventions it is good practice to involve, wherever possible, family carers and independent advocates in planning, monitoring and reviewing how and when they are used.

13. Staff training

13.1 All staff require induction training before being required to work with people who present challenging behaviours. Staff who are expected to employ restrictive physical interventions will require additional, more specialised training. The nature and extent of the training will depend upon the characteristics of the people who may require a physical intervention, the behaviours they present and the responsibilities of individual members of staff.

13.2 Staff should normally only use methods of restrictive physical intervention for which they have received training. Specific techniques should be closely matched to the characteristics of individual service users and there should be a record of which staff are permitted to use different techniques. It is not appropriate for staff to modify the techniques they have been taught.

13.4 The Department of Health and the Department for Education and Skills are working with BILD, and in collaboration with other agencies, to establish an accreditation scheme for those offering training on physical interventions for learning disability and education services. It is envisaged that accreditation within this scheme will provide an important indication of the quality of training available from different trainers and training organisations.

14. Implementation

14.1 Implementation of this guidance will require co-ordinated effort from commissioners, service providers, professionals, care staff and training organisations. The key tasks for implementation are set out below.

- Establishing and implementing appropriate and effective agency policies on the use of physical interventions.

- Maintaining systematic and accurate records and a system for reporting and reviewing incidents.

- Establishing a system to monitor trends over time both with respect to the use of physical interventions with individual service users and to identify overall trends in the use of physical interventions within an organisation.

- Monitoring and reviewing local practice in the light of feedback within the context of clinical governance or other systems of accountability.

- Developing staff training programmes which include regular updating and re-fresher courses. The expectation is that training should normally be provided by trainers who are accredited under the BILD Code of Practice on Training Staff in the use of Physical Interventions.

- Ensuring that staff recruitment, training and work rotas are adjusted to ensure that staff with appropriate expertise are available to service users who may require physical interventions.

15. Co-ordination

15.1 It is important that good practice in the use of physical interventions is properly co-ordinated with other procedures designed to protect vulnerable people. These will include:

- local multi-agency management committees set up to audit policies, procedures and practices for the protection of vulnerable adults (See No Secrets, Section 3);
- the Mental Health Act Commission when physical interventions are employed with anyone who is detained under the Mental Health Act;
- local Area Child Protection Committees.

15.2 Commissioners will wish to ensure that suitable arrangements are in place before approving contracts and, under the new Care Standards Act, inspectors will have responsibility for monitoring and evaluating co-ordination between service providers and other agencies.

References

BILD (2001) Code of Practice for Trainers in the Use of Physical Interventions available from BILD, Campion House, Green Street, Kidderminster, Worcs DY10 1JL.

BILD/DfES (forthcoming) Model Policies for Schools and Local Education Authorities on the Use of Physical Interventions for Pupils with Severe Behavioural Difficulties and Risk Assessment Proforma to Use when Undertaking Risk Assessments on Pupils with Severe Behavioural Difficulties.

Children Act 1989 Guidance and Regulations Volume 4:Residential Care (1991) London: HMSO.

Department for Education and Employment (1998|) Circular 10/98 'Section 550A Of the Education Act 1996: The Use of Force to Control or Restrain Pupils, London: HMSO

Department for Education and Employment, (2001) Letter and accompanying guidance on 'Promoting Positive Handling Strategies' from the Head of DfEE Special Educational Needs Division to Chief Education Officers, issued on 24th April 2001.

Department of Health (2001) A Safer Place: Combating Violence against Social Care Staff, Report of the National Task Force and National Action Plan, Brighton: Pavilion.

Department of Health (1993) Guide on Permissible Forms of Control in Children's Residential Care, London: Department of Health.

Department of Health (2000) No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse, London: Department of Health.

Harris, J. Alan.D. Cornick, M, Jefferson, A. and Mills, R. (1996) Physical Interventions: A Policy Framework. BILD Publications (1996)

Mental Health Act (1983) Code of Practice, Department of Health and Welsh Office, London: The Stationery Office (1999)

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XXXXX/*Guidance on the use of Restrictive Physical Interventions for staff working with children and adults who display extreme behaviour in association with learning disability and/or autistic spectrum disorder* is available on the following websites:
www.doh.gov.uk/qualityprotects/index.htm
www.doh.gov.uk/learningdisabilities.htm

There is also an accessible version of the guidance which is available from:

British Institute of Learning Disabilities
Tel: 01752 202301/01562 723010

Major extracts are also on the BILD website: www.bild.org.uk

Guidance on the Use of Restrictive Physical Interventions for Staff Working with Children and Adults who Display Extreme Behaviour in

Guidance

Pupil Support
Health and SEN

All LEAs in England, Health and Social Services in England, Special Schools

Status: Strongly recommended

Date of Issue: July 2002

Ref: LEA/0242/2002

Related documents: Education Act 1996 - Section 550A

DFEE Circular 10/98 "Section 550A Of The Education Act 1996: The Use Of Force To Control Or Restrain Pupils"

DFEE Circular 14/96 "Supporting Pupils with Medical Needs in Schools"

Superseded documents: None

Important note

This document was produced jointly with the Department of Health (DoH) in 2002. We are in discussion with DoH on revising the document and incorporating it with 'Guidance on the Use of Restrictive Physical Interventions for Pupils with Severe Behavioural Difficulties'. A new version is expected to be available later this year (2012).

In the meantime, please note that the content of this document does not reflect current Government policy and also the following important changes:

- Section 93 of the Education and Inspections Act 2006 has replaced section 550A of the Education Act 1996
- Use of reasonable force – advice for head teachers, staff and governing bodies has replaced DfEE Circular 10/98 Section 550A of the Education Act 1996: The use of force to control or restrain pupils and the DfES letter to Chief Education Officers dated 24 April 2001.
- "Dealing with allegations of abuse against teachers and other staff: guidance for local authorities, head teachers, school staff, governing bodies and proprietors of independent schools" has replaced DfEE circular 10/95 "Protecting Children from

Contents

Foreword

"We welcome this guidance, which has been carefully developed over the past 2 years with considerable help from the health, social care and education sectors.

For the first time, guidance covers all areas of service that children and adults with learning disabilities and difficulties will use throughout their lives.

It is vitally important for all staff to have effective training and support in the use of restrictive physical interventions. People with learning disabilities have a right to be treated with respect, care and dignity especially when they are behaving in ways which maybe harmful to themselves or others and as a result require physical intervention from staff. By using this guidance staff will be helped to act appropriately and in a safe manner, so ensuring effective responses in difficult situations.

We would like to thank all those who have been involved in the production of this material, particularly Professor John Harris and his colleagues at the British Institute of Learning Disability. We are indebted to them for a great deal of hard work since the mid 90's. We would also like to thank all those who responded so positively to the consultation process, including staff, service users and their families.

We hope that you will find this a useful document, which will bring benefits to the day to day lives of people with learning disabilities, their families and all staff who work with them."

Jacqui Smith

Jacqui Smith **Cathy Ashton**

Guidance on the Use of Restrictive Physical Interventions

Action Points for Schools and LEAs

The following points summarise the steps that schools and LEAs need to take to ensure that they have appropriate policies, practices and procedures in relation to the use of restrictive physical interventions.

Underpinning Principles

- The use of force should, wherever possible, be avoided
- There are occasions when the use of force is appropriate
- When force is necessary, it must be used in ways that maintain the safety and dignity of all concerned

Policies

1. Every agency included within the remit of the guidance should have a policy on the use of physical interventions. In general terms, policies will describe the context in which it is appropriate to use restrictive physical interventions
2. Policies should be part of a more general behaviour management strategy
3. Specific strategies and techniques for specific pupils should be outlined in that pupil's behaviour management plan
4. Policies should indicate how children and their families could participate in the planning, monitoring and review of the use of restrictive physical interventions
5. Policies should include reference to the following:

- strategies for preventing and "de-escalating" behaviours that precipitate the use of physical interventions
- descriptions of strategies staff are allowed to use when managing extreme behaviour
- procedures for post-incident support
- how the concept of reasonable force will be determined
- the approach to risk assessment and risk management employed
- distinctions between seclusion, time out and withdrawal
- distinctions between planned and emergency physical interventions
- descriptions of practices which carry elevated levels of risk

Recording

1. The DfES letter to Chief Education Officers dated April 24th 2001 describes the basic procedures and systems for recording incidents involving the use of restrictive physical interventions that schools are expected to follow. These should be taken as a minimum. Where the use of restrictive physical interventions can be anticipated, schools should also consider developing a written protocol that includes:

    - A description of behaviour sequences and settings which may require a physical intervention response
    - A risk assessment which balances the risk of using a restrictive physical intervention against the risk of not using a physical intervention
    - A record of the views of those with parental responsibility
    - A system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages
    - Previous methods which have been tried without success
    - A description of staff who are judged competent to use these methods with this child
    - The ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

2. The use of a restrictive physical intervention, whether planned or unplanned (emergency) should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. The written record should indicate:

    - the names of the staff and service users involved
    - the reason for using a physical intervention (rather than another strategy)
    - the type of physical intervention employed
    - the date and the duration of the physical intervention
    - whether the service user or anyone else experienced injury or distress and, if they did, what action was taken.

3. The views of the service user(s) involved in the incident should also be recorded.

4. Records should be reviewed on a half-termly basis.

GUIDANCE ON THE USE OF RESTRICTIVE PHYSICAL INTERVENTIONS FOR STAFF WORKING WITH CHILDREN AND ADULTS WHO DISPLAY EXTREME BEHAVIOUR IN ASSOCIATION WITH LEARNING DISABILITY AND/OR AUTISTIC SPECTRUM DISORDER

1 Introduction

1.1 This guidance on the use of restrictive physical interventions in special schools, care and health settings, is issued jointly by the Department for Education and Skills/Department of Health. It stands as guidance under Section 7 of the Local Authority and Social Services Act 1970; and as advice to support the implementation of Section 550A of the Education Act 1996, in particular in special school settings catering for pupils with severe behavioural difficulties associated with learning difficulties and/or autistic spectrum disorders. Additionally, this guidance will have relevance for working with pupils with severe emotional and behavioural difficulties. Whilst the principles that underpin this guidance will have wider relevance and implications for children in mainstream schools (and LEAs may wish to bring the guidance to the attention of mainstream schools within their area), this guidance is not intended to cover all forms of extreme behaviours in all schools.

1.2 Many pupils for whom this guidance is intended use health and social care services both inside and outside the school setting, and many will continue to use health and social care services when they become adults and leave school. Consistency in approach is important, both to provide the most effective support for individual service users and to reduce the possibility of confusion or disagreements between staff employed by different agencies. This joint guidance is issued to help ensure that staff in schools and staff working in health and social care settings adopt consistent practices in the use of restrictive physical interventions, based upon a common set of principles. Where there is a clear justification for different practices being sanctioned in schools, compared with health and social care settings (for example, where different legislation applies), this is clearly indicated. In this guidance, the term 'service user' refers to adults and children who receive services in care establishments and/or educational settings.

1.3 The guidance will help staff in health and social services to address important outcomes for children and service users - rights, choice, independence and inclusion - described in the Learning Disability White Paper Valuing People and will contribute to the preparation of Joint Investment Plans.

1.4 Associated guidance on the care of adults with learning disability and/or autism can be found in the Department of Health guidance on the protection of vulnerable adults 'No Secrets' and in the report of the Task Force on Violence Against Social Care Staff 'A Safer Place: Combating Violence Against Social Care Staff. The Mental Health Act (1983, under review) and its associated Code of Practice provides relevant guidance in respect of people who have been detained.

1.5 Guidance for all schools on the use of physical intervention for pupils in school can be found in DfEE Circular 10/98 "Section 550A Of The Education Act 1996: The Use Of Force To Control Or Restrain Pupils", and in guidance issued to Chief Education Officers on Positive Handling Strategies in the letter from DfES dated April 24th 2001 (see appendix 1). Additionally, to assist Local Education Authorities and schools in developing local policies and to help schools establish risk assessment procedures, DfES has commissioned the British Institute of Learning Disabilities (BILD) to produce model policies on the use of physical interventions, together with a risk assessment proforma for pupils who present challenging behaviours.

1.6 In care settings, good practice in the use of physical interventions described in this guidance will be monitored as part of the implementation of the Care Standards Act.

1.7 In the case of children in residential care, the general Guidance and Regulations issued in respect of the Children Act 1989 (Volume 4 Residential Care) addressed the use of physical action such as restraint and holding in the context of good order and discipline. The Children Act Guidance states that in residential care settings 'physical restraint should be used rarely and only to prevent a child harming himself or others or from damaging property' (para 1.82). Section 550A of the Education Act 1996 sets out circumstances in which reasonable force may be used by members of staff in schools. These are when it is reasonable to use force for the purpose of preventing a pupil:

- committing an offence
- causing personal injury or damage to property
- engaging in any behaviour prejudicial to the maintenance of good order and discipline in a school or among any of its pupils.

This Section does not apply to Colleges of Further and Higher Education

1.8 Those concerned with, or responsible for, children in residential care, should read this document in conjunction with earlier Department of Health Guidance on Permissible Forms of Control in Children's Residential Care (1993).

1.9 Those concerned with or responsible for pupils with SEN in schools should read this guidance in conjunction with:

- section 550A of the Education Act 1996 and the associated guidance (DfEE Circular 10/98) 'Section 550A Of the Education Act 1996: The Use of Force To Control Or Restrain Pupils'.
- the letter of 24th April 2001 from DfES to Chief Education Officers on Promoting Positive Handling Strategies for Pupils with Severe Behavioural Difficulties (see Appendix 1).

1.10 The book Physical Interventions: A Policy Framework (BILD 1996) provides additional advice and information on the use of physical interventions in different service settings.

1.11 This guidance has been prepared in the context of The Human Rights Act (1998) and The United Nations Convention on the Rights of the Child (ratified 1991). It is based on the presumption that every adult and child is entitled to :

- respect for his/her private life
- the right not to be subjected to inhuman or degrading treatment
- the right to liberty and security, and
- the right not to be discriminated against in his/her enjoyment of those rights

1.12 All services should be designed to promote independence, choice and inclusion and to establish an environment that enables children and service users maximum opportunity for personal growth and emotional wellbeing.

1.13 Wherever possible, restrictive physical interventions should be used in a way that is sensitive to, and respects the cultural expectations of, children and service users and their attitudes towards physical contact.

1.14 Any restrictive physical Intervention should avoid contact that might be mis-interpreted as sexual.

1.15 Restrictive physical interventions should always be designed to achieve outcomes that reflect the best interests of the child or adult whose behaviour is of immediate concern and others affected by the behaviour requiring intervention. The decision to use a restrictive physical intervention must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing a restrictive physical intervention. A restrictive physical intervention must also only employ a reasonable amount of force - that is the minimum force needed to avert injury or damage to property, or (in schools) to prevent a breakdown of discipline - applied for the shortest period of time.

2 Who should read this guidance?

2.1 This guidance should be used by:

- Service commissioners in health and social care
- Managers of health and social care services
- LEAs
- Governing bodies
- Teachers and other staff working in schools catering for pupils with severe behavioural difficulties, for example, those with emotional and behavioural difficulties, autism and learning difficulties which can result in pupils displaying extreme behaviour
- Staff working in health and social care services
- Persons responsible for the operation of independent sector homes and hospitals
- Registration and Inspection staff
- Ofsted inspectors
- Those who provide training for staff on the use of physical interventions

Commissioning authorities will need to ensure that provider agencies follow this guidance. Registration and Inspection staff will monitor the implementation of this guidance within the terms of the Care Standards regulations.

2.2 The information in this guidance may also be helpful to:

- Parents and those with parental responsibilities
- Independent advocates
- Service users
- Pupils
- Staff working in colleges catering for students with severe behavioural difficulties, for example, those with emotional and behavioural difficulties, autism and learning difficulties which can result in pupils displaying extreme behaviour

3. Definitions

3.1 Different forms of physical intervention are summarised in the table below. It shows the difference between restrictive forms of intervention, which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact, and non-restrictive methods. Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment. The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice. For these reasons this guidance is specifically concerned with the use of restrictive physical interventions.

	Bodily contact	Mechanical	Environmental change
Non restrictive	Manual guidance to assist a person walking	Use of a protective helmet to prevent self injury	Removal of the cause of distress, for example, adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them hitting someone	Use of arm cuffs or splints to prevent self injury	Forcible seclusion or the use of locked doors

3.2 Restrictive physical interventions can be employed to achieve a number of different outcomes:

- to break away or disengage from dangerous or harmful physical contact initiated by a service user
- to separate the person from a 'trigger', for example, removing one pupil who responds to another with physical aggression
- to protect a child or service user from a dangerous situation - for example, the hazards of a busy road.

3.3 It is helpful to distinguish between:

- *planned intervention*, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment (see below) and recorded in care plans
- *emergency or unplanned* use of force which occurs in response to unforeseen events.

3.4 The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled, and the nature of the harm they might cause. These judgements have to be made at the time, taking due account of all the circumstances, including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques deployed should be those with which the staff involved are familiar and able to use safely and are described in the child or service user's support plan. Where possible, there should be careful planning of responses to individual children and adults known to be at risk of self-harm, or of harming others.

3.5 The use of force is likely to be legally defensible when it is required to prevent:

- self-harming
- injury to other children, service-users, staff or teachers
- damage to property
- an offence being committed and
- in school settings, any behaviour prejudicial to the maintenance of good order and discipline within the school or among any of its pupils

3.6 The use of force to restrict movement or mobility or to break away from dangerous or harmful physical contact initiated by a service user will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to children, service users, staff and others and pre-planning responses, where possible. Examples of physical intervention that might generally be considered low risk include:

- members of staff taking reasonable measures to hold a service user to prevent him or her from hitting someone
- A specially designed "arm cuff" to prevent someone self-injuring (see para 7.4)
- Accompanying a person who dislikes physical contact to a separate room where they can be alone for a few minutes while being continuously observed and supported.

3.7 Elevated levels of risk are associated with:

- the use of clothing or belts to restrict movement
- holding someone who is lying on the floor or forcing them onto the floor
- any procedure which restricts breathing or impedes the airways
- seclusion, where an adult or child is forced to spend time alone in a room against their will
- extending or flexing the joints or putting pressure on the joints .
- pressure on the neck chest abdomen or groin areas.

3.8 Planned physical intervention strategies should be:

- agreed in advance by a multidisciplinary or school team working in consultation with the child or service user, his or her carers or advocates and, in the case of a child, those with parental responsibility
- described in writing and incorporated into other documentation which sets out a broader strategy for addressing the service user's behavioural difficulties
- implemented under the supervision of an identified member of staff who has undertaken appropriate training provided by an organisation accredited by BILD.

- recorded in writing so that the method of physical intervention and the circumstances when it was employed can be monitored and, if necessary, investigated.

3.9 Where planned physical intervention strategies are in place, they should be one component of a broader approach to behaviour management, treatment or therapy.

3.10 Unplanned or emergency intervention may be necessary when a service user behaves in an unexpected way. In such circumstances, members of staff retain their duty of care to the service user and any response must be proportionate to the circumstances. Staff should use the minimum force necessary to prevent injury and maintain safety, consistent with appropriate training they have received.

3.11 To the extent that *seclusion* (where an adult or child is forced to spend time alone against their will) involves restricting a person's freedom of movement, it should also be considered a form of physical intervention. The use of seclusion for people detained under the Mental Health Act (1983;under review) is set out in the Code of Practice published in 1999.

3.12 The right to liberty and personal freedom is enshrined Article 5 of the Human Rights Act 1998 and is protected by the criminal and civil law. For these reasons the use of seclusion outside the Mental Health Act should only be considered in exceptional circumstances and should always be proportional to the risk presented by the child or service user.

3.13 Under the Children Act 1989 any practice or measure, such as 'time out' or seclusion, which prevents a child from leaving a room or building of his own free will, may be deemed a 'restriction of liberty'. Under this Act, restriction of liberty of children being looked after by a local authority or accommodated by NHS establishments is only permissible in very specific circumstances, for example when the child is placed in secure accommodation approved by the Secretary of State or where a court order is in operation.

3.14 In care settings, if seclusion is required other than in an emergency (for periods of longer than a few minutes or more frequently than once a week) then staff should seek advice regarding the use of statutory powers under mental health or child care legislation.

Legal considerations

The Human Rights Act 1998 sets out important principles regarding protection of individuals from abuse by state organisations or people working for those institutions. Implementation of this guidance will help to ensure that practice within services is consistent with this Act.

4.1 It is a criminal offence to use physical force, or to threaten to use force (for example, by raising a fist or issuing a verbal threat), unless the circumstances give rise to a 'lawful excuse' or justification for the use of force. Similarly, it is an offence to lock an adult or child in a room without a court order (even if they are not aware that they locked in) except in an emergency when for example the use of a locked room as a temporary measure while seeking assistance would provide legal justification. The use of double or high door handles in classrooms or locking outside doors, as a safety measure and/or security precaution <u>when children are supervised by an adult</u> would be considered a reasonable measure to prevent a significant risk of harm within a school's duty of care to its pupils. Use of physical intervention may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned.

4.2 Under health and safety legislation, employers are responsible for the health safety and welfare of employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of physical interventions. Employers should also establish and monitor safe systems of work and ensure that employees are adequately trained. Employers should also ensure that all employees, including agency staff, have access to appropriate information about adults and children they are working with.

4.3 Schools owe a duty of care to their pupils. Providers of health and social care services owe a duty of care towards all service users. The duty of care requires that reasonable measures are taken to prevent harm. Therefore, the use of "high handles" that are beyond the reach of a child and the use locks or other security measures on outside doors to control visitor entry are permissible, if the child is supervised by an adult. It may be appropriate to employ restrictive physical intervention to prevent a significant risk of harm, for example:

- to prevent an adult or child running toward a busy road
- to prevent an adult or child self-injuring
- to prevent an adult or child injuring another person
- to prevent an adult or child committing an offence.

4.4 Planned physical interventions should only be used as part of a holistic strategy when the risks of employing an intervention are judged to be lower than the risks of not doing so. The use of unplanned or emergency physical intervention is addressed in paragraph 3.10 above and in Section 9 below.

4.5 Any physical intervention should employ the minimum reasonable force to prevent injury or serious damage to property, to avert an offence being committed and, in school settings, to prevent a pupil engaging in extreme behaviour prejudicial to the maintenance of good order and discipline at school or among any of its pupils (see DfEE Circular 10/98 "Section 550A of the Education Act 1996: The Use of Force to Control or Restrain Pupils" for more details).

4.6 Records of incidents involving particular pupils and service users sometimes show that there are set patterns to their behaviour which, if unchecked, will lead to it becoming dangerous or exceptionally disruptive. In these circumstances, it might be necessary to use restrictive physical interventions at an early stage. (see Section 10 on Policies and Section 11 on Recording below).

5. Prevention

5.1 The use of restrictive physical interventions should be minimised by the adoption of primary and secondary preventative strategies.

Primary prevention is achieved by:

- ensuring that the number of staff deployed and their level of competence corresponds to the needs of children and service users and the likelihood that physical interventions will be needed. Staff should not be are left in vulnerable positions
- helping children and service users to avoid situations which are known to provoke violent or aggressive behaviour, for example, settings where there are few options for individualised activities
- care plans or, for school pupils, Positive Handling Plans, which are responsive to individual needs and include current information on risk assessment
- creating opportunities for children and service users to engage in meaningful activities which include opportunities for choice and a sense of achievement
- developing staff expertise in working with children and service users who present challenging behaviours
- talking to children, service users, their families and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others. Some children or service users prefer withdrawal to a quiet area to an intervention which involves bodily contact

Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing 'defusion' techniques to avert any further escalation.

Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of a restrictive physical intervention at an early stage in the sequence may, potentially, be justified if it is clear that:

- primary prevention has not been effective, and
- the risks associated with *not* using a restrictive physical intervention are greater than the risks of using a restrictive physical intervention, and
- other appropriate methods, which do not involve restrictive physical interventions, have been tried without success.

5.2 All prevention strategies should be carefully selected and reviewed to ensure that they do not constrain opportunities or have an adverse effect on the welfare or the quality of life service users (including those in close proximity to the incident), unnecessarily. In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities which might provoke challenging behaviours compared with the impact on the person's overall quality of life if such activities are proscribed. This is likely to require a detailed risk assessment - see section 6 above.

5.3 Devices which are required for a therapeutic purpose, such as buggies, wheelchairs and standing frames (including any supporting harness) may also restrict movement. Such devices should never be provided for the purpose of preventing problem behaviour, although, in extreme circumstances, they might be used to manage risks as defined in section 6. A decision to use therapeutic devices to prevent problem behaviour (for example, strapping someone into a wheelchair) must be agreed by a multi-disciplinary team in consultation with service users, their families (and in the case of children, those with parental responsibility) and advocates, and recorded within an individual's care plan/Positive Handling Plan.

5.4 Devices that are designed specifically to prevent problem behaviours should be considered a form of restrictive physical intervention, even if the service user does not resist the use of such devices. For example, arm splints or protective garments might be used to prevent self-injury. They should only be introduced after a multidisciplinary assessment which includes consultation with service users their families (and in the case of children, those with parental responsibility) and advocates. If used, they should be selected carefully to impose the least restriction of movement required to prevent harm while attempts should continue to be made to achieve the desired outcomes with less restrictive interventions. Such devices should only be used by teachers and carers who have received specific training in their usage. The rational for using any devices and the circumstances in which they may be used must be clearly recorded within an individual's care plan/ Positive Handling Plan.

6 Medication

6.1 In certain situations, the use of medication may be indicated as a method of managing extreme behaviour. Medication must only be administered upon medical advice and must only be used as a routine method of managing difficult behaviour where it is included within an individual's care plan and agreed by a qualified medical practitioner. The use of medication should comply any regulations or national minimum standards issued under the Care Standards Act. Under their duty of care, staff should not give tranquillisers to service users who have contra- indications and any contra indications should always be recorded in their care plan. Except in an emergency, (see Section 9) where there is a significant risk of personal injury or a serious risk of an offence being committed, rapid tranquillisation should not be used as a method of gaining control over adults or children who display violent or aggressive behaviour. Even in an emergency, if force is required to administer a tranquilliser, the degree of force must be reasonable. For further information on managing medication in schools please see DfEE Circular 14/96 "Supporting Pupils with Medical Needs in School".

7 Risk Assessment

7.1 When the use of a restrictive physical Intervention is sanctioned, it is important that appropriate steps are taken to minimise the risk to both staff and service users. Among the main risks to children and service users are that a physical intervention could:

- be used unnecessarily, that is when other less intrusive methods could achieve the desired outcome
- cause injury
- cause pain, distress or psychological trauma
- become routine, rather than exceptional methods of management
- increase the risk of abuse
- undermine the dignity of the staff or service users or otherwise humiliate or degrade those involved
- create distrust and undermine personal relationships

7.2 The main risks to staff include the following:

- As a result of applying a physical intervention they suffer injury
- As a result of applying a physical intervention they experience distress or psychological trauma
- The legal justification for the use of a physical intervention is challenged in the courts
- Disciplinary action

7.3 The main risks of not intervening include:

- staff may be in breach of the duty of care (see 4.3 above)
- children, service users, staff or other people will be injured or abused
- serious damage to property will occur
- the possibility of litigation in respect of these matters

7.4 Whenever it is foreseeable that a service user might require a restrictive physical intervention, a risk assessment should be carried out which identifies the benefits and risks associated with the application of different intervention techniques with the person concerned (see BILD's risk assessment proforma). Where the use of self-harm prevention devices is indicated, staff should be fully trained in their usage. This should always be recorded and incorporated with individual care plans or Positive Handling Plans for school pupils (See DfES letter of April 24 2001 to Chief Education Officers on Promoting Positive Handling Strategies for Pupils with Severe Behavioural Difficulties) and other documents that describe a broader strategy for responding to behavioural difficulties. Where incidents are foreseeable, service users should only be exposed to restrictive physical intervention techniques which are described in their individual records/ Positive Handling Plans following a risk assessment.

8 Proactive use of restrictive physical interventions

8.1 In most circumstances, restrictive physical interventions will be used reactively. Occasionally, it may be considered in the best interests of the child or adult to accept the possible use of a restrictive physical intervention as part of a therapeutic or educational strategy that could not be introduced without accepting that reasonable force might be required. For example, the best way of helping a child to tolerate other children without becoming aggressive might be for an adult to 'shadow' the child and to adjust the level of any physical intervention needed according to the child's behaviour. Similarly, staff might be sanctioned to use a restrictive physical intervention, if necessary, as part of an agreed strategy to help a person who is gradually learning to control their aggressive behaviour in public places. In both examples, the physical intervention is part of a broader educational or therapeutic strategy.

8.2 Where this approach is employed it is important to establish in writing a clear rationale for the anticipated use of the restrictive physical intervention and to have this endorsed by a multidisciplinary meeting which includes, wherever possible, family members (or those with parental responsibility) and an independent advocate. In schools, the possible use of restrictive physical interventions, as part of a broader educational or therapeutic strategy, will be included within the pupil's Positive Handling Plan.

9 Emergency use of restrictive physical interventions

9.1 Emergency use of restrictive physical interventions may be required when service users behave in ways that have not been foreseen by a risk assessment. Research evidence[1] shows that injuries to staff and to service users are more likely to occur when physical interventions are used to manage unforeseen events and for this reason great care should be taken to avoid situations where unplanned physical interventions might be needed.

9.2 An effective risk assessment procedure together with well planned preventative strategies will help to keep emergency use of restrictive physical interventions to an absolute minimum. However, staff should be aware that, in an emergency, the use of force can be justified if it is reasonable to use it to prevent injury or serious damage to property and, in schools, to prevent a pupil engaging in any behaviour prejudicial to the maintenance of good order and discipline in the school or among any of its pupils.

9.3 Even in an emergency, the force used must be reasonable. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration. Before using restrictive physical intervention in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences which might have occurred without the use of a physical intervention.

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[1] Hill, J. and spreat, S. (1987) - “Staff injury rates associated with the implementation of contingent restraint” Mental Retardation, 25, 3, 141-145
Spreat, S.; Lipinski, D.P.; Hill, J. and Halpin, M. (1986) - “Safety indices associated with the use of contingent procedures.” Applied Research in Mental Retardation, 7, 475-481

10 Policies

10.1 The starting point for establishing good practice in the use of restrictive physical interventions is the development of organisational policies which reflect current legislation and case law as well as government guidance, professional codes of practice and local circumstances, including the characteristics of the children or adults within particular services. Policies on physical interventions are expected to be developed in collaboration with local Adult Protection and Area Child Protection Committees.

10.2 Every agency included within the remit of this guidance is expected to have a policy on the use of restrictive physical interventions. The amount of detail needed will depend upon local circumstances but would be expected to cover the areas described in section 10.8 below. In general terms, policies will describe the context in which it is appropriate to use restrictive physical interventions.

10.3 Policies are expected to emphasise that restrictive physical interventions should always be used as part of a more general behaviour management strategy.

10.4 A school's Behaviour Policy and the related Physical Interventions Policy will set out the broad range of strategies staff are allowed to use when attempting to defuse an incident of extreme behaviour.

10.5 Individual Care Plans and, in schools, Positive Handling Plans (see DfES letter of April 24th 2001 to Chief Education Officers on Positive Handling Strategies for Pupils with Severe Behavioural Difficulties) are expected to set out, in detail, the specific strategies and techniques which should, if necessary, be used with each named service user who has been assessed as being at risk of needing restrictive physical interventions. Plans are also expected to list any specific techniques which it would not normally be appropriate to use (whether because the service user has experienced abuse in the past or for some other reason. See Section 6 on Risk Assessment)

10.6 The policy is expected to explain how service users, their families (and in the case of children, those with parental responsibility) and advocates participate in planning, monitoring and reviewing the use of restrictive physical interventions.

10.7 LEAs are also expected to develop their own policies on the use of restrictive physical interventions using this guidance as a framework. LEAs are also expected to inform schools when new pupils who are identified as being at risk of displaying extreme behaviour are due or likely to be placed there. Other important points of reference will be the letter from DfES to Chief Education Officers on Promoting Positive Handling Strategies for Pupils with Severe Behavioural Difficulties and the materials on policy development and implementation being produced by BILD.

10.8 Policies on restrictive physical interventions are expected to include reference to the following:

- Strategies for preventing the occurrence of behaviours which precipitate the use of a physical intervention.
- Strategies for 'de-escalation' or 'defusion' which can avert the need for a physical intervention.
- Procedures for post incident support and de-briefing for staff, children, service users and their families
- The concept of reasonable force where 'reasonableness' is determined with reference to all the circumstances, including
    - The seriousness of the incident:
    - The relative risks arising from using a physical intervention compared with using other strategies.
    - The age, cultural background, gender, stature and medical history of the child or service user concerned.
    - The application of gradually increasing or decreasing levels of force in response to the person's behaviour.
- The approach to risk assessment and risk management employed.
- The distinction between:
    - *seclusion* where an adult or child is forced to spend time alone against their will
    - *time out* which involves restricting the service user's access to all positive reinforcements as part of the behavioural programme
    - *withdrawal* which involves removing the person from a situation which causes anxiety or distress to a location where they can be continuously observed and supported until they are ready to resume their usual activities.
- The distinction between *planned* physical interventions (where incidents are foreseeable) and the use of force in *emergency* situations (which cannot reasonably be anticipated).
- First aid procedures to be employed and those responsible for implementation in the event of an injury or physical distress arising as a result of a physical intervention.
- Policies should clearly describe *unacceptable* practices that might expose service users or staff to foreseeable risk of injury of psychological distress.

10.9 Policies will need to recognise situations where breakaway or disengagement strategies, which involve minimal use of pain or discomfort, may be sanctioned as the least intrusive method which is consistent with the safety of staff and service users. Such methods will be based upon a risk assessment, will be fully documented and will employ only the minimum amount of force required.

10.10 Policies should include a clear statement about the safeguards needed to protect the rights of service users who need constant supervision. Children and service users who lack an awareness of danger may present a risk to themselves or others in public places and for this reason the use of locked doors may be considered. In these circumstances a court order should be obtained. This does not apply to the use of high or double handles in classrooms as a safety measure, or to locking or providing security on outside doors to control visitor entry, provided that children are supervised by an adult.

10.11 Employers and managers are responsible for ensuring that staff receive training, including updates and refresher courses, appropriate to their role and responsibilities within the service. There should be a policy on staff development and training which includes reference to training in the use of physical interventions.

10.12 Normally, only staff who been trained to an appropriate level should be sanctioned to use restrictive physical interventions. In schools, under Section 550A of the Education Act 1996, this will be a teacher or someone who, with the head's authority, has lawful control of pupils. However, in an emergency the use of force by other people can be justified if it is the only way to prevent injury or to prevent an offence being committed. In these circumstances, the use of force should be reasonable and proportionate and, whenever possible, it should reflect the person's previous training in the appropriate use of restrictive physical interventions.

10.13 Employers and managers wishing to engage trainers or training organisations should seek evidence to support the suitability of particular approaches. The BILD Code of Practice for Trainers in the Use of Physical Interventions is an important point of reference for trainers and service providers.

10.14 Policies should be reviewed, evaluated and amended at least every 12 months.

10.15 Agency policies on restrictive physical interventions should be explained to service users, including those who might be exposed to physical interventions. All those who experience physical interventions should be offered the opportunity to discuss the way in which staff have responded to their behaviour and to express their concerns and preferences about future management.

11 Recording

11.1 For schools: Clarifying the text of DfEE Circular 10/98, the DfES letter to Chief Education Officers dated April 24th 2001 describes the basic procedures and systems for recording incidents involving the use of restrictive physical interventions that schools are expected to follow. These should be taken as a minimum. The protocol described below, although designed for care settings, includes much which schools might consider drawing on.

11.2 For health and care settings: If it is foreseeable that a child or adult will require some form of restrictive physical intervention, for each service user, there must be a written protocol which includes:

- A description of behaviour sequences and settings which may require a physical intervention response
- The results of an assessment to determine any contra indications for use of physical interventions
- A risk assessment which balances the risk of using a restrictive physical intervention against the risk of not using a physical intervention
- A record of the views of those with parental responsibility in the case of children and family members in the case of adults
- A system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages (see 11.2 below)
- Previous methods which have been tried without success
- A description of the specific physical intervention techniques which are sanctioned, the dates on which they will be reviewed
- A description of staff who are judged competent to use these methods with this person (see section 11 on Staff Training below)
- The ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

An up-to-date copy of this protocol must be included in the person's individual care plan.

11.3 The use of a restrictive physical intervention, whether planned or unplanned (emergency) should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. The written record should indicate:

- the names of the staff and service users involved
- the reason for using a physical intervention (rather than another strategy)
- the type of physical intervention employed
- the date and the duration of the physical intervention
- whether the service user or anyone else experienced injury or distress and, if they did, what action was taken.

The views of the service user(s) involved in the incident should also be recorded.

11.4 The contents of the incident book should be reviewed on a half-termly basis and appropriate action taken.

11.5 Recording will be used for a number of different purposes;

- compliance with statutory requirements
- monitoring of service users' welfare
- monitoring staff performance and identifying training needs or outcomes
- contributing to service audit and evaluation
- updating medical records

11.6 Services need to ensure that recording methods are in place to meet each of these requirements.

12 Post Incident Management

12.1 Following an incident in which restrictive physical interventions are employed, both staff and service users should be given separate opportunities to talk about what happened in a calm and safe environment. Interviews should only take place when those involved have recovered their composure. Post incident interviews should be designed to discover exactly what happened and the effects on the participants. They should not be used to apportion blame or to punish those involved. If there is any reason to suspect that a service user or a member of staff has experienced injury or severe distress following the use of a physical intervention, they should receive prompt medical attention.

12.2 To help protect the interests of service users who are exposed to restrictive physical interventions it is good practice to involve, wherever possible, family carers and independent advocates in planning, monitoring and reviewing how and when they are used.

13 Staff training

13.1 All staff require induction training before being required to work with people who present challenging behaviours. Staff who are expected to employ restrictive physical interventions will require additional, more specialised training. The nature and extent of the training will depend upon the characteristics of the people who may require a physical intervention, the behaviours they present and the responsibilities of individual members of staff.

13.2 Staff should normally only use methods of restrictive physical intervention for which they have received training. Specific techniques should be closely matched to the characteristics of individual service users and there should be a record of which staff are permitted to use different techniques. It is not appropriate for staff to modify the techniques they have been taught.

13.3 The Department of Health and the Department for Education and Skills are working with BILD, and in collaboration with other agencies, to establish an accreditation scheme for those offering training on physical interventions for learning disability and education services. It is envisaged that accreditation within this scheme will provide an important indication of the quality of training available from different trainers and training organisations.

14 Implementation

14.1 Implementation of this guidance will require the co-ordinated effort from commissioners, service providers, professionals, care staff and training organisations. The key tasks for implementation are set out below.

- Establishing and implementing appropriate and effective agency policies on the use of physical interventions
- Maintaining systematic and accurate records and a system for reporting and reviewing incidents
- Establishing a system to monitor trends over time both with respect to the use of physical interventions with individual service users and to identify overall trends in the use of physical interventions within an organisation
- Monitoring and reviewing local practice in the light of feedback within the context of clinical governance or other systems of accountability
- Developing staff training programmes which include regular updating and re-fresher courses. The expectation is that training should normally be provided by trainers who are accredited under the BILD Code of Practice on Training Staff in the use of Physical Interventions
- Ensuring that staff recruitment, training and work rotas are adjusted to ensure that staff with appropriate expertise are available to service users who may require physical interventions.

15 Co-ordination

15.1 It is important that good practice in the use of physical interventions is properly co-ordinated with other procedures designed to protect vulnerable people. These will include:

- Local multi-agency management committees set up to audit policies, procedures and practices for the protection of vulnerable adults (See No Secrets, Section 3)
- The Mental Health Act Commission when physical interventions are employed with anyone who is detained under the Mental Health Act
- Local Area Child Protection Committees

15.2 Commissioners will wish to ensure that suitable arrangements are in place before approving contracts and, under the new Care Standards Act, inspectors will have responsibility for monitoring and evaluating co-ordination between service providers and other agencies.

References

BILD (2001) Code of Practice for Trainers in the Use of Physical Interventions available from BILD, Campion House, Green Street, Kidderminster, Worcs DY10 1JL.

BILD/DfES (forthcoming) Model Policies for Schools and Local Education Authorities on the Use of Physical Interventions for Pupils with Severe Behavioural Difficulties and Risk Assessment Proforma to Use when Undertaking Risk Assessments on Pupils with Severe Behavioural Difficulties.

Children Act 1989 Guidance and Regulations Volume 4:Residential Care (1991) London: HMSO.

Department for Education and Employment (1998|) Circular 10/98 'Section 550A Of the Education Act 1996: The Use of Force to Control or Restrain Pupils, London: HMSO

Department for Education and Employment, (2001) Letter and accompanying guidance on 'Promoting Positive Handling Strategies' from the Head of DfEE Special Educational Needs Division to Chief Education Officers, issued on 24th April 2001.

Department of Health (2001) A Safer Place: Combating Violence against Social Care Staff, Report of the National Task Force and National Action Plan, Brighton: Pavilion.

Department of Health (1993) Guide on Permissible Forms of Control in Children's Residential Care, London: Department of Health.

Department of Health (2000) No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse, London: Department of Health.

Harris, J. Alan.D. Cornick, M, Jefferson, A. and Mills, R. (1996) Physical Interventions: A Policy Framework. BILD Publications (1996)

Mental Health Act (1983) Code of Practice, Department of Health and Welsh Office, London: The Stationery Office (1999)

APPENDIX 1

Letter from Chris Wells to Chief Education Officers on the Use of Positive Handling Strategies, sent 24th April 2001

To all Chief Education Officers

24 April 2001

Dear Colleague

POSITIVE HANDLING STRATEGIES FOR PUPILS WITH SEVERE BEHAVIOURAL DIFFICULTIES

I am writing to update you on work the Department has carried forward since the consultation on guidance to promote positive handling strategies for pupils with severe behavioural difficulties.

The consultation drew in over 150 thoughtful and thought provoking responses. The key themes to emerge from the consultation were:

- that the key services, such as education and social services, should take a co-ordinated and consistent approach. There was widespread support for the recommendation that LEAs should seek advice on their policies in this area from their Area Child Protection Committee (ACPC);
- that the use of physical force should be seen as but one element of a school's overarching behaviour management policy;
- that incidents requiring the use of physical force should be thoroughly and systematically recorded; and
- that headteachers needed a means to ensure that any training they sanction in the use of physical force is safe, suitable and appropriate.

We have considered the above points, and indeed the broad sweep of the consultation responses, carefully. We will:

- commission, jointly with the Department of Health, the British Institute of Learning Disabilities (BILD) to develop a system to accredit organisations offering training in the use of physical force. As a first step, BILD will shortly produce a voluntary code of practice for all training providers;
- work with the Department of Health to produce joint guidance on the use of physical interventions with children and adults with learning disabilities;

- ask BILD, with the aid of an expert panel, to work up model physical intervention policies for LEAs and schools to draw upon when developing their own - these we will be able to issue in the late spring.

In addition to the above, I attach some guidance taking into account the responses to the promoting positive handling strategies consultation. This is with respect to the development of LEA-wide policies on the use of physical force to control or restrain pupils, new advice on related school based policies and on recording and monitoring incidents. This stands as additional guidance to supplement Circular 10/98 "Section 550a Of The Education Act 1996: The Use Of Force To Control Or Restrain Pupils".

Circular 10/98 provided general guidance on the coverage of Section 550a of the Education Act 1996 and its implications for schools and LEAs. In short, section 550a allows for certain members of staff of a school to use a reasonable degree of force in relation to a pupil for the purposes of preventing him/her doing any of the following:

- committing an offence;
- causing personal injury to, or damage to the property of, any person; or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils.

Implicit in Circular 10/98 was a requirement for LEAs to have a formal policy on the use of force. The Department's advice is that LEAs should link such policies to behaviour support plans. Further, such policies need to be comprehensive and cleared with area child protection committees.

The use of physical force by teachers should be rare. Behaviour management policies should be designed to ensure that early and preventive intervention is the norm, so reducing the incidence of extreme behaviour requiring the use of physical force. This said, the Department accepts that there will be times when staff have no option but to use reasonable force. We recommend that teachers and other staff should only use techniques for using physical force on pupils with which they are familiar and confident, and which are consistent with the school/LEA policy on the use of force. We believe that the creation of whole LEA policies, commented upon by ACPCs and supported by accredited training, will ensure greater consistency and safety when using physical intervention with children with severe behavioural difficulties.

Physical intervention can lead to allegations of inappropriate or excessive use of force, and policies should cross reference to the guidance about dealing with allegations in the Department's Circular 10/95 "Protecting Children from Abuse: The Role of the Education Service". As advised in that Circular staff who are the subject of allegations should not be suspended automatically, or without careful consideration of whether that is the appropriate course of action.

Yours sincerely

CHRIS WELLS
Head of Special Educational Needs Division

AGREEING PROCEDURES FOR THE USE OF PHYSICAL FORCE ON PUPILS

1. It is recommended that LEAs have a written policy on the use of physical force to control or restrain, where necessary, pupils in school, and on procedures for monitoring the use of physical force. This will help to ensure that maintained schools' behaviour policies, and those of independent and non-maintained special schools at which places are funded by the LEA, are in line with the general principles described in their Behaviour Support Plan. Circular 10/98: Section 550a Of The Education Act 1996: "The Use Of Force To Control Or Restrain Pupils" recommended that schools should put in place their own formal policies in this regard. A school's policy on the use of physical force on pupils should draw on its LEA's policy.

2. LEAs should consider whether to make model policies available to their schools for each to fine tune to meet its particular circumstances. The Department will commission the British Institute Of Learning Disabilities (BILD), with the aid of an expert panel, to work up model policies on the use of physical force in relation to pupils with special educational needs and/or severe behavioural difficulties which LEAs and schools may wish to draw upon when developing their own. We shall make these available in the late spring.

3. When reviewing their Behaviour Support Plans, LEAs are recommended to incorporate their policy on the use of physical force into the Plan. As a minimum, it is recommended that the two documents should be clearly cross-referenced. LEAs and schools which place pupils who are under 16 and have special educational needs for their education at colleges in the further education sector are recommended to make sure that the colleges are aware of their policy on the use of physical force.

Agreeing Policies On The Use Of Physical Force On Pupils With Regulatory Bodies

4. Section 550A of the Education Act 1996 and Circular 10/98 sets out the parameters within which school staff are permitted to work. LEAs' policies should fully support staff who need to use reasonable force in the circumstances set out in s550A. Agreeing a policy on how those principles will be applied in practice will help ensure a consistent approach and prevent misunderstandings between agencies if allegations of physical abuse are made. It is recommended that, when drawing up policies on the use of physical force, LEAs work closely with the local Social Services Department and with those responsible for health and safety policy across the Local Authority.

5. It is, of course, important that the policy on the use of physical force does not recommend procedures that might prevent the Local Authority exercising its duty to safeguard the health and safety of its employees and/or the welfare of the children in its care. The Health And Safety Executive expect Local Authorities to have a corporate policy on managing violence against staff, including for education and social services. It is recommended that the policy on the use of physical force on pupils is considered alongside this and, as appropriate, cross referenced with it[2]. Policies should be cleared with an LEA's legal advisers before consultation with other local statutory bodies.

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[2] HSE website: http://www.hse.gov.uk

6. It is important that LEAs are proactive in ensuring that draft policies on the use of physical force are agreed by the other local statutory bodies. LEAs should also consider carefully which statutory bodies to consult. As a minimum, it is recommended that LEAs agree their policies through the local Area Child Protection Committee (ACPC). The full range of statutory bodies with an interest in child protection are represented on the ACPC, including Education itself, Social Services Departments and the Police. Once a policy is agreed LEAs will need to liase closely with colleagues from other parts of the Local Authority and statutory bodies to review the effectiveness of the policy. Much can be gained by LEAs working collaboratively on their policies and the Special Educational Needs Regional Collaboration Projects are likely to provide suitable fora for facilitating this process.

7. It is recommended that children looked after by the Local Authority, in respite care, or cared for by others with legal responsibility for them should, wherever possible, be subject to the same policy on the use of physical force in and out of school. Ideally, the policy will be jointly worked up by the LEA and Social Services Department and, where applicable, the relevant National Health Service Trust.

Schools' Policies

8. It is recommended that schools which have pupils with severe behavioural difficulties should take especial care in preparing the physical force element of their behaviour policies. The use of physical force should be considered within the wider context of other measures - for example, strategies for using diversion, defusing situations, negotiation and establishing and maintaining good relationships. Children with behavioural difficulties sometimes present particularly challenging behaviour that may necessitate the use of reasonable force to prevent injury, or damage to property, or the breakdown of discipline. Wherever possible, this should be anticipated and provided for in the policy. (It might also be helpful to describe situations where it would be inappropriate to use physical force.) As Circular 10/98 notes, head teachers should draw on their LEA's related policy when preparing their school's policy. It may also be useful to look at policies prepared by other schools catering for pupils with similar special educational needs. Complying with a LEA's clear central steer on the use of physical force may make it easier for a school or a member of staff, if challenged, to show that what they did was reasonable and lawful.

Agreeing Policies

9. It is recommended that each maintained school should agree its policy on the use of physical force with its governing body and maintaining LEA. (As the governing body may need to hear disciplinary cases involving members of staff who have used physical force on pupils, it is important that governors are fully aware of the content of the school's policy and understand the context in which staff operate.) Head teachers of non-maintained special schools are also recommended to agree their policy with the governing body.

Schools Taking Pupils From Outside The Home LEA

10. In most cases, it will be impracticable for a school which takes pupils from outside its own Local Authority area to modify its policy on the use of physical force to bring it exactly in line with those of each placing LEA or Social Services Department. Therefore, prior to placing a pupil at the school, it is recommended that the placing authority satisfy itself that it is content for the pupil to be subject to the school's policy. For its part, the school may wish to seek formal confirmation of this point prior to offering a place. If the LEA or co-sponsoring Social Services Department is unable to agree to the general principles of a school's policy, it is recommended that the pupil be placed elsewhere.

11. Where a placing authority is generally supportive of a school's policy, but, at the outset, feels that some adjustments will need to be made to it to accommodate the likely needs of a prospective pupil, it is recommended that these be agreed formally prior to the school offering a place. If the changes involve the use of procedures and techniques for using physical force that are significantly different from those set out in the school's policy and the school nonetheless wishes to offer a place to the pupil, it would be advisable for the school to discuss the proposed agreement with its local Social Services Department. It is recommended that schools inform their LEA and Social Services Department of any significant changes to their policy on the use of physical force and/or the way they operate them.

12. It is often appropriate for outside bodies with a professional interest in a pupil with special educational needs and/or severe behavioural difficulties to be involved in agreeing the procedures which will be followed when using physical interventions on him or her. It is recommended that parents or those with legal responsibility for caring for such pupils should, where practicable, be asked to agree to these also.

Recording Incidents

13. Paragraphs 28-30 of Circular 10/98 offer guidance on recording incidents involving the use of physical force. Paragraphs 30 and 31 describe how these records might be used by investigating authorities when complaints are made and some of the procedures it is advisable to follow. It is important that staff in special schools should follow the procedures outlined carefully.

14. The Circular advises that schools keep detailed, contemporaneous, written reports of all incidents where physical force has been used. (Under its new inspection framework, OFSTED look at all a school's incident reports compiled in the year previous to an inspection.) It is recommended that these should be recorded in an incident book with consecutively numbered pages within 24hrs of the incident but wherever feasible on the day it occurs.

Entries in the incident book should be cross-references to any more detailed records kept elsewhere, such as those examining the possible causes of the incident, the after effects, follow-up action and linkages to previous incidents. It is recommended that schools produce, or build into their behaviour policies explicit instructions on:

- procedures staff are expected to follow when completing records and the time scales they should normally work to; and
- guidance on where copies should be lodged (including where the master set can be found).

15. Schools catering for pupils with severe behavioural difficulties - where there can be appreciable numbers of false allegations against staff - are advised to be especially careful to follow set procedures when recording incidents. A thorough record which shows that the school's procedures were followed diligently might act as a useful aid to staff who are wrongly accused. The corollary is that where no record or an incomplete record is kept of an incident and/or other procedures were not properly followed, the person accused might be vulnerable. The school might also be criticised for poor practice. A pupil's records describing past behaviour will never, by themselves, constitute an admissible defence if a member of staff is charged with assault or a claim for damages is sought. However, it will be a defence to show that a member of staff acted in accordance with S550A of the Education Act 1996, and records of a pupil's behaviour may assist them in making out that defence.

16. The requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 may apply if employees or pupils are injured whilst using techniques in the use of physical force i.e. in the case of death or "major injury" (as defined in the regulations) of a member of staff, or an injury to a pupil requiring hospital treatment. The appropriate enforcing authority (usually the Health and Safety Executive) should be informed if any such incidences are 'reportable'[3].

Monitoring Incidents And Reviewing Procedures

17. It is recommended that the LEA's policy on the use of physical force should set out the circumstances in which incidents should be reported to it. In their responses to the consultation, an appreciable number of LEAs made the point that they find it helpful to obtain as much information on their schools' use of physical force as they can. This enables them to easily identify trend information across the area and see quickly where schools might be experiencing difficulties.

18. It is recommended that the LEA's school link officer or SEN adviser should regularly review a cross section of incident reports from each school catering for children with severe behavioural difficulties. LEAs may wish to agree common practices across all schools for both recording and passing to the LEA records of incidents involving the use of physical force, to aid monitoring of specific or general trends.

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[3] See: HSE leaflets, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDOR), "Everyone's Guide to RIDDOR '95 (1996) HSE31 - free leaflet or available in priced packs. ISBN 0 7176 1077 2 "Reporting school accidents (1997)" EDIS 1 - free information sheet (available from http://www.hse.gov.uk/pubns/edis1/htm

HSE website: http://www.hse.gov.uk

19. At school level, it is important to regularly review the records of incidents to ascertain trend information and to assess the impact of training. It is recommended that head teachers should involve the school's governing body in this process and that feedback on the level and type of incidents involving the use of physical force should be a set item at governors' meetings. It is recommended too that the effectiveness of any training in physical intervention techniques used should be assessed at least annually. Some schools have used computer systems to provide trend information to give early warning of emerging problems. Schools are also recommended to regularly review the effectiveness of their physical intervention and behaviour management policies

20. Opinion was sharply divided amongst those responding to the consultation over whether it is desirable for schools to seek to have their incident records externally audited. DfEE accepts that different systems will suit differing circumstances. There is definite benefit in records being reviewed by a third party with a sufficient level of knowledge and appreciation of the specific circumstances of a school. However, finding people with this level of expertise can be problematic and some, at least, of this validating role is undertaken by the regulatory authorities that routinely visit the school.

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An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Seeking consent:

Working with people with learning disabilities

Contents

Introduction

If your work involves health or social care of any kind for people (anything from helping people with dressing to carrying out major surgery), you need to make sure you have their consent to what you propose to do, if they are able to give it. This respect for people's rights to determine what happens to their own bodies is a fundamental part of good practice. It is also a legal requirement.

The Department of Health, Social Services and Public Safety guidance, Reference Guide to Consent for Examination, Treatment or Care, sets out in detail the current law in Northern Ireland on consent and gives references to legal cases and good practice guidance from regulatory bodies for those who want to know more. This booklet focuses on the particular issues which may arise when seeking consent from adults with learning disabilities. There are separate booklets for those working with children and older people.

The first part of this booklet concentrates on people who have the capacity to give or withhold consent to treatment or care, while the second part gives guidance on how you should act if the person does not have the capacity to consent to treatment or care. It should never be assumed that people are not able to make their own decisions, simply because they have a learning disability. The third part looks at the particular issues which arise when considering if life-prolonging treatment should be withheld or withdrawn from a person.

The support of families, friends, carers and others close to them will often be very important for people with learning disabilities. This guidance uses the phrase 'people close to the person' to refer to all these possible sources of support.

Seeking consent: People with capacity

General points on consent

For a person's consent to be valid, the person must be:

- capable of taking that particular decision ('competent')
- acting voluntarily (not under pressure or duress from anyone)
- provided with enough information to enable them to make the decision.

Seeking consent is part of a respectful relationship with people with learning disabilities, and should usually be seen as a process, not a one-off event. When you are seeking a person's consent to treatment or care, you should make sure they have the time and support they need to make their decision, unless the urgency of their condition prevents this. People who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point, if they have the capacity (are 'competent') to do so. Similarly, they can change their minds and consent to an intervention which they have earlier refused. It is important to let the person know this, so that they feel able to tell you if they change their mind.

Where a patient objects and appears to withdraw consent during treatment or care, it is good practice to stop the procedure, if possible, and to establish the patient's concerns. Sometimes, an apparent objection may reflect pain or distress, rather than withdrawal of consent, and appropriate reassurance may enable you to continue with the procedure. If stopping the procedure at that point would genuinely put the patient's life at risk, you may be entitled to continue until the risk no longer applies.

Adults with the capacity to take a particular decision are entitled to refuse the treatment being offered, even if this will clearly be detrimental to their health. Mental health legislation does provide the possibility of treatment for a person's mental disorder without their consent (in which case more specialist guidance should be consulted). Detention under mental health legislation does not give a power to treat unrelated physical disorders without consent.

Consent is a process. Legally, it makes no difference whether people sign a form to indicate their consent, or whether they give consent orally or even non-verbally (for example by holding out an arm for blood pressure to be taken). A consent form is only a record, not proof that genuine consent has been given. It is good practice to seek written consent if treatment or care is complex, or involves significant risks or side-effects. If the person has the capacity to consent to treatment or care for which written consent is usual but cannot write or is physically unable to sign a form, a record that the person has given oral or non-verbal consent should be made in their notes or on the consent form.

Does the person have capacity?

Adults are always presumed to be capable of taking health and social care decisions, unless the opposite has been demonstrated. This applies just as much to people with learning disabilities as to any other adult. Where any doubt exists, you or an appropriate colleague should assess the capacity of the person to take the decision in question, drawing on both the individual’s carers and the assistance of specialist colleagues such as learning disability teams and speech and language therapists as necessary. This assessment and the conclusions drawn from it should be recorded in the person’s notes or, where appropriate, in a form for adults who are unable to consent.

For people to have the capacity to take a particular decision, they must be able to:

- comprehend and retain information material to the decision, especially as to the consequences of having or not having the intervention in question, and

- use and weigh this information in the decision–making process.

It is very easy for an assessment of capacity to be affected by organisational factors such as pressure of time, or by the attitude of the person carrying out the assessment. It is your professional responsibility to ensure that you make as objective a judgement as you can, based on the principle that the person should be assisted to make their own decision if at all possible. It is essential that the information available for people with learning disabilities is appropriate and accessible (see page 5).

Methods of assessing comprehension and ability to use information to make a choice include:

- exploring the patient’s ability to paraphrase what has been said (repeating and rewording explanations as necessary);
- exploring whether the patient is able to compare alternatives, or to express any thoughts on possible consequences other than those which you have disclosed;
- exploring whether the patient applies the information to his or her own case.

People with learning disabilities will often have support from people close to them (family members, carers or friends) or from advocates, who can help them understand the issues and come to their own decisions. Where appropriate, professionals from local learning disability community teams will also be able to act as ‘health and care facilitators’ on behalf of the person. **However, no one can consent on behalf of another adult.**

Some people may have capacity to consent to some interventions but not to others. People with a mild to moderate learning disability, for example, would probably have capacity to make many straightforward decisions about their own care, but some might lack capacity to take very complex decisions. It should never be assumed that people can take no decisions for themselves, just because they have been unable to take a particular decision in the past.

Capacity should not be confused with your assessment of the reasonableness of the person’s decision. People are entitled to make a decision based on their own religious belief or value system, even if that decision is perceived by others to be irrational, as long as they understand what is entailed in their decision. For example, a person might refuse an operation which you and your colleagues believe is in their best interests because they do not want to take the risk, even if the risks in fact are very low. If a decision seems irrational, discuss it with the person and, where appropriate, those supporting them, and find out the reasons for the refusal. In some cases, further information and discussion may mean the person would want the treatment to go ahead, perhaps in a slightly different form. However, you must never try to coerce the person into changing their decision. Seeking consent is about helping the person make their own, informed, choice, and different people will come to different decisions.

In practice, people also need to be able to communicate their decisions. You should take all steps which are reasonable in the circumstances to help communication between yourself and the person using interpreters and communication aids as appropriate. If you and the person are having difficulties understanding each other, those close to the person may well be able to help, as may specialist colleagues such as speech and language therapists.

What information do people need?

People clearly need enough information before they can decide whether to consent to, or refuse, treatment or care. In particular, they need information about:

- the benefits and the risks of the proposed treatment or care
- what the treatment or care will involve
- what the implications of not having the treatment or care are
- what alternatives may be available
- what the practical effects on their lives of having, or not having, the treatment or care will be.

It is essential that this information is provided in a form that the individual can understand. This may involve using pictures, or explaining what is involved in simple terms and short sentences and being willing to repeat or reword explanations. Communication aids such as boards where people can indicate ‘yes’ or ‘no’ may also be helpful. You should also always check to make sure that the person has understood. If they use a tool such as Makaton, then again an interpreter will be needed. Where a person’s first language is not English, you may need to use an interpreter.

The manner in which information is presented is also important. You should ensure that information is provided in a respectful way, for example by finding an appropriate, private place to discuss confidential matters.

Is the person's decision made voluntarily?

It is very important to ensure that the person's decision is truly their own. Clearly, both you and your colleagues and people close to the person have a role to play in discussing the options, but you should take care that people do not feel forced into making decisions they are not happy with because of pressure from others, or are simply agreeing out of a desire to comply with authority.

When adults lack capacity

General points

Even where information is presented as simply and clearly as possible, some people will not be capable of taking some decisions. This will obviously apply when a person is unconscious, for example. It may also apply to some people with severe learning disabilities. However, you must never make this judgement until all practicable steps have been taken to help the person make their own decision.

If a person is not capable of giving or refusing consent, it is still possible for you lawfully to provide treatment and care. However, this treatment or care must be in the person's "best interests".

No one (not even the person's parents, or others close to them) can give consent on behalf of adults who are not capable of giving consent for themselves. However, those close to the incapacitated person should always be involved in decision-making. Although, legally, the health and social care professionals responsible for the person's care are responsible for deciding whether or not a particular intervention is in that person's best interests, ideally decisions will reflect an agreement between professional carers (doctors, dentists, nurses, social workers etc.) and the individual's family and friends.

Advance directives/Refusal of Treatment

Sometimes people may have expressed clear views in the past as to how they would like to be treated if in future they were to lose capacity. Such views may have been expressed orally or in writing as "advance directives" or "living wills". Advance directives may take a number of forms: they may explicitly refuse particular treatment, or they may spell out the kind of care a person would wish to receive in certain circumstances.

If a person makes an advance refusal of certain kinds of treatment, then such a refusal is legally binding if at the time of making the decision the individual was competent, they understood in broad terms the implications of their decision, and the refusal is applicable to their current situation. Advance directives setting out the kind of care the person would like to receive are not legally binding, but should be influential when deciding what treatment is in the person's best interests.

Best interests

The courts have made clear that people's "best interests" are not limited to what would benefit them medically. Other factors, such as their general wellbeing, their relationships with those close to them, and their spiritual and religious welfare, and the likelihood of their willingness to co-operate should all be taken into account.

The only interests which you should take into account when deciding if particular care or treatment is appropriate are the person's best interests. It is not lawful to balance these interests against the interests of their family, the interests of health and social care professionals, or the interests of other people living with the individual. However, these interests will often be inter-linked: for example the effect of a treatment or care decision on family relations should be taken into account as part of the individual's "best interests", where family support is important to the person with learning disabilities.

Ideally, decisions should be made which both those close to the person and the health and social care team agree are in the person's best interests. If it proves impossible to reach such agreement over significant decisions, the courts can be asked to determine what is in the person's best interests. The courts have stated that certain procedures (including sterilisation for contraceptive purposes and donation of regenerative tissue such as bone marrow) should never be carried out without being first referred to a court. It is very unlikely that it would even be in the best interests of a person lacking capacity to donate a solid organ, but if this were to be considered it should be referred to a court.

Family members cannot require health and social care professionals to provide a particular treatment or care if those involved do not believe that it is appropriate, but as part of a good relationship with those close to the person you should explain why you believe the treatment or care is inappropriate. Where possible, a second opinion should be offered. You must never make assumptions that particular treatment or care is inappropriate just because the patient has a learning disability. This is discriminatory and unlawful.

Where a decision to provide care or treatment is taken on the basis that this is in the person's best interests, the standard consent form should **not** be completed. Instead, you should make a written record (either in the person's notes or on a form for adults who are unable to consent) of the reasons for your decision and the involvement of those close to the person. Any disagreement between the health or social care team and those close to the person should also be recorded.

Withdrawing and withholding life-prolonging treatment

As medical science develops, it has increasingly become possible to prolong a person's life despite the failure of essential bodily functions: for example through artificial nutrition and hydration where a person is not able to absorb food in the usual way, or through artificial ventilation where the person cannot breathe on their own.

Often, there will be no doubt that such care or treatment is benefiting the person and should be continued. However, in certain circumstances, for example where a person is suffering from the last stages of a terminal disease, or where the burdens the treatment imposes on the person outweigh the benefits to the person, it should not automatically be assumed that life should be prolonged at all costs, as this may not be in the person's best interests (see page 8). Such a decision is distinct from a deliberate intervention with the intentional aim of ending life, which constitutes euthanasia and is unlawful.

The same broad principles apply to providing, or withholding, life-prolonging treatment as apply to any other kind of treatment:

- if people with capacity refuse treatment, the refusal must be accepted;
- if people do not have capacity, the decision to provide or withhold life-prolonging treatment must be based on an assessment of their best interests;
- if a person has refused the treatment in advance in a valid advance directive, this refusal must be honoured.

Cardiopulmonary resuscitation can in theory be carried out on any person in whom cardiac or respiratory function ceases. It will not, however, always be appropriate: for example where a person is in the final stages of a terminal illness. Ideally, decisions as to whether or not it will be appropriate to attempt resuscitation should be made in advance, when they can be properly considered. Competent people should be involved in these discussions. Great sensitivity must be used in seeking patients' views on resuscitation, and they should be given as much time and support as they need to make the decision. The BMA, Resuscitation

Council (UK) and RCN have published detailed guidance on what procedures should be followed when decisions about resuscitation need to be made.[1] HPSS Trusts have local policies on resuscitation, along with information about them for patients. Resuscitation should never be withheld on the grounds that a person has a learning disability.

Where a person lacks capacity, the responsibility for taking a decision to withhold or withdraw life-prolonging treatment rests with the doctor in charge of the person’s care. However, those close to the person should always be involved in coming to such a decision, unless the person has made very clear in the past that particular individuals should not be involved in their care. Other health and social care professionals caring for the person should also be involved in the decision-making process. When considering what will be in the person’s best interests you should never make assumptions about the quality of life of someone with severe learning disabilities, or how that person values their life. In particular, you should use the person’s ordinary life with their disability as the baseline from which to judge whether treatment will impose excessive burdens on them.

Legally, artificial nutrition and hydration (ANH) is considered to be medical treatment, and so the same rules should apply as for any other kind of treatment. However, the BMA has suggested that extra safeguards should be followed if the person is unable to take a decision for himself or herself and it is believed that continuing to provide ANH is not in his or her best interests. A senior clinician, not involved in the person’s day-to-day care, should review the case, details should be made available for clinical audit, and if the person is in ‘permanent vegetative state’ or a state very close to PVS, legal advice should be sought. The courts have stated that it is good practice for court approval to be sought before ANH is withdrawn from people in PVS.

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[1] Decisions relating to cardiopulmonary resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 2002, available at www.bma.org.uk/cpr

Examples

A number of examples are given to illustrate the general principles of consent. They are not intended to provide guidance on specific cases but to enable you to assess how the issue of consent may affect your work with people with learning disability. Consent **MUST** be assessed on an individual basis.

Example 1

Mrs. X is a 44 year old woman with a moderate learning disability. She has heavy periods which medical treatment has done little to alleviate. A hysterectomy has been suggested to control her symptoms. She is able to understand what is involved in the operation, and is able to apply this information to her own condition. She therefore has the capacity to decide for herself. Mrs. X does not want to have a major operation, and decides that she would rather cope with the effects of the heavy periods. She refuses the hysterectomy.

Example 2

Mr. B has a severe learning disability. He was found to have a brain tumor which would be fatal if left untreated. A high risk operation was possible. Over a period of weeks, Mr. B was talked through this very difficult decision with support from those who knew him well. Having understood the necessary information, he made a clear decision not to have the operation. He subsequently died – in control of his own body.

Example 3□

Mr. A is 40 and has severe learning disabilities. He lives with his parents and regularly attends a day centre, where he gets on very well with two particular care workers. He particularly enjoys hillwalking. He is currently suffering some discomfort from an inguinal hernia and an operation has been suggested to correct this.

Capacity

Although both clinicians and Mr. A's family have explained the proposed operation on several occasions in very simple terms, Mr. A is not able to understand what an operation might involve, or how it might help his current discomfort. He therefore lacks the capacity to make this particular decision for himself.

Best interests

The surgeon who suggested that Mr. A might benefit from the operation consults Mr. A's parents and other professionals involved with Mr A's care about Mr. A's best interests. The clinical benefits of the treatment are that it will reduce the discomfort which Mr. A is currently experiencing. He will also avoid the danger of possible emergency surgery in the future, should a section of intestine become trapped in the hernia. More generally, Mr. A will be able to enjoy hill-walking again. The clinical disadvantages of the treatment are the risks inherent in any operation. There are, however, other disadvantages, as Mr. A is very frightened of needles – both Mr. A's care worker and his parents explain how distressed he has become in the past when he has had to have an injection.

Decision

The health and social care team and all those close to Mr. A agree that it would be in his best interest to have the operation, but to induce anaesthesia by mask instead of through injection. Mr A's mother and one of his care workers go with him to hospital for the operation and reassure him at each stage.

Example 4

Mr C attends a Respite Centre at weekends. He has a severe learning disability. He requires the support of the centre's staff to meet his personal care needs. This includes washing and changing pads. Mr C is unable to give consent for the performance of such aspects of care. However, a care plan has been agreed with his carers, outlining his normal routine and identifying how these procedures will be carried out, in keeping with the centre's intimate care policy. This document has been signed by his carers, and a copy is kept in his notes. Mr C is familiar with the care workers, and is most relaxed with his key team. Where possible, key team members attend to his personal care needs, explaining to Mr C what they are doing and ensuring his comfort and privacy throughout the procedure.

Further sources of guidance and information

Appelbaum and Grisso,
Assessing competence to consent to treatment – a guide for physicians
and other health professionals (1998) OUP: Oxford

Department of Health, Social Services and Public Safety
Reference Guide to Consent for Examination, Treatment and Care
available at www.dhsspsni.gov.uk

General Medical Council:
Seeking patients' consent: the ethical considerations (1998) GMC:
London. (www.gmc-uk.org)

Joseph Rowntree Foundation,
Plain facts magazine about research for people with learning disabilities
and their supporters: includes an issue on healthcare decision-making
(www.plain-facts.org)

Keywood, Forvargue and Flynn,
Best practice? Health care decision making by, with and for adults with
learning disabilities (1999) National Development Team : Manchester
available from NDT, St Peter's Court, 8 Trumpet Street, Manchester
M1 5LW

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GOOD PRACTICE IN CONSENT

Consent for Examination, Treatment or Care

A HANDBOOK FOR THE HPSS
March 2003

Index

Part 1

Good practice in consent:

Implementation guide for health care professionals

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Good practice in consent:

Implementation guide for health care professionals

Consent for Examination or Treatment

Contents

Introduction

Introduction to this Implementation Guide for Health Care Professionals

This Good practice in consent implementation guide for health care professionals contains a model consent policy and four forms, together with an accompanying patient information leaflet Consent – it's up to you. This model documentation has been developed with the aim of assisting HPSS organisations to promote good practice in the way patients are asked to give their consent to examination or treatment. An electronic version of this documentation can be downloaded from **www.dhsspsni.gov.uk**.

The four forms are designed to meet the needs of different groups of patients at different times:

- Consent form 1 for patients able to consent for themselves
- Consent form 2 for those with parental responsibility, consenting on behalf of a child/young person
- Consent form 3 both for patients able to consent for themselves and for those with parental responsibility consenting on behalf of a child/young person, where the procedure does not involve any impairment of consciousness. This form is shorter than the others, as the fact that the patient is expected to remain alert during the procedure makes some of the information covered in forms 1 and 2 unnecessary. The use of this form is optional.
- Form 4 for adults who lack capacity to consent to a particular treatment. As no-one else can give consent on behalf of such a patient, they may only be treated if that treatment is believed to be in their 'best interests'. This form requires health professionals to document both how they have come to the conclusion that the patient lacks the capacity to make this particular healthcare decision, and why the proposed treatment would be in the patient's best interests. It also allows the involvement of those close to the patient in making this healthcare decision to be documented.

The development of these forms does not change the current position on when written, as opposed to oral, consent to treatment is necessary. It is a matter of local determination what form of consent is appropriate for individual procedures, within the broad guidelines set out in the model consent policy.

Customisation of model documentation

Both consent forms and consent policy should be recognisable across the HPSS and the text included in this implementation guide should not be amended or removed. However, it may be appropriate to customise the documentation to reflect local needs, and the extent to which customisation is acceptable is set out below.

Consent forms - Appendix B

Additional material relevant to local circumstances may be included in consent forms, as long as this does not result in forms becoming too unwieldy or in the font size being reduced inappropriately. HPSS trusts who have developed the practice of documenting anaesthetic consent on the main consent form (as opposed to on the anaesthetic record) should feel free to include such a section within their new forms.

Relevant sections of the forms (such as those dealing with benefits and risks) may be pre-printed where high through-put specialities make this feasible and desirable. If this is done, it will, of course, always be necessary for health professionals to consider whether additional risk/benefit information should be added by hand, to reflect the particular needs of the individual patient. It is essential, however, to ensure that this does not lead to a ‘conveyor belt’ approach to consent in these circumstances.

While consent forms 1 and 2 have been designed in the form of 4 page booklets with the crucial information for patients on the facing inside pages, they may if desired be reduced to 2 sides of a single sheet by making the guidance notes on the back available to health professionals in another way. There must, however, be clear reference on the forms to the availability of those guidance notes, which must be readily accessible. As the guidance notes on consent form 2 (which explain the relatively complicated legal position regarding who may give consent on behalf of a child) may be less familiar to health professionals, it may generally be more appropriate to take this approach for consent form 1 than for consent form 2.

Whatever the format used, a copy of the page documenting the details of the treatment should be offered to the patient, for example through the use of 'no carbon required' (NCR) copies.

"Consent – it's up to you"

The patient information leaflet about the consent form – "Consent it's up to you" should be made available to patients in advance of their being asked to sign a consent form, and may be published in any appropriate format. Text should only be omitted if it will never be relevant (for example the section on anaesthesia could be omitted if the organisation involved would never be seeking consent for anaesthesia).

Consent policy

The model policy has been designed to encourage the addition of local information where indicated. If it is felt to be helpful to extend the scope of the model policy, this should be done by means of a separate schedule so that it does not affect the existing layout of the rest of the policy. This will enable staff moving between HPSS organisations to know exactly where to look for particular information in their new organisation's policy.

Implementation

The required timescales for implementing the model consent documentation are set out in the accompanying HSS circular.

Guidance on consent

This handbook includes a number of guidance documents on consent which are listed below. The department has also published a Reference Guide to Consent for Examination, Treatment or Care. These are all available on the internet at **www.dhsspsni.gov.uk.**

- ☐ Consent –what you have a right to expect (versions for adults, children/young people, people with learning difficulties, parents and relatives/carers)

- ☐ Seeking consent: working with children**,**

- Seeking consent: working with older people,
- Seeking consent: working with people with learning disabilities

The Consent – what you have a right to expect and Seeking consent series of documents may be published in any appropriate format. Text should only be omitted if it will not be relevant. Additional local information should be included where indicated.

Model Policy for Consent for Examination or Treatment

I Introduction

Why consent is crucial

1. Patients have a fundamental legal and ethical right to determine what happens to them. Valid consent to treatment is therefore absolutely central in all forms of health care, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health care professionals and patients.

This policy

2. The Department has issued range of guidance documents on consent (see overleaf), and these should be consulted for details of the law and good practice requirements on consent. This policy sets out the standards and procedures in this [Trust/LHSCG/practice] which aim to ensure that health professionals are able to comply with the guidance. While this document is primarily concerned with health care, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those which involve touching the patient or client.

What consent is – and isn't

3. "Consent" is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

   - be competent to take the particular decision;
   - have received sufficient information to take it; and
   - not be acting under duress.

4. The context of consent can take many different forms, ranging from the active request by a patient of a particular treatment (which may or may not be appropriate or available) to the passive acceptance of a health professional's advice. In some cases, the health professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the health professional will help the patient to decide between them. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and health professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the health professional's clinical knowledge.

5. Where an adult lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, **no one else can give consent on their behalf.** However, treatment may be given if it is in their best interests, as long as it has not been refused in advance in a valid and applicable advance directive. For further details on advance directives see the Department of Health, Social Services and Public Safety's Reference Guide to Consent for Examination, Treatment or Care (chapter 1, paragraph 16).

Guidance on consent

6. The Department of Health, Social Services and Public Safety is issuing a number of guidance documents on consent, and these should be consulted for advice on the current law and good practice requirements in seeking consent. Health professionals must also be aware of any guidance on consent issued by their own regulatory bodies.

- Reference Guide to Consent for Examination, Treatment or Care provides a comprehensive summary of the current law on consent, and includes requirements of regulatory bodies such as the General Medical Council where these are more stringent. Copies are available [insert local details] and may also be accessed on the internet at **www.dhsspsni.gov.uk**.

- Specific guidance, incorporating both the law and good practice advice is available for health professionals working with children, with people with learning disabilities and with older people. Copies of these booklets are available [insert local details] and on the internet at **www.dhsspsni.gov.uk**.

II Documentation

1. For significant procedures, it is essential for health professionals to document clearly both a patient's agreement to the intervention and the discussions which led up to that agreement. This may be done either through the use of a consent form (with further detail in the patient's notes if necessary), or through documenting in the patient's notes that they have given oral consent.

Written consent

2. Consent is often wrongly equated with a patient's signature on a consent form. A signature on a form is evidence that the patient has given consent, but is not proof of valid consent. If a patient is rushed into signing a form, on the basis of too little information, the consent may not be valid, despite the signature. Similarly, if a patient has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Patients may, if they wish, withdraw consent after they have signed a form: the signature is evidence of the process of consent-giving, not a binding contract.

3. It is rarely a legal requirement to seek written consent[1], but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications')
- the procedure involves general/regional anaesthesia or sedation
- providing clinical care is not the primary purpose of the procedure
- there may be significant consequences for the patient's employment, social or personal life
- the treatment is part of a project or programme of research approved by this [Trust/LHSCG]

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[1] The Mental Health (Northern Ireland) Order 1986 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances

[Individual Trusts/LHSCGs may choose to list in an Annex whether written/oral/non-verbal consent is appropriate for specified procedures.]

4.□ If the individual is illiterate, the individual may be able to make their mark on the form to indicate consent. It would be good practice for the mark to be witnessed by a person other than the clinician/practitioner seeking consent, and for the fact that the individual has chosen to make their mark in this way to be recorded in the case notes. Similarly, if the individual has capacity, and wishes to give consent, but is physically unable to mark the form, this fact should be recorded in the notes, or on the consent form.

5. □ Completed forms should be kept with the patient's notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and health professional.

6.□ It will not usually be necessary to document a patient's consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be helpful to do so.

Procedures to follow when patients lack capacity to give or withhold consent

7.□ Where an adult patient does not have the capacity to give or withhold consent to a significant intervention, this fact should be documented in **form 4** (form for adults who are unable to consent to investigation or treatment), along with the assessment of the patient's capacity, why the health professional believes the treatment to be in the patient's best interests, and the involvement of people close to the patient. The standard consent forms should never be used for adult patients unable to consent for themselves. For more minor interventions, this information should be entered in the patient's notes.

8.□ An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. You should involve appropriate colleagues in making such assessments of incapacity, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal ways where appropriate.

9. Occasionally, there will not be a consensus on whether a particular treatment is in an incapacitated adult's best interests. Where the consequences of having, or not having, the treatment are potentially serious, a court declaration may be sought. See Appendix E for details of how to do this.

Availability of forms

10. Standard consent forms and forms for adults who are unable to consent for themselves are reproduced in Appendix B and are available from [local details]. There are three versions of the standard consent form: **form 1** for adults or competent children, **form 2** for parental consent for a child or young person and **form 3** for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care. The use of **form 3** is optional but may be thought more appropriate than form 1 in situations where patients do not need to be made aware of issues surrounding general or regional anaesthesia and do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary. **Form 4** is for adults who are unable to consent to treatment or care.

Availability of Patient Information leaflet about the consent form "Consent – it's up to you"

11. The patient information leaflet about the consent form "Consent – it's up to you" is reproduced in Appendix C and is available from [local details]. It should be made available to patients in advance of their being asked to sign a consent form, and may be published in any appropriate format. Text should only be omitted if it will never be relevant (for example the section on anaesthesia could be omitted if the organisation involved would never be seeking consent for anaesthesia).

III When should consent be sought?

1. When a patient formally gives their consent to a particular intervention, this is only the endpoint of the consent process. It is helpful to see the whole process of information provision, discussion and decision-making as part of ‘seeking consent’. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness of what is proposed and the urgency of the patient’s condition.

Single stage process

2. In many cases, it will be appropriate for a health professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient’s condition and whether there are any significant risks. If the patient is willing for the technique to be used, they will then give their consent and the procedure can go ahead immediately. In many such cases, consent will be given orally.

3. If a proposed procedure carries significant risks, it will be appropriate to seek written consent, and health professionals must take into consideration whether the patient has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the patient understands and consents, the health professional may then proceed.

Two or more stage process

4. In most cases where written consent is being sought, treatment options will generally be discussed well in advance of the actual procedure being carried out. This may be on just one occasion (either within primary care or in a hospital out-patient clinic), or it might be over a whole series of consultations with a number of different health professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the patient still wants to go ahead. The

consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

5. Patients receiving elective treatment, intervention or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process. They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. If a form is signed before patients arrive for treatment, however, a member of the healthcare team **must** check with the patient at this point whether they have any further concerns and whether their condition has changed. This is particularly important where there has been a significant lapse of time between the form being signed and the procedure. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient for example beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

6. While administrative arrangements will vary, it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

Seeking consent for anaesthesia

7. Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and risks. However, in elective treatment it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient will not be in a position genuinely to make a decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in out-patients, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the

patient and their consent is documented in the anaesthetic record, in the patient's notes or on the consent form. Where the clinician providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia. Information for patients' relatives and friends on anaesthesia have been produced by the Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland.

8. In addition, where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

Emergencies

9. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) will follow straight on from each other, and it may often be appropriate to use the patient's notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality.

Treatment of young children

10. When babies or young children are being cared for in hospital, it will not usually seem practicable to seek their parents' consent on every occasion for every routine intervention such as blood or urine tests or X-rays. However, you should remember that, in law, such consent is required. Where a child is admitted, you should therefore discuss with their parent(s) what routine procedures will be necessary, and ensure that you have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, you must do so, unless the delay involved in contacting them would put the child's health at risk.

11. Only people with ‘parental responsibility’ are entitled to give consent on behalf of their children. You must be aware that not all parents have parental responsibility for their children (for example, unmarried fathers do not automatically have such responsibility although they can acquire it). If you are in any doubt about whether the person with the child has parental responsibility for that child, you must check.

IV Provision of information

1. The provision of information is central to the consent process. Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks and benefits (including the risks/benefits of doing nothing). They also need to know whether additional procedures are likely to be necessary as part of the procedure, for example a blood transfusion, or the removal of particular tissue. Once a decision to have a particular treatment/investigation has been made, patients need information about what will happen: where to go, how long they will be in hospital, how they will feel afterwards and so on.

2. Patients and those close to them will vary in how much information they want and in a form the patient understands; from those who want as much detail as possible, including details of rare risks, to those who ask health professionals to make decisions for them. There will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the patient wishes to be well informed about the risks and benefits of the various options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented.

3. The following sources of patient information are available in this [Trust/LHSCG/practice]:

    - [Insert local details, including advice on accessibility/readability for those developing such materials. Also include what specific provision is made for those who, for reasons of disability or otherwise, would not find printed information particularly accessible (Braille, tapes, pictorial materials, interpreters etc.) together with details of local independent advocacy groups where these exist. Some Trusts have developed ‘patient passports’ determining what information is needed at which points in a patient’s ‘journey’ through healthcare. Others have made provision for patients to receive tape recordings of consultations so that they have a permanent record of what was discussed.]

Provision for patients whose first language is not English

4. This [Trust/LHSCG/practice] is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use children to interpret for family members who do not speak English.

    - [Insert local details of how to access translation and interpreting service, what materials are available in which languages etc. Reference other relevant local policies or guidance e.g. on the use of interpreting].*

Access to more detailed or specialist information

5. Patients may sometimes request more detailed information about their condition or about a proposed treatment than that provided in general leaflets. This [Trust/LHSCG/practice] has made the following arrangements to assist patients to obtain such information:

    - [Insert local details In hospitals, this policy can be adapted at Directorate level to include more specific information here. Further information on the most effective medical and health interventions can be obtained from the electronic Cochrane Library (www.cochrane.org). This includes large amounts of up to date information and aims to help people make well informed decisions about health care.]

Access to health professionals between formal appointments

6. After an appointment with a health professional in primary care or in out-patients, patients will often think of further questions which they would like answered before they take their decision. Where possible, it will be much quicker and easier for the patient to contact the healthcare team by phone than to make another appointment or to wait until the date of an elective procedure (by which time it is too late for the information genuinely to affect the

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* Guidance is found in the DHSSPS and Equality Commission document: Racial Equality in Health: Good Practice Guide which is available from the Equality Commission or Strategic Planning Branch, DHSSPS

patient’s choice). [Insert local details of what systems are in place at GP practice/Directorate level e.g. GP surgeries which have a defined hour in the day for phone calls, space in consent form for contact number of appropriate health and social care professional, such as specialist nurse.]

Open access clinics

7.	Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need before proceeding with an investigation or treatment. [Insert local details of relevant arrangements, such as provision of information through primary care.]

V Who is responsible for seeking consent?

1. The health professional carrying out the procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is they who will be held responsible in law if this is challenged later.

2. Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional responsible. However, team work is a crucial part of the way the HPSS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent. If the person cannot write or is physically unable to sign a form, a record that the person has given verbal or non –verbal consent should be made in their notes or on the consent form.

Completing consent forms

3. The standard consent form provides space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

4. If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a health professional involved in their care on the day should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

[Insert local details, where appropriate at Directorate level, covering:

- what training is available for health professionals who do not themselves carry out specific procedures, but could potentially provide the information patients need in coming to a decision.
- what procedures are in place to ensure that the health professionals ‘confirming’ the patient’s consent have genuine access to appropriate colleagues where they are personally not able to answer any remaining questions.]

Responsibility of health professionals

5. It is a health care professional’s own responsibility:

    - to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
    - to work within their own competence and not to agree to perform tasks which exceed that competence.

    If you feel that you are being pressurised to seek consent when you do not feel competent to do so [insert local details of whom to contact, such as clinical governance lead.]

VI Refusal of treatment

1. If the process of seeking consent is to be a meaningful one, refusal must be one of the patient’s/client’s options. A competent adult person is entitled to refuse any treatment. (See paragraph 2 re mental health legislation). The situation for children is more complex: see the Department of Health Social Services and Public Safety Seeking consent: working with children for more detail. The following paragraphs apply primarily to adults.

2. Mental health legislation does provide the possibility of treatment for a person’s mental disorder and its complications without their consent. This legislation does not give power to treat unrelated physical disorders without consent. If, after discussion of possible treatment options, a patient refuses all treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, you (and where possible the patient) should note this on the form.

3. Where a patient has refused a particular intervention, you must ensure that you continue to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

4. If a patient consents to a particular procedure but refuses certain aspects of the intervention, you must explain to the patient the possible consequences of their partial refusal. If you genuinely believe that the procedure cannot be safely carried out under the patient’s stipulated conditions, you are not obliged to perform it. You must, however, continue to provide any other appropriate care. Where another health professional believes that the treatment can be safely carried out under the conditions specified by the patient, you must on request be prepared to transfer the patient’s care to that health professional.

VII Tissue

1.□ The legal position regarding the use of human tissue (including blood samples and other bodily fluids provided for testing) raises very difficult issues and is currently under review. Such tissue can be very valuable in education and research, and its use may lead to developments in medical knowledge and hence improvements in healthcare for all. At present, this [Trust/LHSCG/practice] requires that patients should be given the opportunity to refuse permission for tissue taken from them during surgery or other procedure to be used for education or research purposes. [Insert local details of how this should be done. The system must be well-publicised and transparent, making provision for patients to record their consent or objection to the use of such tissue and for this to be notified to the laboratory. Patients must also be able to record any objections to particular uses or use of particular tissues.]

2.□ Explicit consent is not necessary for public health surveillance using the unlinked anonymous method, but a well-publicised opt-out policy must apply. [Insert local details.]

3.□ The Department of Health, Social Services and Public Safety, in line with what is happening elsewhere in the UK, is currently undertaking a review of the law on the removal, retention and use of organs and tissue. Pending the outcome of the review, the Department will issue an interim statement on the use of tissue. The Department believe that tissue samples may be used for **quality assurance purposes** without requiring specific patient consent **provided** there is an active policy of informing patients of such use. This is essential to ensure the high quality of service which all patients have the right to expect. Wherever possible, samples of tissue used in this way should be anonymised or pseudonymised. [Insert local details of policy.]

VIII Clinical photography, audio and video recordings

1. Photographic, audio and video recordings made for treatment purposes form part of a patient’s record. Although consent to certain recordings, such as X-rays, is implicit in the patient’s consent to the procedure, health professionals should always ensure that they make clear in advance if any photographic, audio or video recording will result from that procedure.

2. Photographic, audio and video recordings which are made for treating or assessing a patient must not be used for any purpose other than the patient’s care or the audit of that care, without the express consent of the patient or a person with parental responsibility for the patient. The one exception to this principle is set out in paragraph 3 below. If you wish to use such a recording for education, publication or research purposes, you must seek consent in writing, ensuring that the person giving consent is fully aware of the possible uses of the material. In particular, the person must be made aware that you may not be able to control future use of the material once it has been placed in the public domain. If a child is not willing for a recording to be used, you must not use it, even if a person with parental responsibility consents.

3. Photographic, audio and video recordings, made for treating or assessing a patient and from which there is no possibility that the patient might be recognised, may be used within the clinical setting for education or research purposes without express consent from the patient/client, as long as this policy is well publicised. However, express consent must be sought for any form of publication.

4. If you wish to make a photographic, audio or video recording of a patient specifically for education, publication or research purposes, you must first seek their written consent (or where appropriate that of a person with parental responsibility) to make the recording, and then seek their consent to use it. Patients must know that they are free to stop the recording at any time and that they are entitled to view it if they wish, before deciding whether to give consent to its use. If the patient decides that they are not happy for any recording to be used, it must be destroyed. As with recordings made with therapeutic intent, patients must receive

full information on the possible future uses of the recording, including the fact that it may not be possible to withdraw it once it is in the public domain.

5. The situation may sometimes arise where you wish to make a recording specifically for education, publication or research purposes, but the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

6. If the patient is likely to be permanently unable to give or withhold consent for a recording to be made, you should seek the agreement of someone close to the patient. You must not make any use of the recording which might be against the interests of the patient. You should also not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

IX Training

[Insert details of training available on consent in this organisation, covering both basic training on the law of consent, and training on any specific procedures used in this organisation.]

Dated:☐

Person responsible for policy:☐

Policy approved by:☐

Policy to be reviewed by [date]:☐

Appendix A

12 Key Points On Consent: The Law In Northern Ireland

When do health professionals need consent from patients?

1.	Before you examine, treat or care for competent adult patients you must obtain their consent.

2.	Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: “can this patient understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the person is incompetent, but may indicate a need for further information or explanation.

3.	Patients may be competent to make some health care decisions, even if they are not competent to make others.

4.	Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children give consent for themselves?

5.	Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents should ideally be involved). In other cases, someone with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent from a patient?

6. It is always best for the person actually treating the patient to seek consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided when seeking consent?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment or course of action, and appropriate alternatives. If a patient is not offered as much information as they reasonably need to reach an informed decision, and in a form they can understand, their consent may not be valid.

Is the patient’s consent voluntary?

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter how the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient’s decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusals of treatment

10. Competent adult patients have the right to refuse treatment, even where it would clearly benefit them. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the foetus.

Mental Health Legislation

11. Mental health legislation provides the possibility of treatment for a person’s mental disorder or its complications without their consent. This legislation does not give power to treat unrelated physical illness without consent.

Adults who are not competent to give consent

12. **No-one** can give consent on behalf of an adult who is not deemed competent. However, you may still treat such a patient if the treatment would be in their best interests. ‘Best interests’ go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these matters. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient’s needs and preferences

If people no longer have capacity but have clearly indicated in the past that they would wish to refuse such treatment in the circumstances in which they now find themselves (an “advance refusal”), the refusal must be accepted.

This summary cannot cover all situations. For more detail, consult the Reference Guide to Consent for Examination, Treatment or Care, available from your HPSS Trust and at www.dhsspsni.gov.uk

Appendix B

Current forms in use in this organisation

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

[HPSS organisation name]

consent form 1

Patient agreement to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name ____________________

Patient's first names ____________________

Date of birth ____________________

☐ Male ☐ Female

HPSS number (or other identifier) ____________________

Responsible health professional ____________________

Job title ____________________

Special requirements ____________________
(e.g. other language/other communication method)

To be retained in patient's notes

Form 1

Patient Identifier/label

Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear) ____________________

____

____

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits ____________________

____

____

Serious or frequently occurring risks ____________________

____

____

Any extra procedures which may become necessary during the procedure

☐ blood transfusion ____________________

☐ other procedure (please specify) ____________________

____

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples that may be taken and any particular concerns of this patient.

☐ The following leaflet/tape has been provided ____________________

This procedure will involve:
☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed ____________________ Date ____________________

Name (PRINT) ____________________ Job title ____________________

Contact details (if patient wishes to discuss options later) ____________________

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed ____________________ Date ____________________

Name (PRINT) ____________________

Top copy accepted by patient: yes/no (please circle)

Form 1

Patient Identifier/label

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion ______________________________

____

____

I agree/do not agree (delete as applicable) to my samples being used for education, research or public health monitoring.

Patient's signature ______________________ Date ______________________

Name (PRINT) ______________________________

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature ______________________ Date ______________________

Name (PRINT) ______________________________

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed ______________________ Date ______________________

Name (PRINT) ______________________ Job title ______________________

Important notes: (tick if applicable)

☐ See also advance directive/living will (e.g. Jehovah's Witness form)

☐ Patient has withdrawn consent (ask patient to sign /date here) ______________________

Guidance to health professionals (to be read in conjunction with consent policy)

What a consent form is for

This form documents the patient's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire to health professionals and patients, by providing a check-list of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way, however, should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf and a separate form is available for this purpose. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- they are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on page 2 of the form or in the patient's notes.

The law on consent

See the Department of Health, Social Services and Public Safety publication Reference Guide to Consent for Examination, Treatment or Care for a comprehensive summary of the law on consent (also available at **www.dhsspsni.gov.uk**).

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

[HPSS organisation name]

consent form 2

Parental agreement to investigation or treatment for a child or young person

Patient details (or pre-printed label)

Patient's surname/family name ______________________________

Patient's first names ______________________________

Date of birth ______________________________

Age ______________________________

☐ Male ☐ Female

HPSS number (or other identifier) ______________________________

Responsible health professional ______________________________

Job title ______________________________

Special requirements ______________________________
(e.g. other language/other communication method)

To be retained in patient's notes

Form 2

Patient Identifier/label

Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear) ____________________

____

____

Statement of health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the child and his or her parent(s). In particular, I have explained:

The intended benefits ____________________

____

____

Serious or frequently occurring risks ____________________

____

____

Any extra procedures which may become necessary during the procedure

☐ blood transfusion ____________________

☐ other procedure (please specify) ____________________

____

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples that may be taken and any particular concerns of this patient and his or her parents.

☐ The following leaflet/tape has been provided ____________________

This procedure will involve:

☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Signed ____________________ Date ____________________

Name (PRINT) ____________________ Job title ____________________

Contact details

(if child/parent wish to discuss options later) ____________________

Statement of interpreter

(where appropriate)

I have interpreted the information above to the child and his or her parents to the best of my ability and in a way in which I believe they can understand.

Signed ____________________ Date ____________________

Name (PRINT) ____________________

Top copy accepted by patient/parent: yes/no (please circle)

Form 2

Patient Identifier/label

Statement of parent

Please read this form carefully. If the procedure has been planned in advance, you should already have your own copy of page 2 which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you and your child. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form and **I confirm** that I have ‘parental responsibility’ for this child.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that my child and I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of the situation prevents this. (This only applies to children having general or regional anaesthesia.)

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save the life of my child or to prevent serious harm to his or her health.

I have been told about additional procedures which may become necessary during my child’s treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion. ______________________________

____

I **agree/do not agree** (delete as applicable) to my child’s samples being used for education, research or public health monitoring.

Signature ______________________ Date ______________________

Name (PRINT) ______________________ Relationship to child ______________________

Child’s agreement to treatment (if child wishes to sign).

I agree to have the treatment I have been told about.

Name ______________________ Signature ______________________

Date ______________________

Confirmation of consent (to be completed by a health professional when the child is admitted for the procedure, if the parent/child have signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the child and his or her parent(s) that they have no further questions and wish the procedure to go ahead.

Signed ______________________ Date ______________________

Name (PRINT) ______________________ Job title ______________________

Important notes: (tick if applicable)

☐ See also advance directive/living will (e.g. Jehovah’s Witness form)

☐ Parent has withdrawn consent (ask parent to sign/date here) ______________________

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form should be used to document consent to a child's treatment, where that consent is being given by a person with parental responsibility for the child. The term 'parent' has been used in this form as a shorthand for 'person with parental responsibility'. Where children are legally competent to consent for themselves (see below), they may sign the standard 'adult' consent form (form 1). There is space on that form for a parent to countersign if a competent child wishes them to do so.

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. The courts have stated that if a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. If children are not able to give consent for themselves, someone with parental responsibility may do so on their behalf.

Although children acquire rights to give consent for themselves as they grow older, people with 'parental responsibility' for a child retain the right to give consent on the child's behalf until the child reaches the age of 18. Therefore, for a number of years, both the child and a person with parental responsibility have the right to give consent to the child's treatment. In law, health professionals only need the consent of one appropriate person before providing treatment. This means that in theory it is lawful to provide treatment to a child under 18 which a person with parental responsibility has authorised, even if the child refuses. As a matter of good practice, however, you should always seek a competent child's consent before providing treatment unless any delay involved in doing so would put the child's life or health at risk. Younger children should also be as involved as possible in decisions about their healthcare. Further advice is given in the Department's guidance Seeking consent: working with children. Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the patient's notes.

Parental responsibility

The person(s) with parental responsibility will usually, but not invariably, be the child's birth parents. People with parental responsibility for a child include: the child's mother; the child's father if married to the mother at the child's conception, birth or later; or if unmarried if he is named on the child's birth certificate (with effect from 15 April 2002); a legally appointed guardian; the Health and Social Services Trust if the child is the subject of a care order; or a person named in a residence order in respect of the child. A father who has never been married to the child's mother or, after 15 April 2002, whose name has not been included on the child's birth certificate will only have parental responsibility if he has acquired it through a court order or parental responsibility agreement with the child's mother.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for children and their parents when making up their minds about treatment. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly.

Guidance on the law on consent

See the Department of Health, Social Services and Public Safety publications Reference Guide to Consent for Examination, Treatment or Care and Seeking consent: working with children for a comprehensive summary of the law on consent (also available at **www.dhsspsni.gov.uk**).

Patient Identifier/label□

[HPSS organisation name] consent form 3
Patient/parental agreement
to investigation or treatment
(procedures where consciousness not impaired)

Name of procedure

(include brief explanation if medical term not clear) ____________________

____

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient/parent. In particular, I have explained:
The intended benefits ____________________

____

Serious or frequently occurring risks□____________________

____

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples that may be taken and any particular concerns of those involved.

☐ The following leaflet/tape has been provided ____________________

Signed ____________________ Date ____________________

Name (PRINT) ____________________ Job title ____________________

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe s/he/they can understand.

Signed ____________________ Date ____________________

Name (PRINT) ____________________ Relationship to patient ____________________

Statement of patient/person with parental responsibility for patient

I agree to the procedure described above.□

I understand that you cannot give me a guarantee that a particular person will perform□ the procedure. The person will, however, have appropriate experience.□

I understand that the procedure will/will not involve local anaesthesia.□

I **agree/don't agree** (delete as applicable) to my samples being used for education,□ research or public health monitoring.□

Signature ____________________ Date□____________________

Name (PRINT) ____________________ Relationship to patient□____________________

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/parent has signed the form in advance)

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signed ____________________ Date ____________________

Name (PRINT) ____________________ Job title ____________________

Top copy accepted by patient/parent: yes/no (please circle)□

Guidance to health professionals (to be read in conjunction with consent policy)

This form

This form documents the patient's agreement (or that of a person with parental responsibility for the patient) to go ahead with the investigation or treatment you have proposed. **It is only designed for procedures where the patient is expected to remain alert throughout and where an anaesthetist is not involved in their care: for example for drug therapy where written consent is deemed appropriate.** In other circumstances you should use either form 1 (for adults/competent children) or form 2 (parental consent for children/young people) as appropriate.

Consent forms are not legal waivers – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients also have every right to change their mind after signing the form.

Who can give consent

Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, if they wish. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf. Even where a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If a patient is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form (see also 'This form' opposite)

If the patient is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A patient will not be legally competent to give consent if:

- they are unable to comprehend and retain information material to the decision and/or
- they are unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives **cannot** be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for patients when making up their minds about treatment. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this overleaf or in the patient's notes.

The law on consent

See the Department of Health, Social Services and Public Safety Reference Guide to Consent for Examination, Treatment or Care for a comprehensive summary of the law on consent (available at **www.dhsspsni.gov.uk**).

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

[HPSS organisation name]

Form 4

Adults who are unable to consent to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name ______________________________

Patient's first names ______________________________

Date of birth ______________________________

☐ Male ☐ Female

HPSS number (or other identifier) ______________________________

Responsible health professional ______________________________

Job title ______________________________

Special requirements ______________________________
(e.g. other language/other communication method)

To be retained in patient's notes

Patient Identifier/label

All sections to be completed by health professional proposing the procedure

A Details of procedure or course of treatment proposed

(NB See guidance to health professionals overleaf for details of situations where court approval must first be sought)

B Assessment of patient's capacity

I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment or care because:

☐ the patient is unable to comprehend and retain information material to the decision; and/or

☐ the patient is unable to use and weigh this information in the decision-making process; or

☐ the patient is unconscious

Further details (excluding where patient unconscious): for example how above judgements reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful.

C Assessment of patient's best interests

To the best of my knowledge, the patient has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient's best interests because:

(Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)

The treatment cannot wait until the patient recovers capacity because:

D Involvement of the patient's family and others close to the patient

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests", and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(to be signed by a person or persons close to the patient, if they wish)

I/We have been involved in a discussion with the relevant health professionals over the care or treatment of ________________________ (patient's name). I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

I **agree/do not agree** (delete as applicable) to his/her samples being used for education, research or public health monitoring.

Any other comments (including any concerns about decision)

Name __________________________________ Relationship to patient ________________

Address (if not the same as patient)____

____

Signature________________________________ Date _________________________________

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)

☐ Yes ☐ No

Details:

Signature of health professional proposing treatment

The above procedure is, in my professional judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature _______________________________ Date _________________________________

Name (PRINT)___________________________ Job title_______________________________

Where second opinion sought, he/she should sign below to confirm agreement:

Signature _______________________________ Date _________________________________

Name (PRINT)___________________________ Job title_______________________________

Form 4

Guidance to health professionals (to be read in conjunction with consent policy)

This form should only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the Mental Health (Northern Ireland) Order 1986, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or 'living will'), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health, Social Services and Public Safety Reference Guide to Consent for Examination, Treatment or Care (www.dhsspsni.gov.uk).

When treatment can be given to a patient who is unable to consent

For treatment to be given to a patient who is unable to consent, the following **must** apply:

- the patient must lack the capacity ('competence') to give or withhold consent to this procedure AND
- the procedure must be in the patient's best interests.

Capacity

A patient will lack capacity to consent to a particular intervention if he or she is:

- unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question; and/or
- unable to use and weigh this information in the decision-making process.

Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in taking their own decisions (this will clearly not apply if the patient is unconscious). This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate.

People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates or supporters.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions.

Best interests

A patient's best interests are not limited to their best medical interests. Other factors which form part of the best interests decision include:

- the wishes and beliefs of the patient when competent
- their current wishes
- their general well-being
- their spiritual and religious welfare

Two incapacitated patients, whose physical condition is identical, may therefore have different best interests. Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, you should attempt to involve people close to the patient (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the patient cannot require you to provide particular treatment which you do not believe to be clinically appropriate. However they will know the patient much better than you do, and therefore are likely to be able to provide valuable information about the patient's wishes and values.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. Donation of regenerative tissue such as bone marrow, sterilisation for contraceptive purposes and withdrawal of artificial nutrition or hydration from a patient in PVS must never be undertaken without prior High Court approval. High Court approval can also be sought where there are doubts about the patient's capacity or best interests.

Appendix C

Patient Information Leaflet – “Consent- it’s up to you”

About the consent form

Before a doctor or other health professional examines or treats you, they need your consent. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision is helpful – for example if your treatment involves sedation or general anaesthesia. You’ll be asked to sign a consent form. If you later change your mind, you’re entitled to withdraw consent – even after signing.

What should I know before deciding?

Health professionals must ensure you know enough to enable you to decide about treatment. They’ll write information on the consent form and offer you a copy to keep as well as discussing the choices of treatment with you. Although they may well recommend a particular option, you’re free to choose another. People’s attitudes vary on things like the amount of risk or pain they’re prepared to accept. That goes for the amount of information, too. If you’d rather not know about certain aspects, discuss your worries with whoever is treating you.

Should I ask questions?

Always ask anything you want. As a reminder, you can write your questions in the space over the page. The person you ask should do his or her best to answer, but if they don’t know they should find some one else who is able to discuss your concerns. To support you and prompt questions, you might like to bring a friend or relative. Ask if you’d like someone independent to speak up for you.

Is there anything I should tell people?

If there's any procedure you **don't** want to happen, you should tell the people treating you. It's also important for them to know about any illnesses or allergies which you may have or have suffered from in the past.

Can I find out more about giving consent?

The Department of Health, Social Services and Public Safety Consent – what you have a right to expect is a detailed guide on consent in versions for adults, children, parents, carers/relatives and people with learning disabilities. Ask for one from your clinic or hospital, or you may read it on the web site (www.dhsspsni.gov.uk).

Who is treating me?

Amongst the health professionals treating you may be a "doctor or nurse in training" – fully qualified as a doctor or nurse, but now doing more specialist medical or nursing training. They range from recently qualified doctors or nurses to doctors or nurses almost ready to be consultants. They will only carry out procedures for which they have been appropriately trained. Someone senior will supervise – either in person accompanying a less experienced doctor or nurse in training or available to advise someone less experienced.

What about anaesthesia?

If your treatment involves general or regional anaesthesia, (where more than a small part of your body is being anaesthetised), you'll be given general information about it in advance. You'll also have an opportunity to talk with the anaesthetist when he or she assesses your state of health shortly before treatment. Hospitals sometimes have pre-assessment clinics which provide patients with the chance to discuss things a few weeks earlier.

Will samples be taken?

Some kinds of operation involve removing a part of the body (such as gall bladder or a tooth). You would always be told about this in advance. Other operations may mean taking samples as part of your care. These samples may be of blood or small sections of tissue, for example of an unexplained lump. Such samples may be further checked by other health professionals to ensure the best possible standards. Again, you should be told in advance if samples are likely to be taken.

Sometimes samples taken during operations may also be used for education, research or public health monitoring in the future interests of all HPSS patients. The HPSS Trust treating you will have a local system for checking whether you're willing for this to happen.

Photographs, audio and video tapes

As part of your treatment some kind of photographic record may be made – for example X-rays, clinical photographs or sometimes an audio or video tape. You will always be told if this is going to happen. The photograph or recording will be kept with your notes and will be held in confidence as part of your medical record. This means that it will normally be seen only by those involved in providing you with care or those who need to check the quality of care you have received. The use of photographs and recordings is also extremely important for other HPSS work, such as teaching or medical research. However, we will not use yours in a way that might allow you to be identified or recognised without your express permission.

What if things don't go as expected?

Amongst the many operations taking place every day, sometimes things don't go as they should. Although the doctor involved should inform you and your family, often the patient is the first to notice something amiss. If you're worried – for example about the after-effects of an operation continuing much longer than you were told to expect – tell a health professional right away. Speak to your GP, or contact your clinic – the phone number should be on your appointment card, letter or consent form copy.

What are the key things to remember?

It's your decision! It's up to you to choose whether or not to consent to what's being proposed. Ask as many question as you like, and remember to tell the team about anything that concerns you or about any medication, allergies or past history which might affect your health.

Questions to ask health professionals

As well as giving you information health professionals must listen and do their best to answer your questions. Before your next appointment, you can write some down in the space below.

Questions may be about the **treatment itself,** for example:

- ☐ What are the main treatment options?
- ☐ What are the benefits of each of the options?
- ☐ What are the risks, if any, of each option?
- ☐ What are the success rates for different options – for this unit or for you (the surgeon)?
- ☐ Why do you think an operation (if suggested) is necessary?
- ☐ What are the risks if I decide to do nothing for the time being?
- ☐ How can I expect to feel after the procedure?
- ☐ When am I likely to be able to get back to work?

Questions may also be about how the treatment might affect your future state of health or style of life, for example:

- ☐ Will I need long-term care?
- ☐ Will my mobility be affected?
- ☐ Will I be able to drive?
- ☐ Will it affect the kind of work I do?
- ☐ Will it affect my personal/sexual relationships?
- ☐ Will I be able to take part in my favourite sport/exercise?
- ☐ Will I be able to follow my usual diet?

Health professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

Appendix D

Useful contact details

[e.g. risk managers, training managers, clinical governance leads, clinical ethics committees]

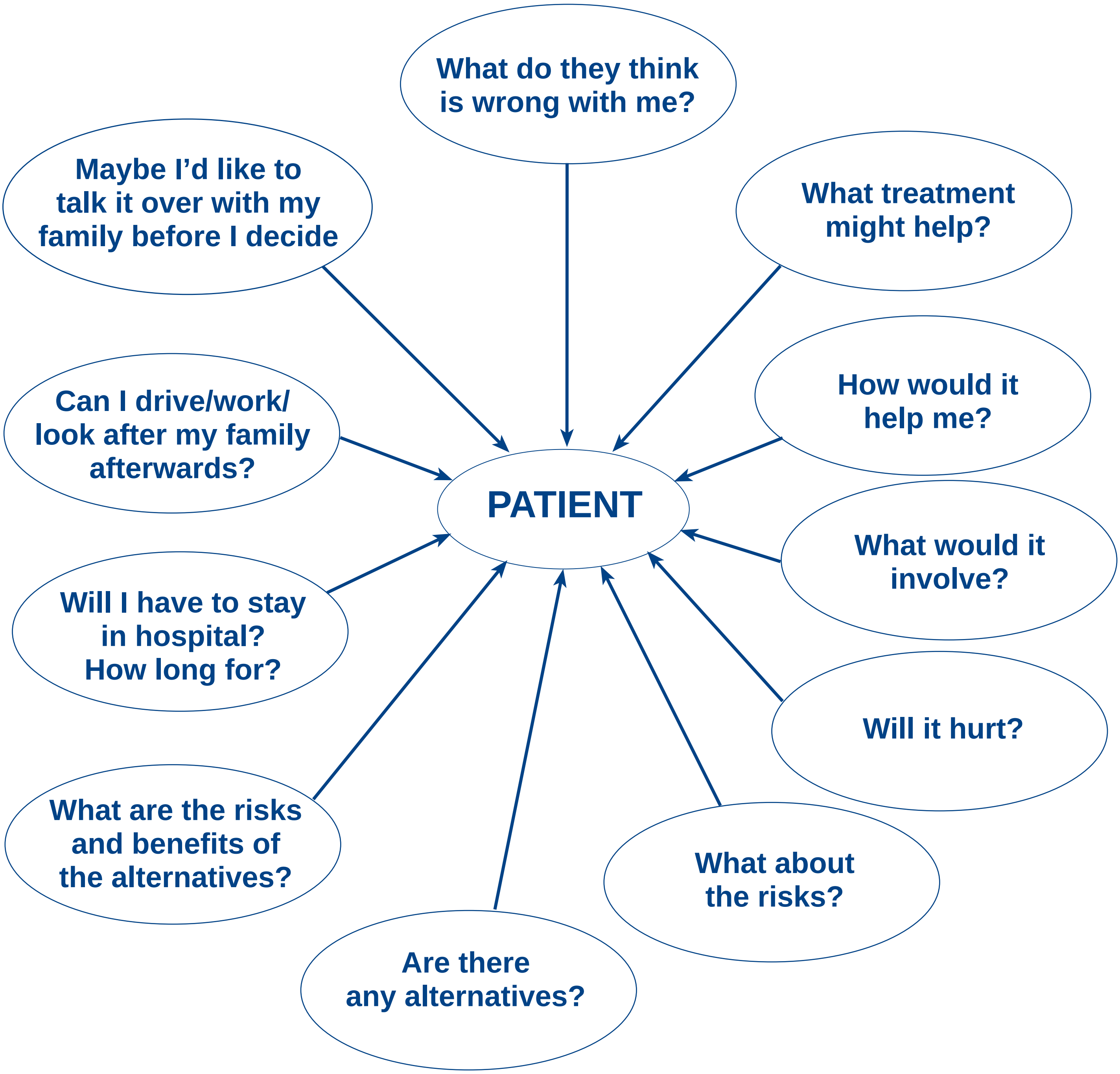
Appendix E

How to seek a court declaration

[e.g. details of how to contact the organisation’s legal services, what information they will require etc.]

Appendix F

Seeking consent: remembering the patient’s perspective



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Ref No. 202/02

March 2003

NHS

National Institute for
Mental Health in England

Mental Health Policy Implementation Guide

Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings

mental health questions? **ask NIMHE**
www.nimhe.org.uk

Contents

Foreword

The issue of responding to and managing aggression and violence is one of the major challenges of modern mental health services. Whilst it has been a service challenge for many years contemporary issues are compounded by increased problems of substance abuse, use of weapons, and an increase in violence in society generally. Criticism has rightly focused on the need for increased preventative measures and the inadequacy of staff training in the prevention, management and review of aggression and violence.

The Government is profoundly committed to service user and staff safety. A core value underpinning our modernisation programme within mental health care is that service users should receive care that promotes their safety and well-being. The same safety commitment is made to staff and the wider public.

The National Institute for Mental Health in England and the National Patient Safety Agency believe action to establish standards for managing challenging behaviours, education and training, and accreditation is long overdue. Organisations need to be more systematic in how they respond to this, moving away from the 'ad-hoc' responses of the past.

Whilst definitive empirical evidence is scarce in this area a body of knowledge around good practice is emerging and will be significantly contributed to by the forthcoming NICE Guidelines. These positive practice standards have been developed through wide consultation and discussion. I believe that their publication marks the beginning of a new emphasis on enlightened care and safety.

Louis Appleby
National Director for Mental Health

Introduction

The positive practice standards set out in this guidance have been developed to support mental health service providers and to enable them to review their current policies and procedures relating to education, training and practice in the safe and therapeutic management of aggression and violence. The aim is to reassure mental health service users and staff about the effectiveness of the process for its recognition, prevention and management. A further objective is to promote positive practice initiatives to protect service users, staff and visitors who are exposed to aggression and violence through the audit, benchmarking and clinical governance of services.

With the publication of the Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision (DoH, 2002) – and the development of trustwide Acute Care Forums, mental health service providers should be well placed to begin this work.

The positive practice standards are being put in place pending the National Institute for Clinical Excellence (NICE) publishing Guidelines on the Short Term Management of Disturbed (Violent) Behaviour in Psychiatric Inpatients. This document does not replace the Mental Health Act Code of Practice (1999).

The National Institute for Mental Health in England (NIMHE) will be working closely with the Counter Fraud and Security Management Service (CFSMS) on a number of initiatives relating to the safe and therapeutic management of aggression and violence. The CFSMS was launched in April 2003 and has policy and operational responsibility for the management of security in the NHS. Their remit is broad but incorporates the following elements: tackling aggression and violence against staff and professionals working in the National Health Service (NHS); ensuring the security of property and assets; ensuring the security of drugs, prescription forms and hazardous materials; and ensuring the security of maternity and paediatric wards. This includes work previously carried out under the zero tolerance campaign.

NIMHE will be encouraging feedback on these Positive Practice Standards over the coming months from all key stakeholders, seeking views and comments on their content and relevance. Definitive guidance will be published in 2004 following, the publication of the NICE guidelines and will incorporate recommendations from inquiries and investigations.

NIMHE is seeking examples of effective governance arrangements, positive practice initiatives in the safe and therapeutic management of aggression and violence, for inclusion in future guidance, NIMHE collaborative projects and dissemination via practice development networks.

Background

A number of reports, inquiries and investigations have highlighted concerns regarding; the content and quality of education and training provided to staff, the experience, qualifications and practice credibility of trainers, the absence of, national practice standards or guidance, the lack of mandatory accreditation and regulation schemes for trainers and training programmes. The most notable of these include:

- Standing Nursing Midwifery Advisory Committee: Mental Heath Nursing – Addressing Acute Concerns (SNMAC 1999).
- UKCC Nursing in Secure Environments (1999).
- UKCC Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care (2002).
- Mental Health Act Commission Biennial Reports (1999, 2001, 2003).
- National Audit Office A Safer Place to Work – Protecting NHS Hospital and Ambulance Staff from Violence and Aggression (2003).

Aggression and violence can be predicted and is often preventable. However, in the past greater emphasis has been placed on skills development relating to the physical management of aggression and violence rather than skills development in:

- Recognition, prevention and de-escalation.
- Organisational, environmental and clinical risk assessment.
- Risk management.
- Care Programme Approach and Care Co-ordination.
- The use of advanced directives or negotiated care plans.

Accounts of injuries (both psychological and physical) to staff and service users following exposure to aggression, violence and the process of restraining, are well documented. In the most serious cases, death has occurred. It is only through a multi-dimensional approach that mental health service providers can address the problem of aggression and violence in its inpatient services. This approach should be aimed at minimising its occurrence and promoting a safe and therapeutic environment for people to live in, work in and visit.

Comments on the Positive Practice Standards should be forwarded to:

Gary O'Hare/Colin Dale
Joint Project Managers
c/o Carol Childs
NIMHE
Osprey House
Albert Street
Redditch
Worcestershire
B97 4DE
Tel: [redacted]
Fax: [redacted]
Email: [redacted]

1. Preventing and Minimising Aggressive and Violent Behaviour

1.1 Rationale

Approaches to minimising aggression and violence are multi faceted in nature. The primary focus when dealing with aggressive behaviour should be that of recognition, prevention and de-escalation in a culture that seeks to minimise the risk of its occurrence through effective systems of organisational, environmental and clinical risk assessment and management. This approach should also promote therapeutic engagement, collaboration with service users and the use of advanced directives. Services and staff should encourage mutual respect, and recognise the need for privacy, dignity and, racial and cultural diversity as essential values that must be engendered and asserted in all policy, education, training and practice initiatives. Staff, service users and carers groups identified, during focus groups held as part of the National Audit (Royal College of Psychiatrists 2000), a number of issues which influenced the development of violent incidents These included: lack of access to privacy; lack of access to open space and fresh air; boredom; inadequacy of staffing levels and skill mix; lack of opportunity to participate in therapy, social activities and poor staff attitudes.

The Counter Fraud and Security Management Service (CFSMS) is currently developing a standard national syllabus for recognition, prevention and de-escalation training. It is anticipated that in the future this training will be mandatory for designated groups of staff, consequently any education and training initiatives relating to aggression and violence should be discussed with and developed in conjunction with the CFSMS.

1.2 Positive Practice Standards

1.2.1 All staff must receive recognition, prevention and de-escalation skills awareness training as part of an organisational induction programme. The content of which should be based upon an organisational risk assessment relating to incidence of work place aggression and violence.

1.2.2 Mental health service providers must ensure that all policies, procedures, education and training programmes promote recognition, prevention and de-escalation as the first line approach when responding to aggressive behaviour. Physical interventions should be viewed as a final option in a hierarchy of therapeutic interventions.

1.2.3 All Multi-disciplinary team members must receive clinical risk assessment/ management, including ethnic and cultural awareness, education and training as part of an organisational induction programme. They should also attend regular (at least every two years) update programmes as part of their continuous professional development.

1.2.4 Assessment and the management of risk is an essential part of the care and treatment provided for service users and is an integral part of the Care Programme Approach (CPA), care co-ordination, and the Single Assessment Process for Older People. It is essential that on admission a clinical risk assessment of all individuals is carried out and a risk management plan is put in place. This should be conducted in collaboration with the service user and their carer wherever possible.

1.2.5 Risk assessments and risk management plans should be regularly reviewed with the service user and their carer wherever possible. Plans should record known triggers to aggressive/violent behaviour based on previous history and discussion with service users and their carers/families. Changes in levels of risk should be recorded, communicated and risk management plans changed accordingly.

1.2.6 Mental health service providers should ensure that systems are in place to regularly review multidisciplinary team staffing levels and skill mix on inpatient wards/units. This is to ensure that they provide sufficient capacity to provide a safe and therapeutic environment for all, as well as providing dedicated time for staff to spend with service users their carers and families to engage in therapeutic and social activities.

1.2.7 Mental health service providers should work in collaboration with service users and, where appropriate, their carer(s) to develop individualised advanced directives so that future interventions, wherever possible, meet the specific needs and wishes of service users as part of their overall package of care.

1.2.8 Clear and effective communication is an integral part of prevention and de-escalation of aggression and violence, but is of greater importance for people who have hearing or visual impairment, cognitive impairment or whose first language is not English. Mental health service providers must ensure that education, training, policies and procedures emphasise the need for clear and effective communication with all service users. Where necessary this will involve access to interpreters and staff with specific communication skills e.g. signing.

2. Board Level Responsibilities and Organisational Policies and Procedures

2.1 Rationale

Mental health service providers have a duty of care to provide a safe environment for their staff, service users and visitors. Policies and procedures should define the organisation's philosophy and values, and set out a framework of practice within which staff must operate. Responsibility for this should be taken at board level in both NHS Trusts and senior management teams in the independent and voluntary sectors.

Policies and procedures must be based on best available evidence, contemporary practice and be consistent with CFSMS directives.

It is essential that policies and procedures are reviewed at least every 12 months taking into account emerging research, local audit, recommendations and lessons to be learnt from reports, investigations, inquiries and positive practice initiatives.

2.2 Positive Practice Standards

2.2.1 All mental health service providers must have in place policies and procedures relating to the safe and therapeutic management of aggression and violence. A named Board member should be responsible for overseeing their development, implementation and regular review as part of clinical governance. Policies should cover:

- Recognition, prevention and de-escalation strategies.
- Risk assessment and management.
- Approaches for the actual management of aggression and violence.
- Use of extra care areas or low stimulus environments.
- The use of seclusion.
- Race Relations Amendment Act (2000).
- Human Rights Act (1998).
- Anti-discrimination and anti-bullying.
- The use of medication and rapid tranquillisation.
- Physical care and observation during and post restraint.
- Basic life support.
- Health and safety policies in accordance with the Health and Safety Legislation.
- Post incident support, review and reconciliation.

- Root cause analysis and sharing lessons learned.
- Recording, Reporting, Monitoring and Audit.

2.2.2 The Nursing and Midwifery Council (NMC; formerly the UKCC) 'The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care' (UKCC, 2002 Appendix 6) provides further recommended topics for inclusion in Trust policies.

2.2.3 Mental health service providers need to work with commissioners to enable high quality service provision, by ensuring existing resources are used efficiently and potential gaps identified.

3. Service User Involvement

3.1 Rationale

Service users are experts by experience. Training for staff in relation to the safe and therapeutic management of aggression and violence is often far removed from the reality of emotional and psychological trauma of actual incidents for all of those involved or witnessing them.

Service users/groups are well placed to inform staff on the individual effects of aggression and violence, its management and the collective effect on the dynamics of the ward/unit environment. Information and involvement should be sought from:

- Patient Councils/Boards.
- Service User Forums.
- Patient Advice and Liaison Service (PALS).
- Service User Incident Analysis.

Complaints feedback from service users should influence the development, delivery and evaluation of education, training and clinical practice.

Enabling trained service users to influence or become directly involved in the planning, delivery and evaluation of education, training and practice will provide staff with a level of understanding/insight and accountability that is related directly to real human experience.

3.2 Positive Practice Standards

3.2.1 Mental health service providers, in collaboration with service users, should quantify the extent of service user involvement and ensure that appropriate training is available to enable them to contribute to this and other areas of staff education, training and practice.

3.2.2 Trained service users or user groups should be involved in the development of all education and training programmes relating to the safe and therapeutic management of aggression and violence.

3.2.3 Trained service users or user groups should, wherever possible, be involved with the delivery of education and training programmes to staff in the safe and therapeutic management of aggression and violence. Where this is not possible then an agreed service user perspective should be included in education and training programmes being delivered.

3.2.4 Trained Service users/groups should be involved in the audit and evaluation of education and training programmes, and their impact in clinical practice.

4. Families and Carers Involvement

4.1 Rationale

Families and carers often have extensive first hand experience of dealing with aggression and violence and have developed individual ways of managing this. Their experiences are vital in understanding individual responses. Carers can also witness and experience, in inpatient settings, the management of aggression and violence and the effect that this has on themselves, their relative and other service users can be traumatic. For carers, how aggression and violence is managed will be a key indicator of the quality of care being delivered. This can have a major impact on the user, carer and their relationship with multidisciplinary teams.

4.2 Positive Practice Standards

4.2.1 Mental health service providers, in collaboration with carers, should quantify the extent of carer involvement and ensure that appropriate training is available to enable them to contribute to this and other areas of staff education, training and practice

4.2.2 Trained carers or carer groups should be involved in the development of all education and training programmes relating to the safe and therapeutic management of aggression and violence.

4.2.3 Trained carers or carer groups should wherever possible be involved with the delivery of education and training programmes to staff in the safe and therapeutic management of aggression and violence. Where this is not possible then an agreed carers perspective should be included in education and training programmes being delivered.

4.2.4 Trained carers or carer groups should be involved in the audit and evaluation of education and training programmes, and their impact in clinical practice.

5. Black and Minority Ethnic Groups

5.1 Rationale

Inside Outside: Improving Mental Health Service for Black and Minority Ethnic Communities in England (NIMHE 2003) acknowledges the problems experienced by Black and Minority Ethnic (BME) groups in mental heath care. These problems include an over-emphasis on institutional and coercive care; professional and organisational requirements given priority over individual needs and rights; and that institutional racism exists within mental health care. BME service users are more likely to be subject to compulsory admission to hospital, prescribed anti-psychotic medication, restraint and seclusion. BME groups are over represented in secure care environments, particularly in medium secure units.

Service users from the Black and Ethnic minorities, particularly young black males on the whole received more coercive spectrum of care in the mental health services. There is evidence that support the view that service providers over-predict dangerousness in black people.

It is self-evident that racist abuse would compound feelings of persecution in the black and minority ethnic service users. An atmosphere where expressions of racism is tolerated or disregarded, or given low priority would breed a sense of frustration and hostility. The victims would feel unsupported, devalued, dehumanised and objectified.

5.2 Positive Practice Standards

5.2.1 All staff must receive race and cultural diversity awareness education and training particularly in respect of the recognition, prevention and de-escalation of aggression and violence.

5.2.2 The use of interpreters, for those people whose first language is not English, is essential in ensuring effective collaboration between staff, service users and their carers/advocates when assessing, planning, delivering and evaluating care. This will help to minimise the risk of misinterpretation of actions and behaviours on both sides.

5.2.3 Spiritual, religious, and cultural needs, beliefs and behaviours are part of the whole person and must be understood and taken into consideration by staff when working with service users, families and carers and responding to their needs and actions.

5.2.4 Services must ensure that education, training and trainers are ethnically reflective of the community.

5.2.5 Mental health service providers must ensure that service users have access to worship space, faith leaders and religious/faith groups, and that staff are informed of and sensitive to religiously/culturally significant dates and practices.

5.2.6 Mental health service providers must ensure that service users can access culturally appropriate opportunities and materials for therapy, leisure and education.

5.2.7 All mental health service providers should set out a written policy dealing with racist abuse, which should be disseminated to all members of staff and displayed prominently in all public areas under their control. This policy should be strictly monitored and a written record kept of all incidents in breach of the policy. If any racist abuse takes place by anyone, including service users in a mental health setting, it should be addressed and appropriate actions sanctioned.

6. Women in Mental Health Services

6.1 Rationale

Mainstreaming gender and women's mental health implementation guide (DOH, 2003) recognises that women need to be listened to, have their experiences validated and to be kept safe whilst experiencing and recovering from mental ill health.

There needs to be a greater acknowledgement of women's needs and a greater importance placed on the underlying causes and context of their mental distress in addition to their symptoms. Women should be cared for and supported by services that promote empowerment, choice, self-determination, safety, privacy and dignity

6.2 Positive Practice Standards

6.2.1 Multidisciplinary teams should work in collaboration with female service users in assessing their history relating to aggression and violence. From this assessment a clear plan of care should take into account issues pertaining to:

- Domestic violence.
- Experience of child sexual, physical and emotional abuse, sexual assault/rape.
- Self harm.
- Attitudes to others, i.e. male or female who have committed the offence against the women.
- Safety, Privacy and Dignity.
- Clinical risk assessment and management related to pregnancy.
- Experiences within previous accommodation including Mental Health Services.
- Their vulnerability to exploitation.

6.2.2 Women's involvement with planned interventions is essential in order to minimise the potential trauma and damage that physical intervention may cause. Planned interventions should form part of individualised care plans or advanced directives.

6.2.3 Mental health service providers must ensure staff receive appropriate education and training in gender awareness and the safety and other specific needs of female service users.

6.2.4 Women should be involved in the development and delivery of all education and training programmes relating to the safe and therapeutic management of aggression and violence. Where this is not possible then an agreed woman's perspective should be included in the education and training programme being delivered.

6.2.5 Women should be involved in the audit and evaluation of training, and its impact on clinical practice.

6.2.6 Mental health service providers should have policies and procedures relating to women's safety when receiving care and treatment in inpatient wards/units. Policies and procedures should be reviewed every two years.

6.2.7 Mental health service providers should monitor all incidents of sexual harassment to inform future reduction strategies.

7. Age Awareness

7.1 Rationale

Many mental health service providers deliver inpatient care for children and young people, as well as older people. While the positive practice standards set out in this guidance should apply across all mental health inpatient services it is important that specific positive practice standards relating to these potentially vulnerable groups are highlighted.

7.2 Positive Practice Standards

7.2.1 Mental health service providers must ensure that specific programmes of education and training are developed and delivered to multidisciplinary teams working with children and young people for the safe and therapeutic management of aggression and violence. Physical interventions/techniques should be specific to age and physical development.

7.2.2 All education, training, policies and procedures should incorporate:

- Child protection arrangements.
- The Children Act (1989).
- Recommendations from the Climbie Inquiry (2003).
- A full induction prior to unsupervised contact with children and young people.
- The Green Paper ‘Every Child Matters’ (2004).
- NSF For Children; Emerging Findings (2003).
- NSF For Children; Standard for Hospital Services (2003).
- Common law.
- Duty of Confidence.
- Information sharing.
- Human Rights Act 1998.
- Data Protection Act 1998.

The Royal College of Nursing ‘Restraining, holding still and containing children and young people’ (RCN, 2003) provides further guidance for staff.

7.2.3 Children and young people should be cared for in environments which promote engagement, safety from exploitation or abuse, recovery and self determination, minimise stigmatism and recognise the development needs of the child or young person. Environments should also promote culturally sensitive practice and disability awareness.

7.2.4 Mental health service providers must ensure that specific programmes of education and training are developed and delivered to multidisciplinary teams working with older people for the safe and therapeutic management of aggression and violence.

7.2.5 All education, training, policies and procedures should incorporate:

- Physical and psychological needs of older people – The Single Assessment Process (2001).
- Capacity to give consent to treatment.
- Mental Health Act 1983.
- Mental Health Act Code of Practice (1999).
- Procedures to protect Vulnerable Adults – No Secrets (2000).
- National Service Framework for Older People (2001).
- Guidance for Restrictive Physical Interventions – How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder (2002).

7.2.6 Older people should be cared for in environments which promote engagement with the older person, their carer(s) and family, safety from exploitation or abuse, privacy and dignity, minimises stigma and recognises the psychological as well as the physical needs of the older person.

8. People with Learning Disability and Mental Health Problems

8.1 Rationale

Many service users with learning disabilities also suffer from mental health problems and are often cared for in combined mental health and learning disability trusts/organisations. Whilst the positive practice standards set out in this document are relevant to all inpatient services, there are specific issues which mental health service providers should consider in relation to this group.

Within the field of learning disabilities there has been some exemplary work produced by the Department of Health, Department for Education and Skills, and the British Institute for Learning Disabilities. In 2002 the Department of Health and the Department of Education and Skills produced the first joint Guidance for Restrictive Physical Interventions – How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder (DOH, 2002). This joint guidance is identified as an integral part of both the Valuing People White Paper: A New Strategy for Learning Disability for the 21st Century and the National Minimum Standards for Care Homes for Young Adults and Adult Placements.

The British Institute for Learning Disabilities (BILD) published its Code of Practice for Trainers in the Use of Physical Interventions: Learning Disability, Autism, Pupils with Special Educational Needs (BILD, 2001). The BILD Code of Practice provides clear guidance for providers and commissioners of education and training in this field. BILD have also developed, and are currently, running a national accreditation scheme for physical intervention training organisations who deliver training to services for people with learning disabilities, autism and pupils with special educational needs.

8.2 Positive Practice Standards

8.2.1 Mental health service providers who also provide services for people with learning disabilities must ensure that the Guidance for the Restrictive Physical Interventions – How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder is incorporated into organisational policies, procedures, education and training programmes and reflected in clinical practice.

8.2.2 Mental health service providers who also provide services for people with learning disabilities need to be aware of the BILD Code of Practice and integrate it into educational and training programmes where possible. Organisations should also refer to the Code of Practice when commissioning external education and training for staff who work with people with learning disabilities and autistic spectrum disorder.

8.2.3 Mental health service providers who also provide learning disability services should seek accreditation for its training via the British Institute of Learning Disabilities Accreditation scheme. This scheme is specifically for the Learning Disabilities field.

9. Recording and Reporting

9.1 Rationale

Timely and accurate recording and reporting is central to clinical governance arrangements and Health and Safety legislation to ensure accurate information is available to Trust Boards, managers, front line staff and trainers. This will enable organisations to identify lessons to be learnt from incidents; identify emerging themes; inform positive practice; and meet the organisation's obligations under Health and Safety legislation.

It is anticipated that all health bodies will be required to nominate a suitable candidate for the role of Local Security Management Specialist (LSMS) from early 2004. LSMS staff will be working with the police to investigate incidents, take witness statements, oversee the reporting systems and co-ordinate, at a local level, security management related work. In addition, there is a Legal Protection Unit which will be working with the CPS to increase the number of prosecutions of offenders, and offering cost-effective advice to health bodies on a wide range of sanctions that can be pursued

9.2 Positive Practice Standards

Training

9.2.1 Trainers should ensure any injuries or incidents which occur during education and training programmes are accurately recorded and reported through established reporting systems.

9.2.2 A named Trust Board member should have responsibility for monitoring injuries and incidents occurring on education and training programmes via annual clinical governance reporting systems, which should include:

- Number and type of injury.
- Techniques associated with the injury.
- Review and follow up of the incident to conclusion.
- Key themes.
- Lessons to be learned.
- Proposed local strategies to minimise future re-occurrence.

Practice

9.2.3 All incidents of aggression and violence should be recorded and reported by staff with support from their line managers. Detailed specific reports should be taken of all incidents.

9.2.4 Reporting procedures for physical and non-physical incidents are set out in Directions issued by the Secretary of State through the CFSMS, and within the National Patient Safety Agency (NPSA) National Reporting and Learning System.

9.2.5 Trust Boards should have root cause analysis systems in place to review incidents, and a named person responsible for the review and monitoring of incidents of aggression and violence via annual clinical governance reporting systems. Reports should include:

- Number of incidents.
- Type of incident.
- Location and time of incident.
- Possible causes.
- Injuries to service users.
- Injuries to staff.
- Outcome of reviews.
- Emerging themes.
- Lessons to be learned.
- Strategies to reduce episodes of violence and aggression.
- Ethnicity.
- Age.
- Gender.
- Staff involved and their education and training.

9.2.6 Where the seriousness of the incident warrants it, an internal review should take place. The membership should include a Trust Board member and an external independent member for transparency.

10 Partnership Working and Protocols

10.1 Rationale

The main deficiency emerging from recent high profile cases has been the failure of the police, local health services and related agencies such as social services to work together effectively to protect potentially vulnerable individuals in their care. There is a need to facilitate more effective partnership working at the local level, whilst at the same time recognising the distinct contributions required from each organisation.

10.2 Positive Practice Standards

10.2.1 Mental health service providers should establish multi-agency mental health partnership boards which should include the Police; Crown Prosecution Service (CPS), Service Users, Carers, Advocates, Health and Local Authority managers, Ambulance Service Personnel, and other key stakeholders to:

- Develop effective and mutually beneficial communication and information sharing systems.
- Clarify roles, responsibilities and purpose when dealing with situations involving users of mental health services.
- Determine the circumstances when CS incapacitant spray might be used in adult inpatient mental health settings by police.
- Agree the processes for the bringing of criminal proceedings against service users in mental health settings.
- Develop joint approaches to education, training, policy and practice.
- Share lessons to be learned and positive practice initiatives.
- Develop systems for the tracking of cases/proceedings through to conclusion.

11 Development and Delivery of Education and Training

11.1 Rationale

It is essential that education and training in the safe and therapeutic management of aggression and violence is developed and delivered by trainers who have expertise and practice credibility. This is aimed at ensuring that the education and training delivered is fit for purpose and based upon an organisational risk assessment of work placed aggression and violence.

11.2 Positive Practice Standards

11.2.1 All education and training in the safe and therapeutic management of aggression and violence should be based on a thorough environmental and clinical risk assessment of the service, its users and visitors, a training needs analysis for staff and developed in accordance with CFSMS initiatives.

11.2.2 Education and training programmes should be developed in consultation with multidisciplinary teams, service users or user groups, advocates, carers or carer groups, managers and trainers. Programmes should be tailored to the specific needs of the service and its users to ensure its appropriateness and acceptability, particularly concerning age, gender, racial and cultural diversity.

11.2.3 Education and training programmes must be reviewed and evaluated annually in consultation with multidisciplinary teams, service users/groups, carers/ groups, managers and trainers.

11.2.4 Education and training programmes should be delivered in a supportive manner and within a safe environment, which is responsive to the diverse needs and capabilities of staff.

11.2.5 Mental Health service providers must ensure that information and education is available to service users in respect of their personal safety, and actions to take if they are exposed to aggression, violence, harassment or abuse whilst being cared for in mental health settings (e.g. information booklets/advice leaflets provided as part of admission packs, regular seminars/workshops for service user groups).

11.2.6 Particularly vulnerable service users should benefit from personal strategies as part of their care plan.

12 Education and Training – Trainers

12.1 Rationale

National reports and inquiries, as well as frontline staff, managers, and trainers themselves have highlighted the lack of systematic evidence regarding the background, qualifications, status and practice credibility of trainers in the recognition, prevention and management of aggression and violence. All have raised concerns regarding inconsistencies in the quality and content of education and training programmes and the lack of any mandatory national accreditation and regulation scheme for trainers. NIMHE will be developing proposals for a national accreditation and regulation scheme for both trainers and education and training programmes during 2004.

The CFSMS is currently developing a national syllabus for recognition and prevention training in mental health and learning disability settings, and it is anticipated that this training will be mandatory with programmes in place for training trainers which will be quality assured.

12.2 Positive Practice Standards

12.2.1 In the absence of a mandatory accreditation and regulation scheme, mental health service providers should ensure the following:

- They have evidence of the credentials, philosophy, and value base of the trainer's organisation.
- They have evidence of the experience, qualifications, and practice credibility of the person(s) who will deliver education/training programmes.
- The education and training being delivered is professional, based within an ethical and legal framework.
- It promotes the safety of service users, staff and visitors as being essential and equal.
- Is based on service need following a thorough risk assessment and training needs analysis undertaken by the mental health service provider.
- The education and training programme should be based on best available evidence and contemporary practice and is delivered in a professional manner.
- Issues of indemnity insurance are clarified.
- Demonstrates ethnic and cultural awareness/sensitivity.

12.2.2 Mental health service providers must ensure their training staff attend appropriate 'Train the Trainer' programmes in order that training delivered by them:

- Promotes service user and staff safety.
- Emphasise the recognition, prevention and de-escalation of aggression and violence strategies.
- Recognises race and culture diversity.
- Recognises issues of age and gender.
- Use physical intervention as a last resort.
- Promotes service user engagement and reconciliation.
- Based within an ethical and legal framework.

Appropriate Train the Trainer programmes should also:

- Developing standards for training and practice.
- Assess competencies of trainers.
- Demonstrate regular review and evaluation.

12.2.3 All trainers must attend an annual update/refresher course which incorporates a reassessment of the trainer's competencies to practice.

12.2.4 All trainers must have extensive knowledge and understanding of the challenges and implications for clinical practice in mental health service provision. This should be demonstrated via a portfolio of evidence or a relevant professional qualification (health/social care/ teaching).

12.2.5 All trainers must have a recognised teaching or assessment qualification e.g. BEd., Cert. Ed., PGCE, C&G 7307, ENB 998, or student assessor courses developed and delivered by local academic institutions. Where this is not the case then it should be achieved within two years as part of their Continuous Professional Development.

12.2.6 Trainers remain professionally accountable for what they teach and its influence on practice. They must promote the highest standards of professionalism to those whom they teach. Trainers need to remain clinically up-to-date and clinically credible.

12.2.7 All trainers must maintain a portfolio of evidence to support continuous professional development and life long learning.

12.2.8 Internal trainer's portfolios should be reviewed annually by their employing organisation.

12.2.9 Mental health service providers should review potential education and training providers against the above criteria prior to commissioning external education and training in the safe and therapeutic management of aggression and violence.

13 Education and Training – Staff

13.1 Rationale

The safe and therapeutic management of aggression and violence can be extremely difficult and stressful. The use of physical interventions in the management of aggression and violence can potentially present high risks to service users and staff alike. It is essential that staff are trained using best available evidence and knowledge, skills and attitudes are regularly kept up-to-date.

13.2 Positive Practice Standards

13.2.1 All staff who work in areas where they may be exposed to aggression and/or violence, or may need to become involved with physically restraining service users must undertake education and training in the recognition, prevention, de-escalation and management of aggression and violence. This should include physical intervention skills, at induction or as soon as is practicably possible, but no later than within three months of starting their employment or moving to the area where these skills are required.

13.2.2 Where staff have been unable to access such training prior to working in mental health services, Trust Boards (and their independent sector and voluntary sector equivalents) as an interim measure, must ensure that systems are in place to ensure that recognition, prevention and de-escalation of aggression and violence awareness forms part of the ward/unit induction programme. This should make clear what the staff member's response and role should be when faced with incidents involving aggression and violence. These principles should also be applied to students, bank, agency and all staff unfamiliar to the ward/unit.

13.2.3 All staff who undertake recognition, prevention, de-escalation and physical skills training must attend regular refresher/update education and training programmes.

- Programmes including physical skills annually.
- Programmes not including physical skills every two years.

13.2.4 Mental health service providers must ensure that bank and agency staff are adequately trained for the environment they are expected to work in for their own safety and the safety of others. This should be achieved through specifying their requirements in contractual agreements between the respective organisations.

13.2.5 The NMC (formally the UKCC) 'The Recognition and Therapeutic Management of Violence in Mental Health Care' (UKCC, 2002, Appendix Five) provides recommendations for training programmes which should be used as a framework.

14 Physical Care and Observation During Restraint

14.1 Rationale

Situations requiring the use of physical restraint constitute a medical emergency and should be treated as such by mental health service providers. A number of reports, inquiries, and inquests have identified the need for multidisciplinary teams, involved in the restraint of service users, to receive training and have an awareness of the physiological risks associated with the use of physical restraint. This should include the access to and training in basic life support skills and the operation of basic life support equipment.

14.2 Positive Practice Standards

14.2.1 On admission, or at least within 24 hours of admission, service users should have a basic physical examination and their physical condition and needs assessed, with particular attention to conditions which may impact on cardio-pulmonary function or muscle and joint impairment, e.g. Asthma, heart disease, obesity, medication, Arthritis, or propensity for using illicit drugs and/or alcohol, and women who are pregnant.

14.2.2 Where an older person is assessed the Single Assessment Process should be followed to ensure a full and comprehensive assessment of their physical needs, with particular attention to the older person's level of physical frailty.

14.2.3 Service users who stay in hospital for six months or more should have their physical needs and condition fully assessed by a medical practitioner every six months for the first year and annually thereafter.

14.2.4 Any physical condition which may increase the risk to the service user of collapse or injury during restraint should be clearly documented in the service user's records and communicated to all multidisciplinary team members.

14.2.5 Where there is a foreseeable risk a care plan should clearly identify the physical condition and the strategies to minimise the risk to the service user. This care plan should be communicated to all multidisciplinary team members and regularly reviewed and evaluated with the service user and, where appropriate, their carer/advocate.

14.2.6 All staff who may be involved in the restraint process must be trained in:

- Basic life support skills and attend annual updates.
- The physical risks associated with restraint, i.e. positional asphyxia/sudden collapse.

- Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action.
- Use of emergency equipment.
- Knowing how to summon appropriate assistance.

14.2.7 In all wards/units where the use of restraint is foreseeable there should be immediate access to basic life support equipment which is regularly checked (i.e. weekly) and maintained in working condition.

14.2.8 In all wards/units where the use of restraint is foreseeable and where urgent medical assistance may be required, there should be systems in place to ensure immediate access to medical/para-medical assistance via on-call duty doctor, cardio-pulmonary resuscitation teams, or para-medical services.

14.2.9 Any person subject to physical restraint should be medically assessed at the earliest opportunity but no longer than 2 hours after the commencement of the physical restraint. Any injuries must be reported through established reporting systems.

14.2.10 Any person subject to restraint should be physically monitored continuously during restraint and at least every 2 hours post restraint for a period of up to 24 hours. This check should include:

- Care in the recovery position where appropriate.
- Pulse.
- Blood pressure.
- Respiration.
- Temperature.
- Fluid and food intake and output.

If consent and co-operation for these observations is not forthcoming from the person subject to this process, then it should be clearly documented in their records why certain checks could not be performed and what alternative actions have been taken.

14.2.11 Physical monitoring is especially important:

- Following a prolonged or violent struggle.
- If the service user has been subject to enforced medication or rapid tranquillisation.
- If the service user is suspected to be under the influence of alcohol or illicit substances.
- If the service user has a known physical condition which may inhibit cardio-pulmonary function e.g. asthma, obesity (when lying face down).

14.2.12 Wherever possible, restraining service users on the floor should be avoided. If, however, 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. In exceptional situations where the service user needs to be placed in the prone position (face down) this should be for the shortest possible period of time to bring the situation under control.

14.2.13 If seclusion is considered as an alternative strategy to physical restraint, when managing actual violence, then Chapter 19 of the Department of Health and Welsh Office, (1999) Mental Health Act 1983 Code of Practice must be followed.

15 Environmental Safety

15.1 Rationale

Environmental safety is everyone's business, service users, staff and visitors should reasonably be able to expect that the environment that they live in, work in and visit promotes; safety for all, therapeutic engagement, collaboration, and recovery. The National Patient Safety Agency (NPSA) is currently undertaking a project which will focus on the creation of a safer environment on acute psychiatric wards.

The Commission for Health Improvement (CHI) has commissioned the Royal College of Psychiatrists (RCP) Research Unit to undertake a National Audit of Violence between 2003 and 2005. As with the previous audits undertaken in 2000 and 2001 by the RCP Research Unit the outcomes will be extremely useful for mental health service providers.

15.2 Positive Practice Standards

15.2.1 The Royal College of Psychiatrists Guidelines for the Management of Imminent Violence (RCP, 1998) and the Mental Health Policy Implementation Guide National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments (DOH, 2002) provides useful guidance to services when considering, commissioning new or refurbishing mental health facilities. Trusts and other mental health service providers should work with the Estates Departments to incorporate such guidance in future developments, or when undertaking environmental risk assessments.

16 The Use of Pain in the Management of Actual Violence

16.1 Rationale

The application of pain to manage violence is an issue of great concern needing further debate in light of Human Rights Legislation and developing systems of training and practice which minimise the use of pain in many situations. The Royal College of Nursing (RCN), Mental Health Act Commission (MHAC) and the British Institute of Learning Disabilities (BILD) have position statements on the use of pain. The NICE review will provide guidance on this issue in due course.

16.2 Positive Practice Standards

16.2.1 The RCN (1997) advise 'Physical interventions should not rely on the infliction of pain'. The MHAC (1999) state that 'Physical interventions should not rely on the infliction of pain to restrain a patient'.

16.2.2 The BILD Code of Practice provides useful guidance which is applicable to all care settings. 'Techniques that cause pain or discomfort pose major ethical, legal and moral difficulties. For this reason they should never be taught where an alternative pain free method can achieve the desired outcome' (BILD, 2001)

16.2.3 Pain or discomfort should be avoided wherever possible, however there maybe extraordinary situations where pain or discomfort is unavoidable for both staff and service users, i.e. need to breakaway from an attacker or its use is deemed the only way to safely resolve an emergency when alternative interventions have been considered and proven ineffective. In such circumstances the members of staff involved must record and report such action through established reporting systems. The decision and action taken needs to be justified as being the minimum use of force, which is proportionate to the risk associated with that particular set of circumstances.

16.2.4 Mental health service providers should review their existing systems of education, training and practice and provide clear guidance to multi-disciplinary teams on exceptional circumstances where the use of pain may be acceptable and circumstances where it is unacceptable.

16.2.5 All staff using physical interventions including the use of pain do so in accordance with their code of professional practice/conduct. Where staff are not professionally bound by a code, they must always act within the expectations and policies of their employer, and work in a way that meets the published professional code of conduct for their particular discipline, e.g. nursing and the NMC, social care and the General Social Care Council.

17 Clinical Audit and Monitoring

17.1 Rationale

Clinical audit is at the heart of clinical governance (NICE 2002) and is an essential tool in raising the quality of care through:

- Assessing the quality of practice against agreed standards.
- Highlighting areas of concern regarding the quality and cost-effectiveness of patient care.
- Improving practice through informed feedback.
- Acknowledging and reaffirming these positive practice standards.

Clinical audit should be an integral part of service culture in order to monitor service responsiveness to the various aspects of patient care. The safe and therapeutic management of aggression and violence is a central feature to care delivery for staff, service users, and carers.

17.2 Positive Practice Standards

17.2.1 The positive practice standards outlined in this document should be audited to enable mental health service providers to benchmark current education, training and clinical practice. Essence of Care Benchmarking (Department of Health, 2001) provides a useful framework for services.

17.2.2 Mental health service providers should, through their clinical governance arrangements, identify a named Board level member responsible for ensuring that clinical audit and monitoring is carried out.

17.2.3 Service users or user group and carers or carers group/advocates should be involved in the process of clinical audit.

17.2.4 Results of clinical audit should be disseminated to all stakeholders for recommendations to be made regarding future education, training and practice.

17.2.5 Audit and monitoring should adhere to regulations of the Data Protection Act (1998) and supplementary documents.

18 Post Incident Support, Review and Reconciliation

18.1 Rationale

Exposure to aggression and violence and its management can be a traumatic experience for all concerned invoking fear, anger, resentment, or a combination of these. Service users, staff, and visitors who witness such incidents can be affected, as can their therapeutic relationships and the therapeutic culture or milieu of a clinical environment.

18.2 Positive Practice Standards

18.2.1 Mental health service providers should have systems in place with appropriately skilled staff to ensure that a menu of post incident support and review are available and take place within a culture of learning lessons. The following groups should be considered:

- Staff involved in the incident.
- Service users.
- Carers and family, where appropriate.
- Other service users who witnessed the incident.
- Visitors who witnessed the incident.

18.2.2 The aim of any review should seek to learn lessons and seek reconciliation of the therapeutic relationship between staff, service users and their carers.

References

British Institute of Learning Disabilities (2001) *BILD Code of Practice for Trainers in the Use of Physical Interventions: Learning Disability, Autism, Pupils with Special Educational Needs*

Data Protection Act (1998), London, The Stationery Office

Department for Education and Skills (2004) Children's Green Paper – *Every Child Matters*

Department of Health (1999) *Addressing Acute Concerns: Report by the Standing Nursing and Midwifery Advisory Committee*. London HMSO

Department of Health (1999) *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach: A Policy Booklet*

Department of Health (2003) *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England.* NIMHE

Department of Health (2002) *Mental Health Policy Implementation Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments*

Department of Health (2002) *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*

Department of Health (2003) *National Service Framework for Children: Getting the Right Start: Emerging Findings*

Department of Health (2003) *National Service Framework for Children: Getting the Right Start: Standard for Hospital Services*

DoH (2001) *National Service Framework for Older People*

Department of Health (2003) *National Service Framework for Older People: a report of progress and future challenges*

Department of Health (2000) *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*

Department of Health (2000) *Safety, Privacy and Dignity in Mental Health Units*

Department of Health (1989) *The Children Act*. The Stationery Office

Department of Health (2002) *The Single Assessment Process Guidance for Local Implementation*

Department of Health (2002) *Women's Mental Health: Into the Mainstream. Strategic Development of Mental Health Care for Women*. Department of Health, October 2002

Department of Health & Department for Education & Skills (2002) *Guidance for Restrictive Physical Interventions – How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder*. London: Department of Health, July 2002

Department of Health (1999) *Working Together To Safeguard Children*

Department of Health & Home Office (2003) *The Victoria Climbié Inquiry: report of an inquiry by Lord Laming*. London, HMSO

Department of Health & the Welsh Office (1999) *Mental Health Act 1983 Code of Practice.* London, HMSO

Guidance on the discharge of mentally disordered people and their continuing care in the community (1994) HSG(94)27

Health & Safety at Work Act (1974) London, HMSO

Health & Safety Commission (1992) *The Management of Health and Safety at Work Approved Code of Practice* London HMSO

Human Rights Act (1998) London. The Stationery Office

Mental Health Act Commission (1999) *Eighth Biennial Report 1997 – 1999*. HMSO, Norwich

Mental Health Act Commission (2001) N*inth Biennial Report 1999 – 2001*. HMSO, Norwich

Mental Health Act Commission (2003) *Tenth Biennial Report 2001 – 2003*. HMSO, Norwich

National Audit Office (2003) *Safer Places to Work: protecting NHS hospital and ambulance staff from violence and aggression*. London HMSO

National Institute for Clinical Excellence (2002) *Principles for Best Practice in Clinical Audit*. Radcliffe Medical Press

National Institute for Clinical Excellence (2002) *Schizophrenia – Core interventions in the treatment and management of Schizophrenia in primary and secondary care*

Race Relations (Amendment) Act 2000. HMSO

Royal College of Nursing (1997) *The Management of aggression and violence in places of care. An RCN Position Statement*. RCN, London

Royal College of Psychiatrists (1998) *Guidelines for the Management of Imminent Violence*. Royal College of Psychiatrists, London

Royal College of Psychiatrists College Research Unit (2000) *National Audit of the Management of Violence in Mental Health Settings Final Report: Year 1, June 2000*. Royal College of Psychiatrists, London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Nursing in Secure Environments: A Scoping Study Conducted on Behalf of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting by the Faculty of Health, University of Central Lancashire*

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2002) *The Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care*

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CLINICAL PRACTICE GUIDELINES

improving practice:
improving care

Violence

The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments

This guideline was commissioned by the National Institute for Health and Clinical Excellence (NICE)

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Disclaimer

As with any clinical guideline, recommendations may not be appropriate for use in all circumstances. A limitation of a guideline is that it simplifies clinical decision-making (Shiffman 1997). Decisions to adopt any particular recommendations must be made by the practitioners in the light of:

- ✦ available resources
- ✦ local services, policies and protocols
- ✦ the patient's circumstances and wishes
- ✦ available personnel
- ✦ clinical experience of the practitioner
- ✦ knowledge of more recent research findings.

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Terminology

1. Where the term 'carer' is used, this refers to unpaid carers as opposed to paid carers (for example, caseworkers).
2. Where the term 'service user' is used, this refers to users of mental health services.
3. Where the term 'staff member' or 'health care professional' is used, this refers to any nursing or allied health care professions or other medical staff, including health care assistants.

Legal review

These guidelines have been referred to principles of law summarised by NICE solicitors and have undergone a legal review as part of the stakeholder and validation process.

Abbreviations

Technical terms

ABS	agitated behaviour scale (Corrigan 1989)
AED	automated external defibrillators
ALS	advanced life support
ARP	aggression risk profile (Kay et al. 1987)
BARS (1)	behavioural activity rating scale (Swift et al. 1998)
BARS (2)	Barnes akathisia rating scale (Barnes 1989)
BLS	basic life support
BPRS	brief psychiatric ratings scale (Overall & Gorham 1962)
BVC	Brøset violence checklist (Almvik 1996)
CGI	clinical global impressions scale (Guy & Bonato 1970)
CGI-I	clinical global impression of improvement – subscale of CGI (Guy & Bonato 1970)
CGI-S	clinical global impressions severity of illness scale – subscale of CGI (Guy & Bonato 1970)
CO	constant observation
CPR	cardiopulmonary resuscitation
EAQ	environment assessment questionnaire (Lanza 1996)
EPS	extrapyramidal symptoms
GCI	global clinical impressions scale
GDG	Guideline Development Group
HCR-20	historical/clinical/risk – 20-item scale, version 2 (Webster et al. 1997)
HIV	human immunodeficiency virus
IFP	information for the public version
ILS	immediate life support
i/m	intramuscular injection
i/v	intravenous injection
MBPRS	modified brief psychiatric ratings scale (Tariot et al. 1993)
MMSE	mini mental state examination (Folstein et al. 1975)
MOAS	modified overt aggression scale (Kay et al. 1988)
NOSIE-30	nurses observation scale for in-patient evaluation (Honigfeld et al. 1966)
OAS	overt agitation scale (Yudofsky 1997)
PANSS	positive and negative syndrome scale (Kay et al. 1987)
PANSS-EC	positive and negative syndrome scale exited component -subscale of PANSS (Kay et al. 1987)
PICU	psychiatric intensive care unit
PCF	patient characteristic form b (Lanza 1996)
PCL-SV	psychopathy checklist: screening version (Hart et al. 1995)
PRN	pro-re-nata medication
QNS	quantified neurological scale (Convit et al. 1994)
RAPP	routine assessment of patient progress (Ehmann et al. 1995)
RCT	randomised controlled trial
RSU	regional secure unit
SO	special observation
SOAS	staff observation aggression scale (Palmestierna & Wistedt 1987)
SOAS-E	extended staff observation aggression scale (Hallenstinsen et al. 1998)
SOAS-R	staff observation aggression scale revised (Nijman et al. 1999)
SORS	special observation record sheets
SPC	summary of product characteristics
TSRS	target symptom rating scale (Barber et al. 2002)
VAS	any visual analogue scale, for example, likert scale
VRAG	violence risk appraisal guide (Harris et al. 1993; Webster et al. 1994).

Organisations

BNF	British National Formulary
DH	Department of Health
MHRA	Medicines and Healthcare Products Regulatory Agency (formerly Medical Devices Agency)
NCC-NSC	National Collaborating Centre for Nursing and Supportive Care
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
NMC	Nursing and Midwifery Council (formerly the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC), formerly the Standing Nursing and Midwifery Advisory Committee (SNMAC).
NPSA	National Patient Safety Agency
NSF	National Service Framework
RCN	Royal College of Nursing
RCPsych	Royal College of Psychiatrists
SMS	the NHS Security Management Service
ScHARR	School of Health and Related Research, University of Sheffield
UKCC	The United Kingdom Central Council for Nurses, Midwives and Health Visitors. The role of this body has now been taken over by the Nursing and Midwifery Council (NMC).

General glossary

(This is partially based on *Clinical epidemiology glossary* by the Evidence Based Medicine Working Group, www.ed.ualberta.ca/ebm; *Information for national collaborating centres and guideline development groups*, (NICE 2001).

Acute care setting: short-term (approximately 30 days) in-patient care or emergency services or other 24-hour urgent care settings.

Admission unit: type of unit into which a service user is admitted either directly from emergency departments or from ambulance services.

Actuarial: a statistical method.

Actuarial prediction: this involves the use of statistical models and risk factor tools to predict an individual's behaviour. Risk factors measured by actuarial tools can be static (unchangeable) or dynamic (changeable).

Advance directive: a document that contains the instructions of a person with mental health problems setting out their requests in the event of a relapse, an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent. It also contains people who they wish to be contacted and any other personal arrangement that they wish to be made.

African Caribbean: of or pertaining to both Africa and the Caribbean; used to designate the culture, way of life, etc or the characteristic style of music of those people of black African descent who are, or whose immediate forebears were, inhabitants of the Caribbean (West Indies) (Oxford English Dictionary Online).

Aggression: a disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained.

Anaesthetised: general anaesthesia is a state of narcosis (unconsciousness), analgesia (lack of awareness of pain) and muscle relaxation. It is one stage beyond deep sedation. It implies loss of airway control and protective reflexes, and requires the constant attention of trained personnel to keep the patient safe. There is normally no verbal contact. There are, of course, various depths of anaesthesia, and the risk of obstructed or depressed respiration increases as the anaesthesia deepens.

Antecedents: warning signs that indicate a service user is escalating towards a violent act.

Antipsychotics: a class of prescription medications used to treat psychotic conditions.

Benzodiazepines: refers to any of several similar lipophilic amines used as tranquillizers or sedatives or hypnotics or muscle relaxants.

Bias: a tendency for the results to depart systematically, either lower or higher, from the 'true' results. Bias either exaggerates or underestimates the 'true' effect of an intervention or exposure. It may arise for several reasons, such as errors in design or the conduct of the study.

Bipolar disorder: a condition formerly known as manic depressive disorder, that involves the presence of depressive episodes, along with periods of elevated mood known as mania. Symptoms of mania include an abnormally elevated mood, irritability, an overly inflated sense of self-esteem, and distractibility.

Black: refers to those members of ethnic minority groups who are differentiated by their skin colour or physical appearance, and may therefore feel some solidarity with one another by reason of past or current experience, but who may have many different cultural traditions and values.

Breakaway: a set of physical skills to help separate or breakaway from an aggressor in a safe manner. They do not involve the use of restraint.

Calming: reduction of anxiety/agitation.

Cardiovascular compromise: failure of the heart and circulatory system to produce adequate blood flow to the vital organs leading to collapse and often to death.

Cardiopulmonary resuscitation: combined artificial ventilation and cardiac massage technique for reviving a person whose heart and breathing have stopped and who is unconscious.

Case-control study: a study in which the effects of a treatment or management approach in a group of patients is compared with the effects of a similar group of people who do not have the clinical condition (the latter is called the control group).

Clinical effectiveness: the extent to which an intervention (for example, a device or treatment) produces health benefits (i.e. more good than harm).

Cochrane collaboration: an international organisation in which people retrieve, appraise and review available randomised controlled trials. The Cochrane database of systematic reviews contains regularly updated reviews on a variety of issues. The Cochrane Library is the database for the collaboration. It is electronic and regularly updated.

Cohort study: follow-up of exposed and non-exposed groups of patients (the 'exposure' is either a treatment or condition), with a comparison of outcomes during the time followed-up.

Common law: is that body of legal doctrines and principles developed by the courts through their decisions. For example, the common law doctrine of necessity and the principles of negligence have been developed by the courts over time.

Co-morbidity: co-existence of a disease or diseases in a study population in addition to the condition that is the subject of study.

Confidence interval (CI): the range of numerical values in which we can be confident that the population value being estimated were found. Confidence intervals indicate the strength of evidence; where confidence intervals are wide they indicate less precise estimates of effects.

Cost effectiveness: the cost per unit of benefit of an intervention. In cost effectiveness analysis, the outcomes of different interventions are converted into health gains for which a cost can be associated – for example, cost per additional pressure ulcer prevented.

Cost impact: the total cost to the person, the NHS or to society.

Crash bag: the equipment necessary to resuscitate an individual if they suffer a cardiac arrest.

David Bennett Inquiry: public inquiry into the death of David Bennett, a 38 year old black man, who died while being restrained in a medium secure unit in the early hours of Saturday 31 October 1998.

De-escalation: a complex range of skills designed to abort the assault cycle during the escalation phase, and these include both verbal and non-verbal communication skills (CRAG 1996).

De-escalation room: this should be a low stimulus room, where a service user can go to calm down. It should not normally be the seclusion room, which is a specific room set aside for the purpose of seclusion, and which must meet specifications that are principled in the Mental Health Act Code of Practice. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention. This is not the case when a service user is asked to use the de-escalation room.

Deep sedation: a reduction of consciousness and motor and sensory activity, where verbal contact is progressively lost, and then (dangerously) if excessive airway control and protective reflexes are lost.

Disturbed: to be experiencing emotions and exhibiting behaviours that deviate from the accepted norm as a result of mental ill health.

Dystonia: a slow movement or extended spasm in a group of muscles.

Economic evaluation: comparative analysis of alternative courses of action in terms of both their costs and consequences.

Effectiveness: the extent to which a specific intervention, when used under ordinary circumstances, does what it is intended to do. Clinical trials that assess effectiveness are sometimes called management trials (NICE 2002).

Efficacy: the extent to which an intervention produces a beneficial result under ideal conditions. Clinical trials that assess efficacy are sometimes called explanatory trials and are restricted to participants who fully co-operate.

Emergency departments: any care setting designed to provide emergency treatment and care (previously known as accident and emergency).

Environment: the physical and therapeutic external conditions or surroundings.

Epidemiological study: a study that looks at how a disease or clinical condition is distributed across geographical areas.

Exceptional circumstances: those circumstances that cannot reasonably be foreseen and as a consequence cannot be planned for.

Extrinsic: factors that are external to the individual.

Follow-up: observation over a period of time of an individual, group or population whose relevant characteristics have been assessed in order to observe changes in health status or health-related variables.

Forensic services: mental health services based on authority derived from judicial actions.

Gender: those characteristics of women and men that are socially determined, as opposed to 'sex' which is biologically determined (*Mainstreaming gender and women's mental health implementation guide 2003*).

Gold standard: a method, procedure or measurement that is widely accepted as being the best available.

Good practice point: a recommendation for good practice, based on the experience of the Guideline Development Group.

Guideline recommendation: a systematically developed statement that is derived from the best available research evidence, using predetermined and systematic methods to identify and evaluate evidence relating to the specific condition in question.

Health technology assessment: the process by which evidence on the clinical effectiveness and the costs and benefits of using a technology in clinical practice is systematically evaluated.

Incidence: the number of new cases of illness commencing, or of persons falling ill during a specified time period in a given population.

Intrinsic: factors present within the individual.

Key worker: the health care professional who is the first line of contact for a person with mental illness.

Light sedation: a state of rest and reduction of psychological activity, but verbal contact is maintained.

Low secure units: low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed/violent behaviour in the context of a serious mental disorder and who require the provision of security (Department of Health, Mental health policy implementation guide 2002).

Mania: an irrational but irresistible motive for a belief or action. It can also be used to refer to a mood disorder and an affective disorder in which the victim tends to respond excessively and sometimes violently.

Mechanical restraint: a method of physical restraint involving the use of authorised equipment applied in a skilled manner by designated health care professionals. Its purpose is to safely immobilise or restrict movement of part/s of the body of the individual concerned.

Medium secure unit: usually houses service users who are detained under the Mental Health Act, but who do not need to be detained in high security hospitals.

Meta-analysis: a statistical method of summarising the results from a group of similar studies.

Minority ethnic group: a group which is numerically inferior to the rest of the population in a state, and in a non-dominant position, whose members possess ethnic, religious or linguistic characteristics which differ from those of the rest of the population and who, if only implicitly, maintain a sense of solidarity towards preserving their culture, traditions, religion or language. (F. Capotorti (1985) 'Minorities', in Bernhardt R et al. (editors) *Encyclopedia of public international law*. Amsterdam: Elsevier, vol.8, p.385.)

Negative predicative value: the probability that an individual is truly disease-free given a negative screening test.

NHS Security Management Service (SMS) also known as the Counter Fraud and Security Management Service: is a special health authority which has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the National Health Service (http://www.cfsms.nhs.uk/).

Number needed to harm: the number of people (calculated statistically) who need to be treated to cause one bad outcome. The lower the number needed to harm, the higher the likelihood of harm (NICE, Schizophrenia guideline 2002).

Number needed to treat: the number of patients who need to be treated to prevent one bad outcome (i.e. a good outcome). It is the inverse of the risk difference (NICE, Schizophrenia guideline 2002).

Observation: a two-way relationship, established between a service user and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user (*The recognition, prevention and therapeutic management of violence in mental health care,* (2002) London: United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting).

Occulogyric crisis: sudden spasm of conjugate movement, mainly upward, so that the eye rolls upwards into the back of the head.

Odds ratio (OR): ratio of the odds of the outcome in the treatment group to the corresponding odds in the control group. Again, for an adverse outcome, an odds ratio below one indicates that the treatment reduces the risk (Glasziou 2001).

Pain compliance: a method of physical intervention that employs skills and techniques, such as thumb locks, which deliberately involve inducing pain. These techniques are only permitted in exceptional circumstances, as part of the short-term management of disturbed/violent behaviour. They are only used once other methods have been tried and proved unsuccessful and must be a proportionate, reasonable and justifiable response to a situation.

Parenteral: method of administering medication or nutrition other than via the digestive tract, such as intravenous, subcutaneous or intramuscular.

Patient: the term 'service user' is preferred to refer to people with mental illness in this guideline. The term 'patient' is used under the following conditions:

- generic and typical usage, such as 'NICE programme for patients', 'Patient Bill of Rights'
- NICE recommendations that are required to be quoted verbatim
- frequently used noun compounds – for example, patient sample (NICE, Schizophrenia guideline 2002).
- in the sections that describe accident and emergency settings, the term 'patient' is normally used.

Phase 3 studies: are expanded controlled and uncontrolled trials. They are performed after preliminary evidence suggesting effectiveness of the drug has been obtained in phase 2. They are intended to gather the additional information about effectiveness and safety that is needed to evaluate the overall benefit-risk relationship of the drug, before undertaking a licensing application with an appropriate regulatory authority.

Phase 3 studies also provide an adequate basis for extrapolating the results to the general population and are the basis for product communication to the physician. Phase 3 studies usually include several hundred to several thousand people.

Physical intervention: is a skilled hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

PICU (psychiatric intensive care unit): psychiatric intensive care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed/violent phase of a serious mental disorder (Department of Health, Mental health policy implementation guide 2002).

Positive/therapeutic engagement: may be defined as a skilled nursing intervention that aims to empower the patient to actively participate in their care. Rather than 'having things done to them' – like observations – the patient negotiates the level of engagement that will be most therapeutic.

Positive predicative value: the probability that a person actually has the disease, given that they test positive using a given screening test.

Predictive validity: a risk assessment tool would have high predictive validity if the predictions it makes of disturbed/violent behaviour in a sample became true (i.e. it has both high sensitivity and specificity).

Prevalence: the proportion of persons with a particular disease within a given population at a given time.

Principle of proportionality: requires that one should not go beyond what is necessary to achieve the object pursued.

PRN (Prorenata): medication that may be used as the occasion arises; when necessary.

Psychiatric in-patient settings: any care setting in which psychiatric treatment is given to inpatients.

Psychosocial interventions: the term is used to refer to a range of social, educational, occupational, behavioral, and cognitive interventions. Within the short-term management of disturbed/violent behaviour, the two main psychosocial interventions are de-escalation and observation.

QT interval: the period in the cardiac cycle between depolarisation (causing contraction) and repolarisation of the heart muscle. Some drugs prolong this interval. This can lead to the development of arrhythmias (abnormal electrical activity in the heart), which may cause cardiovascular collapse and death.

Randomised controlled trial (RCT): a clinical trial in which the treatments are randomly assigned to subjects. The random allocation eliminates bias in the assignment of treatment to patients and establishes the bias for the statistical analysis.

Rapid tranquillisation: the use of medication to calm/lightly sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place, and allowing comprehension and response to spoken messages throughout the intervention. Although not the overt intention, it is recognised that in attempting to calm/lightly sedate the service user, rapid tranquillisation may lead to deep sedation/anaesthesia.

Relative risk: an estimate of the magnitude of an association between exposure and disease that also indicates the likelihood of developing the disease among persons who are exposed, relative to those who are not. It is calculated by the ratio of incidence of disease in the exposed group divided by the corresponding incidence in the non- exposed group.

Respiratory effect: the changes in thoracic or abdominal circumference that occurs as the subject breathes.

Retrospective cohort study: a study in which a defined group of persons with an exposure, and an appropriate comparison group who are not exposed, are identified retrospectively and followed from the time of exposure to the present, and in which the incidence (or mortality) rates for the exposed and unexposed are assessed.

Seclusion: the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed/violent behaviour that is likely to cause harm to others. Seclusion should be used as a last resort, for the shortest possible time. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of shortage of staff; where there is any risk of suicide or self-harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

Seclusion room: this is a room that is fit for purpose, as defined by the principles laid out in the Mental Health Act Code of Practice. It should only be used for the purpose of carrying out seclusion. As such, it should be distinguished from a low stimulus room, where a service user can go simply for the purpose of de-escalation.

Sensitivity: percentage of those who developed a condition who were predicted to be at risk.

Sleep: a condition of body and mind such as that which normally recurs for several hours every night, in which the nervous system is inactive, the eyes closed, the postural muscles relaxed, and consciousness practically suspended (Oxford English Dictionary).

Specificity: percentage of those correctly predicted not to be at risk.

Systematic review: a way of finding, assessing and using evidence from studies (usually RCTs) to obtain a reliable overview.

Threat control override symptoms: a combination of feeling threatened and losing the sense of internal control of our own thoughts and actions. This cluster of symptoms tends to be most related to an increased risk of disturbed/violent behaviour toward others.

Torsade de pointes: is a medical condition, the name of which means in French 'twisting of the points'. It is a potentially deadly form of ventricular tachycardia. On the electrocardiogram (ECG/EKG), it will present like ventricular tachycardia, but the QRS complexes will swing up and down around the baseline in a chaotic fashion – which prompted the name.

Validity: the extent to which a variable or intervention measures what it is supposed to measure or accomplish.

Internal validity: of a study referring to the integrity of the design.

External validity: of a study referring to the appropriateness by which its results can be applied to non-study patients or populations.

Violence: the use of physical force that is intended to hurt or injure another person (Wright 2002).

Vulnerability: specific factors that relate to the likelihood of an individual being victimised, taken advantage of, or exploited by others. Vulnerable individuals may be subject to verbal abuse or harassment, physical or sexual abuse or intimidation, coercion into unwanted acts and bullying. Assessment of vulnerability may include consideration of mental state, physical/physiological conditions, psychological or social problems, cultural or gender issues.

1. Executive summary

The National Institute for Health and Clinical Excellence (NICE) commissioned the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) to develop guidelines on the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and emergency departments for mental health assessments. This follows referral of the topic by the Department of Health and Welsh Assembly Government. This document describes the methods for developing the guidelines and presents the resulting recommendations. It is the source document for the NICE short-form version, the Quick reference guide (the abridged version for health professionals) and the Information for the public (the version for patients and their carers), which will be published by NICE and be available on the NICE website (www.nice.org.uk). The guidelines were produced by a multidisciplinary Guideline Development Group (GDG) and the development process was undertaken by the NCC-NSC.

The main areas examined by the guideline were:

- environment and alarm systems
- prediction: antecedents, warning signs and risk assessment
- training
- working with service users
- de-escalation techniques
- observation
- physical interventions
- seclusion
- rapid tranquillisation
- post-incident review
- emergency departments
- searching.

Recommendations and good practice points based on the best available evidence of clinical and cost effectiveness are presented. However, there was a dearth of evidence in all areas covered by this guideline and all recommendations and good practice points were arrived at by the GDG using formal consensus methods.

Evidence published after 2003 was not considered, with the exception of rapid tranquillisation, where evidence published up to 2003 was considered to ensure that up-to-date trials could be included for medications. Subsequently no further evidence has been submitted as relevant or likely to impact on the recommendations prior to publication.

Health care professionals should use their clinical judgement and consult with service users when applying the recommendations and good practice points described in this guideline, which aim at reducing the negative physical, social and financial impact of managing disturbed/violent behaviour in adult psychiatric in-patient settings and emergency departments in the short-term (within 72 hours).

2 Principles of practice

The principles outlined below describe the ideal context in which to implement the recommendations and good practice points contained in this guideline. These have been adapted from the NICE clinical practice guideline: *Pressure ulcer prevention* (2003). The principles in the NICE clinical practice guideline: *Pressure ulcer prevention* (2003) went through a consensus process, were refined and published in order to describe the ideal context in which to implement guideline recommendations. (Adapted from the Royal College of Nursing (2001) clinical practice guidelines: *Pressure ulcer risk assessment and prevention. Recommendations.*)

Person-centred care

- Service users and their carers should be made aware of the guideline and its recommendations and be referred to the *Information for the public* version (IFP).
- Service users and their carers should be involved in shared decision-making about the preferred choice of intervention for the short-term management of disturbed/violent behaviour through the use of their care plans or advance directives.

A collaborative inter-disciplinary approach to care

- All members of the inter-disciplinary team should be aware of the guidelines and all interventions should be documented in the service users' health care records.

Organisational issues

- An integrated approach should be taken to the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings, with a clear strategy and policy supported by management.
- Care should be delivered in a context of continuous quality improvement where improvements to care following guideline implementation are the subject of regular feedback and audit.
- Commitment to and availability of education and training are needed to ensure that all staff, regardless of profession, are given the opportunity to update their knowledge base and are able to implement the guideline recommendations.
- Service users should be cared for by personnel who have undergone appropriate training and who know how to initiate and maintain correct and suitable preventative measures. Staffing levels and skill mix should reflect the needs of service users and health care professionals.

3 Key priorities for implementation

The reader is referred to the evidence reviews for a summary of the supporting evidence and evidence statements (Section 7). The grading systems can be found in 7.4 and 7.5. A full account of all the recommendations in the guideline can be found in Section 8. (The key recommendations follow the order in which they appear in Section 8.)

The following nine recommendations have been identified as priorities for implementation.

Prediction

- Measures to reduce disturbed/violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers should ensure that there is a full risk management strategy for all their services.

Training

- All service providers should have a policy for training employees and staff-in-training in relation to the short-term management of disturbed/violent behaviour. This policy should specify who will receive what level of training (based on risk assessment), how often they will be trained, and also outline the techniques in which they will be trained.
- All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed/violent behaviour, and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with disturbed/violent behaviour.
- All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of immediate life support (Resuscitation Council UK). This covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators.
- Staff who employ physical intervention or seclusion should, as a minimum, be trained to basic life support (Resuscitation Council UK).

Commentary

No studies were identified that specifically addressed the issues described in the five key priorities above – the extent to which risk assessment and risk management reduce the risk of disturbed/violent behaviour; the effectiveness of policies on training or training itself in relation to the management of disturbed/violent behaviour; or training in relation to resuscitation in psychiatric settings. The GDG carefully considered the available evidence and used formal consensus techniques to extrapolate and develop these recommendations. In the opinion of the GDG the fulfilment of the last two recommendations above constitutes a duty of care (see also the legal preface, page 20).

Working with service users

- Service users should have access to information about the following in a suitable format:
  - which staff member has been assigned to them and how and when they can be contacted
  - why they have been admitted and, if detained, the reason for detention; the powers used and their extent; and rights of appeal
  - what their rights are with regard to consent to treatments, complaints procedures, and access to independent help and advocacy
  - what may happen if they become disturbed/violent.

  This information needs to be provided at each admission, repeated as necessary and recorded in the notes.

Commentary

Although no studies were identified that specifically addressed the issue of information provision for service users, the GDG viewed this as an important issue requiring guidance. The GDG maintains it is a legal right that detained service users are given this information and that this information should be viewed as a right for all service users (see also the legal preface, page 20).

- Service users identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advance directive. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review.

Commentary

Although no studies were identified that specifically addressed the issue of advance directives, the GDG – in particular those with personal experience of the issue – felt that it was important for service users to be able to have input into their care. The GDG did not consider that discussing these issues with appropriate service users would cause unnecessary anxiety. The GDG used formal consensus techniques to develop this recommendation.

Rapid tranquillisation, physical intervention and seclusion

- Rapid tranquillisation, physical intervention and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. These interventions are management strategies and are not regarded as primary treatment techniques. When determining which interventions to employ, clinical need, safety of service users and others, and, where possible, advance directives should be taken into account. The intervention selected must be a reasonable and proportionate response to the risk posed by the service user.

Commentary

There is a lack of evidence relating to the effectiveness of these three interventions, particularly for physical intervention and seclusion. Therefore the GDG felt the need to stress caution when implementing these interventions, and used formal consensus techniques to derive this recommendation (see also the legal preface, page 20).

Physical intervention

- During physical intervention, one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

Commentary

There is limited evidence in this area. However, a number of high profile inquiries – most recently, the inquiry into the death of David Bennett – have stressed the need for staff to protect a service user's head and airway during the physical intervention process. The inquiry suggests that failure to do so, and the application of pressure to certain parts of the body, may endanger the life of the service user. The focus groups conducted for this guideline also heard reports from participants who described finding it difficult to breathe during physical intervention, due to their head not being sufficiently supported. After consultation with experts, including trainers, the GDG used formal consensus techniques to develop recommendations in this area. The GDG considers the protection of the head when appropriate to constitute a duty of care (see also the legal preface, page 20).

- A number of physical skills may be used in the management of a disturbed/violent incident.
  - The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.
  - Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain.
  - The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, service users and/or others.

Commentary

There is limited evidence in this area. A great deal of discussion took place in the course of the development of the guideline concerning this issue. To ensure a balanced representation at guideline development meetings, experts holding differing perspectives were invited to give presentations. Using formal consensus techniques, the GDG derived a recommendation that restricts the use of pain to the immediate rescue of staff, service users or others.

4 Background to the guideline

Background to commissioning of the guideline

In March 2002, the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) was commissioned by NICE to develop cost effective and clinically relevant guidelines on the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and emergency departments. The remit from the Department of Health and Welsh Assembly Government was as follows:

> To prepare clinical guidelines for the NHS in England and Wales for the short-term management of disturbed/violent behaviour in in-patient psychiatric settings, including consideration of pharmacological, physical (including seclusion and restraint), preventative and psychosocial interventions.

Relationship to other key developments, such as National Service Frameworks (NSFs), other guidelines and policies

The short-term management of violence is a key Government target. This is outlined in the recently developed Mental Health National Service Framework (1999), which stipulates that staff should be competent to assess the risk of violence, manage individuals who may become disturbed/violent, and that staff should know how to assess and manage risk and ensure safety. The effective short-term management of disturbed/violent behaviour is a means of helping to minimise the risk of injury to the individual service user, other service users and staff involved in these types of incident.

The short-term management of violence is also a key aim in the cross-Government NHS zero tolerance zone campaign, which was launched in 1999. The aim of this initiative is to combat violence against NHS staff, where violence is defined as:

Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health. (www.nhs.uk/zerotolerance/definitions.htm)

In the light of the serious nature of disturbed/violent behaviour in adult psychiatric in-patient settings and emergency departments, the interventions for the short-tem management of disturbed/violent behaviour in adult psychiatric in-patient settings and related topics were selected as the focus for this NICE guideline.

The Royal College of Psychiatrists produced a guideline (RCPsych guideline) on the short-term management of disturbed/violent behaviour, The management of imminent violence in 1998, which was due to be updated. All the archive material for this guideline was obtained, search strategies and critical appraisal sheets examined, and copies of the original evidence reviews were considered. The original appraisal of the guideline undertaken by St George's hospital was also obtained (see Appendix 12). The guideline and all archive material were then appraised using the agree tool (see Appendix 11). On this basis, it was decided that the RCPsych guideline should be used as a basis for the current guideline, meaning that this guideline would update and replace the RCPsych guideline, while also extending it into new areas. Searches for this guideline did not therefore go back further than 1995, unless otherwise stated, as this period was covered by the RCPsych searches. All studies included from RCPsych guideline can be found in the evidence tables of included studies for this guideline (Appendix 5). All evidence statements in this guideline take into account both the evidence base contained in the RCPsych guideline and that generated from any new studies included here.

The NICE guideline on schizophrenia (2002) also reviewed rapid tranquillisation in relation to the treatment of schizophrenia. This current guideline builds on this work developed by the National Collaborating Centre for Mental Health (NCC-MH).

The NICE guideline on bipolar disorder (forthcoming 2006) will also review the issue of rapid tranquillisation in relation to the treatment of mania.

In addition to this guideline, several further initiatives are also currently underway which seek to improve the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings. These are:

- The collaborative work being undertaken by the National Institute for Mental Health in England (NIMHE) and the NHS Security Management Service (SMS) which are in the process of establishing a core training curriculum for the short-term management of disturbed/violent behaviour, and a national accreditation scheme for trainers. The core training curriculum is expected to be announced in 2005 and the accreditation scheme is expected to come into force in 2005. The NCC-NSC and the GDG have worked closely with these agencies in developing this guideline and the recommendations and good practice points within it.
- A national audit of the short-term management of disturbed/violent behaviour is being carried out by the Royal College of Psychiatrists on behalf of the Healthcare Commission. The first phase of the audit was scheduled to run concurrently with the development of this guideline. The NCC-NSC liaised closely with the Royal College of Psychiatrists and is grateful to them for helping develop the audit criteria listed in this guideline (see Section 9).
- The David Bennett Inquiry raised important concerns about the treatment of black service users within the NHS. While the inquiry examined the whole of Mr Bennett's care, many of the recommendations produced by the inquiry are relevant to the scope of this guideline. Each of these recommendations has been carefully considered and reflected upon when developing the recommendations and good practice points in this guideline.
- Additional consultation work with black service users was also undertaken by the NCC-NSC in the course of the development of this guideline. We are grateful to Black Orchid in Bristol and Footprints UK in Walthamstow for running focus groups for us. This work was used to inform the recommendations and good practice points – see, in particular, the section on working with service users found in Section 8.4. The NCC-NSC also ran a focus group with health care professionals experienced in the area of black mental health (see Appendix 14).

Clinical need for the guideline

Disturbed/violent behaviour by an individual in an adult in-patient psychiatric setting poses a serious risk to the individual, other service users and staff. In 1998/99, an NHS Executive survey found that there were approximately 65,000 violent incidents against staff across the NHS.

The scope of the guideline discusses the short-term management of disturbed/violent behaviour in adult psychiatric settings, excluding learning disabilities (72 hours). The guidance applies to all adult persons aged 16 or more.

5 Aims of the guideline

5.1 Aims of the guideline

These are to:

- evaluate and summarise the clinical and cost evidence for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and emergency departments (for mental health assessment)
- highlight gaps in the research evidence
- formulate evidence-based and, where possible, cost-effective clinical practice recommendations on the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings, based on the best evidence available to the GDG
- provide audit criteria to assist with the implementation of the recommendations.

5.2 Who is this guideline for?

As detailed in the guideline scope (see Appendix 2), the guideline is of relevance to:

- mental health care professionals and other staff who work in adult psychiatric in-patient settings and emergency departments
- service users
- families and carers
- managers and those responsible for service delivery.

5.3 Groups covered by the guideline

The recommendations made in the guideline cover the care of:

- Adults (>16)

Groups not covered

- Children and adolescents below the age of 16 years
- Adults with learning disabilities
- Patients with a primary diagnosis of substance abuse
- Patients with organic brain disorders or progressive neurological disease.

Health care setting

The recommendations apply to health care professionals who are involved in the short-term (72 hours) management of disturbed/violent behaviour across the range of adult psychiatric in-patient settings and emergency departments in the UK.

Interventions and related topics covered

- Environment and alarm systems
- Prediction: antecedents, warning signs and risk assessment
- Training
- Working with service users
- De-escalation techniques
- Observation
- Physical interventions
- Seclusion
- Rapid tranquillisation
- Post-incident review
- Emergency departments
- Searching.

Interventions not covered

- Interventions for the short-term management of disturbed/violent behaviour in community psychiatric settings, non-psychiatric in-patient settings and learning disability settings.
- Interventions for the long-term management of disturbed/violent behaviour in psychiatric settings.

Audit support

The guideline provides audit criteria for the key priorities drawn up in conjunction with the Royal College of Psychiatrists Healthcare Commission audit team. (See section 9).

5.4 Guideline Development Group

The guideline recommendations were developed by a multidisciplinary and lay Guideline Development Group (GDG), convened by the NICE-funded National

Collaborating Centre for Nursing and Supportive Care (NCC-NSC), with membership approved by NICE. Members include representatives from:

- service user groups
- nursing
- field of psychiatric medicine and emergency medicine
- allied health
- pharmacy
- legal training
- training
- researchers
- staff from the NCC-NSC.

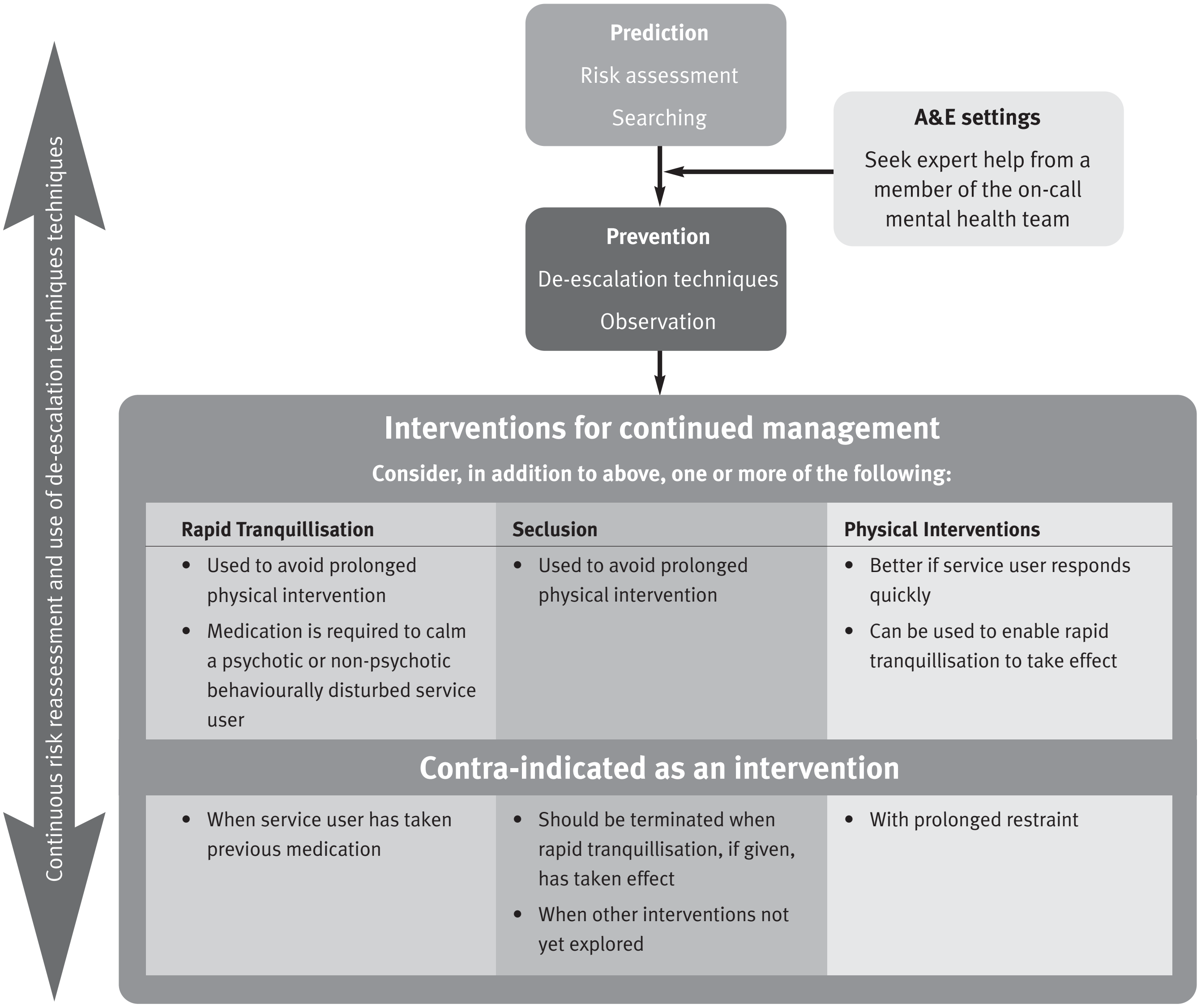
A list of GDG members is attached (Appendix 1).

The GDG met 15 times between May 2002 and November 2004.

All members of the GDG were required to make formal declarations of interest at the outset, and at the beginning of each GDG meeting. This information was recorded in the meeting minutes and kept on file at the NCC-NSC.

6 Care pathway for the short-term management of disturbed/violent behaviour

Overview algorithm for the short-term management of disturbed/violent behaviour



Prediction
Risk assessment
Searching

A&E settings
Seek expert help from a member of the on-call mental health team

Prevention
De-escalation techniques
Observation

Interventions for continued management

Consider, in addition to above, one or more of the following:

Rapid Tranquillisation	**Seclusion**	**Physical Interventions**
• Used to avoid prolonged physical intervention • Medication is required to calm a psychotic or non-psychotic behaviourally disturbed service user	• Used to avoid prolonged physical intervention	• Better if service user responds quickly • Can be used to enable rapid tranquillisation to take effect
Contra-indicated as an intervention		
• When service user has taken previous medication	• Should be terminated when rapid tranquillisation, if given, has taken effect • When other interventions not yet explored	• With prolonged restraint

6.1 Introduction

This guideline considers the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and emergency departments (for mental health assessments). It considers a number of interventions and related issues. Although separate from one another, each of the interventions and related issues described here form part of an integrated pathway of care. It is hoped that the order in which these topics are discussed will facilitate this pathway of care.

The algorithm on page 19 represents an overview of this integrated pathway of care from a starting point of predicting violence, to its prevention and if necessary to the selection of interventions for the continued management of disturbed/violent behaviour. Emphasis is placed on the importance of maintaining risk assessment and de-escalation techniques throughout the care pathway process. Also this guidance focuses on the importance of staff training and service user perspectives.

This full version of the guideline presents the methodology and results of the systematic reviews of the evidence on which the recommendations have been based, in conjunction with expert review and consensus techniques. The structure of this version of the guidance begins from the pretext that prevention is the most desirable management strategy for the short-term management of disturbed/violent behaviour. Firstly, the following areas are examined: the environment, organisation and alarms, and then prediction, which is sub-divided into three areas, namely: antecedents of disturbed/violent behaviour, warning signs and risk assessment. Since none of the interventions discussed in this guideline can be safely practiced without adequate training, the guideline then turns to staff training needs. This is followed by an examination of service user perspectives, and issues raised in relation to black and minority ethnic groups, gender and other related concerns, all of which staff need to be conversant with before employing the interventions described in this guideline. The guideline then turns to preventative psychosocial interventions for continued management of disturbed/violent behaviour: de-escalation techniques and observation, before examining the other interventions: physical intervention, seclusion and rapid tranquillisation. It then considers post-incident reviews. Finally the guideline considers special issues relating to the short-term management of disturbed/violent behaviour in emergency departments for those requiring mental health assessments only, and the issue of searching.

The following background information is offered to contextualise the issues addressed in the evidence reviews, the recommendations, and good practice points that follow.

6.1.1 Legal preface

This takes place within a multi-faceted legal framework. Compliance is a core measure of quality and good practice. For example, the management of disturbed/violent behaviour frequently involves interventions to which an individual does not – or cannot – consent. It is especially important that such interventions are in accordance with best practice.

Failure to act in accordance with the guideline may not only be a failure to act in accordance with best practice, but in some circumstances may have legal consequences. For example, any intervention required to manage disturbed behaviour must be a reasonable and proportionate response to the risk it seeks to address.

The service should ensure access to competent legal advice when required, in relation to the management of disturbed/violent behaviour.

The law provides the authority to respond to disturbed/violent behaviour in some circumstances, and it sets out considerations that are extremely important when service providers have to decide what action they may take. The contribution of the law to the management of disturbed/violent behaviour should be recognised as positive and facilitative.

All those involved in the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments should:

- be familiar with, in particular:
  - the relevant sections of the Mental Health Act 1983 and its current Code of Practice
  - the principles underlying the common law doctrine of 'necessity'
  - the requirements of the relevant articles of the European Convention on Human Rights, including Article 2 (right to life) and Article 3 (the right to be free from torture or inhuman or degrading treatment or punishment), Article 5 (the right to liberty and security of person save in prescribed cases) and Article 8 (the right to respect for private and family life), and the principle of 'proportionality'
  - the Health and Safety at Work Act 1974, which place duties on both employers and employees, and applies to the risk of violence from patients and the public
  - the Management of Health and Safety at Work Regulations 1992, which places specific duties on the employer to ensure suitable arrangements for the effective planning, organisation, control, maintenance and review of health and safety (these

duties include ensuring that the risk assessments are undertaken and implemented)

- receive regular training on the legal aspects of the management of disturbed/violent behaviour
- ensure that a comprehensive record is made of any intervention necessary to manage an individual's disturbed/violent behaviour, including full documentation of the reason for any clinical decision
- ensure or contribute to ensuring that all aspects of the management of disturbed/violent behaviour are monitored on a regular basis, and that any consequential remedial action is drawn to the attention of those responsible for implementing it
- be aware of the obligations owed to a service user while their disturbed/violent behaviour is being managed, and of parallel obligations to other service users affected by the disturbed/violent behaviour, to members of staff, and to any visitors
- ensure or contribute to ensuring that any service user who has exhibited disturbed/violent behaviour should not be the subject of punitive action by those charged with providing them with care and treatment, and that where the disturbed/violent behaviour is thought to warrant criminal sanction, it is drawn to the attention of the proper authority.

6.2 Prevention

6.2.1 Environment and alarm systems

Environmental factors are believed to be important determinants of disturbed/violent behaviour in psychiatric in-patient settings. A therapeutic environment is one that allows individuals to enjoy safety and security, privacy, dignity, choice and independence, without compromising the clinical objectives of the service. Comfort, noise control, light, colour and access to space will all have an impact on the well-being of both staff and service users. However, to date there has been very little research conducted to ascertain how the environment affects staff and service users of in-patient psychiatric settings.

The little existing research in this area has suggested that high traffic areas in in-patient units are the location of the largest number of assaults. Several studies have indicated that the highest proportion of assaults occur in either the day room/communal room or in the corridors (Carmel 1989; Coldwell and Naismith 1989; Lanza et al. 1993; Rosenthal et al. 1992), suggesting that assault frequency is related to either a chance encounter or that crowding (service user population density) is a significant factor. Studies of temporal variation show that most assaults occur during mealtimes and afternoons and increase in frequency until late evening (Carmel 1989; Lanza et al. 1993; Manfredini et al. 2001).

Recent national guidance documents have highlighted the need for in-patient psychiatric settings to not only be safe and secure for staff and service users, but further have recommended that the quality of design and finish should also be a prime consideration. Indeed, recent audit reports have indicated that many UK psychiatric in-patient facilities have failed to meet basic standards for a decent working or residential care environment and these wards are rated by staff, service users and visitors as noisy, hot, smelly and dirty (College Research Unit 2000; 2001).

Alarm systems are also an essential environmental safety feature in psychiatric in-patient settings. The report Violence and aggression to staff in health services, outlines three types of alarm system:

Panic buttons

Panic button systems are hardwired systems operated by strategically placed buttons installed throughout the area where a threat exists. When they are activated, an audible or visual alarm is triggered on a monitoring console. [...] panic buttons may be useful in treatment and consulting rooms, where their location is known only to members of staff (Health & Safety Commission 1997, p21).

Personal alarms

Personal alarms may be of the simple 'shriek' type or may form part of more complex systems. [...] They are most effective in situations where other people may hear them and can respond (Health & Safety Commission 1997, p21).

More complex personal alarms

More complex systems may be suitable in particularly high-risk areas. They include personal alarms linked to fixed detection systems by infra red or radio systems (Health & Safety Commission 1997, p23).

The RCPsych guideline suggested that personal and institutional alarms and communication devices are a useful means of pre-empting disturbed/violent behaviour and of protecting staff when instances of disturbed/violent behaviour arise. However, there is a paucity of research in this area.

6.2.2 Prediction: antecedents, warning signs and risk assessment

While most service users in psychiatric in-patient settings are not disturbed/violent, a small minority place health care professional and other service users at serious risk of assault. Therefore the prediction of short-term disturbed/violent behaviour is not an outcome that is measured for its own sake, but is part of a risk management plan that works towards minimising disturbed/violent behaviour and aggression, allowing both service users and staff to feel safe. As a consequence, risk assessment must be seen as an essential intervention, possibly the single most important intervention, in the therapeutic management of disturbed/violent behaviour. Worryingly, a survey conducted in 1999 by the Standing Nursing and Midwifery Advisory Committee (SNMAC) found that risk management, which should logically follow from risk assessment, is poorly defined and practice is highly variable (SNMAC, 1999). Furthermore, they found that risk assessment was not regarded as an essential aspect of clinical practice (SNMAC, 1999). While nothing can ever be predicted with 100 per cent accuracy, prediction of short-term disturbed/violent behaviour and risk assessment is integral to the management of disturbed/violent behaviour in psychiatric in-patient healthcare settings. The recent UKCC – now the Nursing and Midwifery Council (NMC) – report stresses:

> 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 recognition, prevention and therapeutic management of violence in mental health care* (2002) London: United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting, p15, p22).

Much of the research pre-1995 (the cut-off point for the majority of the searches underlying the original RCPsych guideline) suggested that risk factors of short-term psychiatric in-patient disturbed/violent behaviour can be identified. Key risk factors appear to include a history of disturbed/violent behaviour, young age and number of admissions. However, Stein (1998) argues that the real challenge is not their identification, but in how they should be combined and weighted. He states:

> The prediction of [...] harm to others is a complex and unreliable synthesis of observed past behaviour (both inside and outside of hospital [...]). The key predictors are well understood but there is much less agreement about how they should be weighed [...]

Therefore the issue that faces mental health care professionals is how the best predictive validity can be attained. Three main approaches have been adopted:

- the clinical approach ('first generation')
- the actuarial approach ('second generation'), which includes actuarial tools or checklists
- structured clinical judgement ('third generation').

Most of the literature prior to 1995 suggests that clinical judgement has poor positive predictive validity of around 33 per cent (Doyle and Dolan 2002). Therefore a 'second generation' of risk assessment studies adopted actuarial measures, in an attempt to raise the positive predictive validity of short-term psychiatric in-patient disturbed/violent behaviour. This actuarial approach depends on 'assessors reaching judgements based on statistical information according to fixed and explicit rules' (Doyle and Dolan 2002). Actuarial checklists have been created to enhance this process. Both the use of checklists and this general approach have been suggested to improve predictive validity (Doyle and Dolan 2002). However, there are noticeable disadvantages to this approach, in particular the tendency it generates to focus on static factors, such as history of disturbed/violent behaviour, demographic information and diagnosis, without taking individual service user needs into consideration.

Most recently, it has been suggested that prediction needs to be carefully slotted into a more holistic approach, which places emphasis on the empirical or static factors isolated by the actuarial approach, whilst combining it with clinicians' judgements. This 'third generation' approach, described by Doyle and Dolan (2002) as 'structured clinical judgement' has the advantage of placing emphasis on the service user as an individual and allowing risk to be seen as a moving rather than static entity, so that stage of disease, and any fluctuations in personal and environment factors are taken into consideration. Such an approach seems to mirror the objectives of the UKCC report, where it states that:

> 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 nature and level of risk should be subject to regular review (*The recognition, prevention and therapeutic management of violence in mental health care* (2002) London: United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting, p15, p22).

6.3 Training

There are currently no formal regulations governing training for the short-term management of disturbed/violent behaviour in the UK. There are more than 700 training providers in the UK. The David Bennett Inquiry (2004) recommended that a national approach to training should be set up in the next year. The National Institute for Mental Health in England (NIMHE) is currently mapping the various training packages on offer in the UK and, in conjunction with the NHS Security and Management Service (SMS), is drawing up a core training curriculum for the UK and setting up an accreditation scheme for trainers.

At present, very few of the training programmes are based on evidence of either the effectiveness of training or the benefits perceived by staff and/or service users. As Leadbetters and Perkin (2002) states:

> The assumption that training is the key element in reducing risk and increasing safety is common [...] Such simplistic populist assumptions support quick-fix organisational solutions [. . .] and are challenged by conclusions from emergent research across the human services (Leadbetter and Perkins 2002, p20-21).

As training is expensive, it is necessary that services are able to measure its benefits. Without such an evidence base, there is a danger that training that is beneficial and possibly life-saving will not be sought or offered.

6.4 Working with service users

6.4.1 Service user perspectives

In recent years a great deal has been written within guidance material on the need to involve service users in their care. One of the guiding principles of the National Service Framework (NSF) on mental health is to involve service users and their carers in the planning and delivery of care (Mental Health National Service Framework 1999). This principle is echoed by the Department of Health, which argues that:

> In order to create a genuinely patient-centred service several processes should be created to enable users to contribute to the design and delivery of care. The aim is to promote a non-judgemental, non-patronising, collaborative approach to care (Department of Health, Mental health policy implementation guide 2002, p14).

The UKCC has laid out a number of principles that they believe need to be met in order to fulfil such aims in relation to adult service users in psychiatric in-patient settings. It argues that:

- The prevention and management of disturbed/violent behaviour 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 and 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 (*The recognition, prevention and therapeutic management of violence in mental health care* 2002).
- 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 inquiry into 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 be incorporated into these perspectives (*The recognition, prevention and therapeutic management of violence in mental health care* 2002).

6.4.2 Minority ethnic groups

The David Bennett Inquiry (2004) highlighted the importance of considering the needs of black and minority ethnic groups when managing disturbed/violent behaviour in the short-term. For the purpose of this guideline, the following definition of minority ethnic group has been adopted:

> **Minority ethnic group:** A group which is numerically inferior to the rest of the population in a state, and in a non-dominant position, whose members possess ethnic, religious or linguistic characteristics which differ from those of the rest of the population and who, if only implicitly, maintain a sense of solidarity towards preserving their culture, traditions, religion or language. (F. Capotorti (1985) 'Minorities', in Bernhardt R et al. (editors) *Encyclopedia of public international law.* Amsterdam: Elsevier, vol.8, p.385.)

The importance of this area is widely recognised by health care professionals (Fernando 1998) and has recently been highlighted by a number of high profile inquiries. The most recent of which is the inquiry into the death of David 'Rocky' Bennett, an African Caribbean service user who died whilst being restrained on a secure unit.

The literature, around mental health and minority ethnic groups, highlights particular concerns relating to black and African Caribbean service users. For the purpose of this guideline the following definition of black, taken from *They look after their own, don't they?* (DH/Social Service Inspectorate 1998), has been adopted:

> **Black:** refers to those members of the ethnic minority groups who are differentiated by their skin colour or physical appearance, and may therefore feel some solidarity with one another by reason of past or current experience, but who may have many different cultural traditions and values.

For this purpose of this guideline, the following definition of African Caribbean has been adopted:

> Of or pertaining to both Africa and the Caribbean; used to designate the culture, way of life, etc or the

> characteristic style of music of those people of black African descent who are, or whose immediate forebears were, inhabitants of the Caribbean (West Indies) (Oxford English Dictionary Online).

It is maintained that black and particularly African Caribbean service users are over-represented within the mental health services in the UK, particularly in forensic settings. A variety of reasons have been advocated, including:

- prevalence of schizophrenia amongst African Caribbean service users (Ndegwa 2000)
- institutional racism (Sashidharan 2003; Department of Health 2005).

It is also suggested that recent shifts in Government policy have led to a more punitive approach within mental health services, particularly secure settings, and that young black African Caribbean men have been made to bear the burden of this altered approach (Fernando et al. 1998). Again it has been asserted that this burden reflects racial stereotyping that regards young African Caribbean men as 'big, black and dangerous' (Prins H, *Big, black and dangerous? Report of the Committee of Inquiry into the death in Broadmoor hospital of Orville Blackwood and a Review of the deaths of two other Afro-Caribbean patients* 1993). It is suggested that this stereotyping affects the treatment of African Caribbean service users within many mental health settings. (Littlewood and Lipsedge 1997).

As a result of the concerns relating to the treatment of African Caribbean service users, the review in this guideline has given particular attention to the short-term management of the disturbed/violent behaviour of African Caribbean service users in psychiatric in-patient settings. However, it has not done so to the exclusion of other ethnic groups.

6.4.3 Gender

As far as possible, gender needs must also be taken into consideration in the short-term management of disturbed/violent behaviour in psychiatric in-patient settings. For the purpose of this guideline the following definition of gender has been adopted:

> Gender describes those characteristics of women and men that are socially determined, as opposed to 'sex', which is biologically determined. (*Mainstreaming gender and women's mental health implementation guide* 2003).

While general differences between men and women in terms of mental health have been recognised, (for example, women are more likely to self-harm and suffer from depression, and men more likely to experience earlier onset and more disabling courses of schizophrenia), a recent report by the Department of Health, *The women and mental health strategy* (2003) stresses that these differences should be used to inform our understanding of an individual, rather an obscure their individuality. A further report reinforced the message that women's mental health needs to be conducted in relation to an individual woman's experiences, beliefs and struggles, as well as her ethnic group, age and sexual preferences (*Good practices in mental health* 1996).

In terms of managing disturbed/violent behaviour in psychiatric in-patient settings, the main concern raised in *The women and mental health strategy* has been to identify gender specific needs, such as single-sex facilities, and to ensure that both male and female service users feel safe, listened to and involved in identifying and meeting gender related needs (*Mainstreaming gender and women's mental health implementation guide* 2003).

6.4.4 Other special concerns

This evidence review focuses specifically on disabilities, other than learning disabilities (excluded from this guideline), and aims to consider the effects of sensory impairment. It has been noted that service users with such sensory impairments are particularly vulnerable when managed using the interventions discussed in this guideline. One such example is the restraining of a deaf service user's hands, thereby preventing them from communicating.

Very little has been written on the needs of service users with a disability in relation to the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

6.5 Psychosocial intervention

6.5.1 De-escalation techniques

De-escalation (also referred to as 'defusing' or 'talk-down') involves the use of various psychosocial short-term techniques aimed at calming disruptive behaviour and preventing disturbed/violent behaviour from occurring. Every effort is made to avoid confrontation. This can include talking to the service user, often known as verbal de-escalation, moving service users to a less confrontational area, or making use of a specially designated space for de-escalation. Stevenson and Otto (1998) offer the following definition of verbal de-escalation:

> What is verbal de-escalation? A nurse might describe it as "talking the patient down," but it is actually a complex, interactive process in which a patient is redirected towards a calmer personal space.

There are competing theoretical approaches to de-escalation, including verbal de-escalation. Some approaches make use of communication theory (for example, Paterson and Leadbetter 1997), others of situational analysis (Rix 2001). All approaches emphasise the need to observe for signs and symptoms of anger and agitation, approaching the person in a calm controlled manner, giving choices and maintaining the service users dignity. Some approaches suggest mirroring the patient's mood. De-escalation techniques also emphasise the therapeutic use of the nurse's own personality and relationship with the person (use of self) as one method to interact therapeutically with the patient.

In all approaches to de-escalation, stress is laid on the need for training and self-awareness. For example, Rix (2001) comments:

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

However, a recent report notes that, despite the emphasis that is often placed on the importance of de-escalation, little research has been carried out into the effectiveness of any given approach, leaving nurses to contend with conflicting advice and theories:

> 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 and 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 (National Institute for Social Work Research Unit 2000, p24).

6.5.2 Observation

Although much of the research carried out on observation has been undertaken in relation to the management of suicide and self-harm, the UKCC report (Feb 2002), which focuses on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings, argues that these principles form a good basis for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings. The UKCC report (Feb 2002) recommends that the principles of observation found in *Addressing acute concerns* (1999) – a report that focuses on the management of suicide and self-harm – should be adopted nationwide.

> 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 preventing interventions (*The recognition, prevention and therapeutic management of violence in mental health care* (2002) London: United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting, p24).
>
> [...] observation (carried out as set out in Addressing acute concerns) should underpin all other strategies (*The recognition, prevention and therapeutic management of violence in mental health care* (2002) London: United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting, p24).

Addressing acute concerns defines observation as "'regarding the patient attentively' while minimising the extent to which they feel that they are under surveillance" (p2). The UKCC report (Feb 2002), regards observation as a 'core nursing skill' and 'arguably a primary intervention in the recognition, prevention and therapeutic management of violence' (*The recognition, prevention and therapeutic management of violence in mental health care* 2002) It suggests that observation must be a two-way relationship, established between a service user and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user. This relationship is considered to be the basis on which risk assessment, violence management and a programme of supportive observation can then be undertaken (*The recognition, prevention and therapeutic management of violence in mental health care* 2002).

Addressing acute concerns outlines four levels of observation – general observation, intermittent observation, within eyesight, within arms length – which, with slight modification, have been adopted within this current guideline. Other reports and studies detail a variety of other terms and levels of observation. The UKCC report, *The recognition, prevention and therapeutic management of violence in mental health care* (2002) argues that there is a need for the terminology to be standardised, quoting the following passage from *Addressing acute concerns*:

> Research on the nursing practice of observing patients who are at risk from self harm, or of causing harm to others, shows that there is no consistency in the definition of terms, principles or processes. In some trusts there is no written policy

> for observation. Trusts vary greatly in the indications for observation and in the personnel that are thought appropriate to perform it. Where policies and procedures do meet reasonable standards, they may not be implemented properly (*Addressing acute concerns* 1999, p15).

Whilst the UKCC report, *The recognition, prevention and therapeutic management of violence in mental health care* (2002) has stressed the value of observation, *Addressing acute concerns* suggests that both nurses and service users have found this a difficult intervention with many nurses considering it custodial and lacking in therapeutic value (*Addressing acute concerns* 1999).

6.6 Other interventions

6.6.1 Physical interventions

In the UK the physical intervention primarily used in the short-term management of disturbed/violent behaviour is manual holding, rather than the use of mechanical devices such as belts, body vests or handcuffs. These devices are rarely and only used in exceptional circumstances, usually within high security settings. Physical intervention is predominantly described in the literature as restraint. In this guideline, this terminology is avoided because of its association with particular techniques, associated with control and restraint (C&R) and its various modifications. C&R was originally developed in 1981 for prison staff and was taken up by the special hospitals in the mid 1980s. It is still widely used in the NHS, although modifications have been developed to make these techniques more appropriate to the therapeutic care of service users – for instance, C&R general services, which modifies uses of pain as a restraint technique (Wright 1999). Although still widely used, we believe that the association of the term 'restraint' with this approach is unhelpful, as a wide range of physical interventions are now currently employed, many very different from C&R or its modifications, such as MAPA, which makes use of therapeutic holding.

The use of pain compliance as a method of managing violent behaviour is controversial amongst health care professionals and service providers. Although practice currently continues in some services, the recommendations in this guideline severely restrict its use for rescue purposes only (see Section 8, para 1.8). For the purpose of this guideline, physical intervention is defined as:

> A skilled hands-on method of physical restraint involving trained designated health care professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

The current Code of Practice to the Mental Health Act 1983 states that physical intervention should be a last resort:

> Physical restraint should be a last resort, only being used in an emergency where there appears to be a real possibility of significant harm if withheld. It must be of the minimum degree necessary to prevent harm and be reasonable in the circumstances. (18.10-18.11)

There appears to be a dearth of knowledge about current practice. The literature review undertaken for the UKCC report in 2002, found 'no high quality studies that evaluated either the use of restraint or of seclusion in those with mental illness' (*The recognition, prevention and therapeutic management of violence in mental health care* 2002) The rate of physical interventions per annum in the UK is currently unknown. At present the National Institute for Mental Health in England (NIMHE) is compiling a register of all the techniques used in the UK.

6.6.1.1 Staff injury

A significant issue relating to the use of physical interventions is the possibility of injury to staff or service users. A US study in a maximum security forensic hospital found costs incurred in relation to staff injury from violent incidents accounted for 2 per cent of the hospital budget; 45 per cent of injuries were sustained during physical interventions (Hillbrand et al. 1996).

6.6.1.2 Sudden death

Sudden death can occur when physical intervention is used, although this is a rare event. The David Bennett Inquiry drew attention to the need for a central agency to record physical intervention-related deaths in the UK. The national reporting and learning system is a non-mandatory system set up by The National Patients Safety Agency (NPSA) which records anonymised data on sudden death in in-patient settings. The confidential inquiry has also now extended its recording of homicides and suicides to cover all sudden and unexplained deaths involving mental health service users.

6.6.2 Seclusion

Seclusion is the formal placing of a service user in a specially designated room for the short-term management of disturbed/violent behaviour. While it is recognised that this intervention is unpopular with service users, it is sometimes the preferred course of action to prevent prolonged physical intervention where rapid tranquillisation is contra-indicated or when service users have indicated a preference for it in advance directives.

The RCPsych Council Report (41) argues that the definition of seclusion needs to be broad to allow for the seclusion room door being open, closed but unlocked or locked. Therefore, for the purpose of this guideline, the following definition of seclusion has been taken from the Code of Practice:

> Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. Seclusion should be used as a last resort; for the shortest possible time. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of shortage of staff; where there is any risk of suicide or self-harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

Seclusion must be differentiated from asking a service user to go to a designated room for the purpose of calming down. The latter is a de-escalation technique and the seclusion room should not routinely be used for this purpose. Seclusion, if chosen, is not viewed as a therapeutic intervention. It simply allows for a period of calming in the service user and should always be managed in a designated room for seclusion, separating the service user from other service users and placing them in a positive milieu (Cashin 1996).

6.6.3 Rapid tranquillisation

6.6.3.1 Definitions

Rapid tranquillisation (also called urgent sedation): the use of medication to calm/lightly sedate the service user and reduce the risk to self and/or others. The aim is to achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place, whilst allowing comprehension and response to spoken messages throughout.

Calming: a reduction of anxiety/agitation.

Light sedation: a state of rest and reduction of psychological activity, but verbal contact is maintained.

Deep sedation: a reduction of consciousness and motor and sensory activity, where verbal contact is progressively lost.

Anaesthetised: a state of narcosis (unconsciousness), analgesia (lack of awareness of pain) and muscle relaxation. It is one stage beyond deep sedation. It implies loss of airway control and protective reflexes, and requires the constant attention of trained personnel to keep the patient safe. There is normally no verbal contact.

Sleep: a condition of body and mind such as that which normally recurs for several hours every night, in which the nervous system is inactive, the eyes closed, the postural muscles relaxed, and consciousness practically suspended.

Of all these terms, sleep is the one with the greatest terminological inexactitude. For the purposes of this guideline we have adopted this definition from the Oxford English Dictionary. However, because of its inexactitude, we have generally avoided using this term.

6.6.3.2 Rapid tranquillisation

Rapid tranquillisation – or urgent sedation (Broadstock 2001) as it is sometimes called – is used in situations requiring the rapid control of agitation, aggression or excitement. In the UK, deep sedation/sleep is not considered a desirable endpoint for rapid tranquillisation. A state of calm is preferred, with the service user remaining conscious where possible.

For the purposes of this guideline, rapid tranquillisation describes the use of medication to control severe mental and behavioural disturbance, including aggression associated with the mental illness of schizophrenia, mania and other psychiatric conditions. It is used when other less coercive techniques of calming a service user, such as verbal de-escalation or intensive nursing techniques, have failed. It usually involves the administration of medication over a time-limited period of 30-60 minutes, in order to produce a state of calm/light sedation. Other medication regimes would be administered over longer periods of time and not time limited.

Rapid tranquillisation differs from rapid neuroleptisation, which is the practice of giving a high dose antipsychotic at the beginning of ongoing treatment with the aim of rapidly stabilising symptoms. Rapid neuroleptisation has been found to be hazardous and no more effective than standard treatment (Royal College of Psychiatrists 1997).

The medications used for rapid tranquillisation should ideally have a low level of side effects and rapid onset of action. At present, there is no worldwide formal agreement on which drugs should be used as first line for rapid tranquillisation. As a consequence, there is a wide variation in the type of medications used in rapid tranquillisation throughout the world. This has been compounded by changes in the stated aims of rapid tranquillisation over recent years – that is to calm rather than put to sleep (Cunnane 1994; Pereira et al. 2003).

There is also little agreement about the doses to be used. Rapid tranquillisation is not a recognised clinical procedure in the British National Formulary (BNF). Although the use of high dose antipsychotics has been criticised by several inquiries (Royal College of Psychiatrists 1995), expert clinician opinion may from time to time support prescribing outside the dose limits set by the BNF or SPC (RCPsych draft report on antipsychotic drugs). The BNF has been formally consulted in the preparation of these guidelines and will carefully consider the findings to decide whether to incorporate any of the recommendations into its guidance at a future date, following the publication of this guideline.

This lack of standardisation also reflects the fact that very few randomised controlled trials have been conducted that examine the efficacy of medicines used for the purpose of rapid tranquillisation. Their use is often based purely on clinical experience. Overall there is a lack of high quality clinical trial evidence surrounding the drugs used for rapid tranquillisation and their safety, a point which has been noted in a number of recently conducted systematic reviews (Cure and Carpenter 2002; Carpenter 2002; Carpenter and Berk 2002). Clinical trials that examine the effectiveness and safety of drugs used for rapid tranquillisation encounter a number of ethical issues. Service users recruited into these clinical trials should ideally represent those with highly agitated states in circumstances similar to those encountered in normal clinical practice. Unfortunately such service users are normally unable to give consent, due to their highly agitated states.

6.6.3.3 Route of administration

It is generally accepted that oral formulations should be offered in the first instance. If these are refused or are inappropriate, medication should be administered parenterally. This involves administration by intramuscular (i/m) injection or, in exceptional circumstances, intravenously. The latter should only be done with extreme caution and with appropriate supervision and monitoring, as clarified by the recommendations in this guideline.

6.6.3.4 Drugs used for rapid tranquillisation

The classes of drugs commonly used in the UK for rapid tranquillisation are benzodiazepines and antipsychotics.

6.6.3.4.1 Benzodiazepines

Benzodiazepines are frequently used as first line treatments for rapid tranquillisation. Some, such as diazepam, have erratic and slow absorption intramuscularly and are associated with prolonged sedation following repeated doses. Lorazepam has a shorter elimination half-life than many other benzodiazepines, which limits the risk of excessive sedation due to the cumulative effects of the drug. For this reason it is often chosen as the first drug of choice in rapid tranquillisation. There is a risk of respiratory depression when benzodiazepines are given in high doses or when used in combination with other hypnosedatives, including alcohol and some illicit drugs (Broadstock 2001).

6.6.3.4.2 Antipsychotics

Antipsychotics are commonly used as second line treatments for rapid tranquillisation and, in some cases, as first line treatments if benzodiazepines are contraindicated or have proven ineffective in the past. Older antipsychotics (commonly called conventional antipsychotics) have a greater propensity to cause extrapyramidal side effects than the newer (commonly called atypical) antipsychotics.

6.6.3.4.3 Combination of drugs

Combinations of a benzodiazepine, an antipsychotic, and other drugs may be given either deliberately or inadvertently in rapid tranquillisation. It has become common practice to co-administer both a benzodiazepine and antipsychotic together. There is no evidence of a higher incidence of adverse effects with this combination and it is considered to have advantages, such as allowing a lower dose of the antipsychotic to be given when administered with a benzodiazepine (Beer et al. 2001). It has also been noted that there are other problems with combinations such as olanzapine and lorazepam, which will addressed in the recommendations.

In pharmaceutical practice it is stated that if combinations of intramuscular (i/m) injections are used they should not be mixed together in the same syringe.

Users may also inadvertently receive combinations of drugs through poor control of PRN prescribing. The practice of routinely prescribing a wide range of drugs for PRN use, without clear guidelines or preference, may lead to users inadvertently receiving combinations of drugs.

6.6.3.4.4 High doses

Sometimes it is necessary to knowingly exceed the BNF upper dose limits and knowingly use drugs outside of their marketing authorisation (off-label). In such circumstances, clinicians are referred to the recommendations of the Royal College of Psychiatrists' consensus statement of the use of high dose antipsychotic medication. For the purpose of rapid tranquillisation, care must be taken to ensure that high doses do not accidentally occur through the use of PRN medication given in combination with regular medication. If PRN medication is given, it is important to allow time for the drug to work before giving further doses by either oral or intramuscular means. In addition, clinicians must bear in mind that the plasma concentration of the antipsychotic is not only affected by the total dose, but also the route of administration. Clinicians should also be aware that absorption from intramuscular administration (i/m) can occur far more rapidly when a service user is agitated, excited or physically overactive (Keck 1991).

6.6.3.4.5 Dangers associated with antipsychotics

There are two main areas of concern with the use of antipsychotics for rapid tranquillisation – extrapyramidal effects and cardiac effects.

Extrapyramidal side effects are mostly associated with conventional antipsychotics. Side effects such as dystonia and occulogyric crisis are very unpleasant for the service user and may adversely affect their future preparedness to access either treatment or services. Fortunately the side effects can mostly be rapidly reversed by administration of antimuscarinic drugs such as procyclidine. The availability of atypical antipsychotic drugs provides an opportunity to avoid these side effects.

The second main issue of concern relevant to rapid tranquillisation is the rare occurrence of drug induced arrhythmias and sudden cardiac death. This happens because of the manner in which some antipsychotic drugs affect cardiac ventricular repolarisation in susceptible individuals. The main measure of ventricular repolarisation is the QT interval – the time from the onset of ventricular depolarisation to complete repolarisation. A number of cardiac, metabolic and other factors, such as physical exertion and stress, impact on the QT interval. Where the service user has a prolonged QT interval, they may be at increased risk of cardiac arrhythmias, particularly torsade de pointes. The cardiac QT interval usually measured as the QTc interval (QT corrected for heart rate) is a useful if somewhat imprecise indicator of the risk of cardiac events. This prolongation can be congenital or acquired however, service users who already have prolonged QT repolarisation are at risk of developing arrhythmia when given drugs which further lengthen the QT interval. Service users who have had Torsade de Pointes are at an increased risk, even where this was caused by a different drug. Service users with left ventricular dysfunction or hypertrophy are also at an increased risk as are service users with liver disease (Day et al. 1993). Diuretics also appear to increase risk. Women who have a longer QT interval on average than men appear to be at an increased risk of Torsade de Pointes (Rautaharju et al. 1992; Makkar et al. 1993).

An issue that further complicates the relationship between antipsychotics, ventricular tachycardia and sudden cardiac death is that service users are known to be a high-risk group for cardiovascular death (Hensen et al. 1997). However, it is known that QT prolongation and resulting arrhythmias are drug concentration related (Drici et al. 1998; Warner et al. 1996; Reilly 2000; Ray et al. 2001). It is also important to note that several case reports of sudden death involved agitated service users who were subject only to physical interventions. As discussed above, physical interventions have been linked to increased risk of arrhythmia, as has the use of illicit drugs, such as ecstasy (Drake and Broadhurst 1996) and cocaine (Pereira 1997).

6.6.3.5 Acute manic or mixed episodes in bipolar affective disorder

For service users with bipolar affective disorder the British Association of Psychopharmacology (BAP) guidelines should be taken into consideration.

6.6.3.6 PRN medication

Although only rapid tranquillisation is mentioned directly in the scope, PRN medication pro re nata (as needed) medication is also sometimes used in a similar way to rapid tranquillisation in psychiatric in-patient settings. A recent editorial suggests that very little has been written on the effectiveness of PRN medication as a short-term measure for managing disturbed/violent behaviour and that those studies that do consider this issue contain serious flaws (Ray and Meador 2002).

6.6.3.7 Service user views

Service user satisfaction with rapid tranquillisation was rarely, if ever, measured as a part of the few existing clinical trials.

6.7 Emergency departments

This guideline also considers the short-term management of disturbed/violent behaviour for adults with psychiatric illness who present in emergency departments for mental health assessment, immediately prior to admission to an adult psychiatric in-patient setting.

All the interventions and related topics (excluding environment, observation and seclusion) are relevant to emergency departments. However, emergency settings sometimes have special requirements in addition to those addressed in psychiatric in-patient settings. These requirements are considered in the specific recommendations in Section 8.

7 Methods and findings

7.1 Summary of development process

The methods used to develop this guideline are based on those outlined by Eccles and Mason (2001) and in the NICE technical manual (www.nice.org.uk).

The following sources of the evidence were used to inform the guideline:

- Cochrane reviews: Salias and Fenton (2002), Carpenter and Berk (2002), Cure and Carpenter (2002), Aleman and Kahn (2001)
- The Royal College of Psychiatrists' *Clinical guidelines on the prevention and management of imminent violence* (see agree tool in Appendix 11 and summary of St George's report in Appendix 12)
- Other recent guidelines and reports (see Section 14)
- Reviews of assessment processes, tools, tests and instruments for identifying those at risk (NCC-NSC)
- Reviews of the interventions currently used in the UK for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings (NCC-NSC)
- Reviews of studies examining patients' views and experiences of the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings (NCC-NSC)
- Reviews of the evidence on costs and economic evaluations (ScHARR)
- Reviews on other topics and areas related to the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings in the UK (NCC-NSC)
- The minority ethnic groups section was further informed by *Breaking the circles of fear*, Sainsbury's Centre for Mental Health (2002) – see Appendix 13 for appraisal with agree tool – and focus groups, run through black service user organisations and with relevant health care professionals, organised by the NCC-NSC (see Appendix 14).

The stages used to develop this guideline were as follows:

- Develop scope of guideline
- Convene multidisciplinary GDG
- Review submission of evidence from stakeholders
- Develop review questions
- Identify sources of evidence
- Retrieve potential evidence
- Evaluate potential evidence
- Undertake systematic reviews of the evidence
- Extract relevant data from studies meeting methodological and clinical criteria
- Interpret each paper, taking into account the results including, where reported, the beneficial and adverse effects of the interventions; costs and acceptability to service users; level of evidence; quality of studies; size; precision of effect and relevance; and generalisability of included studies to the scope of the guideline
- Prepare evidence reviews and tables which summarise and grade the body of evidence
- Draw up evidence statements
- Formulate conclusions about the body of available evidence, based on the evidence reviews by taking into account the factors above
- Trawl any recent and relevant guidance literature in areas where evidence is weak or lacking and present this to the GDG for comment
- Send out evidence reviews for peer review
- Agree final recommendations by formal consensus voting and apply recommendation gradings
- Submit first drafts (short version and full versions) of guidelines for feedback from NICE registered stakeholders
- Consideration by GDG of stakeholders comments following first stage consultation
- Submit final drafts of all guideline versions (including Information for the public version and quick reference guide with algorithms) to NICE for second stage of consultation. The Guideline Review Panel (GRP) also comment at this stage
- Consideration by GDG of stakeholders and GRP's comments
- Final copy of the short form version is submitted to NICE for sign off, prior to publication of all edited versions.

7.2 Key clinical questions

The GDG identified the key clinical questions that were raised by the scope. Each of these questions related to an intervention or area addressed in the scope.

An algorithm detailing how the scope was translated into clinical questions can be found in Appendix 3.

Each of the clinical questions is outlined in the relevant methods section of this guideline.

7.3 Review methods

7.3.1 Search strategies

Search strategies were devised to identify the best available evidence for the interventions and related topics discussed in the guideline (see Appendix 4). It was recognised very early within the process that, in most instances, this evidence would not constitute meta-analyses, systematic reviews or randomised controlled trials (RCTs). Therefore searches were not limited to these study designs.

Where little evidence was available, studies were included in related areas, from which evidence could be extrapolated.

Searches were not limited to English language citations. Relevant European foreign language papers were translated. Unpublished and published papers were included.

The search strategies were structured as follows:

- an overarching strategy for interventions – covering environment, prediction, de-escalation, observation, physical interventions, seclusion and rapid tranquillisation, along with service user and staff perspectives on these interventions – across a wide range of databases
- a search of additional databases to identify guidance and reports not indexed in databases searched
- a topic specific search strategy on major databases – see Appendix 4 for more details.

Hand searching was not undertaken, following NICE advice that exhaustive searching on every guideline review topic is not practical or efficient (Mason 2002).

Reference lists of relevant order papers were checked for articles of potential relevance.

Each evidence review was sent for peer review, prior to the first consultation phase, in an attempt to identify any further relevant papers. GDG members were invited to nominate any relevant research that may have been missed.

The databases searched, logs of results and all search strategies can be found in Appendix 4. Unless otherwise stated, all searches were run from 1985-2002/3. Searches began from this date as this guideline updates the RCPsych guideline, *The management of imminent violence* (1998), which was due for review. GDG members were asked throughout out the guideline development process whether any further relevant research had been identified, post search, that might impact on the recommendations.

For each intervention and related topic evidence of effectiveness, evidence of harm and cost effectiveness information was sought.

7.3.2 Sifting and reviewing the evidence

Once articles were retrieved, the following sifting process took place:

- 1st sift: sift for material that potentially meets eligibility criteria on basis of title/abstract by two reviewers
- 2nd sift: full papers ordered that appear relevant and eligible or where relevance/eligibility not clear from abstract
- 3rd sift: full articles critically appraised and checked by one reviewer. More than 50 per cent of all articles in the guideline were then critically appraised by an independent reviewer as a quality check.

7.3.3 Data extraction

Study appraisal and methodological quality were assessed using checklists designed with assistance from the Centre for Statistics in Medicine at Oxford University. (Quality principles can be found in Appendix 10.) Data was abstracted by a single reviewer and evidence tables compiled. More than 50 per cent of all articles were then subject to a second quality assessment by a second reviewer. Any discrepancies between reviewers were resolved by discussion. Where needed, a third reviewer assisted with decisions on the inclusion or exclusion of a study.

The following were extracted where possible (the reporting of many studies sometimes lacked essential detail) and relevant:

> Author, setting, number of participants at baseline and follow-up, methods and details of baseline and outcome measures, results including summary statistics and 95 per cent confidence intervals, and comments made on methodological quality.

Masked assessment, whereby data extractors are blind to the details of the journal, authors etc., was not undertaken because there is no evidence to support the claim that this minimises bias (Cullum et al. 2003).

7.3.4 Data synthesis

All studies were put into evidence tables and summarised using a qualitative narrative approach. No quantitative analysis was carried out for this review. Summary statistics of significance were reported in the evidence tables.

7.3.5 Appraisal of methodological quality

Very limited evidence for each of the review questions listed below was found. Therefore the resulting evidence reviews must be viewed as mapping exercises that aimed to highlight the range of research undertaken (which was often of mixed quality), in order to facilitate informed discussion by the GDG, to assist with deliberations around recommendation formulation and also to identify research gaps. Where a study was particularly weak it was excluded (see Appendix 6). It was considered particularly weak where the number of confounders and flaws were great enough to jeopardise the results. Concerns regarding the quality of individual studies are detailed in the relevant evidence table.

A large range of quality related concerns were commonly found across many of the studies included in these review. These included:

- inappropriately small sample sizes
- inter-rater reliability not always quantified where applicable
- conclusions do not always appear to be supported by a study's results
- methodologies are not always sound (that is, don't adhere to standard processes)
- designs do not always appear appropriate – sometimes this is recognised by the authors
- methods of analysis are not always clearly outlined
- under-reporting
- lack of detail about follow-up duration, losses to follow-up and drop-out rates
- descriptions of interventions are not always adequate
- description of how outcomes were measured are not always adequate or are sometimes lacking
- poor reporting.

Where the studies in a review raise other, more specific, quality concerns, these are mentioned under the evidence summary for each review.

Authors were not contacted about any of the included studies, due to time constraints and the age of many of the studies.

In areas without sufficient evidence, previous guideline material was collated to help facilitate informed discussion by the GDG.

Clinicians and service users were also invited to give presentations on areas without sufficient evidence at guideline development group meetings to facilitate discussion. They acted as experts in these capacities. They sat within the group and entered fully into discussion. However, they were not GDG members and did not have voting rights, nor were they involved in drawing up the final wording of the recommendations.

The GDG then considered the evidence statements derived from the evidence reviews and used formal consensus methods (see Section 7.7) to derive recommendations and good practice points, particularly for those areas where research evidence was lacking or weak. They drew upon their own and others' clinical expertise and experience as necessary.

7.4 Evidence grading

Once individual papers had been assessed for methodological quality and relevance in terms of the clinical questions, they were graded according to the levels of evidence currently used by NICE.

Classification of evidence:

Level of evidence	Type of evidence
1++	High quality meta-analyses, systematic review of RCTs, or RCTs with a very low risk of bias.
1+	Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias.
1-	Meta-analyses, systematic review of RCTs, or RCTs with a high risk of bias*.
2++	High quality systematic reviews of case-control or cohort studies. High quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal.
2+	Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal.
2-	Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal.*
3	Non-analytic studies (for example, case reports, case series).
4	Expert opinion, formal consensus.

*Studies with a level of evidence '-' should not be used as a basis for making a recommendation

The available evidence for each intervention and related topic was compiled into individual evidence reviews, including health economics information. A summary of all recent reports and guidelines on the topic was also compiled. All this information was then presented to the GDG. The methods and findings from each of these reviews are outlined in Section 7.8.

7.5 Grading recommendations

The grading of recommendations involves a process of assessment in which the available evidence is interpreted in relation to the clinical questions asked. Where evidence is lacking or is not directly related to every area covered by the clinical question, the recommendation will demand some degree of consensus. For example, it is possible to have sound methodological evidence in an area that is not particularly relevant to the target audience of the guideline. When applied to the target audience, this would therefore result in a lower grade of recommendation than the evidence might initially seem to suggest, since inferences would have to be made from the available evidence that are beyond the empirical data. This will be the case where the evidence only partially covers the clinical question that the guideline sets out to answer. Where no, or insufficient evidence is available, recommendations have to be arrived at using formal consensus methods alone.

In this guideline, D grade recommendations are differentiated from good practice points (GPP), which also have little or no evidence. Both carry a D grade status, but unlike D grade recommendations, GPPs are principles of practice.

The recommendations for this guideline were graded A to D, using the current NICE approach.

A	At least one meta-analysis, systematic review or RCT rated as 1++, and directly applicable to the target population, **or** A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.Evidence drawn from a NICE technology appraisal.
B	A body of evidence including studies rated as 2++, directly applicable to the target population and demonstrating overall consistency of results, **or** Extrapolated evidence from studies rated as 1++ or 1+.
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, **or** Extrapolated evidence from studies rated as 2++.
D	Evidence level 3 or 4, **or** Formal consensus.
D (GPP)	A good practice point (GPP) is a recommendation for best practice based on the experience of the GDG.

The schizophrenia guideline used an older grading system that had only three grades A-C. Some recommendations that carry a C grade in the schizophrenia guideline carry a D grade in the current guideline. However, there is no difference in evidence level.

In the current guideline, good practice points, as well as D grade recommendations were arrived at using a formal consensus method.

7.6 Cost effectiveness review and analysis

7.6.1 Identification of papers

Searches were undertaken by ScHARR, alongside the clinical literature reviews, to identify relevant cost effectiveness, cost utility and cost-benefit analyses. Details of the databases searched and the search strategies can be found in Appendix 9. Titles and abstracts were sifted and relevant papers ordered by one reviewer.

7.6.2 Reviewing the evidence

Eligible papers were assessed by one reviewer using the Drummond checklist (Drummond et al. 1996). Evidence tables of the included studies were also produced by one reviewer.

7.6.3 Estimation of cost effectiveness

The scope of the guideline is broad and includes the assessment of risk, as well as the short-term management of disturbed/violent behaviour across the whole of range of adult in-patient settings. Little if any economic evidence was found for most areas of the guideline. Limited primary economic analysis was undertaken in relation to immediate life support (ILS) training. However, in many areas the evidence base was too weak to allow even limited primary economic analysis. See full details in Appendix 9.

7.7 Consensus process

Due to a dearth of good quality evidence, many of the recommendations in this guideline were arrived at solely, or in large part, by means of formal consensus methods. Three consensus meetings were held in March 2004.

A modified nominal group technique was used to finalise the recommendations and good practice points. An external facilitator was used to chair the meeting. The consensus process was facilitated by computerised voting consoles, which assured anonymity and allowed percentages to be quickly calculated. It also allowed the

GDG to view the range of responses in the form of a graph immediately voting had occurred. Consensus was set at 80 per cent, unless a significant group within the GDG all voted against a recommendation. For example, if all the psychiatrists voted against a recommendation, even though 80 per cent agreement was achieved overall, it was considered that consensus had not been reached.

Prior to voting on each recommendation and good practice point, a discussion took place and modifications were made as necessary. The wording was re-typed if necessary and then displayed on a screen so that GDG members could see the recommendation or good practice point they were voting on. If consensus was achieved, the GDG moved on to discuss the next recommendation or good practice point. However, if consensus was not achieved, the recommendation or good practice points was discussed a second time, modifications made to reflect the concerns of the GDG and another vote took place. After debate on some areas, consensus was achieved for all recommendations.

7.8. Methods for individual evidence reviews

7.8.1 Introduction

This guideline is divided into a number of interventions and related topics. For most of these areas separate literature searches were undertaken (see Appendix 4). The number of papers found, included and excluded and the details of the resulting evidence base are discussed separately for each area. Section 7.3 details the reviewing process that was common to all areas of the guideline. Where there were deviations from this process, this is highlighted in the following relevant sections.

7.8.2 Prevention

7.8.2.1 Environment

7.8.2.1.1 **Objectives**

The original RCPsych evidence base on environment was examined. The following hypothesis was used to inform search strategies:

RCPsych hypothesis

- Characteristics of the human and physical environment have powerful effects in mitigating and preventing, or exacerbating and precipitating the manifestation of violence.

After sifting and quality appraisal 17 papers were included by the RCPsych reviewer. However, the evidence base was too weak to offer support for this hypothesis.

Current guideline (update of RCPsych guideline)

Three review questions were identified by the GDG and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs). Unlike the RCPsych review, this review did not consider staff characteristics associated with an increased rate of disturbed/violent behaviour. Instead these were considered in the prediction review.

Review questions

- What factors in the physical environment of adult psychiatric in-patient settings contribute to either the promotion or reduction of disturbed/violent behaviour?
- What factors in the physical environment of psychiatric in-patient settings reduce the risks in relation to disturbed/violent behaviour?
- What are staff and service users' views about the role of the ward environment in promoting or reducing disturbed/violent behaviour in psychiatric in-patient settings?

The studies had to meet the following inclusion criteria:

7.8.2.1.2 **Selection criteria**

Types of studies

Systematic reviews through to before and after designs. Qualitative studies were also included (evidence levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- Measurement of environmental factors that may impact on the short-term management of disturbed/violent behaviour.
- Service users' and clinicians' views.

7.8.2.1.3 **Clinical evidence**

Seventy-five articles were identified, after combining the results of the main 'intervention' searches and the specific search for the 'physical environment'. Thirty-two articles were ordered. Nine of the ordered articles were not directly related to the research questions and were therefore not included for the present review. Seven of the remaining 23 articles were included in the evidence review. In addition, seven papers from the RCPsych review were considered relevant and were included in this review. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6).

Appraisal of methodological quality

In addition to the quality concerns mentioned in Section 7.3.5, the studies raised the following methodological concerns:

- All of the studies are largely descriptive in content and none had a controlled comparison group.
- The variation between studies in regard to the methods of data collection, outcome variables and statistical analysis make it impossible to aggregate the results.
- Overall, the methodological quality, execution and reporting of the included studies are poor.

Included studies

Three of the studies are uncontrolled before-and-after designs with one an interrupted time-series design, one a correlation study and two qualitative studies.

Three of the studies (Rauter et al. 1997; Haller et al. 1996; Velasco et al. 1996) were concerned with the effects of a cigarette-smoking ban in in-patient psychiatric settings. Two of the studies (Haller et al. 1996; Velasco et al. 1996) concluded that smoking bans on locked in-patient wards do not have an effect on increased violence by service users. Haller et al. (1996) indicated that although staff were in favour of the intervention, service users held decidedly negative feelings towards the smoking ban. There was no increase in aggressive behaviour in the outcome measures used in the study. The prospective study by Velasco et al. (1996) found the number of verbal assaults increased after implementing the ban, as did the consumption of nicotine replacement products by the service users. The authors suggest that dangerous behaviour did not follow the implementation of the smoking ban. The methodological quality of the study by Rauter et al. (1997) is insufficient to draw any reliable conclusions regarding smoking bans in psychiatric in-patient facilities.

An interrupted time-series design was used to evaluate the effects of removing the Music Television (MTV) channel from the television of a maximum-security facility (Waite et al. 1992). The analysis indicated that there was a significant reduction in aggressive behaviour following the removal of MTV from the television. Although the study is well designed and executed, the relevance of these findings to the UK context is uncertain (for example, the number of psychiatric settings in the UK where a music television station is received is unknown).

Mistral et al. (2002) conducted a qualitative study in a intensive psychiatric care environment to evaluate the effect a £70,000 ward refit, training on risk assessment and control and restraint techniques, and clarity on rules and sanctions on staff illness, staff turnover, patient aggression and the rate of seclusion. Although results were not significant, there was a positive trend for all outcomes.

Johnson et al. (1997) conducted a qualitative study to explore service users and experiences prior to an aggressive incident. A phenomenological approach was used. Five key themes emerged: lack of space; relationships; restrictions on privileges; lack of power versus feelings of powerfulness during aggressive incidents; and ineffective self-empowerment strategies.

The study by Nijman (1999) is concerned with crowding in psychiatric in-patient units and aggressive behaviour. However, the study is poorly designed and the statistical methodology is flawed. The study is essentially a correlation study. The RCPsych review also included three studies that examined the issue of crowding (Palmstierna and Wistedt 1995; Lanza et al. 1994; Palmstierna et al. 1991). These studies suggested that crowding increased the rate of violent incidents.

A further study in the RCPsych review – Hunter and Love (1996) – used an uncontrolled before and after study to evaluate the effectiveness of procedural changes at mealtime on the number of violent incidents at mealtimes. A number of suggestions were implemented: plastic utensils were substituted for silverware; music selected by the hospital music therapists was played; the dinning room, gym and courtyard were left open after meals for service users with special privileges; and food service workers were trained in therapeutic communication. This study showed a significant (40 per cent) reduction in violent incidents.

Two further studies in the RCPsych review considered staff roles. A participant observer study by Katz and Kirkland (1990) suggested that good leadership, structured staff roles and predictable routines are associated with less violence on wards. While a retrospective cohort study (James et al. 1990) suggested that high staff turnover and extensive use of agency staff was associated with an increase in violent incidents.

Another descriptive study included in the RCPsych review found that video cameras detected more, but milder, episodes of violence than nurses (Crowner et al. 1994).

None of the above studies significantly changed the findings of the RCPsych review.

Evidence statements

Level of evidence	Evidence statement
Level 4	The evidence suggests that environmental factors – such as crowding, banning smoking, high staff turnover and limit setting – affect on the incidence of disturbed/violent incidents. However, further research is needed to identify additional environmental factors.
Level 4	The evidence suggests that both staff and service users believe that environmental factors – such as banning smoking, limit setting, medication, seclusion, physical interventions and communication – affect the incidence of disturbed/violent incidents. Further research is needed to identify additional factors.

7.8.2.1.4 **Economic evidence**

No studies containing relevant economic data were found (see Appendix 9).

7.8.2.2 Alarm systems

7.8.2.2.1 **Objectives**

No specific searches on alarm systems were undertaken in the RCPsych guideline. Any papers would have been included under the environment review.

In the current guideline, three review questions were identified by the GDG and used to inform all searches (see Appendix 4 for search strategy, databases searched and search log).

Review questions

- ✦ Are personal and institutional alarms and communication devices an effective means of alerting staff to occurrences of disturbed/violent behaviour in adult psychiatric in-patient settings?
- ✦ What principles of practice are necessary to ensure the effectiveness of personal and institutional alarms and communication devices in reducing disturbed/violent behaviour in psychiatric in-patient settings?
- ✦ What are staff and service users' views about the effectiveness of alarms in reducing disturbed/violent behaviour in psychiatric in-patient settings?

7.8.2.2.2 **Selection criteria**

Types of studies

Systematic reviews through to before and after designs. Qualitative studies were also included (evidence levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- ✦ Any measures of change to management of short-term disturbed/violent behaviour or rates of disturbed/violent episodes as a result of alarms.
- ✦ Service users' and clinicians' views of alarms.

7.8.2.2.3 **Clinical evidence**

Eighty-one studies were identified in the initial sift. These were then subjected to two further sifts by two reviewers. After sifting for relevance and duplicates, 70 full papers were ordered. However, most were opinion pieces, anecdotal reports or fell outside the inclusion criteria for this review.

Seven papers were primary research studies. However, after critical appraisal and quality assessment only one of these contained information relevant to the research questions. References were checked for missing articles but no further studies were identified. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6.)

Included studies

- ✦ The only included study did not address the question of effectiveness of alarms as measured by changes in incidence rates or impact on management and could have been excluded on this basis.
- ✦ A summary of this study has been included to provide information on the existing research in this area.

A postal survey of 122 NHS and 19 private acute admission wards within the M25 area was conducted (Bowers et al. 2002), with the aim of assessing current safety and security measures. The questionnaire was divided into four sections: survey of banned items; searching policy; practice (for example, locking doors, counting cutlery); items present or absent (for example, alarms, intercom systems, CCTV). Response rate was 70 per cent, not including 17 discarded responses, because they were not from acute admissions wards. Results were analysed with descriptive statistics and Pearson correlation tests. Fifty-six percent of respondents had panic alarms that sounded in the whole unit. In 18 per cent they sounded in the ward only while 13 per cent of wards did not have any. Personal alarms were issued in 44 per cent of trusts whilst 45 per cent didn't use them. Forty-two percent of trusts had an emergency telephone extension and 45 per cent did not. Panic alarms were found in all rooms in 36 per cent of trusts, some rooms for 32 per cent and in only one room for 20 per cent. Whilst 3 per cent of trusts had panic alarms only in the office, 87 per cent did not. The authors note two types of unrelated security systems were identified by the report: type A (door security, restrictions and banned items) and type B (searches, guards and alarms).

In nine wards that had taken part in a previous study (Bowers et al. 2002), type A was associated positively with absconding rates and type B negatively with aggressive/angry behaviour. However, these results should be tested in a larger sample. The survey does not discuss the efficiency of alarms. The survey has been replicated in Northern Ireland. However, the results were only published in 2004. As such, they fall outside the cut-off point for searching on this topic, which was 2002. This study will be considered in the update.

Evidence statements

Level of evidence	Evidence statement
Level 4	There is insufficient evidence to determine whether personal and institutional alarms and communication devices are an effective means of alerting staff to occurrences of disturbed/violent behaviour.
Level 4	There is insufficient evidence to determine which principles of practice are necessary to ensure the effective use of personal and institutional alarms and communication devices.
Level 4	There is insufficient evidence to ascertain staff and service users' views about the effectiveness of alarms in reducing disturbed/violent behaviour in psychiatric in-patient settings.

7.8.2.2.4 Economic evidence

No studies containing relevant economic data were found (see Appendix 9).

7.8.2.3 Prediction: antecedents, warning signs and risk assessment

7.8.2.3.1 Objectives

The original RCPsych guideline evidence base on prediction was examined. A list of excluded studies was available in the archived information received from the Royal College of Psychiatrists Research Institute. The following information was taken from the final report in the RCPsych guideline, which states that this hypothesis was used to inform the search strategies:

RCPsych hypothesis:

- It is possible, in acute clinical settings, to predict with reasonable accuracy which patients are more likely to become aggressive or violent in the near future.

After sifting and quality checks, 16 references on prediction were included in the RCPsych evidence review.

However, the included studies did not offer generalisable criteria in support of this hypothesis, so the RCPsych guideline concluded that:

The studies do not provide a clear consensus on items that would be clinically useful for short-term prediction across a variety of clinical settings. This does not mean that prediction (still less assessment) is impossible; only that no generalisation can be made from these results. (Royal College of Psychiatrists, 1998, p45)

Current guideline

The current guideline aims to assess whether research undertaken since 1995 now offers consensus on items and tools that are clinically useful in the short-term prediction of violent/aggressive behaviour. Four review questions were identified and used to inform the search strategy (see Appendix 4 for search strategy, databases searched and search logs).

Review questions:

- What are the risk factors and antecedents for disturbed/violent behaviour in psychiatric in-patient settings? Do they have good predictive validity?
- Which instruments most reliably predict disturbed/violent behaviour in psychiatric settings in the short-term? Do they have good predictive validity?
- Are there any identifiable staff characteristics that act as risk factors for disturbed/violent behaviour?
- What factors do service users and staff report as increasing the risk of disturbed/violent behaviour?

The studies had to meet the following inclusion criteria:

7.8.2.3.2 Selection criteria

Risk factors/antecedents/staff characteristics

Types of study

Prospective cohort studies (with or without controls) to before and after studies, and qualitative studies (level 2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- Measurement of risk factors/antecedents.
- Staff characteristics associated with disturbed/violent behaviour.

Predictive instruments

Types of study

Prospective cohort studies (with or without controls) (level 2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of interventions

Actuarial checklists/tools and structured clinical judgement checklists/tools.

Types of outcome

- Sensitivity.
- Specificity.
- Positive and negative predictive values.

Service user and staff perspectives

Types of study

Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

Staff and service user views on risk factors, antecedents, predictive instruments and staff characteristics associated with disturbed/violent behaviour.

7.8.2.3.3 Clinical evidence

The same search strategy covered all the review questions. One thousand and twenty five studies were identified in the initial sift. After sifting for relevance and duplicates 290 full papers were ordered. However 40 further duplicates were later identified.

On scrutiny, 120 were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review (see Appendix 7 for all primary research papers that fell outside the inclusion criteria). There were also 14 letters or editorials. A further 19 studies were on topics to be considered elsewhere in the guideline and were critically appraised in subsequent evidence reviews. Seventy-three primary research papers were identified; 61 met the inclusion criteria. No study offered evidence above level 2. References were checked but no further studies were identified. In addition, all papers (16) from the RCPsych prediction review, five papers from the RCPsych environment review and two papers from the RCPsych review of restraint and seclusion were considered relevant and were included in this review. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6).

Included studies

I Antecedents or warning signs

Eight studies were included that considered the antecedents or warning signs of short-term disturbed/violent behaviour. Four were UK studies, set in a variety of psychiatric in-patient environments. Three were US studies; two were set in veterans' medical centres; the other in a general psychiatric unit. The final study was undertaken in Norway, set in a secure unit. A range of study designs was used. One study was a prospective cohort, four were retrospective cohorts, one was a cross-sectional study within a prospective cohort, one was a survey and the other used semi-structured interviews. Although most of the studies associated violence with verbal abuse and aggressive/agitated behaviour, only the prospective cohort study is a sufficient design to allow predictors of violence to be discussed. The one prospective cohort study (Whittington and Patterson 1996) found no significant difference in behaviour between non-violent and violent cohorts in the 24 hours prior to an aggressive incident, although aggressive behaviour was the best predictor of short-term violence. However, they did note significant differences in behaviour three days prior to an aggressive incident. The violent cohort showed increased levels of anger and aggression ($p=0.0001$), verbal abuse, $P<0.05$), threatening gestures/stance ($p<0.01$) and abnormal activity level ($p<0.05$) compared to the non-violent cohort. This study was set in a rural hospital in the UK. The predictive validity of this study and the generalisability of these findings need to be validated by further prospective cohort studies that examine antecedents of short-term violence across a variety of settings. Three further studies in the RCPsych review examined antecedents. Only one study (Sheridan et al. 1990) noted anything different, commenting that staff limit setting often preceded violent incidents.

None of the above studies significantly change the findings of the RCPsych review.

Evidence statement

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that the following may act as antecedents/warning signs for the occurrence of disturbed/violent incidents: verbal abuse, aggressive/agitated behaviour, threatening gestures and abnormal activity levels and staff-limit setting.

II Clinical approaches to prediction ('first generation')

The literature searches yielded seven prospective cohort studies investigating clinical judgement as a means of violence prediction. One study (McNiel and Binder 1991), included in the RCPsych review, did not offer information on predictive validity. Two studies (McNiel and Binder 1995, included in the RCPsych review; Haim 2002) suggested low positive predictive values for clinical prediction. The first study was set in a locked facility in the US and the other in a forensic psychiatric hospital in Israel. Three studies (Nijman et al. 2002; Rabinowitz et al. 1999; McNiel et al. 1998) suggested that clinicians' judgement had a better predictive validity than the earlier analysis allowed and demonstrated positive predictive values of 41 per cent, 58 per cent and 75 per cent and negative predictive values of 76.9 per cent, 86 per cent and 98 per cent respectively. The three studies were conducted in a range of adult psychiatric in-patient settings, and were undertaken in different countries – the first in Israel, the second in Holland and the third in the US. In a final study (Hoptman et al 1999) the overall specificity arrived at by clinicians was 79 per cent, with a corresponding sensitivity of 54 per cent. This study was set in the US, in a forensic psychiatric hospital. It is a distinctive study in that 57.4 per cent of the participants were African-American and only 35 per cent Caucasian. In most of the other studies the majority of participants were of Caucasian origin.

Whilst four of the seven of the included studies suggest that clinicians are able to predict violence with a greater degree of accuracy than has previously been suggested, there are no identifiable features to explain the greater degree of clinician predictive accuracy found in these four studies. One study relates accuracy to confidence, but does not state if this is also related to experience. Another study admits that the inability of the study to provide an underlying reason for the high predictive value is a key weakness of the design. In order for clinicians' judgements alone to be recommended over and above other approaches to prediction, further studies that are tested across a variety of settings are required to validate these findings. Whilst the general trend of the studies stresses that clinicians may be able to predict violence with some degree of accuracy, there is a lack of consensus amongst the studies.

None of the studies significantly change the findings of the RCPsych review in which five further studies (Kirk 1989; Janofsky et al. 1988; McNiel et al. 1988; Apperson et al. 1983; Yesavage 1983) also indicated the low predictive validity of clinicians' judgement.

Evidence statement

Level of evidence	Evidence statement
Level 4	The evidence suggests that clinicians' judgement has a relatively low predictive validity, only slightly better than chance.

III Actuarial approaches ('second generation')

III.i Risk factors

Whilst antecedents or warning signs are risk factors, in this review they are distinguished from more static variables which could be used to predict violence – such as diagnosis, demographic variables etc – which are referred to as risk factors. It is such risk factors that this next group of studies examines.

The literature search identified the following relevant studies: eight prospective cohort studies; six retrospective cohort studies; one cross-sectional study; two prospective case-controlled studies; and one retrospective/historic case-controlled study.

Seven prospective cohort studies identified the following significant risk factors:

- community violence, male gender, young age, younger age at first hospitalisation, more frequent visitors – at least monthly, not having own clothing, low level of self-care functioning, number of admissions, duration of admission, coercive behaviour and lack of satisfaction of care, a diagnosis of organic psychotic condition, personality disorder, schizophrenia, and bi-polar affective disorder.

Five further studies in the RCPsych reviews also examined risk factors. The studies noted the following risk factors:

- history of violence, hostile suspiciousness, agitation-excitement, thinking disturbances, use of intoxicants, command hallucinations, impostor delusions and delusions about personal targets.

Only prior community violence/history of violence was mentioned in more than one study as a risk factor, and it was then only regarded as a risk factor within the first one to two days of admission and not afterwards.

The other prospective cohort study (Owen et al. 1998a) examined the risk factors amongst adult recidivists in psychiatric acute care settings, including geriatrics. It identified the following significant risk factors: being older, widowed, having personality disorder, or organic brain disorder, being detained under the Mental Health Act, and being highly sedated prior to the incident.

Within the studies there are no risk factors that consistently emerge, except for prior community violence. There is also no consensus within the studies as to how these various risk factors ought to be weighted. These studies only serve to illustrate that a huge range of variables are possible risk factors. However, most of the studies did suggest that demographic variables were largely irrelevant in risk prediction.

Most of the studies did not discuss the predictive validity of this approach. One study, which discusses community violence as a risk factor (Beck and Bonner 1988), notes a positive predictive validity for the first day of admission of 31 per cent – slightly worse than that averaged by clinicians' judgement in the studies discussed in Section II. One study (McNiel et al. 1998), notes that the actuarial approach was significantly better than clinician prediction. However, in this study clinician prediction was particularly low (true positives = 26.7 per cent, false positives = 73.3 per cent). Only one study (Rabinowitz and Garelik-Wyler 1999) shows a higher positive predictive value of 61.6 per cent and a negative predictive value of 69.3 per cent in predicting the violent group of service users. On the basis of these results it has not been possible to establish risk factors for the prediction of violence.

None of the studies significantly change the findings of the RCPsych review.

Evidence statements

Level of evidence	Evidence statement
Level 2+ to 2-	The evidence suggests that the following may be risk factors for disturbed/violent behaviour: community violence, male gender, young age, younger age at first hospitalisation, not having own clothing, low level of self-care functioning, number of admissions, duration of admission, coercive behaviour + lack of satisfaction of care, a diagnosis of organic psychotic condition, personality disorder, schizophrenia, and bi-polar affective disorder. However, further research is needed to reliably determine additional factors that may need to be considered across different populations.
Level 4	There is insufficient evidence to determine how various risk factors associated with disturbed/violent behaviour in psychiatric in-patient settings ought to be weighted.

III.ii Predictive actuarial tools

Eleven prospective cohort studies were identified through the literature searches. These studies assessed the predictive validity of a range of actuarial tools or checklists in adult in-patient psychiatric settings as a means of predicting violence (see Table 1, page 42). A wide range of risk factors was considered. Echoing the findings from the review of the actuarial approaches to determining risk factors considered in Section III.i above, there is no agreement amongst the tools examined here as to which risk factors are most important, or how the various risk factors ought to be weighted.

None of the studies took place in the UK. Five took place in the US; one in Australia; one in Sweden; one in Norway; one in Spain; one in Italy; and one in Taiwan. There is a need to test these actuarial tools in a European and a UK context. Research into prediction of violence in psychiatric in-patient settings involving the use of these tools is still at a preliminary stage. None of the studies considered whether prediction with a particular tool led to a decrease in disturbed/violent behaviour/incidents.

On the basis of the clinical evidence, no one tool emerged as the 'gold standard'. Six studies (Chou et al. 2002; Ehmann et al. 2001; Arango et al. 1999; Krakowski et al. 1999; Almvik et al. 1998; Yesavage 1984) reported on the positive and negative predictive values established using this approach. With the exception of the Brøset violence checklist, which is still in a preliminary stage of development, the various actuarial tools showed consistently higher positive and negative predictive values than those established by clinical judgement alone in the aforementioned analysis (see Table 1, page 42). These results suggest that important developments have been made since the RCPsych guideline. Whilst more research is needed to validate the findings of these studies, and to test the instruments across a range of settings, the clinical evidence suggests that there is a trend towards greater predictive accuracy with actuarial tools than with clinical judgement alone.

Only three studies in the RCPsych review considered the use of actuarial tools. Since the completion of the RCPsych review, more studies as outlined here have examined the predictive accuracy of actuarial tools These studies suggest that actuarial tools offer greater predictive accuracy that clinical judgement alone.

Evidence statements

Level of evidence	Evidence statement
Level 4	There is insufficient evidence on which to determine a 'gold standard' predictive actuarial tool.
Level 4	The current evidence suggests a trend towards greater predictive accuracy with actuarial tools than with clinical judgement alone. However, further comparative research is needed.

TABLE 1

Tool	Number of studies	Purpose of tool	Significant results/ predictive validity	Known advantages	Known limitations
SOAS (Palmstierna; Wistedt 1989)	Three (Palmstierna, 1989; Chou et al. 2002; Grassi et al. 2001)	Records individual incidents. Includes verbal and physical aggression and property damage. These are not rated separately (Bowers 1999).	**Study 1** highlighted history of violence against property and substance abuse. **Study 2** highlighted history of violence, psychotic diagnosis and history of smoking. **Study 3** highlighted younger age, single, living with nuclear family and acute psychosis.	Tries to separate means, aims and results of aggressive incidents. Good inter-rater reliability (0.96) Some evidence for predictive validity. The most widely used scale, therefore allowing comparison between studies (Bowers, 1991)	Conflates severity with outcome. Means and aims of aggression incompletely conceptualised (Bowers 1991).
SOAS-E (Hallenstinsen et al. 1998)		Same as SOAS	Authors argue that the new categories are exhaustive.	Same as SOAS.	Adds 11 additional warning signs.
SOAS-R (Nijman 1999)	One (Grassi et al. 2001)	Same as SOAS	Highlighted acute psychosis.	Same as SOAS	Has a new scoring system to objectify the severity of a violent episode.
RAPP (Ehmann et al. 1995)	One (Ehmann et al. 2001)	21-item scale that assesses symptoms and functional domains.	RAPP total negative predictive value = 95 per cent, positive predictive values of 78 per cent and 62 per cent in two random subsets. RAPP safety score (sensitivity = 81 per cent, specificity = 96 per cent, positive predictive value = 87 per cent improvement over change = 62 per cent).	No information available.	No information available.
MOAS (Kay et a., 1988; Bowers 1999)	One (Ehmann et al. 2001)	Retrospective record of most serious incidents in pat week. Includes four dimensions: verbal and physical aggression, property damage and self-harm.	Rating 3 or 4 was used to determine aggressive behaviour. The following were noted as risk factors: female, alcohol abuse and non-paranoid schizophrenia.	Easy to collect and does not need a heavy commitment from ward nurses. Good inter-rater reliability (0.85-0.94). Moderate longitudinal correlations for the same patient (Bowers 1999).	Loss of information on individual incidents, their antecedents and consequents. Conflates severity with outcome. Diverse behaviours grouped together.
NOSIE (Honigfield 1966)	Two (Swett & Mills 1977; Krakowski et al. 1999)	Measures three positive factors: social competence, social interest and neatness; and three negative factors: irritability, psychosis and motor retardation.	**Study 1** – irritability scale significant predictor (positive predictive value = 78 per cent, negative predictive value = 79 p er cent). **Study 2** – irritability, difficulty following ward instructions.	No information available.	No information available.

TABLE 1 (CONTINUED)

Tool	Number of studies	Purpose of tool	Significant results/ predictive validity	Known advantages	Known limitations
BPRS(Overall, Gorham 1962)	Five (Swett & Mills 1977; Krakowski et al. 1999; Yesavage 1984; McNeil 1995; Werner 1983)	24-items. Ratings range from 1-7 with higher rating indicating More severe symptoms.	**Study 1** – schizophrenia rating was significant in combination with low neuroleptic serum levels and violence prior to admission. **Study 2** – Total BPRS score was not significantly related to assault. **Study 3** – Severe psychotic symptoms were significant. **Study 4** – sensitivity – 55 per cent, specificity – 64 per cent. **Study 5** – true positives (0.27), true negatives (0.39).	No information available.	No information available.
MMSE (Folstein et al. 1975)	One (Swett & Mills 1977)	11 'yes-no' questions asked by psychiatrist to service user.	Total MSME score was not significantly related to assault.	No information available.	No information available.
QNS (Convit 1994)	One (Krakowski et al. 1999)	Assesses neurological symptoms.	Severe neurological symptoms were significantly related to assault.	No information available.	No information available.
BVC (Almvik 1996)	One (Almvik & Woods 1998)	Assessed whether service users were confused, irritable, boisterous, physically threatening, verbally threatening, attacking objects.	Sensitivity = 74 per cent, specificity = 91 per cent, false positives = 66 per cent, (true positives = 70 per cent, false negatives = 24 per cent, true negatives = 71 per cent).	Simple six-item checklist.	Authors comment tool was at a preliminary stage of development in 1998.
PANSS(Kay et al, 1992)	Two (Ehmann et al. 2001; Arango et al. 1999)	Assesses psychopathology.	**Study 1** – sensitivity = 67 per cent, specificity = 91 per cent, positive predictive value = 71 per cent, base rate = 24 per cent, improvement over chance = 47 per cent. **Study 2** – total PANSS score – sensitivity = 31.3 per cent, specificity = 91.5 per cent, positive predictive value = 55.5 per cent, negative predictive value = 79.6 per cent. Insight into psychotic symptoms, general psychopathy score and violence in previous week correctly classified 84.1 per cent of service users (sensitivity = 50 per cent, specificity = 95.7 per cent, positive predictive value = 80 per cent, negative predictive value = 79.6 per cent.	No information available.	No information available.
PCF (Lanza et al. 1996)	One (Chou et al. 2002)	Scale includes: sociodemographic data, medical diagnosis, time since admission, history of assaults and history of drug and alcohol abuse.	Significant service user characteristics: history of violence (OR=4.14) psychotic diagnosis (OR=2.07), history of smoking (OR=1.45) and duration of admission (OR=0.99).	No information available.	No information available.

TABLE 1 (CONTINUED)

Tool	Number of studies	Purpose of tool	Significant results/ predictive validity	Known advantages	Known limitations
EAQ (Lanza et al. 1996)	One (Chou et al. 2002)	Scale includes: location time, date, number of patients on ward and their acuity level, space density, and number of staff on ward.	Severity of assault was related to space density and staff/patient ratio.	No information available.	No information available.
ARP (Kay et al. 1987)	One (Kay et al. 1988)	39 item tool covering four main areas: demographics, current psychiatric diagnosis, history of aggression and clinical profile.	Physical aggression was predicted by anger, hostility, history of attacks on others, history of greater total aggression (p⇠0.01). Verbal aggression was predicted by motor excitement, difficulty with gratification, depressed feelings (p⇠0.025) Total aggression was predicted by younger age, more acutely ill, more threatening of violence by history, previously rated more agitated and labile in affect (p⇠0.05).		

IV Structured clinical judgement instruments ('third generation')

Three studies examined the usefulness of instruments that measure structured clinical judgement. Two were European studies – one set in Sweden and the other in the UK – and the third was a US study. Two of these were prospective cohort studies and are described here.

The first prospective cohort study was undertaken in Sweden, (Belfage et al. 2000). It considered both the HCR-20 (historical/clinical/risk – 20-item scale, version 2) and the PCL:SV (psychopathy checklist: screening version) within a maximum security correctional setting. The study found that history of violence was not a good predictor of future violence. The authors suggest that this is unsurprising in a setting where all patients will score highly on the H-10 – the historical part of the tool. The R-5 showed the best predictive validity (p=0.004). Thirty of 41 participants were psychopaths for whom the R-5 was the only tool with any predictive validity (p = 0.002). The PCL:SV showed a higher score for violent recidivists and was significant when considered in conjunction to older age (p<0.1).

The second prospective cohort study (Hill et al. 1996) was conducted in the US in a state hospital to assess whether the PCL:SV was a good predictor of aggression amongst 55 male forensic psychiatric service users. The authors found that the PCL:SV total was a significant predictor of aggression. The PCL:SV was then reduced to presence or absence of psychopathy, where it again predicted aggression (multiple r = 0.69; R2=0.48; Beta = 0.69).

Three other studies that examine the effect size of the PCL and the PCL: SV are mentioned by Doyle and Dolan (2000). They also note a good predictive validity for the tool in a forensic setting. However, as of yet, insufficient research has been carried out to test the predictive validity of these instruments in UK adult psychiatric in-patient settings. More studies also need to be undertaken to validate the results of these studies. All studies are detailed in Table 2, page 45.

All these studies have taken place since the RCPsych review. They suggest that structured clinical judgement gives a greater predictive accuracy than clinicians' judgement alone, similar to that achieved by the use of actuarial tools.

Evidence statements

Level of evidence	Evidence statement
Level 4	The evidence suggests that there is trend towards greater predictive accuracy with structured clinical judgement tools than with clinical judgement alone, similar to that achieved by the use of actuarial tools.
Level 4	There is insufficient evidence on which to determine a 'gold standard' structured clinical judgement instrument.

TABLE 2

Tool	Number of studies	Purpose of tool	Results/predictive validity	Known advantages	Known limitations
PCL:SV (Hart et al. 1995)	Three (Doyle et al, 2002; Belfrage 2000; Hill 1996)	12-item instrument to assess psychopathy. Scored 0 (not present) 1 (maybe) 2 (present).	**Study 1** PCL:SV total score and interpersonal subscale = best predictors of any violence (sensitivity = 0.76, sensitivity = 0.50) Interpersonal subscale = best predictor of violence against persons resulting in injury (sensitivity = 0.76, sensitivity = 0.50) (compared with VRAG and H-10). **Study 2** High scores on part 2 suggested recidivism. **Study 3** The PCL:SV total was a significant predictor of aggression. The PCL:SV when reduced to presence or absence of psychopathy again predicted aggression (multiple r = 0.69; R2 = 0.48; Beta = 0.69).	Quicker, shorter and easier to administer than the psychopathology checklist revised (PCL-R). Psychometrically sound. Not so concerned with overt criminal acts as the PCL and the PCL-R.	No information available.
VRAG (Harris et al. 1993; Webster et al. 1994)	One (Doyle 2002)	Includes 12 variables including: PCL-R score, elementary school maladjustment, age (negative associated with violence) personality disorder, separation from parents before 16, failure on previous conditional release, history of non-violent offences, never married, diagnosis of schizophrenia, severity of injury to victim during index offence, alcohol abuse, male victim of index offence. All items are given integer weights.	Did not show good predictive validity (but this was a retrospective study).	No information available.	No information available.
HCR-20 (Webster et al. 1997)	Two (Doyle et al. 2002; Belfrage, 2000) (one study only considered the H-10)	A 20-item checklist, divided into 10 historical items (H-10), five clinical items (C-5) and five risk management items (R-5), allowing the scale to examine past, present and future times. It is scored either 0 (no) 1 (maybe) 2 (yes)	**Study 1** Risk management sub-score had best predictive validity in correction maximum security institutions. **Study 2** H-10 did not show better predictive validity that the PSL:SV (see above).	No information available.	No information available.

Three further studies examine the predictive validity of the PCL and PCL: SV and note the effect size for this instrument amongst forensic psychiatric patients. The effect sizes are given as follows: d = 0.63, d = 1.92, AUC of ROC at 3 month = 0.75 (Dolan, Doyle 2000).

V Staff characteristics associated with the likelihood of aggressive incidents

Nine studies were identified which examined the relationship between staff characteristics and assault (Flannery et al. 1995; Flannery et al. 2001; Chou et al. 2001; Chou et al. 2002; Lanza et al. 1997; Owen et al. 1998b; Soares et al. 2000; Augestad and Vatten 1994; Ray 1988; Morrisson 1998). In addition a further five studies were identified in the RCPsych review (Whittington and Wykes 1996; Binder and McNeil 1994; Whittington 1994; Whittington and Wykes 1994; Carmel and Hunter 1991). All the studies, except one (Lanza, 1997), surveyed staff in a range of psychiatric settings. Lanza (1997) was set in a neuropsychiatric department in a veterans' hospital in the US. This study found no relationship between staff characteristics and assault. The other 12 studies identified the following characteristics as significant correlates of staff characteristics and the occurrence of aggressive incidents:

> younger age, between youngest and oldest age, work experience, training in the management of violence, and grade, lack of training and limit setting/confrontation, authoritarianism, social restrictiveness, young age, limited supervision and gender. (It was also suggested that gender was non-significant (Binder and McNeil 1994). The study (Augestad and Vatten 1994) which emphasises gender as significant notes that whilst overall risk for men was significantly higher, the relative risk according to ward type was similar for men and women). Several other correlates were identified, but were not significant.

There was no consistency across the studies.

None of the studies significantly change the findings of the RCPsych review.

Evidence statement

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that the following staff characteristics may be associated with increased occurrence of incidents of disturbed/violent behaviour: younger age, level of experience, training and grade, gender, and involvement in limit-setting activities. However, further research is needed.

VI Service user perspectives on reasons for assault

Seven studies were identified which examined service user perspectives on the causes of disturbed/violent behaviour.

One Canadian study surveyed a heterogeneous group of 12 thought-ordered individuals across two hospitals. Service users reported that factors that caused violence tended to be external rather than internal (that is caused by factors on the ward rather than by illness). The results of this study would need to be validated on a larger scale and replicated across other settings, before any evidence-based conclusions could be drawn about service user perspectives on the causes of aggressive incidents.

Another study (Whittington and Wykes 1996) conducted semi-structured interviews with staff in the UK to ascertain whether aversive stimulation (such as limit setting) had occurred prior to an assault. The results were verified by interviews with some service users and witnesses, indicating that some form of aversive stimulation often precedes an assault. However, the study is unclear about the number of service users who were interviewed or the extent to which they agreed with staff. The study reports that many staff believed that aversive stimulation trigger the majority of the aggressive incidents (see staff perspectives below).

One survey (Gillig et al. 1998) found that service users saw less of a causal connection between their own verbal abuse of staff and the physical abuse of staff than staff ($p<0.05$). However, they saw more of a causal connection between verbal abuse of service users by staff and physical violence against staff, than staff ($p<0.05$). This pattern and significance was echoed with regards to hostility and threats. Service users identified staff use of drugs and alcohol ($p<0.05$), the use of forced medication ($p<0.05$), restraints ($p<0.05$) and seclusion ($p<0.05$) as causes underlying violent incidents. They also stressed cross-cultural racism as a cause of violence.

Another study that used incident forms, a survey and interviews for data collection (Duxbury 2002) noted that service users believed that external and situational factors (such as interactions with staff and restrictive regimes) were largely to blame for violent incidents ($p<0.001$).

A further study using semi-structured interviews (Bensley et al. 1995), noted that service users, like staff, considered restrictions on service users' smoking, access to outdoors, defective staff clinical skills, service users not being treated with respect, as well as the use of seclusion and restraint, to contribute to violent incidents. Service users were also concerned that rules were not adequately explained.

Using video footage and interviews (Crowner et al. 1995) it was found that 12 per cent of service users argued that they had been playing with the victim, 12 per cent claimed that they had been subjected to verbal abuse, and 8 per cent claimed that they had been subjected to objectionable behaviour. The other 41 per cent gave a range of responses – from no response to anger at ward rules, and anger at unwanted sexual attention.

Ilkiwa-lavelle and Grenyer, (2003) found that service users believe improved handling of inter-personal conflicts would prevent violent incidents.

Evidence statement

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that service users regard external factors (such as limit setting, verbal abuse by staff and other service users, lack of respect by staff and harassment) as likely reasons for assault rather than internal factors (that is, caused by illness).

The RCPsych review did not specifically consider this issue.

VII Staff perspectives on reasons for assault

Nine studies were identified which examine staff perspectives on reasons for assault.

Four studies (Gim et al. 1999; Duxbury 1999; Gillig et al.1998; O'Sullivan and Meagher 1998) carried out questionnaire surveys to assess health care professionals' views on the risk factors associated with psychiatric in-patient violence. The first study is set in Ireland; the second in Singapore; the third in the UK; and the fourth in the US. The following were proposed as risk factors by staff but not validated:

> personality disorder, schizophrenia, substance abuse, intoxication, violent lifestyles, active hallucinations, paranoid ideas against others, non-compliance with treatment, internal factors and provocation.

Only personality disorder was mentioned in two of the studies, although all studies mention internal factors, including diagnosis. These suggest that staff emphasise diagnosis over other variables. However, more studies are needed before the generalisability of these findings can be assessed.

Two studies (Whittington 1996; Bensley 1995) conducted semi-structured interviews with staff. One study (Whittington 1996) attempted to assess whether they had caused aversive stimulation prior to an assault. After validating the results of the interviews by interviewing service users and witnesses, it was noted that 86 per cent of all assaults were preceded by some form of aversive stimulation (such as limit setting), although the authors suggest an interplay with diagnosis. These results require validation and replication across a variety of settings.

Using semi-structured interviews (Bensley 1995) found that staff believed inadequate staffing levels was the single factor that most contributed to assaults on staff. Like service users, staff were also concerned about service user restrictions on smoking, access to outdoors, staff clinical skills, service users being treated with respect, as well as the use of seclusion and restraint on the wards. Staff also mentioned a need for training in the management of violence, as well as concerns about the general physical environment. However, the study was of low quality.

Using incident forms, questionnaires and interviews (Duxbury 2002) noted that staff most commonly reported problematic interaction and restrictive environments as the causes of violence/aggression. However, staff did not consider their own personal interactions with service users to be problematic. Staff were unable to identify a cause for 26 per cent of all incidents. Staff attributed much more weight to internal factors (that is, illness) as underlying causes of violence/aggression than service users.

Using focus groups and surveys (Delaney et al. 2001), the following were noted as impacting on the possible risk of violence: service user history; service user status and mode of arrival; ongoing informal nurse assessment; individualised care; peer support and administrative responsiveness; nursing stress; and current policies/manuals. However, the study was of low quality.

Ilkiwa-lavelle (2003) found that staff believed the service user's illness to be a key causal factor, whereas service users believed inter-personal conflicts were relevant. Staff believed improved medical management would prevent violent incidents.

Evidence statement

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that staff users regard internal factors (that is, caused by illness) and the interplay between internal and external factors (such as staff limit setting) as contributing to disturbed/violent behaviour.

The RCPsych review did not specifically consider this issue.

7.8.2.3.4 Economic evidence

No studies containing relevant economic data were found (see Appendix 9).

7.8.3 Training

7.8.3.1 Objectives

No specific searches on training systems were undertaken in the RCPsych guideline.

Current guideline

Two review questions were identified by the GDG and used to inform all searches:

- What are the most effective and safe training programmes for the prevention of and the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings?
- What are the views of staff and service users about the various training programmes in adult psychiatric in-patient settings and their content?

Included studies were subdivided into more specific review questions that related to each of the interventions and related topics covered in this guideline.

7.8.3.2 Selection criteria

Types of studies

Systematic reviews to controlled before-after studies. Qualitative studies were also included. (Evidence levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcomes

- Effectiveness of training packages in managing or reducing disturbed/violent behaviour.
- Safety of training packages managing or reducing disturbed/violent behaviour.
- View of staff and service users on the various training programmes for managing or reducing disturbed/violent behaviour.
- Increased staff knowledge resulting from training.
- Staff attitude change resulting from training.
- Reduction in the number of disturbed/violent incidents.
- Reduction in the number of staff days lost through illness.

7.8.3.3 Clinical evidence

Two hundred and thirty nine papers were identified in the initial sift. Eighty-four studies were ordered. After quality checking, 22 studies were included in the review. Eight studies were excluded. The remaining studies were overviews. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6).

Appraisal of methodological quality

In addition to those mentioned in section 7.3.6, the following methodological concerns were raised by these studies:

- All the studies included in this review have relatively small sample sizes.
- For most of the studies the training package was not specified.
- Where the training package was specified, insufficient details were provided to allow meaningful comparisons to be made with other training packages.
- Long-term outcomes, such as improvement in service user care, were not measured.

Included studies

Fourteen before and after studies were included in this review. One of these before and after studies (Perkins and Leadbetter 2002) is conducted in an area outside of the scope of the guideline. However, this study is included here because the CALM technique that it evaluates is one of many training packages used in the UK for the short-term management of violence. Two pilot studies are also included. The first study (Frey and Weller 2000) is included, despite only being a pilot study, since it is the only study that considers the effectiveness of training service users, rather than staff, as a means of reducing in-patient violence in adult psychiatric settings. The second study (Bournemouth University, unpublished) is included since it is one of only two studies to evaluate the effectiveness of training in a clinical environment. Of the other studies included, one study is a retrospective cohort study, and seven are cross-sectional surveys.

As the studies often address multiple issues, the findings of the studies have been grouped together under topics. This means that some studies are referred to a number of times.

I.a Review question: what are the most effective and safe training programmes for the prevention of and the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings?

The effectiveness of training staff in interventions for the short-term management of violence: general outcomes.

Increased knowledge

In a before and after study (Calabro et al. 2002), significant increases were noted immediately after training in non-violent crisis intervention (CPI) in post-test knowledge scores (p<0.001), positive change of attitude towards the techniques taught (p<0.001), self-efficacy (p<0.01) and positive change in behavioural intention (p<0.05). A further before and after study (Ilkiw-Lavalle et al. 2002), found that staff knowledge improved significantly immediately after training, with ancillary staff improving by the largest effect size (2.25). Staff with no prior training had the greatest improvements immediately after training (p<0.01) A before and after study (Paterson et al. 1992) noted a significant increase in knowledge immediately after training in post-test knowledge scores (p=<1%). Stress, as assessed by a general health questionnaire, was also significantly reduced (p=<1%). In a controlled before and after study (Rice 1985), significant improvements were found in all areas of knowledge (self-defence and patient restraint written test p<0.0001 for lesser security staff only) immediately after training.

None of these studies assess the effectiveness of training in a clinical environment.

Attitude changes

A before and after study (Collins 1994), found that staff were less likely to hold service users entirely responsible for their behaviour, and acknowledge facts such as service user fear as causative immediately after training and at six months post training. In a before and after study using the CALM techniques in a school for children with learning difficulties (Perkins 2002), no significant changes in staff attitude toward pupil aggression were noted.

In a before and after study (Collins 1994), staff confidence was found to increase immediately after training. Staff remained more confident six months post training. In a before and after study using the CALM techniques in a school for children with learning difficulties (Perkins and Leadbetter 2002), it was noted that 82 per cent of staff interviewed expressed increased confidence in their ability to deal with an aggressive incident six months post training.

None of these studies assess the effectiveness of training in a clinical environment

Number of disturbed/violent incidents

In a retrospective cohort study (Carmel and Hunter 1990), training in managing aggressive behaviour and CPR was not found to be significantly linked to the number of violent incidents on the wards. In a before and after study (Sjöström et al. 2001), no significant reduction in the number of aggressive incidents using the social dysfunction aggression scale (SDAS-9) was noted six weeks after training.

In a controlled before and after study (Rice 1985), there was a significant reduction in violent incidents (p<0.05) for the 18 months after training. Taxis (2002) shows a dramatic decrease in the use of seclusion and restraint after a 42 month period of training.

In a before and after study (Whittington and Wykes 1996), it was noted that wards that sent the majority of their staff to a one-day training course that did not involve restraint training noticed a significant reduction in assaults (p<0.05) for the 28 days after training. Staff who took part in training had a 31 per cent lower rate of assault after training than those who did not take part. The decrease was unusual but did not reach significance.

Staff injuries and missed workdays

In a retrospective cohort study (Carmel and Hunter 1990), when wards highly compliant with training were compared to wards with low training compliance, a significant positive relationship was noted between those trained in managing aggressive behaviour and the number of staff injuries (p<0.005).

In a retrospective cohort study (Carmel and Hunter 1990), a significant relationship was noted between individual staff who were trained in either managing aggressive behaviour or CPR and a reduction in staff injuries based on monthly reports over the course of a year (p<0.001).

In a before and after study (Martin 1995), it was noted that two years after a training programme was initiated, although the number of aggressive incidents increased along with the level of aggression, the number of staff injuries fell and the number of missed work days fell resulting in a saving (in relation to missed workdays) of $173, 960 (year 1); $2, 478 (year 2); $2, 414 (year 3). (NB: Not enough information reported to assess quality).

In a controlled before and after study (Rice 1985), there was a significant reduction in lost work days on wards that took part in the training relative to those that did not (p<0.001) for the 18 months post training.

In a before and after study, Sjöström et al. (2001) noted that six weeks after training, no significant reduction in the number of staff on sick leave was noted.

Prediction and risk assessment

In a cross-sectional survey of 193 UK trusts providing mental health services (Davis 2001), just over 50 of the 84 per cent replying provided training on risk assessment for harm to others.

A before and after study (Ilkiw-Lavalle et al. 2002), found that staff knowledge of prediction was significantly increased immediately after training (p<0.01).

None of these studies assess the effectiveness of training in a clinical environment.

De-escalation techniques

In a before and after study (Paterson et al. 1992), 'blinded' raters judged that there was a significant increase in staff competence in de-escalation immediately after training.

In a before and after study (Philips and Rudestam 1995), judges rated that immediately after training, the experimental group of staff who received training placed significantly more value on non-aggressive responses to service user violence/aggression (p=0.05) than a control group who were not trained, or a control group who received only didactic training.

A controlled before and after study (Wondrak and Dolan 1992), trained student nurses to deal with verbal abuse. Using role-play, blind raters noted that there was significant improvement for those trained immediately after training, compared to those not trained in all areas except empathy, eye contact and anger levels. Post test, the attendees appeared more relaxed to blind raters (p=0.031), less upset (p=0.001) and had a more effective use of posture (p=0.005). On self-reported questionnaires, three areas achieved significance in those trained: feeling less angry (p=0.002); feeling less out of control (p=0.005); and feeling less threatened (p=0.035); in a similar situation.

In a before and after study using the CALM techniques in a school for children with learning difficulties (Perkins and Leadbetter 2002), semi-structured interviews suggested that verbal de-escalation appeared to have increased six months after training.

None of these studies assess the effectiveness of training in a clinical environment.

Restraint

In a before and after study (Paterson et al. 1992) 'blinded' raters judged that there was a significant increase in staff competence in control and restraint and disengagement immediately after training.

In a before and after study (Philips and Rudestam 1995), immediately after training, judges rated the experimental group of staff who received training as significantly more competent in physical skills as well, as displaying less fear and aggression (p=0.05), than a control group who were not trained, or a control group who received only didactic training.

In a controlled before and after study (Rice 1985), there were significant improvements in areas of skill (sensitive situations skill test p<0.001) and audiotaped simulations test (p<0.01) immediately after training. There was also a significant increase in the on-ward job reactions scale six weeks after training for maximum security workers, compared to controls (p<0.01). This scale measures how comfortable participants are in their interactions with service users.

In an unpublished pilot study conducted by Bournemouth University, the effectiveness of restraint and breakaway techniques were considered in a psychiatric intensive care unit (PICU). The study used a prospective cross-sectional approach over 32 months. During this period, 346 adverse incident forms were collected. They did not record the use of breakaway techniques, however, when 19/22 staff were interviewed retrospectively, three recalled using recognised breakaway techniques, one a restraint technique and one an unrecognised technique. Staff did not recall any techniques used being inappropriate or ineffective. They recalled problems with taking the client to the floor. All were satisfied with the training they had received, but wanted more frequent refresher courses and a greater emphasis on de-escalation.

Parkes (1996) conducted a before and after study in a 44-bed medium secure unit to assess the effectiveness of a four-day C&R training course. Interviews were conducted with all staff involved in a restraint incident for the 18 months prior to training and the 12 months after all staff had been trained. Data was collected on all 340 incidents involving physical restraint. One hundred and forty-nine incidents involving restraint occurred after training. For statistical purposes these were compared with 149 incidents immediately prior to training. Staff injuries during the restraint phase increased after training (p<0.05). Injuries to service users during restraint phase did not significantly alter post training. No other significant changes in injury rates were noted. Overall changes in injury rates were not significant. There were no significant changes in difficulty rating or risk rating after training. The modal number of staff restraining a person increased to three after training. The highest number of staff involved in a single restraint decreased from 10 to six after training.

Only two studies – Bournemouth University, (unpublished) and Parkes (1996) – assessed the effectiveness of training in a clinical environment. However, the first was a pilot.

Evidence statements

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that short-term improvements in knowledge, skills and reduction in stress occur after staff training in the management of disturbed/violent behaviour.
Level 4	The lack of evaluations of the effectiveness of training in a clinical environment mean that a 'gold standard' training package for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings cannot be determined.

I.b Review question: how effective was training service users in the management of their disturbed/violent behaviour?

One before and after pilot study (Frey and Weller 2000) examined the effect on incidences of aggressive and violent behaviour of training service users to respect themselves, peers and staff. Service users demonstrated a significant increase in knowledge, based on a questionnaire immediately after the training ($p<0.05$). A nurses' survey indicated a reduction in aggressive behaviour in the week after training ($p<0.05$). Authors claim that the training inadvertently led staff to alter their behaviour. It caused staff to become more aware of the causes of service user aggression, through examining the feedback. It is therefore unclear whether changes of staff behaviour or training service users had the most impact on reducing violence.

Evidence statement

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that training service users to respect themselves, peers and staff may reduce the occurrence of disturbed/violent incidents.

I.c Review question: What are the views of staff about the various training programmes in adult psychiatric in-patient settings and their content?

General perspectives

Staff assessment of training needs

In a Canadian cross-sectional survey (Chaimowitz and Moscovitch 1991) of medical students to assess the adequacy of training to deal with violent incidents, 34.3 per cent thought that staff psychiatrists were adequately trained; 24.4 per cent thought that psychiatric residents were adequately trained; 50.4 per cent thought that nurses were adequately trained; and 79.5 per cent wanted improvements in education and training for staff. In a cross-sectional survey of medical trainees in New Zealand (Coverdale et al. 2001), only 30 per cent had training in the management of violence and only 36 per cent of these viewed it as adequate. Only 62 per cent of those who were psychiatry trainees had received training in the management of violence.

PICU ward managers at a PICU conference took part in a UK cross-sectional survey (Clinton et al. 2001). Eighty-one percent of respondents stated that they would attend a course on violence management, however only 17 per cent were aware of relevant courses in their locality.

In a before and after study (Ilkiw-Lavalle et al. 2002), it was noted that staff with previous training would have preferred to focus on special skills rather than repeat basic training.

In a cross-sectional study using semi-structured interviews (Southcott et al. 2000), it was noted that staff wanted more frequent refresher courses (three to six monthly). In an unpublished pilot study by Bournemouth University, it was noted that, of the staff interviewed, 19/22 wanted more frequent refresher courses and a greater emphasis on de-escalation.

Staff satisfaction with training

In a before and after study (Goodykoontz and Herrick 1990), it was found that staff felt more confident in their ability to handle violent situations after training. They stated, four months after training, that they were more likely to intervene than they had been, rather than waiting for hospital security. After training, they felt that they had a plan of how to proceed when faced with a violent incident.

In a controlled before and after study (Rice 1985), the training course was well received (mean = 5.5 on a 6-point scale where 6 is the best possible score). The results were little altered at six weeks and 15 months.

In a cross-sectional study using semi-structured interviews (Southcott et al. 2000), it was noted that staff were generally satisfied with the training that they had received and felt that the techniques that they had learnt were both effective and appropriate immediately after training. (All staff received training in control and restraint and breakaway techniques).

In an unpublished cross-sectional pilot study with retrospective interviews (Bournemouth University) it was noted that of all staff interviewed, 19/22, were satisfied with the training they had received.

In a before and after study using interviews with a standard form (Parkes, 1996), staff felt safer and more in control when relocating the service user after having received training. They felt that C&R techniques appeared more professional to observers than unauthorised holds. Staff felt that training made it easier to hold the service user for a protracted length of time.

Staff perspectives relating to specific interventions

Prediction and risk assessment

In a before and after study (Collins 1994), nurses believed that some prediction of violence was possible immediately after the training course and six months post training.

De-escalation techniques

In a before and after study (Beech 1999), students nurses were confident that they could manage verbal aggression immediately after training ($p=0.0000$).

In a cross-sectional study using semi-structured interviews four months after training (Southcott et al. 2002), it was noted that staff felt that de-escalation training should be provided before breakaway training.

Restraint

In a cross-sectional study using semi-structured interviews four months after training (Southcott 2002), it was noted that staff felt that the process of restraint was often messy and unco-ordinated and could be improved with better planning. (All staff received training in control and restraint and breakaway techniques).

Self-defence

In a before and after study (Beech 1999), immediately after training, student nurses believed that they would be able to protect themselves using reasonable force ($p<0.0000$).

Evidence statements

Level of evidence	Evidence statement
Level 4	Staff perceive that training in the short-term management of disturbed/violent behaviour is beneficial and that it also increases confidence in dealing with disturbed/violent behaviour
Level 4	The evidence suggests that staff often feel that their need for training is not met.

I.d Review question: what are the views of service users about the various training programmes in adult psychiatric in-patient settings and their content?

In a controlled before and after study (Rice 1985), it was noted that after staff training, service users showed positive changes on a modified Coppersmith self-esteem inventory – a scale measuring depression and anxiety from an adjective checklist and on a modified feelings scale. The results were significant on maximum secure wards ($p<0.05$). The questions were given to each service user weekly from six weeks before training until six weeks after training. The researcher had wanted to assess service user responses to staff training through a ward atmosphere scale, but staff objected.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is insufficient evidence to determine service user perspectives on service user training to help service users manage their aggressive and/or disturbed/violent behaviour.

II Current practices in training in the UK

Four cross-sectional studies were found that examined current training arrangements in the UK.

Wright et al. (2000) examined the policies for the management of violence in PICUs and RSUs. One hundred and twelve wards were surveyed, 33 policies were returned (representing a good geographical spread). Nine percent of policies were current and not awaiting update; 9 per cent were out of date; 27 per cent were undated. Less than two-thirds of the policies had a stated aim or a definition of violence. Three-quarters of the policies stressed the need to report incidents, have post-incident team support, review the incident, outlined expectations and responsibilities of staff, emphasised prevention and de-escalation and had a commitment to train all appropriate staff. Just over half also mentioned the need for refresher courses. However, where a commitment to training was mentioned, less than half stated who was responsible for ensuring training was provided. Ninety four percent of policies listed physical restraint as an acceptable method for managing violence. However, less than half the policies listed unacceptable methods of restraint.

Lee et al (2001) investigated the training that is undertaken in PICUs and RSUs. One hundred and twelve units were contacted (760 staff) and there was a 47 per cent response rate. It was noted that it was possible to identify a core curriculum of 12 techniques across a range of courses: taking the patient to the floor, three-person restraint team, sitting and standing the patient, negotiating stairways and doors, restraining hold, roles within team, turning the patient over, breakaways, entry into and exit from seclusion, blocking punches, blocking kicks, separating fighting patients. Eighty-two percent of staff were able to identify the organisation that provided their training. Most initial courses lasted for five days. Respondents in RSUs were significantly more likely to be taught breakaway techniques ($p=0.03$), entry and exit from vehicles ($p=0.00017$) and defence against weapons ($p=0.02$) than respondents in PICUs. The three techniques most commonly used in practice were verbal de-escalation, restraining holds and use of three-person team. Thirty one percent of respondents did not state that their courses contained ethical and safety issues or verbal de-escalation. While 39 per cent received training within three months of taking up post, 21 per cent did not receive training for a year or more and 8 per cent had received no training at the time of the survey. Ninety-eight percent stated that they expected to attend a refresher course. Confidence in the skills learnt was high (mean = 4.63 on a six-point scale).

Davis et al. (2001) approached clinical directors in 193 NHS trusts that provide mental health services to assess how much risk assessment training takes place. The survey had an 82 per cent response rate. Just over 50 per cent provided training on risk assessment for harm of others. Most trusts provided training on mental health legislation. Most trusts provided annual training courses, but these were not compulsory. Clinical directors noted that staff attendance was low, but that many staff received additional training as part of routine clinical work or courses such as MRCPsych. Around 50 per cent provided follow-up courses. The existence of written policies varied; most trusts had policies on observation.

Bleetman and Boatman (2001) conducted a cross-sectional questionnaire survey across 305 acute and community trusts, 30 ambulance trusts, 40 personal training organisations, and 63 corporate organisations. Mental health trusts were excluded. The aim was to provide an overview of control and restraint issues in the health services. The response rate was low. Acute and community trusts – 29 per cent; ambulance trusts – 30 per cent; training organisations – 45 per cent; corporate organisations – 13 per cent. The following results were noted: no significant difference in levels of confidence in the reporting process was found between those trusts using a specific aggressive/violent incident form and those using a general form. No significant results were found on the use of PPE or personal alarms. Training organisations reported the following results: 72 per cent stated staff were certificated to deliver training – but no standardisation; 56 per cent reported trainers were qualified first aiders; 78 per cent offered non-physical conflict management; and 67 per cent offered training in physical skills (types of skills outlined). Fifty percent knew skills taught were operationally effective. The evaluation of content of training packages appears subjective. This demonstrates the lack of standardisation in the UK. Authors note that it was not possible to reach any firm conclusions about the effectiveness of training techniques employed in the UK on the basis of this study.

Taken together, these four studies suggest that the following constitute the core curriculum of training courses in the UK:

- taking the patient to the floor
- three-person restraint team
- sitting and standing the patient
- negotiating stairways and doors
- restraining hold
- roles within team
- turning the patient over
- breakaways
- entry into and exit from seclusion
- blocking punches
- blocking kicks
- separating fighting patients.

However, the limited scope of these studies limits the generalisability of their findings.

Evidence statement

Level of evidence	Evidence statement
Level 4	The evidence on current training practices in the UK indicates that there is a lack of standardisation in the way staff are targeted for courses, and in the range of interventions covered. In addition, the effectiveness of training has not been adequately evaluated in a clinical environment.

7.8.3.4 Economic evidence

No studies containing relevant economic data were found. The following additional exploratory cost analysis was carried out (for full details see Appendix 9).

- The cost effectiveness of life support training was considered. It was concluded that the cost per QALY of immediate life support (ILS) training with automated external defibrillators (AED) under scenario 1 is around £23,000. Sensitivity analysis shows that this may be cost effective (i.e. cost per QALY of £20K or less), if one or other of the factors are favourably different from scenario 1.
- Scenario 5 suggests that advanced life support (ALS) training (where cost of training will be more than twice ILS) is highly unlikely to be cost effective.

7.8.4 Staff and service user perspectives

7.8.4.1 Staff and service user perspectives – general

7.8.4.1.1 **Objectives**

No specific searches on staff and service user perspectives were undertaken in the RCPsych guideline.

Current guideline

Three review questions were identified by the GDG to be addressed in this review:

Review questions

- Do staff and service users perceive themselves to be safe in psychiatric in-patient settings?
- What impact does disturbed/violent behaviour in psychiatric in-patient settings have on staff and/or service users?
- What are staff and service users' attitudes towards the

short-term management of disturbed/violent behaviour?

7.8.4.1.2 **Selection criteria**

Types of studies

Systematic reviews to before and after studies. Qualitative studies were also included (level 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

General staff and service user perspectives on the short-term management of disturbed/violent behaviour.

7.8.4.1.3 **Search strategy**

No specific searches were undertaken to identify papers that discussed staff and/or service user perspectives on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings, since all searches were broad enough to retrieve papers that examined staff and/or service user perspectives. The articles that form the basis of this review were identified by the various searches for each of the interventions covered in this guideline. However, rather than looking at a single intervention or area, we considered this topic in relation to the short-term management of disturbed/violent behaviour as a whole.

7.8.4.1.4 **Clinical evidence**

Eleven papers that examine general staff and service users' perspectives on the short-term management of disturbed/violent behaviour were identified by our searches. After critical appraisal, nine papers were included in this review. One was excluded. The other papers were overviews of a general nature, and were therefore ineligible. (Evidence tables of studies included only in this review can be found in Appendix 5. Evidence tables of studies excluded only from this review can be found in Appendix 6).

General: staff and service user attitudes towards disturbed/violent behaviour in psychiatric in-patient settings

Nine studies were identified which considered staff attitudes towards disturbed/violent behaviour. A range of study designs and perspectives were examined, making the results difficult to synthesise.

I.a Review question: do staff and service users perceive themselves to be safe in psychiatric in-patient settings?

In a survey (Baxter et al. 1992), it was noted that staff felt uncomfortable with the belief that they should be able to predict violent incidents and were concerned about the frequency with which violence occurred. They felt that there was a lack of support/protection from the hospital.

One cross-sectional study (Thomas et al. 1995) examined staff attitudes toward service user safety. Seventy five percent of nurses rated both themselves and service users as safe. However a smaller (unspecified) number of nurses stated that they believed that service users actually felt safe.

An overt researcher-as-participant study (Quirk et al. 2004) considered strategies used by service users to keep safe in adult psychiatric in-patient settings. The study was supplemented by interviews with staff, service users and advocacy work, as well as by results from a national audit. The following strategies for managing risk of violence were identified: avoiding risky situations, avoiding service users who explicitly warned others to keep away, finding a safe haven (like a bedroom), getting 'specialled' or not resisting it, using de-escalation techniques, allying oneself with someone high in the 'pecking order', making risk assessments of other service users (including proactive information gathering), warning staff about another service user, and getting discharged. The authors note that avoidance tactics were harder to employ in certain circumstances, like the canteen, where service users had to rely more heavily on staff. The authors concluded that service users take an active role in making a safe environment for themselves and are not passive recipients of safety interventions by staff. They suggest that, in part, this results from feeling unable to rely on staff to ensure their safety.

I.b Review question: what impact does disturbed/violent behaviour in psychiatric in-patient settings have on staff and or service users?

Using mostly interviews and/or questionnaires one study (Wykes and Whittington 1998), used a case-control design; one study (Cheung et al. 1997), used a cross-sectional approach; eight studies were identified which sought to examined the impact of violence on staff. None were found that looked at the general impact of violence on service users.

Two studies looked specifically at the impact of physical assault. Poster and Ryan (1989) tracked staff responses to physical assault over the course of a year. Although the authors noted that 82 per cent of nurses had resolved the crisis by week six, they also noted that 21 per cent of staff met responder criteria six months after the event, and 16 per cent met responder criteria one year after the event. The authors argue that there is a need to support staff to help them cope with their responses to physical assault. Omérov (2002) used interviews to assess the impact of physical attack and found that 43 per cent of staff felt insulted by the attack and one-third of staff felt angry. Men were more likely to be frightened ($p<0.05$) and women were more likely to feel surprised ($p<0.01$) regardless of the outcome of the assault. Most staff felt very uncomfortable after the assault, brought the incident home, found it hard to relax, had frequent nightmares and found returning to work difficult. All but one staff member would have welcomed self-defence training and refresher courses. The majority of staff requested some kind of post-incident debriefing. Interviews were performed three days after an incident. There was no long-term follow-up.

Wykes and Whittington (1998) noted a significant difference between non-assaulted and assaulted nurses in terms of psychological distress in relation to the general health questionnaire anxiety scale. Participants were assessed twice – once within 10 days of the incident and once approximately four weeks later. Comparisons were made with baseline scores in a control group. There was a decrease in distress levels between the first time and the second. However, two new victims met the diagnosis criteria for post-traumatic stress disorder (PTSD) at the second time, according to the post-traumatic stress scale (PTSS).

In debriefing procedures, it was noted (Flannery et al. 1995) that staff who had been verbally assaulted had similar PTSD-like symptoms and disruption in mastery and meaning similar to those who had suffered physical or sexual assault. Time between debriefing and incident is not specified. There was no long-term follow-up.

Using SOAS, Cheung et al. (1997) noted that one-third of staff were emotionally shaken by the incidents they had been involved in, even though the rate of injuries requiring treatment was low.

Gillig et al. (1998) noted that 18 per cent of the staff they interviewed were considering changing their careers because of the emotional impact of violence/aggression.

In a questionnaire survey of Swedish and UK nurses (Nolan et al. 2001) it was found that less support was available for UK nurses following an incident ($p<0.01$), although they were significantly more likely to experience violence ($p<001$), sustain minor injuries and experience violence involving a weapon ($p<0.05$) than Swedish nurses. UK nurses reported lower self-esteem ($p<0.05$), and if they had experienced violence in the preceding 12 months were more likely than their Swedish counterparts to always find their jobs psychologically taxing ($p<0.05$). In the study overall, a significant positive correlation was found between self-esteem and feedback from line managers ($p<0.05$).

In a further questionnaire survey of Swedish nurses (Soares et al. 2000), it was noted that victims of violence were more likely to be less satisfied with their salary ($p<0.05$), complain of insufficient lighting and poor ventilation ($p<0.001$) complain about noise ($p<0.001$), find their psychological environment taxing ($p<0.005$), report that their work site was unpleasant ($p<0.005$), feel restless ($p<0.05$), feel less proud of their organisation ($p<0.005$), and state that they lacked resources ($p<0.005$).

I.c Review question: what are staff and service users' attitudes towards the short-term management of disturbed/violent behaviour?

Eight studies attempted to elicit nurses' attitudes toward the management of disturbed/violent incidents.

Support/control emerged as a major theme in one survey (Lowe et al, 2002). Junior nurses were more likely to place an emphasis on limit setting and controlling strategies than senior nurses. Roper and Anderson (1991) conducted an ethnographic study on an in-patient emergency psychiatric unit to explore the variables underlying service user/staff interactions that might lead to violent incidents. Staff control emerged as a key theme, along with staff tension, helplessness/hopelessness, and counter-transference.

In a phenomological study, Cutcliffe (1999) noted a relationship between a nurse's ability to deal with an incident in a manner that promoted a therapeutic outcome and the nurse feeling supported in their work. Whilst there may not be a causal relationship between these two outcomes, this finding suggests the importance to nurses of being able to maintain a therapeutic relationship with service users.

Using semi-structured interviews, Spokes et al. (2002) found that nurses identified three key areas related to violence management: their clinical skills, personal characteristics (such as an ability to remain calm), and interpersonal skills.

Employing causal modelling, Morrison (1993) noted that psychiatric nurses disagree amongst themselves over how to define the seriousness of an incident.

Cutcliffe (1998) also noted that the decision to report an incident as violent depended on the therapeutic relationship between nurse and service user. Using unstructured interviews, Critchon (1997) noted that nurses' management strategies were dependent on the diagnosis and gender of the service users, as well as the seriousness of the aggressive action. For example, seclusion was felt more appropriate for male service users.

Again using unstructured interviews, this time with video vignettes, Critchon et al. (1998) noted that Canadian nurses tended to advocate more controlling measures – like PRN medication and seclusion – whilst UK nurses tended to opt for less controlling techniques – like de-escalation. UK nurses were also more likely to talk to the service user about what had happened.

Using a phenomenological approach, Carlsson et al. (2000) identified seven themes underlying nurses management strategies: respecting one's fear, respecting the client, touch, dialogue, situated knowledge, stability, mutual regard, and pliability.

Five studies examined service user perspectives of violence in psychiatric in-patient settings. Three studies used questionnaires; one study (Kumar and Ng 2001) conducted a focus group; and one study (Lancee 1995) used role-play scenarios.

One survey (Svensson and Hansson 1994) assessed the effect of personality traits, diagnosis and perceived coercion on service users' satisfaction with psychiatric in-patient settings. It was noted that service users with a higher level of 'trait aggressive nonconformity' were significantly less satisfied with the ward's physical and psychosocial environment ($p<0.05$), the treatment design ($p<0.05$) and the treatment programme ($p<0.05$). Service users with a higher level of trait sociability were more satisfied with the treatment programme ($p<0.05$). Service users with affective disorders had significantly better satisfaction than service users with schizophrenia concerning: information and influence ($p=0.004$), ward environment ($p=0.005$) and general satisfaction ($p=0.003$). Service users who were involuntarily admitted were less satisfied with care in the areas of staff-patient relationship, ward environment, treatment programme and general satisfaction ($p<0.001$). A significant two-way interaction was detected between perceived coercion and the personality trait, aggressive nonconformity ($p=0.05$). Service users who perceived improvement in their condition had higher satisfaction with ward environment ($p<0.01$), treatment design ($p<0.01$), treatment programme ($p<0.001$) and general satisfaction ($p<0.01$). The phenomenon of acquiescence was not related to reported levels of satisfaction. The authors comment that careful consideration needs to be given to how to collect satisfaction scores from service users with schizophrenia or who perceived coercion in connection with their treatment.

Another survey (Gillig et al. 1998) noted that service users reported more depression and worry ($p<0.05$) and a change in appetite ($p<0.05$) than staff as a result of violence in psychiatric in-patient settings.

A further survey (Thomas et al. 1995) investigated service user reactions to being assaulted. They noted that female service users were more likely than their male counterparts to feel happy with staff responses to an incident (39 per cent vs. 23 per cent). However, they noted that women were less likely than men to feel safe on the wards (57 per cent vs. 81 per cent).

Six service users took part in a focus group (Kumar 2001) to discuss the experiences of being either perpetrators, victims or witnesses of violence. Several members fell into several or all of these categories. Six overarching themes were identified: firstly, that an imbalance of power exists in the mental health system; secondly, that violence has psychological sequelae; thirdly, that the mental health service is not geared to help victims of 'institutional violence'; fourthly, that the present mental health system fosters violence; fifthly, that a radical change is needed in the infrastructure of the mental health system; and sixthly, that reinforcement and reform may come from parallel efforts by staff and service users. Although acknowledging that the results may not be generalisable to a wider population, the authors argue that information saturation was achieved.

Role-play was used (Lancee 1995) to assess service user responses to different limit setting styles. Ninety-six service users participated, with limit setting styles ranging from belittlement to affective involvement with options. Service user anger at a particular limit setting style was the primary outcome variable. Three independent variables were considered: limit setting style, impulsivity and diagnosis. All proved significant (limit setting $p<0.001$, impulsivity $p<0.001$, diagnosis, $p<0.05$). The interaction between diagnosis and style had a greater significant ($p<0.01$). For all diagnostic groups, belittlement was most likely to cause anger. Impulsive service users were more likely to respond with anger to all limit setting styles than non-impulsive service users; non impulsive users had low anger for three limit setting styles – solution with options, affective involvement without options, and affective involvement with options. Service users with high impulsivity only responded with low anger to affective involvement with options. The same was also true of service users with schizophrenia. The sample size was too small to make other diagnosis specific observations. The authors argue that the study confirms that interpersonal factors play an important role in the management of anger in adult psychiatric in-patient settings.

Lanza et al. (1994) used interviews to compare staff and service user recollection of a violent incident. She found that with regard to 'objective' measures – such as limit setting and service users' actions during assault – there was general agreement between staff and service users. However, with regard to 'subjective' measures – such as the relationship between staff and service users, content of service users' speech, loudness of speech, number of staff and service users involved, and the cause of the incident – there was much less agreement.

Evidence statements

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that staff and service users believe that building therapeutic relationships, in which service users feel respected, leads to less disturbed/violent incidents. Key areas to be addressed in building such relationships include limit setting, and imbalance of power.
Level 4	The limited evidence suggests that service users are adversely affected by in-patient disturbed/violent behaviour.

7.8.4.1.5 **Economic evidence**

No studies containing relevant economic data were found (see Appendix 9).

7.8.4.2 Minority ethnic groups

7.8.4.2.1 **Objectives**

No specific searches on minority ethnic groups were undertaken in the RCPsych guideline.

Current guideline

Two review questions were identified and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs).

- Does race/ethnicity of a service user or staff member make a difference to how they are treated when they are involved in a disturbed/violent incident in adult in-patient settings?
- Do staff and/or service users perceive that the race/ethnicity of a service user or staff member makes a difference to how they are treated when they are involved in a disturbed/violent incident in adult psychiatric in-patient settings?

7.8.4.2.2 **Selection criteria**

Types of studies

Systematic reviews to before and after studies. Qualitative studies were also included. (Evidence level 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- Impact of ethnicity on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
- Staff and service user perspectives on the impact of ethnicity on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
- Bias in treatment or diagnosis, (prevalence/incidence rates).
- Effects of ethnicity/race on service users and/or staff.

7.8.4.2.3 **Clinical evidence**

One hundred and sixty eight papers were identified by our searches. After sifting for duplicates and papers outside the scope, 41 were ordered. Only 23 of these papers were included. Ten were excluded. The rest were overviews or outside the scope of the review. There were 13 UK studies and 10 US studies. Some of the US studies are based in psychiatric services for veterans (ex-military), a specialised population. Study settings varied from general acute psychiatric to specialist services – forensic or psychiatric intensive care. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6).

To supplement the evidence base for this review we also conducted three focus groups, two with black service users and one with health care professionals with expertise in working with black service users (see Appendix 14).

Included papers covered three broad areas that fall within the scope of the guideline: prediction, interventions and admission. Special review questions were devised to focus the review in each of these areas.

I Prediction

Seventeen studies were identified which addressed these questions. A range of study designs and perspectives were examined, making the results difficult to synthesis.

I.a Review question: can disturbed/violent behaviour in psychiatric in-patient settings be linked to ethnicity?

The following studies suggested that black and minority ethnic service users exhibited higher levels of violence toward others than white service users: Dixon (2000); Commander et al. (1997a), (1997b); Sheehan et al. (1995); Lloyd and Moodley (1992); Chen et al. (1991); Chu, (1985); Lawson et al. (1984). Six of these were UK studies Dixon et al. (2000); Commander et al. (1997a); Commander et al. (1997b); Sheehan et al. 1995, Lloyd and Moodley 1992; Chen et al. (1991); and two were US studies (Chu, 1985; Lawson 1984). Four were prospective studies: Commander et al. (1997a); Commander et al. (1997b); Chu (1985); Lawson et al. (1984); two retrospective chart reviews (Dixon 2000; Sheehan et al. 1995); one cross sectional (Lloyd and Moodley 1992) and one case-control (Chen 1991).

The following studies found that levels of violence towards others were not related to ethnicity: Kho et al. (1998), a UK prospective study; and Feinstein and Holloway (2002), a UK cross sectional study. In addition, a qualitative UK study by Morley et al. (1991) found that 53 per cent of service users who were sectioned were not considered dangerous by their relatives.

The following studies suggested that other ethnic groups exhibited higher levels of violence toward others than black and minority ethnic service users: Kho et al. (1998) showed Asian patients to be more aggressive. Lawson et al. (1984) showed whites to be more violent, to make more threats and to commit more self-destructive acts.

Evidence statement

Level of evidence	Evidence statement
Level 4	The limited evidence from these studies is conflicting; it is therefore not possible to ascertain if different cultural groups exhibit higher or lower levels of disturbed/violent behaviour than other groups.

I.b Review question: are the tools used to predict disturbed/violent behaviour in psychiatric in-patient settings ethnically/racially biased?

A large number of tools were identified in the prediction evidence review. The majority of these make no mention of testing for racial bias. Therefore, it must be presumed that they have not been tested for racial bias. This is the case for the following tools which were found to indicate that black service users were more likely to be violent than white service users: Chu (1985) using the brief psychiatric rating scale and the Itil-Keskiner psychopathology rating scale.

Hutton et al. (1992) found that the overt hostility scale tended to suggest a greater propensity for aggressive or violent acts amongst black service users than occurred amongst white service users, and could lead to an erroneous interpretation as race was the only variable to emerge as a determinant of over hostility.

Choca et al. (1990) tested the cultural sensitivity of the Millon clinical multiaxial inventory to assess whether it was culturally fair. This personality instrument has weighted scores to provide different norms for black, white and Hispanic individuals to address potential bias. This study concluded that this test was a useful tool for prediction that takes account of racial bias, however some adjustment is needed to the item and scale levels.

Clinician prediction was also found to be at risk of racial bias: Hoptman et al. (1999) a US prospective study; McNiel and Binder (1995) a US retrospective chart review; and Strakowski et al. (1995) a US retrospective chart review. Minnis et al. (2001) surveyed British psychiatrists to test assessment bias in relation to violence. They suggested that racial stereotyping did not occur at first interview. Silver (2000) illustrates the effect of confounding according to the locality of the individual's residence and how this may effect reporting of results of violent incidents. Reubin et al. (1997) suggested that elevated levels of the enzyme creatine kinase can be used as a biological marker to predict aggression amongst African Americans. This finding could not verified from any other study.

Evidence statement

Level of evidence	Evidence statement
Level 4	On the basis of the available evidence, it is not possible to determine a 'gold standard' tool for the prediction of disturbed/violent behaviour appropriate for use amongst different ethnic groups.

II Interventions

II.a Review question: is intervention choice for the short-term management of disturbed/violent behaviour ethnically/racially biased?

One study specifically addressed this question.

Chen et al. (1991) found a significantly higher number of African Caribbean service users were given high dose neuroleptic medication for disturbed/violent behaviour than service users from other ethnic backgrounds ($p<0.03$).

Evidence statement

Level of evidence	Evidence statement
Level 4	There is insufficient evidence (one study) to assess whether African Caribbean service users are given rapid tranquillisation more often than service users from other ethnic backgrounds.

II.b Review question: do staff and/or service users perceive that the race/ethnicity of a service user or staff member makes a difference to how they are treated when they are involved in a disturbed/violent incident in adult psychiatric in-patient settings?

Three studies examined attitudes of service users towards violence management in psychiatric in-patient settings in relation to ethnicity.

A qualitative UK study (Secker and Harding 2002), proposed key themes arising from interviews with African Caribbean service users relating to loss of control, experiences of racism and relationships with staff. Relationships with staff are very rarely experienced as positive.

A prospective UK study (Commander et al. 1997a), found that Asian and white service users are significantly more satisfied with in-patient treatment than black service users.

A UK descriptive survey (Wilson and Francis 1997), found that African Caribbean service users and African service users felt misunderstood as a consequence of being feared, ignored or stereotyped.

The two focus groups that the NCC-NSC commissioned from black service user organisations found that black service users perceived that they were given more restrictive interventions because of their race/ethnicity (see Appendix 14).

No studies were identified that examined staff perspectives on race/ethnicity in relation to the use of the interventions considered in this guideline for the short-term management of disturbed/violent behaviours in psychiatric in-patient settings.

The focus group which the NCC-NSC ran with nine health care professional who had experience of working with black and minority ethnic service users found that these health care professionals felt that the short-term management of disturbed/violent behaviour in the UK is racially/ethnically biased (see Appendix 14).

Evidence statements

Level of evidence	Evidence statement
Level 4	The limited evidence base suggests that black/ethnic service users perceive that there is racial/ethnic bias in staff choice of intervention for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings. Staff-service user relationships, and feelings of being stereotyped, ignored and afraid, are key areas of concerns for this group.
Level 4	Limited evidence from a focus group suggest that staff perceive that there is racial/ethnic bias in staff choice of intervention for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

III Admission

III.a Review question: are admission procedures ethnically/racially biased?

Commander et al. (1997a) mapped the pathways to admission for three ethnic groups (black, white and Asian). This study found that black service users were less likely to be receiving care from a health care professional prior to admission and that two-thirds of admissions involved the police.

Involvement of the police was examined in two studies, both from the US. Morley (1991) identified the role of police in admissions to hospital for African Caribbean service users experiencing psychotic symptoms. Commander et al. (1997a) noted that two-thirds of African Caribbean service user admissions involved the police and that the admission of Asian service users also had a higher level of police involvement than the admission of white service users. As both are US studies, it is difficult to generalise from them to the UK population. However, the two focus groups that the NCC-NSC ran with black service users also found that police involvement was often mentioned in connection with admission (see Appendix 14). Again, it is not possible to generalise on the basis of this small study to the UK population in general.

Evidence statement

Level of evidence	Evidence statement
Level 4	Limited evidence suggests that black service users may be likely to have experienced police involvement during the admission process.

7.8.4.2.4 **Economic evidence**

No studies containing relevant economic data were found (see Appendix 9).

7.8.4.3 Gender

7.8.4.3.1 **Objectives**

No specific searches on gender were undertaken in the RCPsych guideline.

Current guideline

Two review questions were identified and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs).

- What impact does gender have on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?
- What are staff and service users' perspectives on whether gender has an impact on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?

7.8.4.3.2 **Selection criteria**

Types of studies

Systematic reviews to before and after studies. Qualitative studies were also included. (Evidence levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcomes

- Impact of gender on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
- Staff and service user perspectives on the impact of gender on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

7.8.4.3.3 **Search strategy**

Searches were run from 1998-2003/6, to capture current legislation, attitudes and organisation of care.

7.8.4.3.4 **Clinical evidence**

Three hundred and seventeen studies were identified in the initial sift. After sifting for relevance and duplicates, 20 full papers were ordered. Three met the inclusion criteria and 14 were excluded. All the other papers were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review. References were checked but no further studies were identified. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6).

Included studies

I Review question: what impact does gender have on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?

One study was included that considered the gender differences among perpetrators of violent assaults resulting in injury to staff: a case-control study in the US (Lam et al. 2000). This study showed no difference in the proportion of male and female psychiatric in-patients perpetrating such violence (20 per cent of male patients vs. 18 per cent of female patients).

No studies were found that answered the question of whether male and female perpetrators of violence in the in-patient psychiatric setting were treated differently.

One small cross-sectional survey of 59 psychiatric inpatients (31 males, 28 females, representing only 39 per cent of eligible patients) was included that considered the different experiences of male and female patients who were potential or actual victims of other patients (Thomas et al. 1995). A similar proportion of the men and women reported harassment (physical or verbal or sexual) by other patients (68 per cent of males and 75 per cent of females) or having been hit (42 per cent of males and 36 per cent of females). More women were molested sexually (32 per cent of females and 7 per cent of males, $p=0.01$) and fewer females felt safe on the wards (57 per cent vs. 81 per cent of males, $p=0.05$). While many incidents were not reported to staff, more females were satisfied with the staff response when they did report an incident (25 per cent vs. 7 per cent of males, $p=0.05$). However, the small and possibly unrepresentative sample precludes generalisation from this data.

One case-control study from the US, involving more than 200 staff over a period of 2.5 years, examined whether the gender of staff was a factor in the risk of being assaulted by a psychiatric in-patient (Binder and McNiel 1994). In this study, staff gender was not associated with the risk of being assaulted for doctors, nurses or both disciplines together, but nurses were more likely to be assaulted than doctors.

Evidence statement

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that the gender of staff or service users does not impact on the incidence of disturbed/violent behaviour in psychiatric in-patient settings.

II. Review question: what are staff and service users' perspectives on whether gender has an impact on the short-term management of disturbed/violent in in-patient psychiatric settings?

No studies addressed this review question.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is no evidence to determine staff and service user perspectives on the impact or influence of gender on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

7.8.4.3.5 **Economic evidence**

No studies containing relevant economic data were found (see Appendix 9).

7.8.4.4 Other special concerns

7.8.4.4.1 **Objectives**

No specific searches on other special concerns were undertaken in the RCPsych guideline.

Current guideline

Two review questions were identified and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs).

- What special considerations are needed in the short-term management of disturbed/violent behaviour where the service user has physical disabilities?
- What are the staff and service users' perspectives of the considerations needed for the short-term management of disturbed/violent behaviour where the service user has physical disabilities?

7.8.4.4.2 **Selection criteria**

Types of studies

Systematic reviews to before and after studies. Qualitative studies were also included. (Evidence levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- Impact of special concerns on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
- Staff and service user perspectives on the impact of special concerns on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

7.8.4.4.3 **Search strategies**

Searches were run from 1998-2003/6, to capture current legislation, attitudes and organisation of care.

7.8.4.4.4 **Clinical evidence**

Nine papers were found in our searches. However all were excluded as none of them addressed the review questions.

Evidence statements

Level of evidence	Evidence statement
Level 4	There is no evidence that identifies the special considerations that are needed in relation to the short-term management of disturbed/violent behaviour where the service user has physical disabilities.
Level 4	There is no evidence to determine staff and service users' perspectives on what special considerations are required in relation to the short-term management of disturbed/violent behaviour where the service user has physical disabilities.

7.8.4.4.5 **Economic evidence**

No studies containing relevant economic data were found (see Appendix 9).

7.8.5 Psychosocial interventions

Original RCPsych guideline

The original RCPsych evidence review covering all psychological interventions, including both de-escalation techniques and observation, was examined. Their searches were undertaken based on the following review questions and hypotheses:

RCPsych review questions

- Can psychological interventions have the effects of reducing aggressive behaviour?
- Are particular psychological interventions more effective in reducing aggressive behaviour?

RCPsych hypotheses

- That psychological interventions can have the effect of reducing levels of disturbed/violent behaviour.

RCPsych sub-hypotheses

- That psychological interventions have no effect in reducing levels of aggressive behaviour.
- That particular psychological interventions are more effective in reducing levels of aggressive behaviour.
- That psychological interventions are similar in terms of reducing aggressive behaviour.

After sifting and quality checks, only eight papers relating to psychological interventions were included by the RCPsych reviewer.

The reviewer indicated that no evidence had been found on which evidence-based recommendations could be made:

> In conclusion, I found it impossible to answer our original hypotheses. We had no good evidence to support any of our original hypotheses. [...] We are unable to comment on whether any intervention is more effective that any other in reducing levels of aggression (RCPsych unpublished evidence review).

7.8.5.1 De-escalation techniques

7.8.5.1.1 **Objectives**

Current guideline

The current guideline focuses more specifically on particular psychological interventions – that is, de-escalation and observation. Two review questions were identified and used to inform the search strategy (see Appendix 4 for search strategy, databases searched and search logs).

Review questions:

- Are psychosocial techniques, such as de-escalation, effective in pre-empting, dissipating or preventing disturbed/violent behaviour in adult psychiatric in-patient settings?
- What are staff and service users' views about the effectiveness and appropriateness of de-escalation techniques as a means of diffusing disturbed/violent and potentially violent situations in adult psychiatric in-patient settings?

7.8.5.1.2 **Selection criteria**

Types of studies

Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- The effectiveness of de-escalation techniques at decreasing the number of disturbed/violent incidents and potentially violent incidents without the use of other interventions.
- Staff and service user perspectives on de-escalation techniques.

7.8.5.1.3 **Clinical evidence**

One hundred and ten studies were identified in the initial sift. After sifting for relevance and duplicates, 10 full papers were ordered. Seven were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review. References were checked and four further studies were identified and ordered. However, only four studies were primary research papers, three of which proved relevant to the research question. No study offered evidence above level III. No additional studies from the RCPsych review were included. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6).

Included studies

A prospective observation study (Jambunathan and Bellaire 1996) attempted to evaluate the effectiveness of crisis prevention (CPI) techniques in preventing the need for mechanical restraint and seclusion. Techniques were assigned levels and these were linked with a stage of escalation (see table below). Ten registered nurses prospectively collected data in four-hour shifts. All were trained in CPI on 12-hour initial training and four-hour refresher course. The study evaluated aggressive incidents including a wide cross-section of psychiatric patients in a state-run in-patient psychiatric facility. The study suggests that CPI techniques allow most conflict situations (84.2 per cent) to be resolved without the need for mechanical

Table 3 Outline of CPI techniques

Escalation level and associated behaviour	LEVEL 1: Anxiety (Change or increase in behaviours such as crying, pacing, rocking, wringing hands, raising voice)	LEVEL 2: Defensive (Begins to loose rationality, becomes verbal, yelling, belligerent, sarcastic, intimidates, uses verbal threats, shakes fists)	LEVEL 3: Acting out (Loses control, physical episode)	LEVEL 4: Tension reduction (Regains control)
CPI techniques used	Supportive, emphatic, active listening, asking questions, discussing thoughts/feelings, reducing stimuli, refocusing tasks, offering medication as needed.	Limit setting, allow verbal release, isolate situation, assemble a team, planning for de-escalation or physical control.	Physically holding patient, escorting patient to safe area, mechanical restraints or seclusion if CPI unsuccessful.	Attempt to regain therapeutic rapport, coping mechanisms, contracting.

(N.B. Most CPI techniques were verbal de-escalation techniques, however physical restraint is included in the third stage as a CPI technique.)

restraint or seclusion. Most service users' behaviour cues (76.6 per cent) and most staff interventions (69.4 per cent) occurred at level 2. However, there appeared to be a lack of intervention at level 1. It was also noted that more than 50 per cent of the incidents occurred on admission units. More medication was administered where staff did not have an in-depth knowledge of the service users.

While the study is reasonably designed, it is a non-experimental pilot study, observers were not blinded to either staff or service users, and staff were informed that observations would be carried out prior to the study. The results also do not allow the different service user groups to be analysed independently. No supporting evidence is offered for selection of antecedents of violence, or for their division into four levels of escalation. Supporting evidence is also lacking with regard to the relationship between levels of escalation and CPI techniques.

A before and after study at a veterans' medical centre, (Richmond et al. 1996) also measured whether the implementation of de-escalation techniques reduced the use of restraint and seclusion – unlike Jambunathan and Bellaire (1996), they did not treat physical restraint as a de-escalation technique. They suggested that training in verbal de-escalation, 'time out', relaxation techniques, medication, diversional activities and decreased stimulation led to a 47 per cent decrease in restraint use and a 31 per cent decrease in the use of seclusion. Whilst these results seem promising, the study design is non-experimental and confounders are not explored.

Staff perspectives

A qualitative study (Johnson and Hauser 2001) used unstructured interviews to elicit nurses' views on how to de-escalate the escalating service user. The author reported that expert nurses were able to develop an awareness of where service users are on the continuum of escalation, noticing early behavioural and verbal signs, which allowed them to successfully implement de-escalation techniques. However, the sample size was very small, and the method non-experimental.

Service user perspectives

A triangulation study using incident forms, questionnaires and interviews, (Duxbury 2002), noted that service users were not aware of staff using de-escalation techniques ($p<0.000$).

The RCPsych review did not include any studies that evaluated de-escalation techniques. Therefore the findings of this review alter those of the RCPsych psychosocial interventions review, although the evidence presented above is limited.

Evidence statement

Level of evidence	Evidence statement
Level 4	The limited evidence suggests that de-escalation techniques decrease rates of disturbed/violent behaviour.

7.8.5.1.4 Economic evidence

No studies containing relevant economic data were found (see Appendix 9).

7.8.5.2 Observation

7.8.5.2.1 Objectives

Current guideline

Two review questions were identified and used to inform all searches (see Appendix 4 for search strategy, databases searched and search logs).

Review questions:

- Are psychosocial techniques, such as observation, effective in pre-empting and preventing disturbed/violent behaviour in adult psychiatric in-patient settings?

- What are staff and service users' views about the effectiveness and appropriateness of observation as a means of pre-empting and preventing disturbed/violent and potentially violent situations in adult psychiatric in-patient settings?

7.8.5.2.2 **Selection criteria**

Types of studies

Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence Levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- The effectiveness of observation techniques at decreasing the number of disturbed/violent incidents and potentially violent incidents, without the use of other interventions.
- Staff and service user perspectives on observation techniques.

Types of outcome excluded

- Observation which pertained to suicide or self-harm.
- Observation in non-psychiatric in-patient care settings.

7.8.5.2.3 **Clinical evidence**

Seventy-five studies were identified in the initial sift. After sifting for relevance and duplicates 22 full papers were ordered. However, 12 were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review.

Fourteen studies were primary research, however, only nine studies proved relevant to the research question. No study offers evidence above level III. References were checked for missing articles but no further relevant primary studies were identified. No additional studies from the RCPsych review were included. (Evidence tables of included studies are found in Appendix 5. Evidence tables of excluded tables are found in Appendix 6).

Appraisal of methodological quality

In addition to the quality concerns mentioned above, these studies raised the following methodological concerns:

- Most of the studies (with the exception of Bowles and Dodds 2001; Shugar and Rehaluk 1990) did not address the question of effectiveness.

These studies were included to provide a systematic review of the research that has been conducted on observation in psychiatric in-patient settings. Gaps in the research can be readily identified and low graded evidence statements were presented to assist the GDG in their deliberations.

Included studies

Several statewide surveys to establish the reason why constant observation (CO) was used have been conducted in the US. Torkelson and Dobal (1999) carried out a six-month statewide survey focusing primarily on surgical and medical units and their use of CO. Stratified randomisation was used to select hospitals. Authors found that the decision to initiate and discontinue CO could be made by a wide spectrum of people (clinician, nurse, family member). The most common reason for CO was either danger to self or others. Although 84/89 hospitals agreed to participate, very little information on cost was provided. The results are difficult to analyse from the perspective of violence to others, since this is not differentiated from violence to self. The analysis is also flawed. No firm conclusions of the effectiveness of CO are offered.

Moore et al. (1995) also undertook a statewide survey. Hospitals were selected by stratified randomisation; 19/26 agreed to participate, however only 15 made use of constant observation (CO). Of these, only six were psychiatric hospitals. Again a wide spectrum of people made the decision to initiate CO. Those observing requested more training and information. There was a lack of information on costs. No attempt was made to differentiate between different interpretations of CO. The hospitals that used CO to combat violence are not specified.

Bowers et al. (2000) carried out a random stratified sample survey of constant observation (CO) policies in England and Wales. There was no consistency amongst trusts (see Evidence table for full details). Of 26 policies supplied, only two used the same terminology – constant observation had different meanings in different locations; level 1 meant either high or low levels of observation. Differences also existed between official policy and questionnaire responses. It was noted that this is particularly worrying, as agency staff are often used to carry out CO. The report does not discuss the effectiveness of CO.

Shugar and Rehluk (1990) conducted a retrospective controlled cohort study to consider the effectiveness of close observation (CO). Carried out in a psychiatric teaching unit, this study examined the use of CO in both civil and forensic patients. Various predictors signalling the need for CO were identified. However, most patients had CO supplemented by medication, so that it is difficult to assess the efficacy of CO. The authors acknowledge this and therefore only offer tentative conclusions. The authors suggest that CO should only be used as a short-term measure but offer no evidence. While an interesting study, the design is weak and the conclusions may therefore be limited.

Philips et al. (1977b) used a retrospective/historic two-year cross-sectional survey to assess whether a correlation existed between involvement in constant observation (CO) and absenteeism. A statistically positive correlation ($p<0.05$) was noted. Discrepancies were explained in terms of reduced staffing levels forcing a reduction in CO, and high demand for CO obligating nurses not to take sick leave. There is a lack of essential information in this study. The conclusions drawn should be interpreted with caution.

Philips et al. (1977a) identified the type of service users who usually receive continuous observation (CO). Using a retrospective 10-year cohort study, they found that service users receiving CO were most likely to be female and suffering from either schizophrenia or depression. (CO was used for suicide risk for both types of service users, and for behavioural reasons with service users suffering from schizophrenia). The age range for service users with depression was between 30-50, while for schizophrenia, it was between 15-29 years and 35-40 years. Staff concerns about CO related to the length of time an individual nurse was engaged in CO (entire shift) and the effect of CO on other service users and staff within the ward. Seventy-five percent were in favour of a special unit for CO, with 45 per cent suggesting they would be prepared to work there full-time, 34 per cent sometimes and 21 per cent never. The author stresses that more research is necessary to elicit the therapeutic value of CO – a procedure that is identified as cost effective but time consuming.

Bowles and Dodds (2001) report the effect of dismantling the formal observation policy in a 21-bedded acute ward in Bradford. They argue that formal observation became redundant and, after 18 months, one-to-one observation was not used at all, with five to 10 minute checks used only rarely. The number of suicides did not increase, but the levels of absconding were almost halved, with self-harm falling by two-thirds and violence and aggression by a third. Staff sickness was also reduced by two-thirds. Removal of the policy has also meant a saving of £45,000 over 12 months. They state that service users are now more involved in their care and in ward decisions. The authors argue that the removal of this policy – which they describe as an 'outmoded ritual of mental health nursing' – has freed up nurses' time, allowing activities to be set up and time to be 'gifted' to service users as required. Ninety-five percent of service users now receive daily one-to-one time with a nurse, which the authors argue is the most valuable intervention. While the authors acknowledge that the study is too small for the results to be generalised, they insist that it should bring the practice of formal observation into question. This study does not provide enough information about their previous formal observation policy and so is open to a number of interpretations. The one-to-one interventions implemented, once formal observation was dismantled, could be viewed as a more therapeutic and appropriate form of formal observation.

A three-and-a-half month prospective audit was conducted in a psychiatric intensive care unit (Lehane and Rees 1996). It examined responses to incidents that would have formerly led to seclusion. The author notes that one-to-one nursing was used in 86 per cent of cases but does not offer any information on its effectiveness. The sample size is relatively small.

Service user perspectives

One study examined service user perspectives on observation. Jones et al. (2000) conducted a three-month survey in one mental health trust to assess service users' feelings about and preferences within constant and close observation – the highest level out of four levels employed within the trust. The study revealed that mental health service users – including those who exhibited aggressive behaviour, but particularly those with suicidal tendencies – preferred to be observed and felt safest when observed by either nurses they knew or nurses who talked to them.

Staff perspectives

One study considered staff perspectives on observation. Neilson and Brennan (2001) carried out a retrospective/historic audit to determine staff knowledge of and attitudes toward a new hospital special observation (SO) policy and differences between wards with respect to these two variables. This was assessed by a knowledge questionnaire, semi-structured interviews and a score-schedule of a randomised sample of 144 special observation record sheets (SORS). The hospital policy had four levels of SO – red, amber, blue and green – in order of decreasing urgency. Nurses were purposely selected to ensure a broad mix of trained and untrained staff. All staff demonstrated good knowledge of the policy. However, although 35.29 per cent stated that communication and documentation had improved since its implementation, authorising signatures and reasons for SO were often not stated. Staff also felt that decisions about SO were too medically driven (94.2 per cent) and that there was poor medical review of SO (32.36 per cent). In addition, 82.4 per cent felt that blue level was used too frequently, without clinical assessment of need. They also stated that it was impossible for staffing levels to meet current demands of SO (73.6 per cent); 29.41 per cent felt that red level could provoke disturbed patients and 23.6 per cent felt that gender needed greater consideration when allocating staff to SO.

Yonge and Stewin (1992) conducted qualitative research using 'ethnography' – a programme for textual analysis. Findings suggested that close observation (CO) is a procedure that nurses find stressful. Nurses felt that they were also on CO and had to find ways of dealing with emotions caused by this encounter. Meal times and bathroom visits were flagged up as particularly stressful for nurses. None of the nurses interviewed accompanied the patient into the bathroom, even where this was in breach of hospital policy. Nurses also supported one another in handover, attempting to limit the repetitive questions for the patient. At the same time, some saw CO as an opportunity to develop a quality relationship with the patient. Nurses expressed different preferences for certain types of CO patients – psychotic, depressed.

The RCPsych review did not include any studies that evaluated observation. Therefore the findings of this review alter the findings of the RCPsych psychosocial interventions review, although the evidence presented above is limited.

Evidence statements

Level of evidence	Evidence statement
Level 4	It is not possible to ascertain the effectiveness of observation on the basis of the available evidence.
Level 4	The limited evidence suggests that service users prefer to be observed by a nurse that they know and that most staff find observation a stressful procedure.

7.8.5.2.4 **Economic evidence**

No studies containing relevant economic data were found (see Appendix 9).

7.8.6 Other interventions

7.8.6.1 Physical interventions and seclusion

7.8.6.1.1 **Objectives**

The original RCPsych guideline evidence base on restraint and seclusion was examined. A list of excluded studies was available in the archived information received from the Royal College of Psychiatrists' Research Institute. The following information was taken from the final report in the RCPsych guideline, which states that these hypotheses were used to inform their search strategies:

RCPsych hypothesis:

- Restraint when skilfully applied by trained and supervised staff, according to monitored protocols and the context of other methods, is an effective and safe means of coping with overtly violent behaviour.
- When properly used and explained, restraint can be acceptable both to users of services and to staff.
- Seclusion is unnecessary if restraint is properly applied in association with other methods of good practice.

After sifting and quality checks, 16 references on restraint and seclusion were included in the RCPsych evidence review.

However, the included studies did not offer generalisable criteria in support of these hypothesis so the RCPsych review concluded that:

No strongly evidence-based conclusions can be drawn from the quantitative evidence.

Current guideline

Three review questions were identified and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs). Physical intervention includes the use of pain compliance.

Review questions

- Is physical intervention safe and effective for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?
- Is seclusion safe and effective for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?
- What are service users' perspectives on the use of physical intervention and seclusion for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?

7.8.6.1.2 **Selection criteria**

Types of study

Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence levels 1-2).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- Effectiveness and safety of various physical interventions and seclusion when used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
- Staff and service user perspectives on physical interventions and seclusion when used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

7.8.6.1.3 **Clinical evidence**

One hundred and thirty three studies were identified in the initial sift. After sifting for relevance and duplicates 84 full papers were ordered. After quality appraisal, 21 papers were included, seven papers were excluded and 60 were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review. References were checked and 14 further studies were identified and ordered. None met the inclusion criteria. In addition, 10 studies from the RCPsych review were included. (Evidence tables of all included studies can be found in Appendix 5. Evidence tables of all excluded tables can be found in Appendix 6).

Quantitative evidence

A Cochrane review undertaken by Salias and Fenton (2001) focused on the effectiveness of restraint or seclusion or strategies designed to reduce the need for restraint or seclusion in the treatment of mental illness. It found no trials that met the minimum criteria. It concluded:

> In the absence of any controlled trials in those with serious mental illness, no recommendation can be made about the effectiveness, benefit or harmfulness of seclusion or restraint. In view of data from non-randomised studies, use should be minimised for ethical reasons.

This Cochrane systematic review is currently being updated. Contact with the author suggests that the conclusions are unlikely to change.

Four studies in the RCPsych review considered the role of the seclusion room in a psychiatric in-patient setting (Brooks et al. 1994; Craig et al. 1989; Hafner et al. 1989; Kingdon and Bakewell 1988). Two of these studies suggest that use of seclusion rooms reduce violent incidents. However, one study (Kingdon and Bakewell 1988) suggests that violent incidents are better reduced by improved staffing patterns, education and management participation. The fourth study (Brooks et al. 1994) suggests that both levels of restraint and seclusion are increased by overcrowding.

No studies examined the use of pain compliance in physical interventions.

Evidence statements

Level of evidence	Evidence statement
Level 4	There is insufficient evidence to determine the effectiveness and safety of either physical interventions or seclusion for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
Level 4	There is insufficient evidence to determine the effectiveness or acceptability of pain compliance as a technique for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

Sudden death

Evidence from published case series that link physical interventions to adverse reactions was collated (see Evidence tables of included studies, Appendix 5). It was not possible to determine whether there was a relationship between physical interventions and an increased likelihood of sudden death.

Three studies were conducted in attempt to show the relationship between restraint and positional asphyxia. Parkes (2000), Schmidt and Snowden (1999) and Chan et al. (1997) conducted experimental studies on healthy subjects. All suggest that restraint in the prone position does not result in effects likely to cause death and that other factors need to be in situ.

This issue was not specifically addressed in the RCPsych review.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is insufficient evidence to determine the relationship between physical interventions and sudden death.

Staff and service user perspectives

Six studies examined staff perspectives on physical intervention and seclusion:

One study focused on staff decision-making processes. A sample of 64 nurses – a response rate of 77 per cent – were asked about knowledge and experience gained, as well as values and concerns with regard to the practice of seclusion. Key themes emerged around safety and the abuse of seclusion. However, in a further study, nurses stated that seclusion had a place in real world practice (Alty 1997).

Muir-Cochrane (1996) found that, in a sample of seven nurses, the core underlying themes relating to the use of seclusion were control, and that staff saw themselves as gatekeepers who maintain control.

Mason (1997) took a random sample of 25 nurses in a forensic hospital and found decision-making around the use of physical interventions and seclusion to be based upon the need to stick to an original decision. They found that a feeling of being under the gaze of others in authority led to the need to balance the responsibility of an untoward incident, against care of the individual. Furthermore, they found that nurses felt a need to justify their actions to those in authority and therefore tended to adopt positions of safety.

Marangos-Frost and Wells (2000), in an ethnographic study, interviewed six nurses on an unlocked psychiatric ward. They found themes consistent with other studies presented here, in particular concerning the decision-making dilemma of choosing between risking harm to the patient and others, or restraining – both equally unwelcome options. However, the findings were based on those that self-harmed, as well as those that harmed others, and the nurses were very experienced, therefore not representative of the usual ward staff team.

Holzworth and Wills (1999) found a sample of nine nurses in a short-term psychiatric hospital had a preference for seclusion over restraint. However, they noted that overall, there was inconsistency between nursing staff in selecting seclusion, restraint or observation. Lemonidou (2002) conducted a descriptive survey of nurses' attitudes and choice of restrictive intervention. The study involved 190 nurses in adult psychiatric inpatients in five hospitals in Greece. The findings suggest that nurses prefer seclusion to restraint. It was also noted that nearly half of the service users continue to be aggressive after restraints were removed. However, this study focused on the use of mechanical restraints.

The RCPsych review also contained two further studies (Tooke and Brown 1992; Soliday 1985), which compared staff and service user perceptions of seclusion. Service users who had been secluded had less favourable attitudes towards seclusion than either staff or service users who had not been secluded. Some service users saw seclusion as punitive. However, other service users saw a need for seclusion. In one of the studies, staff stated that they could not see how they could cope without access to a seclusion room.

Four studies examined service user perspectives on physical intervention and seclusion:

A relatively recent UK-based study carried out by Sequeria and Halstead (2002) with a sample of 14 in-patients who had been interviewed 12 hours after being restrained, found emergent themes of anger with a sense of injustice, and that service users felt that the intervention was unwarranted. The researchers also noted that anxiety continued long after the incident, along with mental upset. Contrary to this, the study also found that female patients restrained by female staff welcomed the safe feeling of containment, which even led to them seeking restraint.

A study by Gallop et al. (1999) highlighted concerns raised about the effects of restraint on those who may have previously suffered sexual abuse. They found that service users reported negative experiences of being rendered powerless and being degraded. In this study, six out of the 10 participants were restrained for self-harm. Therefore, care is required whilst extrapolating to this review. Nevertheless the study highlights the need to be aware of previous history when considering this intervention.

Bonner et al. (2002) conducted a pilot study in the UK, where he interviewed two members of staff and a service user involved for each incident that resulted in physical restraint. Initial findings suggested that failed communication is an antecedent of restraint. The study further suggested that restraint was used as a last resort to contain and support the patient. The study also suggests that both patient and staff can suffer trauma and distress after the incident and that support, post incident, is important to both groups.

Using a questionnaire survey (Mann et al. 1993), suggested a range of attitudes towards the seclusion room, with only a minority of service users suggesting that there should be no such room. The authors noted that many service users reported that the room was helpful. They noted that these tended to be service users who had no history of substance abuse ($p<0.05$). Conversely, service users with no history of substance abuse more often reported that the room was like a padded cell ($p<0.05$). Service users who used the room for the first time were more likely to report that it was stuffy ($p<0.05$) and to describe it as torture ($p<0.05$). Non-compliers were less likely to label the room safe and secure ($p<0.05$). Service users with disorders other than depressive disorders were more likely to report that once in the seclusion room, it is difficult to get out ($p<0.05$).

Three further studies in the RCPsych review (Wise et al. 1988; Hammill et al. 1986; Binder and McCoy 1983) surveyed service users who had experienced seclusion. Another study (Eriksson and Westrin 1995) surveyed service users about seclusion, rapid tranquillisation and restraint. These studies found a mixed response to these measures. Whilst service users sometimes saw a need for them, on many occasions they felt that they had been used unnecessarily.

None of these studies significantly change the findings of the RCPsych review.

Evidence statements

Level of evidence	Evidence statement
Level 4	The available evidence suggests that staff may find using seclusion and physical interventions traumatic, but also consider that these interventions serve a necessary function.
Level 4	The limited evidence suggests that service users may find seclusion and restraint degrading, although some service users believe that measures, such as seclusion and physical intervention, are sometimes justified.

7.8.6.1.4 Economic evidence

No studies containing relevant economic data were found (see Appendix 9).

7.8.6.2 Rapid tranquillisation

7.8.6.2.1 Objectives

The aim of this review is to examine the evidence on the efficacy and safety of medications currently used for rapid tranquillisation (i/v, i/m, oral (any form) in psychiatric in-patient settings). It builds on the original RCPsych guideline, the NICE schizophrenia guideline (2002) and a recent New Zealand health technology appraisal (2001) all of which also examined this intervention.

I Original RCPsych guideline

The original RCPsych evidence review on rapid tranquillisation was examined. Their searches were undertaken based on the following review questions and hypotheses:

RCPsych review aim

- To produce a systematic review of the use of medication in managing violent incidents in clinical settings in which mental health care is provided.

RCPsych hypotheses and sub-hypotheses

- Is medication effective and safe in preventing and managing violent incidents?
- What are the contra-indications to using medication to manage disturbed/violent behaviour?
- Is the effectiveness of medication related to general sedation or to specific therapeutic effect on an underlying disorder?
- Is medication effective in the management of disturbed/violent behaviour irrespective of the aetiology of disturbed/violent behaviour?

The RCPsych review inclusion criteria:

Any controlled or non-controlled (including qualitative) research studies.

The RCPsych outcome measures:

- The reduction of disturbed/violent behaviour
- An increase of safety to patients and staff
- Measure of therapeutic effectiveness
- Measure of harmful effects of medication
- Measure of the threshold of the use of medication.

Searches were made from 1986-1996 on Medline, Cinahl, Embase and Psychlit.

After sifting and quality checks, 15 references relating to rapid tranquillisation were included by the RCPsych reviewer. Of these, only six were controlled studies that were judged to be fair to good.

The reviewer indicated that no evidence had been found on which evidence-based recommendations could be made.

The review of the literature has shown that using strictly evidence-based criteria, no individual or combined psycho-pharmacological agent (s) is the definitive intervention during or just prior to an act of violence [...] It is clear that more research needs to be carried out if the questions posed in our hypotheses are to be satisfactorily answered.

II Schizophrenia guideline

The systematic review for the NICE schizophrenia guideline (2002) drew on Broadstock (2001) and the Cochrane review of zuclopenthixol acetate (Fenton M et al. 2001). They identified six phase III randomised controlled trials that addressed the issue of rapid tranquillisation in relation to schizophrenia. These have been added to the evidence review for this guideline.

III New Zealand health technology appraisal (HTA) (M Broadstock 2001)

This systematic review identified 12 phase III randomised controlled trials that addressed the issue of rapid tranquillisation. These have been added to the evidence review for this guideline. One of these studies (Thomas et al. 1992) was excluded from the current review, as most of the participants had a primary diagnosis of intoxication and therefore falls outside the population considered in this guideline. Another study (Salzman et al. 1991) was excluded, as it did not appear to be a randomised controlled trial.

Current guideline

The current guideline focuses on the efficacy of rapid tranquillisation as an intervention for the short-term management of disturbed/violent behaviour. However, unlike the RCPsych review, dual diagnosis is not included in the scope. This has meant that some papers included by the RCPsych and the New Zealand HTA are excluded from this review. The inclusion criteria are also more stringent, as only systematic reviews to phase III randomised controlled trials are included, as noted below, which has led to further exclusions from the RCPsych review.

The following questions were identified and used to inform the search strategy of the current review (see Appendix 4 for search strategy, databases searched and search logs).

Review questions:

- What is the effectiveness of brief or fast acting pharmacological interventions for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings?
- How safe are the pharmacological agents that are used for rapid tranquillisation and what are the side effects?
- What are staff and service users' views/perceptions about the effectiveness and appropriateness of pharmacological interventions as a means of intervening in a disturbed/violent or imminently violent situation?
- How safe and effective is PRN medication for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings?

7.8.6.2.2 **Selection criteria**

Types of study

Systematic reviews through to phase III randomised controlled trials (evidence level 1). Qualitative studies and surveys were also included to obtain information on staff and service user views to answer review question 3.

Interventions

Rapid tranquillisation i/v, i/m, and oral (any form).

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All adult in-patient mental health settings, excluding learning disability.

Types of outcome

- Decrease in hostility/aggression
- Tranquillisation
- Sedation/somnolence
- Side effects and adverse reactions
- Satisfaction with care
- Economic outcomes (considered in separate economic review – see Appendix 9).

7.8.6.2.3 **Search strategy**

In addition to the searches covering 1985-2003, searches were also conducted covering 1969-1985 on all databases to ensure that no research papers were missed in the RCPsych review.

7.8.6.2.4 **Clinical evidence**

Eighty-three studies were identified in the initial sift. After sifting for relevance and duplicates 71 full papers were ordered. A further paper was identified through the stakeholder consultation process.

Medication

Twenty-three papers were opinion pieces, anecdotal reports, letters, or fell outside the inclusion criteria for this review. References were checked and one further study was identified.

Eight papers were systematic reviews, seven of which proved relevant to the research question. However, one systematic review was a duplicate, so only six systematic reviews were included. Eleven randomised controlled trials were retrieved; one was excluded because it was already included in an included systematic review. Ten further randomised controlled trials that were not mentioned in any of these systematic reviews were located, all of which proved relevant to the research question. All trials were phase III as advised by NICE. All evidence is level 1.

The rapid tranquillisation search strategy was broad enough to have found any articles on PRN that related to the short-term management of disturbed/violent behaviour. One systematic review (Whicher et al.2002) was found and five further studies were identified.

Service user and staff perceptions

Seven surveys and qualitative studies examined staff and service user perceptions and preferences in relation to rapid tranquillisation and PRN medication. These studies were included, as they address the acceptability of this intervention to staff and service users, and doctors' preferences concerning rapid tranquillisation medications, and therefore supplement the evidence base from randomised controlled trials. All evidence is level 3.

Sudden death

Although sudden death was not searched for specifically, one case study on sudden death was retrieved by the searches. Three further studies were located in references to studies ordered for this review. No study presented evidence above level 2.

Additional search

In addition to the search from 1985-2003, a further search was conducted from 1969-1985 to ensure that no research papers were missed by the RCPsych review. Seventy papers were identified in this search. After sifting for relevance and duplicates, 30 full papers were ordered. A further seven papers were included, 19 papers were excluded and 13 papers were opinion pieces, anecdotal reports, letters, or fell outside the inclusion criteria for this review. References were checked, but no further studies were identified.

Of the seven included papers, three were randomised controlled studies that examined drugs used for rapid tranquillisation. Three were cross-sectional surveys, which examined the use of PRN medication in various relevant settings, and one was a cross-sectional study of service users' attitudes to an incidence of forcible medication.

(Evidence tables of all included studies can be found in Appendix 5. Evidence tables of all excluded tables can be found in Appendix 6).

Appraisal of methodological quality

Common methodological shortcomings were:

- inappropriately small sample sizes (number needed to treat (NNT) not always stated or sufficient)
- participants not always sufficiently agitated to require rapid tranquillisation
- outcome measures not always sufficiently defined
- intention to treat analysis not always clearly described
- statistical measures (OR, RR, CI) not clearly reported.

Included studies

I Systematic reviews

Six systematic reviews were used to inform this review.

Efficacy of medication

Four of these reviews looked at the efficacy of a particular medication. Three reviews were all of very high quality (Cure and Carpenter 2001; Fenton et al. 2001; Carpenter and Berk 2000); a further review was of a lesser quality, but the quality was not overly compromised (Aleman and Kahn 2001). These reviews were used as part of the evidence base for assessing the efficacy of the medications droperidol, zuclopenthixol acetate, clotiapine and risperidone. Three of these reviews examined the efficacy of these medications specifically with reference to rapid tranquillisation (Carpenter and Berk 2002; Fenton et al. 2002; Cure and Carpenter 2001). These three reviews looked at the efficacy of droperidol, clotiapine and zuclopenthixol acetate respectively. All three reviews concluded that the use of these medications in emergency psychiatry was currently only justified in terms of clinical (that is, expert opinion), rather than research evidence. Clotiapine is off patent and currently unavailable in the UK since the manufacturers, Novartis, found the production off patent costs prohibitive. Droperidol was voluntarily withdrawn by the manufacturer, Janssen-Cilag Ltd, from the end of March 2001, amid concerns over the medication's safety as an oral treatment for chronic conditions. Cost effectiveness of production resulted in other forms of the medication also being withdrawn.

The reviewers suggest that further research is needed into the efficacy of droperidol for the purposes of rapid tranquillisation, for which it seemed to be safe, although the evidence underlying the medication's safety is also clinical rather than research-based. Likewise authors of the review on clotiapine also stressed that whilst they did not want to discourage the use of this medication for rapid tranquillisation, more research is needed to establish its efficacy and safety in relation to other medications used for this intervention. Similar conclusions were reached about zuclopenthixol acetate, with the reviewers stressing that there was no evidence to suggest that this medication was either safer or more effective than other medications currently used for rapid tranquillisation. Furthermore zuclopenthixol acetate is slow acting and therefore is normally no longer recommended for rapid tranquillisation. This evidence is graded at level 1.

The evidence from these reviews indicates that none of these medications emerges as a gold standard medication for use in rapid tranquillisation. Zuclopethixol acetate is slow acting and not normally used for rapid tranquillisation and both droperidol and clotiapine are unavailable in the UK for rapid tranquillisation. The evidence tables and meta-analyses relating to these medications are given in Appendix 8.

Evidence statement

Level of evidence	Evidence statement
Level 1+	The available evidence suggests that zuclopenthixol acetate should not normally be used for rapid tranquillisation.

Risperidone

The other systematic review which was included as part of the evidence base for this guideline examined risperidone (Aleman and Kahn 2001), an atypical antipsychotic. This study did not focus on the issue of rapid tranquillisation. However, it was included because it informed the review about the action of this agent and its various side effects. (All meta-analyses from this systematic review are included in Appendix 8).

The review of risperidone (Aleman and Kahn 2001) considered this medication's function for the management of aggression, but excluded a study because it looked specifically at violence, although there were additional quality issues underlying this exclusion. Some attempt was made to counter the heterogeneity of the studies, by carrying out analyses of only double-blinded randomised studies and those with similar doses, in order to assess the significance of various methodological differences between the studies. The reviewers argue that there was a clear superiority of risperidone over conventional antipsychotics (mostly haloperidol). However, the authors acknowledge that the service users in the included studies did not have chronic aggressive behaviour, which limits the generalisability of the result in relation to rapid tranquillisation. The reviewers also note that risperidone is not available as an intramuscular preparation, which further limits its suitability for an emergency situation. The authors' conclusions on the efficacy and appropriateness of risperidone appear to be overly optimistic in relation to the evidence base and should, therefore, be interpreted with caution.

All the papers included in the above reviews are not included separately in the evidence tables. The literature was trawled for further studies that would add to the evidence base of these reviews, but no additional studies were located.

Systematic reviews assessing the safety and efficacy of rapid tranquillisation

Two further systematic reviews were included in this evidence review, but were considered principally in terms of background information. Both reviews had a similar aim to the current review – that is to assess the efficacy and safety of rapid tranquillisation as an intervention for the short-term management of violence (NICE schizophrenia guideline 2002; Broadstock 2001). Both of these reviews stressed the dearth of the evidence base. Neither suggested that one medication emerged as the gold standard medication for use in rapid tranquillisation. The schizophrenia guideline undertook limited meta-analysis while Broadstock did not. Both studies identified medications that they believed were safe and efficacious for rapid tranquillisation on the basis of very limited research evidence. The NICE schizophrenia guideline closely followed the Broadstock review, which is being used as a base for this current review. In addition, many of the recommendations from the schizophrenia guideline were drawn verbatim from the RCPsych review. In addition to recommending the use of intramuscular haloperidol (a conventional antipsychotic) and intramuscular lorazepam (a benzodiazepine), they also suggested that intramuscular olanzapine (an atypical antipsychotic) should be considered for use in rapid tranquillisation for service users with schizophrenia. They suggested that a combination of haloperidol and lorazepam should be used only in exceptional circumstances and also that the BNF limits should not be exceeded, except within exceptional circumstances. They recommended the use of intravenous medications, as the original RCPsych guideline had done, for exceptional circumstances. They also recommended that i/m diazepam and i/m chlorpromazine should not be used for rapid tranquillisation.

The New Zealand health technology appraisal, undertaken by Marita Broadstock, (2001) suggested that benzodiazepines and antipsychotics seemed to be reasonably safe and effective for rapid tranquillisation and that no significant differences in terms of effectiveness were noted between them or between single and combination regimes. The review argued that there was some evidence to suggest that droperidol may be faster acting that other antipsychotics, but equally safe and effective. They found no studies that appraised the effectiveness of valproate or atypicals and therefore did not comment on their efficacy or safety for use in rapid tranquillisation. They also noted that there was some evidence to suggest that there were less extrapyramidal symptoms (EPS) associated with benzodiazepines (lorazepam), or benzodiazepines and antipsychotics (lorazepam and haloperidol) in combination, than when antipsychotics were used alone (haloperidol, clotiapine). Broadstock (2001) notes that the conclusions arrived at are broadly consistent with those found in the RCPsych guideline.

Conclusion

The current guideline is not considering studies where the primary diagnosis is alcoholism or substance abuse. Therefore studies included in these reviews were included or excluded from this guideline review, on the basis of the inclusion criteria outlined above. One study (Thomas et al. 1992), included in both Broadstock (2001) and the RCPsych guideline was excluded in this guideline's review because the study population did not necessary or primarily have a psychiatric illness, and because most of the participants were intoxicated. This trial was also excluded from the Cure and Carpenter (2001) systematic review on these grounds. All other randomised controlled trials included in these reviews were included in the current review and are assessed below, in conjunction with several additional randomised controlled trials identified in the searches.

II Randomised controlled trials

Nineteen randomised controlled trials, not included in the systematic reviews by Cure and Carpenter 2001; Fenton M et al. 2001; Carpenter and Berk 2000 are included in this review. One of these studies reported on two different trials (Garza-Trevino et al. 1989). Eleven of these studies were conducted in the USA. One took place in Israel, one took place in Brazil, one took place in India, one took place in Denmark and the other three were multi-country studies. Unless otherwise stated, all studies compared intramuscular loading (i/m) of various medications. Some studies switched to oral loading after the first 24hours. Where this occurs, it is indicated in the evidence tables.

Haloperidol vs. lorazepam (vs. haloperidol and lorazepam)

Four studies compared the benzodiazepine (i/m) lorazepam and the conventional anti-psychotic (i/m) haloperidol. (Foster et al. 1999; Bieniek et al. 1998; Battaglia et al. 1997; Garza-Trevino et al. – study I, 1989). Two of the studies (Foster et al. 1999; Battaglia et al. 1997) evaluated the efficacy and safety of these two medications against each other. Foster et al. (1999) noted no significant difference between the agitation scores for lorazepam and haloperidol at one hour on the BPRS ($p=0.39$, $WMD=3.26$ [-4.16, 10.68] 95% CI), but did note a significant difference in favour of lorazepam at one hour on the CGI ($p=0.002$, $WMD=0.67$ [0.25, 1.09] 95% CI). Battaglia et al. (1997) noted no significant difference between haloperidol and lorazepam at one hour, based on mean ABS score ($p=0.27$, $WMD=-1.92$ [-5.31, 1.47] 95% CI). Two of the studies (Battaglia et al.; 1997; Garza-Trevino et al. – study I, 1989) considered the efficacy and safety of these two medications against a combination of haloperidol and lorazepam. Battaglia et al. (1997) noted a significant difference between haloperidol and combination at one hour, based on ABS score ($p=0.03$, $WMD=3.85$ [0.46, 7.24] 95% CI) and between lorazepam and the combination at one hour based on ABS score ($p=0.005$, $WMD=-5.77$ [-9.76, -1.78] 95% CI). However, it is unclear if the combination would have been superior if the dose of the single agents had been equivalent to that of the combination. Garza-Trevino et al., study I, 1989 found that the combination was more likely to lead to tranquillisation in 30 minutes. These findings were replicated in ANOVAS. However, the authors suggest that it is unclear whether the combination would have been superior if the dose of the single agents had been equivalent to that of the combination.

One study (Bieniek et al. 1998) only considered the efficacy and safety of haloperidol against that of a combination of haloperidol and lorazepam. No differences were noted between the two groups with ANOVAS, but non-parametric tests indicated that a greater percentage of participants improved after 60 minutes in the combined group.

Whilst two of the studies compared the same single doses, and two of the studies compared the same combined doses, there were many methodological problems with these studies. These problems included: relatively small sample sizes, short follow-up periods, side effects not being recorded, many comparisons performed with no adjustment for p-value, baseline and information not recorded. The studies were also heterogeneous. One study (Garza-Trevino et al. 1989) was not double-blinded, one study (Battaglia et al. 1997) considered sleep as a desirable endpoint, (the other studies did not), and combination doses were not equivalent to single medication doses. With such heterogeneity, meta-analysis was not appropriate.

In terms of efficacy, no study found the antipsychotic to differ from the benzodiazepine. However, given the side effects caused by haloperidol (for example, dystonia), all authors suggested that lorazepam may be the preferred course of treatment. All three studies (Foster et al. 1999; Bienien et al. 1997; Garza-Trevino et al. – study I, 1989) that compared combination against a single medication or medications suggested the superiority of the combination in terms of efficacy. However, two studies note that, since the single dose was not equivalent to the combined dose, it remains unclear whether the combined doses were more effective simply because of the strength of dose. The study (Battaglia et al. 1997) that did not comment on this, regarded sleep as a desirable endpoint and therefore viewed effectiveness in terms of a different outcome. One study (Foster et al. 1999) noted that there is need for more dose response studies.

Conclusion

The studies suggest that the medications (i/m) haloperidol and (i/m) lorazepam are equally effective. It is also suggested that the combination of haloperidol (i/m) with lorazepam (i/m) is also effective. Although there are many methodological problems with the studies, the body of evidence suggests that, either as single agents or in combination, these medications are efficacious. However the dose response comparisons between the combination or the medications as single agents is unclear on the evidence of these trials. Whilst more extrapyramidal side effects (EPS) are recorded with haloperidol, the chosen medication should be dictated by individual service user histories.

Evidence statement

Level of evidence	Evidence statement
Level 1+ to 1-	The available evidence suggests that (i/m) haloperidol and (i/m) lorazepam are equally effective. However, there is no firm evidence for either the efficacy or safety of haloperidol or lorazepam as single agents, or in combination. Haloperidol has been found to result in an increased likelihood of more extrapyramidal effects.

Olanzapine vs. haloperidol vs. placebo

Two trials (Brier et al. 2002; Wright et al.2001) evaluated (i/m) olanzapine against (i/m) haloperidol and against (i/m) placebo. Both studies were large multi-site, multi-country studies. However, they included participants with schizophrenia (571 participants in total). Both authors were involved in both studies and both work for Eli Lilly who sponsored both studies.

It is unclear whether the participants actually required rapid tranquillisation, since all gave consent before being included in the study. Objective measures of behaviour were used in both studies at baseline (PANSS – positive and negative syndrome scale). There was no long-term follow up with either study. Both olanzapine and haloperidol were significantly more effective than placebo in reducing agitation at two and 24 hours in both studies. At 30 minutes, a dose of 5.0mg, 7.5mg or 10mg were significantly more effective than the placebo. Olanzapine was significantly more effective than haloperidol in reducing agitation at 15, 30 and 45 minutes (Wright et al. 2001). In Brier et al. (2002), group sizes did not allow comparison with placebo. Acute dystonia was not associated with olanzapine, but was found in 7 per cent of the haloperidol group. (Wright et al. 2001) Brier et al. (2002) also found that olanzapine was not associated with dystonia. There were no differences between olanzapine, haloperidol and placebo in terms of hypotension and clinically relevant changes in the QTc interval (Brier et al. 2002). On this basis, Brier et al. (2002) suggests that olanzapine has a safer profile than haloperidol. The schizophrenia guideline examined both of these studies and undertook a meta-analysis that slightly favoured olanzapine (see Appendix 8 for results).

Conclusion

Olanzapine (i/m) would appear to be both effective and safe for use in rapid tranquillisation for service users with schizophrenia. It would also appear to have fewer side effects than (i/m) haloperidol and more rapid onset of action. However, in these two trials the populations were only suffering from moderate disturbance where rapid tranquillisation was not necessarily required. Therefore further RCTs with appropriate populations are needed to verify the findings from these trials for use of olanzapine in those who are disturbed/violent. (Level 1 and level 2.)

It has subsequently been noted that a warning has been issued by the manufacturers advising against the use of olanzapine outside the SPC recommended dose, as adverse effects have been recorded.

Evidence statement

Level of evidence	Evidence statement
Level 1+ to 2	The evidence suggests that olanzapine (i/m) is safe and effective for rapid tranquillisation for service users with schizophrenia. However the study population did not necessarily require rapid tranquillisation. The evidence suggests olanzapine (i/m) has fewer side effects and is more rapid in onset than (i/m) haloperidol.

Ziprasidone (vs. haloperidol)

Three studies considered the efficacy and safety of (i/m) ziprasidone (Daniel et al. 2001; Lesem et al. 2001; Brook et al. 2000). Two considered this medication only (Lesem 2001; Daniel et al. 2001), measuring the effectiveness and safety of different doses (2mg vs. 10mg and 2mg vs. 20mg). The other study (Brook et al. 2000) compared (i/m) ziprasidone with (i/m) haloperidol.

Brook et al. (2000) found significant reductions in agitation from baseline at day three that favoured ziprasidone. (BPRS total WMD=-3.06 [-5.68, -0.44]95% CI; BPRS agitation score WMD=-1.13 [-2.23,0.03] 95% CI;CGI-S WMD=-0.34 [-0.55,-0.13]. However, the paper contained insufficient data to calculate the relative reductions in agitation at earlier time periods.

The other two studies, Daniel et al. (2001) and Lesem et al. (2001), employed the same methodology; both were sponsored by Pfizer. It was not clear whether either of the studies dealt with truly agitated participants, since all gave consent. Both 10mg and 20mg were noted to be significantly more effective than 2mgs. A reduction of two or more on BARS scale at two hours after initial injection showed the following significant result for 10mgs (p=0.003, OR=0.32 [0.15, 068] 95% CI), and the following for 20mgs (p<0.00001, OR0.04 [0.01,0.16] 95% CI). Lesem et al. (2001) argues that 10mg is a therapeutic dose but probably at the lower end of the spectrum, especially given the agitation levels of the participants in the study. There was no significant difference in side effects with any of the doses. Most side effects were moderate, suggesting the reasonable safety of this atypical antipsychotic. The study Brook et al. (2000), comparing haloperidol with ziprasidone, did not consider rapid tranquillisation, but the management of acute psychosis. In this context, compared to haloperidol, ziprasidone was significantly more effective in managing aggression by day seven. However, no firm conclusions about the relative effectiveness of ziprasidone compared to haloperidol as an agent for rapid tranquillisation can be arrived at on the basis of this study.

Conclusion

It would seem that (i/m) ziprasidone 20mg is relative safe for use in rapid tranquillisation. Its effectiveness needs further testing with more highly agitated participants. Whilst meta-analysis of these two studies would have been possible, the value of doing so appears limited, given that the participants did not necessarily require rapid tranquillisation and no comparison with other medications was made (level 1). The relative effectiveness and safety of (i/m) ziprasidone compared to (i/m) haloperidol as an agent for rapid tranquillisation cannot be established on the basis of this evidence (level 2). Ziprasidone received a black box warning in 2002 in relation to its QTc prolonging potential, which may be increased in situations of high arousal.

Evidence statements

Level of evidence	Evidence statement
Level 1-	The evidence suggests ziprasidone (i/m) is safe for use in rapid tranquillisation, however its effectiveness with highly agitated service users is not known.
Level 2	The relative effectiveness and safety of (i/m) ziprasidone compared to (i/m) haloperidol as an agent for rapid tranquillisation cannot be established on the basis of this evidence.

Loxapine vs. haloperidol (vs. thiothixene)

Four studies examined the use of (i/m) loxapine. Three compared it to haloperidol (IM) (Tuason 1986; Fruensgaard et al. 1977; Paprocki and Versiani 1977) and the other to (i/m) thiothixene (Dubin and Weiss 1986). Neither Tuason 1986 nor Dubin and Weiss 1986 were double-blinded and in one of these studies (Dubin and Weiss 1986), it is unclear whether participants required rapid tranquillisation. However, the other two studies (Fruensgaard et al.1977; Paprocki and Versiani 1977) were double blinded. All medications achieved significant improvement from baseline and there were no significant difference in numbers of adverse reactions between groups, except in one study (Fruensgaard et al. 1977) where (i/m) loxapine 50mgs produced more pronounced sedation ($p<0.025$). Haloperidol 5mg did not differ in median time to rapid tranquillisation from loxapine 25mg (Tuason 1986) (at two hours OR=0.32 [0.09,1.22] 95% CI based on CGI ratings for global improvement. The same is also true of the mean BPRS scores at two hours WMD =1.10 [0.78, 1,42]). Nor did haloperidol 5mg differ in median time to rapid tranquillisation from loxapine 50mgs (Fruensgaard et. al. 1977; Paprocki and Versiani, 1977). There is insufficient data to calculate 95 per cent CI for these two studies. However, thiothixene 10mgs (Dubin and Weiss 1986) was significantly less tranquillising in the initial phase of treatment than loxapine 25mgs (60min vs. 95min) $p=0.0008$ OR=9.00 [2.49,32.57] 95% CI.

Conclusion

The studies had various limitations which make it difficult to formulate firm conclusions about the relative effectiveness and safety of (i/m) loxapine compared to either (i/m) haloperidol or (i/m) thiothixene for use in rapid tranquillisation. However, at the doses prescribed, loxapine would appear to provide a more rapid tranquillising effect than thiothixene (level 1).

Evidence statement

Level of evidence	Evidence statement
Level 1-	The evidence is not conclusive for the effectiveness or safety of (i/m) loxapine compared with either (i/m) haloperidol or (i/m) thiothixine.

Thiothixene and lorazepam vs. haloperidol and phenobarbital

A further study also considered the use of (i/m) thiothixene in combination with (i/m) lorazepam against (i/m) haloperidol in combination with (i/m) phenobarbital (Garza-Trevino et al. 1989 – study II). This study was not double-blinded, there was a very short follow-up period (24 hours) and the side effects were not described, although the authors claim that there were few indications of over-sedation or dystonic reactions. There appeared to be no difference in effectiveness between the two groups. The authors argue therefore that a combination of antipsychotic and a hypnosedative is a useful intervention for the management of agitated behaviour.

Conclusions

It is difficult to generalise concerning the effectiveness and safety of these medication combinations on the basis of only one study, given the various limitations noted above.

Evidence statement

Level of evidence	Evidence statement
Level 1-	The evidence for thiothixene and lorazepam vs. haloperidol and phenobarbital combinations is inconclusive.

Haloperidol (vs. flunitrazepam, vs. molidone, vs. midazolam and sodium amytal vs. midazolam, vs. chlorpromazine)

Four trials (Binder and McNiel 1999; Dorevitch et al. 1999; Wyant et al. 1990; Reschke 1974) evaluated the efficacy and safety of five further medications against (i/m) haloperidol; (i/m) flunitrazepam, (i/m) molindone, and (i/m) midazolam, (i/m) sodium amytal, and (i/m) chlorpromazine. Neither of the first two studies showed a significant difference between haloperidol and the other medication in terms of effectiveness. Flunitrazepam showed a slightly quicker reduction in aggression at 30 minutes, but this did not reach significance at 90 minutes on the OAS scale (p=0.37 OR=3.00 [0.27, 33.08]). Molidone showed slightly less reduction in symptoms at three hours. Erythema at injection site was slightly more common for molidone than haloperidol. This side effect is not discussed in relation to (i/m) flunitrazepam. Both studies had small sample sizes and neither used objective measures to evaluate behaviour at baseline. In the study of molidone there was no adjustment to the p value to account for the many comparisons and outcomes (outcomes were not restricted to rapid tranquillisation). It was also difficult to assess whether side effects resulted from the oral phase of the intervention.

The study of (i/m) haloperidol vs. (i/m) midazolam or (i/m) sodium amytal (Wyant et al. 1990) randomly assigned participants to either (i/m) haloperidol 10mg, (i/m) midazolam 5mg or (i/m) sodium amytal 250mg. Over two hours, (i/m) sodium amytal and (i/m) midazolam proved significantly more effective than haloperidol in terms of mean global ratings for motor agitation (p< or =0.05), but there was no significant difference in hostility rating (p<0.10). This study has several limitations, not least being a very small sample size. It is also only single blinded. In addition, there is insufficient data in the paper to calculate 95 per cent CI. Side effects are not mentioned. On both these counts it could have been excluded, but is reported here to illustrate the available research on these medication combinations. The authors recognise the need for a large-scale future study comparing midazolam with lorazepam.

In the study of (i/m) haloperidol vs. (i/m) chlorpromazine aggression was significantly more effectively controlled with (i/m) haloperidol 5mgs and 2mgs (p<0.05) compared to (i/m) haloperidol 1mg, (i/m) chlorpromazine 25mgs or (i/m) placebo. More adverse reactions were noted with haloperidol (transient hypertension, drowsiness (awake), dry mouth and mild EPS) than chlorpromazine, although there was greater somnolence with chloropromazine. The study had a very small sample size. Most participants in this study were women.

Conclusions

Given the limitations of the studies, no firm conclusion can be reached about the relative superiority of these medications compared to haloperidol, although both flunitrazepam and molindone appear to be reasonably safe and effective within these trials. The study of midazolam and sodium amytal did not mention side effects. These trials' limitations mean that no firm conclusions about these medications can be drawn. The study of midazolam used sleep as a desirable endpoint, making comparisons with other studies difficult. Chlorpromazine (i/m) was slower acting than haloperidol, although it had fewer side effects. Chlorpromazine (i/m) is no longer considered a suitable medication for rapid tranquillisation, since it is a local irritant if given intramuscularly; carries a risk of cardiovascular complications; causes hypotension due to ·-adrenergic receptor blocking effects, especially in the doses required for rapid tranquillisation; and is erratically absorbed. Its effect on QTc intervals also suggests that it is unsuitable for use in rapid tranquillisation.

Evidence statement

Level of evidence	Evidence statement
Level 2-	The evidence for haloperidol (vs. flunitrazepam, vs. molidone, vs. midazolam and sodium amytal vs. midazolam, vs. chlorpromazine) is inconclusive.

Haloperidol plus promethazine (vs. lorazepam vs. midazolam)

One study (Trec 2003) compared (i/m) halperidol-promethazine with (i/m) midazolam. Clinicians decided doses within a range of 7.5-15mgs of (i/m) midazolam and 5mgs of (i/m) halperidol plus 25-50mgs (i/m) promethazine. More somnolence was noted in the midazolam group. One man suffered respiratory depression with (i/m) midazolam 15mgs and recovered after being given (i/v) flumazenil 0.25mgs. One woman with epilepsy suffered a grande mal seizure with (i/m) haloperidol 5mgs and (i/m) promethazine 50mgs. When ratios of those either asleep or tranquil at one hour were considered, the study favours midazolam (OR=0.49 [0.22, 1.09] 95% CI, NNT=12.5 [6.4, 77.7] 95% CI). However, a larger percentage of these patients were asleep in the midazolam group than in the haloperidol + promethazine group (93 per cent compared to 87 per cent). If only those patients who were tranquil at one hour are considered, the treatment favours haloperidol + promethazine (OR=2.91 [1.64, 5.18] 95% CI). No definitions are provided for tranquil or asleep. The preferred outcome in the UK context is considered to be tranquil (calm) and conscious.

The other study (Alexander 2004), compared (i/m) haloperidol and promethazine combined with (i/m) lorazepam. Doses were (i/m) haloperidol 10mgs plus (i/m) promethazine 25-50mgs or (i/m) lorazepam 4mgs. (i/m) Haloperidol plus (i/m) promethazine was significantly more likely to induce sleep for all time periods (p=0.00). (i/m) Haloperidol plus (i/m) promethazine also resulted in quicker onset of tranquillisation (p=0.0001)/sleep (p=0.0000). Four people in the lorazepam group were never tranquil; one person in the haloperidol plus promethazine group was never tranquil. No adverse reactions were noted with haloperidol plus promethazine. One person in the lorazepam group with history of bronchial asthma complained of moderate worsening of respiratory difficulty; one person reported nausea and dizziness. There was no dystonia. Sleep was considered the desirable endpoint. When ratios of those either asleep or tranquil at one hour are considered, the study favours haloperidol (OR=5.44 [1.16, 25.52] 95% CI). However, a larger percentage of these patients were asleep in the haloperidol + promethazine group than in the lorazepam group (98 per cent compared to 90 per cent). If only those patients who were tranquil at one hour are considered, the treatment favours lorazepam (OR=0.33 [1.18, 0.58] 95% CI).

Conclusions

Unlike most of the other studies in this review, both were large studies of a high methodological quality. Despite this, after consultation with two independent methodological advisers, it was decided that meta-analysis would not be appropriate for the following reasons. Firstly, it is not clear that the two benzodiazepines (midazolam and lorazepam) are sufficiently similar clinically to be treated as a single class, nor is it clear that the two benzodiazepine doses are equivalent, which could make the effect size vary. Secondly, the primary outcome was four hours in TREC (2003) but 15 minutes in Alexander (2004). These were rated by blinded assessors (Alexander 2004). While TREC (2003) did take measurements at 20 minutes, these were not made by blinded raters. There is also a danger of masking differences in effect when combining different time points.

One of these trials (Alexander 2004) considered sleep the primary desirable outcome. However, the study did detail numbers asleep and numbers tranquil at each endpoint (as did Huf 2003). Alexander (2004) argues that sleep is a safer option for staff however, no significant difference in injury rates were noted with lorazepam, which was less sleep inducing. Neither study mentioned whether monitoring procedures – for example, observation, ECG, etc. – were put in place once participants were classified as asleep. There is disagreement between the studies as to whether haloperidol plus promethazine is actually more likely to induce sleep than a benzodiazepine. As sleep is not normally considered a desirable endpoint for rapid tranquillisation, the studies suggest that haloperidol plus promethazine may be effective in rapid tranquillisation when sleep is a desirable outcome, which has been suggested as being a safer option for staff. However, if tranquil (calm) is the desirable endpoint, lorazepam alone is favoured.

Few patients treated with (i/m) haloperidol plus (i/m) promethazine suffered dystonic reactions, since promethazine has anti-cholingeric properties.

Evidence statement

Level of evidence	Evidence statement
Level 1+	The available evidence suggests that haloperidol with promethazine i/m is effective in rapid tranquillisation by inducing sleep. The evidence suggests lorazepam i/m is effective in rapid tranquillisation by calming the service user.

Heterogeneity

The included studies had many heterogeneous aspects/deficiencies in reporting, such as differing settings, and insufficient time to allow NNT to be calculated. Furthermore, some studies did not contain sufficient data to allow the OR to be calculated. The studies also had different comparator medications, doses and outcomes (for example, sleep as the endpoint and sleep as an adverse effect). In addition, the term sleep is often loosely defined in these studies, which further complicated any comparison. Follow-up periods also differed across studies. After methodological advice, it was considered that in the face of such heterogeneity, meta-analysis would be inappropriate.

Appraisal of methodological quality

There were also many methodological quality issues – for instance, most studies did not report their method of randomisation nor how they ensured blinding/lack of bias. It was felt that meta-analysing studies of low quality might therefore be misleading. Furthermore the outcome measurements were not comparable or always clearly defined. Actual dosages given in the studies also make comparisons within and between studies difficult.

Evidence statements

Level of evidence	Evidence statement
Level 1+ to 1-	A gold standard medication for rapid tranquillisation has not yet been established
Level 1+ to 1-	There appear to be no conclusive benefits in terms of effectiveness of one antipsychotic over another; of antipsychotics over benzodiazepines; or of combination medications over single medication regimes for rapid tranquillisation.
Level 1+ to 1-	The body of evidence suggests rapid tranquillisation as an intervention for the short-term management of disturbed/violent behaviour is both reasonably effective and reasonably safe. This evidence suggests that both benzodiazepines and antipsychotics appear to be effective and reasonably safe for use in rapid tranquillisation.
Level 4	It is not possible to determine the safety or effectiveness of medications other than antipsychotics and benzodiazepines for rapid tranquillisation.

III Studies other than randomised controlled trials

Most of the non-randomised studies which examined rapid tranquillisation that were identified investigated medications which were considered in the randomised controlled trials or systematic reviews discussed above. One study discussed a medication not considered elsewhere. This study (Lee et al. 1992) was a prospective cohort study (n =10) that considered the use of lithium citrate. There were considerable limitations to this study noted by the authors, such as a lack of a wash out period and the lack of a double-blind control. They suggest that this medication may be an alternative treatment to neuroleptics or benzodiazepines, particularly for service users who demonstrate persistently agitated behaviour, despite treatment with neuroleptics, benzodiazepines, barbiturates and/or antihistamines. However, they recognised the need for a randomised controlled trial.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is insufficient evidence of the safety or effectiveness of lithium citrate for use in rapid tranquillisation for those who demonstrate persistently agitated behaviour.

IV Sudden death and rapid tranquillisation

No randomised controlled trials had death as an adverse event. However, four case studies were identified in which death was linked to medication.

One case study reported in a letter, noted that a young adult who was given (i/v) diazepam 20mg and (i/v) haloperidol 20mgs by a GP and psychiatrist at home suffered a fatal cardiac arrest (Quesnstedt et al. 1992). One other case of sudden death (Dolan et al.1995) occurred after rapid tranquillisation. In this case, post-mortem examination revealed some congestion of the pulmonary parenchyma. The author expressed concern that the autopsy had partially attributed the cause of death to medication, when sudden death in similar circumstances, without the presence of medication, is known to occur.

In another study (Lynch and Kotsos 2001), a white female was found at home with a fatal dose of benzatropine. It is unclear whether a suicide attempt was made.

In the final study (Kumar 1997) an aggressive service user was restrained and stopped breathing before rapid tranquillisation took place, but a toxic level of chlorpromazine was found in his blood after treatment with chlorpromazine, zuclopenthixol acetate and zuclopenthixol decanoate in the weeks preceding his death. One study did not specify the ethnicity of the deceased; the other three studies all noted that the deceased were Caucasian; three service users were male, the other was female.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is insufficient evidence to determine whether there is an association between sudden death and the pharmacological interventions used for the short-term management of disturbed/violent behaviour.

V Qualitative studies and surveys

Our searches identified seven qualitative studies which were deemed to be of reasonable quality to merit inclusion in this review. Three were conducted in the UK, one in the USA, one in Israel and one in Sweden.

Two of studies set in the UK did not specifically ask staff and service users about their feelings and beliefs about rapid tranquillisation.

The first study (Hyde et al.1998) compared user dissatisfaction scores with incidents of rapid tranquillisation and found that there was no correlation between a service user satisfaction score and their experience of this intervention. However, as the questionnaire did not ask service users to score their satisfaction/dissatisfaction with this intervention, there are many other confounders that could obscure this correlation. It is unclear what the aims of the questionnaire were. The other UK study (Duxbury 2002) asked staff, service users and medical staff for their views on the approaches used to manage violence. Again, there was no specific reference to rapid tranquillisation, but a disparity was noted between actual violence reported in incident forms and the use of rapid tranquillisation. The authors suggest that this is a worrying trend. They note that both staff and service users agreed that there was a need for greater alternatives to restraint, seclusion and rapid tranquillisation.

The third study (Burgess 1997) reviewed doctors' medication preferences for rapid tranquillisation. The study took the form of two cross-sectional surveys conducted in Oxfordshire – the first in 1990 and the second in 1994-5 – to assess the effect of guidance issues by the Royal College of Psychiatrists. The following outcome measures were considered: drug of choice; route of choice; other drugs used if situation not rapidly resolved by drug of choice; mean dose (second study only); desired endpoint (second study only); time to desired endpoint (second study only). Doctors were asked to rate the same scenario of a psychotic patient. Study 1 showed the following results: 56 per cent response rate (sent to consultants only). The drug of choice was chlorpromazine. The route of choice was intramuscular (93 per cent) against intravenous (7 per cent). Forty-two other drugs were used if the situation was not rapidly resolved by drug of choice, suggesting no consensus. These included neuroleptics, benzodiazepines, anticonvulsants and paraldehyde.

Study 2 showed the following results: 77 per cent response rate from registrars, junior doctors and consultants – 69 per cent response rate from consultants. The drug of choice was chlorpromazine (25 per cent), with haloperidol + lorazepam (22 per cent) and haloperidol alone (16 per cent). Junior doctors were more likely than consultants to use a short acting antipsychotic and a benzodiazepine as first line treatment ($p<0.05$). The route of choice was intramuscular/oral (93 per cent) against intravenous (7 per cent). Mean dose: chlorpromazine 103.4mg, haloperidol alone 9.6 mg, haloperidol + lorazepam 9.2mgs of haloperidol. Other drugs used if the situation was not rapidly resolved by drug of choice included increasing the dose of neuroleptic medication, adding benzodiazepine and adding clopixol acuphase. 14 per cent would use clopixol acuphase as first line treatment either alone or with other drugs; 62 per cent would consider clopixol acuphase at some point in the first 24 hours. The desired endpoint was: patient non-sedated but calm, 59 per cent; patient sedated but mobile, 31 per cent; patient asleep, 10 per cent. Time to desired endpoint was: within one hour, 21 per cent; within 6 hours, 43 per cent; within 12 hours, 16%; within 24 hours, 10%; more than 24 hours, 6 per cent.

The authors noted that by 1990, only 7 per cent of doctors used a short acting antipsychotic + a benzodiazepine, with 35 per cent in 1994 ($p<0.001$). However only consultants were surveyed in 1990 and the study showed that significantly more junior doctors than consultants would choose this drug combination in 1994 ($p<0.05$). The authors also noted that: a) haloperidol continued to be prescribed at a higher dosage equivalent than chlorpromazine, even when used in combination with a benzodiazepine; b) i/v administration is unpopular despite reports that diazepam plus haloperidol is the most rapid effect method of rapid tranquillisation; c) that while the preferred endpoint is non-sedated but calm, most advocated highly sedative drugs, i.e. benzodiazepines. The authors posited that the introduction of local protocols, in line with RCPsych guidance, many have further altered doctors' choices and suggested that an additional survey is required to monitor this.

The other four studies surveyed service users, with the aim of discovering their views about forcible medication. One study (Haglund et al. 2003), also interviewed staff. In the study, service user and nurse perceptions of forced medication differed. Nurses focused more on positive effects of medications, while service users stressed the negatives. Less service users retrospectively approved of forced medication than anticipated by nurses. Nurses mentioned no alternatives to rapid tranquillisation.

However, all service users mentioned at least one alternative (dialogue, more explanation of ill-health, coaxing, waiting, no medication, no injection). Nurses perceived these measures necessary to improve health. The authors noted that service users were more likely to accept forced medication from a nurse they knew.

Another study (Schmeid and Ernst 1983) asked service users to rate the retrospective acceptability of both seclusion and rapid tranquillisation. Service users were asked immediately after the intervention and also once psychosis passed. Service users found rapid tranquillisation more unacceptable than seclusion or restraint ($p=0.01$; for men only $p=0.001$). However, many service users were unclear on their feelings about these interventions and did not know which staff member had instigated the intervention. The authors note that this was particularly true for male service users, many of whom had alcohol related problems. This is now an old study and although rapid tranquillisation was the least acceptable of these interventions, it is not possible to generalise whether service users in the UK also prefer seclusion to rapid tranquillisation. The author suggests that it is beneficial for service users to discuss their feelings after the use of one of these interventions.

Greenberg et al. (1996) conducted structured telephone interviews with service users two weeks after discharge. There was a 50 per cent loss to follow-up. The authors noted that 60 per cent of service users interviewed retrospectively agreed that rapid tranquillisation had been beneficial, while 43 per cent felt that they should be coerced in similar situations in the future. However, the authors acknowledge that the responses of those lost to follow-up might have been more negative.

In another study, where semi-structured interviews were conducted on the ward, a far more negative response to rapid tranquillisation was noted. Only 4/11 service users retrospectively approved of rapid tranquillisation and one of these did so only in the most vague of terms. The rest all disapproved. However staff believed that 7/11 service users had retrospectively approved of the use of this intervention.

Schwartz et al. (1988), in a small study in one hospital setting, assessed service users' mental state both before and after forcible medication (service users with organic brain disorder were excluded). They argued that those who retrospectively disagreed with the treatment did not recognise that they had an illness that had required hospitalisation; did not agree that the hospitalisation was necessary; or that it had been helpful ($p<0.01$). They also noted significant differences between those who did and those who did not retrospectively agree with forcible medication on the BPRS scales for thought disturbances and hostile suspiciousness. At discharge, the following eight items were significant for those who did not retrospectively agree with the forcible medication: conceptual disorganisation ($p<0.05$); mannerisms and posturing ($p<0.01$); grandiosity; hostility; suspiciousness; unco-operativeness; unusual thought content ($p<0.001$). In the light of these findings, the authors argue that judicial review of forcible medication is seldom required.

Evidence statement

Level of evidence	Evidence statement
Level 4	The evidence suggests that service users' retrospective responses to rapid tranquillisation are variable. Both staff and service users agree that, where possible and appropriate, alternatives to restraint, seclusion and rapid tranquillisation are preferable.

VI PRN medication

Although only rapid tranquillisation is mentioned directly in the scope, pro re nata (PRN) – as needed – medication is also sometimes used in a similar way to rapid tranquillisation in psychiatric in-patient settings. For this reason, a review of the use of PRN medication in this context was undertaken.

Effectiveness

One systematic review (Whicher et al. 2002) was found that examined the efficacy of PRN for the short-term management of aggressive behaviour. No randomised trials were found which met the inclusion criteria for this review.

Whicher et al. (2002) conclude that:

> This common current practice has no support from randomised trials. Current practice is based on clinical experience and habit rather than high quality evidence. Current practice, therefore, outside of a well designed, conducted and reported randomised trial, is therefore difficult to justify.

No further studies were identified which examined the effectiveness of PRN medication as a pharmacological intervention for the short-term management of disturbed/violent behaviour.

Staff perspectives

A study by Geffin et al. (2002a) examined the beliefs of doctors and nurses in in-patient psychiatric units about PRN medication for psychiatric disorders. They concluded that nurses and doctors have different views about the effectiveness of antipsychotics and benzodiazepines. They noted that some of these views are at odds with the known properties of these medications. They argue therefore that doctors should always specify the usage when writing PRN prescriptions. They argue that further education is needed to achieve best practice in PRN medication.

A second survey by Geffin et al. (2002b) examined the uses of PRN medication in two large psychiatric units. The authors noted that while a maximum daily dose was normally specified (87 per cent), indications for use were only specified in 6 per cent of cases. Staff noted medication-related morbidity in 37 per cent of service users taking PRN medication, compared to 3 per cent on only regular scheduled medication. Forty-nine percent of PRN medication was given for agitation. However, administration records frequently failed to specify a reason for use in 48 per cent of cases. Nearly two-thirds of administrations (64 per cent) had no recorded outcome. Of the remaining 26 per cent, 76 per cent were reported as being partially or completely effective, with the remainder recorded as ineffective. Higher daily doses of PRN medication were given to manic patients, males, younger patients and those with substance abuse disorders. Co-prescription of typical antipsychotics PRN with atypical antipsychotics was common (64 per cent).

Three further studies were found which also examined the use of PRN medication. One was set in Canada (Craven et al. 1987); two were set in the USA (Walker 1991; Craig and Bracken 1995). A finding of two of these studies (Craven et al. 1987; Walker 1991) was that indications were not always included in the prescriptions. Where an indication was given, only one was specified, although the prescriptions was often used for a number of indications. Minimum intervals between doses were not always stated and maximum daily doses were also not always specified. In addition very few of the prescriptions specified an end-date.

The other study (Craig and Bracken 1995), noted a difference between the use of PRN medication with service users who had a discrete period of disruptive behaviour and those who had intermittent periods throughout their stay. The following results were significant: half of the intermittent vs. more than 90 per cent of those with discrete episodes had an increase in their medication or had their medication changed during the study month (p=0.03). The authors noted that 12/27 service users who had antipsychotic medication serum levels drawn either before or after the study were found to be in a sub-therapeutic range, with two-thirds below detection. They suggest the importance of checking serum levels to ensure that these are adequate, in order to reduce the need for PRN medication.

Evidence statement

Level of evidence	Evidence statement
Level 4	The evidence suggests that the use of PRN medication for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings is inconsistent and may not be appropriately administered or monitored. Health care professionals require education on the appropriate use of PRN medication

7.8.6.2.5 **Economic evidence**

There are two papers that are economic analyses of rapid tranquillisation. One is a UK-based cost minimisation study (Hyde et al. 1998) and the other is a cost consequence analysis, based in Canada (Laurier et al. 1997). Both compare zuclopenthixol acetate with haloperidol. The two papers are in disagreement regarding which of the two medications is more cost effective and thus the literature is inconclusive. Zuclopenthixol acetate is no longer recommended for RT due to a long onset of action. See discussion above. (For details of the health economics review, see Appendix 9).

7.8.7 Emergency departments

7.8.7.1 Objectives

No specific searches into the short-term management of disturbed/violent behaviour in emergency departments were undertaken in the RCPsych guideline.

Two review questions were identified and used to inform all searches (See Appendix 4 for search strategies, databases searched and search logs)

Review questions

- How is disturbed/violent behaviour by psychiatric patients best managed in the short-term in emergency departments, immediately prior to admission to an adult psychiatric in-patient setting?
- What are the views of staff and service users about the short-term management of disturbed/violent behaviour by psychiatric patients in an emergency department?

These questions were addressed in relation to the various interventions and related topics covered in this guideline and specific review questions were devised (see below).

7.8.7.2 Selection criteria

Types of studies

Systematic reviews to before and after studies (levels 1-2). Qualitative studies were also included.

Types of participants

Adult psychiatric service users <16 years, excluding people with a primary diagnosis of substance abuse, older persons with an organic mental disorder (for example, any form of dementia) or a progressive neurological disease (for example, Parkinson's disease).

Types of setting

All emergency departments.

Types of outcome

- Appropriateness, effectiveness and safety of interventions and related concerns for the short-term management of disturbed/violent behaviour of psychiatric patients presenting to emergency departments.
- Staff and service user perspectives on the appropriateness, effectiveness and safety of interventions and related concerns for the short-term management of disturbed/violent behaviour in emergency departments.

7.8.7.3 Clinical evidence

Eighty-one papers were identified in the initial sift. After sifting for relevance and duplicates, 50 full papers were ordered; 18 met the inclusion criteria; 12 were excluded. All the other papers were opinion pieces, anecdotal reports or fell outside the inclusion criteria for this review. References were checked but no further studies were identified. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6).

Appraisal of methodological quality

In addition to the quality concerns raised above, these studies had the following methodological problems:

- confounders not considered or taken into account
- inappropriate sample size
- much anecdotal 'evidence' based on author's experience and reflection rather than on primary research.

I Prevention

Seventeen studies addressed issues around prevention of disturbed/violent behaviour in emergency departments.

I.i Environment

I.i.a Review question: how does the environment and organisation impact on disturbed/violent behaviour by psychiatric patients in emergency departments, immediately prior to admission to an adult psychiatric in-patient setting?

No studies addressed this review question.

I.i.b Review question: what are the views of staff and service users about how the environment and organisation impacts on the short-term management of disturbed/violent behaviour by psychiatric patients in an emergency department?

Lillywhite et al. (1995) audited the interview rooms and surveyed the staff of a mental health service to assess the safety of interview rooms in a general hospital outpatients' department, general hospital emergency department and a psychiatric hospital, according to 10 safety criteria, and to assess medical staff's ratings of the relative importance of these 10 criteria. Emergency department rooms scored least well in terms of suitability for interviewing potentially aggressive patients, scoring poorly on every criteria other than 'alarm bell.' This was due to: a) the isolated position from other staff, especially at night when most psychiatric assessments take place b) cubicles used are cramped, with inadequate seating and a lack of privacy c) the emergency department is where junior doctors are most likely to assess disturbed and potentially violent patients, and unlikely to have the support of psychiatric trained nurses or access to their notes prior to assessment. Features felt to be most important with agitated/potentially violent patients were space, access, layout, weapons, alarm and ease of exit. The study indicated a large disparity between the features of the ideal interviewing situation and those actually available. The authors recommend safety features should be incorporated, and that violent incidents should be monitored and logged, reviewed and acted upon. The numbers of staff surveyed were low (22) and of those only three were emergency department staff which, divided between three sites, provides a weak basis for generalisation.

Burns and Harm (1993) conducted a questionnaire and interview study of 682 emergency nurses. Interviewees reported feeling that there was a lack of concern for their personal safety. Emergency nurses found debriefings helpful. It was suggested that critical incident stress debriefing teams should formulate strategies for involving nurses in the debriefing process and that nurse peers should play a significant role in the debriefings.

Cembrowicz and Shepherd (1992) conducted a survey of staff in a UK emergency department, which concluded that fitted furniture and padded seating should be installed, and that potential weapons should be stored out of sight. They suggest that CCTV may deter casual hooliganism, but will be ignored by the highly intoxicated. In their view, security officers tend to be under-trained. They suggest that the use of uniforms may aggravate a violent situation.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is insufficient evidence to determine how the environment and organisation impacts on the incidence of disturbed/violent behaviour by psychiatric patients in an emergency department. The limited evidence suggests that staff feel that the environment in emergency departments often puts them at risk of disturbed/violent behaviour.

I.ii Prediction: antecedents, warning signs and risk factors

I.ii.a Review question: how is disturbed/violent behaviour by psychiatric patients best predicted in emergency departments, immediately prior to admission to an adult psychiatric in-patient setting, and what are the key risk factors?

In a survey of staff and records in the violent incident book of the A&E department of a UK general hospital, Cembrowicz and Shepherd (1992) reported that in four of the last 20 incidents recorded, the violent patient was known to have a psychiatric illness. They found nursing staff and male doctors were most frequently assaulted;

receptionists least frequently. The recording of information by staff was haphazard, sometimes due to time pressures, because they hadn't been injured themselves or because they wanted to avoid being blamed if they made frequent reports. If an assailant used a weapon, it was most likely to be any implement that happened to be ready-to-hand. The study concluded that staff need to be aware of body language which signals an angry outburst (flared nostrils, staring eyes, aggressive stance, pointing and pacing) and the risks of violent behaviour associated with intoxication.

Beck et al. (1991) conducted a case-control study using record review of 99 patients identified over six months as violent (evidence of assault or battery) or potentially violent (verbal threat or staff impression of poor control and anger or agitation); 95 control patients, judged not to be violent or potentially violent; and staff interviews. They found that women were more often violent, and men were more often potentially violent, made threats or were a source of concern to staff ($p<0.03$). Study patients were, on average, four years younger than control patients ($p<0.005$), more often brought in by police, and subsequently hospitalised (62 per cent vs. 29 per cent).

Cooper (1988) undertook a retrospective survey of patients referred by a general emergency department to a psychiatric unit. He analysed the antecedents and mapped the course of violent behaviour. Thirty percent had physically attacked another person immediately prior to presentation in the emergency department. Most of this violence was perpetrated by non-psychotic individuals in the throws of an interpersonal crisis. Twenty-five percent were found to be acutely intoxicated with alcohol, but intoxication may have gone undetected in many more. The majority of patients referred from an emergency department to a psychiatric ward were judged to be non-psychotic, presenting with situational crises and personality disorders rather than a major mental illness.

In a cross-sectional survey of all 130 qualified staff in the emergency departments of two hospitals, Lee et al. (2001) found that greater self-efficacy (judgements of what one can accomplish, rather than skills one possesses) was observed in higher grade staff who had experienced higher levels of aggression. The author notes that the nature of the association between self-efficacy and levels of violent behaviour encountered is not illuminated by this study. This study did not differentiate between violence committed by people with psychiatric illness and people without psychiatric illness.

Evidence statement

Level of evidence	Evidence statement
Level 4	Limited evidence suggests that heightened arousal, depressive symptoms and alcohol intoxication are antecedents of disturbed/violent behaviour in emergency departments.

I.ii.b Review question: what are the views of staff and service users about prediction of disturbed/violent behaviour by psychiatric patients in an emergency department?

No studies addressed this review question.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is no evidence on risk factors for disturbed/violent behaviour in emergency departments from the perspective of staff and service users.

II Training

II.a Review question: how effective is training in the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments immediately prior to admission to an adult psychiatric in-patient setting?

No studies addressed this review question.

II.b Review question: What are the views of staff and service users about training in the short-term management of disturbed/violent behaviour by psychiatric patients in an emergency department?

No studies addressed this review question.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is no evidence to determine the effectiveness of training in the short-term management of disturbed/violent behaviour in emergency departments, nor staff views on such training.

III Minority ethnic groups, gender and other special concerns

III.i.a Review question: how do ethnicity, gender or other special concerns impact on the short-term management of disturbed/violent behaviour by psychiatric patients in A&E settings, immediately prior to admission to an adult psychiatric in-patient setting?

No studies addressed this review question.

III.i.b Review question: what are the views of staff and service users about the impact of ethnicity, gender or other special concerns on the short-term management of disturbed/violent behaviour by psychiatric patients in an emergency department?

No studies addressed this review question.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is no evidence to ascertain whether: ethnicity, gender or special concerns (for example, disability) impact on or influence the approach to short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments. There is no evidence to determine staff or service user perspectives on whether ethnicity, gender or other special concerns influence or have an impact on the short-term management of disturbed/violent behaviour in emergency departments.

IV Psychosocial techniques

IV.i De-escalation techniques

IV.i.a Review question: are de-escalation techniques an effective tool for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments, immediately prior to admission to an adult psychiatric in-patient setting?

Lee et al. (2001) found that nurses' aggression management training did not appear to equip them with the skills required to manage violent behaviour in emergency departments. He recommends that aggression management training should encourage nurses to examine their beliefs about violence and should focus on diffusion and de-escalation of violence, rather than control and restraint techniques.

Lane (1986) reports case studies of three patients admitted to the emergency department. He describes how techniques employing empathy (a combination of the suspension of judgement and sympathetic and creative imagination) were used to manage violence where more severe measures (restraint and medical management) might otherwise have been used. Generalisability is very limited.

IV.i.b Review question: what are the views of staff and service users about the use of de-escalation techniques for the short-term management of disturbed/violent behaviour by psychiatric patients in an emergency department?

No studies addressed this review question.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is no evidence to suggest that de-escalation techniques are an effective tool for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments.

IV.ii Observation

IV.ii.a Review question: is observation an effective tool for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments, immediately prior to admission to an adult psychiatric in-patient setting?

No studies addressed this review question.

IV.ii.b Review question: what are the views of staff and service users about the use of observation for the short-term management of disturbed/violent behaviour by psychiatric patients in an emergency department?

No studies addressed this review question.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is no evidence on whether observation is an effective tool for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments.

V Other Interventions

V.i Pharmacological interventions: rapid tranquillisation and PRN medication

V.i.a Review question: are pharmacological interventions effective and safe for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments, immediately prior to admission to an adult psychiatric in-patient setting?

Roberts and Geeting (2001) describe the use of ketamine to tranquillise a dangerous and violent patient on admission to the emergency department. Within two to three minutes of intramuscular administration of 480mg ketamine (5mg/kg), violent activity had completely ceased. Mild sinus tachycardia and transient hypertension were observed 10 minutes after initial sedation, but all vital signs were normal 50 minutes after ketamine administration. Ketamine effects dissipated within two hours, however additional aliquots of lorazepam were required to control agitation over the next 12 hours. No immediate complications from ketamine or emergence phenomena were observed.

The authors argue that given ketamine's wide safety profile, potent anaesthetic effects, rapid onset, ease of intramuscular administration, absence of respiratory depression and short duration of action, it is considered useful for immediate tranquillisation of selected, undifferentiated, uncontrollable adults, who are in a life-threatening situation that requires immediate medical intervention. Concomitant use of benzodiazepines and selected use of atropine are suggested to ameliorate emergence phenomena, and to dry excessive oral secretions. The authors stress that, after use, close monitoring of cardiovascular parameters is essential. This is a case study of a single patient, so it is not possible to generalise.

V.i.b Review question: what are the views of staff and service users about the use of pharmacological interventions for the short-term management of disturbed/violent behaviour by psychiatric patients in an emergency department?

Binder and McNiel (1999) conducted a cross-sectional survey of 20 medical directors of psychiatric emergency departments. The aim was to assess how acutely violent patients were managed in psychiatric emergency rooms, to examine medical directors' practices and to investigate emergency department characteristics. Fourteen reported that acutely violent patients are usually put in restraints and medicated intramuscularly or intravenously and given a medical assessment only after they were less agitated. Thirteen used the same acute medication regimen for all violent patients, regardless of eventual diagnosis. Eleven used haloperidol plus lorazepam, with or without benzatropine. Five used droperidol, in one case alongside lorazepam and diphenhydramine. Fifteen stated that the intramuscular route was the most common, two preferred the intravenous route whenever possible. All 20 felt that their preferred medication regimen was effective for calming the violent patient, usually after one dose and always after one to two repeated doses. Only three stated that agitated patients will usually take medications orally and that mechanical restraints are rarely used. Factors cited as allowing them to use less coercive techniques included: a system where most contacts were with people who were known to the system or who had case management protocols; a computerised system where information on patients is available within 30 to 60 seconds; a less violent patient population; and the availability of nurse clinicians who know the population. Results suggest that the strategies most frequently advocated in recent review articles for the assessment and management of violent patients are not generally applied by those responsible for the emergency management of acutely violent patients. Clinicians appeared to place the highest priority on prevention of patient and staff injuries, by rapidly reducing violent behaviour through restraints and intramuscular medications – typically a combination of neuroleptics and benzodiazepines – irrespective of diagnosis. The authors suggest that one could argue that these practices involve risks of excessive coercion, overmedicating patients, and exacerbating underlying medical conditions. On the other hand, the clinical experience of practitioners suggests that these strategies rapidly ameliorate acute violence and thereby reduce the risk of injury.

No studies were found on the use of PRN in emergency departments.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is no evidence to suggest that different medication regimes are either more effective or safe for rapid tranquillisation in emergency departments than medication regimes commonly used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings. The limited evidence suggests that staff in emergency departments may use inappropriate strategies for dealing with the short-term management of disturbed/violent behaviour in service users.

V.ii Physical interventions

V.ii.a Review question: are physical interventions effective and safe for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments, immediately prior to admission to an adult psychiatric in-patient setting?

In Beck et al. (1991), a study in a psychiatric emergency service, psychotic patients who were restrained were 6.36 times more likely to be hospitalised than were psychotic patients who were not restrained ($p<0.05$). Non-psychotic patients who were restrained were 5.36 times more likely to be hospitalised than non-psychotic patients who were not restrained ($p<0.03$). Patients brought in by police were more likely to be put into restraints than patients brought in by others, and more likely than patients who came in unaccompanied.

V.ii.b Review question: what are the views of staff and service users about the use of physical interventions for the short-term management of disturbed/violent

behaviour by psychiatric patients in an emergency department?

Foust and Rhee (1993) conducted a prospective descriptive questionnaire study of all staff in an emergency department over nine months, to determine the incidence of battery (wilful and unlawful use of force or violence on the person of another) against emergency department medical staff by patients or visitors. Over the course of the study period, 19 instances of battery occurred. In eight cases, battery occurred when the patient was restrained, and four when the patient was restrained, but restraint was being modified.

The department's unusual restraint policies were described, whereby all patients placed on psychiatric or substance abuse 'holds' (requiring that they are a danger to themselves, to others or gravely disabled) be restrained with a loosely applied cloth belt that encircles the abdomen. Four of the incidents occurred when the patient was in abdominal restraint only, and eight other incidents when in abdominal and extremity restraint. The restraint procedures were not described. It was noted that 79 per cent of battery was carried out by patients with psychiatric problems or who were intoxicated. Consistent with other studies, incidents were significantly under-reported. In only four cases were hospital incident forms filled in. Authors recommend that strategies to prevent or control violence should be concentrated on evening and nightshifts.

Evidence statement

Level of evidence	Evidence statement
Level 4	There is insufficient evidence to assess whether physical interventions are either effective or safe for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments, on the basis of the available literature.

V.iii Seclusion

V.iii.a Review question: is seclusion effective and safe for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency, immediately prior to admission to an adult psychiatric in-patient setting?

No studies addressed this review question.

V.iii.b Review question: what are the views of staff and service users about the use of seclusion for the short-term management of disturbed/violent behaviour by psychiatric patients in an emergency department?

No studies addressed this review question.

Evidence statements

Level of evidence	Evidence statement
Level 4	There is an absence of evidence to determine whether seclusion is either effective or safe for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments. There is an absence of evidence to determine staff or service user views on the use of seclusion for the short-term management of disturbed/violent behaviour by psychiatric patients in emergency departments.

7.8.7.4 Economic evidence

No studies containing relevant economic data were found (see Appendix 9).

8 Recommendations and good practice points

All recommendations derive from the available evidence, GDG input and formal consensus processes, all of which are detailed in previous sections. The grading of the recommendations is explained in Section 7.4.

8.1 Guidance

** Please note that the numbering of the recommendations and good practice points within this section remains consistent with the numbering included in the NICE version of the guideline. The NICE version of the guideline is available via the NICE website at the following address: www.nice.org.uk/page.aspx?o=244477*

1.1 Environment (in-patient psychiatric settings)

The physical and therapeutic environment can have a strong, mitigating effect on the short-term management of disturbed/violent behaviour. The following recommendations are the minimum requirements that should be expected within in-patient psychiatric settings.

*See evidence statement page 36, para 7.8.2.1.3.

1.1.1 Safety and security

1.1.1.1 When staff are engaged in the short-term management of disturbed/violent behaviour, every effort should be made to manage the service user in an open care setting. **[D]**

1.1.1.2 All services should provide a designated area or room that staff may consider using, with the service user's agreement, specifically for the purpose of reducing arousal and/or agitation. In services where seclusion is practised, this area should be in addition to a seclusion room (see recommendation 1.1.1.3). **[D]**

1.1.1.3 In services in which seclusion is practised, there should be a designated seclusion room fit for purpose. This room should allow clear observation, be well insulated and ventilated, have access to toilet/washing facilities and be able to withstand attack/damage. **[D]**

1.1.1.4 Secure, lockable access to a service user's room, bathroom and toilet area is required, with external staff override. **[D(GPP)]**

1.1.1.5 The internal design of the ward should be arranged to facilitate observation, and sight lines should be unimpeded (for example, not obstructed by the opening of doors). Measures should be taken to address blind spots within the facility, including consideration of the use of CCTV and parabolic mirrors. **[D]**

1.1.1.6 Facilities should ensure routes of safe entry and exit in the event of an emergency related to disturbed/violent behaviour. **[D]**

1.1.1.7 There should be a separate area to receive service users with police escorts. **[D(GPP)]**

1.1.2 Activities and external areas

1.1.2.1 The environment should take into account the service user's needs.

- Services should be able accommodate service users' needs for engaging in activities and individual choice – there should be an activity room and a dayroom with a television, as boredom can lead to disturbed/violent behaviour.
- Service users should have single sex toilets, washing facilities, day areas and sleeping accommodation.
- There should be a space set aside for prayer and quiet reflection. **[D]**

1.1.2.2 There should be daily opportunities for service users to engage in physical exercise, group interaction, therapy and recreation. **[D(GPP)]**

1.1.2.3 There should be access to the day room at night for service users who cannot sleep. **[D(GPP)]**

1.1.2.4 Service users should be able to have easy access to fresh air and natural daylight. **[D(GPP)]**

1.1.2.5 Where practicable, access to an external area should be via the unit and where necessary, appropriate standards of fencing should be provided. **[D]**

1.1.3 Service user concerns

1.1.3.1 The environment should take into account service user needs for:

- safety
- privacy
- dignity
- gender – and cultural-sensitivity
- sufficient physical space

- social and spiritual expression. **[D]**

1.1.3.2 Where possible, service users should have privacy when making phone calls, receiving guests, and talking to a staff member. **[D(GPP)]**

1.1.3.3 Facilities should have adequate means of controlling light, temperature, ventilation and noise. **[D(GPP)]**

1.1.3.4 Internal smoking areas/rooms should have powerful ventilation and be fitted with a smoke-stop door(s). **[D(GPP)]**

1.1.3.5 All areas should look and smell clean. **[D(GPP)]**

1.1.3.6 Suitable access facilities are needed for people who have problems with mobility, orientation, visual or hearing impairment or other special needs. **[D(GPP)]**

1.1.4 Alarms

*See evidence statement page 37, para. 7.8.2.2.3.

1.1.4.1 Each service should have a local policy on alarms and determine the need for alarms according to a comprehensive risk assessment of the clinical environment, service users and staff. The policy should be disseminated, and staff made familiar with its contents. **[D]**

1.1.4.2 Comprehensive risk assessment of the clinical environment should be used to determine whether supplementary personal alarms should be issued to individual staff members and vulnerable service users. **[D(GPP)]**

1.1.4.3 Collective responses to alarm calls should be agreed before incidents occur. These should be consistently applied and rehearsed. **[D(GPP)]**

1.1.4.4 Furniture should be arranged so that alarms can be reached and doors are not obstructed. **[D(GPP)]**

1.1.4.5 Alarms should be accessible in interview rooms, reception areas and other areas where one service user and one staff member work together. **[D(GPP)]**

1.1.4.6 All alarms (for example, panic buttons and personal alarms) should be well maintained and checked regularly. **[D(GPP)]**

1.1.5 Clinical environment

1.1.5.1 There should be a regular and comprehensive general risk assessment to ensure the safety of the clinical environment. **[D(GPP)]**

1.1.5.2 Bed occupancy should be decided at a local level and this level should not be exceeded, because overcrowding leads to tension, frustration and overstretched staff. **[D(GPP)]**

1.1.5.3 There should be a stable and consistent in-patient team, as high staff turnover and overuse of short-term bank, locum and agency health care staff may create an unsafe environment. **[D(GPP)]**

1.1.6 Interagency working

1.1.6.1 Local protocols should be developed to ensure that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between different agencies. Such policies should set out what constitutes an emergency requiring police intervention. **[D(GPP)]**

1.2 Prediction

Disturbed/violent behaviour can never be predicted with 100 per cent accuracy. However, this does not mean that risk assessment should not be carried out.

1.2.1 Policy

1.2.1.1 Measures to reduce disturbed/violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers should ensure that there is a full risk management strategy for all their services. **[D]**

1.2.2 Risk assessment

1.2.2.1 Risk assessment should include a structured and sensitive interview with the service user and, where appropriate, carers. Efforts should be made to ascertain the service user's own views about their trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these. Sensitive and timely feedback should complete this process. **[D(GPP)]**

1.2.2.2 Risk assessment should be used to establish whether a care plan should include specific interventions for the short-term management of disturbed/violent behaviour. **[D(GPP)]**

1.2.2.3 When assessing for risk of disturbed/violent behaviour, care needs to be taken not to make negative assumptions based on ethnicity. Staff members should be aware that cultural mores may manifest as unfamiliar behaviour that could be misinterpreted as being aggressive. The assessment of risk should be objective, with consideration being given to the degree to which the perceived risk can be verified. **[D(GPP)]**

1.2.2.4 All staff should be aware of the following factors that may provoke disturbed/violent behaviour:

- attitudinal
- situational
- organisational

- environmental. **[D(GPP)]**

1.2.2.5 Actuarial tools and structured clinical judgement should be used in a consistent way to assist in risk assessment, although no 'gold standard' tool can be recommended. **[D]**

1.2.2.6 Since the components of risk are dynamic and may change according to circumstance, risk assessment (of the environment and the service user) should be ongoing and care plans based on an accurate and thorough risk assessment. **[D]**

1.2.2.7 The approach to risk assessment should be multidisciplinary and reflective of the care setting in which it is undertaken. The findings of the risk assessment should be communicated across relevant agencies and care settings, in accordance with the law relating to patient confidentiality. **[D]**

Commentary

Further details of the law relating to patient confidentiality can be found on the General Medical Council website (http://www.gmc-uk.org) and from the Department of Health website (http://www.dh.gov.uk).

1.2.3 Antecedents and warning signs

*See evidence statement page 39, para.7.8.2.3.3.

1.2.3.1 Certain features can serve as warning signs to indicate that a service user may be escalating towards physically violent behaviour. The following list is not intended to be exhaustive and these warning signs should be considered on an individual basis.

- Facial expressions tense and angry.
- Increased or prolonged restlessness, body tension, pacing.
- General over-arousal of body systems (increased breathing and heart rate, muscle twitching, dilating pupils).
- Increased volume of speech, erratic movements.
- Prolonged eye contact.
- Discontentment, refusal to communicate, withdrawal, fear, irritation.
- Thought processes unclear, poor concentration.
- Delusions or hallucinations with violent content.
- Verbal threats or gestures.
- Replicating, or behaviour similar to that which preceded earlier disturbed/violent episodes.
- Reporting anger or violent feelings.
- Blocking escape routes. **[D(GPP)]**

1.2.4 Risk factors

*see evidence statement page 40, para. 7.8.2.3.3.

Certain factors can indicate an increase risk of physically violent behaviour. The following lists are not intended to be exhaustive and these risk factors should be considered on an individual basis.

1.2.4.1 Demographic or personal history should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features.

- History of disturbed/violent behaviour.
- History of misuse of substances or alcohol.
- Carers reporting service user's previous anger or violent feelings.
- Previous expression of intent to harm others.
- Evidence of rootlessness or 'social restlessness'.
- Previous use of weapons.
- Previous dangerous impulsive acts.
- Denial of previous established dangerous acts.
- Severity of previous acts.
- Known personal trigger factors.
- Verbal threat of violence.
- Evidence of recent severe stress, particularly loss event or the threat of loss.
- One or more of the above in combination with any of the following:
  - cruelty to animals
  - reckless driving
  - history of bed-wetting
  - loss of a parent before the age of eight years. **[D(GPP)]**

1.2.4.2 Clinical variables should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features.

- Misuse of substances and/or alcohol.
- Drug effects (disinhibition, akathisia).
- Active symptoms of schizophrenia or mania, in particular
  - delusions or hallucinations focused on a particular person
  - command hallucinations
  - preoccupation with violent fantasy
  - delusions of control (especially with violent theme)
  - agitation, excitement, overt hostility or suspiciousness.
- Poor collaboration with suggested treatments.

- Antisocial, explosive or impulsive personality traits or disorder.
- Organic dysfunction. **[D(GPP)]**

* See evidence statements pages 46 and 47, para 7.8.2.3.3. v, vi, vii.

1.2.4.3 Situational variables should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features.

- Extent of social support.
- Immediate availability of a potential weapon.
- Relationship to potential victim (for example, difficulties in relationship are known).
- Access to potential victim.
- Limit setting (for example, staff members setting parameters for activities, choices etc.).
- Staff attitudes. **[D(GPP)]**

1.3. Training

Staff need to have the appropriate skills to manage disturbed/violent behaviour in psychiatric in-patient settings. Training in the interventions used for the short-term management of disturbed/violent behaviour safeguards both staff and service users. Training that highlights awareness of racial, cultural, social and religious/spiritual needs, and gender differences, along with other special concerns, also mitigates against disturbed/violent behaviour. Such training should be properly audited to ensure its effectiveness.

* See evidence statements on page 50, para. 7.8.3.3 Ia, and on page 51, para. 7.8.3.3 Ib

1.3.1 Policy

1.3.1.1 All service providers should have a policy for training employees and staff-in-training, in relation to the short-term management of disturbed/violent behaviour. This policy should specify who will receive what level of training (based on risk assessment), how often they will be trained, and also outline the techniques in which they will be trained. **[D]**

1.3.1.2 All service providers should specify who the training provider is and ensure consistency in terms of training and refresher courses. **[D]**

1.3.1.3 Training relating to the management of disturbed/violent behaviour should be subject to approved national standards. **[D]***

1.3.1.4 If participants on training courses demonstrate inappropriate attitudes then trainers should pass this information onto the relevant line manager for appropriate action. **[D]**

** The NHS security management service (SMS) is developing a training curriculum for the management of violence. The National Institute for Mental Health in England (NIMHE) is drawing up an accreditation scheme for trainers. The work is due for completion in 2005.*

1.3.2 Specific staff training needs

1.3.2.1 There should be an ongoing programme of training for all staff in racial, cultural, spiritual, social and special needs issues to ensure that staff are aware of and know how to work with diverse populations and do not perpetuate stereotypes. Such courses should also cover any special populations – such as migrant populations and asylum seekers – that are relevant to the locality. **[D]**

1.3.2.2 All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents and risk factors of disturbed/violent behaviour and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with disturbed/violent behaviour. **[D]**

1.3.2.3 Staff members responsible for carrying out observation and engagement should receive ongoing competency training in observation, so that they are equipped with the skills and confidence to engage with service users. **[D]**

1.3.2.4 All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of immediate life support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators). **[D]**

1.3.2.5 Staff who employ physical intervention or seclusion should as a minimum be trained to basic life support (BLS – Resuscitation Council UK). **[D]**

1.3.2.6 All staff whose level of need is determined by risk assessment should receive training to ensure current competency in the use of physical intervention, which should adhere to approved national standards. **[D]**

1.3.2.7 Service providers should ensure that staff's capability to undertake physical intervention and physical intervention training courses is assessed. **[D]**

1.3.2.8 All staff whose level of need is determined by risk assessment should receive ongoing competency training in the use of seclusion. Training should include appropriate monitoring arrangements for service users placed in seclusion. **[D]**

1.3.2.9 All staff involved in rapid tranquillisation should be trained in the use of pulse oximeters. **[D]**

1.3.2.10 Prescribers and those who administer medicines should be familiar with and have received training in rapid tranquillisation, including:

- the properties of benzodiazepines; their antagonist, flumazenil; antipsychotics; antimuscarinics; and antihistamines
- the risks associated with rapid tranquillisation, including cardio-respiratory effects of the acute administration of these drugs, particularly when the service user is highly aroused and may have been misusing drugs; is dehydrated or possibly physically ill
- the need to titrate doses to effect. **[D]**

1.3.2.11 All staff involved in undertaking of searches should receive appropriate instruction, which is repeated and regularly updated. **[D]**

1.3.3 Incident recording

1.3.3.1 Training should be given to all appropriate staff to ensure that they are aware of how to correctly record any incident, using the appropriate local templates. **[D]**

1.3.4 Refresher courses

1.3.4.1 Services should review their training strategy annually to identify those staff groups that require ongoing professional training in the recognition, prevention and de-escalation of disturbed/violent behaviour and in physical intervention to manage disturbed/violent behaviour. **[D]**

*See evidence statement page 53, para. 7.8.3.3. Ib

1.3.5 Evaluating training

1.3.5.1 All training should be evaluated, including training in racial, cultural, religious/spiritual and gender issues, along with training that focuses on other special service user concerns. **[D]**

1.3.5.2 Independent bodies/service user groups should, if possible, be involved in evaluating the effectiveness of training. **[D]**

* See evidence statements on page 50, para. 7.8.3.3 Ia, and page 53, para. 7.8.3.3 II.

1.3.6 Service user training/involvement in training

1.3.6.1 Service users and/or service user groups should have the opportunity to become actively involved in training and setting the training agenda, for example groups with potential vulnerabilities such as:

- service users with a sensory impairment
- black and minority ethnic service users
- service users with a physical impairment
- service users with a cognitive impairment
- female service users
- service users with communication difficulties. **[D]**

1.4 Working with service users

There is a growing acceptance that service users in adult psychiatric in-patient settings ought to be involved in their care, as far as possible. This extends to the short-term management of disturbed/violent behaviour, where service user input can be made through measures such as advance directives. Listening to service users' views and taking them seriously is now also regarded as an important factor in the short-term management of disturbed/violent behaviour. Service users may also have physical needs that need to be taken into account, when using the interventions discussed in this guideline.

The recommendations and good practice points that follow also address the needs that arise from diversity (cultural, social, religious/spiritual and gender-related needs) and physical needs in the context of the short-term management of disturbed/violent behaviour. It is important that service users should not be treated less favourably on the basis of their culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs.

*See evidence statement on page 57, para. 7.8.4.1.4 Ic, and on page 58, para. 7.8.4.2.1 Ia.

1.4.1 Creating a feeling of safety and understanding

Preventing disturbed/violent behaviour is a priority. Providing relevant information so that service users feel safe and understand what may happen to them in the event that they become disturbed/violent will help prevent unnecessary aggravation.

1.4.1.1 All service users, regardless of culture, gender, diagnosis, sexual orientation, disability, ethnicity or religious/spiritual beliefs should be treated with dignity and respect. **[D]**

1.4.1.2 Service users should have access to information about the following in a suitable format:

- which staff member has been assigned to them and how and when they can be contacted
- why they have been admitted (and if detained, the reason for detention, the powers used and their extent, and rights of appeal)
- what their rights are with regard to consent to treatments, complaints procedures, and access to independent help and advocacy
- what may happen if they become disturbed/violent.

This information needs to be provided at each admission, repeated as necessary and recorded in the notes. **[D]**

Commentary

Although no studies were identified that specifically addressed the issue of information provision for service users, the Guideline Development Group viewed this as an important issue requiring guidance. The Group maintain it is the legal right that detained service users are given this information and that this information should be viewed as a right for all service users. (See also the legal preface on page 20, para. 6.1.1)

1.4.1.3 An effective and fair complaints procedure should be put in place. **[D(GPP)]**

1.4.1.4 Where at all possible, service users should have a choice of key worker. **[D(GPP)]**

1.4.1.5 Service users identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advance directive. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review. **[D]**

Commentary

Although no studies were identified that specifically addressed the issue of advance directives, the Guideline Development Group (in particular those with personal experience of the issue) felt that it was important for service users to be able to have input into their care. The Group did not consider that discussing these issues with appropriate service users would cause unnecessary anxiety. The Group used formal consensus techniques to develop this recommendation.

1.4.1.6 During the staff/service user risk assessment interview, where a risk of disturbed/violent behaviour is discussed or identified as a possibility, intervention and management strategies (and the service user's preferences regarding these) should be recorded in the service user's care plan and health care record. Efforts should be made to ascertain the service user's own views about their trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these. The service user should be given a copy of the care plan and, subject to their agreement, a copy should be given to their carer. **[D(GPP)]**

1.4.1.7 The physical needs of the service user should be assessed on admission or as soon as possible thereafter and then regularly reassessed. The care plan should reflect the service user's physical needs. **[D(GPP)]**

1.4.1.8 Following any intervention for the short-term management of disturbed/violent behaviour, every opportunity should be taken to establish whether the service user understands why this has happened. Where possible, this should be carried out by a staff member not directly involved in the intervention. This should be documented in the service user's notes. **[D]**

1.4.1.9 Staff should take time to listen to service users, including those from diverse backgrounds, (taking into account that this may take longer when using interpreters), so that therapeutic relationships can be established. **[D(GPP)]**

1.4.1.10 All services should have a policy for preventing and dealing with all forms of harassment and abuse. Notification of this policy should be disseminated to all staff and displayed prominently in all clinical and public areas. **[D]**

1.4.1.11 In the event of any form of alleged abuse, the matter should be dealt with by staff as soon as is practicable, in accordance with relevant policies of the service. **[D(GPP)]**

1.4.1.12 During the administration or supply of medicines to service users, confidentiality should be ensured. **[D(GPP)]**

1.4.1.13 Prescribers should be available for and responsive to requests from the service user for medication review. **[D(GPP)]**

1.4.1.14 Staff should be encouraged to talk to service users from diverse backgrounds, including those with special needs, about their experiences and to offer them support and understanding, especially if their experience has been negative. **[D]**

1.4.2 Pregnant women

1.4.2.1 Special provision should be made for pregnant women, in the event that interventions for the short-term management of disturbed/violent behaviour are needed. These should be recorded in the service user's care plan. **[D(GPP)]**

1.4.3 Black and minority ethnic service users

See also recommendation 1.2.2.3.

*See evidence statements on pages 58 and 59, paras. 7.8.4.2.3 Ia, Ib, IIb, IIIa

1.4.3.1 Services must identify a board member to take specific responsibility for all matters relating to equality and diversity. Responsibilities must include the nature and adequacy of service provision in relation to the short-term management of disturbed/violent behaviour, training on all matters relating to equality and diversity, monitoring service usage by ethnicity and consultation with local black and minority ethnic groups. **[D]**

1.4.4 Service users with disabilities

*See evidence statement page 61, para. 7.8.4.4.4.

1.4.4.1 Each service should have a policy that outlines the procedures for dealing with service users who have disabilities, including those with physical or sensory impairment and/or other communication difficulties. **[D(GPP)]**

1.4.4.2 Individual care plans should detail staff responsibilities for de-escalation, rapid tranquillisation, physical intervention and seclusion of service users who have disabilities, including those with physical or sensory impairment and/or other communication difficulties. **[D(GPP)]**

1.4.5 Managing the risk of HIV or other infectious diseases

Policy

1.4.5.1 Services should have policies in place, developed in conjunction with the trust infection control officer or relevant officer in the service, that outline the reasonable steps that can be taken to safeguard staff and other service users if a service user who has HIV, hepatitis or other infectious or contagious diseases is acting in a manner that may endanger others. **[D(GPP)]**

1.4.5.2 If staff are aware that a service user has HIV, hepatitis or other infectious or contagious diseases, the advice of the trust infection control officer or relevant officer in the service should be sought. **[D(GPP)]**

Confidentiality issues

1.4.5.3 Service users are owed important obligations of confidentiality, but these are not absolute. In certain circumstances they may be breached to safeguard others. This is particularly relevant where a service user has HIV, hepatitis or other infectious or contagious diseases, and is acting in a manner that puts others at risk. Legal and ethical advice should be sought in these circumstances. **[D(GPP)]**

1.4.5.4 If any service user or staff member has sustained any injury during the management of disturbed/violent behaviour where blood has been spilt or the skin has been broken, or there has been direct contact with bodily fluids (all bodily fluids should be treated as potentially infectious), the local infection control policy should be followed. **[D(GPP)]**

1.5 Searching

The undertaking of necessary and lawful searches of both service users and visitors can make an important contribution to the effective management of disturbed/violent behaviour in psychiatric in-patient settings. Unlawful, insensitive and unnecessary searches can also exacerbate disturbed/violent behaviour. Searches should be undertaken by appropriately trained staff.

See also recommendation 1.3.2.11 (Training).

1.5.1 Policy

1.5.1.1 All facilities should have an operational policy on the searching of service users, their belongings and the environment in which they are accommodated, and also the searching of visitors. Where necessary, the policy should refer to related policies, such as those for substance misuse and police liaison. The searching policy should be in place in order to ensure the creation and maintenance of a safe and therapeutic environment for service users, staff and visitors. **[D]**

1.5.1.2 The searching policy should address all aspects of personal through to environmental searching – from the decision to initiate a search through to the storage, return or other disposal (including the lawful disposal of any items such as firearms and illicit drugs) of items found. **[D]**

1.5.1.3 Post search support for all those involved should be provided. **[D]**

1.5.1.4 The searching policy should set out, in terms that can easily be understood by all those with responsibilities under the policy, the legal grounds for undertaking searches in the absence of consent. **[D]**

1.5.1.5 The searching policy should specifically address the searching of service users detained under the Mental Health Act; informal service users without capacity to consent at the time of the search; informal service users with capacity to do so; and staff and visitors. **[D]**

1.5.1.6 The searching policy should also extend to the routine and random searching of detained service users, where it is proposed to do so because there is a pressing social need to do so (for example, there is a chronic substance abuse problem on the ward) and undertaking such searches is a proportionate response to that need. **[D]**

1.5.2 Carrying out searches

1.5.2.1 The level of intrusiveness of any personal search undertaken must be a reasonable and proportionate response to the reason for the search. Ordinarily rub down or personal searching should be provided for in the policy, together with procedures for their authorisation in the absence of consent. **[D]**

1.5.2.2 All searches should be undertaken with due regard to the service user's dignity and privacy and by a member(s) of staff of the same sex. **[D]**

1.5.2.3 The searching policy should provide for the circumstances in which a service user physically resists being searched. In this event a multidisciplinary decision should be made as to the need to carry out a search using physical intervention. If a decision is made not to proceed, then the searching policy should set out the options available to deal with the situation. **[D]**

1.5.2.4 The searching policy should make provision for the following:

- service users, staff and visitors should be informed that there is a policy on searching
- the consent of the person it is proposed to search should always be sought
- the person being searched should be kept informed of what is happening and why
- a comprehensive record of every search should be made, including its justification
- any consequent risk assessment and risk management should be placed in the appropriate records. **[D]**

1.5.2.5 Following every search undertaken where consent has been withheld, there should be a post-incident review that includes an advocacy service or hospital managers visiting the service user who has been searched. **[D]**

1.5.2.6 The exercise of powers of search should be audited regularly and the outcomes reported regularly to the trust board or appropriate body. **[D]**

1.6 De-escalation techniques

De-escalation involves the use of techniques that calm down an escalating situation or service user; therefore, action plans should stress that de-escalation should be employed early on in any escalating situation. Action plans should be developed at a local level, detailing how to call for help in an emergency.

* See evidence statement page 63, para.7.8.5.1.3.

See also recommendation 1.1.1.2 (Environment) and recommendation 1.3.2.2 (Training).

1.6.1 General

1.6.1.1 A service user's anger needs to be treated with an appropriate, measured and reasonable response. De-escalation techniques should be employed prior to other interventions being used. **[D(GPP)]**

1.6.1.2 Staff should accept that in a crisis situation they are responsible for avoiding provocation. It is not realistic to expect the person exhibiting disturbed/violent behaviour to simply calm down. **[D(GPP)]**

1.6.1.3 Staff should learn to recognise what generally and specifically upsets and calms people. This will involve listening to individual service users and carer's reports of what upsets the service user, and this should be reflected in the service user's care plan. **[D(GPP)]**

1.6.1.4 Staff should be aware of, and learn to monitor and control, their own verbal and non-verbal behaviour, such as body posture and eye contact etc. **[D(GPP)]**

1.6.1.5 Where possible and appropriate, service users should be encouraged to recognise their own trigger factors, early warning signs of disturbed/violent behaviour, and other vulnerabilities. This information should be included in care plans and a copy given to the service user. Service users should also be encouraged to discuss and negotiate their wishes should they become agitated. **[D(GPP)]**

1.6.1.6 Where de-escalation techniques fail to sufficiently calm a situation or service user, staff should remember that verbal de-escalation is an ongoing element of the management of an escalating individual. Verbal de-escalation is supported but not replaced by appropriate physical intervention. **[D(GPP)]**

1.6.2 De-escalation techniques

1.6.2.1 One staff member should assume control of a potentially disturbed/violent situation. **[D(GPP)]**

1.6.2.2 The staff member who has taken control should:

- consider which de-escalation techniques are appropriate for the situation
- manage others in the environment, for example removing other service users from the area, enlisting the help of colleagues and creating space
- explain to the service user and others in the immediate vicinity what they intend to do
- give clear, brief, assertive instructions
- move towards a safe place and avoid being trapped in a corner. **[D(GPP)]**

1.6.2.3 The staff member who has taken control should ask for facts about the problem and encourage reasoning. This will involve:

- attempting to establish a rapport and emphasising co-operation
- offering and negotiating realistic options and avoiding threats
- asking open questions and inquiring about the reason for the service user's anger, for example 'What has caused you to feel upset/angry?'

- showing concern and attentiveness through non-verbal and verbal responses
- listening carefully and showing empathy, acknowledging any grievances, concerns or frustrations, and not being patronising or minimising service user concerns. **[D(GPP)]**

1.6.2.4 The staff member who has taken control should ensure that their own non-verbal communication is non-threatening and not provocative. This will involve:

- paying attention to non-verbal cues, such as eye contact and allowing greater body space than normal
- adopting a non-threatening but safe posture
- appearing calm, self-controlled and confident without being dismissive or over-bearing. **[D(GPP)]**

1.6.2.5 Where there are potential weapons, the disturbed/violent person should be relocated to a safer environment, where at all possible. **[D(GPP)]**

1.6.2.6 Where weapons are involved, a staff member should ask for the weapon to be placed in a neutral location rather than handed over. **[D(GPP)]**

1.6.2.7 Staff should consider asking the service user to make use of the designated area or room specifically for the purpose of reducing arousal and/or agitation to help them calm down. In services where seclusion is practised, the seclusion room should not routinely be used for this purpose (see recommendation 1.1.1.2). **[D(GPP)]**

1.7 Observation and engagement

The primary aim of observation should be to engage positively with the service user. This involves a two-way relationship, established between a service user and a staff member, which is meaningful, grounded in trust, and therapeutic for the service user. Observation is an intervention that is used both for the short-term management of disturbed/violent behaviour and to prevent self-harm. The recommendations and good practice points below are specifically directed towards the use of observation as an intervention for the short-term management of disturbed/violent behaviour. However, many are also applicable where observation is used to prevent self-harm. The terminology covers both uses of observation.

*See evidence statement page 66, para. 7.8.5.2.3.

See also recommendation 1.3.2.3 (Training).

1.7.1 Policy

1.7.1.1 Each service should have a policy on observation and engagement that adheres to contemporary NICE terminology and definitions. This policy should include:

- who can instigate observation above a general level
- who can increase or decrease the level of observation
- who should review the level of observation
- when reviews should take place (at least every shift)
- how service users' perspectives will be taken into account
- a process through which a review by a full clinical team will take place if observation above a general level continues for more than one week. **[D]**

1.7.2 Definitions of levels of observation

1.7.2.1 The observation terminology used in this guideline should be adopted across England and Wales to ensure consistency of use. **[D]**

1.7.2.2 *General observation* is the minimum acceptable level of observation for all in-patients. The location of all service users should be known to staff, but not all service users need to be kept within sight. At least once a shift a nurse should set aside dedicated time to assess the mental state of the service user and engage positively with the service user. The aim of this should be to develop a positive, caring and therapeutic relationship with the service user. This assessment should always include an evaluation of the service user's moods and behaviours associated with risks of disturbed/violent behaviour, and these should be recorded in the notes. **[D]**

1.7.2.3 *Intermittent observation* means that the service user's location should be checked every 15 to 30 minutes (exact times to be specified in the notes). Checks need to be carried out sensitively in order to cause as little intrusion as possible. However, this check should also be seen in terms of positive engagement with the service user. This level is appropriate when service users are potentially, but not immediately, at risk of disturbed/violent behaviour. Service users who have previously been at risk of harming themselves or others, but who are in a process of recovery, require intermittent observation. **[D]**

1.7.2.4 *Within eyesight* means the service user should be kept within eyesight and accessible at all times, by day and by night and, if deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed. It is required when the service user could, at any time, make an attempt to harm themselves or others. It may be necessary to search the service user and their belongings, while having due regard for the service user's legal rights and conducting the search in a sensitive way. Positive engagement with the service user is an essential aspect of this level of observation. **[D]**

1.7.2.5 *Within arms length* is needed for service users at the highest levels of risk of harming themselves or others, who may need to be supervised in close proximity. On specified occasions, more than one member of staff may be necessary. Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the service user is an essential aspect of this level of observation. **[D]**

1.7.3 Possible antecedents or warning signs that observation is required

1.7.3.1 In addition to the antecedents that indicate disturbed/violent behaviour (see recommendation 1.2.3.1), observation above a general level should be considered if any of the following are present:

- history of previous suicide attempts, self-harm or attacks on others
- hallucinations, particularly voices suggesting harm to self or others
- paranoid ideas where the service user believes that other people pose a threat
- thoughts or ideas that the service user has about harming themselves or others
- threat control override symptoms
- past or current problems with drugs or alcohol
- recent loss
- poor adherence to medication programmes or non-compliance with medication programmes
- marked changes in behaviour or medication
- known risk indicators. **[D(GPP)]**

1.7.4 Carrying out observation

1.7.4.1 Designated levels of observation should only be implemented after positive engagement with the service user has failed to dissipate the potential for disturbed/violent behaviour. **[D(GPP)]**

1.7.4.2 The least intrusive level of observation that is appropriate to the situation should always be adopted, so that due sensitivity is given to a service user's dignity and privacy, whilst maintaining the safety of those around them. **[D(GPP)]**

1.7.4.3 Decisions about observation levels should be recorded by both medical and nursing entries in the service user's notes. The reasons for using observation should be clearly specified. **[D(GPP)]**

1.7.4.4 All decisions about the specific level of observation should take into account:

- the service user's current mental state
- any prescribed medications and their effects
- the current assessment of risk
- the views of the service user as far as possible. **[D(GPP)]**

1.7.4.5 When making decisions about observation levels, clear directions should be recorded that specify:

- the name/title of the persons who will be responsible for carrying out the review
- the timing of the review. **[D(GPP)]**

1.7.4.6 Observation skills should be used to recognise, prevent and therapeutically manage disturbed/violent behaviour. Specific observation tasks should be undertaken by registered nurses, who may delegate to competent persons. **[D]**

1.7.4.7 Nurses and other staff undertaking observation:

- should take an active role in engaging positively with the service user
- should be appropriately briefed about the service user's history, background, specific risk factors and particular needs
- should be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment
- should be able to increase or decrease the level of engagement with the service user, as the level of observation changes
- should be approachable, listen to the service user, know when self-disclosure and the therapeutic use of silence are appropriate and be able to convey to the service user that they are valued. **[D(GPP)]**

1.7.4.8 An individual staff member should not undertake a continuous period of observation above the general level for longer than two hours. **[D]**

1.7.4.9 The service user's psychiatrist/on-call doctor should be informed of any decisions concerning observation above the general level as soon as possible. **[D(GPP)]**

1.7.4.10 A nominated hospital manager should be made aware when observation above the general level is implemented, so that adequate numbers and grades of staff can be made available for future shifts. **[D(GPP)]**

1.7.4.11 Staff members should be aware that service users sometimes find observation provocative, and that it can lead to feelings of isolation and even dehumanisation. **[D(GPP)]**

1.7.5 Service user needs

1.7.5.1 The service user should be provided with information about why they are under observation, the aims of observation and how long it is likely to be maintained. **[D(GPP)]**

1.7.5.2 The aims and level of observation should, where appropriate, be communicated with the service user's approval to the nearest relative, friend or carer. **[D(GPP)]**

1.7.5.3 Although difficult, where possible, the handover from one nurse or staff member to another should involve the service user so that they are aware of what is being said about them. **[D(GPP)]**

1.8 Other interventions

Where de-escalation techniques have failed to calm a service user, it may be necessary to make use of additional interventions, such as physical intervention, rapid tranquillisation and seclusion to manage the incident. All such interventions should only be considered once de-escalation techniques have been tried and have not succeeded in calming the service user.

The choice of intervention(s) will depend on a number of factors, but should be guided primarily by:

- service user preference (if known)
- the clinical needs of, and risks to, the service user
- obligations to other service users affected by the disturbed/violent behaviour
- the protection of staff, service users and visitors
- the facilities available within the particular setting.

The intervention selected must amount to a proportionate and reasonable response to the risk posed. This section should be read alongside the Mental Health Act Code of Practice (www.dh.gov.uk/assetRoot/04/07/49/61/04074961.pdf).

1.8.1 Overarching recommendations

See also recommendations 1.3.2.4 and 1.3.2.5 (Training); 1.9.1.1 and 1.9.1.2 (Incident reporting).

1.8.1.1 Rapid tranquillisation, physical intervention and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. These interventions are management strategies and are not regarded as primary treatment techniques. When determining which interventions to employ, clinical need, safety of service users and others, and, where possible, advance directives should be taken into account. The intervention selected must be a reasonable and proportionate response to the risk posed by the service user. **[D]**

Commentary

There is a lack of evidence relating to the effectiveness of these three interventions, particularly for physical intervention and seclusion. The Guideline Development Group therefore felt the need to stress caution when implementing these interventions, and used formal consensus techniques to derive this recommendation. (See also the legal preface on page 20, para. 6.1.1).

Equipment

1.8.1.2 A crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line resuscitation medications) should be available within three minutes in health care settings where rapid tranquillisation, physical intervention and seclusion might be used. This equipment should be maintained and checked weekly. **[D]**

Personnel

1.8.1.3 At all times, a doctor should be quickly available to attend an alert by staff members when rapid tranquillisation, physical intervention and/or seclusion are implemented. **[D]**

Commentary

There is limited evidence in this area. However, a number of high profile inquiries, most recently, the inquiry into the death of David Bennett, have stressed the need for a doctor to be available to attend an alert by staff members when rapid tranquillisation, physical interventions and/or seclusion have been implemented. The inquiry into the death of David Bennett recommended that a doctor should be available within 20 minutes of such an alert. Some mental health services currently rely on emergency services in the event of such an incident. The GDG believes that dialing for emergency services in the event of an alert is not sufficient in itself. After much discussion, the GDG felt that half-an-hour is a reasonable amount of time in which to expect a doctor to be present. Formal consensus techniques were used to derive this recommendation.

Legal concerns

1.8.1.4 All staff need to be aware of the legal framework that authorises the use of rapid tranquillisation, physical intervention and seclusion. The guidance of the Mental Health Act Code of Practice (chapter 19) should be followed, with any departures from that guidance clearly recorded and justified as being in the service user's best interest. **[D(GPP)]**

Service user concerns

1.8.1.5 When using interventions such as rapid tranquillisation, physical intervention or seclusion, steps should be taken to try to ensure that the service user does not feel humiliated (such as respecting a service user's need for dignity and privacy commensurate with the needs of administering the intervention). **[D(GPP)]**

1.8.1.6 The reasons for using rapid tranquillisation, physical intervention or seclusion should be explained to the service user at the earliest opportunity. **[D(GPP)]**

1.8.1.7 After the use of rapid tranquillisation, physical intervention or seclusion, the service user's care plan should be reassessed and the service user should be helped to reintegrate into the ward milieu at the earliest safe opportunity. **[D(GPP)]**

1.8.1.8 Service users should be given the opportunity to document their account of the intervention in their notes. **[D(GPP)]**

1.8.2 Physical intervention

*See evidence statements on pages 67 and 69, para. 7.8.6.1.3.

See also recommendation 1.3.2.6 (Training).

Carrying out physical intervention

1.8.2.1 During physical intervention, staff should continue to employ de-escalation techniques. **[D]**

1.8.2.2 There are real dangers with continuous physical intervention in any position. Physical intervention should be avoided if at all possible, should not be used for prolonged periods, and should be brought to an end at the earliest opportunity. To avoid prolonged physical intervention, an alternative strategy, such as rapid tranquillisation or seclusion (where available), should be considered. **[D]**

Commentary

There is limited evidence in this area. However, a number of high profile inquiries, most recently, the inquiry into the death of David Bennett, have stressed the dangers of prolonged restraint. The GDG was aware that the inquiry into the death of David Bennett recommended that a three-minute limit be placed on any period of restraint. However, this recommendation was not evidenced-based. Furthermore the three-minute limit is not used by other services, the prison service and the police service, which advocate different limits. The GDG discussed this issue at length and consulted with experts. It was noted that a time limit might endanger staff and other service users. Given the lack of evidence for a time limit, the GDG therefore decided that a time limit should not be set on physical interventions, but that the dangers of prolonged restraint should be highlighted, and the use of restraint discouraged. A recommendation was therefore made which advocates that any use of physical interventions should be brought to an end at the earliest opportunity, and periods of prolonged restraint should be avoided. Formal consensus techniques were used to draw up this recommendation. The David Bennett Inquiry makes particular reference to the use of the prone position. However, the evidence base surrounding the dangers of positional restraint is weak. Furthermore, the GDG believes that there are dangers related to restraint in any position and therefore decided not to highlight one position as safer than another, but to discourage restraint for prolonged periods in any position.

1.8.2.3 During physical intervention, one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored. **[D]**

Commentary

There is limited evidence in this area. However, a number of high profile inquiries, most recently, the inquiry into the death of David Bennett, have stressed the need for staff to protect a service user's head and airway during the restraint process. The inquiry suggests that failure to do so, and the application of pressure to certain parts of the body, may endanger the life of the service user. The focus groups conducted for the guideline also heard reports from participants who described finding it difficult to breathe during restraint, due to their head not being sufficiently supported. Although the National Institute of Mental Health In England (NIHME) and the NHS Security Management Service (SMS) are currently developing a curriculum for training that will cover this area, the GDG felt that this was an area of particular concern. After consultation with experts, including trainers, the GDG therefore decided to use formal consensus techniques to develop recommendations in this area. The GDG considers the protection of the head when appropriate to constitute a duty of care. See also the legal preface on page 20, para. 6.1.1

1.8.2.4 During physical intervention, under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well being of the service user should be continuously monitored throughout the process. **[D]**

1.8.2.5 A number of physical skills may be used in the management of a disturbed/violent incident.

- The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.
- Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain.

- The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, service users and/or others. **[D]**

Commentary

There is limited evidence in this area and the GDG was aware that the application of pain to help manage a violent/disturbed situation is a sensitive topic. However, currently around 50 per cent of training courses in England and Wales teach the use of pain as a technique that can be applied as part of a physical intervention. The GDG therefore felt that it was necessary to make a recommendation on this issue. A great deal of discussion took place in the course of the development of the guideline concerning this issue. To ensure a balanced representation at guideline development meetings, experts holding differing perspectives were invited to give presentations. Using formal consensus techniques the GDG finally derived a recommendation that restricts the use of pain to the immediate rescue of staff, service users or others.

1.8.2.6 Mechanical restraints are not a first-line response or standard means of managing disturbed/violent behaviour in acute mental health care settings. In the event that they are used, it must be a justifiable, reasonable and proportionate response to the risk posed by the service user, and only after a multidisciplinary review has taken place. Legal, independent expert medical and ethical advice should be sought and documented. **[D]**

Commentary

There is limited evidence in this area and the GDG was aware that the use of mechanical restraints is a sensitive issue. However, such restraints are used in very exceptional circumstances, usually in high secure hospitals. The GDG therefore felt that it was necessary to make a recommendation in this area. This stresses that mechanical restraints can only be used in such exceptional circumstances and only after a multidisciplinary review has taken place. Formal consensus techniques were used to draw up this recommendation.

1.8.3 Seclusion

*See evidence statements on pages 67 and 69, para. 7.8.6.1.3.

See also recommendations 1.1.1.3 (Environment) and 1.3.2.8 (Training).

Carrying out seclusion

1.8.3.1 The use of seclusion should be recorded in accordance with the guidance in the Mental Health Act Code of Practice. **[D]**

1.8.3.2 Seclusion should be for the shortest time possible and should be reviewed at least every two hours and in accordance with the guidance in the Mental Health Act Code of Practice. The service user should be made aware that reviews will take place at least every two hours. **[D]**

1.8.3.3 If seclusion is used, an observation schedule should be specified. **[D(GPP)]**

1.8.3.4 A service user in seclusion should retain their clothing, as long as it does not compromise their safety and the safety of others. **[D(GPP)]**

1.8.3.5 Service users in seclusion should be allowed to keep personal items, including those of religious or cultural significance (such as some items of jewellery), as long as they do not compromise their safety or the safety of others. **[D(GPP)]**

Rapid tranquillisation and seclusion

1.8.3.6 The use of seclusion with rapid tranquillisation is not absolutely contraindicated. However, the following advice should be carefully considered and followed.

- If the service user is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously.
- The service user should be monitored by 'within eyesight' observation by an appropriately trained individual.
- Once rapid tranquillisation has taken effect, seclusion should be terminated. **[D(GPP)]**

1.8.4 Rapid tranquillisation

*See evidence statement on page 78, para. 7.8.6.2.4 II, and on page 80, para. 7.8.6.2.4 V.

See also recommendations 1.3.2.4, 1.3.2.9 and 1.3.2.10 (Training).

1.8.4.1 Medication for rapid tranquillisation, particularly in the context of physical intervention, should be used with caution, owing to the following risks:

- loss of consciousness instead of tranquillisation
- sedation with loss of alertness
- loss of airway
- cardiovascular and respiratory collapse
- interaction with medicines already prescribed or illicit substances taken (can cause side effects such as akathisia, disinhibition)
- possible damage to patient–staff relationship
- underlying coincidental physical disorders. **[D]**

Policy

1.8.4.2 Local protocols should be produced that cover all aspects of rapid tranquillisation. Such protocols should be in accordance with legal requirements (especially in respect of detained patients, the consent to treatment, and the emergency treatment powers and duties under the Mental Health Act), and relevant NICE guidance, and should be subject to review. **[D]**

Risks associated with rapid tranquillisation

1.8.4.3 There are specific risks associated with the different classes of medications that are used in rapid tranquillisation. The specific properties of the individual drugs should be taken into consideration. When combinations are used, risks may be compounded. Staff need to be aware of the following.

For benzodiazepines:

- loss of consciousness
- respiratory depression or arrest
- cardiovascular collapse (in service users receiving both clozapine and benzodiazepines).

For antipsychotics:

- loss of consciousness
- cardiovascular and respiratory complications and collapse
- seizures
- subjective experience of restlessness (akathisia)
- acute muscular rigidity (dystonia)
- involuntary movements (dyskinesia)
- neuroleptic malignant syndrome
- excessive sedation.

For antihistamines:

- excessive sedation
- painful injection
- additional antimuscarinic effects. **[D(GPP)]**

Circumstances for special care

1.8.4.4 Extra care should be taken when implementing rapid tranquillisation in the following circumstances:

- the presence of congenital prolonged QTc syndromes
- the concurrent prescription or use of other medication that lengthens QTc intervals, both directly and indirectly
- the presence of certain disorders affecting metabolism, such as hypo- and hyperthermia, stress and extreme emotions, and extreme physical exertion. **[D]**

Carrying out rapid tranquillisation

1.8.4.5 The service user should be able to respond to communication throughout the period of rapid tranquillisation. The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user or to others. **[D]**

1.8.4.6 When a service user is transferred between units, a full medication history, including the service user's response to medications, any adverse effects, and an advance directive should accompany them. Where possible, the service user's account of their experience of rapid tranquillisation should also be included. On discharge, all such information should be filed in their health care record and be subject to regular review. **[D(GPP)]**

Oral therapy for rapid tranquillisation

1.8.4.7 Oral medication should be offered before parenteral medication as far as possible. **[D]**

*See evidence statement on page 81, para 7.8.6.2.4 VI.

1.8.4.8 All medication given in the short-term management of disturbed/violent behaviour should be considered as part of rapid tranquillisation (including pro re nata [PRN] medication taken from an agreed rapid tranquillisation protocol or as part of an advance directive). **[D]**

1.8.4.9 Oral and intramuscular medications should be prescribed separately and the abbreviation of o/i/m should not be used. **[D]**

1.8.4.10 When the behavioural disturbance occurs in a non-psychotic context, it is preferable to initially use oral lorazepam alone, or intramuscularly if necessary. **[B]**

1.8.4.11 When the behavioural disturbance occurs in the context of psychosis, to achieve early onset of calming/sedation, or to achieve a lower dose of antipsychotic, an oral antipsychotic in combination with oral lorazepam, should be considered in the first instance. (See chart for rapid tranquillisation at end of section.) **[D]**

1.8.4.12 The Medicines and Healthcare products Regulatory Agency (MHRA) has warned against the use of risperidone or olanzapine in the treatment of behavioural symptoms of dementia, due to increased risk of stroke and death. **[B]**

1.8.4.13 Sufficient time should be allowed for clinical response between oral doses of medication for rapid tranquillisation. (See chart for rapid tranquillisation at end of section.) **[B]**

Parenteral therapy for rapid tranquillisation

*See evidence statements on page 74 and 77, para. 7.8.6.2.4 II.

1.8.4.14 If parenteral treatment proves necessary, the intramuscular route (i/m) is preferred over intravenous (i/v) from a safety point of view. The service user should be transferred to oral routes of administration at the earliest opportunity. **[D]**

1.8.4.15 Where rapid tranquillisation through oral therapy is refused, is not indicated by previous clinical response, is not a proportionate response, or is ineffective, a combination of an intramuscular antipsychotic and an intramuscular benzodiazepine (i/m haloperidol and i/m lorazepam) is recommended. **[B]**

1.8.4.16 In the event of moderate disturbance in service users with psychosis, i/m olanzapine* may also be considered. Intramuscular lorazepam should not be given within one hour of i/m olanzapine. Oral lorazepam should be used with caution. **[B]**

** The manufacturer has issued a warning that use outside of the details contained within the Summary of Product Characteristics may increase the risk of fatality.*

1.8.4.17 There is not sufficient evidence that the safety of either combination of i/m haloperidol with i/m promethazine or i/m midazolam alone has been sufficiently demonstrated in the UK. However, it has been shown to be effective and relatively safe elsewhere. The GDG is therefore not able to recommend either for routine psychiatric practice in the UK. **[B]**

Commentary

The GDG were of the opinion that the evidence was not clinically relevant to the UK context because the outcome of the studies had sleep as a primary outcome, whereas in the UK and increasingly elsewhere the primary objective is to calm the service user to enable other psychosocial techniques to be employed.

1.8.4.18 Sufficient time should be allowed for clinical response between intramuscular (i/m) doses of medications for rapid tranquillisation. (See chart for rapid tranquillisation at end of section.) **[B]**

1.8.4.19 The use of two drugs of the same class for the purpose of rapid tranquillisation should not occur. **[D]**

1.8.4.20 Medications should never be mixed in the same syringe. **[D(GPP)]**

1.8.4.21 When using i/m haloperidol as a means of managing disturbed/violent behaviour, an antimuscarinic agent, such as procyclidine or benzatropine, should be immediately available to reduce the risk of dystonia and other extrapyramidal side effects, and should be given intramuscularly or intravenously as per manufacturer's recommendations. **[D]**

1.8.4.22 Intravenous administration of benzodiazepines or haloperidol should not normally be used except in very exceptional circumstances, which should be specified and recorded. This decision should not be made by junior medical staff in isolation. **[D]**

1.8.4.23 If immediate tranquillisation is essential, then intravenous administration may be necessary. If it is used, staff should be appropriately trained to recognise symptoms of respiratory depression, dystonia or cardiovascular compromise (such as palpitations, significant changes in blood pressure, or collapse). **[D]**

1.8.4.24 If intravenous medication is used, the service user should never be left unattended. Intravenous administration should never occur without full access to the full support and resuscitation as outlined in recommendations 1.3.2.4 and 1.8.1.2. **[D]**

1.8.4.25 In very exceptional circumstances, which should be specified and recorded, i/m haloperidol in combination with i/m promethazine, or i/m midazolam alone may be considered as an alternative to intravenous administration of benzodiazepines or haloperidol. This decision should not be made by junior staff without discussion with the senior on-call psychiatrist. **[D]**

Medications not normally used for rapid tranquillisation

1.8.4.26 Zuclopenthixol acetate injection is not recommended for rapid tranquillisation due to long onset and duration of action. However, zuclopenthixol acetate injection may be considered as an option for rapid tranquillisation when:

- it is clearly expected that the service user will be disturbed/violent over an extended period of time
- a service user has a past history of good and timely response to zuclopenthixol acetate injection
- a service user has a past history of repeated parenteral administration
- an advance directive has been made indicating that this is a treatment of choice.

It should never be administered to those without any previous exposure to antipsychotic medication. The British National Formulary (BNF) and manufacturer's summary of product characteristics (SPC) should be consulted regarding its use. **[B]**

Medications not recommended for rapid tranquillisation

1.8.4.27 The following medications are not recommended for rapid tranquillisation.

- Intramuscular or oral chlorpromazine or oral (a local irritant if given intramuscularly; risk of cardiovascular complications; causes hypotension due to ·-adrenergic receptor blocking effects, especially in the doses required for rapid tranquillisation; is erratically absorbed; its effect on QTc intervals suggests that it is unsuitable for use in rapid tranquillisation). **[C]**
- Intramuscular diazepam. **[C]**

- Thioridazine. **[C]**
- Intramuscular depot antipsychotics. **[D]**
- Olanzapine or risperidone should not be used for the management of disturbed/violent behaviour in service users with dementia. **[C]**

Doses for rapid tranquillisation

It is recognised that clinicians may decide that the use of medication outside of the SPC is occasionally justified, bearing in mind the overall risks. However, where the regulatory authorities or manufacturer issues a specific warning that this may result in an increased risk of fatality, the medication should only be used strictly in accordance with the current marketing authorisation.

1.8.4.28 When using rapid tranquillisation there may be certain circumstances in which the current BNF uses and limits and SPC may be knowingly exceeded (for example, for lorazepam). This decision should not be taken lightly and the risks should not be underestimated. A risk–benefit analysis should be recorded in the case notes and a rationale should be recorded in the care plan. Where the risk–benefit is unclear, advice may be sought from clinicians not directly involved in the service user's care. **[D]**

Commentary

The inquiry into the death of David Bennett recommends that BNF limits should not be exceeded when giving rapid tranquillisation. The GDG carefully discussed this issue at length and it was felt that in certain circumstances there are grounds for knowingly exceeding BNF limits and for using medications off licence, where this is recognised clinical practice. However, the GDG stresses that a decision to exceed BNF limits should not be taken lightly and the risk of doing so should be carefully assessed. It also stresses that, where the risk benefit is unclear, it may be desirable to seek advice from staff members who are not directly involved in the service user's care. The GDG also wishes to stress that any decision to exceed BNF limits must be recorded in the case notes and a rationale recorded in the care plan. This recommendation was drawn up using formal consensus techniques.

1.8.4.29 If current BNF or SPC doses are exceeded, it is particularly important that frequent and intensive monitoring of a calmed service user is undertaken, with particular attention to regular checks of airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration. **[D]**

1.8.4.30 In all circumstances of rapid tranquillisation, the prescriber and medication administrator should pay attention to:

- the total dose of medication prescribed
- arrangements for review
- issues of consent, BNF and SPC requirements and physical and mental status of the service user. **[D]**

1.8.4.31 The dose of antipsychotic medication should be individualised for each service user. This will be dependent on several factors, including the service user's age (older service users generally require lower doses); concomitant physical disorders (such as renal, hepatic, cardiovascular, or neurological); and concurrent medication. **[D(GPP)]**

1.8.4.32 A specialist mental health pharmacist should be a member of the multidisciplinary team in all circumstances where rapid tranquillisation is used. These pharmacists have a responsibility to monitor and ensure safe and appropriate usage of medication. **[D]**

Care after rapid tranquillisation

1.8.4.33 After rapid tranquillisation is administered, vital signs should be monitored and pulse oximeters should be available. Blood pressure, pulse, temperature, respiratory rate and hydration should be recorded regularly, at intervals agreed by a multidisciplinary team, until the service user becomes active again. **[D]**

1.8.4.34 In the following circumstances, more frequent and intensive monitoring by appropriately trained staff is required and should be recorded in the care plan. Particular attention should be paid to the service user's respiratory effort, airway, and level of consciousness:

- if the service user appears to be or is asleep/sedated
- if intravenous administration has taken place
- if the BNF limit or SPC is exceeded
- in high-risk situations
- where the service user has been using illicit substances or alcohol
- where the service user has a relevant medical disorder or concurrently prescribed medication. **[D]**

1.8.4.35 If verbal responsiveness is lost as a consequence of administration of medication, a level of care identical to that needed for general anaesthesia should be given. **[D]**

CHART FOR RAPID TRANQUILLISATION

Medication	Time to max plasma concentration	Approx plasma half-life	Licensed indications as at August 2004 (see current summary of product characteristics [SPC])	Notes
Haloperidol injection (SPC)	15–60 min (SPC and http://www.intox.org/databank/documents/pharm/haloperi/ukpid24.htm)	10–36h (SPC and http://www.intox.org/databank/documents/pharm/haloperi/ukpid24.htm)	Schizophrenia: treatment of symptoms and prevention of relapse. Other psychoses; especially paranoid. Mania and hypomania. Mental or behavioural problems, such as aggression, hyperactivity and self-mutilation in the mentally retarded and in patients with organic brain damage. As an adjunct to short-term management of moderate to severe psychomotor agitation, excitement, violent or dangerously impulsive behaviour. Nausea and vomiting.	
Haloperidol oral solution (SPC)	2–6h http://www.intox.org/databank/documents/pharm/haloperi/ukpid24.htm)	10–36h http://www.intox.org/databank/documents/pharm/haloperi/ukpid24.htm)	Schizophrenia and other psychoses. Short-term adjunctive management of psychomotor agitation, excitement, violent or dangerously impulsive behaviour, mental or behavioural disorders, especially when associated with hyperactivity and aggression. Short-term adjunctive management of severe anxiety, restlessness and agitation in the elderly, intractable hiccup, nausea and vomiting, Gilles de la Tourette syndrome and severe tics.	
Haloperidol tablets (SPC)	2–6 h (http://www.intox.org/databank/documents/pharm/haloperi/ukpid24.htm)	1–36h (http://www.intox.org/databank/documents/pharm/haloperi/ukpid24.htm)	Schizophrenia and other psychoses. Short-term adjunctive management of psychomotor agitation, excitement, violent or dangerously impulsive behaviour, mental or behavioural disorders, especially when associated with hyperactivity and aggression. Short-term adjunctive management of severe anxiety, restlessness and agitation in the elderly, intractable hiccup, nausea and vomiting, Gilles de la Tourette syndrome and severe tics.	
Lorazepam injection (SPC)	60–90 min	12–16h	Pre-operative medication or premedication for uncomfortable or prolonged investigations. The treatment of acute anxiety states, acute excitement or acute mania. The control of status epilepticus.	
Lorazepam tablets (SPC)	2h	12h	Short-term treatment of moderate and severe anxiety. Short-term treatment of anxiety in psychosomatic, organic and psychotic illness. Short-term treatment of insomnia associated with anxiety. Pre-medication before operative dentistry and general surgery.	
Olanzapine dispersable tablets (SPC)	5–8h	32–50h	Treatment of schizophrenia. Maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. Treatment of moderate to severe manic episode. In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder.	Not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.

CHART FOR RAPID TRANQUILLISATION (CONTINUED)

Medication	Time to max plasma concentration	Approx plasma half-life	Licensed indications as at August 2004 (see current summary of product characteristics [SPC])	Notes
Olanzapine injection (SPC)	15–45 min	32–50h	Indicated for the rapid control of agitation and disturbed behaviours in patients with schizophrenia or manic episode, when oral therapy is not appropriate. Treatment with olanzapine powder for solution for injection should be discontinued, and the use of oral olanzapine should be initiated, as soon as clinically appropriate.	The manufacturer has issued a warning that use outside of the details contained within the SPC may increase the risk of fatality. i/m olanzapine may produce a five-fold increase in plasma concentration vs. the same dose given by the oral route. Not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.
Olanzapine tablets (SPC)	5–8h	32–50h	Treatment of schizophrenia. Maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. Treatment of moderate to severe manic episode. In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder.	Not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.
Risperidone dispersable tablets (SPC)	1–2h	24h	The treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent. Maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. Treatment of mania in bipolar disorder.	Not licensed for the treatment of behavioural symptoms of dementia.
Risperidone liquid (SPC)	1–2h	24h	The treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent. Maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. Treatment of mania in bipolar disorder.	Not licensed for the treatment of behavioural symptoms of dementia.
Risperidone tablets (SPC)	1–2h	24h	The treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent. Maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. Treatment of mania in bipolar disorder.	Not licensed for the treatment of behavioural symptoms of dementia.

1.9 Incident reporting and post incident reviews, following rapid tranquillisation, physical intervention and seclusion

See also recommendation 1.3.3.1 (Training).

1.9.1 Incident reporting

1.9.1.1. Any incident requiring rapid tranquillisation, physical intervention or seclusion should be recorded contemporaneously, using a local template. **[D]**

1.9.1.2 Incidents of physical assault should be reported to the NHS Security Management Service (SMS) as per Secretary of State directives November 2003 (www.cfsms.nhs.uk/files/VAS%20directions%20250204.pdf). **[D]**

1.9.2 Post-incident reviews

1.9.2.1 A post incident review should take place as soon after the incident as possible, but in any event within 72 hours of the incident ending. **[D(GPP)]**

1.9.2.2 Mental health service providers should have systems in place with appropriately skilled staff to ensure that a range of options of post incident support and review mechanisms are available and take place within a culture of learning lessons. The following groups should be considered:

- staff involved in the incident
- service users
- carers and family where appropriate
- other service users who witnessed the incident
- visitors who witnessed the incident
- independent advocates
- local security management specialist (SMS). **[D(GPP)]**

1.9.2.3 The aim of a post incident review should be to seek to learn lessons, support staff and service users, and encourage the therapeutic relationship between staff, service users and their carers. **[D(GPP)]**

1.9.2.4 The post incident review should address what happened during the incident, any trigger factors, each person's role in the incident, how they felt during the incident, how they feel at the time of the review, how they may feel in the near future, and what can be done to address their concerns. If possible, a person not directly involved in the incident should lead the review. **[D(GPP)]**

1.9.2.5 Appropriate support, including ongoing individual post incident review sessions, should be available as required. **[D(GPP)]**

1.9.2.6 One-off post incident review sessions have been shown to be unhelpful and should not be undertaken. **[B]**

1.9.2.7 Consequential sick leave and the return to work should be monitored and positively and carefully managed to ensure that staff are supported. **[D(GPP)]**

1.9.2.8 Consequential sick leave should be audited to identify trends within the organisation to inform future strategy and training in relation to the management of disturbed/violent behaviour. **[D(GPP)]**

1.10 Emergency departments

Service users will often attend and be admitted to psychiatric in-patient services through emergency departments. The following section applies specifically to emergency department staff when caring for service users requiring mental health assessments. Recommendations in sections 1.2, 1.3, 1.4, 1.5, 1.6, 1.8 (except 1.8.3) and 1.9 also apply.

1.10.1 Training

*See evidence statement on page 83, para 7.8.7.3 IIb.

1.10.1.1 In addition to ongoing competency training in the management of disturbed/violent behaviour, appropriate staff groups in emergency departments should receive training in the recognition of acute mental illness and awareness of organic differential diagnoses. Service user involvement should be encouraged. **[D]**

1.10.2 Risk

*See evidence statement page 83, para 7.8.7.3 I.ii.b.

1.10.2.1 Emergency units should have a system in place to alert staff to patients known by the unit to pose a risk of disturbed/violent behaviour, so that steps can be taken to minimise risks to staff and other patients. The system should be reviewed at reasonable intervals to avoid stigmatisation. **[D(GPP)]**

1.10.3 Mental health assessments

1.10.3.1 On making an initial assessment, if staff working in emergency departments decide a mental health assessment is required, they should seek specialist advice from the relevant mental health professional. **[D]**

1.10.4 Environment

*See evidence statements on page 82, para 7.8.7.3 Ii.

1.10.4.1 Every emergency department should have at least one designated interview room for mental health assessments. Larger emergency departments (more than 75,000 attendances a year) may require additional rooms. The room(s) should be close to or part of the main emergency department receiving area. **[D]**

1.10.4.2. The designated interview room(s) should be made available on a priority basis for mental health assessments. It should be of a sufficient size to comfortably accommodate six seated persons, be fitted with an emergency call system, an outward opening door, and a window for observation, have reasonable ventilation, contain soft furnishings and be clear of potential weapons. **[D]**

1.10.4.3 Staff interviewing a patient in the designated interview room should always inform a senior member of the emergency nursing staff before commencing the interview. **[D(GPP)]**

1.10.4.4 Ordinarily a chaperone should be present, and interviews without chaperones should only proceed after discussion with relevant staff. When a staff member is alone, five-minute checks via the interview room window should occur whilst the interview is taking place. **[D(GPP)]**

1.10.5 Personnel

1.10.5.1 Every emergency department should have access to an identified consultant psychiatrist for liaison with providers of local mental health services. **[D(GPP)]**

1.10.5.2 Appropriate psychiatric assessment should be available within one hour of alert from the emergency department, at all times. **[D]**

1.10.5.3 In addition to a mental health liaison team, there should be at least one registered mental nurse working with every emergency department. Larger emergency departments (more than 75,000 attendances a year) may require more. **[D(GPP)]**

1.10.5.4 Emergency departments should be encouraged to employ registered mental nurses. **[D(GPP)]**

1.10.6 Rapid tranquillisation

*See evidence statement on page 85, para 7.8.7.3. V.i.b.

1.10.6.1 The decision to use rapid tranquillisation in an emergency setting should be taken by a senior medical member of staff, where at all possible. **[D(GPP)]**

1.10.6.2 Mental health staff should be contacted at the first available opportunity, after the administration of rapid tranquillisation. **[D(GPP)]**

1.10.6.3 If rapid tranquillisation is considered necessary, prior to formal diagnosis and where there is any uncertainty about previous medical history (including history of cardiovascular disease, uncertainty regarding current medication, or possibility of current illicit drug/alcohol intoxication), lorazepam should be considered as the first-line drug of choice. Where there is a confirmed history of previous significant antipsychotic exposure, and response, haloperidol in combination with lorazepam is sometimes used. **[D(GPP)]**

1.10.7 Communication provision

1.10.7.1 For patients whose preferred language is not English, interpreting services should be provided. Provision should also be made for patients who have communication difficulties who may need additional support, for example, visual aids, simplified language, or an interpreter who can sign. **[D(GPP)]**

9 Audit criteria

NICE produce audit criteria in their guidelines based on the key priorities for implementation, where these can be easily translated into audit criteria. The audit criteria detailed below related to those key priorities that can be easily audited.

In addition to producing these audit criteria, the NCC-NSC has liaised closely with the audit team at the Royal College of Psychiatrists, which have been devising audit tools and conducting an audit on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings on behalf of the Healthcare Commission. These audit tools cover the main areas discussed in this guideline. These audit tools can be used on at a local level and copies can be freely downloaded from the Royal College of Psychiatrist website at the following URL: http://www.rcpsych.ac.uk/cru/qual.htm

Possible objectives for an audit

- To ensure that the environment is safe and helps prevent disturbed/violent behaviour.

People who could be included in an audit and time period for selection

- Staff who work or have close associations with the ward/unit being audited.
- People who do not have direct links with the ward/unit, for example service user representatives; community health council members in Wales and patient forums in England; staff from other areas involved in the care pathway.

Criterion	Exception	Definition of terms
1. . There is an effective risk assessment and risk management plan to manage risk of disturbed/violent behaviour in the case notes of each service user at high risk. Refer to key priority 1 (recommendation 1.2.1.1)	Nil	
2. Services have a policy for training employees and staff-in-training in the short-term management of disturbed/violent behaviour. Refer to key priorities 2 to 5 (recommendations 1.3.1.1, 1.3.2.2, 1.3.2.4, 1.3.2.5)	Nil	The policy will specify • who will receive what level of training (based on risk assessment) • how often they will be trained • an outline of the techniques in which they will be trained (for example, training in de-escalation techniques) • that staff involved in rapid tranquillisation should receive ongoing competency training to a minimum of immediate life support (ILS) • that staff involved in physical intervention or seclusion should be trained to a minimum of basic life support (BLS).
3. On each admission, it has been recorded that a service user has access to information in a suitable format concerning: • which staff member has been assigned to them and how and when they can be contacted • why they have been admitted (and if detained, the reason, the powers used and their extent, and rights of appeal) • their rights regarding consent to treatments, complaints procedures and access to independent help and advocacy • what may happen to them if they become disturbed/violent. Refers to key priority 6 (recommendation 1.4.1.2)	Nil	A suitable format includes offering the information to the service user in: • their preferred language • in a format which is accessible if they have communication difficulties.
4. The service user's care plan contains an up-to-date advance directive detailing the service users preferred strategies in the event of a disturbed/violent incident. Refers to key priority 7 (recommendation 1.4.1.5)	a) The service user who is not able to give an advance directive and who does not have an advocate or carer. b) The service user who has turned down the opportunity to record an advance directive. c) The service user who is not at any risk of becoming disturbed/violent.	The term 'preferred strategies' refers to the service user's choice of rapid tranquillisation, physical intervention and/or seclusion that may be used without a service user's consent.
5. The record of an incident involving rapid tranquillisation, seclusion and/or physical intervention adequately justifies the use of these interventions and the procedures taken during these interventions and any adverse outcomes. Refers to key priorities 8 and 9 recommendations 1.8.1.1, 1.8.2.3)	Nil	

10 Recommendations for research

The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those that are most representative of the full range of recommendations. All of the recommendations for research should consider the importance of including study-level variables relating to gender, ethnicity and those with special concerns. These research recommendations have been drawn up by GDG consensus. Further clarification has been added by the NICE technical advisor.

Prospective cohort studies are required to identify antecedents of disturbed/violent behaviour in adult psychiatric in-patient settings.

Before and after studies, surveys, cross-sectional studies and cohort studies should be undertaken to establish the following, in relation to the deliberate application of pain in physical interventions used for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings, and in accident and emergency settings:

- effectiveness
- ethical and legal and safety aspects
- role within range of physical interventions taught to staff
- staff and service user perceptions.

Before and after studies, surveys, cross-sectional studies and cohort studies should be undertaken to investigate the following aspects of mechanical restraints for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings, and in accident and emergency settings:

- effectiveness
- ethical and legal and safety aspects
- role within range of physical interventions taught to staff
- staff and service user perceptions.

Qualitative and survey research is needed to examine service users' – including black and minority ethnic groups' – views on the antecedents and risk factors of disturbed/violent behaviour, and the use of observation, de-escalation techniques, physical interventions and seclusion for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and in accident and emergency settings.

Clinical trials and longitudinal cohort studies should be conducted in large, well-designed randomised controlled studies with adult psychiatric in-patients (including black and minority ethnic groups) that compare the utility, acceptability, safety and desirable endpoints of available medicines and their dosages for rapid tranquillisation and PRN regimes (including atypical and antipsychotics), and assess the long-term side effects.

Controlled before and after studies are needed to evaluate the major training programmes identified by the National Institute for Mental Health in England (NIMHE) and the Counter Fraud and Security Management Service (SMS). These studies must assess the short-term and long-term effectiveness of the training programme in psychiatric in-patient settings and assess the safety of the techniques used in these training packages for both staff and service users.

Prospective cohort studies are needed to develop valid and reliable prediction tools for use in psychiatric in-patient settings appropriate for use in the UK that:

- may predict the imminent onset of disturbed/violent behaviour
- confirm the predictive validity of key risk factors and assist clinical judgement in risk prediction.

Controlled before and after studies that examine whether observation and/or de-escalation techniques minimise the need for seclusion, restraint or rapid tranquillisation are needed.

National audit data collections are required on the incidence of sudden death among psychiatric service users (including ethnicity, age, and gender) receiving rapid tranquillisation and on death/morbidity associated with restraint and seclusion.

Prospective cohort studies, before and after studies and qualitive research is needed to develop restraint techniques, which allow communication between deaf service user and deaf and visually impaired service users and staff, as well as other physically impaired service users, while also ensuring staff and service user safety.

11 Dissemination of the guidelines

- The guideline will be produced in a full and summary format and a version for the public (Information for the public).
- Full copies of the guideline will be available through the NICE website (http://www.nice.org.uk) in PDF format and summary through the National Electronic Library for Health (NeLH (http://www.nelh.nhs.uk/) and National Guideline Clearinghouse (http://www.guidelines.gov).

12 Validation

The guideline was validated through two stakeholder consultation processes. The first and second drafts were submitted to NICE in April and June 2004. NICE obtained and collated stakeholders' comments, which were considered by the GDG.

13 Scheduled review of the guideline

The process of reviewing the evidence is expected to begin four years after the date of issue of this guideline. Reviewing may begin earlier than four years, if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within two years of the start of the review process.

14 Guidelines and reports consulted

For full reference details on each of these publications, please see the next section.

A safer place to work: protecting NHS hospital and ambulance staff from violence and aggression.

Assessment and clinical management of risk of harm to other people. Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk.

Breaking the circles of fear – a review of the relationship between mental health services and African and Caribbean communities. A report from the Sainsbury Mental Health Centre.

C&R techniques and deaf people: a *discussion paper.*

Clear expectations, consistent limits. The Centre for Residential Child Care.

Clinical risk management: a clinical tool and practitioners manual. The Sainsbury Centre for Mental Health.

Commission for Racial Equality-Annual Report 2002.

Consensus statement of the use of high dose antipsychotic medication. Royal College of Psychiatrists.

Cross-cultural psychiatry: a practical guide. D Bhugra and K Bhui.

Dealing with violence against nursing staff: an RCN guide for nurses and managers.

Ethnicity and mental health service provision. Academic Unit, Northern Birmingham Mental Health Trust.

Guidance on restrictive physical interventions for people with learning disability and autistic spectrum disorder, in health, education and social care settings. Department of Health.

Guidelines for prevention of workplace violence for health care and social service workers. AM Herman and CN Jeffress.

Guidelines for reducing violence in mental health services. Ministry of Health, New Zealand.

Guidelines for the provision of advice and training in the prevention and management of conflict, aggression and violence – codes of practice. Institute of Conflict Management.

Inside outside – improving mental health services for black and minority ethnic communities in England. Department of Health.

'Letting through the light' (Odiri) – a training pack on black people and mental health (1998). Race Equality Unit.

Mainstreaming gender and women's mental health implementation guide.

Management of Imminent Violence: Clinical practice guidelines to support mental health services. Royal College of Psychiatrists.

Mental Health Act 1983 and Department of Health Code of Practice to the Mental Health Act 1983 (3rd edn.).

Mental health nursing: addressing acute concerns. Report by the Standing Nursing and Midwifery Advisory Committee.

Mental health policy and implementation guide: national minimum standards for general adult services in psychiatric intensive care units (PICU) and low secure environments. Department of Health.

Mental health policy implementation guide: adult acute in-patient care provision. Department of Health.

Mental health policy implementation guide: adult acute in-patient care provision. Department of Health.

Modern standards and modern services: mental health, National Service Framework.

National visit 2: improving care for detained patients from black and minority ethnic communities preliminary report. The Sainsbury Centre for Mental Health.

Not just bricks and mortar: report of the Royal College of Psychiatrists working party on the size, staffing, structure, siting and security of new acute adult psychiatric in-patient Units. Royal College of Psychiatrists.

Nursing in secure environments United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting.

Physical interventions – a policy framework. British Institute of Learning Disabilities.

Physical restraint – practice, legal, medical and technical, considerations. Practice Paper No.2. The Centre for Residential Childcare.

Position statement on the use of seclusion and restraint. American Psychiatric Nurses Association.

Practice guidance: safe and supportive observation of patients at risk: *mental health nursing: addressing acute concerns.* Standing Nursing and Midwifery Advisory Committee.

Procedural guidelines for physical restraint and seclusion mental health policy. Mental Health Section, Ministry of Health, New Zealand.

Psychiatric services to accident and emergency department: *report of a joint working party of the Royal College of Psychiatrists and the British Medical Association for Accident and Emergency Medicine.*

Psychiatric services to accident and emergency departments. Royal College of Psychiatrists.

Racism and mental health – prejudice and suffering. Editor K Bhui.

Raised voices – African-Caribbean and African users' views and experiences of mental health services in England and Wales. MIND Publication.

Rapid tranquillisation: a questionnaire survey of practice. *Psychiatric Bulletin*.

Recommendations on the use of restraints and isolation – clinical practice guidelines. Collége des Médecins du Québec.

Report of the review of security at high security hospitals. Department of Health.

Review paper for the national task force: violence against social care staff. National Institute for Social Work Research Unit.

Safer working in the community: a guide for NHS managers and staff on reducing the risks for violence and aggression. Royal College of Nursing.

Safety for trainees in psychiatry: report of the collegiate trainees' committee working party on the safety of trainees. Royal College of Psychiatrists.

Safety, privacy and dignity in mental health units: guidance on mixed sex accommodation for mental health services. Department of Health.

Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care, clinical guideline. National Collaborating Centre for Mental Health.

Seclusion and restraint practice standards: a review and analysis. National Mental Health Association.

Seclusion, control and restraint. Royal College of Nursing.

Secure futures for women: making a difference, women's mental health strategy. Department of Health.

Sexual abuse and harassment in psychiatric settings. Royal College of Psychiatrists.

Social division and difference: black and ethnic minorities. NHS National Programme on Forensic Mental Health Research and Development.

Standards of places of safety under Section 136 of the Mental Health Act (1983). Royal College of Psychiatrists.

Strategies for the management of disturbed and violent patients in psychiatric units. Royal College of Psychiatrists.

The association between antipsychotic drugs and sudden death: report *of the working group of the Royal College of Psychiatrists' Psychopharmacology Sub-Group.* Royal College of Psychiatrists.

The prevention and management of aggression: a good practice statement. Clinical Resource and Audit Group, Working Group on Mental Illness, The Scottish Office.

The recognition, prevention and therapeutic management of violence in acute in-patient psychiatry: *A literature review and evidence-based recommendations for good practice.* Prepared for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

The recognition, prevention and therapeutic management of violence in mental health care. United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting.

Violence and aggression to staff in health services: guidance on assessment and management. Health and Safety Commission.

Women and secure psychiatric services: *A literature review.*

Women in context: good practice in mental health services for women. Good Practices in Mental Health.

15 References

Abdon-Beckman D (1997) An awkward position: restraints and sudden death. *Journal of Emergency Medical Services*; 22:88-90, 92, 94.

Agarwal M, Roberts M (1996) Violence among psychiatric in-patients at an interim secure unit: changes in pattern over a two-year period. *Medicine, Science and Law*; 36(1):31-36.

Aleman A, Kahn RS (2001) Effects of the atypical antipsychotic risperidone on hostility and aggression in schizophrenia: a meta-analysis of controlled trials. *European Neuropsychopharmacology*; 11:289-293.

Alexander J. Tharyan P, Adams C, John T, Mol C, Philip J (2004) Rapid tranquillisation of violent or agitated patients in a psychiatric emergency setting. Pragmatic randomised trial of intramuscular lorazepam versus haloperidol plus promethazine. *British Journal of Psychiatry;* 185:63-9.

Allen D, Tynan H (2000) Responding to aggressive behaviour: impact of training on staff members' knowledge and confidence. *Mental Retardation*; 38(2):97-104.

Allen MH (2000) Managing the agitated psychotic patient: a reappraisal of the evidence. *Journal of Clinical Psychiatry*; 61(14):11-20.

Almvik R (1996) Prevention of psychiatric in-patient violence. *Norwegian Journal of Nursing*; 16:51-53.

Almvik R, Woods P (1998) The Brøset violence checklist (BVC) and the prediction of in-patient violence: some preliminary results. *Psychiatric Care*; 5(6):208-211.

Almvik R, Woods P (1999) Predicting in-patient violence using the Broset violence checklist (BVC). *The International Journal of Psychiatric Nursing Research*; 4(3):498-505.

Alty A (1997) Nurses' learning experience and expressed opinions regarding seclusion practice within one NHS trust. *Journal of Advanced Nursing*; 25:786-93.

American Psychiatric Nurses Association. (2000) *Position statement on the use of seclusion and restraint.* USA.

Apperson LJ, Mulvey EP, Lidz CW (1993) Short-term clinical prediction of assaultive behavior: artifacts of research methods. *American Journal of Psychiatry*; 150(90):1374-1379.

Arango C, Calcedo-Barba AC, Gonzáles-Savador T, Calcedo-Ordónez A (1999) Violence in in-patients with schizophrenia: a prospective study. *Schizophrenia Bulletin*; 25(3):493-503.

Arnetz JE, Arnetz BB (2001) Violence towards health care staff and possible effects on the quality of patient care. *Social Science and Medicine*; 53:417-427.

Augestad LB, Vatten LJ (1994) Five-year risk of assault on employees in a psychiatric hospital. *Safety Science*; 18:113-24.

Barlow F, Wolfson P (1997) Safety and security: a survey of female psychiatric in-patients. *Psychiatric Bulletin*; 21:270-272.

Barlow K, Grenyer B, Ilkiw-Lavalle O (2000) Prevalence and precipitants of aggression in psychiatric in-patient units. *Australian and New Zealand Journal of Psychiatry*; 34:967-974.

Battaglia J, Moss S, Rush J, Kang J, Mendoza R, Leedom L, Dubin W, McGlynn C, Goodman L (1997) Haloperidol, lorazepam, or both for psychotic agitation? A multicenter, prospective double-blind, emergency department study. *American Journal of Emergency Medicine*; 15(4):335-340.

Baxter E, Hafner RJ, Holme G (1992) Assaults by patients: the experience and attitudes of psychiatric hospital nurses. *Australian and New Zealand Journal of Psychiatry*; 26:567-573.

Beck JC, Bonnar J (1988) Emergency civil commitment: predicting hospital violence from behaviour in the community. *Journal of Psychiatry and Law*; 16(3):379-388.

Beck JC, White KA, Gage B (1991) Emergency psychiatric assessment of violence. *American Journal of Psychiatry*; 148(11):1562-1565.

Beech B (1999) Sign of the times or the shape of things to come? A three-day unit of instruction on aggression and violence in health settings for all students during pre-registered nurse training. *Nurse Education Today*; 9:610-616.

Beer MD, Pereira SM, Paton C *Psychiatric intensive care.* London: Greenwich Medical Media Limited, P.47.

Belfrage H, Fransson G, Strand S (2000) Prediction of violence using the HCR-20: a prospective study in two maximum security correctional institutions. *Journal of Forensic Psychiatry*; 11(1):167-175.

Bell L, Stark C (1998) *Measuring competence in physical skills in residential childcare.* Social work research findings No.21. Edinburgh: Scottish Office Social Work Services Group.

Bell MD, Rao VJ, Wetli CV (1992) Positional asphyxia in adults: a series of 30 cases from the Dade and Broward county, Florida, medical examiners office from 1990-1992. *American Journal of Forensic Medical Pathology*; 13:101-7.

Benjaminsen S, Gotzsche Larsen K, Norrie B, Harder L, Luxhoi A (1996) Patient violence in a psychiatric hospital in Denmark. Rate of violence and relation to diagnosis. *Nordic Journal of Psychiatry*; 50(3): 233-242.

Bensley L, Nelson N, Kaufman J, Silverstein B, Shields JW (1995) Patient and staff views of factors influencing assaults on psychiatric hospital employees. *Issues in Mental Health Nursing*; 16(5): 433-446.

Bhui K, Outhwaite J, Adzinku F, Dixon P, McGabahann L, Pereira S, Strathdee G (2001) Implementing clinical guidelines on the management of imminent violence on two acute psychiatric wards in-patient units. *Journal of Mental Health*; 10(5): 559-569.

Bick P, Lennox HA (1986) Intramuscular lorazepam to restrain violent patients. *The Lancet*; 1(8474), 206.

Bieniek SA, Ownby RL, Penalver A, Domingues RA (1998) A double-blinded study of lorazepam versus the combination of haloperidol and lorazepam in managing agitation. *Pharmacotherapy*; 18:57- 62.

Binder RL, McCoy SM (1983) A study of patients' attitudes toward placement in seclusion. *Hospital and Community Psychiatry*; 34(11): 1052-1054.

Binder RL, McNiel DE (1994) Staff gender and risk of assault on doctors and nurses. *Bulletin of the American Academy of Psychiatry and the Law*; 22(4): 545-550.

Binder RL, McNiel DE (1999) Contemporary practices in managing acutely violent patients in 20 psychiatric emergency rooms. *Psychiatric Services*; 50(12): 1553-1554.

Bjorkly S (1995) Open-area seclusion in the long-term treatment of aggressive and disruptive psychotic patients, an introduction to a ward procedure. *Psychological Reports*; 76(1): 147-157.

Bleetman A, Boatman P (2001) *An overview of control and restraint issues for the health service.* Department of Health commissioned report.

Bobon J, Bobon DP, Breulet M, Colinet M, Devroye A, Pinchard A (1968) Un traitement d'urgent de l'agitation le droperidol (R4749). *Acta Neurologica Belgica*; 68:103-115.

Boisvert CM, Faust D (1999) Effects of the label 'schizophrenia' on causal attributions of violence. *Schizophrenia Bulletin*; 25(3): 479-491.

Bonner G, Lowe T, Rawcliffe D, Wellman N (2002) Trauma for all: a pilot study of the subjective experience of physical restraint for mental health in-patients and staff in the UK. *Journal of Psychiatric & Mental Health Nursing*; 9:465-73.

Bornstein PE (1985) The use of restraints on a general psychiatric unit. *Journal of Clinical Psychiatry*; 46(5): 175-178.

Bourn J (2003) *A safer place to work: protecting NHS hospital and ambulance staff from violence and aggression*. National Audit Office. London: The Stationary Office.

Bournemouth University (unpublished 2001) 'Study of control and restraint effectiveness from Bournemouth University – Dorset Community Trust' in Bleetman A, Boatman P *An overview of control and restraint issues for the health service*; Appendix 12:266-282.

Bowers L (1999) A critical appraisal of violent incident measures. *Journal of Mental Health*; 8(4): 339-349.

Bowers L (2000) The expression and comparison of ward incident rates. *Issues in Mental Health Nursing*; 21:365-374.

Bowers L, Gournay K, Duffy D (2000) Suicide and self-harm in in-patient psychiatric units: a national survey of observation policies. *Journal of Advanced Nursing*; 32(2): 437-444.

Bowers L, Parks A (2001) Special observation in the care of psychiatric in-patients: a literature review. *Issues in Mental Health Nursing*; 22:769-786.

Bowers L, Crowhurst N, Alexander J, Callaghan P, Eales S, Guy S, McCann E, Ryan C (2002) Safety and security policies on psychiatric acute admission wards: results from a London-wide survey. *Journal of Psychiatric and Mental Health Nursing*; 9:427-433.

Bowles N, Doods P (2001) Eye for an eye. *Open Mind*; 108 (April/March): 17-19.

Brayley J, Lange R, Baggoley C, Bond M, Harvey P (1994) The violence management team. An approach to aggressive behaviour in a general hospital. *Medical Journal of Australia*; 161:4-258.

Brier A, Meehan K, Birkett M, David S, Ferchland I, Sutton V, Taylor CC, Palmer R, Dossenbach M, Kiesler G, Brook S, Wright P (2002) A double-blind, placebo-controlled dose-response comparison of intramuscular olanzapine and haloperidol in the treatment of acute agitation in schizophrenia. *Archive of General Psychiatry*; 59:441-448.

Broadstock M (2001) *The effectiveness and safety of drug treatment for urgent sedation in psychiatric emergencies: a critical appraisal of the literature*. Health technology appraisal report; 4(1). New Zealand.

Brockman M, McLean J (2000) *Review paper for the national task force: violence against social care staff.* National Institute for Social Work Research Unit.

Brook S, Lucey J, Gunn KP (2000) Intramuscular ziprasidone compared with intramuscular haloperidol in the treatment of acute psychosis. *Journal of Clinical Psychiatry*; 61(12): 933-941.

Brooks KL, Mulaik JS, Gilead MP, Daniels BS (1994) Patient overcrowding in psychiatric hospital units: effects on seclusion and restraint. *Administration and Policy in Mental Health*; 22(2): 133-144.

Buckley P, Walshe D, Colohan H, O'Callaghan E, Mulvany F, Gibson T, Waddington JL, Larkin C (1990) Violence and schizophrenia – A study of the occurrence and clinical correlates of violence among schizophrenic patients. *Irish Journal of Psychological Medicine*; 7:102-108.

Burgess S (1997) Emergency drug treatment of disturbed psychotic patients. *Auditorium;* 6(1): 28-30.

Burns C, Harm NJ (1993) Emergency nurses' perceptions of critical incidents and stress debriefing. *Journal of Emergency Nursing*; 19(5): 431-436.

Calabro K, Mackey TA, William S (2002) Evaluation of training designed to prevent and manage patient violence. *Issues in Mental Health Nursing*; 23:3-15.

Capotori F (1985) 'Minorities', in Bernhardt R et al. (editors) *Encyclopedia of public international law*. Amsterdam: Elsevier, vol.8.

Caplan CA (1993) Nursing staff and patient perceptions of the ward atmosphere in a maximum-security forensic hospital. *Archives of Psychiatric Nursing*; 7(1): 23-29.

Carlsson G, Dahlberg K, Drew N (2000) Encountering violence and aggression in mental health nursing: a phenomenological study of tacit caring knowledge. *Issues in Mental Health Nursing*; 21:533-545.

Carmel H, Hunter M (1989) Staff injuries from in-patient violence. *Hospital and Community Psychiatry*; 40:41-46.

Carmel H, Hunter M (1990) Compliance with training in managing assaultive behaviour and injuries from in-patient violence. *Hospital and Community Psychiatry*; 41(5): 558-560.

Carmel H, Hunter M (1991) Psychiatrists injured by patient attack. *Bulletin of the American Academy of Psychiatry and the Law*; 19(3): 309-316.

Carpenter MD, Hannon VR, McCleery G, Wanderling JA (1988) Ethnic differences in seclusion and restraint. *Journal of Nervous and Mental Disease*; 176:726-31.

Carpenter S, Berk M (2000) Clotiapine for acute psychotic illnesses (Cochrane review) in *The Cochrane Library*; issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Cashin A (1996) Seclusion: the quest to determine effectiveness. *Journal of Psychosocial Nursing and Mental Health Services*; 34:17-21.

Cembrowicz SP, Shepherd JP (1992) Violence in the accident and emergency department. *Medicine, Science and the Law*; 32(2): 118-122.

Chaimowitz GA, Moscovitch A (1991) Patient assaults on psychiatric residents: the Canadian experience. *Canadian Journal of Psychiatry*; 36:107-111.

Chan TC, Vilke GM, Neuman T, Clausen JL (1997) Restraint position and positional asphyxia. *Annals of Emergency Medicine*; 30:578-86.

Chen EY, Harrison G, Standen PJ (1991) Management of first episode psychotic illness in Afro-Caribbean patients. *British Journal of Psychiatry*; 158:517-22.

Cheung P, Schweitzer I, Tuckwell V, Crowley KC (1996) A prospective study of aggression among psychiatric patients in rehabilitation wards. *Australian and New Zealand Journal of Psychiatry*; 30:257-262.

Cheung P, Schweitzer I, Crowley K, Tuckwell V (1997a) Violence in schizophrenia: role of hallucinations and delusion. *Schizophrenia Research*; 26:181-190.

Cheung P, Schweitzer I, Crowley K, Tuckwell V (1997b) Aggressive behaviour in schizophrenia: role of state versus trait factors. *Psychiatric Research*; 72:41-50.

Cheung P, Schweitzer I, Crowley KC (1997c) A prospective study of assaults on staff by psychiatric in-patients. *Medicine, Science and Law*; 73(1): 46-52.

Cheung P, Schwitzer I, Crowley K, Tuckwell V (1997) Aggressive behaviour in schizophrenia: the role of psychopathology. *Australian and New Zealand Journal of Psychiatry*; 31:62-67.

Choca JP, Shanley LA, Peterson CA, Van Denburg E (1990) Racial bias and the MCMI. *Journal of Personality Assessment*; 54:479-90.

Chou K-R, Lu R-B, Chang M (2001) Assaultive behaviour by psychiatric in-patients and its related factors. *Journal of Nursing Research*; 9(5): 139-150.

Chou KR, Lu RB, Mao WC (2002) Factors relevant to patient assaultive behaviour and assault in acute in-patient psychiatric units in Taiwan. *Archives of Psychiatric Nursing*; 16(4): 187-195.

Chu CC, Sallach HS, Zakeria S, Klein HE (1985) Differences in psychopathology between black and white schizophrenics. *International Journal of Social Psychiatry*; 31:252-7.

Clark J (1997) A survey into violence against medical staff in Dundee psychiatric services and a survey regarding the safety of interview rooms used. *Health Bulletin*; 55(6): 413-421.

Clinton C, Pereira S, Mullins B (2001) Training needs of psychiatric intensive care staff. *Nursing Standard*; 15(34): 33-36.

Clinton JE, Sterner S, Stelmachers Z, Ruiz E (1987) Haloperidol for sedation of disruptive emergency patients. *Annals of Emergency Medicine*; 16(3): 319-322.

Coid J, Kahtan N, Gault S, Jarman B (2000) Ethnic differences in admissions to secure forensic psychiatry services. *British Journal of Psychiatry*; 177:241-7.

Collége des Médecins du Québec (1999) *Recommendations on the use of restraints and isolation – clinical practice guidelines.* Canada: Collége des Médecins du Québec.

College Research Unit, Royal College of Psychiatrists (2000) *National audit of the management of violence in mental health settings: year 1.* June. London: Royal College of Psychiatrists.

College Research Unit, Royal College of Psychiatrists (2001) *National audit of the management of violence in mental health settings: year 2*. October. London: Royal College of Psychiatrists.

Collins J (1994) Nurses' attitudes towards aggressive behaviour, following attendance at the prevention and management of aggressive behaviour programme. *Journal of Advanced Nursing*; 20:117-131.

Commander MJ, Cochrane R, Sashidharan SP, Akilu F, Wildsmith E (1997) *Ethnicity and mental health service provision*. Birmingham: Academic Unit, Northern Birmingham Mental Health Trust.

Commission for Racial Equality (2002) *Commission for Racial Equality annual report.* London: CRE.

Convit A, Volavaka J, Czober P, de-Asis J et al. (1994) Effect of subtle neurological dysfunction in response to haloperidol treatment in schizophrenia. *American Journal of Psychiatry*; 151(1): 49-56.

Cooper AJ (1988) A clinical study of violence in patients referred on a form I to a general hospital psychiatric unit. *Canadian Journal of Psychiatry*; 33(8): 711-715.

Corrigan P, Holnes EP, Luchins D, Basit A, Delaney E, Gleason W, Buican B, McCracken S (1995) The effects of interactive staff training on staff programming and patient aggression in a psychiatric ward. *Behavioural Interventions*; 10(1): 17-32.

Coverdale J, Gale C, Weeks S, Turbott S (2001) A survey of threats and violent acts by patients against training physicians. *Medical Education*; 35:154-159.

Craig C, Ray F, Hix C (1989) Seclusion and restraint: decreasing the discomfort. *Journal of Psychosocial Nursing and Mental Health Services*; 27(7): 17-9.

Craig TJ, Bracken J (1995) An epidemiological study of PRN/stat medication use in a state psychiatric hospital. *Annals of Clinical Psychiatry*; 7(2): 57-64.

Craven JL, Voore PM, Voineskos G (1987) PRN medication for psychiatric patients. *Canadian Journal of Psychiatry*; 32(3): 199-203.

Crichton J (1997) The response of nursing staff to psychiatric in-patient misdemeanour. *The Journal of Forensic Psychiatry*; 8(1): 36-61.

Crichton JHM, Callanan TS, Beauchamp L, Glasson M, Tardiff H (1998) Staff response to psychiatric in-patient violence: an international comparison. *Psychiatric Care*; 52(2): 50-56.

Croker K, Cummings AL (1995) Nurses' reactions to physical assault by their patients. *Canadian Journal of Nursing Research*; 27(2): 81-93.

Crowner ML, Peric G, Stepcic F, Van Oss E (1994) A comparison of video cameras and official incident reports in detecting in-patient assaults. *Hospital and Community Psychiatry*; 45(11): 475-8.

Crowner M, Peric G, Stepcic F, Ventura F (1995) Psychiatric patients' explanations for assaults. *Psychiatric Services*; 46(6): 614-615.

Cullum N, Deeks J, Sheldon T, et al. (2003) Beds, mattresses and cushions for pressure sore prevention and treatment. (Cochrane review) in: *The Cochrane Library*, issue 1, 2001. Chichester, UK: John Wiley & Sons, Ltd.

Cure S, Carpenter S (2001) Droperidol for acute psychosis (Cochrane review) in: *The Cochrane Library*, issue 4, 2001. Chichester, UK: John Wiley & Sons, Ltd.

Cutcliffe JR (1999) Qualified nurses' lived experience of violence perpetrated by individuals suffering from enduring mental health problems: a hermeneutic study. *International Journal of Nursing Studies*; 36:105-116.

Daffern M, Howells K (2002) Psychiatric in-patient aggression: a review of structural and functional assessment approaches. *Aggression and Violent Behavior*; 7:5-497.

Daniel DG, Potkin SG, Reeves KR, Swift RH, Harrigan EP (2001) Intramuscular (IM) ziprasidone 20mg is effective in reducing acute agitation associated with psychosis: a double-blind, randomised trial. *Psychopharmacology*; 155:128-134.

Davies S, Thornicroft G, Leese M, Higgingbotham A, Phelan M (1996) Ethnic differences in risk of compulsory psychiatric admission among representative cases of psychosis in London. *British Medical Journal*; 312:533-537.

Davis S (1991) Violence by psychiatric in-patients: a review. *Hospital and Community Psychiatry*; 42(6): 585-590.

Davis S (1997) Close observation: how to improve assessments. *Nursing Times*; 93(24): 54-56.

Davis S, Amoz T, Appleby L (2001) How much risk training takes place in mental health services. *Psychiatric Bulletin*; 25:217-219.

Day CP, James OFW, Butler TJ, Campbell RWF (1993) QT Prolongation and sudden death in patients with alcoholic liver disease. *Lancet*; 341**:**1423-8.

Deafway (2002) *C&R techniques and deaf people*: a *discussion paper.* Lancashire: Mayflower Hospitals.

Delaney J, Cleary M, Jordon R, Horsfall J (2001) An exploratory investigation into the nursing management of aggression in acute psychiatric settings. *Journal of Psychiatric and Mental Health Nursing*; 8:77-84.

Delaney KR (1994) Calming an escalated psychiatric milieu. *Journal of Child and Adolescent Psychiatric Nursing*; 7(3): 5-13.

Dennis S (1998) Formal observation in the acute in-patient setting: policy, training and practice. *Mental Health Care*; 2(1): 26-28.

Department of Health (1997) *National Service Framework for Mental Health*. London: DH.

Department of Health (1998) Code of practice to the Mental Health Act 1983 (3rd edition). London: The Stationery Office.

Department of Health (1998) 'They look after their own don't they?' in: *Community care for black and minority ethnic older people.* London: DH.

Department of Health (1999) *Modern standards and modern services: Mental Health National Service Framework.* London: DH.

Department of Health (2000) *Report of the review of security at high security hospitals.* London: DH.

Department of Health (2000) *Safety, privacy and dignity in mental health units: guidance on mixed sex accommodation for mental health services*. London: DH.

Department of Health (2001) *Mental health policy implementation guide: adult acute in-patient care provision*. London: DH.

Department of Health (2002) *Stopping violence against staff working in the NHS, NHS Zero Tolerance.* London: DH. www.nhs.uk/zerotolerance/intro.htm

Department of Health (2002) *Guidance on restrictive physical interventions for people with learning disability and autistic spectrum disorder in health, education and social care settings*. London: DH.

Department of Health (2002) *Mental health policy and implementation guide: national minimum standards for general adult services in psychiatric intensive care units (PICU) and low secure environments.* London: DH.

Department of Health (2002) *Mental health policy implementation guide: adult acute in-patient care provision*. London: DH. www.doh.gov.uk/mentalhealth/inpatientcp.pdf.

Department of Health (2003) *Secure futures for women: making a difference, women's mental health strategy.* London: DH.

Department of Health (2003) *Forms of nurse and pharmacist prescribing and supply of medicines.* London: DH.

Department of Health (2003) *Mainstreaming gender and women's mental health implementation guide.* London: DH.

Department of Health (2005) *Delivering race equality in mental health care: an action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett*. London: DH.

DiNitto DM, Webb DK, Rubin A (2002) Gender differences in dually-diagnosed clients receiving chemical dependency treatment. *Journal of Psychoactive Drugs*; 34(1): 105-117.

Dixon M, Oyebode F, Brannigan C (2000) Formal justifications for compulsory psychiatric detention. *Medicine, Science and Law*; 40:319-26.

Dolan M, Boyd C, Shetty G (1995) Neuroleptic induced sudden death – a case report and critical review. *Medicine, Science and Law*; 35(2): 169-174.

Dolan M, Doyle M (2000) Clinical and actuarial measures and the role of the psychopathy checklist. *British Journal of Psychiatry*; 177:303-311.

Donat DC (1998) Impact of a mandatory behavioural consultation on seclusion/restraint utilization in a psychiatric hospital. *Journal of Behavior Therapy and Experimental Psychiatry*; 29:13-19.

Dorevitch A, Katz N, Zemishlany Z, Aizenberg D, Weizman A (1999) Intramuscular flunitrazepam versus intramuscular haloperidol in the emergency treatment of aggressive psychotic behavior. *American Journal of Psychiatry*; 156(1): 142-144.

Doyle M, Dolan M, McGovern J (2002) The validity of North American risk assessment tools in predicting in-patient violent behaviour in England. *Legal and Criminological Psychology*; 7:141-154.

Drake WM, Broadhurst PA (1996) QT-interval prolongation with ecstasy. *South African Medical Journal*; 86**:**180-1.

Dreyfus JK (1987) Nursing assessment of the ED patient with psychiatric symptoms: a quick reference. *Journal of Emergency Nursing*; 13(5):278-281.

Drici MD, Wang WX, Li X, Woosley RL, Flockhart DA (1998) Prolongation of QT interval in isolated feline hearts by antipsychotic drugs. *Journal of Clinical Psychopharmacology*; 18:477-481.

Drummond M, Jefferson T (1996) Guidelines for authors and peer reviewers of economic submissions to the BMJ. *British Medical Journal*; 313:275-283.

Dubin, WR, Weiss KJ (1986) Rapid tranquillisation: a comparison of thiothixene with loxapine. *Journal of Clinical Psychiatry*; 47(6): 294-297.

Dunn J (1989) Psychiatric intervention in the community hospital emergency room. *Journal of Nursing Administration*; 19(10): 36-40.

Dutt R, Ferns P (1998) *Letting through the light (Odiri) – a training pack on black people and mental health*. London: Race Equality Unit, Department of Health.

Duxbury J (1999) An exploratory account of registered nurses' experience of patients' aggression in both mental health and general nursing settings. *Journal of Psychiatric and Mental Health Nursing*; 6:107-114.

Duxbury J (2002) An evaluation of staff and patient views of and strategies employed to manage in-patient aggression and violence on one mental health unit: a pluralistic design. *Journal of Psychiatric and Mental Health Nursing*; 9:325-337.

Eaton S, Ghannam M, Hunt N (2000) Prediction of violence on a psychiatric intensive care unit. *Medicine, Science and Law*; 40(2): 143-146.

Eccles M, Mason J (2001) *How to develop cost conscious guidelines*.. Health technology assessment; 5 (16). London: National Institute for Health and Clinical Excellence (NICE).

Edworthy J, Loxley S, Dennis I (1991) Improving auditory warning design: relationship between warning sound parameters and perceived urgency. *Human Factors*; 33(2): 205-231.

Ehmann TS, Higgs E, Smith Gn, Au T, Altman S, Lloyd D (1995) The routine assessment of patient progress: a mixed format rating scale for nurses. *Comprehensive Psychiatry*; 36:289-295.

Ehmann T S, Smith G N, Yamamoto A, McCarthy N, Ross S, Au T, Flynn S W, Altman S, Honer W G (2001) Violence in treatment resistant psychotic in-patients. *The Journal of Nervous and Mental Disease*; 189(10): 716-721.

El Badri SM, Mellsop G (2002) A study of the use of seclusion in an acute psychiatric service. *Australian and New Zealand Journal of Psychiatry*; 36:399-403.

Elbogen EB, Williams AL, Kim D, Tomkins AJ, Scalora MJ (2001) Gender and perceptions of dangerousness in civil psychiatric patients. *Legal and Criminological Psychology*; 6:215-228.

Ellwood AL, Rey LD (1996) Awareness and fear of violence among medical and social work students. *Family Medicine*; 28(7): 488-492.

Erickson L, Williams-Evans SA (2000) Attitudes of emergency nurses regarding patient assaults. *Journal of Emergency Nursing*; 26(3): 210-215.

Eriksson KL, Westrin CG (1995) Coercive measures in psychiatric care. Reports and reactions of patients and other people involved. *Acta Psychiatrica Scandinavia*; 92(3): 225-230.

Fabrega HJ, Mezzich J, Ulrich RF (1988) Black-white differences in psychopathology in an urban psychiatric population. *Comprehensive Psychiatry*; 29:285-97.

Fann WE, Linton PH (1972) Use of perphenazine in psychiatric emergencies: the concept of chemical restraint. *Current Therapeutic Research*; 14(8): 478-482.

Feinstein A, Holloway F (2002) Evaluating the use of a psychiatric intensive care unit: is ethnicity a risk factor for admission? *International Journal of Social Psychiatry*; 48:38-46.

Feldman HS (1982) Loxapine succinate as initial treatment of hostile and aggressive schizophrenic criminal offenders. *Journal of Clinical Pharmacology*; 22:366-370.

Fenton M, Coutinho ESF, Campbell C (2001) Zuclopenthixol acetate in the treatment of acute schizophrenia and similar serious mental illnesses (Cochrane review) in: *The Cochrane Library*, issue 4, 2001. Chichester, UK: John Wiley & Sons, Ltd.

Fernando S, Ndegwa D, Wilson M (1998) *Forensic psychiatry*, *race and culture*. London: Routledge.

Fernando S (2002) *Mental health, race and culture*. Basingstoke, England: Palgrave.

Fernando S (2003) *Cultural diversity, mental health and psychiatry: the struggle against racism.* London: Routledge.

Finnema EJ, Dassen T, Halfens R (1994) Aggression in psychiatry: a qualitative study focusing on the characterization and perception of patient aggression by nurses working on psychiatric wards. *Journal of Advanced Nursing*; 19:1088-1095.

Flannery RB Jr, Hanson MA, Penk WE (1995) Patients' threats: expanding definition of assault. *General Hospital Psychiatry*; 17:451-453.

Flannery RB Jr., Hanson MA, Penk WE, Pastva GJ, Navon MA, Flannery GJ (1997) Hospital downsizing and assaults on staff. *Psychiatric Quarterly*; 68(1) 67-76.

Flannery RB Jr, Lizotte D, Laudani L, Staffieri A, Walker AP (2001) Violence against women and the assaulted staff action program. *Administration and Policy in Mental Health*; 28(6): 491-498.

Flannery RB Jr, Stone P, Rego S, Walker AP (2001) Characteristics of staff victims of patient assault: ten year analysis of the assaulted staff action program (ASAP). *Psychiatric Quarterly*; 72(3): 237-248.

Fletcher E, Stevenson C (2001) Launching the tidal model in an adult mental health programme. *Nursing Standard*; 15(49): 33-36.

Folstein MF, Folstein SE, McHugh PR (1975) Mini mental state: a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*; 12:189-198.

Foster PL, Cavness C, Phelps MA (1999) Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. *Archives of Psychiatric Nursing*; 8(5): 269-271.

Foster S, Kessel J, Berman ME, Simpson GM (1997) Efficacy of lorazepam and haloperidol for rapid tranquillisation in a psychiatric emergency room setting. *International Clinical Psychopharmacology*; 12:175-179.

Foust D, Rhee KJ (1993) The incidence of battery in an urban emergency department. *Annals of Emergency Medicine*; 22(3): 89-91.

Franco H, Galanter M, Castanda R, Patterson J (1995) Combining behavioural and self-help approaches in the in-patient management of dually diagnosed patients. *Journal of Substance Abuse Treatment*; 12(3): 277-232.

Frey RD, Weller J (2000) Behavioural management of aggression through teaching interpersonal skills. *Psychiatric Services*; 52(5): 607-609.

Friedman RS (1986) Profile of psychiatric emergency patients. *Emergency Psychiatry for Clinical Administrators*; 25-35.

Fruensgaard K, Korsgaard S, Jøgensen H, Jensen K (1977) Loxapine versus haloperidol parenterally in acute psychosis with agitation. *Acta Psychiatrica Scandinavia*; 56:256-264.

Gallop R, Engels S, DiNunzio R, Napravnik S (1999) Abused women's concerns about safety and the therapeutic environment during psychiatric hospitalization. *Canadian Journal of Nursing Research*; 31(2): 53-70.

Gallop R, McCay E, Guha M, Khan P (1999) The experience of hospitalization and restraint of women who have a history of childhood sexual abuse. *Health Care Women International*; 20:401-16.

Garza-Trevino ES, Hollister LE, Overall JE, Alexander WF (1989) Efficacy of combinations of intramuscular antipsychotics and sedative-hypnotics for control of psychotic agitation. *American Journal of Psychiatry*; 146(12): 1598-1601.

Geffen J, Cameron A, Stokes J, Sorensen L, Roberts M, Geffen L (2002a) Pro re nata medication for psychoses: the knowledge and beliefs of doctors and nurses. *Australian and New Zealand Journal of Psychiatry*; 36(5): 642-8.

Geffen J, Sorensen L, Stokes J, Cameron A, Roberts MS, Geffen L (2002b) Pro re nata medication for psychoses: an audit of practice in two metropolitan hospitals. *Australian and New Zealand Journal of Psychiatry*; 36(5): 649-656.

Gillig PM, Markert R, Barron J, Coleman F (1998) A comparison of staff and patient perceptions of the causes and cures of physical aggression on a psychiatric unit. *Psychiatric Quarterly*; 69(1): 45-60.

Gim YS, Cheng SOB, Hong TL, Chin MWB, Hen WH, Lee YJ (1999) Nurses' experiences in identifying and managing violence precipitants in a psychiatric in-patients' setting. *Singapore Nursing Journal*; 26(1):21-24.

Glasziou P, Irwig L, Bain C, Colditz G (2001) *Systematic review in health care: a practical guide.* Cambridge University Press; p34.

Goldberg RJ (1989) The use of constant observation in general hospitals. *International Journal of Psychiatry in Medicine*; 19(2): 193-201.

Goldmeier J, Silver SB (1988) Women staff members and ward atmospheres in a forensic hospital. *International Journal of Offender Therapy and Comparative Criminology*; 32(3): 257-265.

Good Practices in Mental Health (1996) *Women in context: good practice in mental health services for women.* London: Good Practices in Mental Health.

Goodykoontz L, Herrick CA (1990) Evaluation of an in-service education programme regarding aggressive behaviour on a psychiatric unit. *The Journal of Continuing Education in Nursing*; 31(3): 129-133.

Grange JT, Corbett SW (2002) Violence against emergency medical services personnel. *Prehospital Emergency Care*; 6(2): 186-190.

Grassi L, Marangoni C, Zanchi P, Vanni A (2001) Characteristics of violent behaviour in acute psychiatrist in-patients: a five year study. *Acta Psychiatrica Scandinavia*; 104(4): 273-279.

Greenberg WM, Moore-Duncan L, Herron R (1996) Patients' attitudes toward having been forcibly medicated. *Bulletin of the American Academy of Psychiatry and the Law*; 24(4): 513-524.

Greenblatt RL, Davis WE (1992) Accuracy of MCMI classification of angry and psychotic black and white patients. *Journal of Clinical Psychology*; 48:59-63.

Gudjonsson G, Rabe-Hesketh S, Wilson C (1999a) Life events, ethnicity and perceptions of discrimination in patients with severe mental illness. *Social Psychiatry and Psychiatric Epidemiology*; 34:600-8.

Gudjonsson G, Rabe-Hesketh S, Wilson C (1999b) Violent incidents on a medium secure unit over a 17-year period. *The Journal of Forensic Psychiatry*; 10(2): 249-263.

Hafner RJ, Lammersma J, Ferris R, Cameron M (1989) The use of seclusion: a comparison of two psychiatric intensive care units. *Australian and New Zealand Journal of Psychiatry*; 23(2): 235-239.

Haglund K, Von Knorring L, Von Essen L (2003) Forced medication in psychiatric care: patients' experiences and nurse perceptions. *Journal of Psychiatric and Mental Health Nursing*; 10:65-72.

Haim R, Rabinowitz J, Lereya J, Fenning A (2002) Predictions made by psychiatrists and psychiatric nurses of violence by patients. *Psychiatric Services*; 53(5): 622-624.

Haller E, McNeil DE, Binder RL (1996) Impact of a smoking ban on a locked psychiatric unit. *Journal of Clinical Psychiatry*; 57(8): 329-332.

Hallsteinsen A, Kristensen M, Dahl AA, Eilertsen DE (1998) The extended staff observation aggression scale (SOAS-E): development, presentation and evaluation. *Acta Psychiatrica Scandinavia*; 97(6): 423-426.

Hammill K, McEvoy JP, Koral H, Schneider N (1986) Seclusion: inside looking out. *Nursing Times*; 83(5): 38-39.

Harris GT, Rice ME, Quinsey VL (1993) Violent recidivism of mentally disordered offenders: the development of a statistical prediction instrument. *Criminal Justice and Behavior*; 20:315-335.

Harris J, Allen D, Cornick M, Jefferson A, Mills R (1996) *Physical interventions – a policy framework*. Kidderminster: British Institute of Learning Disabilities.

Harris GT, Rice ME (1997) Risk appraisal and management of violent behaviour. *Psychiatric Services*; 48(9): 1168-1176.

Hart SD, Hare RD, Forth AE (1994) 'Psychopathy as a risk marker for violence: development and validation of a screening version of the revised psychopathy checklist' in Monhan J, Steadman HJ (editors) *Violence and mental disorder: development in risk assessment.* The John D. and Catherine T. MacArthur Foundation series on mental health development. Chicago: Chicago University, Chicago Press; 81-98.

Hayworth RM (1973) Positive outcome in psychiatric crisis: evaluation of thioridazine concentrate in an intensive short-term psychiatric programme. *Psychomatics*; 14:42-45.

Health and Safety Commission. (1997) 2nd ed. *Violence and aggression to staff in health services: guidance on assessment and management*. Norwich: Health and Safety Commission; p.21-23.

Heilbrun K, O'Neill ML, Strohman LK, Bownan Q, Philipson J (2000) Expert approaches to communicating violence risk. *Law and Human Behavior*; 24(1): 137-148.

Hem E, Steen O, Opjordsmoen S (2001) Thrombosis associated with physical restraints. *Acta Psychiatrica Scandinavia*; 103:73-5.

Hensen V, Arnesen E, Jacobsen BK (1997) Total mortality in people admitted to a psychiatric hospital. *British Journal of Psychiatry*; 170:186-190.

Herman AM, Jeffress CN (1998) *Guidelines for prevention of workplace violence for health care and social service workers.* OSHA 3148. Washington: Occupational Safety and Health Administration, US Department of Labor.

Hill C D, Rogers R, Bickford ME (1996) Predicting aggressive and socially disruptive behavior in a maximum security forensic psychiatric hospital. *Journal of Forensic Sciences*; 41(1): 56-59.

Hill S, Petit J (2000) The violent patient, part 1: ways to 'de-escalate'; when and how to restrain. *The Journal of Critical Illness*; 15(8): 430-434.

Hillbrand M, Foster HG, Spitz RT (1996) Characteristics and costs of staff injuries in a forensic hospital. *Psychiatric Services*; 47:10:1123-25.

Hillbrand M (2001) Threatening and non-threatening verbal aggression as predictors of physical aggression in violent psychiatric patients. *Journal of Threat Assessment*; 1(2): 63-74.

Hobbs FDR (1994) General practitioner's changes to practice due to aggression at work. *Family Practice – An International Journal*; 11(1): 75-79.

Hodges V, Sandford D, Elzinga R (1986) The role of ward structure on nursing staff behaviours: an observational study of three psychiatric wards. *Acta Psychiatrica Scandinavica*; 73(1): 6-11.

Holzworth Wills RAWC (1999) Nurses' judgments regarding seclusion and restraint of psychiatric patients: a social judgment analysis. *Research in Nursing and Health*; 22:189-201.

Hoptman MJ, Yates, KF, Patalinjug MB, Wack RC, Convit A (1999) Clinical prediction of assaultive behaviour among male psychiatric patients at a maximum-security forensic facility. *Psychiatric Services*; 50(11): 1461-1466.

Hundertmark J (2002) The impact of mainstreaming patient care in Australian emergency departments and liaison services. *Australian and New Zealand Journal of Psychiatry*; 36(3): 424.

Hunter JD, Carney Love C (1996) Total quality management and the reduction of in-patient violence and costs in a forensic psychiatric hospital. *Psychiatric Services*; 47(7): 751-754.

Hunter ME, Love CC (1993) Types of weapons and patterns of use in a forensic hospital. *Hospital and Community Psychiatry*; 44(11): 1082-1084.

Hunter ME, Love CC (1996) Total quality management and the reduction of in-patient violence and costs in a forensic psychiatric hospital. *Psychiatric Services*; 47(7): 751-754.

Hurlebaus A (1994) Aggressive behaviour management for nurses: an international issue? *Journal of Healthcare Protection Management*; 10(2): 97-106.

Hurlebaus AE, Link S (1997) The effects of an aggressive behaviour management programme on nurses' levels of knowledge, confidence and safety. *Journal of Nursing Staff Development*; 13(5): 260-265.

Hutton HE, Miner MH, Blades JR, Langfeldt VC (1992) Ethnic differences on the MMPI overcontrolled-hostility scale. *Journal of Personality Assessment*; 58:260-8.

Hyde CE, Harrower-Wilson C (1996) Psychiatric intensive care in acute psychosis. *International Clinical Psychopharmacology*; 11(suppl 2): 61-65.

Hyde CE, Harrower-Wilson C, Morris J (1998) Violence, dissatisfaction and rapid tranquillisation in psychiatric intensive care. *Psychiatric Bulletin*; 22:480-483.

Hyde CE, Harrower-Wilson C, Ash PE (1998) Cost comparison of zuclopenthixol acetate and haloperidol. *Psychiatric Bulletin*; 22:140-143.

Ilkiw-Lavalle O, Grenyer BFS, Grapham L (2002) Does prior training and staff occupation influence knowledge acquisition from an aggression management training programme? *International Journal of Mental Health Nursing*; 11:233-239.

Ilkiw-Lavalle O, Grenyer BFS (2003) Differences between patient and staff perceptions of aggression in mental health units. *Psychiatric Services*; 54(3): 389-393.

Independent inquiry into the death of David Bennett. (2003) An Independent Inquiry set up under HSG(94)27. www.image.guardian.co.uk/sys-files/society/documents/2004/02/12/Bennett.pdf.

Institute of Conflict Management. (2003) *Guidelines for the provision of advice and training in the prevention and management of conflict, aggression and violence -codes of practice.* www.conflictmanagement.org

Jacoby LE, Jones SL (1984) The psychiatric clinical specialist in the emergency room. *Journal of Psychosocial Nursing*; 22(5): 8-13.

Jambunathan J, Bellaire K (1996) Evaluating staff use of crisis prevention intervention techniques: a pilot study. *Issues in Mental Health Nursing*; 17(6): 541-58.

James DV, Fineberg NA, Shah AK, Priest RG (1990) An increase in violence on an acute psychiatric ward. A study of associated factors. *British Journal of Psychiatry*; 156(6): 846-852.

Janofsky JS, Spears S, Neubauer DN (1988) Psychiatrists' accuracy in predicting violent behavior on an in-patient unit. *Hospital and Community Psychiatry*; 39(10): 1090-1094.

Jayne D, Schloss PJ, Alper S, Menscher S (1994) Reducing disruptive behaviours by training students to request assistance. *Behaviour Modification*; 18(3): 320-338.

Johnson B, Martin M-L, Guha M, Montgomery P (1997) The experience of thought-disordered individuals preceding an aggressive incident. *Journal of Psychiatric and Mental Health Nursing*; 4:213-220.

Johnson ME, Hauser PM (2001) The practices of expert psychiatric nurses: accompanying the patient to a calmer personal space. *Issues in Mental Health Nursing*; 22(7): 651-668.

Jones J, Ward M, Wellman N, Hall J, Lowe T (2000) Psychiatric in-patient's experience of nursing observation: a United Kingdom perspective. *Journal of Psychosocial Nursing*; 38(12): 10-20.

Jost von F, Zmorski T (1973) Mesoridazine (TPS 23 Sandoz) Bei Akuten Psychotischen zuständen. *Schweizer Archiv für Neurologie, Neurochirurgie and Psychiatrie*; 112(1): 131-142.

Junginger J, Parks-Levy J, McGuire L (1998) Delusions and symptom-consistent violence. *Psychiatric Services*; 49(2): 218-220.

Katz P, Kirkland FR (1990) Violence and social structure on mental hospital wards. *Psychiatry*; 53(3): 262-277.

Kay B (1995) *The experience of burnout in psychiatric/mental health nursing: an interpretative interactionist approach.* Doctoral dissertation. Austin: University of Texas.

Kay SR, Fiszbein A, Opler LA (1987) The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*; 13:261-276.

Kay SR, Wolkenfeld F, Murrill LM (1988) Profiles of aggression among psychiatric patients II: covariates and predictors. *The Journal of Nervous and Mental Disease*; 176(9): 547-556.

Kay SR, Fiszbein A, Opler LA (1992) *Positive and negative syndromescale (PANSS) manual.* Toronto: Multi Health Systems.

Kho K, Sensky T, Mortimer A, Corcos C (1998) Prospective study into factors associated with aggressive incidents in psychiatric acute admission wards. *British Journal of Psychiatry*; 172:38-43.

King J, Watkins K (1998) Developing an observational form for assessing patients' mental health. *British Journal of Therapy and Rehabilitation*; 5(4): 210-215.

Kingdon DG, Bakewell EW (1988) Aggressive behaviour: evaluation of a non-seclusion policy of a district psychiatric service. *British Journal of Psychiatry*; 153:631-634.

Kirk A (1989) The prediction of violent behavior during short-term civil commitment. *Bulletin of the American Academy of Psychiatry and the Law*; 17(4): 345-353.

Kopecky HJ, Kopecky CR, Yudofsky SC (1998) Reliability and validity of the overt agitation severity scale in adult psychiatric in-patients. *Psychiatric Quarterly*; 69(4): 301-323.

Kozub ML, Skidmore R (2001) Least to most restrictive interventions. A continuum for mental health care Facilities. *Journal of Psychosocial Nursing and Mental Health Services*; 39:32-8.

Krakowski M, Czobor P (1997) Violence in psychiatric patients: the role of psychosis, frontal lobe impairment, and ward turmoil. *Comprehensive Psychiatry*; 38(4): 230-236.

Krakowski M, Czobor P, Chou JCY (1999) Course of violence in patients with schizophrenia: relationship to clinical symptoms. *Schizophrenia Bulletin*; 25(3): 505-517.

Kribel DM (1983) Hospital staff taught how to handle disruptive patients. *Hospital*; 1:54.

Kumar A (1997) Sudden unexplained death in a psychiatric patient – a case report: the role of phenothiazines and physical restraint. *Medicine, Science and Law*; 37(2): 170-5.

Kumar S, Guite H, Thornicroft G (2001) Service users' experience of violence within a mental health system: a study using grounded theory approach. *Journal of Mental Health*; 10(6): 597-611.

Kumar S, Ng B (2001) Crowding and violence on psychiatric wards: explanatory models. *Canadian Journal of Psychiatry*; 46(5): 433-437.

Lam JN, McNiel DE, Binder RL (2000) The relationship between patients' gender and violence leading to staff injuries. *Psychiatric Services*; 51(9): 1167-1170.

Lamdan R, Schindler DRB (1996) Constant observation in a medical-surgical setting: the role of consultation-liaison psychiatry. *Psychosomatics*; 37(4): 368-373.

Lancee W, Gallop R, McCay E, Toner B (1995) The relationship between nurses' limit-setting styles and anger in psychiatric in-patients. *Psychiatric Services*; 46(6): 609-613.

Landau J (1993) *The experiences of seven nurses who relate with violence-prone psychiatric in-patients*. (Unpublished doctoral dissertation. New York University).

Lane FE (1986) Utilizing physician empathy with violent patients. *American Journal of Psychotherapy*; 40(3): 448-456.

Lanza ML (1988) Factors relevant to patient assault. *Issues in Mental Health Nursing*; 9:239-257.

Lanza ML, Kayne HL, Hicks C, Milner J (1991) Nursing staff characteristics related to patient assault. *Issues in Mental Health Nursing*; 12:253-265.

Lanza ML, Kayne HL, Hicks C, Milner J (1993) Environmental characteristics related to patient assault. *Issues in Mental Health Nursing*; 15(3): 319-335.

Lanza ML, Kayne, HL, Pattison IV, Hicks C, Islam S (1994) Predicting violence: nursing diagnosis versus psychiatric diagnosis. *Nursing Diagnosis*; 5(4): 151-157.

Lanza ML, Kayne HL, Pattison I, Hicks C, Islam S (1996) The relationship of behavioural cues to assaultive behaviour. *Clinical Nursing Research*; 5(1): 6-27.

Lanza ML, Kayne HL, Gulliford D, Hicks C, Islam S (1997) Staffing of in-patient psychiatric units and assaults by patients. *Journal of the American Psychiatric Nurses Association*; 3(2): 42-48.

Lanza ML (1998) A multidisciplinary course to teach staff to conduct psychodynamic group psychotherapy for assaultive men. *Perspectives in Psychiatric Care*; 34(1): 28-35.

Lart R, Payne S, Beaumont B, MacDonald G, Mistry T (1999) *Women and secure psychiatric services*: a *literature review* CRD Report 14. University of York: Centre for Reviews and Dissemination.

Laurier C, Kennedy W, Lachaine J, Garipy L, Tessier G (1997) Economic evaluation of zuclopenthixol acetate compared with injectable haloperidol in schizophrenic patients with acute psychosis. *Clinical Therapeutics*; 19(2): 316-329.

Lawson WB, Yesavage MD, Werner PD (1984) Race, violence and psychopathology. *Journal of Clinical Psychiatry*; 45:7:294-7.

Lazarus A (1994) Transferring psychiatric patients into managed care networks, *Annals of Clinical Psychiatry*; 6(2): 141-142.

Lazarus A (2001) Physical restraints, thromboembolism, and death in two patients. *Journal of Clinical Psychiatry*; 62:207-8.

Leadbetter D, Paterson B (1995) 'De-escalating aggressive behaviour' in: Kidd B, Stark C (editors) *Management of violence in health care*. London: Gaskell/Royal College of Psychiatrists.

Leadbetter D, Perkins J (2002) An evaluation of aggression management training in a special educational setting. *Emotional and Behavioural Difficulties*; 7:19-34.

Lee F (2001) Violence in A&E: the role of training and self-efficacy. *Nursing Standard*; 15(46): 33-38.

Lee HK, Reddy TB, Travin S, Bluestone H (1992) A trial of lithium citrate for the management of acute agitation of psychiatric in-patients: a pilot study. *Journal of Clinical Psychopharmacology*; 12(5), Letters to the Editor, 362-3.

Lee S, Wright S, Sayer J, Parr A, Gray R, Gournay K (2001) Physical restraint training for nurses in English and Welsh psychiatric intensive care and regional secure units. *Journal of Mental Health*; 10:151-62.

Lehane M, Rees C (1996) Alternatives to seclusion in psychiatric care. *British Journal of Nursing*; 5(16): 974-979.

Lemonidou C, Priami M, Merkouris A, Kalafati M, Tafas C, Plati C (2002) Nurses' perceptions toward seclusion and use of restraints for psychiatric patients in Greece. *European Journal of Psychiatry*; 16(2):81-90.

Lenehan GP, Gastfriend DR, Stetler C (1985) Use of haloperidol in the management of agitated or violent, alcohol intoxicated patients in the emergency department: a pilot study. *Journal of Emergency Nursing*; 11(2): 72-79.

Lesem, MD, Zajecka JM, Swift RH, Reeves KR, Harrigan EP (2001) Intramuscular ziprasidone, 2mg versus 10mg, in the short-term management of agitated psychotic patients. *Journal of Clinical Psychiatry*; 62(1): 12-18.

Lillywhite A, Morgan N, Walter E (1995) Reducing the risk of violence to junior psychiatrists. *Psychiatric Bulletin*; 9:24-27.

Linaker OM, Busch-Iversen H (1995) Predictors of imminent violence in psychiatric in-patients. *Acta Psychiatrica Scandinavica*; 92:250-4.

Linaker OM (2000) Dangerous female psychiatric patients: prevalence and characteristics. *Acta Psychiatrica Scandinavia*; 101:67-72.

Lindsey M, Hosie A (2000) *The Edinburgh inquiry – recommendation 55 – the independent* evaluation report. The University of Strathclyde and the former Centre for Residential Child Care. www.down.edinburgh.gov.uk/calm/calm_evaluation_report.doc

Littlewood R, Lipsedge M (1997) 3rd Ed. *Aliens and alienists: ethnic minorities and psychiatry.* London: Routledge – an imprint of Taylor & Francis Books.

Lloyd K, Moodley P (1992) Psychotropic medication and ethnicity: an in-patient survey. *Social Psychiatry and Psychiatric Epidemiology*; 27:95-101.

Logan PH (1988) Aggression management. *Journal of Clinical Psychiatry*; 49(10): 412-413.

Lowe T, Wellman N, Taylor R (2003) Limit-setting and decision-making in the management of aggression. *Issues and Innovations in Nursing Practice*; 41(2): 154-161.

Lynch M, Kotsos A (2001) Fatal benzotropine toxicity. *Medicine, Science and Law*; 41(2): 155-158.

Mahli GD, Holloway F, Taylor D (1999) Zuclopenthixol acetate (clopixol acuphase) for rapid sedation. *International Journal of Psychiatry in Clinical Practice*; 3:135-136.

Makkar RR, Fromm BS, Steinman RT, Meissner MD, Lehmann MH (1993) Female gender as a risk factor for torsade de pointes associated with cardiovascular drugs. *Journal of the American Medical Association*; 270 (21) 2590-7.

Man PL, Chen CH (1973) Rapid tranquillisation of acutely psychotic patients with intramuscular haloperidol and chlorpromazine. *Psychomatics*; 14:59-63.

Manfredini R, Vanni A, Peron L, la Cecilia O, Smolensky MH, Grassi L (2001) Day-night variation in aggressive behaviour among psychiatric in-patients. *Chronobiology International*; 18(3): 503-511.

Mann LS, Wise TN, Shay L (1993) A prospective study of psychiatric patients' attitudes toward the seclusion room experience. *General Hospital Psychiatry*; 15:177-182.

Marangos-Frost S, Wells D (2000) Psychiatric nurses' thoughts and feelings about restraint use: a decision dilemma. *Journal of Advanced Nursing*; 31:362-9.

Martin KH (1995) Improving staff safety through an aggressive management programme. *Archives of Psychiatric Nursing*; 9(4): 211-215.

Marx JI, Levinson RM (1988) Statutory change and 'street-level' implementation of psychiatric commitment. *Social Science and Medicine*; 27:1247-56.

Mason AS, Dewolfe AS (1974) Usage of psychotropic drugs in a mental hospital I: as needed (PRN) antipsychotic medications. *Current Therapeutic Research*; 16(8): 853-860.

Mason J, Nicolson D, Wilson D (2002) *Systematic review methods for national guidelines*. (Unpublished discussion paper).

Mason T (1997) An ethnomethodological analysis of the use of seclusion. *Journal of Advanced Nursing*; 26:780-9.

Mason T (1998) Gender differences in the use of seclusion. *Medicine, Science and Law*; 38(1): 2-9.

Mason T, Whitehead E (2001) Some specific problems of secluding female patients. *Medicine, Science and Law*; 41:315-24.

McElroy S, Keck PE, Stanton SP, Tugrul KC, Bennett JA, Strakowski SM (1996) A randomised comparison of divalproex oral loading versus haloperidol in the initial treatment of acute psychotic mania. *Journal of Clinical Psychiatry*; 57(4): 142-146.

McNiel DE, Binder RL, Greenfield TK (1988) Predictors of violence in civilly committed acute psychiatric patients. *American Journal of Psychiatry*; 145(8): 965-970.

McNiel DE, Binder RL (1989) Relationship between preadmission threats and later violent behaviour by acute psychiatric in-patients. *Hospital and Community Psychiatry*; 40(6): 605-608.

McNiel DE, Binder RL (1991) Clinical assessment of the risk of violence among psychiatric in-patients. *American Journal of Psychiatry*; 148(10): 1317-3121.

McNeil DE, Binder RL (1994a) Screening for risk of in-patient violence: validation of an actuarial tool. *Law and Human Behavior*; 18(5): 579-586.

McNeil DE, Binder RL (1994b) The relationship between acute psychiatric symptoms, diagnosis, and short-term risk of violence. *Hospital and Community Psychiatry*; 45(2): 133-137.

McNiel DE, Binder RL (1995) Correlates of accuracy in the assessment of psychiatric in-patients' risk of violence. *American Journal of Psychiatry*; 152(6): 901-6.

McNiel DE, Sandberg DA, Binder RL (1998) The relationship between confidence and accuracy in clinical assessment of psychiatric patients' potential for violence. *Law and Human Behaviour*; 22 (6): 655-669.

Mendoza R, Djenderedjian A.H, Adams J, Ananth J (1987) Midazolam in acute psychotic patients with hyperarousal. *Journal of Clinical Psychiatry*; 48(7): 291-292.

Middelboe T, Schjodt T, Byrsting K, Gjerris A (2001) Ward atmosphere in acute psychiatric in-patient care: patients' perceptions, ideals and satisfaction. *Acta Psychiatrica Scandinavica*; 103(3): 212-219.

Ministry of Health (1994) *Guidelines for reducing violence in mental health services.* New Zealand: Ministry of Health, Mental Health Section.

Ministry of Health. (June 1993 and June 1995) *Procedural guidelines for physical restraint and seclusion. Mental health policy*. New Zealand: Ministry of Health, Mental Health Section.

Minnis H, McMillan A, Gillies M, Smith S (2001) Racial stereotyping: survey of psychiatrists in the United Kingdom. *British Medical Journal*; 323:905-6.

Mistral W, Hall A, McKee P (2002) Using therapeutic community principles to improve the functioning of a high care psychiatric ward in the UK. *International Journal of Mental Health Nursing*; 11:10-17.

Moore P, Berman K, Knight M, Devine J (1995) Constant observation: implications for nursing practice. *Journal of Psychosocial Nursing*; 33(3): 46-50.

Morgan S (2000) *Clinical risk management: a clinical tool and practitioners' manual*. London: The Sainsbury Centre for Mental Health.

Morley R, Wykes T, MacCarthy B (1991) Attitudes of relatives of Afro-Caribbean patients: do they affect admission? *Social Psychiatry and Psychiatric Epidemiology*; 26:187-93.

Morrison A, Sadler D (2001) Death of a psychiatric patient during physical restraint. Excited delirium: a case report. *Medicine, Science and Law*; 41:46-50.

Morrison EF (1989) Theoretical modelling to predict violence in hospitalized psychiatric patients. *Research in Nursing and Health*; 12:31-40.

Morrison EF (1992) A coercive interactional style as an antecedent to aggression in psychiatric patients. *Research in Nursing and Health*; 15(6): 421-431.

Morrison EF (1993) A comparison of perceptions of aggression and violence by psychiatric nurses. *International Journal of Nursing Studies*; 30(3): 261-268.

Morrison EF (1998) The culture of caregiving and aggression in psychiatric settings. *Archives of Psychiatric Nursing*; 12(1): 21-31.

Morrison P, Lehane M (1995) Staffing levels and seclusion use. *Journal of Advanced Nursing*; 22:1193-202.

Morrison P, Lehane M, Palmer C, Meehan T (1997) The use of behavioural mapping in a study of seclusion. *Australian and New Zealand Journal of Mental Health Nursing*; 6:11-8.

Moss AJ (1993) Measurement of the QT interval and the risk associated with QTc interval prolongation: a review. *American Journal of Cardiology*; 72:23-25.

Mouren P, Poiso Y, Guigou G (1976) 'Étude du l'action du sultopride sur le symptom cible 'agitation': a propos de 31 observations. *La Semaine des Hôpitaux*; 52(24): 1147-1452.

Muir-Cochrane E, Harrison B (1996) Therapeutic interventions associated with seclusion of acutely disturbed individuals. *Journal of Psychiatric and Mental Health Nursing*; 3(5): 319-325.

Muir-Cochrane E (1996) An investigation into nurses' perceptions of secluding patients on closed psychiatric wards. *Journal of Advanced Nursing*; 23:555-63.

Myers S (1990) Seclusion: a last resort measure. *Perspectives in Psychiatric Care* 26(3): 24-28 [erratum appears in *Perspectives in Psychiatric Care* 1991; 27(2): 15].

National Collaborating Centre for Mental Health. (2002) *Schizophrenia: core interventions in the treatment and management of schizophrenia in primary and secondary care, clinical guideline.* Commissioned by National Institute for Health and Clinical Excellence. London: NICE.

Ndegwa D (2000) *Social division and difference: black and ethnic minorities.* London: NHS National Programme on Forensic Mental Health Research and Development.

Neilson O, Brennan W (2001) The use of special observations: an audit within a psychiatric unit. *Journal of Psychiatric and Mental Health Nursing*; 8:147-155.

NHS Executive (1999) *Safety, privacy, and dignity in mental health units: guidance on mixed sex accommodation for mental health services*, London: Department of Health.

Nield-Anderson L, Doubrava J (1993) Defusing verbal abuse: a program for emergency department triage nurses. *Journal of Emergency Nursing*; 19(5): 441-445.

Nijman H, Merckelback H, Evers C, Palmstierna T, à Campo J (2002) Prediction of aggression on a locked psychiatric admissions ward. *Acta Psychiatrica Scandinavia*; 105:390-395.

Nolan P, Soares J, Dallender J, Thomsen S, Arnetz B (2001) A comparative study of the experiences of violence of English and Swedish mental health nurses. *International Journal of Nursing Studies*; 38:419-426.

Novaco RW, Renwick SJ (1997) *Anger predictors of the assaultiveness of forensic hospital patients.* 27th Congress of the European Association for Behavioral and Cognitive Therapies, Venice, Italy. USA.

Nuller IuL, Rabihovich MM (1971) Comparative assessment of the action of lithium carbonate, haloperidol and the preparation IB-503 in the treatment of manic states. *Zhurnal Neuropatologii I Psikiatrii Imeni SS Korsakova*; 71(2): 277-283.

O'Connell B, Young J, Brooks J, Hutchings J, Lofthouse J (2000) Nurses' perceptions of the nature and frequency of aggression in general ward setting and high dependency areas. *Journal of Clinical Nursing*; 9:602-610.

Office of Mental Retardation and Developmental Disabilities (1998) *Strategies for crisis intervention and prevention: instructors guide.* New York: Office of Mental Retardation and Developmental Disabilities.

O'Halloran RL, Frank JG (2000) Asphyxial death during prone restraint revisited: a report of 21 cases. *American Journal of Forensic Medical Pathology*; 21:39-52.

Omerov M, Wistedt B (1997) Manageable violence in a new ward for acutely admitted patients. *European Psychiatry*; 12(6): 311-315.

O'Sullivan M, Meagher D. (1998) Assaults on psychiatrists – a three-year retrospective study. *Irish Journal of Psychiatric Medicine*; 15(2): 54-7.

Oulis P, Lykouras L, Dascalopoulou E, Psarros C (1996) Aggression among psychiatric in-patients in Greece. *Psychopathology*; 29:174-180.

Overall J, Gorham P (1962) The brief psychiatric rating scale. *Psychology Reports*; 22:788-812.

Owen C, Tarentello C, Jones M, Tennant C (1998a) Violence and aggression in psychiatric units. *Psychiatric Services*; 49(11):1452-1457.

Owen C, Tarentello C, Jones M, Tennant C (1998b) Repetitively violent patients in psychiatric units. *Psychiatric Services*; 49(11): 1458-1461.

Palmstierna T, Wisledt B (1987) Staff observation scale: presentation and evaluation. *Acta Psychiatrica Scandinavia*; 76:657-663.

Palmstierna T, Wistedt B (1989) Risk factors for aggressive behaviour are of limited value in predicting the violent behaviour of acute involuntarily admitted patients. *Acta Psychiatrica Scandinavia*; 81:152-155.

Palmstierna T, Wistedt B (1990) Risk factors for aggressive behaviour are of limited value in predicting the violent behaviour of acute involuntarily admitted patients. *Acta Psychiatrica Scandinavia*; 81:152-155.

Palmstierna T, Huitfeldt B, Wistedt B (1991) The relationship between crowding and aggressive behavior on a psychiatric intensive care unit. *Hospital and Community Psychiatry*; 42(12): 1237-1240.

Palmstierna T, Wistedt B (1995) Changes in the pattern of aggressive behaviour among in-patients with changed ward organisation. *Acta Psychiatrica Scandinavica*; 91(1): 32-5.

Paprocki J, Versiani M (1977) A double-blinded comparison between loxapine and haloperidol by parenteral route in acute schizophrenia. *Current Therapeutic Research*; 21(1): 80-100.

Parkes J (1996) Control and restraint training: a study of its effectiveness in a medium secure psychiatric unit. *The Journal of Forensic Psychiatry*; 7(3): 525-534.

Parkes J (2000) Sudden death during restraint: a study to measure the effect of restraint positions on the rate of recovery from exercise. *Medicine, Science and Law*; 40:39-44.

Paterson B, Turnbull J, Aitken I (1992) An evaluation of a training course in the short-term management of violence. *Nurse Education Today*; 12:368-375.

Paterson B, Leadbetter D, McCornish A (1997) De-escalation in the management of aggression and violence. *Nursing Times*; 93(36):58-61.

Paterson B, Leadbetter D, McComish A (1998) Restraint and sudden death from asphyxia. *Nursing Times*; 94: 62-4.

Paterson B, Bradley P, Stark C, Saddler D, Leadbetter D (2003) Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. *Journal of Psychiatry and Mental Health Nursing*; 10:3-15.

Patterson RD (1982) *Guidelines for auditory warning systems on civil aircraft.* London: Civil Aviation Authority.

Peniston EG, Kulkosky PJ (1988) Group assertion and contingent time-out procedures in the control of assaultive behaviors in schizophrenics. *Medical Psychotherapy: An International Journal*; 1:131-141.

Penny WD, Frost D (1997) Neural network modelling of the level of observation decision in an acute psychiatric ward. *Computers and Biomedical Research*; 30:1-17.

Penochet JC (1979) Tolérance du sultopride. *La Semaine des Hôpitaux*; 55(7-8): 408-409.

Perera R, Kraebber A, Schwartz M (1997) Prolonged QT interval and cocaine use. *Journal of Electrocardiology*; 30:337-339.

Perkins J, Leadbetter D (2002) An evaluation of aggression management training in a special educational setting. *Emotional and Behavioural Difficulties*; 7(1): 19-34.

Phillips D, Rudestam KE. (1995) Effect of non-violent self-defence training on male psychiatric staff members' aggression and fear. *Psychiatric Service*; 462:164-168.

Phillips M, Peacocke J, Hermanstyne L, Rosales A, Rowe M, Smith P, Steele C, Weaver R (1977a) Continuous observation – part I. *Canadian Psychiatric Association Journal*; 22(1): 22-28.

Phillips M, Peacocke J, Hermanstyne L, Rosales A, Rowe M, Smith P, Steele C, Weaver R (1977b) Continuous observation – part II: absenteeism amongst nursing staff as a response to the extra workload. *Canadian Psychiatric Association Journal*; 22(1): 29-30.

Pisarcik Lenehan G, Stetler C (1985) Use of haloperidol in the management of agitated or violent, alcohol-intoxicated patients in the emergency department: a pilot study. *Journal of Emergency Nursing*; 11(2): 72-79.

Piyakulmala S, Corbett L, Ahluwalia Y, Berry RA, Meltzer HY (1977) High dose pimozide in the treatment of acutely agitated schizophrenia. *Current Therapeutic Research*; 22(4): 453-461.

Plutchik R, van Praag H M (1990) A self-report measure of violence risk, II, *Comprehensive Psychiatry*; 31(5): 450-456.

Pollanen MS, Chiasson DA, Cairns JT, Young JG (1998) Unexpected death related to restraint for excited delirium: a retrospective study of deaths in police custody and in the community. *Canadian Medical Association Journal*; 158:1603-7.

Poster EC, Ryan JA (1989) Nurses' attitudes toward physical assault by patients. *Archives of Psychiatric Nursing*; 3(6): 315-322.

Poster EC (1996) A multinational study of psychiatric nursing staffs' beliefs and concerns about work safety and patient assault. *Archives of Psychiatric Nursing*; 10(6):365-373.

Powell G, Caan W, Crowe M (1994) What events precede violent incidents in psychiatric hospitals? *British Journal of Psychiatry*; 165:107-112.

Prins H (1986) 'Dangerous behaviour: the law and mental disorder', London: Tavistock in: Fernando S, Ndegwa D, Wilson M (1998) *Forensic psychiatry, race and culture*. London: Routledge.

Questnsted M, Ramsa R, Bernadt M (1992) Rapid tranquillisation. *British Journal of Psychiatry*; 161, correspondence, 573.

Quirk A, Lelliot P, Seale C (2004) Service users' strategies for managing risk in the volatile environment of an acute psychiatric ward. *Social Science and Medicine*; 59 (12): 2573-83.

Rabinowitz J, Mark M (1999a) Risk factors of violence among long-stay psychiatric patients: a national study. *Acta Psychiatrica Scandiavica*; 99:341-347.

Rabinowitz J, Garelik-Wyler R (1999b) Accuracy and confidence in clinical assessment of psychiatric in-patients' risk of violence, *International Journal of Law and Psychiatry*; 22 (1): 99-106.

Rae M (Unpublished 2003) *Pain compliance.* British Institute of Learning Disabilities Debate.

Raja M, Azzoni A, Lubich L (1997) Aggressive and violent behavior in a population of psychiatric in-patients. *Social Psychiatry and Psychiatric Epidemiology*; 32:7-434.

Raja M, Azzoni A (2000) Second generation antipsychotics in emergency care settings: a prospective naturalistic study. *General Hospital Psychiatry*; 22:107-114.

Rankins RC, Hendey GW (1999) Effect of a security system on violent incidents and hidden weapons in the emergency department. *Annals of Emergency Medicine*; 33(6): 676-679.

Rappard Ph, Parr N (1981) Sultorpide et psychoses aiguës dysthymiques maniaques. *La Semaine Hôpitaux*; 57(43-44): 1841-1843.

Raskin VD, Dresner N, Miller LJ (1991) Risks of restraints versus psychotropic medication for pregnant patients. *American Journal of Psychiatry*; 148 (12): 1760-1761.

Rasmussen K, Levander S (1996) Individual rather than situational characteristics predict violence in a maximum security hospital. *Journal of Interpersonal Violence*; 11(3): 376-390.

Rautaharju P, Zhou SH, Wong S, Calhoun HP, Berenson GS, Prineas R, Davignon A (1992) Sex differences in the evolution of the electrocardiographic QT interval with age. *Canadian Journal of Cardiology*; 8:690-5.

Rauter UK, de Nesnera A, Grandfield S (1997) Up in smoke? Linking patient assaults to a psychiatric hospital's smoking ban. *Journal of Psychosocial Nursing*; 35(6): 35-40.

Ray CL, Subich LM (1998) Staff assaults and injuries in a psychiatric hospital as a function of three attitudinal variables. *Issues in Mental Health Nursing*; 19:277-289.

Ray WA, Meredith S, Thapa PB, Meador KG, Hall K, Murray KT (2001) Antipsychotics and the risk of sudden cardiac death. *Archives of General Psychiatry*; 58:1161-67.

Ray WA, Meador KG (2002) Antipsychotics and sudden death: is thioridazine the only bad actor? *British Journal of Psychiatry*; 180:483-484.

Rees C, Lehane M (1996) Witnessing violence to staff: a study of nurses' experience. *Nursing Standard*; 11(13/15): 45-47.

Reid Y, Johnson S, Morant N, Kuipers E, Szmukler G, Bebbington P, Thornicroft G, Prosser D (1999) Improving support for mental health staff: a qualitative study. *Social Psychiatry and Psychiatric Epidemiology*; 34:309-315.

Reinert RE, Hermann CG (1960) Unexplained deaths during chlorpromazine therapy. *Journal of Nervous and Mental Diseases*; 131:435-42.

Reschke RW (1974) Parenteral haloperidol for rapid control of severe, disruptive symptoms of acute schizophrenia. *Diseases of the Nervous System*; 35(3): 112-115.

Resnick M, Burton BT (1984) Droperidol vs. haloperidol in the initial management of acutely agitated patients. *Journal of Clinical Psychiatry*; 45(7): 298-299.

Reubin T, Spitz, Hillbrand M, Foster HG, Svetina CJ (1997) Ethnicity, aggression, and serum ceatine kinase in hospitalised male forensic patients. *Ethnicity and Disease*; 7:259-270.

Ricard N, Sauriol L, Bélanger MC, Chouinard G (1999) Direct cost of care for patients with schizophrenia treated with haloperidol in an emergency unit. *Psychiatric Services*; 50(10): 1287-1288.

Rice ME, Helzel MF, Varney GW, Quinsey VL (1985) Crisis prevention and intervention training for psychiatric hospital staff. *American Journal of Community Psychology*; 13(3):289-304.

Richmond I, Trujillo D, Schmelzer J, Phillips S, Davis D (1996) Least restrictive alternatives: do they really work? *Journal of Nursing Care Quality*; 11(1):29-37.

Rix R (2001) 'De-escalation techniques' in: Beer MD, Pereira SM, Paton C *Psychiatric intensive care*. London: Greenwich Medical Media Limited.

Roberts JR, Geeting GK (2001) Intramuscular ketamine for the rapid tranquillisation of the uncontrollable, violent, and dangerous adult patient. *The Journal of Trauma Injury, Infection, and Critical Care*; 51:1008-1010.

Roper JM, Anderson NLR (1991) The interactional dynamics of violence, part I: an acute psychiatric ward. *Archives of Psychiatric Nursing*; V(4):209-215.

Rose S, Bisson J, Wessely S (2003) Psychological debriefing for preventing of post-traumatic stress disorder (PTSD) (Cochrane review) in: *The Cochrane Library*, issue 1, 2002. Chichester, UK: John Wiley & Sons, Ltd.

Rosenbaum M (1991) Violence in psychiatric wards: role of the lax milieu. *General Hospital Psychiatry*; 13(2): 115-121.

Rosenthal TL, Edwards NB, Rosenthal RH, Ackerman BJ (1992) Hospital violence: site, severity, and nurses' preventive training. *Issues in Mental Health Nursing*; 13(4): 349-356.

Ross MM, Hoff LA, McComas J, Carswell A, Bunn H, Coutu-Wakulczyk G (1998) Strengthening the interdisciplinary education of nurses in violence prevention, detection and intervention. *Nurse Educator*; 23(3): 17-18.

Royal College of Nursing (1992) *Seclusion, control and restraint.* London: RCN.

Royal College of Nursing (1998) *Dealing with violence against nursing staff: an RCN guide for nurses and managers.* London: RCN.

Royal College of Nursing (1998) *Safer working in the community: a guide for NHS managers and staff on reducing the risks for violence and aggression.* London: RCN.

Royal College of Psychiatrists *Draft report on antipsychotic drugs* (unpublished).

Royal College of Psychiatrists (1993) *Consensus statement of the use of high dose antipsychotic medication*, CR26. London: Royal College of Psychiatrists.

Royal College of Psychiatrists (1995) *Strategies for the management of disturbed and violent patients in psychiatric units,* CR41. London: Royal College of Psychiatrists.

Royal College of Psychiatrists (1996) *Assessment and clinical management of risk of harm to other people: special working party on clinical assessment and management of risk*; CR53. London: Royal College of Psychiatrists.

Royal College of Psychiatrists and British Medical Association (1996) *Psychiatric services to accident and emergency departments: report of a joint working party of Royal College of Psychiatrists and the British Association for Accident and Emergency Medicine, CR43.* London: Royal College of Psychiatrists.

Royal College of Psychiatrists (1996) *Sexual abuse and harassment in psychiatric settings*; CR 52. London: Royal College of Psychiatrists.

Royal College of Psychiatrists (1997) *Standards of places of safety under section 136 of the Mental Health Act (1983)*, CR61.London: Royal College of Psychiatrists.

Royal College of Psychiatrists (1997) *The association between antipsychotic drugs and sudden death: report of the working group of the Royal College of Psychiatrists' Psychopharmacology Sub-Group*, CR57. London: Royal College of Psychiatrists.

Royal College of Psychiatrists (1998) *Management of imminent violence: clinical practice guidelines to support mental health services*, OP41, London: Royal College of Psychiatrists.

Royal College of Psychiatrists (1998) *Not just bricks and mortar: report of the Royal College of Psychiatrists working party on the size, staffing, structure, siting and security of new acute adult psychiatric in-patient units*, CR62. London Royal College of Psychiatrists.

Royal College of Psychiatrists (1999) *Safety for trainees in psychiatry: report of the collegiate trainees' committee working party on the safety of trainees,* CR78. London: Royal College of Psychiatrists.

Royal College of Psychiatrists (2004) *Psychiatric services to accident and emergency departments*, CR118. London: Royal College of Psychiatrists.

Royal Pharmaceutical Society of Great Britain (2001) *British national formulary*. London: British Medical Association and the Royal Pharmaceutical Society of Great Britain.

Ryan JA, Poster EC (1989) The assaulted nurses: short-term and long-term responses. *Archives of Psychiatric Nursing*; 3(6): 323-331.

Ryden MB, Feldt KS, Oh HL, Brand K, Warne M, Weber E, Nelson J, Gross C (1999) Relationships between aggressive behavior in cognitively impaired nursing home residents and use of restraints, psychoactive drugs, and secured units. *Archives of Psychiatric Nursing*; 13(4): 170-178.

Salias E, Fenton M (2001) Seclusion and restraint for people with serious mental illnesses (Cochrane review*)* in: *The Cochrane Library*, issue 1, 2002. Chichester, UK: John Wiley & Sons, Ltd.

Salib E, Ahmed AG, Cope M (1998) Practice of seclusion: A five-year retrospective review in north Cheshire. *Medicine, Science and the Law*; 38(4): 321-327.

Salzman C, Solomon D, Miyawaki E, Glassmand R, Rood L, Flowers E, Thayer S (1991) Parenteral lorazepam versus parenteral haloperidol for the control of psychotic disruptive behavior. *Journal of Clinical Psychiatry*; 52(4): 177-180.

Sashhidharan SP (2003) *Inside outside – improving mental health services for black and minority ethnic communities in England*. London: Department of Health.

Schmeid K, Ernst K (1983) Isolierung and zwangsinjektion in urteil der betroffenen patienten und des pflegepersonals. *Archiv für Psychiatrie und Nervenkrankenheiten*; 233:211-222.

Schmidt P, Snowden T (1999) The effects of positional restraint on heart rate and oxygen saturation. *The Journal of Emergency Medicine*; 17:777-82.

Schwart HI, Vingiano W, Perez CB (1988) Autonomy and the right to refuse treatment: patients' attitudes after involuntary medication. *Hospital and Community Psychiatry*; 39(10): 1049-1054.

Secker J, Harding C (2002) African and African Caribbean users' perceptions of in-patient services. *Journal of Psychiatric & Mental Health Nursing*; 9(2): 161-167.

Segal SP, Watson MA, Goldfinger SM, Averbuck DS (1988) Civil commitment in the psychiatric emergency room. *Archives of General Psychiatry*; 45:748-772.

Seletti B (2002) Psychiatrie et urgences'. *Annales Medico Psychologiques*; 160:187-191.

Semonin-Holleran R, Bulcholz J (2000) Use of conscious sedation in the emergency department. *Journal of Emergency Nursing*; 19(5): 468.

Sequeira H, Halstead S (2002) Control and restraint in the UK: Service user perspectives. *The British Journal of Forensic Practice*; 4:9-18.

Sheehan JD, Hardie T, Watson JP (1995) Social deprivation, ethnicity and violent incidents on acute psychiatric wards. *Psychiatric Bulletin*; 19:597-599.

Shepherd M, Lavender T (1999) Putting aggression into context: an investigation into contextual factors influencing the rate of aggressive incidents in a psychiatric hospital. *Journal of Mental Health*; 8(2): 159-170.

Sheridan M, Henrion R, Robinson L, Baxter V (1990) Precipitants of violence in psychiatric in-patient settings. *Hospital and Community Psychiatry*; 41(7): 776-780.

Shiffman R (1997) Representation of clinical practice guidelines in conventional and augmented decision tables. *Journal of Medical Informatics Association*; 4(5): 382-393.

Shugar G, Rehaluk R (1990) Continuous observation for psychiatric in-patients: a critical evaluation. *Comprehensive Psychiatry*; 30(1): 48-55.

Silver E (2000) Race, neighborhood disadvantage, and violence among persons with mental disorders: the importance of contextual measurement. *Law and Human Behavior*; 24:449-56.

Simpson D, Anderson I (1996) Rapid tranquillisation: a questionnaire survey of practice. *Psychiatric Bulletin*; 20:149-152.

Singh SP, Croudace T, Beck A, Harrison G (1998) Perceived ethnicity and the risk of compulsory admission. *Social Psychiatry and Psychiatric Epidemiology*; 33:39-44.

Sjöström N, Eder DN, Malm U, Beskow J (2001) Violence and its prediction at a psychiatric hospital. *European Psychiatry*; 16:459-465.

Sloore H (1988) Use of the MMPI in the prediction of dangerous behavior. *Acta Psychiatrica Belgica*; 88(1): 42-51.

Smith AD, Humphreys M (1997a) Characteristics of in-patients transferred to a locked ward in a Scottish psychiatric hospital. *Health Bulletin*; 55(2): 77-82.

Smith AD, Humphreys M.(1997b) Physical restraint of patients in a psychiatric hospital. *Medicine, Science and Law*; 37(2): 145-149.

Smith A (1997) Survey of locked facilities in Scottish psychiatric hospitals. *Psychiatric Bulletin*; 21:77-79.

Soares JJF, Lawoko S, Nolan P (2000) The nature, extent and determinants of violence against psychiatric personnel. *Work and Stress*; 14(2): 105-120.

Soliday SM (1985) A comparison of patients and staff attitudes toward seclusion. *Journal of Nervous and Mental Disease*; 173(5): 282-6.

Soliman AE, Reza H (2001) Risk factors and correlates of violence among acutely ill adult psychiatric in-patients. *Psychiatric Services*; 52(1): 75-80.

Soloff PH, Gutheil TG, Wexler DB (1985) Seclusion and restraint in 1985: a review and update. *Hospital & Community Psychiatry*; 36(6): 652-657.

Southcott J, Howard A, Collins E (2002) Control and restraint training in acute medical health care. *Nursing Standard*; 16(27): 33-36.

Spokes K, Bond K, Lowe T, Jones J, Illinworth P, Brimblecome N, Wellman N (2002) Hovis – the Hertfordshire/Oxfordshire violent incident study. *Journal of Psychiatric and Mental Health Nursing*; 9(2): 199-209.

Standing Nursing and Midwifery Advisory Committee (1999) *Mental health nursing: addressing acute concerns.* London: Department of Health.

Standing Nursing and Midwifery Advisory Committee (1999) 'Practice guidance: safe and supportive observation of patients at risk' in: *Mental health nursing: addressing acute concerns*. London: Department of Health.

Steadman HJ, Braff J, Morrissey JP (1988) Profiling psychiatric cases evaluated in the general hospital emergency room. *Psychiatric Quarterly*; 59(1): 10-22

Steel E (1999) *Seclusion and restraint practice standards: a review and analysis*. Alexandria, US: National Mental Health Association.

Steiner T, Wiebe C, Gebhardt RP (1999) Aggressive behaviour against self and others among first-admission patients with schizophrenia. *Psychiatric Services*; 50(1): 85-90.

Stevenson S, Otto MP (1998) Finding ways to reduce violence in psychiatric hospitals. *Journal for Healthcare Quality*; 20(4): 28-32.

Stotsky BA (1977) Relative efficacy of parenteral haloperidol and thiothixene for the emergency treatment of acutely excited and agitated patients. *Diseases of the Nervous System*; 38(12): 967-973.

Strakowski SM, Lonczak HS, Sax KW, West SA, Crist A, Mehta R et al. (1995) The effects of race on diagnosis and disposition from a psychiatric emergency service. *Journal of Clinical Psychiatry*; 56:101-7.

Stratton SJ, Rogers C, Brickett K, Gruzinski G (2001) Factors associated with sudden death of individuals requiring restraint for excited delirium. *American Journal of Emergency Medicine*; 19:187-91.

Svensson B, Hansson L (1994) Patient satisfaction with in-patient psychiatric care. The influence of personality traits, diagnosis and perceived coercion. *Acta Psychiatrica Scandinavia*; 90:379-384.

Swett C, Mills T (1997) Use of the NOSIE to predict assaults among acute psychiatric patients. *Psychiatric Services*; 48(9): 1177-1180.

Swett C (1985) Psychotropic medications used during mechanical restraint of patients. *Current Therapeutic Research*; 38(4): 621-626.

Tardiff K (1981) Emergency control measures for psychiatric in-patients. *Journal of Nervous and Mental Disease*; 169:10-618.

Tardiff K (1983) A survey of drugs used in the management of assaultive in-patients. *Bulletin of the American Academy of Psychiatry and the Law*; 11(3): 215-222.

Taxis JC (2002) Ethics and praxis: alternative strategies to physical restraint and seclusion in a psychiatric setting. *Issues in Mental Health Nursing*; 23:157-70.

Taylor T, Paton C, Kerwin RK (2000) *Bethlem and Maudsley NHS Trust prescribing guidelines*. London: Taylor & Francis Medicine.

The Centre for Residential Child Care (1997) *Clear expectations, consistent limits.* Scotland: The Centre for Residential Child Care.

The Centre for Residential Childcare. (1995) *Physical restraint – practice, legal, medical and technical considerations*. Practice paper No.2. Scotland: The Centre for Residential Child Care.

The Mental Health Act Commission (1999) *Eighth biennial report*. London: The Stationery Office.

The Mental Health Act Commission (1999-2001) *Ninth biennial report*. London: The Stationery Office.

The Mental Health Act Commission (2001-2003) *Tenth biennial report. Placed amongst strangers*. London: The Stationery Office.

The Sainsbury Centre for Mental Health (2000) *Acute problems: a survey of the quality of care in acute psychiatric wards*. London: The Sainsbury Centre for Mental Health.

The Sainsbury Mental Health Centre (2002) *Breaking the circles of fear – a review of the relationship between mental health services and African and Caribbean communities.* London: The Sainsbury Centre for Mental Health.

The Scottish Office (1996) *The prevention and management of aggression: a good practice statement*, Clinical Resource and Audit Group. Working Group on Mental Illness. Edinburgh: The Scottish Office.

The Stephen Lawrence Inquiry (1999) *Racism*. Report of an Inquiry by Sir William Macpherson of Cluny. Advised by: Cook T, Sentamu J, Stone R. London: The Stationary Office; Ch6; para 6.6.

Thomas C, Bartlett A, Mezey GC (1995) The extent and effects of violence among psychiatric in-patients. *Psychiatric Bulletin*; 19:600-604.

Thomas H, Schwatz E, Petrilli R (1992) Droperidol versus haloperidol for chemical restraint of agitated and combative patients. *Annals of Emergency Medicine*; 21:407-13.

Toch H, Adams K, Greene R (1987) Ethnicity, disruptiveness, and emotional disorder among prison inmates. *Criminal Justice and Behavior*; 14:93-109.

Tooke SK, Brown JS (1992) Perceptions of seclusion: comparing patient and staff reactions. *Journal of Psychosocial Nursing and Mental Health Services*; 30(8): 23-6.

Torkelson DJ, Dobal MT (1999) Constant observation in medical-surgical settings: a multi-hospital study. *Nursing Economics*; 17(3): 149-155.

Travin S, Lee HK, Bluestone H (1990) Prevalence and characteristics of violent patients in a general hospital. *New York State Journal of Medicine*; 90:591-595.

TREC Collaborative Group (2003) Rapid tranquillisation for agitated patients in emergency psychiatric rooms: a randomised trial of midazolam versus haloperidol plus promethazine. *British Medical Journal*; 327:708-713.

Tse SK, Wong TW, Lau CC, Yeung WS, Tang WN (1999) How good are accident and emergency doctors in the evaluation of psychiatric patients? *European Journal of Emergency Medicine*; 6:297-300.

Tuason VB (1986) A comparison of parenteral loxapine and haloperidol in hostile and aggressive acutely schizophrenic patients. *Journal of Clinical Psychiatry*; 47:126-129.

Üeçok VA, Kora K, Bostanci F, Er F (1996) Seclusion in closed psychiatric wards in Turkey. *European Journal of Psychiatry*; 10(3): 149-154.

United Kingdom Central Council for Nursing, Midwifery and Mental Health Nursing (2002) *The recognition, prevention and therapeutic management of violence in mental health care.* London: UKCC.

University of Central Lancashire (1999) *Nursing in secure environments.* London: United Kingdom Central Council for Nursing, Midwifery & Health Visiting.

Van Rybroek GJ, Kuhlman TL, Maier GJ, Kaye MS (1987) Preventive aggression devices (PADS): ambulatory restraints as an alternative to seclusion. *Journal of Clinical Psychiatry*; 48(10): 401-5.

Velasco J, Eells TD, Anderson R, Head M, Ryabik B, Mount R, Lippmann S (1996) A two-year follow-up on the effects of a smoking ban in an in-patient psychiatric service. *Psychiatric Services*; 47(8): 869-871.

Waite BM, Hillbrand M, Foster HG (1992) Reduction of aggressive behavior after removal of music television. *Hospital and Community Psychiatry*; 43(2): 173-6.

Walker R (1991) PRN psychotropic drug use on a psychiatric unit. *Psychiatric Quarterly*; 621:1-8.

Wang EW, Rogers R, Giles CL, Diamond PM, Herrington-Wang LE, Taylor ER (1997) A pilot study of the personality assessment inventory (PAI) in corrections: assessment of malingering, suicide risk, and aggression in male inmates. *Behavioral Sciences and the Law*; 15(4): 469-482.

Wang, EW, Diamond PM (1999) Empirically identifying factors related to violence risk in corrections. *Behavioural Sciences and the Law*; 17:377-389.

Warner JP, Barnes TRE, Henry JA (1996) Electrocardiographic changes in patients receiving neuroleptic medication. *Acta Psychiatrica Scandinavica*; 93:311-313.

Warner L, Nicholas S, Patel K, Harris J, Ford R (2000) *National visit 2: improving care for detained patients from black and minority ethnic communities. Preliminary report.* London: The Sainsbury Centre for Mental Health.

Webster CD, Harris GT, Rice ME, Cornier C, Quinsey VL (1994) *The violence prediction scheme: assessing dangerousness in high risk men.* Toronto: University of Toronto, Centre of Criminology.

Webster CD, Douglas KS, Eaves D, Hart SD (1997) *HCR-20: Assessing risk of violence (version 2).* Vancouver, Canada: Mental Health Law and Policy Institute, Simon Fraser University.

Werner P D, Rose T L, Yesavage J A, Seeman K (1984) Psychiatrists' judgments of dangerousness in patients on an acute care unit. *American Journal of Psychiatry*; 263-266.

Werner PD, Rose TL, Yesavage JA (1983) Reliability, accuracy, and decision-making strategy in clinical predictions of imminent dangerousness. *Journal of Consulting and Clinical Psychology*; 51(6): 15-825.

Whicher E. Morrison M, Douglas-Hall P (2002) 'As required' medication regimens for seriously mentally ill people in hospital (Cochrane review) in: *The Cochrane Library,* issue 1, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Whittington R, Wykes T (1994) Violence in psychiatric hospitals: are certain staff prone to being assaulted? *Journal of Advanced Nursing*; 19:219-225.

Whittington R (1994) An observational study of associates between nurse behaviour and violence in psychiatric hospitals. *Journal of Psychiatric and Mental Health Nursing*; 1:85-92.

Whittington R, Patterson P (1996) Verbal and non-verbal behaviour immediately prior to aggression by mentally disordered people: enhancing the assessment of risk. *Journal of Psychiatric and Mental Health Nursing*; 3:47-57.

Whittington R, Wykes T (1996) Aversive stimulation by staff and violence by psychiatric patients. *British Journal of Clinical Psychology*; 35:11-20.

Whittington R, Wykes T (1996) An evaluation of staff training in psychological techniques for the management of patient aggression. *Journal of Clinical Nursing*; 5:257-261.

Wilson M, Francis J (1997) *Raised voices – African-Caribbean and African users' views and experiences of mental health services in England and Wales.* London: MIND.

Wilson MR, Soth N, Robak R (1992) Managing disturbed behaviour by architectural changes: making spaces fit the program. *Residential Treatment for Treatment and Youth*; 10(2): 63-74.

Wise TN, Mann LS, Murray C, Lopez CL (1988) Attitudes of non-secluded patients toward seclusion rooms. *General Hospital Psychiatry*; 10:280-284.

Wondrak RF, Dolan BM (1992) Dealing with verbal abuse: evaluation of the efficacy of a workshop for student nurses. *Nursing Education Today*; 12:108-115.

Wood KA (1986) 'Psychological assessment and intervention in the emergency room' in: *Innovations in clinical practice: a source book*; 5:365-381.

Wright S (1999) Physical restraint in the management of violence and aggression in in-patient settings: a review of issues. *Journal of Mental Health*; 8(5): 459-472.

Wright S, Lee S, Sayer J, Parr A, Gournay K (2000) A review of the content of management of violence policies in in-patient mental health units. *Mental Health Care*; 31(11): 373-376.

Wright P, Birkett M, David SR, Meehan K, Ferchland I, Alaka KJ, Saunders JC, Kreuger J, Bradley P, San L, Bernardo M, Reinstein M, Brier A (2001) Double-blind, placebo-controlled comparison of intramusclar olanzapine and intramuscular haloperidol in the treatment of acute agitation in schizophrenia. *American Journal of Psychiatry*; 158(7): 1149-1151.

Wright S, Gray R, Parkes J, Gournay K (2002) *The recognition, prevention and therapeutic management of violence in acute in-patient psychiatry*: a *literature review and evidence-based recommendations for good practice, prepared for the United Kingdom Central Council for Nursing, Midwifery and Health Visiting*. London: United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

Wyant M, Diamond BI, O'Neal E, Sloan A, Borison RL (1990) The use of midazolam in acutely agitated psychiatric patients. *Psychopharmacology Bulletin*; 26(1): 126-129.

Wykes T, Whittington R (1998) Prevalence and predictors of early traumatic stress reactions in assaulted psychiatric nurses. *The Journal of Forensic Psychiatry*; 9(3): 643-658.

Wynn R, Bratlid T (1998) Staff's experiences with patients' assaults in a Norwegian psychiatric university hospital. *Scandinavian Journal of Caring Sciences*; 12:89-93.

Yesavage JA (1983) In-patient violence and the schizophrenic patient. A study of brief psychiatric rating scale scores and in-patient behavior. *Acta Psychiatrica Scandinavica*; 67:5-357.

Yesavage JA (1984) Correlates of dangerous behaviour by schizophrenics in hospital. *Journal of Psychiatric Research*; 18(3): 225-231.

Yonge O, Stewin LL (1992) What psychiatric nurses say about constant care. *Clinical Nursing Research*; 1(1): 80-90.

Zernike W, Sharpe P (1998) Patient aggression in a general hospital setting: do nurses perceive it to be a problem? *International Journal of Nursing Practice*; 4:126-133.

Zohar M, Hadas Z, Modan B (1987) Factors affecting the decision to admit mental patients in a community hospital. *The Journal of Nervous and Mental Disease*; 175(5): 301-305.

Zwarenstein M, Reeves S, Barr H, Mannick M, Koppel I, Atkins J (2000) Interprofessional education: effects on professional practice and health care outcomes (Cochrane review) in: *The Cochrane Library*; issue 1, 2004. Chichester, UK: John Wiley & Sons, Ltd.

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HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

Guidance on Restraint and Seclusion in Health and Personal Social Services

AUGUST 2005

CONTENTS

ANNEXES

WHO SHOULD READ THIS GUIDANCE?

This guidance is intended to be used by:

- service commissioners in health and social care;
- managers of health and social care services;
- staff/professionals working with children and adults who may require to use restraint and/or seclusion;
- internal monitors of services and/or facilities;
- persons responsible for the operation of independent sector services or homes;
- Registration and Inspection staff;
- trainers and training providers.

The information in this guidance may also be helpful to:

- parents and those with parental responsibilities;
- Health and Social Services Councils;
- the Mental Health Review Tribunal;
- the Mental Health Commission;
- independent advocates;
- service users.

1. INTRODUCTION

Background to this guidance

1.1 This guidance on the use of restraint and seclusion is issued by the Department of Health and Social Services (DHSSPS) to inform practice across the Health and Personal Social Services (HPSS) bodies and their agents. It is the result of work undertaken by a HPSS Working Group, initiated by the DHSSPS Human Rights Liaison Group to assist in promoting human rights in these key areas.

1.2 The Liaison Group recognised that restraint and seclusion was an issue of common concern across HPSS and best tackled collaboratively. The Working Group which compiled the guidance was multi-professional and comprised of members from both the voluntary and statutory sectors. The outline terms of reference of the group are provided at **Annex A** and the membership at **Annex B**. Aspects of this guidance relating to the legislative context were taken forward through a sub-group and **Annex C** provides details of those involved.

Purpose of this guidance

1.3 The guidance is intended to be of an overarching nature, to be used to inform at provider level, the development of policies and procedures, training and practice across the relevant client groups in both hospital and other residential settings. The starting point for establishing good practice in the use of restraint and seclusion is the development of organisational policies, which reflect current legislation and case law as well as Departmental guidance, professional Codes of Practice and local circumstances, including the characteristics of the children or adults cared for within particular services. Every agency included within the remit of this guidance is expected to have a policy on the use of restraint and/or seclusion. The definitions of restraint and seclusion for the purpose of this guidance are examined at Section 2. The amount of detail needed will depend upon local circumstances but it should cover the areas set out in **Annex D** (example of HSS Trust Management of Aggression Policy), **Annex E** (example of HSS Trust Protocol on the Use of Physical Restraint and **Annex F** (example of HSS Trust Policy on Seclusion), as appropriate.

1.4 This guidance is issued to help ensure that staff working in various health and social care settings adopt consistent practices in the use of restrictive physical interventions and seclusion based upon common sets of principles. This will provide the most effective support for individual service users and reduce the possibility of confusion or disagreements between staff employed by different agencies.

1.5 This guidance will help staff in health and social services and elsewhere to address important outcomes for children and other service users, such as protecting and promoting their rights, providing appropriate choices, promoting independence and encouraging their social inclusion.

1.6 This guidance, by providing a clear framework to inform staff's practice in these complex areas of work, seeks to facilitate service standards which are consistent with best practice in relation to safeguarding service users and the Human Rights Act and that also reduce the risk to staff of litigation. **HSS Trusts should use the guidance to inform the production of policies and procedures on the use of restraint and/or seclusion.**

Legislative context

1.7 This guidance has been prepared in the context of The Human Rights Act (1998) and The United Nations Convention on the Rights of the Child (ratified 1991). It is based on the presumption that every adult and child is entitled to:

- respect for his/her private and family life;
- the right not to be subjected to inhumane or degrading treatment;
- the right to liberty and security; and
- the right not to be discriminated against in his/her enjoyment of those rights.

1.8 People are also protected under domestic legislation in terms both of the protection of their rights and the potential for redress through the criminal and civil law for assaults against the person.

1.9 Underlying this guidance is the principle that actions must both comply with the letter of the law and incorporate the spirit of respect for human rights.

Legislative position

1.10 The issues of restraint and seclusion are not usually dealt with in primary legislation. Generally, these procedures are informed by guidance and regulations. There is, therefore, little uniformity of approach across both client groups and service areas. There is an increasing focus on the legitimacy of restricting the liberty of an individual, arising from increased awareness of the potential for challenge as a breach of an individual's rights. In addition, increased awareness of individual's rights to seek redress through resort to the criminal and civil courts has raised both staff's and employers' interest in ensuring these processes are used as a last resort, in a safe and therapeutic manner and in a way which protects both staff and the service user.

1.11 Section 4 (Legislative Context) and paragraph 5.2 of this guidance provide detailed consideration of some of the key legislative considerations which need to be considered when using either restraint or seclusion.

When may restraint or seclusion be appropriate?

1.12 Restraint and seclusion should be used only for controlling violent behaviour or to protect the service user or other persons. In exceptional circumstances, physical intervention may be necessary to give essential medical treatment. The decision to use either is extremely serious and restraint and seclusion should only be used as follows:

- as intervention of **last resort;**
- where other, less restrictive, strategies have been unsuccessful, although an emergency situation may now allow time to try those other strategies;
- **never** for punishment;
- in reaching the decision, consideration should also be given to the individual needs of each service user in deciding the best method of control or restraint to be employed.

1.13 Decisions to use either restraint or seclusion have serious civil liberties implications as these interventions limit or restrict the freedom of movement of an individual. Section 4 on the Legislative Context covers these issues in more detail.

Risk assessment

1.14 Risk assessment is an essential element in the care and treatment of all patients and clients and should underpin the guidance which service providers make available to staff. It could be argued that it is one of the most fundamental interventions in the recognition, prevention and therapeutic management of violence and aggression. The use of other interventions such as observation, psychosocial interventions or restraint should be part of a management plan based on an assessment of risk. While it is acknowledged that the occurrence of aggressive or violent incidents are not always predictable, assessment of risk, followed by a properly developed management plan is essential to the prevention and management of aggression and violence. Being able to predict who is more likely to engage in a violent act may enable staff to reduce the risk.

Current position - questionnaire

1.15 To examine the current available guidance across Northern Ireland, the working group issued a questionnaire to all statutory agencies and a selection of independent providers. A copy of the questionnaire and the summary findings are at **Annex G.**

Existing professional or practice guidance

1.16 Guidance on the use of restraint for adults is available in the book *Physical Interventions: A Policy Framework* (BILD 1996), which provides advice and information on the use of physical interventions in different service settings.

Equality Impact Assessment: equality screening

1.17 This paper has been screened for equality implications and the findings are given in **Annex H**.

2. DEFINITIONS AND CONCEPTS

Definition of "service user"

2.1 In this guidance, the term 'service user' is used to refer to adults and children who receive services from HPSS organisations and their agents in care establishments, hospitals or any other health settings and within their own homes.

Definition of "restraint"

2.2 **Different forms of physical intervention are summarised in the table below.** The table demonstrates the difference between restrictive forms of intervention, which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact, and non-restrictive methods. Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment. The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice. For these reasons, this guidance is specifically concerned with the use of restrictive physical interventions. For the purpose of this guidance the terms "restraint" and "physical restraint" mean "restrictive physical interventions".

Examples of non-restrictive and restrictive physical interventions

	Bodily contact	**Mechanical**	**Environmental change**
Non restrictive	Manual guidance to assist a person walking	Use of a protective helmet to prevent self injury	Removal of the cause of distress, for example, adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them hitting someone	Use of arm cuffs or splints to prevent self injury	Forcible seclusion or the use of locked doors

2.3 Physical restraint can, therefore be summarised as:

The use of any part of one's body, or mechanical method, to prevent, restrict or subdue movement of any part of another person's body. It can be employed to achieve a number of different outcomes:

- to break away or disengage from dangerous or harmful physical contact initiated by a service user;

- to separate the person from a ‘trigger’, for example, removing one service user who has responded to another with physical aggression;

- to protect a service user from a dangerous situation – for example, the hazards of a busy road.

2.4 It is helpful to distinguish between:

- *planned intervention*, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment and recorded in care plans; and

- *emergency or unplanned* use of force which occurs in response to unforeseen events.

2.5 In common law anyone who has the duty to care for another person is expected not to interfere unduly with the personal freedom and autonomy of the person in his/her care. Nevertheless, if restraint is necessary for the safety of that person or others it may be justified as long as it is the **absolute minimum necessary for the minimum time possible**. As this raises the questions of what constitutes necessity and what is the absolute minimum of restraint in a given situation, it is useful to identify general principles. The section on Principles Involved (including Statement of Principles at paragraph 5.19) addresses this in more detail.

Definition of “proportionate”

2.6 The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled, and the nature of the harm likely to be caused. These judgements have to be made at the time, taking due account of all the circumstances, the unpredictable nature of the work and including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques employed should be those with which the staff involved are familiar and able to use safely and are described in the service user's support plan. Where possible, there should be careful planning of responses to individual service users who are known to be at risk of self-harm, or of harming others.

2.7 The use of force is likely to be legally defensible when it is required to prevent:

- self-harming or potentially self-harming behaviours;

- injury to self, other service-users, or staff ;

- serious damage to property;
- an offence being committed.

2.8 The use of force to restrict movement or mobility or to break away from dangerous or harmful physical contact initiated by a service user will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to service users, staff and others and pre-planning responses, where possible. (See paragraph 1.14 on "Risk assessment".)

Definition of "seclusion"

2.9 Seclusion is the **supervised confinement** of a service user alone in a room, the essence being the involuntary isolation of the individual. In the Mental Health (Northern Ireland) Order 1986 Code of Practice, the Mental Health Commission define seclusion as 'the forcible denial of the company of other people by constraint within a closed environment". The service user is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other means of exit available to the service user. This situation would also arise where the door is not locked from outside but the service user is unable to open the door, due to, for example, the height of the door handles or the person's physical disability. The breadth of the definition is important because the practice of seclusion is subject to very stringent control and recording in comparison to other procedures.

2.10 The issue of seclusion is particularly complex. Seclusion is an emergency procedure, only to be resorted to when there is an immediate risk of significant physical harm. There is general agreement that it should not be considered as a form of treatment; the aim should be simply that of safe containment. Seclusion is usually unpleasant, and difficult for a service user to view other than as punishment, and not a therapeutic experience. In 1996, the Royal Colleges of Psychiatry and Nursing published a joint review into strategies for managing disturbed violent patients ("*Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units").* The reason for the review stemmed from the well-founded and widespread concern about the potential for the misuse of seclusion. Concerns had focused on its use for prolonged periods of time (Department of Health and Social Security, 1980; Department of Health and Social Security, 1985 – full references to these reports and those below in this paragraph are given at section 6 of this guidance) as well as on the indications for, and frequency of, its use. Matters came to a head with the occurrence of several deaths, notably those of Sean Walton at Moss Side Hospital in 1988 and of three patients at Broadmoor Hospital (Department of Health, 1993). In 1992 the Committee of Inquiry into complaints at Ashworth Hospital strongly recommended the abolition of seclusion within that hospital as well as a wider, statutory prohibition (Department of Health, 1992). Since the Ashworth Inquiry the Special Hospitals have made it their stated policy to limit the use of seclusion to exceptional circumstances and to promote alternative approaches for the management of violence. **This approach is endorsed by this Working Group which recommends its adoption.**

2.11 In considering seclusion there is a need to draw a distinction between:

- *seclusion* where a service user is forced to spend time alone against his/her will;
- *time out* which involves restricting the service user's access to all positive reinforcements as part of a behavioural programme (this is explored in more detail in paragraph 2.13); and
- *withdrawal* which involves removing the person from a situation which causes anxiety or distress, to a location where he/she can be continuously observed and supported until ready to resume usual activities.

2.12 The 1996 review (see paragraph 2.10 above) noted that:

> "Any credible review of the use of seclusion must consider other, more routine and therapeutic approaches to aggression that might forestall or replace the practice."

Definition of "time out"

2.13 Time out is a procedure whereby the service user is separated temporarily from the current environment as part of a planned and recorded therapeutic programme to modify his/her behaviour. The breadth of its definition is open to misuse to encompass what is, in fact, seclusion. Although a distinction is made between it and seclusion, in practice it is less readily separable. This potential for confusion is open to abuse. The widespread use of time out, particularly with certain service user groups, such as children or those with a learning disability, makes it difficult to regulate to the same extent as seclusion. It has been recommended that the term 'time-out' be avoided in preference to a clear description of the procedure that is actually proposed. Such an approach inevitably raises the issue of consent, which should underwrite all therapeutic processes. **The term 'time out', or another comparable term, must state explicitly exactly what this entails within the practice of the unit and procedures regarding consent etc for its use. Policies should also provide for ensuring that the understanding of service users is clearly recorded and the action monitored and reported to a senior staff member as soon as possible: in the case of children, parents or those with parental responsibility should also be informed at the earliest possible opportunity.**

Nature and types of physical interventions

2.14 There are three broad categories of physical interventions as described by Harris et al (1996):

- **direct physical contact** between a member of staff and services user;
- **the use of barriers** to limit freedom of movement;
- **materials or equipment which restrict or prevent movement.**

2.15 **Physical intervention skills** are described by McDougall (1996) as a set of techniques that are designed and taught to momentarily prevent or curtail a behaviour which is deemed to be dangerous to that individual or others.

2.16 No physical intervention, whether planned or emergency, should ever intend or knowingly be allowed to cause pain.

Planned physical interventions

2.17 The planned use of physical interventions involves the use of an agreed strategy which includes the possible use of physical intervention to intervene in a sequence of behaviours with the aim of avoiding or reducing injury/injuries.

2.18 Planned physical interventions, including restraint for the purposes of medical interventions, should be part of a broader therapeutic strategy. It is envisaged that there may be rare occasions when restraint might be necessary, in someone's best interests, to facilitate urgent medical treatment. Where medication may be used to facilitate restraint in the management of disturbed or violent behaviour, reference should be made to the recent NICE guidance "The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments".

2.19 Planned physical interventions are normally used as a last resort. Strategies designed to manage aggressive/violent behaviours should include:

i. ecological strategies and the environment of the service user;
ii. early intervention and de-escalation;
iii. emergency use of physical intervention.

(i) Ecological strategies and the environment of the service user (primary prevention)

2.20 Ecological Strategies involve providing environments likely to reduce the likelihood of aggressive or violent behaviours occurring. It involves changing aspects of an individual's personal environment to minimise situations arising that are known precursors to the service user displaying behaviours which have implications for the safety of him/herself or others.

2.21 It is the context in which violence occurs that is of most importance when considering measures to limit the use of restraint and/or seclusion. Violence may reflect the expectations of the staff, low levels of staffing or changing staffing. The emphasis is moving from the control of violence to its prevention by measures such as an improved environment and staffing, both in levels and skills. Crucial to this are staff attitudes, training, good communications and supervision.

2.22 Children are particularly responsive to their surroundings. Special attention needs to be paid to creating a safe environment for disturbed and violent children. A designated safe area or safe room may be helpful, but this should reflect normal domestic living space as far as possible. Children and adults with certain disabilities, such as autism, benefit from routine, regularity and predictability in their lives which in turn makes disturbed and violent behaviour less likely to occur. People of all ages are less likely to show such behaviour if they are provided with choices or are kept active with relevant challenges.

2.23 In a designated safe area, it is necessary to minimize the risk of self injury or of serious damage to property. In achieving this aim, it is important to balance the service user's need to be cared for in an environment which reflects normal living space (in terms of decoration and furnishings, where appropriate) with the need to ensure his/her safety.

2.24 Trusts and other providers in constructing operational guidance for the use of seclusion and/or restraint need to consider how they can manage the service users' environment or care setting to limit the potential for violent and/or aggressive behaviour. Environment, in this context, includes both the physical environment and the level and qualification of staff. A comprehensive understanding of how setting, staff and service users can interact is necessary to ensure preventative as well as reactive strategies are in place to deal with service users with complex and at times challenging needs.

(ii) Early intervention and de-escalation (secondary prevention)

2.25 Plans for early intervention and de-escalation are instigated after it becomes clear that an aggressive episode of behaviour is likely to occur. They seek to prevent the escalation of such behaviours and in all cases they should be individualised to the service user concerned. These approaches focus on communication, negotiation, use of staff body language, personal space etc. with the overall aim of maintaining safety.

2.26 The use of physical interventions generally raises a number of serious issues for service users, staff and service providers alike. The following are some issues which should be considered more fully, with each organisation regularly providing clear guidelines and advice to staff.

- Consent of service users issues as covered in DHSSPS Guidance "Good Practice in Consent", particularly where there are issues relating to children and the competence of other service users to provide valid consent.

- Assessment for benefit and risks associated with the procedure.

- Legal, ethical and professional issues.
- Physical health status of the service user.
- Impact on individual of intervention.
- Least restrictive physical intervention.
- Particular vulnerability of service users taken into account.
- Staff requirements.
- Method of recording, reporting and reviewing.

(iii) Emergency use of physical interventions

2.27 Emergency physical interventions may be required in response to unexpected episodes of aggressive or violent behaviours. Physical interventions can be justified to maintain the safety of the service user or others. However, the amount of force used must be proportionate to the level of threat presented by the service user - staff should use the minimum amount of force for the least amount of time required with the aim of maximising the safety of everyone involved.

2.28 Following the use of emergency physical interventions, procedures should be followed which entail recording/reporting the incident and the updating of the service user's individual care plan to include assessment of risk, preventative strategies and a programme of planned responses to any such future behaviour. (See paragraphs 3.9-3.18 on Post-Incident Management Monitoring).

3. QUALITY ASSURANCES, COMPLAINTS AND ADVOCACY ARRANGEMENTS AND POST INCIDENT MANAGEMENT AND MONITORING

Quality assurances

3.1 All services should be designed to promote independence, choice and inclusion and to establish an environment that enables service users, regardless of age or need, maximum opportunity for personal growth and emotional wellbeing.

3.2 In care settings, good practice in the use of restraint and seclusion described in this guidance will be monitored as part of HSS Trusts' compliance with the Duty of Quality requirements established by the HPSS Order 2003, which commenced in April 2003. The establishment of the HPSS Regulatory and Improvement Authority (HPSSRIA), which is scheduled to become operational in 2005, will also ensure that standards of practice and levels of compliance in these areas will be regulated on an independent basis across the statutory and independent sectors. It is also expected that local policies and procedures explain how service users, their families (and in the case of children, those with parental responsibility) and advocates participate in planning, monitoring and reviewing the use of restraint and/or seclusion.

3.3 Under health and safety legislation, employers are responsible for the health safety and welfare of their employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of restraint and seclusion. Employers should establish and monitor safe systems of work and ensure that employees are adequately trained. Employers should also ensure that all employees, including agency staff, have access to appropriate information about service users with whom they are working.

- Leadbetter and Trewartha (Leadbetter, D and Trewartha, R (1995) A question of restraint, *Care Weekly*, 18 May, 10-11) noted that employers have to give equal priority to the safety of staff and service users. Under Health and Safety legislation (Health and Safety at Work Act 1974), they must ensure their staff's welfare against foreseeable risks and provide adequate training to ensure a safe working environment. This obligation has been reinforced by civil cases successfully brought by employees against their employers. Leadbetter and Trewartha cite the case of Walker v. Northumberland County Council (1994) where the judgement hinged on the council's failure in their duty of care in that they had not taken action to avoid or mitigate 'reasonably foreseeable' risks to their employee's health.

- Lindsay and Hosie (Lindsay, M and Hosie, A (2000) *The Edinburgh Inquiry - Recommendation 55. The Independent Evaluation Report.*

University of Strathclyde and the former Centre for Residential Child Care) state that in the case of litigation employers would have to demonstrate that the method of restraint they chose best suited the needs and circumstances of their clients and, on the basis of the best available advice, was likely to address the demands of day to day practice. The problem is that there is a striking absence of evidence about the respective merits of the various techniques.

3.4 Commissioning authorities will need to ensure that provider agencies' policies and procedures follow this guidance where restraint and/or seclusion is used. Registration and Inspection staff will also monitor the implementation of the resulting policies and procedures in the course of their work across the statutory and independent sectors.

Complaints and advocacy arrangements

3.5 Complaints arrangements should follow policies developed for Trusts in response to the “Guidance on Handling HPSS Complaints: Hospital and Community Health and Social Services (April 2000)” and Children Order (Article 45(3)) requirements in respect of complaints and representations made in relation to children's social services.

3.6 Trust staff should ensure that complainants are easily able to make a complaint, that this process is simple and aimed at satisfying the complainants' concerns. Where necessary staff should provide information on the Advocacy Service available. Responses to complainants should be timely and emphasise early resolution. Staff should be informed of the existence of a complaint and appropriate staff involved in the investigatory process. Staff should also be informed of the outcome of any complaints made in respect of them.

3.7 Discussions should take place on the investigatory process and feedback from complaints should inform any review of complaints at team meetings.

3.8 Training and awareness building should usually be managed within the organisation, with lessons emerging from complaint case studies used to promote the development of good practice. To this end, Trusts and other providers should annually monitor complaints received in relation to the use of restraint and seclusion. This annual review should be used to inform, where necessary, the revisions of policies and procedures and the design of staff training and support processes.

Post-Incident Management and Monitoring

General

3.9 It is recognised that Post- Incident Management and Monitoring (PIM&M) is critical where restraint or seclusion are used. Some Trusts may regularly audit the use of these processes as this is considered good practice. Auditing and monitoring should be carried out on a multi-disciplinary basis, where appropriate.

3.10 The PIM&M procedure will have the following elements clearly itemised within it:

- feedback to those with parental responsibility/carers that does not infringe on the service user's right to confidentiality;
- debriefing the service user after the incident;
- providing information on how to make a complaint;
- service users who are injured will always be examined by a doctor following the incident;
- Trust accident/incident form will be completed as soon as possible after the incident, stating exactly what happened – **no assumptions: facts only** (examples of incident forms are given at Annex I (a) - Restraint Report Form - and Annex I (b) (Seclusion Report Form – organisations will develop their own format to cover their particular circumstances);
- details of all/incidents are recorded in service users' files. In some instances, this record is required even where a separate monitoring form is in use.
- Reports to outside agencies (Mental Health Commission, HPSSRIA etc).

3.11 If staff are injured – a statement must be completed to include as a minimum the following information:

- place where injury happened;
- number of staff on duty and their location at the time of the incident;
- number of service users in the area.

Staff

3.12 Where staff are injured the following actions are required:

- refer staff to Occupational Health Department or Accident and Emergency Department if injured. If they decline, advise them to contact their own GP and record this advice;

- accident report form to be completed according to Trust policy requirements.

3.13 It is important that staff are made aware of the potential emotional shock that may follow on from an assault or injury. Managers/peers need to be supportive, recognising that even minor incidents, such as verbal abuse/comments, can be traumatic. Staff should be given the opportunity to talk and express how they feel. A de-briefing discussion after an incident can assist those involved. Relevant areas for discussion include:

- identification of cause/trigger factors to incident;
- ascertaining what exactly occurred;
- identifying staff's role in the incident;
- ascertaining the feelings of staff involved;
- what learning experiences and/or training needs can be identified from incident.

Staff Support

3.14 Employers have responsibilities to support all staff. To this end, individual members of staff involved in an incident must be given an opportunity to discuss their feelings. This will include:

- individual/group discussion with the line manager;
- access to confidential counselling from Occupational Health Department through self-referral or line management referral;
- awareness of professional body or Trade Union role/support;
- multidisciplinary review/debriefing discussion of incident with colleagues/peers to allow staff to review, reflect and talk about their views following the occurrence;
- access to confidential staff care or support system.

Monitoring Arrangements

3.15 Effective monitoring procedures are essential and must be comprehensive and timely. Monitoring includes:

- the risk of violence being regularly assessed by appropriate senior staff which will vary according to the setting;

- assessing the effectiveness of the implementation of existing policies and procedures, identifying any gaps or need for updating;

- reassessing the effectiveness of countermeasures introduced and disseminating good practice examples;

- discussions at staff meetings, senior staff meetings etc. to raise issues arising with a view to improving safeguards for both service users and staff. This should include ensuring staff are aware of whistle blowing policy and feel confident in using it;

- recording and analysis of complaints made, ensuring that reports are regularly brought to the attention of the Trust's Chief Executive under Clinical and Social Care Governance arrangements.

Audit

3.16 Audit mechanisms should focus on a number of factors which can give managers a baseline assessment on the effective implementation of policy, such as:

- number of incidents of physical injuries sustained by service users as a result of a violent episode;

- number of incidents of physical injuries sustained by staff as a result of a violent episode;

- number of incidents of verbal/threatening behaviour to staff/service users;

- number of occasions that physical restraint, "time out" or equivalent was carried out in a setting, identifying any possible explanation for peaks and troughs in its usage over time.

3.17 It can be helpful to use audit information to compare levels of violence, restraint or seclusion across similar service areas to ascertain if there are any environmental factors (see paragraphs 2.20-2.24) which are either serving to reduce or increase levels in any setting.

Where service users are injured

3.18 If a service user is injured as a consequence of the use of restraint, the following action is required:

- ensure the service user receives appropriate and timely medical assistance;

- notify carer, parent or those with parental responsibility immediately of the injury and the steps taken to deal with the injury, securing appropriate consent for treatment where necessary;

- make a detailed record of the event and the consequences in the service user's case file;

- complete an accident report form and inform the Trusts Risk Management Unit which will make any other necessary notifications;

- complete a Physical Intervention Monitoring/Restraint Report Form (example attached at **Annex I(a) – organisations will develop their own forms to cover their particular circumstances**);

- senior managers review incident on discussion with staff and ascertain if there are any training, support or supervisory matters which require to be addressed;

- inform service user, carer, parent or those with parental responsibility of the Trust's complaints arrangements and how to access them.

4. LEGISLATIVE CONTEXT

General

4.1 Generally, primary legislation makes little explicit reference to the use of restraint and seclusion, with the issue being dealt with in most areas by Guidance and Regulation. The exception to this is the education sector where the use of restraint in schools by authorized persons is regulated by primary legislation and by detailed guidance. There is, however, no uniformity of approach across different sectors and no standard threshold indicating when restraint or seclusion can be used legally. Legislatively and in terms of best practice, restraint and seclusion in relation to the care of service users should only be used in exceptional circumstances and it must be ensured that all techniques used are approved, safe and in compliance with international rights standards. The DHSSPS has issued guidance on consent (Good Practice in Consent) with which staff should acquaint themselves.

4.2 The remainder of this section considers **the European Convention on Human Rights (ECHR)** and **the United Nations Convention on the Rights of the Child (UNCRC)** before outlining some case decisions to assist with identifying situations where the use of restraint or seclusion is potentially open to challenge under these international conventions. It concludes with comment on the legislative context for specific groups of service users who are identified as particularly vulnerable.

The European Convention on Human Rights (ECHR) as incorporated by the Human Rights Act 1998

4.3 Many of the following paragraphs use children's cases for illustrative purposes. This reflects the expertise of the legal issues sub-group whose remit was to specifically address the issue in respect of children. The messages emerging have, however, wider application and the working group has edited the sub-group's contribution and extended parts of the material to the wider field.

4.4 The Human Rights Act 1998, which came fully into force in October 2000, enables most of the rights enshrined in the ECHR to be pursued in the domestic courts rather than through the European Court of Human Rights (ECtHR). All public authorities are obliged to discharge their functions in accordance with the rights sets out in the ECHR and the courts must take Convention rights into account when deciding cases. These rights apply to both children and adults.

4.5 In the context of the use of restraint and seclusion the following articles of the ECHR should be taken into consideration.

Article 3 ECHR

4.6 No one shall be subjected to torture or inhuman and degrading treatment or punishment.

Article 5 ECHR

4.7 Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(a) the lawful detention of a person after conviction by a competent court;

(b) the lawful arrest or detention of a person for non compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;

(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority;

(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purposes of bringing him before the competent legal authority;

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, and of drug addicts or vagrants;

(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

Article 8 ECHR

4.8 1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The United Nations Convention on the Rights of the Child (UNCRC)

4.9 The UNCRC is an international treaty on children’s rights, which all countries have signed with the exception of U.S.A. and Somalia. The key relevant provisions of the UNCRC are set out below.

Article 1 UNCRC

4.10 For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2 UNCRC

4.11 States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

4.12 States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians or family members.

Article 3 UNCRC

4.13 In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

4.14 States Parties undertake to ensure the child such protection and care as is necessary for his or her well being, taking into account the rights and duties of his/her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end shall take all appropriate legislative and administrative measures.

4.15 States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff as well as competent supervision.

Article 12 UNCRC

4.16 States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 19 UNCRC

4.17 States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, legal guardians or any other person who has the care of the child.

Article 25 UNCRC

4.18 States Parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 37 UNCRC

4.19 States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner, which take account of the needs of a person of his/her age. In particular every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.

(d) Every child deprived of his/her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 39 UNCRC

4.20 States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self respect and dignity of the child.

The United Nations Committee on the Rights of the Child

4.21 The implementation of the UNCRC is monitored by the United Nations Committee on the Rights of the Child. In the "Concluding Observations of the United Nations Committee on the Rights of the Child, United Kingdom of Great Britain & Northern Ireland", October 2002[1] the Committee expressed concern about figures indicating that children had sustained injuries as a result of the use of restraints and control in prison. In addition, the Committee expressed concern about the frequent use of physical restraint in residential institutions and in custody as well as the placement of children in solitary confinement in prisons.

4.22 The Committee recommended the review of the use of restraint and solitary confinement in relation to children and young people in custody, education, health and welfare institutions to ensure compliance with the UNCRC in particular articles 25 and 37 UNCRC (paragraphs 4.18 and 4.19 respectively of this Guidance).

4.23 The Committee also expressed concern that the principle of primary consideration for the best interests of the child is not consistently reflected in legislation and policies affecting children and recommended that the principle of the best interests of the child as a paramount consideration should be enshrined in all legislation and policy affecting children.

Restraint and seclusion: human rights issues and the key caselaw

4.24 Seclusion is described in the Department of Health (England and Wales) Code of Practice (1999) as:

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[1] The Concluding Observations of the UN Committee on the Rights of the Child published on 9 October 2002 and available online at www.unhchr.ch/tbs/doc.nsf

> *"the supervised confinement of a patient in a room, which may be locked for the protection of others from significant harm."*

4.25 In practice, seclusion is a form of solitary confinement which can be used for therapeutic, containing or punitive purposes. The purpose of restraint has been described by the Department of Health as the use of physical force against a patient to minimise unacceptable behaviour. Both seclusion and restraint in relation to the care of service users raise potential human rights issues. A number of these issues have been raised in the domestic courts and further guidance can be obtained from the case law of the European Court of Human Rights (ECtHR).

4.26 The leading domestic authority on the use of restraint in the mental health context remains the House of Lords decision in *Pountney* v *Griffiths* [1976] AC 314 where it was held that hospital staff had "powers of control over mentally disordered patients, whether admitted voluntarily or compulsorily, though the nature and duration of the control varies with the category of patient to which the patient belongs." The ECtHR decision in *Herczegfalfy* v *Austria* [1992] has placed the concept of medical necessity at the core of any intervention of this type. The ECtHR stated that:

> "the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with…..The established principles of medicine are admittedly decisive in such cases; **as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading**. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist." (Highlighting added.)

4.27 The question of the burden of proof in relation to whether a medical necessity has been "convincingly shown" was examined in *R* v *Dr M and others* ex parte *N* [2003] 1 WLR 562 where the Court of Appeal held that while the requirement was not equivalent to a criminal burden of proof it still required a high standard of proof. The decision in this case is an important one in that the Court of Appeal reviewed the common law authorities on consent to treatment. Simon Brown LJ found that the "therapeutic necessity" test applied both to patients with and without capacity. This decision would appear to indicate that where treatment of questionable therapeutic benefit is administered to a patient who strongly opposes it, and which will, if administered, involve the use of physical force with possible detrimental effects to the patient's health, that this will constitute a violation of Article 3 of the Convention. This approach should, therefore, apply to the use of restraint and seclusion of all service users who have capacity and to those whose capacity may be questioned as a consequence of their age or other impairment.

4.28 In order to breach the terms of Article 3 of the Convention the treatment in question must reach a particular threshold of severity. (See *S* v *Airedale NHS*

Trust [2002] EWHC 1780). Brief periods of seclusion and proportionate instances of restraint are, therefore, unlikely to reach the requisite threshold to constitute a breach of a Convention Right.

4.29 There is the possibility that restraint and seclusion could be argued as a breach of Article 5 of the ECHR. In the context of adult mental health the developing jurisprudence has held that Article 5 protections are restricted to the determination of whether detention is lawful or not. (See *R* v *Governor of Parkhurst Prison* ex parte *Hague* [1992] 1 AC 58.) Where detention of a child or adult takes place on a non-statutory basis then the possibility of an Article 5 breach arising from the use of either seclusion or restraint is a real one.

4.30 Similarly, treatment that falls short of medical necessity may constitute a breach of Article 8 of the ECHR. However, the broad justifications available in Article 8(2) are likely to render many interventions with service users to be in accordance with the ECHR.

4.31 The decision in *Herczegfalfy* found that there was no breach of Article 8 where the individual was restrained and force fed in circumstances where he was "entirely incapable of taking decisions for himself." It remains to be determined whether differential treatment of service users deemed to lack capacity because of age or intellectual impairment will fall foul of the anti-discrimination provisions of Article 14 of the Convention. It should be noted that a mere assertion of differential treatment is not enough to ground an Article 14 point. (See Carswell LCJ's discussion in *Re Jean McBride* [2003]).

Impact of legislation for specific service users

Professional guidance relating to medical settings

4.32 The British Medical Association in a recent publication set out a number of considerations in relation to the use of restraint in respect of the care of children in medical settings:[2]

1. Restraint should only be used where it is necessary to give essential treatment or to prevent a child from significantly injuring him/herself or others.

2. Restraint is an act of care and control, not punishment.

3. Unless life prolonging or other crucial treatment is immediately necessary, the approval of a court should be sought where treatment involves restraint or detention to override the views of a competent

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[2] British Medical Association, *Consent, Rights and Choices in Health Care for Children and Young People,* BMJ Books, 2001.

young person, even if the law allows doctors to proceed on the grounds of parental consent.

4. All steps should be taken to anticipate the need for restraint and to prepare children, their families and staff for its use.

5. Wherever possible, the members of the health care team involved should have an established relationship with the child and should explain what is being done and why.

6. Treatment plans should include safeguards to ensure that restraint is the minimum necessary to achieve the clinical therapeutic aim, and that both the child and parents have been informed what will happen and why the use of restraint is considered necessary.

7. Restraint should only be used in the presence of other staff, who can act as assistants and witnesses, unless there is no other means of protecting the service user or others.

8. Any use of restraint or detention should be recorded in the medical case records. These issues are appropriate subject for clinical and social care audit.

4.33 The Royal College of Nursing has issued Guidance on the use of restraining and preventing children from leaving a medical setting.[3]

Children's residential care services

4.34 The relevant provisions on children's residential care services are to be found in the Children (Northern Ireland) Order 1995, regulations made under the Order and in Volume 4 (Residential Care) of the associated series of volumes of "Guidance and Regulations". There is no reference at all in the 1995 Order to the use of restraint or isolation. The Children's Homes Regulations (Northern Ireland) 1996, made under the Children Order, make provision at regulation 8 in relation to control and discipline. Regulation 8 (2) sets out measures which should not be used on children in a children's home; and regulation 8 (3) gives measures which the regulations do not prohibit, including "the taking of any action immediately necessary to prevent injury to any person or serious damage to property".

4.35 These provisions are considered under 'Good Order and Discipline' in Chapter 4 of Volume 4 of the Guidance and Regulations. In particular, the following areas are set out and dealt with:

- Disciplinary Measures – general (Paragraph 4.14)

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[3] The Royal College of Nursing. *Restraining, Holding Still and Containing Children: Guidance for Good Practice.* London: RCN, 1999.

- Permitted disciplinary measures (Paragraphs 4.15 – 4.19)

- Prohibited measures (paragraph 4.20)
  Corporal punishment
  Deprivation of food and drink
  Restriction or refusal of visits/communications
  Requiring a child to wear distinctive or inappropriate clothing
  The use or withholding of medication or medical or dental treatment
  The use of accommodation to physically restrict the liberty of any child
  Intentional deprivation of sleep
  Imposition of fines
  Intimate physical searches

- General principles governing interventions to maintain control (Paragraph 4.21)

- Methods of care and control of children which fall short of physical restraint or the restriction of liberty (Paragraph 4.42)

- Use of physical presence of staff (Paragraphs 4.43 – 4.24)

- Holding (Paragraphs 4.2.5 – 4.25)

- Touching (Paragraphs 4.27 – 4.28)

- Physical restraint (Paragraphs 4.29 – 4.34)

- Restriction of liberty (Paragraphs 4.35 – 4.39)

- Monitoring (Paragraph 4.40)

4.36 The Children Order guidance provides specific guidance on the use of restraint and the restriction of liberty. Paragraph 4.13 specifically prohibits the locking of children in their bedroom at night "whatever their age and competence". The Guidance outlines permissible forms of care and control and establishes a comprehensive list of general principles governing interventions to maintain control.

Foster care

4.37 The Foster Placement (Children) Regulations (NI) 1996 provide for the approval of Foster Parents (Regulation 3), the Review and Termination of Approval (Regulation 4), Placements (Regulation 5) and Termination of Placements (Regulations 7).

4.38 Regulations 3(6)(b) provides that an authority shall not place a child with an approved foster parent unless he enters into a written agreement with it covering the matters specified in Schedule 2 (Matters and obligations to be covered in foster care arrangements). Pursuant to Paragraph 5 of the Schedule each foster carer must specifically agree "Not to administer corporal punishment to any child placed with him".

4.39 Under the Guidance issues in respect of the Children (NI) Order 1995 (Volume 3 Family Placements and Private Fostering) at paragraph 4.31 (Assessment and approval of foster carers) there is a duty placed on the social worker to 'ascertain the applicant's views on discipline with particular regard to the issue of corporal punishment which is not regarded as an appropriate means of correcting children'. The term "corporal punishment" is then defined to cover 'any intentional application of force as a form of punishment, including slapping, pinching, squeezing, shaking, throwing objects and rough handling. It would also include punching or pushing in the heat of the moment in response to violence from young people. It does not prevent a person taking necessary physical action where any other course of action would be unlikely to avert immediate danger of physical injury to the child or to another person, or to avoid immediate danger to property. Verbal abuse, derogatory remarks and pointed jokes can cause psychological harm to a child and should be avoided'.

4.40 In relation to children who are privately fostered, the Trust does not approve or register private foster parents but must satisfy itself that the arrangements are satisfactory that the private foster parents are suitable. The responsibility for safeguarding and promoting the welfare of the privately fostered child rests with the parents. Regulation 2(2)(j) of The Children (Private Arrangements for Fostering) Regulations 1996 places a duty on the Trust to satisfy itself that the private foster parent is being given any necessary advice. Pursuant to Chapter 15 (Suitability of the foster parent) of the Guidance Volume 3 there is reference to discipline with particular regard to the issue of corporal punishment (paragraphs 15.13-15.14). The definition of corporal punishment is provided and there is requirement that a child should not be refused meals or drink as punishment nor restricted from visiting or being visited by family and friends as a means of punishment. The UK National Standards for Foster Care requires policies to be in place on corporal punishment to ensure that each child in foster care is protected from all forms of corporal punishment (smacking, slapping shaking) and all other humiliating forms of treatment or punishment.[4]

There is no legislative provision in relation to the use of restraint and isolation for the child who is in foster care – either under the Children (NI) Order 1995 itself or any regulations issued thereafter. There is similarly, no specific guidance in relation to restraint and isolation. However the Trust is under a duty to assess foster carers (and give advice to private foster carers) and in this context these issues may be addressed by the individual Trusts. Guidelines are

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[4] Published by the National Foster Care Association on behalf of the UK Joint Working Party on Foster Care.

issued by the National Foster Care Association on the Care and Control of Children in Foster Homes.

Secure accommodation

4.41 Article 44 of the Children (NI) Order 1995 sets out the criteria by which a child can be placed or kept in secure accommodation. The associated regulations are the Children (Secure Accommodation) Regulations 1996. This statutory provision permits the restriction of liberty of children but also ensures that any such decisions taken by the Trust or others are scrutinised and endorsed by the Court. A child cannot be placed or kept in secure accommodation unless it appears that

(a) (i) he has a history of absconding and is likely to abscond from any other description of accommodation; and

(ii) if he absconds, he is likely to suffer significant harm; or

(b) that if he is kept in any other description of accommodation he is likely to injure himself or other persons." (Article 44)

4.42 The criteria must apply and once it no longer applies then the child must not continue to have his liberty restricted (even if there is a court order authorising the restriction currently in existence). The definition of "restriction of liberty" is a matter which is to be determined by the Court and may include any practice or measure which prevents a child from leaving a room or building of his own free will. This is a measure of last resort and will only be permitted when it is evidenced that there is no appropriate alternative. The onus is therefore on the Applicant to show that everything else has been comprehensively considered and rejected. The secure placement should only be for as long as is absolutely necessary (and not for the duration of the Court Order itself). The Trust have a duty to take reasonable steps to avoid the need for children to be placed in secure accommodation (The Children (NI) Order 1995; Schedule 2 paragraph 8(c)).

4.43 There is one unit in Northern Ireland which provides secure accommodation for children at Lakewood in Bangor.

Services provided under the mental health legislation

4.44 The use of restraint and seclusion in respect of service users is not referenced in the primary legislation, the Mental Health (NI) Order 1986. The Code of Practice, which accompanies the Mental Health (NI) Order 1986, does, however, provide limited guidance on the use of restraint and seclusion generally.[5] Section 5.33 requires every Unit of Management (i.e HSS Trust) to have a policy on the use of all forms of physical restraint (physical restraint in

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[5] 1992, Belfast, HMSO

the context of this guidance includes locked ward doors, time out and seclusion). Sections 5.32 – 5.53 of the Code of Practice gives guidance on restraint, locked doors on open wards, time out and seclusion. Within this Guidance there is, however, no specific reference to children and young people.[6]

4.45 In the case of *S* v *Airedale NHS Trust* a young person who was a mental health in-patient challenged his detention in seclusion by the NHS Trust while they sought a more suitable placement to meet his needs. S was being held in a locked room at night because a bed was not yet available for him at a secure unit. He argued that the NHS Trust was obliged to follow the Mental Health Code of Practice (1999) and that there had been a breach of Article 3 ECHR in relation to the conditions he was held under and a breach of Article 8 ECHR. The High Court rejected the application stating that the conditions he was held under were not poor enough to constitute a breach of Article 3 ECHR. It was concluded that the NHS Trust had acted lawfully, but S appealed to the Court of Appeal, which considered his case alongside the case of Colonel Munjaz who was challenging the policy at Ashworth Hospital not to follow the Mental Health Code of Practice when patients were secluded for more than three days.[7]

4.46 Seclusion is defined in paragraph 19.16 of the 1999 Code of Practice as the supervised confinement of a patient in a room, which might be locked to protect others from significant harm. The Code states that seclusion should be used as a last resort and for the shortest period of time; that a decision to seclude should be taken by a doctor or nurse in charge and that the continued need for seclusion should be reviewed every two hours by a nurse and every four hours by a doctor. The question before the Court of Appeal was whether seclusion was capable of infringing Articles 3, 5 and 8 of the ECHR as incorporated by the Human Rights Act 1998. It was no longer argued that in these particular cases a breach of Article 3 had occurred.

4.47 The Court of Appeal accepted that there was an implied power for the authorities to seclude a person who was compulsorily detained under the Mental Health Act within a hospital setting as a "necessary ingredient flowing from the power of detention for treatment". In addition, seclusion could amount to medical treatment. The Court was of the view that there was no doubt that seclusion could potentially amount to inhuman and degrading treatment or punishment prohibited under Article 3 ECHR, but segregation from other detained patients did not itself constitute such treatment. Seclusion also infringed Article 8 (2) ECHR unless it could be justified under Article 8(2) ECHR. However, the further seclusion of a detained patient did not amount to a deprivation of liberty for the purposes of Article 5 ECHR which was concerned

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[6] See also the Mental Health Act 1983, Revised Code of Practice (1999) which applies in England and provides more detailed guidance on restraint, seclusion, locked wards and also contains a detailed section on children and young people.

[7] The Court of Appeal gave judgment in both cases in R (*Munjaz) v Mersey Care NHS Trust and R(S)v Airedale National Health Service Trust and others* [2003] EWCA Civ 1036 (16 July 2003)

with the lawfulness not the conditions of detention, although there would be a breach of Article 5 (1) ECHR if a person was detained in a type of institution which was inappropriate to meet the purpose of his detention.

4.48 Where issues relating to a patient's human rights were engaged, the Code of Practice should be followed by all hospitals unless there was good reason to depart from it in individual cases. In the Munjaz case, the Court held that the wholesale departure from the Code of Practice in certain groups of cases based on the length of time spent in seclusion was unlawful. In the case of S, on the facts the Court found his seclusion (which was in breach of the Code of Practice and used on the basis that there was no other more suitable placement available for him) to be unjustified.

Other areas of interest

4.49 Although not directly related to the HPSS sector, the following examples of interpretation of the law in other sectors are of interest and knowledge of them may assist staff working in settings which interface with either the education or youth justice sectors.

Education sector

4.50 Article 4 of the Education (NI) Order 1998 came into force on 21 August 1998 and authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

4.51 Non teaching staff are also authorised to use reasonable force in these circumstances provided they have been authorised by the Principal to have lawful control or charge of pupils.

4.52 Detailed guidance for schools is contained in "Guidance on the Use of Reasonable Force to Restrain or Control Pupils", DE Circular 1999/9 and is included in "Pastoral Care in Schools; Child Protection". A copy of this guidance is attached at **Annex J** for reference.

Youth justice

4.53 The use of restraint and seclusion of children in a custodial youth justice setting is regulated by the Juvenile Justice Centre Rules (NI) 1999. Regulation 29 allows for the use of "forms of control" approved by the Secretary of State in dealing with "unruly children".[9] Regulation 30 allows for the use of temporary confinement of a child for up to 24 hours. These Rules must be interpreted in light of the ECHR as incorporated by the Human Rights Act 1998.

4.54 In a recent case taken by the Howard League for Penal Reform in England[10] an 18 year old applicant (who was 17 at the time complained of) argued that his segregation on two periods for five and four days respectively in a segregation unit in a young offenders centre and the conditions under which he was detained there amounted to a breach of the Young Offender Institution Rules 2000 ("the Rules") and a breach of his rights under Article 3 and Article 8 of the European Convention On Human Rights. The judge held that there had been a breach of the Rules, but on the facts no breaches of Articles 3 and 8 of the Convention. It is of note, however, that the judge stated that, although he was not making a finding under Article 3 in this particular case, he was prepared to accept that solitary confinement of a child (in other words, someone under 18) could amount to a breach of Article 3 in circumstances where it would not in relation to an adult. In respect of Article 8 he stated:

> " *I hope I may be permitted merely to utter this warning: there are clear dangers in placing young people in segregation units in relation to their rights enshrined in Article 8".*

Conclusion

4.55 The legal issues relating to the use of restraint and seclusion are complex. The discussion above has, therefore, sought to highlight issues which staff and their employers need to take into account in using these procedures with any service user. The use of restraint and seclusion are measures of last resort. Staff in making use of either procedure should have a clear understanding of the rights of service users and when it is appropriate for them to employ either restraint or seclusion and the safeguards that should be in place to ensure they are not subject to legal challenge. Employers have a duty to provide key staff with training on human rights considerations under ECHR and other relevant international instruments, and that their policies and procedures ensure that work in these difficult areas is of a high professional standard. There is, therefore, a clear link between this section of the guidance and those relating to policy, training, complaints and management and monitoring arrangements.

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[9] This is the wording of Regulation 29

[10] *The Queen on the Application of BP v The Secretary of State for the Home Department* [2003] EWHC 1963 Admin

5. PRINCIPLES INVOLVED

General

5.1 This section discusses some of the key principles relating to the use of restraint and/or seclusion and ends with a statement of principles which should underpin the use of these interventions.

5.2 Important principles regarding the protection of individuals from abuse by State organisations or the staff working within them are set out in the Human Rights Act 1998. In addition, it is a criminal offence to use physical force, or to threaten to use force, unless the circumstances give rise to a ‘lawful excuse’ or justification for the use of force. Similarly, it is an offence to lock a service user in a room without a court order (even if they are not aware that they locked in) or the consent of the service user, except in an emergency when for example the use of a locked room as a temporary measure while seeking assistance would provide legal justification. For children, rules are specified in the regulation 6 of the Children (Secure Accommodation) Regulations (NI) 1996 (“the 72 hours rule”). Use of physical intervention may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned.

5.3 The use of restraint and seclusion should always be designed to achieve outcomes that reflect the best interests of the individual service user whose behaviour is of immediate concern and others immediately affected by the behaviour.

5.4 The decision to use restraint or seclusion must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing either restraint or seclusion as a method of intervention.

5.5 Efforts to minimise the use restraint or seclusion should be in place. This may require the adoption of primary and secondary preventative strategies.

5.6 Primary prevention is achieved by:

- ensuring that the number of staff deployed and their level of competence corresponds to the needs of service users and the likelihood that physical interventions will be needed. Staff should not be placed in vulnerable positions;
- helping service users to avoid situations which are known to provoke violent or aggressive behaviour, for example, settings where there are few options for individualised activities;
- developing care plans, which are responsive to individual needs and include current information on risk assessment;

- creating opportunities for service users to engage in meaningful activities which include opportunities for choice and a sense of achievement;

- developing staff expertise in working with service users who present challenging behaviours;

- talking to service users, their families and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others. Some service users prefer withdrawal to a quiet area to an intervention which involves bodily contact.

5.7 Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing 'defusion' techniques to avert any further escalation. Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of interventions at an early stage in the sequence may, potentially, be justified if it is clear that:

- primary prevention has not been effective, and

- the risks associated with *not* acting are greater than the risks of using restraint or seclusion; and

- other appropriate methods, which do not involve restraint or seclusion, have been tried without success.

5.8 All prevention strategies should be carefully selected and reviewed to ensure that they do not, except through necessity, either constrain opportunities or have an adverse effect on the welfare or the quality of life of service users (including those in close proximity to the incident) . In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities, which might provoke challenging behaviours compared with the impact on the person's overall quality of life if such activities are proscribed. This is likely to require a detailed risk assessment.

5.9 Particular regard should be had to service users' attitudes towards physical contact, physical stature, age, gender and previous life experiences when restraint is being used. Restraint and seclusion should be used as measures of a last resort and in a way that is sensitive to, and respects the cultural expectations of service users. Any physical intervention used in restraint should avoid contact that might be misinterpreted as sexual.

5.10 Where restraint is employed staff must ensure that they only employ a reasonable amount of force, that is, the minimum force needed to avert injury or serious damage to property, applied for the shortest possible period of time.

Planned physical interventions should only be used as part of a holistic strategy where the risks of employing an intervention are judged to be lower than the risks of not doing so.

Proactive use of restrictive physical interventions

5.11 In most circumstances, restraint or seclusion will be used reactively. Occasionally, it may be considered in the best interests of the service user to accept the possible use of an intervention as part of a therapeutic or educational strategy that could not be introduced without accepting that reasonable force might be required. For example, the best way of helping a child to tolerate other children without becoming aggressive might be for an adult to 'shadow' the child and to adjust the level of any physical intervention needed according to the child's behaviour. Similarly, staff might be sanctioned to use restraint, if necessary, as part of an agreed strategy to help a person who is gradually learning to control his/her aggressive behaviour in public places. In both examples, the physical intervention is part of a broader educational or therapeutic strategy.

5.12 Where this approach is employed it is important to establish in writing a clear rationale for the anticipated use of intervention and to have this endorsed by a multidisciplinary meeting which includes, wherever possible, family members (or those with parental responsibility) and an independent advocate.

Emergency use of restrictive physical interventions

5.13 Emergency use of restrictive physical interventions may be required when service users behave in ways that have not been foreseen by a risk assessment. Research evidence shows that injuries to staff and to service users are more likely to occur when restraint is used to manage unforeseen events and for this reason great care should be taken to avoid situations where unplanned physical interventions is used.

5.14 An effective risk assessment procedure together with well planned preventative strategies will help to keep emergency use of restraint to an absolute minimum. However, staff should be aware that, in an emergency, the use of force can be justified if it is reasonable to use it to prevent injury or serious damage to property.

5.15 Even in an emergency situation, any force used must be reasonable. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration. Before using restraint in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences, which might have occurred without the use of a physical intervention.

5.16 There must be a written protocol, which includes:

- a description of behaviour sequences and settings which may require the use of restraint or seclusion;
- the results of any assessment which has determined any contra-indications for the use of physical interventions;
- a risk assessment which balances the risk of using physical intervention against the risk of not using a physical intervention;
- a record of the views of the service user or those with parental responsibility in the case of children, and family members in the case of adults not deemed competent to make informed choices;
- a system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages;
- a record of previous methods which have been tried without success;
- a description of the specific physical intervention techniques which are sanctioned, and the dates on which they will be reviewed;
- details of staff who are judged competent to use these methods with this person;
- the ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

5.17 An up-to-date copy of this protocol must be included in the service user's individual care plan.

5.18 The use of a restraint or seclusion should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. See paragraphs on Post-Incident Management and Monitoring (paragraphs 3.9-3.18).

STATEMENT OF PRINCIPLES

5.19 **The following principles should underpin the use of restraint and seclusion with service users across the range of client groups**.

- **The philosophy of care is the least restrictive and controlling possible for the individual service user.**

- **Prevention strategies are in place to minimise the need to use either of these interventions.**

- **Institutions or settings employing either restraint and/or seclusion have clearly defined policies for the management of violent service users.**

- **Restraint and seclusion are interventions of last resort, used for the minimum time necessary to protect life, to safeguard from harm or to prevent serious damage to property.**

- **The management of disturbed and violent behaviour requires a multidisciplinary approach to planning for the care and treatment of the service user.**

- **The principles for the management of disturbed and violent behaviour which poses a risk to the individual or other service users are the same whatever the institution or setting.**

- **Planned use of these interventions is based on a risk assessment and is part of the care plan for the individual service user, of which they are informed.**

- **The risk assessment specifies if there are reasons why a specific intervention should not be employed with an individual service user.**

- **The age, gender, personal characteristics of the service user and setting specific factors are all drawn together to inform the use of any approach designed to manage or control behaviours.**

- **The use of these interventions is recorded in a standardised manner as soon as possible after the incident.**

- **Post incident monitoring is carried out at a senior level within the service to:**

    - **ensure compliance with human rights requirements;**

    - **ensure compliance with the *last resort* principle;**

  - **ensure that the minimum amount of force was used for the shortest possible period of time;**

  - **compliance with the policies and procedures;**

  - **that staff involved were appropriately trained; and**

  - **determine what lessons can be extracted to inform future practice, training or staff support.**

- **Staff employing these interventions are appropriately trained to ensure they use the procedures to promote the well being and best interests of service users and in a manner consistent with the Human Rights Act and the European Convention on Human Rights.**

- **Staff working with children ensure that their practice is consistent with the United Nations Convention on the Rights of the Child and that complaint procedures are available in a child friendly format.**

- **Staff and service users have opportunities for de-briefing after the use of these interventions.**

- **Management strategies for disturbed and violent behaviour should be regularly monitored and audited.**

- **Service users and their families are aware of how to complain if they are dissatisfied about the way they were managed prior to, during and after the incident.**

6. REFERENCE/BIBLIOGRAPHY

Physical Interventions – Definitions and Purpose

"Physical Interventions. A Policy Framework." Harris. J. et al (1996) British Institute of Learning Disabilities (BILD).

"Physical Restraint. A Review of the Literature". McDougall. T. (1996). Psychiatric Care, 3 (4) 132-136

"Guidance for Restrictive Physical Interventions. How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder." Department of Health

"Legal Issues Arising from the Care and Control of Children with Learning Disabilities who also present Sever Challenging Behaviour. A Guide for Parents and Carers." The Mental Health Foundation

"Mental Health (Northern Ireland) Order 1986 Code of Practice" H.M.S.O.

"Restraining, Holding Still and Containing Children and Young People 2003. Guidance for Nursing Staff." Royal College of Nursing

Restraint and Isolation in Mental Health

Law

Mental Health Act 1983 and Revised Code of Practice (England)
The Mental Health (NI) Order 1986 and Code of Practice for the Mental Health (NI) Order 1986

Cases

R (Munjaz) v Mersey Care National Health Service Trust and Others
R (S) v Airedale National Health Service Trust & Others [2003] EWCA Civ 1036
Hutchison Reid v UK (50272199) 14 BHRC 41 (EHCR)
R (on the application of KB) v Mental Health NHS Trust Exp. L Times, Dec 8 1997 CCA
Johnson v UK 1999 27 EHRR 296
R v Secretary of State for Scotland 1989 SCLR 784
Case of Paul and Audrey Edwards v the UK

Journals

"Uncomfortable truths" Hewitt D, NLJ 2003 153 (7078) 661-2
"False imprisonment in mental health cases" Canal S, NJL 1999 149 (6887) 6867

Articles

“Why aren’t mentally ill children getting the support they need?” 19/6/01 *BBC Newsonline*
“ Hospitals wrong to disregard Code of Practice, Appeal Courts rules”
http;//www.mind.org.uk
“Psychiatric patients denied basic rights”
http://www.society Guardian.co.uk
“Seclusion room interventions in Acute Care Psychiatry”
http://www.crpnm.mb.ca/seclude.html

Newspapers

“Mentally ill will not be held in cells*”* Nelson F, *The Times*, Nov 18 2000, 13
“A room of one’s own-seclusion is at last lawful” Hewitt D, *The Times* Nov 26 2002
“Non offenders to be locked up indefinitely”- Goodchilds, *Independent* Sunday June 23, 2002, 10

“Thousands of NHS Patients being detained illegally” Dyer C, *Guardian* Feb 5 1998
“Voluntary Patient held unlawfully” Patton *Guardian* Oct 30 1997 B

Policy

“Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments”. The National Institute for Clinical Excellence (NICE) February 2005. (Developed by the National Collaborating Centre for Nursing and Supportive Care) www.nice.org.uk

“Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units.” The Royal College of Psychiatrists and the Royal College of Nursing, March 1996 www.rcpsych.ac.uk/publications/cr/cr41 - Cases cited in the context of this publication are:

Department of Health (1992) *Report of the Committee of Inquiry into Complaints about Ashworth Hospital.* London: HMSO.
- (1993) *Report of the Committee of Inquiry into the Death in Broadmoor Hospital of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients: “Big, Black and Dangerous”*. London: HMSO.
Department of Health and Social Security (1980) *Report of the Review of Rampton Hospital.* London: HMSO.
- (1985) *Report to the Secretary of State for Social Services Concerning the Death of Mr Michael Martin at Broadmoor Hospital on 6th July 1984*. London: HMSO

Disruptive Pupils

Cases

Purvis v Buckinghamshire CC [1999] ELR 231

Tyrer v UK 1978
R(on the application of L,A Child) v J School Governors Feb 27 2003

Newspapers

"Classrooms ban detention after pupil cites human rights" Kielbie P, *Independent*, Jan 7 2003, 9
"Greater protection urged for accused teachers" Firn D, *Financial Times* 25 Aug 2003
"Teachers want training in restraint techniques" Fri 2 April 1999 *BBC Newsonline*

Policy

Pastoral Care in Schools. Child Protection
Pastoral Care: Guidance on the use of reasonable force to restrain or control pupils.
A structured framework for the development of a policy the use of reasonable force/safe handling all school sectors
Westminster City Council
Policy audience for schools on the use of physical restraint.
Denver Public Schools Student Services Manual
Section 10: Policies and Procedures regarding Student Restraint
Toronto Catholic District School Board
Physical restraint-A guideline for the use of physical restraint

<u>Children In Custody</u>

Law

Juvenile Justice Centre Rules (NI) 1999

Cases

R (on the application of the Howard League for Penal Reform) v Secretary of State July 2003

Articles

"Fighting for the rights of children" Crook F, Sun Nov 10 2002
http://observer.guardian.co.uk/comment/story/069038370500.html

"Government reported to UN for breaching rights of children in Prison" Howard League, Thurs 19 Sept 2002
http://web.ukonline.co.uk/howard.league/press/2002/19902.htm

"Blunkett faces high court challenge for failure to protect children in prison" Howard League, July 2002
http://web.ukoline.co.uk/howard.league/press/2002/29762.htm

Newspapers

"Segregation of teenage inmates is child abuse" Bernetto J, *Independent* Feb 11
"Prisoners could sue over degrading jail conditions". Burns, *Guardian* Dec 11 2002
"Court upholds rights of jailed youngsters" Dyer C, *Guardian* Nov 30 2002

Children In Care

Law

Statutory Instrument 2001 No3967
The Children's Homes Regulations (NI) 1996
The Children's Order Guidance & Regulations, Volume 4, Residential Care

Cases

X v Brown [2003] EWCA Civ 181 CA

Articles

"Measuring Competence in Physical Restraint Skills in Residential Child Care." Bell L and Stark C,
http://www.scotland.gov.uk/cru/documents/refin21.htm

"Physical restraint: Important information for residents and families"
http://www.nchcfa.org/restrain.asp

"Physical restraint-Part 1: Use in Acute and Residential Care Facilities. Best Practice" Vol. 6 Issue 3 2002

"Physical Restraint in Acute and Residential Care."
David Evans, Jackie Wood, Leonnie Lambert and Mary Fitzgerald

"Learning from Each Other: Success stories and ideas for reducing restraint/Seclusion in Behavioural Health" - American Psychiatric Association

"Children's rights and the use of physical force" Fortin J,
Child and Family Law Quarterly, Vol.113 No 3 2001

Policy

Clear Expectations, Consistent Limits. The Centre for Residential Child Care
Physical Restraint-Practice, Legal, Medical & Technical Considerations. The Centre for Residential Child Care
"Restraining, holding still and containing children" - Guidance for Good Practice-Royal College of Nursing.
"Children's Views on Restraint" Dr Roger Morgan OBE, Children's Rights Director, Commission for Social Care Inspectorate

Miscellaneous

The Government of the United Kingdom of Great Britain & N. Ireland. Response to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment-Visit to N. Ireland-Dec 1999

"Connecting Mental Health and Human Rights": Gavin Davidson, Maura McCallion and Michael Potter, on behalf of the Northern Ireland Human Rights Commission.

"Independent Inquiry into the death of David Bennett": report of enquiry set up by the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority.

"Good Practice in Consent" – a handbook for DHSSPS, 2003. www.dhsspsni.gov.uk/publications

"A question of restraint". Leadbetter, D and Trewartha, R (1995), Care Weekly, 18 May 10-11.

"The Edinburgh Inquiry – Recommendations 55. The Independent Evaluation Report". Lindsay M and Hosle, A (2000). University of Strathclyde and the former Centre for Residential Child Care.

"Guidance on Handling HPSS Complaints: Hospitals and Community Health and Social Services" (April 2000).

ANNEX A

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

OUTLINE TERMS OF REFERENCE

Restraint and seclusion can be used in a variety of health and social care settings eg. residential/nursing homes, children's homes, hospitals and facilities accommodating people with a learning disability and mental health problems. There are possible implications for Articles 3, 5 and 8 of the ECHR. The purpose of this piece of work is to develop guidelines for staff to ensure that any restraint or seclusion is reasonable, proportionate and justifiable in the circumstances and that appropriate documentation is completed.

Methodology

- Examine current policies and procedures.
- Examine current practices, including local audits, work in progress, research reports - is there evidence of best practice anywhere?
- Examine current documentation and recording mechanisms.
- Examine complaints in this area to identify weaknesses and areas for action.
- Examine existing case law to identify issues and guiding principles.

Product

User-friendly, practical guidelines which:

(a) are human rights compliant and which have been validated by the appropriate professions, legal advisors, the NIHRC, the Equality Commission;

(b) have been quality assured; and

(c) are capable of incorporation into training for new and existing staff, where relevant.

Accountability

Boards, Trusts etc. will be asked to report on progress on implementation of the guidelines within the framework of Priorities for Action and the Health and Well-being Investment Plans. It is not envisage that this piece of work will be issued as a Departmental circular as the objective is to support and encourage staff to develop a human rights culture within their organisations and their own policies and procedures to implement the guidance. This approach recognises that different organisations will be at different stages of applying practice and have varying needs depending on their client group and whether they are residential or community based services.

ANNEX B

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

MEMBERSHIP

Mrs Marion Reynolds (Chair)	Social Services Inspectorate, DHSSPS
Ms Tara Caul	Children's Law Centre
Mr Arthur Dick	Down Lisburn HSS Trust
Ms Heather Ellis	Human Rights Liaison Group
Mrs Roisin Gallanagh	School of Nursing, University of Ulster
Mr Gene Gillease	Western Equality & Human Rights Forum
Dr Joan McGuinness	Armagh & Dungannon HSS Trust
Mr Clinton Stewart	North & West Belfast HSS Trust
Ms Alison Wilson	Secure Units, Lakewood
Ms Linda Wilson	Barnados
Mr Cecil Worthington	Ulster Community and Hospitals HSS Trust
Mr Niall Young	Homefirst HSS Trust
Mr Stewart Love	Human Rights Unit, DHSSPS

ANNEX C

MEMBERSHIP OF SUB-GROUP ON LEGISLATIVE CONTEXT

Tara Caul
Prof Tony McGleenan
Henry Tower QC
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ANNEX D

EXAMPLE OF HSS TRUST
MANAGEMENT OF
AGGRESSION POLICY

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1.0 POLICY STATEMENT AND TRUST'S PRINCIPLES

It is the policy of this Trust to promote an organisational culture and develop associated structures that prevent aggression in the workplace. The Trust seeks to equip all staff with the appropriate attitudes, knowledge and skills to work with service users in those situations which critically challenge how they are supported. This will enable management of aggression to be achieved in a caring manner by the implementation of training and policy initiatives that promote best practice.

This approach must fit with the wider quality issues of clinical and social care governance and controls assurance. Each service should develop, where appropriate, local procedures reflecting the ethos of this policy.

The existing law requires that individuals do not interfere with the rights of others, eg the use of physical intervention techniques. Such action can, however, be defended if it is intended to prevent harm to the service user or others. Members of Trust staff must be able to demonstrate clearly that they act at all times in the best interests of the individual.

The following are the Trust's principles underpinning the policy.

- Service users and carers should be treated with respect at all times and their dignity maintained.

- Person centred approaches, sensitive to the needs of the individual and promoting effective communication between service users and staff, should be practised to help reduce the likelihood of aggressive incidents.

- Prevention of aggression is preferable to intervention at a later stage.

- The use of physical intervention techniques, may on occasions be necessary to fulfil a duty of care. However, these should be kept to an absolute minimum and carried out within local service guidelines. Physical intervention techniques when used will take full account of the service user's need for respect, privacy and dignity as well as social and cultural considerations.

- The personal safety of staff, service users, carers, students on placement and other persons carrying out authorised tasks on behalf of the Trust is of paramount importance to this Trust. Personal safety takes priority over damage to property.

- The Trust recognises its legal and moral responsibility to reduce risk to staff, service users, carers, students on placement and others to the lowest level practicable.

- Trust staff have individual and collective responsibility for ensuring that aggressive incidents are kept to a minimum and effective risk management procedures are in place to secure this aim. The safety of service users is everyone's responsibility.

- The training and support provided to Trust staff will recognise these principles and will provide staff with a tool-kit of skills that will enable them to manage difficult situations in a person-centred manner.

2.0 DEFINITION OF AGGRESSION

The Trust defines aggression as behaviour resulting in damaging or harmful effects (physical or psychological) on another person or persons. This includes:

- verbal abuse
- non verbal abuse (eg stalking)
- threats of physical abuse
- physical abuse
- threats of sexual abuse
- sexual abuse
- damage to property

The above definition includes behaviour directed at staff, service users, carers, students on placement and other persons carrying out authorised work on behalf of the Trust.

3.0 RESPONSIBILITIES

[Describe the relevant responsibilities within the Trust]

The Trust Board has the responsibility for overseeing the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. The Chief Executive in conjunction with his colleagues on the operational Management Team is charged with meeting these responsibilities. The Operational Management Team, which includes the Heads of Service in the Trust, directs all Trust initiatives to reduce the risks of aggression whilst providing person-centred services to service users. The Operational Management Team is accountable through the Chief Executive to the Trust Board.

3.1 Staff Responsibilities

All staff have a responsibility to ensure that their behaviour towards service users and their carers reflect a person-centred approach. Staff should be aware of the impact of their own behaviour and how this could precipitate or increase the severity of an incident of aggression. All staff who work directly with service users should endeavour to be aware of the risk factors for aggressive behaviour. Trust training will reinforce the value of appropriate communication skills. Staff are obliged to adhere to this policy and associated training at all times.

While it is the legal responsibility of the Trust to provide safe systems of work, individuals have a personal responsibility to follow safe working practices.

3.2 Management Responsibilities

Chief Executive

The Chief Executive carries overall responsibility for the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. He is responsible to:

- ensure that appropriate arrangements are in place within the Trust to manage aggression;
- ensure that those systems that are in place are in line with clinical and social care governance;
- ensure that effective monitoring systems are in place to quality assure these arrangements

Heads of Service

- Ensure that their staff are aware of the policy and that its relevance to their work is recognised
- Ensure any additional local procedures in a particular service area fits with the Trust-wide approach.
- Allocate resources (time, people and financial outlay) according to areas of highest risk.
- Ensure staff are adequately trained.
- Provide High level monitoring of the level and effectiveness of training.
- High level monitoring of incident patterns.
- Develop systems which will support staff and service users following an aggressive incident.
- Communicate, where appropriate information, information about significant known risks to ensure remedial action is taken to address these.

Service Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Implement Trust recruitment and selection procedures to ensure that applicants are fully aware of the roles and inherent risks associated with

the job. This should facilitate the selection of an appropriate person for the post.

- Ensure staff are adequately trained.
- If necessary draw up service specific local procedures to support and underpin the Trust-wide policy and approach.
- Ensure that appropriate risk assessments of aggressive behaviour associated with use of Trust's services have been carried out in conjunction with staff, service users and carers and using a multi-disciplinary approach. This should occur within the annual service-planning cycle.
- Fully implement the Trust's incident reporting policy
- Ensure that any risks identified are managed appropriately through an action-plan approach. These risks should be reviewed within an agreed timescale
- Ensure arrangements to support and supervise staff are implemented and monitor their effectiveness.
- Ensure that managers have a system for investigating any aggressive incidents in their area.
- Monitor and implement lessons learned from incidents and provide feedback and information to staff and the Risk Management Unit.
- Inform their Service Head of areas of significant risk to ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

First Line Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Provide Induction Training for new staff.
- Implement Trust recruitment and selection procedures to ensure that persons applying are fully aware of the roles and inherent risks associated with the job. This should facilitate the selection of an appropriate person for the post
- Ensure appropriate management of aggression and the provision of learning and skills development. This should include, as appropriate, training in a multi-disciplinary and at times multi-agency fashion.
- Ensure all training given to their staff is formally recorded and staff's training is kept up to date.
- Ensure that appropriate risk assessments are carried out and remain up to date.
- Involve other disciplines, as appropriate, in the management and assessment of risk of aggressive incidents.

- Ensure all incidents are reported promptly to the Trust's Incident Reporting Centre.
- Carry out investigation of any incidents occurring, supported by their Service Manager and the Risk Management Unit for significant incidents.
- Arrange for appropriate and comprehensive support for employees following an incident.
- Promote team-working.
- Monitor practice (formally and informally) and ensure the best standard by ongoing supervision.
- Use manpower planning skills to release staff for training.
- Keep Service Manager informed of any significant risks or implementation problems and ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

Supervisory Management

- Promote best practice by example and on the job training for staff.
- Assist in implementing risk assessment procedures.
- Ensure that all incidents are reported promptly.
- Inform first-line manager of significant risks or problems and the arrangements required to reduce risk.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

3.3 Special Responsibilities

Consultants and Lead Clinicians/Social Care Professionals

- Responsible to ensure adequate and appropriate assessment of the service user presenting a risk because of aggressive behaviour. Although this process may initially start with one discipline it will in many cases involve a multi-disciplinary approach and may also require involvement from other Trusts and agencies as appropriate.
- Following assessment, development of management/care/treatment plans.
- Monitor, review and adjust these plans following re-assessment of the service user.
- Ensure that known risks are communicated where appropriate to staff and others to ensure other decisions are properly informed.
- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.

- Ensure that their staff receive appropriate induction and updated training, and support and supervision.
- Implement the Trust's Incident Reporting Policy.
- Ensure that their staff are aware of arrangements for post-incident staff support and that these are readily available when required.
- Lessons learned from incidents should be effective in changing practice in the workplace. Any information from this process should be passed on to the relevant staff and the Risk Management Unit.
- Promote team-working.

Head of Operational Support

- Chairs the Health and Safety Committee
- Provides quarterly reports to the Operational Management Team about aggressive incidents including learning points.
- Senior manager responsible for risk management advice, as member of the strategic Operational Support Team.
- Manages the Service Manager responsible for the Risk Management Unit.
- Responsible for alerting other senior managers to significant risk issues to ensure timely, appropriate responses.

Risk Manager

- Service manager responsible for managing the Risk Management Unit.
- Provides professional advice on Trust-wide management of risk.
- Devises, develops and reviews policies and procedures to reduce risk.
- Devises and manages risk assessment processes.
- Manages the process of reporting and monitoring incidents ensuring that managers are kept informed about incidents reported in their area and any significant implications for work practices.
- Responsible for analysing trends and providing managers with quarterly information about lessons to be learnt.
- Manages the training function for the reduction of risk.
- Advises managers at every level on targeting high risk areas.
- Provides assistance to managers to find risk solutions, leading to action plans.
- Ensures that the Trust minimises the risk of civil and criminal liability and that there is appropriate legal defence where cases are filed against the Trust.

Head of Human Resources

- Senior manager responsible for Occupational Health Services, learning and development and all other human resource issues.

- Sets high-level recruitment and selection procedures.
- Responsibility for redeployment and disciplinary issues.
- Provides high-level specialist advice to the Trust in the above areas.
- Establishes processes and protocols and makes arrangements for post-incident staff support and monitors its effectiveness.

Occupational Health Sister

- Manages the process of pre-employment health assessments.
- Provides a service for pre-employment risk assessment.
- Provides specialist advice to managers on employee's health.
- Advises managers and employees on return to work following an incident.
- Provides approved courses for Trust is First-Aiders.
- Organises appropriate health surveillance.
- Provides a work-place assessment service for managers

Human Resources Managers

- Provide advice on managing the processes of recruitment and selection.
- Advise managers on performance management issues.
- Assist and advice managers in implementing disciplinary procedures etc..

Trade Union Health and Safety Representatives

- May investigate hazards and dangerous occurrences in the workplace.
- May investigate complaints relating to health, safety and welfare at work by the staff they represent.
- May make appropriate representations to Trust Management in respect of the above issues.
- May carry out inspections in respect of the above issues.
- May represent appropriate staff in consultations with Trust Management, or inspectors of any enforcing agency.
- May attend meetings of safety committees, as appropriate, in connection with the above functions.

4.0 ARRANGEMENTS FOR MANAGING AGGRESSION

4.1 Organisational Risk Assessment

Information from the individual assessments of service users and risk factors regarding the working environment must feed into a process. This will help inform the broader assessment of risk of a ward, Trust facility/department or caseload. It is important that a collective view of risk is formed, as this is the way risk can best be managed and high-risk areas can be appropriately targeted.

The process is as follows:

- first-line managers of the ward/department/Trust facility have responsibility to initiate the process;
- risk issues from individual risk assessments are drawn together and patterns of risk are identified;
- consideration of any factors which may increase or decrease risk in any place where staff are at work;
- assessments should result in the production of action plans to prioritise and manage high risk and significant risk issues;
- information from this assessment should be used to inform their line manager so that a picture of risk emerges. This will enable the Service Manager to make plans to manage risk through the annual service-planning cycle and also on a day-to-day basis;
- finally, this process should inform the Heads of Service and the Operational Management Team about significant Trust-wide risks.

The organisational assessment of the risk of aggression will include:

- the actual number of incidents;
- the service user groups involved;
- the perceived risks associated with the work situation and procedures;
- staff perceptions of risk;
- the use of preventative strategies;
- the appropriateness of support and supervision arrangements provided by the Trust;

4.2 Individual Risk Assessment

Appropriate professionals should routinely carry out suitable and sufficient risk assessments in conjunction with staff, service users and carers. These assessments must be completed and reviewed at appropriate regular intervals and should include consideration of the risk of aggressive behaviour associated with the use and provision of Trust services.

The individual service user's risk assessment must address the following areas:

- harm to self or others;
- past history of aggression, its pattern, frequency and seriousness;
- likelihood of any possible incident;
- individuals who may potentially be at risk;
- precautions that already exist;
- any further actions that need to be taken to reduce risk.

Following risk assessment a reasoned judgement must be reached and recorded regarding the assessed degree of risk. Appropriate action and communication must then be taken on the basis of that judgement. The initial risk assessment will be reviewed and may change to reflect the ongoing management of the service user's care. Where there is disagreement between professionals regarding the proposed strategy of managing risk, decisions should be taken to a more senior level.

4.3 Communication of Risk Information

Managers and staff must consider their responsibility to provide information about significant risks which may affect other departments/services within the Trust. This should include sharing information about measures in place to address the risks. Information should be exchanged with all people who may be at risk in a timely and easily understood manner. Care must be taken to preserve the confidentiality of service user's information. Serious and imminent danger to others will however on rare occasions form a reasoned basis for the sharing of confidential information.

In addition, all managers have a legal responsibility (under Health and Safety legislation) to inform other persons not employed by the Trust who may be at risk due to the actions, or failure to act, of the Trust.

4.4 Recruitment and Selection

Recruitment and selection documentation should be explicit about the nature of the work, and any foreseeable risks in handling challenging behaviours. Profiles of facilities should be used and reviewed regularly. Recruitment panels, where appropriate, may assess staff's ability, (or potential ability) to deal with situations where aggressive behaviours may occur. At recruitment the pre-employment risk assessment process developed by Occupational Health should be followed.

4.5 Staff Learning and Development

4.5.1 Induction

Managers must ensure that all new staff attend the organisational induction programme. They must agree a personal development plan for the next twelve months for all new staff. New staff will be required to read and understand their responsibilities within the Management of Aggression policy. Line managers should discuss any questions and clarify issues so that new staff have a clear idea of what to expect and how best to manage the different situations.

Training courses should be available, if possible before service commences, or as soon as possible thereafter.

4.5.2 Monitoring and Supervision

People responsible for staff must assist staff with their professional development. They are also responsible for assisting with the development of a competent staff team by identifying training needs.

Ongoing monitoring of compliance with the requirements of the Management of Aggression policy and staff performance will be included in the supervision process.

4.5.3 Training and Development

All staff will have the opportunity to develop their knowledge and skills in a person-centred approach to managing aggression. Appropriate learning and development initiatives currently within the Trust will facilitate this process. The need for staff development will be identified as part of the process of risk assessment. Learning and development will be targeted to address assessment of actual risks and will include the use of information from previous incidents or potential incidents.

The experience and knowledge of service users and carers will be incorporated when staff development resources are being produced and implemented.

Overseeing learning and skills development will be the responsibility of the first line manager and should, where appropriate, include training in a multi-disciplinary and at times multi-agency fashion.

Management of Aggression learning and development objectives will be evaluated in terms of how effectively the knowledge and skills learned have been applied to the workplace by staff. This training should be service specific.

4.5.4 Performance Management and Redeployment

Managers have a responsibility to constantly monitor the performance of staff in managing aggression. If managers or staff are aware of any performance issues this should be addressed using some or all of the following options:

- counselling;
- further training;
- job advice;
- redeployment options;
- disciplinary action.

Where staff have experienced a particularly traumatic incident/s the manager has special responsibility to consider how best to support staff in the working environment.

4.6 Managing an Incident

4.6.1 Reporting, Investigating and Monitoring

Information is essential to assist in the reduction and prevention of incidents, the need for staff development and evaluation of the efficacy of training or other interventions.

The Trust's Incident Reporting Procedure must be implemented throughout Divisions as follows:

- all incidents of aggression must be reported as soon as possible to the person in charge of the relevant area/department by the person(s) directly involved;
- all staff must use the Trust's Incident Report Form to report all significant incidents of aggression (as defined in this policy) and forward immediately to the Incident Reporting Centre at Trust Headquarters;
- major incidents must be reported to the Incident Reporting Centre within 24 hours or as soon as possible. This is a legal requirement under the Reporting of Injuries Diseases and Dangerous Occurrences, (Northern Ireland), Regulations 1997. The responsibility for reporting under these regulations lies with the Risk Management Unit. Managers and staff discharge their responsibility once they have reported to the Incident Reporting Centre.

Line managers must investigate every incident that occurs within their business areas. However, serious or highly significant incidents must involve the Risk Management Unit.

These reporting and investigatory arrangements do not detract from the legal responsibilities placed upon the Trust to formally investigate and report on individual incidents where injury has occurred.

The significance of aggressive incidents will vary within the differing service areas in the Trust. It is the responsibility of the Service Manager to define which incidents are significant for their particular area.

The importance of reporting incidents should be promoted more positively by demonstrating how effective information collection and analysis can contribute to the implementation of appropriate change measures eg training initiatives, resource strategies etc..

Managers should monitor the frequency and severity of incidents in their business areas. The Risk Management Unit will produce reports at agreed intervals for managers to assist them in this task. Areas most at risk need to be clearly identified and remedial measures put in place.

4.6.2 Post Incident Support

The Trust wishes to promote a culture of support that permeates the total organisation. Each service should demonstrate a commitment to providing support to staff, service users and carers involved in an incident.

Service managers are responsible for ensuring that the individual receives the appropriate form of support.

The form of support should be responsive to individual need and the following options should be offered:

- support immediately after the incident within the department/unit (Group or individual);
- opportunity to go off duty;
- contact relative, friend or Trade Union representative;
- taxi Home/Transport arrangements;
- assistance and accompaniment to hospital;
- ongoing managerial contact with individual in a considerate/supportive manner;
- long-term support eg staff care, occupational health.

Managers should be aware of the potential long-term effects of an incident and the incremental effects of a series of incidents on their staff's well-being and performance.

If a member of staff feels it is necessary to pursue legal action against an aggressor in the context of their work the Trust will, where appropriate, offer emotional support to staff through the resulting legal process.

4.6.3 Post Incident Review

Each service should have an Incident Review Procedure. Service managers must demonstrate that their service reviews individual incidents within a prescribed time period from the incident occurrence, (ideally 4-7 days post incident).
It is the manager's responsibility to investigate all incidents of significance within their area of responsibility.

The process of incident review should involve consultation with those involved; ie staff, service user, carer or any other person involved in the incident. Each incident should be examined in terms of:

- antecedents – actions, stressors, behaviour etc that may have contributed to the incident;
- nature of incident;
- how it was handled – identify positive and negative staff interactions and strategies adopted that influenced the effectiveness with which the incident was handled.

4.6.4 Learning from Incidents

Incident Review should be regarded as an opportunity:

- to learn from experience;
- to obtain information to prevent/reduce the risk of further incidents;
- to improve services/resources where necessary;
- to promote a learning culture.

It is important that lessons are learned and conclusions drawn from each and every experience. Managers should promote learning from experience and team working throughout their business areas. Opportunities to share learning across the Trust should be maximised to prevent the reoccurrence of similar incidents in other Trust facilities/departments. These may include: management of aggression training sessions, team meetings, and manager's meeting.

4.6.5 Arrangements to Assist Staff Returning to Work Following an Incident

Every effort will be made to provide support to staff in returning to work following an incident. This will include:

- advice from Occupational Health;

- advice from Personnel Services;
- supportive return to work interview with the line manager;
- implementation as soon as possible, of any organisational learning from the incident;
- provision of any required training in management of aggression.

It is primarily the line-manager's responsibility to provide all possible positive support in re-integrating the member of staff back into the workplace.

4.6.6 Contact with External Organisations

Health and Safety Executive (Northern Ireland)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997, require that certain incidents of aggression must be reported to the Health and Safety Executive. In certain circumstances these reports must be made within 24 hours of the incident occurring. This is a legal requirement and failure to meet this requirement constitutes a criminal offence. The Risk Management Unit is responsible for making these reports and it is the responsibility of persons reporting incidents to report them promptly to the Incident Reporting Centre, Trust Headquarters. In cases of death or serious injury these reports should be made by telephone with the form sent on by post, as soon as possible.

Mental Health Commission

It is the responsibility of the Trust to immediately notify the Commission of the following:

- the death of any service user not resulting from natural causes in both the hospital and community settings;
- suspected suicides in both settings;
- sexual assaults in both settings;
- actual or alleged physical assaults by members of staff in both settings.

Where any of the above incidents have occurred within the community, the Commission would not normally require a report on service users who have not received care or treatment for a mental disorder for more than two years.

Written reports of incidents must be submitted to the Mental Health Commission within six weeks of the incident occurring and must include the following information:

- a brief account of the circumstances of the incident;
- information on the mental state of the service user, particularly at the time of the incident;
- information regarding any other person involved in the incident indicating whether staff, other service user or member of the public;
- a copy of the minutes of the multi-disciplinary review meeting.

Where there was no multi-disciplinary involvement with the service user the Commission expects to receive information on the Trust's own investigation of the incident including any proposed action taken as a result of the investigation.

The Commission expects that the Trust will record, monitor and review all incidents and will inspect records and review management's policies and procedures regarding all untoward events.

Registration and Inspection Unit (R&I Unit)

The same reporting requirements for the Mental Health Commission apply for this external agency. The R&I Unit only requires reports with regard to Trust's residential facilities.

Office of Care and Protection

Where any person suffering from a mental disorder has been referred to the Office of Care and Protection, and has been the victim of mishaps or accidents and suffered injury/loss/damage to property which might entitle him/her to compensation, then the Office of Care and Protection needs to be notified. This is to ensure the rights of such persons are protected.

Police Involvement

The Trust recognises the legal right of employees and others to be protected by the police. The Trust may in exceptional cases instigate legal proceedings for those situations in the interests of Trust staff and the community. This may be against the wishes of individuals who have suffered the consequences of aggression but it may be necessary for the protection of others.

The Trust's training programme and service specific procedures should include guidance for staff on the recognition of those situations when it would be appropriate to call for the assistance of the police.

APPENDIX 1 Committees and Groups with Management of Aggression Responsibilities

APPENDIX 2 OTHER RELEVANT TRUST DOCUMENTS

For example:

Health and Safety Policy

Untoward Incident Reporting Policy

Managing Diversity Policy

Confidentiality Policy

Managing Attendance Policy

Special Observation Policy

APPENDIX 3 RELEVANT LEGISLATION

Mental Health (Northern Ireland) Order 1986, ***ISBN 0-11-066595***

Children (Northern Ireland) Order 1995, ***ISBN 0-337-92257-8***

The Northern Ireland Health and Personal Social Services Order 1991

Health and Safety at Work Order (Northern Ireland) 1978 ***ISBN 0-11-084039-9***

Management of Health and Safety (Northern Ireland) Regulations (1992) ***ISBN 0-337-90359-X***

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (1997) ***ISBN 0-337-93043-0***

APPENDIX 4 SOURCES OF FURTHER INFORMATION

B.I.L.D, Physical Interventions, a policy framework, 1996, *ISBN 1-873791-86-0*

Dealing with Violence against Nursing Staff, an RCN Guide for Nurses and Managers, 1998, order code 000837

Violence at Work, UNISON

The Management of Aggression and Violence in Places of Care. An RCN position statement, 1997, order code 000 713

Mental Health (Northern Ireland) Order 1986, Code of Practice, 1992, *ISBN 0-337-077142*

Violence and Aggression to Staff in the Health Services. Guidance on Assessment and Management. Health and Safety Commission, Health Services Advisory Committee, 1997, *ISBN 0-7176-1466-2*

Management of Imminent Violence, clinical practice guidelines to support mental health services. Occasional paper, 1998, Royal College of Psychiatrists Research Unit.

Trainers in the Management of Actual or Potential Aggression. Code of Professional Conduct and Minimum Training Standards RCN Institute 1997

Practitioner-Client relationships and the Prevention of Abuse, UKCC, 1999

Code of Professional Conduct, UKCC, June 1992

Protecting the Public, UKCC, July 1997

Guidelines for Mental Health and Learning Disabilities Nursing, UKCC, April 1998

Guidelines for Records and Record-keeping, UKCC, October 1998.

ANNEX E

EXAMPLE OF HSS TRUST

Protocol on the Use of Physical Restraint

Mental Health Hospital Services and Adolescent Psychiatric Inpatient Services

TABLE OF CONTENTS

1.0 Introduction

This policy underpins the Trust's *"Management of Aggression Policy"* and should be read in conjunction with it. It is specifically written for Mental health Hospital Services and Adolescent Psychiatric Inpatient Services, it is not applicable to any other business area of the Trust.

The law requires that individuals do not unnecessarily/arbitrarily interfere with the rights of others, e.g. the use of physical intervention techniques. However, such action may be defended *if it is intended to prevent harm to the service user or others.* Trust staff must be able to demonstrate that they have acted at all times with regards to the best interest of the individual. All physical restraint must be carried out in accordance with the principles and ethos taught in the Management of Aggression training provided by the Trust.

Since staff have a responsibility for the health and safety of themselves and others, they must give assistance in managing aggression where and when necessary. This does not mean that all staff will become involved directly with the physical restraint of a service user, but that they may be able to provide other supporting assistance in meeting the needs of the situation.

In compliance with Section 75 of the Northern Ireland Act 1998, this policy/protocol has been drawn up, with the underlying principle, that this course of action should not adversely impact any of the 9 equality groups set out in Section 75 of the above Act.

2.0 When should physical restraint be used?

Physical restraint is designed to take control of a dangerous situation, limiting the person's freedom for no longer than necessary to end or reduce the potential harm to self or others.

Staff should attempt to remain calm and use de-escalation techniques before, and during, the use of physical restraint. Physical restraint should only be used when all other approaches at de-escalation have failed and/or physical aggression is actual or imminent.

The degree of restraint must be reasonable in the circumstances and the force used deemed the minimum required to deal with the potential harm. All physical restraint should be applied in a manner that attempts to defuse, rather than provoke, further aggression.

Physical restraint should only be employed as a proportionate response to aggression likely to harm the service user or others. Damage to property does not usually warrant the use of restraint, unless the act in itself is going to cause danger to others or the service users themselves.

The number of staff required to safely employ physical restraint will depend on the situation. If alone and faced with real or potential violence staff should attempt to escape from the situation, then summon assistance by the most appropriate means e.g. use of alarm systems, shout for help etc..

3.0 Training

[Provide information on any training available to staff.]

4.0 Best Practice in the use of Physical Restraint

There are basic principles that should be borne in mind when using physical restraint. These principles and practical guidance for their implementation are contained within the Trust's Management of Aggression training courses. Staff attending these courses will be provided with this knowledge and skill.

- Service users should be treated with respect at all times and their dignity maintained.

- De-escalation must be attempted at all times, continuous explanation and reassurance is required in restraint situations, the aim being to encourage the service users' co-operation and a return to voluntary control as soon as is safely possible.

- Well-briefed, trained and a co-ordinated staff response will be the most effective means of dealing with restraint situations.

- The aim is to restrain the service user safely in a low stimulus environment. This may mean moving the service user or asking others to leave.

- Preferably staff taking the lead in restraint situations should be those who have received training within the Trust as they will be able to provide advice and guidance to others.

5.0 Weapons

For the purpose of this document a weapon is defined as:

"Any object that is made, adapted or intended to be used to cause physical injury to a person"

A concise dictionary of Law (1192) pp 282
Oxford University Press, Oxford

Staff are not expected to disarm a person of a weapon that may be used to inflict harm on others, the Trust does not provide training on weapons disarmament. Judgements must be made using professional knowledge and experience, risk assessment and management of aggression training. Reasonable efforts should be made to isolate the person with the weapon and to summon appropriate assistance to the situation, this may mean contacting the police.

6.0 Involvement of Police Service of Northern Ireland

There may be times when the level of threat posed or the nature of the attack means that staff are not appropriately, or safely, equipped to manage the situation and police involvement will be required. At these times it will be the responsibility of the nurse in charge of the unit to action appropriate assistance. The use of the police for assistance will trigger the completion of an untoward incident review.

7.0 Management of physical restraint

1. One person should take the lead in the restraint and nominate others to assist him/her.

2. In a team restraint situation the person taking care of the head should co-ordinate the restraint. The rest of the team should take their instruction from the co-ordinator.

3. The service users' co-operation should be sought and encouraged at all times.

4. Communication with the service user is imperative throughout and he/she should be kept informed of what is happening to encourage his/her co-operation.

5. All persons not involved in the restraint should be asked to leave however, other staff should be available to provide additional assistance if required.

6. The doctor should be called to see the service user as soon as possible after commencement of restraint in the adult wards. Young People's Centre staff should refer to the procedure for restraint of an individual in their unit.

7. A full account of the incident must be documented clearly and concisely in the service user's notes and on the incident form and a physical intervention monitoring form must be completed (see Appendix 1).

8. If physical restraint is employed for more than half an hour a review must be carried out by the nurse manager/duty nurse manager at that time, and every half-hour thereafter to ensure that only intermittent restraint is used. This review must be fully documented in the service user's notes.

9. Following restraint the nursing team must review their interventions. The multi-disciplinary team must review the interventions as soon as possible.

Appendix 1
Physical Intervention Monitoring Form - Sample

Trust
PHYSICAL INTERVENTION MONITORING FORM

Service User's Name	Service User's Number	Unit/Ward	Date of Incident

Exact time commenced and exact location am/pm	Exact time discontinued and exact location am/pm

Staff action(s) immediately PRIOR to using physical intervention (please tick

1. None-insufficient time ☐
2. Told the service user to stop ☐
3. Attempts to de-escalate the situation (specific in comments section) ☐
4. Administration of PRN medication ☐
5. Counselling ☐
6. Other (specify in comments section) ☐

Why did you first intervene? ***(tick one box only)***
Aggressive behaviour in progress

1. Towards others ☐
2. To self ☐
3. Other (specify) ☐

Details of all people involved

Name	Job title	Role/Responsibility	Method used*

*Key
1. Looking after the head
2. Immobilisation of the legs
3. Immobilisation of an outstretched arm
4. Immobilisation of a bent arm
5. Immobilisation of the hand
6. Taking over from a colleague

Breakaway (please indicate point of contact eg wristgrab, method used to breakaway and subsequent actions.)

Service User's position during the restraint

Column 1 – Please indicate all positions that the service user was held in during the restraint process. Number from 1 accordingly.
1st position – 1,
2nd position – 2 etc
Column 2 – Please indicate the SINGLE position that was maintained the most throughout the restraint process

1. Sitting on a chair/sofa	☐	☐
2. Sitting on a bed	☐	☐
3. Sitting on the floor	☐	☐
4. Kneeling on the floor	☐	☐
5. Lying on a bed – face up	☐	☐
6. Lying on a bed – face down	☐	☐
7. Lying on the floor – face up	☐	☐
8. Lying on the floor – facedown	☐	☐
9. Walking to another area	☐	☐
10. Standing	☐	☐

Use of protective clothing or other equipment by staff

Not used	☐	Plastic apron	☐
Latex gloves	☐	Cut-resistant gloves	☐
Ligature cutters	☐	Eye wear	☐

Injuries occurring during the intervention process

Service User	*Injury*	*Staff*
☐	No visible injury	☐
☐	Reddening/bruising	☐
☐	Swelling	☐
☐	Lacerations/Cuts	☐
☐	Scratches	☐
☐	Friction burns	☐
☐	Thermal burns/Scalds	☐
☐	Other – Please specify In the ‘comments’ box	☐

Subsequent Action
'As required' medication given

No Further Action Required ☐ **Orally** ☐ **Injection** ☐ **Time administered** ☐

Comments: Further details of actual behaviour preceding restraint, and attempts made to prevent the situation escalating any injuries sustained, use of protective clothing or equipment and any other relevant points.			
Date of Completion	Name of person leading		Signature
For administration use only Incident form no…………………………		Copies to: Incident Report Centre	

TO BE COMPLETED BY THE PERSON IN CHARGE AT THE TIME OF THE PHYSICAL INTERVENTION TAKING PLACE

ANNEX F

EXAMPLE OF HSS TRUST

POLICY ON SECLUSION

Definition for Seclusion

The forcible denial of the company of other people by constraint within an enclosed environment.

(Code of practice Mental Health NI Order 1986)

The objective of seclusion is the short term safe containment of patients who are displaying severely disturbed behaviours which are likely to cause harm to themselves or others. It is an emergency management procedure, used only when all other reasonable steps/measures have been exhausted.

Seclusion facilities

Seclusion should be in a safe, secure and clearly identified room which offers maximum opportunity for observation. The room should have adequate heating, lighting and ventilation. Patients should be asked regularly if they require to use the toilet and be escorted to and from the toilet. Staff must make a careful judgement as to what the patient is permitted to take into the room. The patient must always be clothed when placed in seclusion but all belts, ties and shoe laces that could cause harm must be removed. Safety must always be a priority.

The decision to authorise any visit to a patient in seclusion rests with the patients consultant or a medical officer acting on the consultants behalf.

Courtyards should not be sued for seclusion. Where patients wish to access a Courtyard the door must remain unlocked, permitting the patient to re-enter the unit.

Procedure for the use of seclusion

The initial decision to place a patient in seclusion can be taken by:

The Medical Officer
The Nurse-In-Charge of the unit
The Nurse Duty Officer

Where the decision is taken by someone other than a doctor the medical officer should be contacted immediately. The patient should be constantly observed by a designated nurse until the authorisation is obtained from the medical officer.

If not involved in the decision to seclude a patient the nurse duty officer should be informed as soon as possible.

Where seclusion is required frequently or for extended periods, the patient must be referred to the multi-disciplinary team for consideration of their legal status, if not subject to detention.

A nurse should be present and observe the patient from outside the seclusion room door when:

A. the patient has been sedated prior to being secluded.

B. The patient is on constant supervision.

The purpose of seclusion should be explained to the patient, where possible.

Observation

The objective of observation is to assess the condition of the patient, ensure his/her well-being and to determine whether seclusion can be terminated.

The patient should be directly observed at least every 15 minutes and more frequently if individual circumstances demand. A documented report must be made every 15 minutes. This should include information on the patients mood, behaviour, appearance and any request made by the patient. In the case of continued seclusion a review should take place every two hours by the nurse in charge and every four hours by a doctor.

If seclusion continues for more than eight hours consecutively or 12 hours in total over a period of 48 hours, the responsible consultant should be informed by the nurse in charge, to ascertain if a review is necessary.

Record keeping

Detailed records should be maintained in the patients care plan of any use of seclusion, this will include:-

The reasons for its use
Time commenced
Medical staff involved and time of notification
Nurse Duty Officer and time of notification
Nurse in charge of unit
Staff to patient ratio
Staff allocated for observation
Reports on observation and reviews
Time terminated

In addition to recording in the patient care plan, the information will also be forwarded via the day/night report to Nursing Administration for central recording/audit purposes.

Patient requested "Seclusion"

Seclusion is not regarded as a treatment technique. However there may be times when a quiet period in a room may help to reduce agitation or alleviate distress. Individual patients may request time separated from the presence of others. This is not regarded as seclusion unless the door is locked.

Occasionally the patient may request/insist that the door be locked. Where the patient can open the door from inside the room this is not defined as seclusion, however where a patient request time alone in a locked room and cannot open the door from inside this should in all circumstances be regarded as seclusion. The patient should be observed every 15 minutes as per policy and asked if they wish to leave the seclusion room. Seclusion must be terminated immediately on request by the patient.

Use of unlocked seclusion room

There may be occasions where the seclusion room is accessed by a patient with the door unlocked, this does not meet the definition of seclusion. In all cases it should be authorised by the Nurse-In-Charge, discussed with the multi-disciplinary team and recorded in the patients care plan and day/night report.

ANNEX G

QUESTIONNAIRE AND SUMMARY OF FINDINGS

1. To assist in establishing the current position, a questionnaire was issued in June 2003 to all HSS Trusts and to a range of other service providers.

2. The questionnaire issued to providers is attached as an Appendix to this annex.

3. A total of 81 responses were received, greater than the number of organisations approached as in some cases corporate responses were received from units within organisations while others gave a single response. 54 responses were received from HSS Trusts, including Hospital HSS Trusts and Community HSS Trusts, and 27 from voluntary or private organisations and both adult and children's services were covered.

4. The questionnaires asked about restraint and seclusion policies and practices under four main headings:

   Policies and Procedures
   Monitoring Arrangements
   Training
   Complaints Procedure

Policies and Procedures

5. Most of the organisations responding indicated that some policies and procedures on restraint and seclusion were in place: for restraint of adults – 46; restraint of children – 13; seclusion of adults – 6; and seclusion of children – 5. There were 17 organisations which said they did not have or did not need these policies or procedures – however, some of these were in the process of developing a policy. Of those with policies and practices, a number were high level policies, and others were by reference to standards and guidance of professional organisations, eg Royal College of Nursing. Some were detailed documents for the particular organisation and others were relatively brief guidelines. In some instances, although lacking a policy on restraint or seclusion, training was provided on management of violence and aggression.

6. A few organisations (9 in total) said they had facilities for seclusion.

Monitoring Arrangements

7. 15 organisations indicated they had conducted a local audit of practice in relation to restraint and 5 in relation to seclusion.

8. Proformas were available in 32 organisations for recording restraint and in 9 organisations for seclusion.

9. Arrangements were in place to review each client group in the use of restraint in 42 organisations and on the use of seclusion in 8 organisations.

Training

10. For restraint, 53 organisations provided information to their staff of policies and procedures and 39 provided training to staff. For seclusion, 9 organisations indicated that they provided information and 5 training.

11. On the inclusion of human rights implications in training, 33 organisations indicated that it was included for restraint and 7 for seclusion.

Complaints

12. The response to the questionnaire indicated that 45 organisations had mechanisms in place to scrutinise complaints on restraint and 7 had mechanisms in place for seclusion.

Outcome

13. The responses to the questionnaires and the accompanying papers provides very useful background to the working group in establishing the current positions and considering the extent and content of the guidance required.

Annex G, Appendix

HSS TRUST/OTHER SERVICE PROVIDER

QUESTIONNAIRE ON RESTRAINT & SECLUSION

(Please return completed Questionnaires by 27 June 2003)

Name of Trust/Other service provider: …………………………………………………….

Name of Member of staff
responsible for completing
this questionnaire: …………………..…………………………………………………….

Position in Organisation: ……………………………………………………………

Business area/programme of care ………………………………………………

Contact telephone number:…..…………………………………………………...

E-mail address: …………………………………………………………………

Policies & Procedures

1. Do you have policies and procedures, which inform, across all client groups, the use of:

- restraint of adults Yes ☐ No ☐
- restraint of children Yes ☐ No ☐
- seclusion of adults Yes ☐ No ☐ N/A ☐
- seclusion of children Yes ☐ No ☐ N/A ☐

If you have answered **Yes** to any of the above please forward copies of the policies and procedures when returning the completed questionnaire.

If you have answered **No** please outline below what arrangements are in place to regulate the use of **both** restraint and seclusion.

2. Do you have a definition of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of these with the completed questionnaire.

3. Do you have facilities for seclusion: Yes ☐ No ☐

If **Yes** please provide details on the facility and any other information which you feel would be helpful to us in understanding your provision.

Monitoring Arrangements

4. Has your organisation conducted a local audit of practice in relation to:

- the use of restraint with any client group Yes ☐ No ☐
- the use of seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of the audit report with the completed questionnaire.

5. Do you have pro forma for each client group to record use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please forward a copy of the pro forma with the completed questionnaire.

6. Do you have arrangements in place to review each client group the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **<u>Yes</u>** please provide copies of any pro formas used **or** outline below these arrangements.

<u>Training</u>

7. Do you have arrangements in place to inform staff across all professional groups and programmes of care of your policies and procedures regarding the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **<u>Yes</u>** please outline the arrangements below

8. Do you provide training to staff on the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please attach a sheet detailing the **range** of training provided, the **frequency** at which it is provided and the **number** of staff trained each year. If you have a written training programme on restraint and/or seclusion, please enclose it with the completed questionnaire.

9. Please name the type of training provided, indicating, where appropriate, the accrediting body.

10. Does your training include consideration of the human rights implications of using:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If you have answered **Yes** please outline the issues covered.

Complaints Procedures

11. Do you have mechanisms in place to scrutinize complaints to identify weaknesses and areas for action in respect of the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If you have answered **Yes** please provide details below, including how you have specifically addressed restraint and seclusion issues in this process.

12. If you have any other comments, which you feel would assist us in this area please outline these.

Completed Questionnaires should be returned **by 27 June 2003 to:**

Mrs Heather Humphries
Room C4.22
Castle Buildings, Stormont
BELFAST BT4 3SQ
Email [redacted]

Many thanks for your assistance

ANNEX H

DRAFT GUIDANCE ON RESTRAINT AND SECLUSION IN HEALTH AND PERSONAL SOCIAL SERVICES

EQUALITY IMPACT ASSESSMENT: EQUALITY SCREENING

1. BACKGROUND

1.1 Section 75 of the Northern Ireland Act 1998 requires all public authorities in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity -

- **between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;**
- **between men and women generally;**
- **between persons with a disability and persons without; and**
- **between persons with dependants and persons without.**

1.2 In addition, without prejudice to the above obligation, public authorities must also, in carrying out their functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

1.3 Schedule 9 of the Act requires public authorities to prepare Equality Schemes, which should state, among other things, the authorities' arrangements for assessing the likely impact of policies adopted, or proposed to be adopted, by the authority on the promotion of equality of opportunity. Schedule 9 also requires a public authority, in publishing the results of an assessment, to give details of any consideration given to measures which might mitigate any adverse impact of the policy on the promotion of equality of opportunity and alternative policies which might better achieve the promotion of equality of opportunity.

1.4 Equality Schemes are in place for the Department of Health, Social Services and Public Safety and all Health and Social Services Boards and Trusts. The Department and its associated bodies are committed to promoting equality of opportunity.

2. PROPOSALS

2.1 The proposed guidance on Restraint and Seclusion in Health and Personal Social Services (HPSS) is intended to assist HPSS bodies in developing and implementing policies on restraint and seclusion. The purpose is to protect and promote the human rights of anyone in their care who may be subject to such procedures. It is designed to help ensure compliance with, and respect for, the provisions of the Human Rights Act, which gives effect to the European Convention on Human Rights, and other human rights conventions.

2.2 Restraint and seclusion issues, as defined in the guidance, may arise in a range of care settings, such as residential homes for the elderly, children or disabled people, in hospitals, in day-care centres, health centres and where people are being cared for in their own homes.

3. EQUALITY IMPACT ASSESSMENT SCREENING

3.1 Specific areas of concern in relation to the issues of restraint and seclusion may arise for young people, older people and persons with a disability who are in a position of being cared for, whether in a residential setting or otherwise. It is therefore possible that these proposals could differentially impact on **persons of different age** and **persons with or without a disability**. However, no quantifiable evidence is available on the groups subject to restraint and seclusion procedures in HPSS.

3.2 There is no indication of any differential impact in terms of the other seven Section 75 distinctions:

- **between men and women generally;**
- **persons of different marital status;**
- **persons of different religious belief;**
- **persons with/without dependants;**
- **persons of different political opinion;**
- **persons of different racial group;**
- **persons of different sexual orientation.**

3.2 These proposals are intended to inform the development of policies by Health and Social Services Trusts, Boards and other agencies. All public authorities designated as such for the purposes of Section 75 will in any event have to screen these policies as they are developed, to determine whether a full Equality Impact Assessment is desirable. This fact affords a double safeguard regarding equality of opportunity.

4. CONCLUSION

4.1 The proposals are intended to be entirely beneficial in protecting and preserving the human rights of the people affected. There is no adverse impact on other people. Accordingly, it is considered that the proposals do not have an adverse impact in terms of any of the Section 75 distinctions.

4.2 It is also considered that these proposals will have no effect on good relations between persons of different religious belief, political opinion or racial group.

ANNEX I(a)

HSS TRUST

RESTRAINT REPORT FORM

This form should be completed if physical restraint is used in the management of any incident or accident.

Physical restraint refers to any method of responding to aggressive or violent behaviour which involves some degree of direct physical force to limit or restrict movement or mobility, ie the actions of one person which restricts the movements of another person. Physical restraint implies the restriction of a person's movement which is maintained against resistance. It is therefore qualitatively different form other forms of physical contact such as manual prompting, physical support or guidance.

Physical Restraint may involve:

1. **Direct physical contact between a member of staff and a client** eg holding a client's hand to prevent him hitting etc.
2. **The use of barriers, such as locked doors, to limit freedom of movement,** eg placing someone in a chair with a table in front so that he/she can cannot easily stand up or move away, locking doors, etc.
3. **Materials or equipment which restrict or prevent movement,** eg strapping someone into a wheelchair, having a person wear a helmet to reduce the effects of head banging, placing splints on a person's arms to restrict movement, etc.

(A) Form Reference Number ☐

(B) Type of Restraint used: Physical Contact ☐ Barriers ☐ Equipment ☐

(C) Outline the reasons why restraint was used

(D) Outline details of the method of restraint used (who was involved in the restraint procedure; what procedure was used; who carried out different elements of the procedure; what areas of eth body were in contact etc).

(E) Time restraint started: ☐ Time restraint stopped: ☐
(24 hr clock) (24 hr clock)

(F) Outline the individual's response to the restraint procedure being applied.

(G) Was a body check of the individual completed following the restraint procedure?

Check completed	Check refused	Delayed as may have caused Further aggression
☐	☐	☐

Outline details of any injury noted

(H) Outline the tasks completed in recording and reporting this incident (eg IRI form completed; reported incident to carer, manager etc)

(I) Outline any issues arising from this incident which may influence future contact with this individual.

Name of person
Completing form _________________ Signature ____________________

Date _________________

Please return to ____________________ by ___________________

ANNEX I(b)

HSS TRUST

SECLUSION REPORT FORM

Ward No. Date:

Patient's Name ______________________ Status and Reg No. ____________

Description of Incident ____
____
____
____
____
____
____
____
____
____
____

Alternative Measures Tried Prior to Seclusion ______________________________
____
____
____
____
____
____

Patient checked for harmful objects/clothing Yes/No

Nurses present ____

Authorisation for seclusion given by ______________________________________

Ward Doctor/Duty Doctor informed _______________ At ___________________

Visited by Doctor _________________________ At (time) ___________________

Senior Nurse Manager _____________________ Notified at (time) ____________

Duration of Seclusion: From ____________________ To __________________

Monitor Chart Completed Yes/No

2 Hourly Review by Nurses ____

4 Hourly Review by Doctor ____

Signed: ______________________
(Nurse in Charge)

CLINICAL SERVICES MANAGER'S REPORT

Signed: ______________________

ANNEX J

DENI CIRCULAR NUMBER 1999/9 –

PASTORAL CARE: GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Subject:

Pastoral Care: Guidance on the Use of Reasonable Force to Restrain or Control Pupils

Circular Number:
1999/9

Date of Issue:
8 March 1999

Audience:

- Principals and Boards of Governors of all grant-aided schools;
- Education and Library Boards;
- Council for Catholic Maintained Schools;
- Association of Governing Bodies of Voluntary Grammar Schools;
- Northern Ireland Council for Integrated Education; and
- Teachers' Unions.

Summary of Contents:

This Circular provides clarification and guidance on the use of reasonable force, by teachers and other authorised staff, to restrain or control pupils in certain circumstances. It gives guidance about who can use reasonable force, when it is appropriate to use it, and the procedures for recording incidents where reasonable force was used. It also advises that schools should have a written policy about the use of reasonable force which should be made known to parents.

Enquiries:

Any enquiries about the contents of this Circular should be addressed to:

Mr Jackie Simpson (Tel: 01247-279247)
Pupil Support Branch
Department of Education
Rathgael House
Balloo Road
BANGOR
BT19 7PR

Status of Contents:
Advice
Information for schools

Related Documents:
Circular 1999/10
(Pastoral Care in Schools: Child Protection)

Superseded Documents:
None

Expiry Date:
Not applicable

DENI Website:
This Circular is also available on
http://www.deni.gov.uk

PASTORAL CARE: GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

1. All schools have a pastoral responsibility towards the pupils in their charge and should therefore take all reasonable steps to ensure that the welfare of pupils is safeguarded and that their safety is preserved. The Board of Governors and the Principal of each school also have a duty to promote and secure good behaviour and discipline on the part of pupils at the school.

2. Article 4 of the Education (Northern Ireland) Order 1998, which came into force on 21 August 1998, clarifies powers which already exist under common law. It enables a member of staff of a grant-aided school to use, in relation to any pupil at the school, such force as is reasonable in the circumstances to prevent a pupil from:

   a. committing an offence;

   b. causing personal injury to, or damage to the property of, any person (including the pupil himself); or

   c. engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils, whether during a teaching session or otherwise.

3. The right of a member of staff to use such force as is reasonable to restrain or control a pupil applies:

- where the member of staff is on the premises of the school; or
- elsewhere at a time when he/she has lawful control or charge of the pupil concerned;
- to teachers at the school, **and** to any other member of staff who with the authority of the principal has lawful control or charge of pupils.

4. **The need to use reasonable force to restrain or control a pupil should be rare.** This Circular and the attached Appendix provide clarification and guidance on a number of issues relating to the use of "reasonable force" by teachers and others to restrain or control pupils. **However, it is emphasised that corporal punishment remains unlawful, and that neither Article 4 nor this Circular, in any way, authorise teachers or others to use any degree of physical contact which is deliberately intended to cause pain or injury or humiliation.** The application of reasonable force to restrain or control a pupil is to be used as a last resort, only when other behaviour management strategies have failed, and when the pupil, other pupils, members of staff, or property are at risk, or the pupil is seriously compromising good order and discipline.

Article 4 does not however prevent any person from exercising his/her right under common law to defend themselves against an attack provided he/she does not use a disproportionate degree of force to do so. The purpose of Article 4 is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Need for Schools to Have a Written Policy

5. The use of reasonable force is only one of the strategies available to schools and teachers to secure pupils' safety and well being and also to maintain good order and discipline. All those who may have to use reasonable force with pupils must clearly understand the options and strategies open to them, and they must know what is regarded as acceptable action on their part and what is not. It is important, therefore, that schools have a clear written policy about the use of reasonable force to restrain or control pupils. This should be understood by teachers, authorised staff, pupils and parents and should form part of the school's policy on discipline and child protection within its overall pastoral care policy.

6. In drawing up a written statement of the school's disciplinary policy, as required in Article 3 of the 1998 Order, it is recommended that the Board of Governors, in consultation with the Principal, should:

- include a statement setting out the school's policy and its guidelines on the use of reasonable force to restrain or control pupils;
- discuss these with staff who may have to apply them; and
- issue or make them known to parents and pupils.

Boards of Governors should also have regard to any advice issued by Education and Library Boards and, where appropriate, the Council for Catholic Maintained Schools.

7. The Department has asked a Working Group, comprising representatives from the Education and Library Boards, CCMS and schools, who are already drafting best practice guidelines for schools on a wide range of disciplinary matters, to draft a model policy for schools on the use of reasonable force based on the guidance in this Circular. This will be available later this year. Schools may wish to draw up their own policies in the meantime in order to provide guidance to staff and others on the use of reasonable force and its place in the school's strategies for maintaining good behaviour and discipline.

8. A statement of the school's policy on the use of reasonable force to restrain or control pupils should be included with the information the school gives parents about its overall policy on discipline and standards of behaviour.

9. The Department considers that it would also be useful if schools designated an experienced senior member of staff (the Principal or a senior teacher, or perhaps the designated teacher for child protection) as having special responsibility for providing guidance to other staff on the use of reasonable force. This teacher should also assume responsibility for notifying parents about incidents where reasonable force has had to be used and for dealing with any complaints which may emerge. This will help to ensure a consistent approach within the school to the use of reasonable force and the reporting arrangements.

C JENDOUBI (MRS)
School Effectiveness Division

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Appendix

GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Who may use reasonable force?

Teachers

1. Article 4 of the 1998 Order authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

Non-teaching staff

2. Other members of staff at the school are also authorised to use reasonable force in the circumstances described at 1. above, provided they have been authorised by the Principal to have lawful control or charge of pupils. This might, for example, include classroom assistants, midday supervisors, and escorts. In addition the authorisation could extend to education welfare officers and educational psychologists.

3. In determining which non-teaching staff to authorise, Principals will wish to have regard to the roles and responsibilities of the staff concerned. In particular they should consider whether the staff have a responsibility to supervise pupils as part of their normal duties or whether, from time to time, they may have to take on that responsibility when a teacher is not present.

Volunteers

4. Suitably vetted volunteers normally work only under the direction and supervision of a teacher or other member of staff and should not be expected to assume sole responsibility for the safety and well-being of pupils. Where a situation arises, therefore, where the use of reasonable force may need to be exercised, the volunteer should alert the member of staff in charge and defer to his/her judgement as to the appropriate means of handling the situation.

There may, however, be circumstances in which the Principal may need to authorise a volunteer to use reasonable force in exceptional circumstances. These might include school visits, holidays and residential activities where some degree of delegated responsibility may have to be given to the volunteers in the organisation of activities; where a member of school staff may not be readily available to deal with an incident; and where it is possible that significant harm will occur if action is not taken immediately. Where volunteers are so authorised, it is essential that they receive appropriate training and guidance.

5. **The key issue is that all non-teaching staff and volunteers must be identified and specifically authorised by the Principal to be in control of or in charge of pupils.** The Principal should clearly inform all persons concerned and ensure that they are aware of and understand what the authorisation entails. Principals may find it helpful to arrange for training or guidance to be provided by a senior member of the teaching staff who has been designated as having special responsibility for this matter and who has already received suitable training on the use of reasonable force. Principals should also keep an up to date list of authorised non-teaching staff and others who are so authorised and ensure that teachers know who they are, for example, by placing a list on the staff room notice board.

Where can reasonable force be used?

6. The right of a teacher or other person to use reasonable force applies where the pupil concerned is on the school premises **and** when he/she has been authorised to have lawful control or charge of the pupil concerned elsewhere e.g. supervision of pupils in bus queues, on a field trip, or other authorised out of school activity such as a sporting event or educational visit.

What is meant by reasonable force?

7. There is no precise legal definition of "reasonable force" so it is not possible to state, in fully comprehensive terms, when it is appropriate to use physical force to restrain or control pupils or the degree of force that may reasonably be used. It will always depend on the circumstances of each case. However, there are three relevant considerations to be borne in mind:

- the **use of force** can be regarded as reasonable **only** if the circumstances of the particular incident warrant it. The use of any degree of force is unlawful if the particular circumstances do not warrant the use of physical force. Therefore physical force could not be justified to prevent a pupil from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force;
- the **degree of force** employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. Any force used should always be the minimum needed to achieve the desired result;
- whether it is reasonable to use force, and the degree of force that could reasonably be employed, might also depend on the age, level of understanding and sex of the pupil, and any physical disability he/she may have.

Is it appropriate to use reasonable force in every situation?

8. **Reasonable force should not be used automatically in every situation nor should it be used as a form of discipline. In a non-urgent situation, reasonable force should only be used when other behaviour management strategies have failed.** That consideration is particularly appropriate in situations where the aim is to maintain good order and discipline, and there is no

direct risk to people or property. Any action which could exacerbate the situation needs to be avoided, and the possible consequences of intervening physically, including the risk of increasing the disruption or actually provoking an attack, need to be carefully evaluated. The age and level of understanding of the pupil is also very relevant in those circumstances - physical intervention to enforce compliance with staff instructions is likely to be increasingly inappropriate with older pupils and **should never be used as a substitute for good behaviour management.**

9. Staff may not always have the time to weigh up the possible courses of action and it would be prudent therefore for them to have considered in advance the circumstances when they should and should not use reasonable force. Staff should, whilst taking due account of their duty of care to pupils, always try to deal with a situation through other strategies before using reasonable force. All teachers need to be aware of strategies and techniques for dealing with difficult pupils and situations which they can use to defuse and calm a situation. Best practice guidelines on successful discipline policies are currently being drawn up by a Working Group comprising representatives from schools, the Education and Library Boards and CCMS. These will be circulated to all schools shortly.

When might it be appropriate to use reasonable force?

10. In a situation where other behaviour management strategies have failed to resolve the problem, or are inappropriate (eg in an emergency), there are a wide variety of circumstances in which reasonable force might be appropriate, or necessary, to restrain or control a pupil. They will fall into three broad categories:

a. where action is necessary in self-defence or because there is an imminent risk of injury;

b. where there is a developing risk of injury, or significant damage to property;

c. where a pupil is behaving in a way that is compromising good order and discipline.

11. Examples of situations that fall into one of the first two categories are

- a pupil attacks a member of staff, or another pupil;
- pupils are fighting;
- a pupil is causing, or at risk of causing, injury or damage by accident, by rough play, or by misuse of dangerous materials, substances or objects;
- a pupil is running in a corridor or on a stairway in a way in which he/she might have or cause an accident likely to injure him- or herself or others;
- a pupil absconds from a class or tries to leave school (**NB this will only apply if a pupil could be at risk if not kept in the classroom or at school**).

12. Examples of situations that fall into the third category are:

    - a pupil persistently refuses to obey an order to leave a classroom;
    - a pupil is behaving in a way that is seriously disrupting a lesson.

13. However, some practical considerations also need to be taken into account:

    - Before intervening physically a member of staff should seek to deploy other behaviour strategies. Where these have failed, the member of staff should, wherever practicable, tell the pupil who is misbehaving to stop, and what will happen if he/she does not. The member of staff should continue attempting to communicate with the pupil throughout the incident, and should make it clear that physical contact or restraint will stop as soon as it ceases to be necessary. A calm and measured approach to a situation is needed and staff should never give the impression that they have lost their temper, or are acting out of anger or frustration, or to punish the pupil.

    - Sometimes a member of staff should not intervene in an incident without help (unless it is an emergency), for example, when dealing with an older pupil, or a physically large pupil, or more than one pupil, or if the teacher believes he/she may be at risk of injury. In those circumstances the member of staff should remove other pupils who might be at risk, and summon assistance from a colleague or colleagues, or where necessary telephone the Police. The member of staff should inform the pupil(s) that he/she has sent for help. Until assistance arrives the member of staff should continue to attempt to defuse the situation orally, and try to prevent the incident from escalating.

    - Situations where a pupil refuses to obey an order to leave a classroom need to be handled carefully as they can be a prelude to a major confrontation, especially if reasonable force is used to eject older pupils. Where a pupil persistently refuses to leave a classroom and the teacher believes that the use of reasonable force will endanger the teacher or other pupils, the school should have an emergency response procedure whereby assistance can be summoned quickly, for example a trusted pupil is sent for help.

    - If a school is aware that a pupil is likely to behave in a disruptive way that may require the use of reasonable force, it will be sensible to plan how to respond if the situation arises. Such planning needs to address:

        - managing the pupil (eg reactive strategies to de-escalate a conflict, holds to be used if necessary);
        - involving the parents to ensure that they are clear about the specific action the school might need to take;
        - briefing staff to ensure they know exactly what action they should be taking (this may identify a need for training or guidance);

- ensuring that additional support can be summoned if appropriate.

What might be regarded as constituting reasonable force?

14. Physical intervention can take a number of forms. It might involve staff:

- physically interposing between pupils;
- blocking a pupil's path;
- holding;
- pushing;
- pulling;
- leading a pupil by the arm;
- shepherding a pupil away by placing a hand in the centre of the back; or
- (in extreme circumstances) using more restrictive holds.

15. In exceptional circumstances, where there is an immediate risk of injury, a member of staff may need to take any necessary action that is consistent with the concept of "reasonable force", for example, to prevent a young pupil running off a pavement onto a busy road, or to prevent a pupil hitting someone, or throwing something. **However, staff should never act in a way that might reasonably be expected to cause injury, for example by:**

- holding a pupil round the neck, or by the collar, or in any other way that might restrict the pupil's ability to breathe;
- slapping, punching, kicking or using any implement on a pupil;
- throwing any object at a pupil;
- twisting or forcing limbs against a joint;
- tripping up a pupil;
- holding or pulling a pupil by the hair or ear;
- holding a pupil face down on the ground.

16. Staff should also avoid touching or holding a pupil in any way that might be considered indecent.

What action can be taken in self-defence or in an emergency situation?

17. Neither Article 4 nor the guidance contained in this Circular can cover every possible situation in which it might be reasonable for someone to use a degree of force. For example, everyone has the right to defend themselves against an attack provided they do not use a disproportionate degree of force to do so. Similarly, in an emergency, for example if a pupil is at immediate risk of injury or on the point of inflicting injury on someone else, any member of staff would be entitled to intervene whether or not specifically authorised by the Principal to do so. The purpose of Article 4 and this Circular is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Is physical contact with pupils appropriate in other circumstances?

18. The Code of Conduct for staff which has been issued to all schools makes it clear that, although physical contact with pupils should generally be avoided, there can be occasions when physical contact with a pupil may be proper or necessary other than those situations covered by Article 4. For example, some physical contact may be necessary to demonstrate exercises or techniques during PE lessons, sports coaching, music or technology and design, or if a member of staff has to give first aid. Young children and children with special educational needs may also need staff to provide physical prompts or help. Touching may also be appropriate where a pupil is in distress and needs comforting. Teachers should use their own professional judgement when they feel a pupil needs this kind of support. Guidance on these issues can be found in the Code of Conduct, and also in paragraphs 73 and 74 of the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

19. There may be some children for whom touching is particularly unwelcome, because, for example, they have been abused. Physical contact with pupils becomes increasingly open to question as pupils reach and go through adolescence, and staff should also bear in mind that even innocent and well-intentioned actions can sometimes be misconstrued.

Should incidents where reasonable force is used be recorded?

20. It is extremely important that there is a detailed, contemporaneous, written report of any occasion (except minor or trivial incidents) where reasonable force is used. This may help prevent any misunderstanding or misrepresentation of the incident, and it will be helpful should there be a complaint. Schools should keep an up-to-date record of all such incidents, in an incident book. Immediately following any such incident the member of staff concerned should tell the Principal or a senior member of staff and provide a short written factual report as soon as possible afterwards. That report should include:

- the name(s) of the pupil(s) involved, and when and where the incident took place;
- the names of any other staff or pupils who witnessed the incident;
- the reason that force was necessary (eg to prevent injury to the pupil, another pupil or a member of staff);

- briefly, how the incident began and progressed, including details of the pupil's behaviour, what was said by each of the parties, the steps taken to defuse or calm the situation, the degree of force used, how that was applied, and for how long;
- the pupil's response, and the outcome of the incident;
- details of any obvious or apparent injury suffered by the pupil, or any other person, and of any damage to property.

At least annually, the Chairman of the Board of Governors and the Principal should review the entries in the incident book. Records of incidents should be kept for 5 years after the date they occurred.

21. Staff may find it helpful to seek advice from a senior colleague (eg the Principal or senior member of staff who has been designated to provide training and guidance on the use of reasonable force), or a representative of their professional association when compiling a report. They should also keep a copy of the report.

22. Incidents involving the use of force can cause the parents of the pupil involved great concern. It is always advisable to inform parents of an incident involving their child (other than a trivial incident), and give them an opportunity to discuss it. The Principal, or a member of staff to whom the incident is reported, will need to consider whether that should be done straight away or at the end of the school day, and whether parents should be told orally or in writing.

Are complaints about the use of reasonable force likely to occur?

23. Involving parents when an incident occurs with their child, and having a clear policy about the use of reasonable force that staff adhere to, should help to avoid complaints from parents. It will not, however, prevent all complaints, and any complaint from a parent about the use of reasonable force on his/her child should be dealt with in accordance with the procedures set out in the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

24. The possibility that a complaint might result in a disciplinary hearing, or a criminal prosecution, or in a civil action brought by a pupil or parent, cannot be ruled out. In these circumstances it would be for the disciplinary panel or the court to decide whether the use and degree of force was reasonable in all the circumstances. In doing so, the disciplinary panel or court would have regard to the provisions of Article 4. It would also be likely to take account of the school's policy on the use of reasonable force, whether that had been followed, and the need to prevent injury, damage, or disruption, in considering all the circumstances of the case.

Will suitable training and supporting advice on the use of reasonable force be provided for teachers and other authorised staff?

25. Education and Library Boards are being asked to arrange suitable training courses for a senior teacher in each school who will then be responsible for providing "cascade" training and advice to other staff in the school. Boards are being asked to place an emphasis on and cover behaviour management strategies which seek to avoid the need to use reasonable force to restrain or control pupils. Such training will be in the context of schools' behaviour and child protection

policies. Arrangements are also being made for suitable training to be included as part of INSET and initial teacher training courses.

26. The Education and Library Boards are also establishing multi-disciplinary Behaviour Support Teams, to offer professional advice and practical support to schools on a range of behavioural and disciplinary matters, including the use of reasonable force.

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

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Improving Patient Safety: Building Public Confidence

A Response by the Department of Health, Social Services and Public Safety to the Recommendations contained in Shipman Inquiry Reports 3, 4 and 5

November 2006

CONTENTS

EXECUTIVE SUMMARY

It is reported that most people in Northern Ireland are satisfied with the health and social care they receive, but high profile cases, such as the murders carried out by Harold Shipman, naturally lead to public concerns. The Department of Health, Social Services and Public Safety (DHSSPS) recognises the need to respond to these concerns, to improve systems and processes, and to learn from such catastrophic adverse events.

This document represents a DHSSPS response and Action Plan to Shipman Inquiry recommendations taking into account the Government's response to Shipman Inquiry Reports. Implementation of the action plan will involve health and social care professionals, the public, educational establishments, Health and Social Services (HSS) organisations and the DHSSPS.

The broad thrust of this DHSSPS response and action plan is to improve:-

- death certification (3rd Shipman Inquiry Report);
- systems and processes relating to controlled drugs (4th Report); and
- accountability, professional and organisational performance (5thReport).

Clear guidance for health and social care professionals and managers, strengthened governance arrangements and robust regulation will support the good work of professionals and build public confidence.

It should be noted that the DHSSPS response and Action Plan does not extend to the content of *Good Doctors, Safer Patients (July 2006)* which was written by Professor Sir Liam Donaldson in response to some of the recommendations contained in fifth Shipman Inquiry Report. Published alongside this report is another report – *The Regulation of Non –Medical Healthcare Professions.* Both of these documents are currently being consulted upon across the United Kingdom. Once the outcome of consultation is known in 2006/2007, the DHSSPS will assist in the implementation of UK-wide changes, especially those which have local impact.

Much work has already been done to promote clinical and social care governance and to improve the quality and safety of HSS services; these are described in Section 2 of this DHSSPS response.

Section 3 describes changes to improve the verification and recording of the fact of death and completion of the death certificate on the cause of death, referrals to the Coroners Service, registration of deaths and investigations of unexpected deaths. In addition, it recognises the need to work with other government departments, agencies and establishments to further promote appropriate post mortem examinations and compliance with the Human Tissue Act.

Section 4 outlines improvements to the regulation of controlled drugs, enhancements to local monitoring and inspection arrangements, and the need to improve information for patients and carers. It outlines legislative changes to the Misuse of Drugs Regulations and the need for further policy and regulatory changes to develop the role of the Accountable Officer for controlled drugs taking account of different health and social care settings.

Section 5 highlights work already underway to further embed clinical and social governance in general practice and to encourage reporting and learning from adverse incidents and near misses. In addition, it deals with other quality improvement initiatives, such as improving the monitoring of prescribing, medical appraisal, complaints procedures, whistleblowing, the handling of concerns and the GP practice mortality project. It outlines legislative changes to improve the regulation of family practitioner services. In addition it recognises the need to improve recruitment and employment practices and to improve support and governance arrangements in single –handed GP practices.

Information, education and training form a key component of the local action plan. This will include information for the public as well as training for professionals. The commitment to education and training throughout the action plan reflects the importance of supporting individuals and organisations to constantly improve their practice and promote safe, high quality services.

Patient and public safety are at the heart of the work of the Department of Health, Social Services and Public Safety (DHSSPS). This Response and Action Plan to Shipman Inquiry Reports are part of a much wider reform and modernisation programme of health and social services, and of public services in general. The Action Plan (2006/7- 2008/9) will contribute to ongoing efforts to ensure that the best possible quality of care is provided across the Health and Personal Social Services (HPSS) in Northern Ireland.

A detailed Action Plan is available on pages 39 to 48. This Action Plan identifies which organisations are responsible for specific actions, the anticipated outcome and the timeframe for completion. In summary, the actions cover:

Education and Training

- improve quality and safety through education and training;

Death Certification (Section 3)

- improve verification and recording of fact of death;
- enhance completion of medical certification of cause of death;
- improve referral of death to the coroner;
- enhance use of death certification information;
- promote appropriate post mortem examinations; and
- implement Human Tissue Authority's Codes of Practice.

Controlled Drugs (Section 4)

- improve regulation of controlled drugs;
- improve quality in prescribing through enhanced information systems;
- enhance a centralised pharmaceutical inspectorate;
- develop local arrangements for Accountable Officers for controlled drugs;
- promote liaison with other regulatory bodies;
- improve education and training; and
- provide better information for patients and carers.

Improved Governance Systems and Professional Performance (Section 5)

- convene local group to take forward the outcome of consultation on *Good Doctors, Safer Patients* and *The Regulation of Non-Medical Healthcare Professions*;
- enhance and produce an electronic version of Clinical and Social Care Governance portfolios for general practice and actively encourage their use and positive outcomes;
- amend legislation and develop local standards for private general medical and dental practice;
- clarify reporting arrangements for the management of adverse incidents in primary care and promote the cascade of learning arising from incidents;
- develop an incremental approach to improving the quality of prescribing and the attribution of prescribing data to individual GPs and groups, and support these changes through education and training;
- consult on a revised HPSS complaints procedure;
- produce new guidance on how to raise concerns about professional performance in primary care;
- produce further guidance on the handling of concerns about professional performance, to harmonise procedures across the HPSS;
- improve local regulation of family practitioner services;
- further develop and improve recruitment and employment procedures in general practice;
- improve governance arrangements in single-handed general practices;
- extend the scope of the GP Practice Mortality Project in Northern Ireland; and
- continue to work to enhance medical appraisal systems, taking account of the outcome of consultation of *Good Doctors, Safer Patients*.

SECTION 1
OVERVIEW of SHIPMAN INQUIRY RECOMMENDATIONS

1.0 INTRODUCTION

The aim of this document is to set out the response and action plan of the Department of Health, Social Services and Public Safety (DHSSPS) to the Shipman Inquiry recommendations*,* taking account of developments at national level and local Health and Social Services (HSS) arrangements.

Public safety and confidence in health and social services, and quality improvement, are at the heart of this document. This focus is set in the context of the Shipman Inquiry Reports and recommendations on:

> <u>Death Certification</u> – enhanced processes (3rd Report);
>
> <u>Controlled drugs</u>- enhanced inspection and monitoring arrangements (4th Report); and
>
> <u>Safeguarding patients</u>- enhanced systems to improve clinical governance, professional regulation and performance (5th Report).

In addition to the unlawful activities of Harold Shipman, there are three other major reports which highlight the need to make continued progress to improve the quality and safety of service provision. These are Inquiries into the activities of Clifford Ayling, Richard Neale, and William Kerr and Michael Haslam. The common thread of all of these reports is the failure to protect patients and detect, at an early stage, unacceptable professional performance and to make timely interventions in order to promote patient safety.

1.1 SHIPMAN INQUIRY RECOMMENDATIONS

Dame Janet Smith was appointed chair of the Government Inquiry into the activities of a GP named Harold Shipman. The Terms of Reference of the Inquiry are included in Appendix A. The first two Reports related to the extent of the unlawful killing of patients by Shipman and the police investigation of 1998 into allegations of an unusually high death rate in Shipman’s single handed GP practice.

The 3rd Report - *Death Certification and the Investigation of Deaths by the Coroner (July 2003)* considered the present system of death and cremation certification and variation in practice by coroners together with how a lack of regulation, awareness, training and guidance put patients at risk. There are 48 recommendations contained in the Shipman 3 report. Appendix B provides a summary of these recommendations*.*

The 4th report – *The Regulation of Controlled Drugs in the Community* was published in July 2004. It considered how the systems for regulating controlled drugs allowed Shipman to gather large quantities of diamorphine, a controlled drug, which he then used to kill patients. There are 33 recommendations (Appendix C), which are aimed at improving the regulation, inspection, control, monitoring and audit arrangements of controlled drugs, and of the healthcare professionals who prescribe them.

The 5th Report – *Safeguarding Patients: Lessons from the Past, Proposals for the Future,* was published in December 2004. This explores how systems within the health service, including complaints procedures, concerns raised (whistleblowing), together with the fitness to practise procedures enabled Shipman to evade the notice of the authorities responsible for general practitioners. There are 109 recommendations contained in Shipman 5 *(Appendix D*) which cover a range of initiatives aimed at improving clinical governance arrangements so that underperforming doctors can be detected early and those doctors who are performing well can continue to improve. The scope of these recommendations is complex and far reaching; a number of recommendations relate to reforming the General Medical Council and its disciplinary procedures. These particular recommendations are UK wide issues, and are covered by *Good Doctors, Safer Patients*, a report written by the Chief Medical Officer for England, Professor Sir Liam Donaldson. It outlines major changes at local and national levels to enhance public safety. The consultation on this document closed on 10 November 2006.

The 6th report was published in January 2005. This mainly documented the extent of Shipman's unlawful activities during his career as a junior hospital doctor between 1970 and 1974.

In total, the Shipman Inquiry concluded that Harold Shipman killed about 250 patients between 1971- 1998. Of these deaths, Dame Janet Smith was able to positively identify 218.

1.2 STRUCTURE TO SUPPORT A LOCAL NORTHERN IRELAND RESPONSE

A local Shipman Programme Board was convened by the Department of Health Social Services and Public Safety to provide an integrated response to Shipman Inquiry Reports' recommendations. Its terms of reference and accountability arrangements are included in Appendix E. In addition to the Programme Board, a number of sub-groups have been formed to discuss specific complex issues. There are subgroups on:

a) Education and training, (recognising that this is the major component of the local action plan);

b) Development of whistleblowing policies in primary care;

c) Enhancement of underperformance procedures in General Medical and Dental Practice, taking account of new procedures already in place in the secondary sector, and links with the National Clinical Assessment Service; and

d) Enhancing data collection and analysis of prescriptions in general medical practice.

In addition to the above, the work of the DHSSPS Shipman Programme Board links to other departmental groups and activities, including the Review of the HPSS Complaints Procedures, the Northern Ireland Medicines Governance Team, the Safety in Health and Social Care Steering Group, the Medical Appraisal Working Group and the Review of Public Administration Steering Group.

SECTION 2

QUALITY AND SAFETY- KEY HPSS PRIORITIES

2.0 INTRODUCTION

Northern Ireland is unique in UK terms in having integrated health and social services; this, together with certain legislative, regulatory, funding and service commissioning and provision differences facilitates a slightly different perspective to be taken to Shipman Inquiry Reports' recommendations. However, as with national and international quality developments in health and social care in recent years, there has been a greater local emphasis on quality and safety.

Any local response to Shipman Inquiry Reports' recommendations has to be seen in the wider context of developments, which are currently being undertaken, to continually improve the quality of care and performance of health and social care services.

2.1 SUMMARY OF PROGRESS ON QUALITY AND SAFETY

Quality and safety is at the heart of the work of the Department of Health, Social Services and Public Safety (DHSSPS). *Best Practice, Best Care, (2001) s*et out the framework of the DHSSPS to improve quality and safety. Included in this framework was an emphasis on the need to set standards, improve service delivery, and the monitoring and regulation of Health and Personal Social Services (HPSS). This document contained a commitment to:-

> A new system of clinical and social care governance for the HPSS;
>
> A statutory duty of the HPSS for the quality of services provided;
>
> Enhanced regulation of the HPSS, through the formation of a new Authority, (Regulation and Quality Improvement Authority); and
>
> Formal links with national standard setting bodies such as the National Institute for Social Care Excellence (SCIE), and the National Institute for Health and Clinical Excellence (NICE).

Since then, the breadth of change to promote quality and safety in health and social care provision has been extensive. These include:-

- the imposition, from 1 April 2003, of a statutory duty of quality on the HSS Boards and Trusts;
- opening of the social care register, operated by the Northern Ireland Social Care Council (NISCC), which was established to regulate the social care workforce;

- the establishment, from 1 April 2005, of the Regulation and Quality Improvement Authority (RQIA);
- the development of *The Quality Standards for health and Social Care(2006)* to help ensure greater consistency in the quality of services and governance;
- the development of a range of other standards, e.g. Controls Assurance Standards;
- the establishment of the Clinical and Social Care Governance Support Team to support the HPSS in implementing the statutory duty of quality;
- the establishment of links with a range of national best practice and standard setting bodies e.g. NICE and SCIE;
- publication of *Safety First: A Framework for Sustainable Improvement in the HPSS(2006)* ; and
- the development of new arrangements for monitoring and learning from serious adverse incidents in the HPSS.

In addition, the Department has taken action on a wide range of other issues to drive improvements in quality and enhance safety in the HPSS. This has included, for example, reviews undertaken by the Social Services Inspectorate, reviews commissioned from the Regulation and Quality Improvement Authority and other organisations, and a major reform programme to reduce hospital waiting times.

2.2 REVIEW OF PUBLIC ADMINISTRATION

In November 2005, the Secretary of State for Northern Ireland announced sweeping changes to reform public administration. This includes reform to health and social care systems which has at it heart the approach of putting patients first. Changes will include a reduction in the number of Trusts to five by April 2007; functions of HPSS Boards and some functions of the Department being taken on by a new Health and Social Services Authority, by April 2008, and the formation of a new Patient and Client Council to replace the four Health and Social Services Councils. All of these changes are designed to improve the quality of care commissioned or provided by the HPSS. They will also facilitate integration of governance arrangements within larger organisations and enhance working relationships and the exchange of information between professional groups.

SECTION 3 – DEATH CERTIFICATION

3.0 DEATH CERTIFICATION, REGISTRATION AND INVESTIGATION

The 3rd Shipman Inquiry Report made 48 recommendations (Appendix B) on significant changes to death certification, registration and investigation. Recommendations included that all deaths be formally verified by a healthcare professional; that the medical certificate of cause of death (MCCD) become more detailed including a summary of medical history and the chain of events leading to death; that all deaths be referred to the coroner service for investigation including consultation with the deceased's family; random and targeted checks on MCCDs should be carried out by the coroner service; and that all deaths should undergo the same system of certification regardless of whether disposal was to be by burial or cremation.

In March 2004 the Home Office issued a position paper "Reforming the Coroner and Death Certification Service". This made proposals for changes for England and Wales, taking into consideration recommendations from the Shipman Inquiry and the 2003 Report of a Fundamental Review of Death Certification and Investigation in England, Wales and Northern Ireland. This position paper supported the concept of formal verification of death, certification of the medical cause of death by a treating doctor and confirmation of the cause of death by a Medical Examiner within the coroner service.

In a ministerial statement in February 2006, the Department of Constitutional Affairs gave an overview of reform of the coroner service. This included the creation of a service made up of full-time coroners with national leadership across England and Wales, with increased powers of investigation, increased rights and interaction with bereaved families and improved medical support. However, it was not intended to introduce a requirement to report every death to the coroner for second scrutiny.

3.1 NORTHERN IRELAND RESPONSE TO RECOMMENDATIONS IN THE THIRD REPORT

An Interdepartmental Working Group (DHSSPS and NI Court Service, General Register Office and PSNI) was formed in 2004 to consider the application of Home Office proposals to Northern Ireland. Interdepartmental meetings will continue to consider the relevance of the Department for Constitutional Affairs proposals for England and Wales to Northern Ireland. Implementation of local actions will focus on education and training of healthcare professionals who work within the HPSS. These will be part of the comprehensive educational framework to support implementation the DHSSPS Action Plan in response to Shipman Inquiry Reports 3, 4 and 5.

ACTION: Produce comprehensive education and training framework as a major part of the DHSSPS action plan in response to Shipman Inquiry Reports' recommendations contained in Reports 3, 4 and 5.

3.2 THE CORONERS SERVICE FOR NORTHERN IRELAND

Many of the recommendations relate to the coroners service *(Recommendations 1-12, 18-36, 44-46).* The new Coroners Service for Northern Ireland, which was launched in April 2006, has addressed many of the recommendations from the Shipman Inquiry, including the creation of a new regional service with full time Coroners and lead by a High Court Judge *(Recommendations 3, 10, 11)*, and improving information for the public *(Recommendation 44).*

It is recognised, however, that further work needs to be undertaken to ensure appropriate access to independent medical advice for the new Coroners Service.

ACTION: DHSSPS will support the NI Court Service to consider how the Coroners Service might best obtain appropriate medical advice.

3.3 VERIFICATION OF FACT OF DEATH

Healthcare professionals including doctors, nurses and ambulance personnel can, with appropriate training, verify the fact of death but there is variability in how verification of death is recorded.

ACTION: DHSSPS will issue guidance on appropriate verification and recording of the fact of death (*Recommendation 14)*.

3.4 COMPLETION of MEDICAL CERTIFICATE of CAUSE of DEATH (MCCD)

At present there are no plans to significantly change the forms used for death certification across the UK (*Recommendations 13-15*). However training is required at both undergraduate and postgraduate level to ensure that doctors complete the MCCD appropriately.

Discussion is taking place with those responsible for teaching the medical undergraduate curriculum to see how major clinical and social care governance issues might be enhanced; this will include professional responsibilities in relation to appropriate completion of death certification.

In addition, updated guidance on the completion of MCCDs will be developed and cascaded to all doctors in Northern Ireland. Implementation of this will be supported by education and audit.

ACTION: Guidance for doctors on the completion of MCCDs will be developed by DHSSPS in conjunction with the Coroners Service and General Register Office.

3.5 REFERRAL OF DEATHS TO THE CORONER

Doctors, registrars, police officers and funeral directors are required by the Coroners Act (Northern Ireland) 1959 to refer certain deaths to the coroner. These include death by violence or misadventure, as a result of negligence or misconduct or malpractice, due to a work related disease, or if the person has not been seen and treated for the disease causing death within 28 days prior to their death *(Recommendation 42).* Undergraduate and postgraduate training should facilitate appropriate reporting of deaths to the coroner and cascade advice on how to provide appropriate information to the coroner.

An inter agency group, chaired by the Northern Ireland Office, with input from DHSSPS, is developing a Best Practice Guide for Referring Deaths to the Coroner. This guide will include sections for various professions likely to be involved with deaths that should be referred to the coroner, including doctors, ambulance personnel, police and funeral directors.

ACTION: DHSSPS will contribute to the Interagency Group, chaired by the Northern Ireland Office, to produce Best Practice Guide for referring deaths to the Coroner.

3.6 REGISTRATION OF DEATHS (*Recommendations 42-44)*

Where a death has not been reported to the coroner, a relative will register the death by taking the MCCD to the local registrar's office. Information, based on registration of death, is useful for public health planning, and may also be able to indicate clusters of deaths which would merit investigation.

DHSSPS will work with the General Register Office and the Coroners Service to ensure appropriate completion of MCCD and referral of deaths to the Coroner and consider how information might best be utilised to enhance public health and safety.

ACTION: DHSSPS will issue guidance for doctors and registrars on completion of MCCD and referral to coroners.

3.7 INVESTIGATION OF UNEXPECTED DEATH (*Recommendations 32-35)*

A Memorandum of Understanding on Investigation of Serious Incidents Including Untoward Death was launched in Northern Ireland in February 2006. This was a joint initiative by the DHSSPS, the Police Service of Northern Ireland (PSNI), Health and Safety Executive for Northern Ireland (HSENI) and Northern Ireland Court Service, to bring together relevant agencies in order to improve co-ordination of investigations into serious patient incidents. The Memorandum will take effect in the event of an unexpected death or serious untoward harm to a patient requiring joint or simultaneous investigation by the PSNI, the coroner or the HSENI. This will normally happen if an incident involves criminal intent, recklessness and/or gross negligence or, in the context of health & safety, involves a work-related death or serious injury. Such incidents will be serious and may have significant public safety implications.

In addition, a number of other reports have emphasised the need for procedures to inform the investigation of sudden and unexpected deaths in infants and children. In response to this the DHSSPS established an interdepartmental, interagency and multidisciplinary working group. A draft regional multidisciplinary protocol to be followed in cases of sudden or unexpected child deaths from birth to eighteen years will be published for consultation in early 2007.

3.8 INTEGRATED PATHOLOGY SERVICES

Northern Ireland already has a State Pathology Department which provides dedicated forensic pathology service to the Coroners *(Recommendation 41).* The DHSSPS will work with the Northern Ireland Office, which has responsibility for the State Pathology Department, to ensure appropriate post mortem examinations *(Recommendations 37-39)*.

ACTION : DHSSPS will work with the Northern Ireland Office, to promote appropriate post mortem examination, taking account of recommendations (37- 39) contained in the 3rd Shipman Inquiry Report.

3.9 RETENTION OF ORGANS AND TISSUES

Following the report of the NI Human Organs Inquiry (2002), the DHSSPS issued guidance on post mortem examination, retention and disposal of organs and tissues, and bereavement services *(Recommendation 40)*.

The new Regional Bereavement Network was launched in early 2006. It comprises five Area Bereavement Co-ordinators, based in local hospitals, but who will cover each Health and Social Services Board area. This will help to ensure the standards for consent to post mortem examination and use or disposal of organs and tissues are met.

The Human Tissue Act 2004 established the Human Tissue Authority (HTA), a UK- wide regulatory body. The HTA has developed codes of practice

- covering:
- Consent;
- Donation for transplantation;
- Post Mortem examinations;
- Anatomical examination; and
- Removal, storage and disposal of human organs and tissues.

The Coroners Service for Northern Ireland has appointed Coroners Liaison Officers to explain Coroners investigations, post mortem findings and the retention of any organs and tissues after a post mortem examination, including relative's options for their further use or disposal after the coroner has released them *(Recommendation 40 & 44).*

ACTION: All organisations will be required to practise in line with Human Tissue Authority Codes of Practice (September 2006)

3.10 CONCLUSION

The Department of Health, Social Services and Public Safety will work with the Coroners Service for Northern Ireland, the General Register Office for Northern Ireland, State Pathology Department and the HPSS to consider how improvements in each of the stages of death certification, investigation and registration described above can be improved to ensure effective and proportionate investigation of deaths and an improved service for bereaved families.

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SECTION 4 - CONTROLLED DRUGS

4.0 WHAT IS A CONTROLLED DRUG?

Controlled drugs are an essential part of modern clinical care. They are medicines used to in a wide variety of clinical settings, for example:

- The relief of acute pain after a heart attack or fracture;
- The relief of severe chronic pain;
- Palliative care, for example, for patients with terminal cancer;
- The treatment of drug dependence; and
- Anaesthesia.

Controlled drugs, by their nature have the potential for diversion and misuse, with associated harm. Controlled drugs are already subject to specific controls under the Misuse of Drugs Act 1971 and its associated regulations. The Government, as part of its response to the Fourth Shipman Report, is introducing additional measures to strengthen the controls applying to controlled drugs and to improve safety in their use.

4.1 PRESCRIBING OF CONTROLLED DRUGS

There are considerable overlaps between the recommendations contained in the Shipman Inquiry Fourth and Fifth Reports (see Appendix C & D). Many of the recommendations on enhanced governance arrangements for prescribing supply, administration and disposal of controlled drugs should be seen in the overall context of a clinical and social care governance framework which supports quality improvement, education, informed patient choice and enhanced professional regulation.

The Fourth Shipman Inquiry Report considered whether it would be prudent to impose some restrictions on what is, at present, virtually total freedom of doctors to prescribe controlled drugs (*Recommendations 2 to 6*). It recommended restrictions in four main areas:

- Restrictions on doctors who have no legitimate reason to prescribe controlled drugs as part of their normal clinical practice;
- Restrictions on prescribing controlled drugs for oneself or for one’s immediate family;
- Restrictions on doctors who have been convicted of a controlled drug offence or cautioned in relation to a potential offence; and
- Restrictions on the total quantity that can be prescribed and the length of time for which a prescription remains valid.

Following on from this, the Government’s response to the Fourth Report was published in December 2004 - *Safer Management of Controlled Drugs*. This response acknowledged the need to improve current governance arrangements but emphasised the need to do this in a way which did not hinder patients from accessing the treatment that they needed. It recognised the need to work alongside existing NHS systems for improving and ensuring quality of care. In addition to supporting enhanced arrangements for the prescribing of controlled drugs, *Safer Management of Controlled Drugs* also contains a number of proposals in relation to changes to prescriptions and the prescribing process. The purpose of these proposals is to promote the safe and effective use of all controlled drugs and to strengthen the governance arrangements for controlled drugs.

The DHSSPS supported the broad thrust of recommendations contained in the Government's response outlined in *Safer Management of Controlled Drugs.* However, it also recognised that there were inherent strengths in the centralised Northern Ireland system for monitoring and inspection of controlled drugs, which the Inquiry Chair, Dame Janet Smith, specifically mentioned in the Fourth Report (Section 4.4, paragraph 3).

4.2 DHSSPS ACTION TO IMPROVE THE REGULATION OF CONTROLLED DRUGS

The DHSSPS is responsible for amendments to the Misuse of Drugs Regulations in Northern Ireland. These amendments are consistent with amendments to the Regulations in Great Britain, thus ensuring uniformity of approach across the United Kingdom.

The Fourth Report made a number of recommendations to enhance data capture including electronic controlled drug registers, the use of prescriber and patients identifiers on prescriptions, supply of a patient drug record card (PDRC) [1] and the use of standardised forms for controlled drug (CD) prescriptions.

In summary, these recommendations will:

- Enable prescriptions to be written in any form, including typing, printing and any other mode of reproducing words in a visible form, with only the signature necessarily being handwritten.*
- Provide that records may be preserved in a computerised form in accordance with specified best practice.
- Enable the Department or an Authorised Person to request that a register, which is kept in a computerised form, be produced by sending a copy of it in computerised form to the appropriate person.
- Change the maximum validity of prescriptions for Schedule 2, 3 and 4 controlled drugs to 28 days.
- Limit the amount of controlled drug dispensed on a single prescription to 30 days supply.
- Require the inclusion of unique prescriber and patient identifiers on prescription forms. Whilst this proposal relates to controlled drugs it

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[1] The Patient Drug Record Card has been piloted in three sites in England. Early report would indicate that these pilots have been successful. Further studies would be required before full implementation.

will also enable prescribing data in general to be more accurately attributed to individual prescribers.

- Require the issue of a new private prescription form to allow the capture of data relating to private prescriptions for controlled drugs.**
- Require the keeping of electronic records of controlled drugs prescriptions.
- Assist in the capturing information on GP requisitions for controlled drugs (a mechanism for this data capture is already in place in Northern Ireland).
- Require analysis of GP controlled drugs registers.
- Require Standard Operating Procedures (SOPs) for all organisations which stock, handle or administer controlled drugs.
- Require keeping a running balance of stocks of controlled drugs in the controlled drugs register (this will become mandatory with electronic controlled drugs registers).
- Require pharmacists to seek and record the identity of persons collecting Schedule 2 controlled drugs.
- Require those supplying controlled drugs to prepare and supply a patient drug record card (PDRC) for all patients receiving injectable Schedule 2 controlled drugs. The PDRC would record the supply and administration for these medicines and would form part of the audit trail.
- Allow pharmacists to amend technical errors on controlled drugs prescription forms (This may require changes to the Medicines Act 1968).

* Computer generated prescriptions are less prone to error and therefore enhance patient safety and provide greater flexibility for monitoring and audit purposes *(Recommendation 16).*

** In conjunction with the CSA, a private prescription form for controlled drugs was introduced in July 2006 to facilitate the monitoring of private prescribing of controlled drugs.

These changes are being facilitated by amendments to the 2002 Regulations and are being introduced in a phased approach during 2006.7 (*Recommendations 9 to 15, 17, 20 to 27, 29 and 30).* The first two phases of amendments were introduced in January and July 2006. Further amendments will be introduced in 2007/08 in common with the Home Office Controlled Drugs Legislation Programme.

ACTION: The Misuse of Drugs Regulations will need updating with each new phase of changes to the regulation of controlled drugs.

4.3 ENHANCEMENT OF LOCAL MONITORING AND INSPECTION ARRANGEMENTS

The Inquiry's recommendations concerning monitoring and inspection relate to the situation in Great Britain at the time of the Inquiry, which differs from that in Northern Ireland. These differences were commented upon by Dame

Janet Smith, who considered that there was a lack of co-ordination and expertise of inspectorate arrangements in Great Britain, to oversee appropriate governance arrangements both in the healthcare system and the private sector. The Inquiry recommended replacing the current uncoordinated arrangements in Great Britain with a single, integrated, multi-professional inspectorate (*Recommendation 1*).

During the Inquiry, Dame Janet Smith positively acknowledged the existing arrangements in Northern Ireland. She commented:

"*I was very impressed with the way the system of inspection of arrangements for controlled drugs operates in Northern Ireland. The centralised nature of the inspectorate, and its integration with the Department, confer undoubted benefits.….It seems to me that the main advantage of the system in Northern Ireland is that the Inspectorate covers all aspects of the use and abuse of controlled drugs. On the mainland, the arrangements for inspection are fragmented…..It seems to me that there is much to be said for an inspectorate, like that in Northern Ireland, which is focussed solely on its responsibility for the inspection and monitoring of all aspects of controlled drug use.*"

ACTION: DHSSPS intends to build on its current strength of a centralised inspectorate, taking account of the developments at national level through the development of enhanced local governance arrangements, as outlined in the Health Act 2006.

4.4 THE HEALTH ACT 2006 AND ITS LOCAL IMPLICATIONS

The Health Act 2006, contains three provisions in relation to the Fourth Report of the Shipman Inquiry: -

- The appointment of an Accountable Officer by Designated Bodies. In the context of the proposed legislation, the Accountable Officer will be responsible for ensuring the safe and effective use and management of controlled drugs within the organisation.
- A duty to collaborate and share intelligence on controlled drugs. This will place a legal duty on Responsible Bodies to share information and intelligence, within certain constraints, about the use of controlled drugs in the health and social care sector.
- A power of entry and inspection for certain Authorised Persons, which will facilitate the inspection of controlled drugs.

It is envisaged that these provisions will allow the management and use of controlled drugs within healthcare organisations to be more effectively monitored and audited, without impacting on patient care.

The DHSSPS is enjoined in UK-wide legislation to enhance governance arrangements through the appointment of Accountable Officers within HPSS organisations, the establishment of a statutory duty of collaboration between organisations and increasing powers of entry and inspection for certain

Authorised Persons. This primary legislation will enable the DHSSPS to develop regulations to meet HPSS needs and service configuration.

ACTION: DHSSPS to develop Regulations, to underpin the primary legislation relating to the role and function of the Accountable Officer, taking account of to HPSS needs and organisational structures. These will be consulted upon.

In order to clarify for the HPSS the role and responsibilities of the Accountable Officer and the linkages to other organisations and governance structures, the DHSSPS will develop guidance.

ACTION: Guidance will be issued by the DHSSPS to enable local arrangements for the Accountable Officer to be put in place. This will be consulted upon.

4.4 A CONSOLIDATED AND COMPREHENSIVE APPROACH TO IMPROVING GOVERNANCE OF CONTROLLED DRUGS

Against the backdrop of the recommendations contained in the Fourth and Fifth Shipman Inquiry Reports the DHSSPS proposes to build upon the current arrangements in Northern Ireland, that is:

a. The Departmental Inspectorate, based in the Pharmaceutical Branch of the Department of Health Social Services and Public Safety, will consolidate and augment their current inspection and investigative function both within and out-with the HPSS;
b. Designated Bodies will appoint an Accountable Officer who will have responsibility for compliance with governance arrangements in relation to controlled drugs.

This two-stranded approach builds on existing good practice and the expertise and respect for existing inspection arrangements built up over many years. It will arguably provide the most comprehensive system in the United Kingdom. However, the Department also recognises that these have to be complementary to other regulatory and HPSS governance activities carried out by other regulators including the Regulation and Quality Improvement Authority (RQIA). The legislation underpinning RQIA makes provision for collaborative action in areas where there is duality of interest or responsibility. Discussions have been initiated with RQIA relative to its interface with the Pharmacy Inspectorate of the DHSSPS.

ACTION: Progress discussions with RQIA relative to its interface with the Pharmacy Inspectorate of the DHSSPS.

To implement these new inspectorate arrangements, common standards will be developed for developmental and inspection visits, as will be a competency framework for those involved in developmental inspection and/or enforcement visits.

ACTION: Based on an agreed competency framework, the Department will work with professional and educational organisations to ensure access to suitable initial and update training for those involved in developmental, inspection and/or enforcement work. Where possible, such training will be multiprofessional.

4.5 EDUCATION AND TRAINING

The Department of Health in England, in consultation with professional regulatory bodies and education providers, as appropriate, are reviewing the extent to which the undergraduate and postgraduate curricula for healthcare professionals meets the need for training in the basic principles of the safe use and handling of controlled drugs. It is anticipated that all training will incorporate the requirements of the Misuse of Drugs Act 1971 and its associated regulations as well as the responsibilities of the different healthcare professionals.

Emphasis on good communication between all healthcare professionals and between healthcare professionals and their patients will be a key element in all education and training which will be in the following areas, in the first instance:

- Undergraduate education
- Postgraduate training
- Inspection and Monitoring
- Accountable Officers.

ACTION: As part of the local development of an educational framework, in support the DHSSPS action plan, discussions will be held with stakeholders to ensure effective adaptation of local training programmes, where appropriate, and to facilitate local implementation of best practice.

4.6 INFORMATION FOR PATIENTS AND CARERS

The Department of Health in England, is developing a communications strategy and programme, working in conjunction with colleagues across the UK, to improve the information available to patients and carers in relation to controlled drugs, particularly in areas around safe storage in the home, risk of harm if given to anyone other than the patient for whom they were prescribed and safe return of unwanted medicines to a pharmacy.

It is anticipated that healthcare professionals involved in prescribing, dispensing, supplying and administering controlled drugs to patients should convey any specific information about the legal status of controlled drugs in the context of therapeutic value, shared decision taking and discussion of the appropriate use of medicines. This will be backed up by access to factual information either about controlled drugs in general or about particular drugs.

The strategy will look at access to information through various media including suitable leaflets and internet material.

ACTION: Building on the work that is currently underway at national level, the DHSSPS will ensure information for patients and carers is available to meet local need.

4.7 CONCLUSION

Controlled drugs remain an integral part of patient and client care in a number of health and social care settings.

The DHSSPS fully accepts the need to strengthen arrangements on the use of controlled drugs in the HPSS, and in the private/community and voluntary sectors. However, any changes to current arrangements will be directed to improving patient safety and will not hinder patients from accessing the treatment that they need.

The DHSSPS proposes:

- To make clear that responsibility for the proper management of controlled drugs is an integral part of the clinical and social care governance arrangements of the HPSS, and of private and voluntary sector health and social care organisations;
- To augment and strengthen the DHSSPS's controlled drug monitoring and inspection function;
- To ensure that all prescribing of controlled drugs – which in future will include prescribing by healthcare professionals other than doctors and dentists – takes place in the context of good prescribing practice backed by robust clinical governance frameworks, the appointment of Accountable Officers to Designated Bodies, cooperation between Responsible Bodies and appropriate professional regulatory sanctions;
- To further enhance the capturing of information on prescribing and requisitioning of controlled drugs, including private prescribing, and to provide additional analyses of prescribing patterns;
- To set up information systems which enable an audit trail for the movement of certain controlled drugs, including, for example, injectable Schedule 2 drugs such as diamorphine (subject to satisfactory piloting in other parts in the UK), the supply and administration of drugs to the patient; and
- To ensure that patients receive appropriate information about controlled drugs in the context of an informed discussion with the healthcare professionals involved in their care and against a background of information about the safe handling of prescription medicines more generally.

SECTION 5

IMPROVING GOVERNANCE SYSTEMS AND PROFESSIONAL PERFORMANCE

5.0 INTRODUCTION

In the fifth Report, the main emphasis is on systems and legislative approaches to improvement in performance, and enhanced arrangements for the detection and management of underperformance. There are 109 recommendations in this Report which cover:-

a) Improvements in clinical governance systems in general practice and primary care organisations,

b) Changes to complaints procedures;

c) Dealing with concerns about GP performance, including whistleblowing by other professionals (and their protection);

d) Attribution and monitoring of prescribing in general practice;

e) A system for the monitoring of GP practice mortality rates and improving use of death registers;

f) Improvement in medical appraisal systems;

g) Accreditation of GP practices;

h) Improvement in recruitment arrangements into GP practices;

i) Improved monitoring of doctors' performance, data analysis and exchange of information at local and national levels; and

j) Changes to local and national disciplinary procedures.

5.1 GOOD DOCTORS, SAFER PATIENTS

In July 2006, *Good Doctors, Safer Patients* was published for consultation on a UK wide basis. It was developed by Professor Sir Liam Donaldson to respond to the recommendations contained in the fifth Shipman Report, (primarily those relating to improving medical regulation and medical performance). The consultation closed on 10th November 2006. Published alongside this report was another report called -*The Regulation of the Non – Medical Healthcare Professions.*

The potential impact of *Good Doctors, Safer Patients* is far reaching, not just in terms of changes to medical regulation at national level but also in its emphasis on quality improvement and patient safety arrangements in NHS organisations and GP practices, and on the role of employers in local regulation.

ACTION Once the outcome of the consultation on *Good Doctors, Safer patients* is known, the DHSSPS will convene a local group to determine how best the recommendations might be taken forward locally, taking into account different HPSS organisational structures, legislation and governance arrangements.

ACTION: Local changes emerging from the outcome of the review of *The Regulation of the Non Medical Healthcare Professions*, will be taken forward, in collaboration with the different professional groups.

5.2 A FOCUS ON QUALITY AND SAFETY IN THE HPSS

In support of good governance and best practice in the HPSS, *The Quality Standards for Health and Social Care* were published in March 2006. These are complemented by *Safety First; A framework for Sustainable Improvement in the HPSS (2006).* The latter document sets out the Department's policy to promote safety and this is supported by a comprehensive action plan, one element being the development of specific actions relating to Shipman Inquiry Report recommendations. Many of the themes, identified in the 5th Shipman Report overlap with both of these documents, which are designed to raise standards of care, recognising that public involvement in the commissioning, delivery, monitoring and evaluation of health and social care services is essential in order to have a greater understanding of mutual needs and to improve patient experiences and outcomes.

5.3 CLINICAL AND SOCIAL CARE GOVERNANCE IN GENERAL PRACTICE

Dame Janet Smith placed significant emphasis on the role of clinical governance in primary care recognising that this was relatively underdeveloped. *"It seems to be clear that there is indeed some way to go before clinical governance is fully implemented in primary care"* (12.136 – Inquiry Fifth Report). In the context of Shipman, Dame Janet Smith envisaged "clinical governance" as a means to detect underperformance. However, it is recognised that clinical governance has much broader aims relating to both accountability and the general improvement in quality of care. This is about "shifting the mean" on the quality curve so that good practitioners (the majority) strive towards excellence and poor performance is either improved or removed. To do this requires an understanding of the variation in practice and a system that promotes, learns, and shares best practice, and detects, manages and minimises the impact of errors.

5.4 DEVELOPMENT OF CLINICAL AND SOCIAL CARE GOVERNANCE (CSCG) IN GENERAL PRACTICE

The current culture in general practice in Northern Ireland is no different from the rest of the UK in that CSCG is relatively underdeveloped at practice level.

In 05/06, a baseline assessment across the majority of GP practices took place. The assessment looked at the level of practice involvement in the following areas:

- Continuing professional and personal development;
- Audit;
- Risk assessment and risk management;
- Complaints management;
- Evidence-based practice;
- User involvement;
- Identifying, promoting and sharing good practice, learning lessons from best practices as well as poor performance;
- Significant event auditing;
- Professional regulation.

The work to develop clinical and social care governance is designed to bring these and other relevant components together to secure a co-ordinated approach to the provision of high quality care and treatment, while ensuring a focus on the standard of clinical and social care practice. Such an approach will promote high quality effective treatment and care and will ensure that where things go wrong, they are quickly addressed and lessons are learnt to help prevent reoccurrence.

Many CSCG activities have become well established in GP practices over the years, such as, clinical audit and evidence-based chronic disease management programmes. Some of the activities have been more recently introduced e.g. GP appraisal.

Governance in any family practitioner service extends beyond contractual arrangements. It involves GP practices participating in new Northern Ireland arrangements for the promotion of public safety, for example, adverse incident reporting and the further strengthening of whistle blowing policies. It is, however, important that regulatory changes (see below) underpinning good governance are continually reviewed and updated.

5.4.1 General Practice CSCG Toolkit and Portfolio

The CSCG portfolio, as it is known, has been developed on a multi-agency basis involving Clinical and Social Care Governance Support Team (CSCGST), Northern Ireland Medical and Dental Training Agency (NIMDTA), Boards, General Practices and DHSSPS. It provides a set of resource material and practical guidance, taking account of important clinical and social care governance areas, as identified above. It also provides a structured recording format to allow practices to demonstrate their CSCG activities. It includes a section on good practice in the management of controlled drugs. The portfolio will be regularly revised to keep it up to date, taking account of local and national developments on quality and safety.

5.4.2 The Portfolio in 06/07

The portfolio is now being produced on disk following learning from practices in 05/06. In addition, it is to be amended to include guidance on particular areas identified as “gaps” in 05/06 e.g. how to check that an employed nurse is registered. The portfolio will also be streamlined to better fit with the DHSSPS five key quality themes, as identified in the *Quality Standards for Health and Social Care* and will be continually updated electronically.

ACTION: HSS Boards/NIMDTA to produce portfolio electronically in 06/07, and thereafter maintain and develop the CSCG portfolio to take account of local and national developments on quality and safety.

ACTION: All GP practices will be actively encouraged to use the portfolio as part of their practice clinical governance commitment and as evidence of participation in quality improvement and continuing professional development.

5.4.3 Assessment of GP Practices in 05/06

92% of GP practices in Northern Ireland participated in the assessment of clinical and social care governance. The results over the eight domains of CSCG activity, as identified above, have been analysed across each of the four HSS Boards. These results drill down within each of the eight domains into sub domains.

ACTION: HSS Boards will provide a feedback report to all GP practices by Autumn 2006

ACTION: Development needs arising from this process will be supported by regional and/or local education and training, where appropriate, for example, on risk management and the use of risk registers in general practice.

5.5 DEVELOPMENT OF QUALITY STANDANDS

The HPSS Quality Standards, which underpin clinical and social care governance, were published in March 2006. These will be used by RQIA to publicly report on the quality of care provided by the HPSS. RQIA has recently published its methodology for undertaking HPSS clinical and social care governance reviews in 2006/7. Further work will be done to clarify how the Quality Standards might be adapted for general medical services, taking account of GP contractual arrangements and existing CSCG initiatives in primary care.

ACTION: DHSSPS/HSS Boards to consider how the Quality Standards might be made more meaningful to a general practice setting, taking account of existing contractual commitments and clinical and social care governance mechanisms already in place.

5.5.1 CSCG in Primary Dental Care

Considerable work has already been undertaken to progress clinical and social care governance in general dental practice. This includes the development of a local quality assurance manual, an established quality assurance and monitoring system and education and training programme. A clinical and social care governance action plan has been developed to promote governance in primary dental care.

5.5.2 Private general dental and general medical practice

It is acknowledged that further work is required in respect of the development of standards to enhance the regulation and inspection of private general dental (and medical) practice. These practices should be subject to regulation and assessment by the Regulation and Quality Improvement Authority (RQIA), but to do this requires legislative change and the development of specific standards. Development of such standards would draw on the content of the Care Standards already produced for independent hospitals and clinics. Legislative changes will require consultation.

ACTION: Consult on amendments to legislation, and develop local standards for private general dental (and medical) practice, to enhance governance arrangements through inspection and regulation by the Regulation and Quality Improvement Authority, by April 2008.

5.6 REPORTING, MANAGING AND LEARNING FROM ADVERSE INCIDENTS AND NEAR MISSES IN FAMILY PRACTITIONER SERVICES

Both the *Quality Standards for Health and Social Care* and *the Safety First Framework* recognise the importance of culture change to promote quality improvements. Part of this culture change is the promotion of a reporting and learning culture so that adverse incidents can be appropriately managed and investigated and that lessons can be cascaded to others, in order to prevent reoccurrence of incidents. A Regional Reporting Systems Project, led by the Regional Governance Adviser, is underway to standardise definitions, reporting forms and the coding of incidents. Initially commenced in the secondary sector, this project will extend to primary care in 2006/2007.

It is recognised that the promotion of culture change requires education and support. For example, there is different terminology used in general practice, including “significant event analysis”, “adverse incident/events” and “serious adverse incidents”. All of these have slightly different meaning for those involved in the reporting and learning from such incidents. However, the common thread is participation in a system which facilitates quality improvement and the cascade of learning and best practice.

ACTION: Regional Governance Adviser, in collaboration with HSS Boards/HSS Authority and primary care professionals, to clarify reporting and management arrangements for adverse incidents in primary care, as part of the wider HPSS project to promote and standardise reporting and learning from adverse incidents.

ACTION Reporting and learning from adverse incidents in the Family Practitioner Services will be supported by a multidisciplinary education and training programme.

5.7 ENHANCED MONITORING OF PRESCRIBING IN GENERAL PRACTICE

Recommendation *20 and 21* of the Shipman 5 Report relate to the attribution of all prescribing data to individual practitioners, paying particular attention to enhanced arrangements for the monitoring of controlled drugs. 27 million prescriptions per annum are dispensed in the community at a cost of £375 million in 2005. COMPASS reports, which monitor trends in prescribing, and supplies general practitioners and others with useful information about prescribing at practice level, does not yield information about individual prescribers.

The main focus for further development of data collection and analyses of prescriptions will be to improve the effectiveness and efficiency of prescribing, recognising that although there will be many new prescribers in the HPSS in the future, the current systems and reports on prescribing in general practice do not provide a comprehensive picture of prescribing. Changes would improve clinical and social care governance arrangements at GP practice and HPSS Board/Authority level and provide additional data for individual practitioners which could be used, for example, as part of appraisal and continuing professional development.

The production of individual prescribing reports for “principals” in general practice, would require little enhancement to the current COMPASS system. But the success of such a system is dependent on a GP, responsible for the care of an individual patient, writing a prescription on his/her prescription pad containing the correct cipher number. Given the complexities of general practice, with the vast majority of prescriptions generated being computer repeat prescriptions, this is not always easily achieved. In addition, further consideration will have to be given to how to capture the prescribing patterns of locums and other sessional doctors, who, at present, do not have individual cipher numbers and have no monitoring undertaken.

In order to give further consideration to these areas, the Department has convened a subgroup, chaired by the Central Services Agency, to determine how some of these issues might be addressed. Whilst it envisaged that in the longer term electronic prescribing will provide major opportunities to improve prescribing systems, there is a need to develop an incremental approach to enhance the attribution of all prescribing data as part of clinical and social care governance arrangements at individual, GP practice and Health and

Social Services Board/Authority levels. This may include development of individual prescribing reports to GP “principals”; standardised reports on prescribing in single handed GP practices and the provision of GP practice reports on the prescribing patterns of locums employed by the practice.

ACTION: Through the subgroup on prescribing, produce recommendations on an incremental approach to the attribution of prescribing data as part of the commitment to providing timely clinical governance data to individual GPs, GP practices and the HPSS Boards/Authority.

It is recognised that such changes will only be successful if they are accompanied by changes in GP prescribing systems at practice level and supported by changes in GP prescribing behaviour. This will require support, education and training.

ACTION: Support any changes to prescribing systems with an education and support programme to enhance the validity of the data and promote its uses.

5.8 HPSS COMPLAINTS PROCEDURES

The fifth Shipman Inquiry Report included recommendations *(1-18)* which impact on complaints procedures. Whilst the focus is on GPs, some of the recommendations are generic in nature and could have applicability across the HPSS.

The DHSSPS has recently published, for consultation, a revised HPSS Complaints procedure. This revised HPSS complaints procedure has taken into account some of the recommendations made in the fifth Shipman Inquiry Report. The revised complaints procedure is based on the principles of:

- Open and easy access;
- Fair and independent;
- Responsive;
- Promotion of a culture of learning.

The document aims to:

- Raise the standards of complaints handling - by removing barriers to access, strengthening local resolution, clarifying roles and responsibilities and emphasising the importance of learning and improving; and

- Advise and support patients and users – by providing choice, encouraging conciliation and advocacy services and ensuring training.

It considers the tiers of complaints’ investigation and links the HPSS complaints procedures to other statutory obligations under the Children (Northern Ireland) Order 1995, whistleblowing procedures (internal complaints) and the need to offer a timely apology and explanation, if appropriate, of what went wrong and remedial treatment, where necessary.

ACTION: DHSSPS to consult on revised HPSS complaints procedures in 2006. Analyse responses and produce final document by early 2007.

5.9 RAISING CONCERNS (WHISTLE BLOWING)

The fifth Report made a number of recommendations relating to provision of advice, policies and procedures in NHS and private healthcare sectors, to enable staff to raise concerns about the clinical practice or behaviour of individual members of staff *(recommendation 34-38).* This important issue is also highlighted in other Inquiry Reports, such as Kerr/ Haslam.

The DHSSPS is mindful that sometimes staff can have serious concerns about what is happening within their place of work but are too afraid, or unsure how to raise them. Failure to heed warnings has, on occasions, led to devastating consequences for patients, families, staff and healthcare professionals. It is recognised that staff need to be aware of how to raise their concerns and to feel confident to do so.

In January 2000, the Department issued guidance to Health and Social Services Boards and Trusts on the Public Interest Disclosure (Northern Ireland) Order 1998 and the responsibilities of employers. Whilst the underpinning legislation covered all HPSS staff, the guidance did not extend to healthcare professionals working in family practitioner services. This is currently being developed. The DHSSPS intends to issue this guidance to GPs, Dentists, Pharmacists and Opticians by early 2007.

ACTION: DHSSPS to produce policy guidance for HSS Boards/HSS Authority and family practitioner services on how to raise concerns when the performance of an individual primary care practitioner gives rise to concern. This guidance will be accompanied by practice –based leaflets for cascade to staff at local level.

5.10 HANDLING OF CONCERNS ABOUT HEALTH AND SOCIAL CARE PROFESSIONALS

All HPSS organisations have structures and procedures in place for the handling of concerns about the performance of health and social care professionals.

The National Clinical Assessment Service (NCAS) provides expert support to HPSS organisations when concern is expressed about the performance of a HPSS doctor or dentist. This support can range from advice, when the problem first arises, through to formal assessment of performance.
In November 2005, the Department issued "*Maintaining High Professional Standards in the modern HPSS*. This document is a framework for the handling of concerns about doctors and dentists in the secondary sector. It

outlines formal and informal processes that need to be in place in order to improve public safety.

Building on the expertise of NCAS and on the new procedures developed for the secondary sector, guidance will be developed for the primary care sector, to harmonise procedures across the HPSS. A subgroup has been formed to take forward this work. Where formal fitness to practise procedures have to be embarked upon, these will need to take account any new procedures, which emerge following consultation on *Good Doctors, Safer Patients.*

ACTION: DHSSPS to produce guidance on the handling of concerns about performance of general medical and general dental practitioners in the HPSS to harmonise procedures across the HPSS.

5.11 IMPROVING LOCAL REGULATION OF FAMILY PRACTITIONERS SERVICES

Taking account of the issues raised from the Shipman Inquiry, along with its broader health care responsibilities, the DHSSPS proposes to further strengthen the quality of primary care services. In this respect, work is already in hand to introduce Primary Legislation before the end of 2006. The legislative provisions include: -

> extending the functions of the Health Service Tribunal and the powers of the four Health and Social Services Boards in order to address issues regarding suitability, efficiency and probity of GPs, Dentists, Opticians and pharmacists; and
>
> introducing a requirement for practitioners applying to join a Health and Social Services Board List or for those already on such a List to provide certain additional information to the relevant HPSS Board or Boards. This will help demonstrate their fitness to be listed and thus improve the treatment and care of patients.

Currently, for a GP to work in general practice in Northern Ireland, for example, as a locum, out of hours practitioner or contracted GP, the GP needs to be included in the Performers List, which is underpinned by Regulation. A Regional Primary Medical Performers List Advisory Committee has been formed with wide stakeholder involvement, including lay representation, to act in an advisory capacity to HSS Boards, as HSS Boards currently remain accountable for the management of the Performers List within their geographical area. This new Committee advises on changes to procedures and processes to standardise application of the Performers List. Where necessary, the Advisory Committee will provide advice to a HPSS Board where an application to the Performers List raises specific concerns. Such an approach will improve the systems for the sharing of information and best practice across the region and will enhance the quality of general practitioners approved for inclusion in the Performers List.

ACTION: Regional Primary Medical Performers List Advisory Committee to provide HSS Boards with ongoing advice to enhance systems approaches to the management of the Performers List and to advise on specific applications.

When applying to the Performer's List, a GP is required to declare any reasons for dismal from previous employment, criminal convictions, removals from Performers Lists or disqualifications *(Recommendation 44).* In addition, he/she must provide information about any investigation being undertaken against him/her as part of the conditions for continued inclusion of their name on the List. A police check is now also undertaken for new applicants.

5.12 IMPROVEMENT IN RECRUITMENT AND EMPLOYMENT PROCEDURES (*Recommendations 30-33)*

Any application to the medical Performers List requires a new GP to include references to enable checking to take place before an application is endorsed. In addition, the GP contract requires GP practices to follow statutory requirements in respect of employment of individuals. All practices should have clinical governance systems in place which enables quality assurance of its services and promote quality improvement and enhanced patient safety. These systems are reviewed by the contracting HSS Board as part of their commitment to clinical and social care governance in general practice.

In order to enhance employment procedures and to encourage the checking of references, information on good recruitment practices, sample job specifications and advertisements and a standard recruitment form will be included in the Clinical and Social Care Governance portfolio for general practice.

ACTION: Provide further information for GP practices within the CSCG portfolio to enhance recruitment practices and the taking up of references.

5.13 IMPROVING GOVERNANCE ARRANGEMENTS IN SINGLE HANDED PRACTICES (*Recommendation 29)*

Of the 371 GP practices in Northern Ireland, 73 are single-handed. Proportionately, this is similar to other areas in the UK.

Single handed general practitioners are subject to the same contractual, professional and clinical governance arrangements as other GP practices. It is acknowledged that being a single handed GP does not necessarily imply any diminution of service to registered patients. However, any working environment which facilitates professional isolation has the potential to generate clinical and social care governance problems. Within the current General Medical Services arrangements, HPSS Boards are reluctant to endorse the commencement of a new single-handed GP practice, for example, when there is a split in a practice partnership. When a partnership split occurs, some HPSS Boards canvass the registered patients to determine satisfaction with proposed new services prior to reconfiguring local GP services.

Whilst HPSS Boards do provide additional support, when needed, for single – handed practices, for example, placement of a mentor in a practice, this is mainly a reactive rather than a proactive approach to the promotion of good governance. There has been no formal attempt to identify the needs of individual single-handed GP practitioners in the context of support or professional or service development with the aim of improving the quality of care.

ACTION: An assessment of the needs of single-handed GP practices will be done, with the involvement of single-handed GPs and others, with the aim of improving quality and governance arrangements through support and networking for single-handed practices.

The Shipman Reports identified prescribing as a major area of risk. As part of the sub-group work on prescribing, due consideration will be given to extending standardised prescribing reports to singe-handed GP practices to facilitate comparison and learning between single-handed practices.

5.14 PRACTICE MORTALITY MONITORING AND ENHANCED USE OF DEATH REGISTERS (*Recommendations 22-24)*

A project on the monitoring of GP practice mortality data commenced in 2002. The project included the collation, linking and analysis of routine mortality data and involved partnership working between the HSS Boards, the Central Services Agency and the University of Birmingham.

In addition to this, the Eastern Health and Social Services Board carried out further analysis and developed a methodology and process for investigation of high and low mortality at practice level. This was published in September 2005 in the British Journal of General Practice. It concluded that it was possible to explain all outlying practice mortality rates and, most importantly, retain the confidence of practices and GPs.

Further work will be undertaken in 2006 - 2008 to extend the scope of this project with the aim of having a greater understanding of the variation of mortality rates across Northern Ireland. Implementation of the outcomes of this extended project would lead to annual mortality monitoring and would facilitate enhanced use of death registers in practices. In addition it is recognised that the wider application of the methodology used in this project may support quality improvements in other areas.

Improvement in monitoring of GP practice mortality would mean that all GP practices would routinely receive mortality data which would contribute to clinical and social care governance at practice level.

ACTION: HSS Boards to extend the scope of the of the GP Practice Mortality Project to enhance knowledge of variation in GP practice mortality rates across Northern Ireland.

ACTION: Support extension of this project with an educational programme for general practice staff to highlight the benefits and uses of mortality data and the methodology as applied to other routinely collected primary care data.

5.15 MEDICAL APPRAISAL *(Recommendation 25-26)*

Good Doctors, Safer Patients makes a number of recommendations relating to increasing the objectivity of medical appraisal, as part of the 2- stage approach to the revalidation of individuals. The document recognises that there is a need for standardisation within appraisal systems. It also recognises the contribution that appraisal can make to professional development of the individual, and service and quality improvement.

From April 2006, operational responsibility for GP appraisal transferred from HSS Boards and the Regional GP Appraisal Group to a management committee led by Northern Ireland Medical and Dental Training Agency (NIMDTA). This arrangement is underpinned by a formal agreement between HSS Boards and NIMDTA. Appraisers are now employed by NIMDTA to provide high quality appraisals in line with their employment contract. This centralised approach provides an opportunity to standardise the GP appraisal system and to regularly review and update skills and knowledge of appraisers. In addition, further work is being undertaken to enhance the quality assurance of appraisal content and documentation.

A Review of Medical Appraisal in Northern Ireland was commissioned by the DHSSPS in 2005. This Report (January 2006) highlights the need to continue to work towards improving local appraisal systems, not just in general practice but also for all groups of doctors who work within HSS Trusts and Boards, including doctors in training and employed locum doctors.

ACTION: HSS Boards, Trusts and NIMDTA will continue to work to enhance current appraisal systems, recognising that appraisal systems will undergo further change once the outcome of the consultation on *Good Doctors, Safer Patients* is known.

5.16 CONCLUSION

At a time of organisational change within the HPSS, there remains a need to continue to promote quality improvements, professional performance and public safety. Much has already been achieved to promote clinical and social care governance within the HPSS. But more can always be done. The fifth Shipman Inquiry Report provides an opportunity to improve governance arrangements and professional performance in family practitioner services. A greater understanding of variation in practice will shift the “quality curve” towards excellence. The actions identified in this section will be supported by the sharing of best practice and educational and training programmes.

Good Doctors, Safer Patients is a UK wide consultation document which promotes major changes to the professional regulation of doctors. Following completion of this consultation, the DHSSPS will work with local and national organisations to implement change. A complementary UK document on improving non medical regulation will also facilitate change.

ACTION PLAN 2006/2007- 2008/2009

IMPROVING QUALITY THROUGH EDUCATION AND TRAINING				
Action	**Responsibility**	**Outcome**	**Shipman Inquiry Recommendation(s)**	**Completion date**
Produce comprehensive education and training framework in response to Shipman Inquiry Reports' recommendations contained in Reports 3, 4 and 5.	DHSSPS (lead HRD working with professional groups)	Support professionals and facilitate change in death certification processes, controlled drugs management and specific aspects of clinical and social care governance	All relevant recommendations which have local impact	Implement framework by April 2008
DEATH CERTIFICATION - 3RD SHIPMAN INQUIRY REPORT				
Support the NI Court Service to consider how the Coroners Service might best obtain appropriate medical advice.	DHSSPS (Medical and Allied Group) with Coroners Service	Complete scoping exercise on provision of independent medical advice to Coroners Service	1-12, 18-36 & 44-46	September 2007
Issue guidance on appropriate verification and recording of the fact of death.	DHSSPS with NI Ambulance Service and HPSS Professional groups OOH Services	Reduce variability in how verification of death is recorded Develop and cascade best practice	14	April 2007

DEATH CERTIFICATION - 3RD SHIPMAN INQUIRY REPORT *(Continued)*				
Action	**Responsibility**	**Outcome**	**Related Shipman (3rd) Recommendations**	**Completion date**
Produce guidance for doctors on the completion of Medical Certificate of Cause of Death (MCCD).	DHSSPS with Coroners Service and General Register Office	Clarity of best practice for the completion of MCCDs	13-15	September 2007
Develop a best practice guide for referring deaths to the Coroner.	NIO with Coroners Service, PSNI, Ambulance Service & DHSSPS	Convene Interagency Group- agree best practice and produce guidance Appropriate referrals to coroners- service improvement	42	June 2007
Issue guidance for doctors and Registrars on MCCDs and referral to the coroner.	DHSSPS, Coroners Service and General Register Office	Improvement in referrals to Coroner Improvement in usefulness of information for public health	42-44	October 2007
Promote appropriate post mortem examination.	DHSSPS with Northern Ireland Office	Improved autopsy standards and appropriate use of pathology services	37-39	June 2007
HPSS to practice in line with Human Tissue Authority Codes of Practice (Sept. 2006).	HPSS Trusts	Compliance with obligations under the Human Tissue Act 2004	40-44	November 2006

ENHANCING PRESCRIBING, REGULATION, CONTROL AND MONITORING OF CONTROLLED DRUGS				
Action	**Responsibility**	**Outcome**	**Related Shipman ($4^{th)}$ Recommendation(s)**	**Completion date**
Amend Misuse of Drugs Regulations (Northern Ireland) 2002. (Amendments to Regulations implemented 16th January 2006 and 7th July 2006) Further amendments to be introduced during 2007/08 to mirror changes introduced by the Home Office for GB.	DHSSPS (lead Pharmaceutical Inspectorate with Health Development Directorate) in conjunction with amendments introduced by the Home Office for GB	Improvement in prescribing, regulation, control and monitoring of controlled drugs in the statutory, voluntary, community and independent healthcare sectors,	9-15, 17, 20-27, 29 & 30	Ongoing
Build on the current strength of the centralised inspectorate taking account of developments at national level, including the Health Act and local governance arrangements.	DHSSPS (lead Pharmaceutical Inspectorate with HSS organisations and RQIA)	As above. Improved governance arrangements and collaborative working	1	April 2008

ENHANCING PRESCRIBING, REGULATION, CONTROL AND MONITORING OF CONTROLLED DRUGS				
Action	**Responsibility**	**Outcome**	**Related Shipman (4th) Recommendations**	**Completion date**
Develop Regulations, to underpin the primary legislation, relating to the role and function of the Accountable Officer, taking account of HPSS needs and organisational structures and to issue guidance to the HPSS and other organisations to enable the Accountable Officer function to be put in place. Consultation paper to be issued by April 2007 and Regulations to be enacted by April 2008.	DHSSPS (leads Pharmaceutical Inspectorate and PCCD)	Promote safer use and management of controlled drugs within HPSS organisations, through Accountable Officer. Commence legal duty on responsible bodies to share information and intelligence about the use of controlled drugs. Increase powers of entry and inspection of controlled drugs.	1	Guidance - April 2007 Regulations April 2008
Progress discussions about monitoring and regulation of pharmaceutical services. *Agree the areas of commonality between the DHSSPS Inspectorate and RQIA and the essential components of the inspection process.*	DHSSPS (lead pharmaceutical Services with PPMD) and RQIA	Avoidance of duplication of inspection arrangements Consistency of the inspection process across inspection bodies Sharing of information	1	December 2006

ENHANCING PRESCRIBING, REGULATION, CONTROL AND MONITORING OF CONTROLLED DRUGS				
Action	**Responsibility**	**Outcome**	**Related Shipman (4th) Recommendations**	**Completion date**
Agree a competency framework to ensure access to suitable initial and update training for those involved in, inspection and/or enforcement work.	DHSSPS (lead pharmaceutical Services) with educational establishments	Standardisation of pharmaceutical inspection Enhanced skills and competence of inspectors	1	April 2007
Adapt local training programmes to enhance safe use and handling of controlled drugs. *(A CPD programme for the postgraduate training of pharmacists was delivered between September and November 2006).*	DHSSPS (lead Pharmaceutical inspectorate with Dept of Health England) Local professional groups, educational establishments universities	Safe and effective use of controlled drugs through enhanced → Undergraduate training → Postgraduate education Enhanced knowledge of changes to Misuse of Drugs regulation and local governance arrangements for controlled drugs	General	April 2008
Improve information on controlled drugs for patients and carers *Participate in the national programme to improve information to patients and carers*	DHSSPS (lead pharmaceutical inspectorate with Dept. of Health in England), HSS Councils and patient support groups	Improved patient and carer information and involvement in the safe and effective use of controlled drugs	General	April 2007

IMPROVING GOVERNANCE, SYSTEMS AND PROFESSIONAL PERFORMANCE (5th Report)				
Action	**Responsibility**	**Outcome**	**Related Shipman (5th) Recommendation(s)**	**Completion date**
Convene local group to consider local implications following consultation on "Good Doctors, Safer Patients".	DHSSPS (lead Medical and Allied Group with HRD)	Commence implementation of recommendations, consider local legislative impact, and organisational structures and governance arrangements	49- 109 (and may impact on others)	February 2007 / onwards
The outcome of the review of "The Regulation of the Non Medical Healthcare Professions" will be taken forward.	DHSSPS (lead HRD with professional groups)	Enhanced regulation of professionals	Note above, Review was strongly influenced by Shipman Inquiry	February 2007 / onwards
Produce CSCG portfolio for general practice electronically.	CSCGST & NIMDTA	Improve quality of general practice and enhance continuing professional development of practitioners	General	September 2006/ onwards
Encourage GP practices to use CSCG portfolio.	HSS Boards with DHSSPS (lead Medical and Allied with CSGST and NIMDTA)	Demonstration of commitment to implementation of CSCG in general practice Improve quality of care and enhance professional development of practice staff	General	Ongoing
Produce CSCG feedback report following baseline assessment in 2005/6	HSS Boards with DHSSPS (lead Medical and Allied with CSGST)	Identification of best practice and gaps to promote continuing professional development	General	October 2006

IMPROVING GOVERNANCE, SYSTEMS AND PROFESSIONAL PERFORMANCE (5th Report)				
Action	**Responsibility**	**Outcome**	**Related Shipman Inquiry (5th) Recommendations**	**Completion date**
Analyse development needs and gaps emerging from CSCG base line assessment and produce local support and educational programme.	HSS Boards, GP practices, NIMDTA and CSCGST with DHSSPS (lead Medical and Allied Group)	Improve practice performance by addressing CSCG gaps and development needs through education and support	General	December 2006
Make Quality Standards for Health and social care meaningful to a general practice setting.	DHSSPS(lead Medical and Allied with PPMD), HSS Boards, CSCGST	Promote and embed common standards of quality in HPSS general practice, yet avoid duplication Improve quality of general practice	General	April 2007
Develop care standards for private dental practice (and medical). *Amend legislation to facilitate implementation of standards.*	DHSSPS (lead PPMD with Dental and Medical Groups)	Improve registration, regulation and inspection of private establishments by RQIA	General	December 2008
Develop an incremental approach to the attribution of all prescribing in general practice.	DHSSPS (lead Medical and Allied with CSA, PCCD and Pharmaceutical Inspectorate)	Improve the quality of prescribing Facilitate the monitoring of prescribing at individual GP level Standardise monitoring across single handed practices and GP locums	20-21	April 2007/ onwards

IMPROVING GOVERNANCE, SYSTEMS AND PROFESSIONAL PERFORMANCE (5th Report)				
Action	**Responsibility**	**Outcome**	**Related Shipman Inquiry (5th) Recommendations**	**Completion date**
Support changes to prescribing systems in general practice.	HSS Boards/HSS Authority, NIMDTA, DHSSPS (lead Medical and Allied with CSA, PCCD and Pharmaceutical Inspectorate)	Enhance validity of prescribing data and promote its use	20- 21	April 2007/ onwards
Consult on revised HPSS complaints procedures. Analyse responses and produce final document.	DHSSPS (lead PPMD with HSS Authority)	Improved reporting, investigation and learning from complaints Provide greater clarity and ease of access for the public	1-18	March 2007
Clarify arrangements for staff, where clinical practice or behaviour of an individual is causing concern in the family practitioner services.	DHSSPS (lead PCCD with HRD	Improved arrangements for the early recognition of underperformance in family practitioner services Clarification of arrangements and additional information for staff	34-38	February 2007

IMPROVING GOVERNANCE, SYSTEMS AND PROFESSIONAL PERFORMANCE (5th Report)				
Action	**Responsibility**	**Outcome**	**Related Shipman Inquiry (5th) Recommendations**	**Completion date**
Produce guidance on the handling of concerns in general medical and dental practice.	DHSSPS (lead Medical and Allied with HRD)	Harmonise procedures for the handling of concerns in the HPSS building on the expertise of National Clinical Assessment Service	34-38	February 2007
Enhance systems approaches to the management of the Medical Performers List.	HSS Boards with CSA and other stakeholders	Convene Regional Primary Medical Performers List Advisory Committee Advise on specific applications and improve information flows	44 and general	September 2006 / onwards
Provide further information for GP practices to improve recruitment processes and the take-up of references.	HSS Boards with DHSSPS (lead Medical and Allied with CSGST)	Improve recruitment procedures and the exchange of information from employer to employer	30-33	April 2007
Assess need in single-handed GP practices and improve governance arrangements through support and networking arrangements.	HSS Boards with DHSSPS (lead Medical and Allied Group and CSCGST)	Reduce professional isolation of established single –handed practices Improve quality of care	29	April 2008
Extend the scope of the GP practice mortality project.	HSS Boards with DHSSPS (lead M&A)	Enhance knowledge of the variation in GP practice mortality rates	22-24	December 2008

IMPROVING GOVERNANCE, SYSTEMS AND PROFESSIONAL PERFORMANCE (5th Report)				
Action	**Responsibility**	**Outcome**	**Related Shipman Inquiry (5th) Recommendations**	**Completion date**
Support extension of the GP practice mortality project with an education programme.	HSS Boards with DHSSPS (lead Medical and Allied Group)	Improve understanding of the benefits of data collection and analysis	22-24	December 2008
Work to improve medical appraisal systems in the HPSS. *Take account of Good Doctors, Safer Patients in development of appraisal systems.*	HSS Boards, Trusts, NIMDTA (with DHSSPS)	Improve quality of care in the HPSS through appraisal systems and identification of service and professional needs	26	April 2006 and onwards to end of 2008

GLOSSARY

Accountable Officer
Person responsible for ensuring the safe and effective use and management of controlled drugs within a designated body.

Accountability
Being completely responsible for particular actions and being made to publicly explain and justify those actions.

Adverse Incidents
Any event or circumstances that could have or did lead to unintended or unexpected harm, loss or damage to people, property, environment or reputation.

Bureaucracy
A system for controlling or managing that is operated by a large number of officials who are employed to follow rules carefully.

Cipher Number
A number on a prescription which is attributed to an individual prescriber, such as a general practitioner.

Clinical and Social Care Governance
A framework through which local organisations are accountable for the quality of service they provide or commission.

Commissioning
Formally choosing/requesting an organisation or an individual to undertake a piece of work or service.

Controlled Drugs
Controlled drugs are medicines used to treat a variety of clinical conditions. They are subject to special legislative controls because of their potential for harm if wrongly used.

Coroner
Coroners are independent judicial officers who are available to deal with matters relating to deaths that may require further investigation to establish the cause of death.

Cremation
To burn a dead person's body, usually as part of a funeral ceremony.

Data Capture
The collection of data for processing and analysis.

Death Certificate
A certificate issued by the Registrar. It contains the information recorded on the Register of Deaths including the persons name, date and place of death; date and place of birth; occupation and usual address; cause of death. It acts as confirmation of the death to allow burial, cremation, and management of the person's estate.

Forensic Pathology
Forensic pathology is the legal branch of pathology concerned with: determining cause of death (including murder, accident or unexpected death), examination of some wounds and injuries due to crime or negligence; and examination of tissue specimens that may be relevant to rape, or other crimes.

Governance
The rules, processes and behaviour that affect the way in which openness, participation, accountability, effectiveness and coherence are reinforced.

Inherent
Existing as a natural or basic part of something.

Incremental
A series of small advances / increases.

Legitimate
Allowed by law; reasonable and acceptable.

Locum Doctor
A doctor who does the job of another doctor who, for example, is ill or on holiday.

Malpractice
Failure to act correctly or legally when doing a job, sometimes causing injury or death.

Medical Appraisal
Annual appraisal for doctors is a requirement for doctors under contract in the HPSS. In its most basic form, appraisal activities include documenting achieved results (including use of examples to clarify documentation) and indicating if standards were met or not. The appraisal usually includes a development plan to address professional needs. Completion of this plan is then reviewed the following year.

Medical Certificate of Cause of Death
A certificate issued by a doctor recording the main cause of death, and other major medical conditions. It is taken by the family to the Registrar to allow the death to be registered.

Misconduct
Unacceptable or immoral behaviour by someone in a position of authority or responsibility.

Negligence
Not being careful or giving enough attention to people or things that are your responsibility.

Palliative care
Care that aims to relieve suffering and improve the quality of living and dying.

Pathology
The scientific study of disease.

"Principal" GP
A general practitioner who is an independent contractor and one who provides general medical services, under contract, to a registered population of patients. He/she is not a locum or sessional doctor.

Post Mortem Examination
Examination and dissection of a body after death to determine the cause of death or the presence of disease. Sometimes also called an autopsy.

Primary Care
The first point of contact for people outside hospitals in local settings. Primary care health professionals include local GP's, community nurses, social workers, pharmacists, physiotherapists, occupational/speech/language therapists, opticians and dentists among others.

Schedule 2 & Schedule 3 Drugs
It is illegal to possess drugs in schedules 2 or 3 without a prescription or other authority and a Home Office licence is required to produce, import, export or supply substances in these schedules.
Schedule 2 drugs include heroin, cocaine, morphine, pethidine, quinalbarbitone and amphetamine.
Schedule 3 drugs include the majority of barbiturates (excluding quinalbarbitone) Diethylporpion, Mazindol, Phentermine and Buprenorphine.

Schedule 4 Drugs
For drugs in schedule 4 (which includes benzodiazepines and pemoline) no prescription or other authority is required to legally possess them, so long as they are in the form of a medicinal product. No licence is needed to import or export schedule 4 drugs, but authority is required for production and supply.

Sessional Doctor
A qualified doctor who is not working as a partner in a GP practice.

Statutory Duty
A duty or action which is required by law

Underperformance
When someone is not producing the minimum standards required by their profession or their employing organisation.

Whistleblowing
Raising a concern about clinical practice, behaviour or conduct, usually within the employing organisation, or through an independent structure associated with it.

ACRONYMS

BMA – British Medical Association

CSA – Central Services Agency

CSCG – Clinical and Social Care Governance

CSCGST - Clinical and Social Care Governance Support Team

DHSSPS – Department of Health, Social Services and Public Safety

FTP – Fitness to Practice

GMC – General Medical Committee

GPC – General Practice Committee

HPSS - Health and Personal Social Services

HRD – Human Resource Directorate

HSS - Health and Social Services

HSENI - Health and Safety Executive for Northern Ireland

HTA - Human Tissue Authority

M&A – Medical and Allied Group

MCCD - Medical Certificate of Cause of Death

NCSA - National Clinical Assessment Service

NHS – National Health Services

NICE - National Institute for Health and Clinical Excellence

NIMDTA - Northern Ireland Medical and Dental Training Agency

NIO – Northern Ireland Office

NISCC - Northern Ireland Social Care Council

OOH – Out of Hours Services

PCCD – Primary and Community Care Directorate

PCO – Primary Care Organisation

PCT – Primary Care Trust

PDRC - Patient Drug Record Card

PPA – Prescription Pricing Authority

PPMD – Planning & Performance Management Directorate

PSNI – Police Service of Northern Ireland

PSNI – Pharmaceutical Society of Northern Ireland

RQIA - Regulation and Quality Improvement Authority

SCIE - National Institute for Social Care Excellence

SOP - Standard Operating Procedures

REFERENCES

REPORTS AND REVIEWS:

The 1st Report – Death Disguised
www.the-shipman-inquiry.org.uk/reports.asp

The 2nd Report – The Police Investigation of March 1998
www.the-shipman-inquiry.org.uk/reports.asp

The 3rd Report - Death Certification and the Investigation of Deaths by the Coroner (July 2003)
www.the-shipman-inquiry.org.uk/reports.asp

The 4th Report of the Shipman Inquiry – The Regulation of Controlled Drugs in the Community
www.the-shipman-inquiry.org.uk/reports.asp

The 5th Report – Safeguarding Patients: Lessons from the Past, Proposals for the Future, was published in December 2004.
www.the-shipman-inquiry.org.uk/reports.asp

The 6th Report – Shipman: The Final Report, published in January 2005
www.the-shipman-inquiry.org.uk/reports.asp

The Kerr/Haslam Inquiry
http://www.dh.gov.uk/assetRoot/04/11/53/53/04115353.pdf

Independent Investigation into how the NHS Handled Allegations about the Conduct of Clifford Ayling
http://www.dh.gov.uk/assetRoot/04/08/90/65/04089065.pdf

NI Human Organs Inquiry (2002*)* DHSSPS,
www.dhsspsni.gov.uk/index/hss/hoi-home.htm

A Review of Medical Appraisal in Northern Ireland, DHSSPS 2006 – Dr Nick Naftalin/Beeches Management Centre

Safer Management of Controlled Drugs – The Government's response to the Fourth Report of the Shipman Inquiry (December 2004) Department of Health.

Sudden Unexpected Death in Infancy. The report of a working group convened by The Royal College of Pathologists and The Royal College of Paediatrics and Child Health, The Royal College of Pathologists and The Royal College of Paediatrics and Child Health, 2004

www.rcpch.ac.uk

To investigate how the NHS Handled Allegations about the Performance and Conduct of Richard Neale
http://www.dh.gov.uk/assetRoot/04/08/90/63/04089603.pdf

Luce, Tom et al; Death certification and investigation in England, Wales and Northern Ireland: the report of a fundamental review 2003, The Stationery Office, 2003, London

Lewis, R J; Cole, D and Williamson, A; Review of Health and Social Services in the case of David and Samuel Briggs, 2003, Department of Health, Social Services and Public Safety

www.rcpath.org

Legislation:

Children (Northern Ireland) Order 1995

Health Services Primary Care (Amendment) (Northern Ireland) Order, 2006
www.dhsspsni.gov.uk/index/consultations/current_consultations.htm

Misuse of Drugs Act 1971

Misuse of Drugs Regulations (Northern Ireland) 2002

The Health Bill
www.dh.gov.uk/PublicationsAndStatistics/Legislation/ActsAndBills/fs/en

Policy, Guidance and Consultation Documents:

Best Practice, Best Care (2001) - a framework for setting standards, delivering services and improving monitoring and regulation in the HPSS (DHSSPS)
www.dhsspsni.gov.uk/publications/archived/2001/416finaldoc.asp

Good Doctors, Safer Patients (July 2006). Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. Department of Health, England.
www.dh.gov.uk/publications

How to Classify Adverse Incidents and Risk - Guidance for Senior Management Responsible for Adverse Incidents Reporting and Management (2006) DHSSPS.
www.dhsspsni.gov.uk/index/hss/governance.htm

Investigating patient or client safety incidents (unexpected death or serious untoward harm): promoting liaison and effective communications between the Health and Personal Social Services, Police Service of

Northern Ireland, Coroners Service and the Health and Safety Executive for Northern Ireland, Belfast, DHSSPS, 2006

Maintaining High Professional Standards in the Modern HPSS – A disciplinary framework for the handling of concerns about doctors and dentists employed in the HPSS – Circular HSS(TC8)1/2005

Public Attitude Survey 2005, DHSSPS
www.dhsspsni.gov.uk/public_attitudes_survey_2005.pdf

Safety First: A framework for Sustainable Improvement in the HPSS (2006) DHSSPS.
www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Quality Standards for Health and Social Care – Supporting Good Governance and Best Practice in the HPSS (March 2006)
www.dhsspsni.gov.uk/qpi_quality_standards_for_health_social_care.pdf

The Regulation of the non-medical healthcare professions: A review by the Department of Health
www.dh.gov.uk/publications

Articles:

Scally, G and Donaldson, LJ; Clinical governance and the drive for quality improvement in the new HPSS in England. BMJ 1998; 61-65

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APPENDIX A – TERMS OF REFERENCE OF SHIPMAN

Terms of reference published – www.dh.gov.uk (3rd January 2001)

Secretary of State for Health Alan Milburn, today announced the appointment by the Prime Minister of Dame Janet Smith as the Chair of the public inquiry into the circumstances surrounding the crimes of Harold Shipman.

The appointment comes after the announcement in September last year that, subject to parliamentary agreement, the inquiry will be held under the 1921 Tribunals of Inquiry (Evidence) Act.

Harold Shipman, a former GP from Hyde, Greater Manchester, was found guilty on January 31st of 15 charges of murder and of forging the will of one of his patients.

Subject to parliamentary agreement, the terms of reference for the inquiry are:

- After receiving the existing evidence and hearing such further evidence as necessary, to consider the extent of Harold Shipman's unlawful activities.
- To enquire into the actions of the statutory bodies, authorities, other organisations and responsible individuals concerned in the procedures which followed the deaths of those of Harold Shipman's patients who died in unlawful or suspicious circumstances.
- By reference to the case of Harold Shipman to enquire into the performance of the functions of those statutory bodies, authorities, other organisations and individuals concerned with responsibility for monitoring primary care provision and the use of controlled drugs.
- Following those enquiries, to recommend what, if any, steps should be taken to protect patients; and to report to the Secretary of State for Home Affairs and to the Secretary of State for Health.

APPENDIX B - SUMMARY RECOMMENDATIONS FROM SHIPMAN INQUIRY 3RD REPORT

No.	Shipman Report 3
	Recommendations
1.	Coronial system should be entirely different from at present.
2.	The new Coroner Service should be to provide an independent, cohesive system of death investigation and certification.
3.	The Coroner Service should provide leadership, training and guidance for coroners.
4.	The Coroner Service requires medical, legal and investigative expertise.
5.	Both the medical and judicial coroners should be independent office-holders under the Crown.
6.	The Coroner Service should have a corps of trained investigators.
7.	The Coroner Service must be independent of Government and of all other sectional interest.
8.	The Coroner Service should be governed by a Board. Three of the members of the Board would be the Chief Judicial Coroner, the Chief Medical Coroner and the Chief Coroner's investigator.
9.	The Service should also have an Advisory Council.
10.	The Coroner Service should be administered through a regional and district structure, with a regional medical coroner and at least one judicial coroner assigned to each region.
11.	Each region should be divided into between three and seven districts, each with a population of about a million. The staff would operate a service outside the usual office hours.
12.	The Coroner Service should have jurisdiction over every death and over every dead body brought within the boundaries.
13.	There should be one system of death certification applicable to all deaths, whether the death is to be followed by burial or cremation.
14.	The fact that a death has occurred should be confirmed and certified.
15.	The basis for the certification system would be the completion of two forms. Form 1 would record the fact and circumstance of death. Form 2 would contain a summary of the recent medical history and the option of expressing an opinion as to the cause of death.
16.	A statutory duty to complete Form 2 should be imposed upon the consultant responsible for the care of the deceased or the general practitioner with whom the deceased had been registered.
17.	General Medical Council should impose upon doctors a professional duty to co-operate with the death certification system, requiring them to provide an opinion as to the cause of death on Form 2 in cases where it is appropriate to do so.

No.	Shipman Report 3
	Recommendations
18.	All deaths should be reported to the Coroner Service. Deaths where the doctor completing Form 2 had expressed an opinion as to the cause of death would be considered for certification by a coroner's investigator after consultation with the deceased's family.
19.	The coroner Service would take primary responsibility for all post-death procedures.
20.	A proportion of all deaths certified by a coroner's investigator on the basis of the opinion of the Form 2 doctor should be selected randomly for fuller investigation at the discretion of the medical coroner.
21.	A new certificate of cause of death should be designed for completion by a coroner's investigator or by the medical coroner.
22.	Coroner's investigators should be trained to recognise the type of circumstances which make it appropriate for a death to be investigated by the medical coroner.
23.	There should be an inquest only in a case in which the public interest requires it.
24.	In other cases, the product of the further investigation of a death would be a report explaining how and why the deceased died.
25.	Any recommendation made by a judicial or medical coroner should be submitted to the Chief Coroners.
26.	Procedures for Investigation need clarification.
27.	The judicial coroner should be given powers to order entry and search of premises and seizure of property and documents. The medical coroner should be given powers to order the seizure of medical records and drugs.
28.	There should not be an automatic resort to autopsy.
29.	The medical coroner should seek to establish the cause of death to a high degree of confidence.
30.	Disposal of the body should be permitted as soon as possible.
31.	Judicial coroners should direct the investigation but responsibility for the collection of evidence should devolve onto a legally qualified person.
32.	If criminal proceedings have been commenced, there should be no need for an inquest.
33.	If any other agency were to investigate a death the medical coroner would establish the cause of death.
34.	Deaths contributed to by medical error should be investigated by the Coroner Service.
35.	Case of possible medical error should be investigated initially by the medical coroner
36.	Cases of medical error transferred to the regional coroner's office would be investigated under the direction of a legally qualified person.
37.	All autopsies should be carried out to the standards recommended by the Royal College of Pathologists.
38.	Greater use should be made of toxicology.

No.	**Shipman Report 3**
	Recommendations
39.	It should be possible for a medical coroner to authorise a partial autopsy.
40.	Retention of organs and tissues.
41.	The provision of a unified pathology service.
42.	A statutory duty to report concerns about a death.
43.	Employers should encourage their employees to report any concerns.
44.	Educate the public about the functions of the Service.
45.	Systematic audit of every function of the medical and judicial coroners.
46.	Decision made by a medical or judicial coroner would be subject to judicial review. Quicker and cheaper means of appeal should also be provided.
47.	Cremation certification procedures should be strengthened.

APPENDIX C - SUMMARY RECOMMENDATIONS FROM SHIPMAN INQUIRY 4TH REPORT

No.	Shipman Report 4
	Recommendations
1.	A controlled drugs inspectorate should be created, comprising small multidisciplinary inspection teams, operating regionally but co-ordinated nationally.
2.	A medical practitioner should be entitled to prescribe or administer controlled drugs only she s/he needs to do so for the purposes of the 'actual clinical practice' in which s/he is engaged.
3.	It should be a criminal offence for a doctor to prescribe a controlled drug for him/herself or to self administer a controlled drug from his/her own or practice stock.
4.	When a general practitioner (GP) has members of his/her immediate family on his/her list (which should happen only rarely), s/he should inform his/her local primary care trust (PCT) of the position.
5.	The General Medical Council (GMC) should make plain it will be regarded as professional misconduct for a doctor to prescribe controlled drugs for anyone whom s/he does not have a genuine professional relationship.
6.	A medical practitioner convicted or cautioned in connection with a controlled drugs offence should be under a professional duty to report the conviction or caution to the GMC.
7.	The Government should commission an independent review and audit of the way in which the GMC and PCTs are using their powers to restrict the rights of medical practitioners involved in controlled drugs offences to prescribe and administer controlled drugs.
8.	Whenever a restriction is placed on a doctor's prescribing powers, this information must promptly be made available (preferably by electronic means) to those who need to know it, especially pharmacists who require access to such information at all times.
9.	A special printed form should be introduced for use when prescribing a controlled drug, whether within the NHS or on a private basis.
10.	The special form should be in such format as will enable the Prescription Pricing Authority (PPA) to scan the prescribing information into its database so as to permit subsequent analysis and monitoring.
11.	The special form should show the GMC registration number of the medical practitioner to whom the pad of forms has been issued.
12.	The special form should provide the prescriber with a space in which to record a brief description of the condition for which the controlled drug has been prescribed.
13.	Consideration should be given to requiring that the patient's NHS number or some other patient-specific identifier should be included on the special form.
14.	The amount of a controlled drug that can be dispensed on a single prescription should be limited to a supply sufficient to last 28 days.

No.	**Shipman Report 4**
	Recommendations
15.	The duration of validity of a prescription for controlled drugs should be limited to 28 days. This restriction would not apply to drugs in Schedule 5 to the MDR 2001.
16.	When computer generated prescriptions are in genera; use for controlled drugs and when the electronic transmission of prescriptions is introduced, the software should be so designed as to ensure that both the time of issue of a prescription and the time at which it is dispensed are recorded.
17.	The purchase of all stocks of controlled drugs for practice use should follow a procedure that is capable of being monitored.
18.	GPs who keep a stock of Schedule 2 controlled drugs should be required (as now) to keep a CDR and to observe existing safe custody requirements.
19.	When the new arrangements for the provision of out of hours services come into effect, PCTs should establish protocols governing responsibility for the provision of Schedule 2 drugs and for the keeping of any CDR.
20.	There should be some relaxation of the strict requirements that a pharmacist is not permitted to dispense a controlled drug prescription unless there is full compliance with every technical requirements of the MDR 2001.
21.	In the case of a controlled drug supply that must be recorded in the pharmacy CDR, a pharmacist should be required to ask the name and address of the person collection the drugs, unless that information is already known to him/her.
22.	Any healthcare professional, acting in his/her professional capacity, presenting a prescription or requisition for a controlled drug, the supply of which must be recorded in the pharmacy CDR, should, if not known to the pharmacist, be required to provide identification, preferably his/her professional registration card.
23.	Any person collecting controlled drugs in Schedules 3 and 4 from the pharmacy should be required to write and sign his/her name of the back of the prescription form.
24.	Pharmacies should be permitted to keep their CDRs in electronic form.
25.	The keeping of a running balance in pharmacy CDRs should henceforth be regarded as good practice.
26.	The name and professional registration number of the prescriber should be entered in the CDR, as should the name of the pharmacist, responsible for supplying controlled drugs to a patient or his/her representative.
27.	The current requirement that a pharmacy CDR be kept for two years should be amended and the period should be extended to seven or, possibly, ten years.
28.	The RPSGB should provide guidance to its members as to the information and advice to be given to patients and their representatives when receiving a supply of a controlled drug.
29.	Pharmacists should be required to prepare a statutory patient drug record card (PDRC) to accompany every supply of injectable Schedule 2 drugs leaving the pharmacy.

No.	**Shipman Report 4**
	Recommendations
30.	The healthcare professionals who administer such Schedule 2 injectable drugs should be obliged to enter every administration and new supply of such a drug on a master PDRC and should keep a running balance of the remaining stock.
31.	Consideration should be given to changing the law so that all controlled drugs would become the property of the Crown on the death of the patient for whom they were prescribed.
32.	There should be increased formality attaching to the destruction of injectable Schedule 2 controlled drugs dispensed for administration in the community.
33.	It should be the responsibility of PCTs to ensure that suitable arrangements are in place for the disposal of controlled drugs.

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APPENDIX D - SUMMARY RECOMMENDATIONS FROM SHIPMAN INQUIRY 5TH REPORT

No.	**Shipman Report 5**
	Recommendations
1.	“I endorse the provision contained in the draft National Health Service (Complaints) Regulations (the draft Complaints Regulations), whereby patients and their representatives who wish to make a complaint against a general practitioner (GP) will be permitted to choose lodgements with GP practices of PCT”.
2.	Steps should be taken to improve the standard of complaints handling by GP practices.
3.	Draft regulation 30 of the draft Complaints Regulations, which would require GP practices to provide primary care trusts (PCTs) with limited information about complaints received by the practice at intervals to be specified by the PCT, should be amended …
4	There should be statutory recognition of the importance of the proper investigation of complaints to the processes of clinical governance and of monitoring the quality of health care.
5.	On receipt by a PCT of a complaint about a GP, a ‘triage’ (the first triage) of the complaint should be conducted by a member of the PCT’s staff who is appropriately experienced and has access to relevant clinical advice. The object of the first triage is to assess whether complaints are purely private grievance or Clinical Governance issues.
6.	‘Private grievance complaints’ should be dealt with by appropriately trained PCT staff. The objectives in dealing with such complaints should be the satisfaction of the patient and, where possible, restoration of the relationship of trust and confidence.
7.	‘Clinical governance complaints’ should be investigated with the dual objectives of patient protection satisfaction and fairness to doctors. They should be referred for a further triage (the second triage) to a small group comprising two or three people. Second triage should be to decide whether complaint is investigated by PCT or national body.
8.	The investigation of ‘clinical governance complaints’ should not be undertaken by PCT staff. Instead, groups of PCTs should set up joint teams of investigators, who should be properly trained in the techniques of investigation and should adopt an objective approach.

No.	Shipman Report 5
	Recommendations
9.	All ‘clinical governance complaints’ (save those which do not involve serious issues of patient safety and where the underlying facts giving rise to the complaint are clear and undisputed) should be referred to the inter-PCT investigation team. The objective should be to reach a conclusion and to set out the evidence reports which should go to the PCT.
10.	On receipt of the report, the PCT group which carried out the second triage should consider what action to take. It might be appropriate to refer the matter to another body, such as the GMC or the NCAA. Alternatively, it might be appropriate for the PCT to take action itself, if an inconclusive investigation, it should be referred to Health Care Commission.
11.	Neither an intention on the part of the complainant to take legal proceedings, nor the fact that such proceedings have begun, should be a bar to the investigation by a NHS body of a complaint. In circumstances where the NHS body is taking disciplinary proceedings, a complainant should be entitled to see the substance of the report.
12.	In some circumstances, it may be necessary for a NHS body to defer or discontinue its own investigation of a complaint if the matter is being investigated by the police, a regulatory body, a statutory inquiry or some other process. Relevant provisions of the draft complaints regulations should be amended to reflect these principals.
13.	The draft Complaints Regulations, when implemented, should include a power enabling PCTs to refer a complaint to the Health Commission for investigation at any point during the first stage of the complaints procedures. Cases raising difficult or complex issues might be referred to the Health Care Commission for investigation at the time of the second triage.
14.	The draft Complaints Regulations, when implemented, should include a power enabling PCTs to refer a complaint to the Health Commission for investigation at any point during the first stage of the complaints procedures. Cases raising difficult or complex issues might be referred to the Health Care Commission for investigation at the time of the second triage.
15.	Concerns expressed about a GP by someone other than a patient or patient’s representative (e.g. by a fellow healthcare professional) should be dealt with in the same way as patient complaints. Such concerns should be investigated (where necessary) by the inter-PCT investigating team or if complex the Health Care Commission.

No.	**Shipman Report 5**
	Recommendations
16.	Objective standards, by reference to which complaints can be judged, should be established as a matter of urgency. These standards should be applied by those making the decision whether to uphold or reject a complaint and by PCTs and other NHS bodies.
17.	In order to ensure that, so far as possible, complaints about healthcare can reach the appropriate destinations, there should be a 'single portal' by which complaints or concerns can be directed or redirected to the appropriate quarter. This service should also provide information about the various advice services available.
18.	About two years after the Complaints regulations come into force in their entirety, an independent review should be commissioned into the operation of the new arrangements for advising and supporting patients who wish to make a complaint.
19.	The powers of PCTs should be extended so as to enable them to issue warnings to GPs and to impose financial penalties on GPs in respect of misconduct, deficient professional performance or deficient clinical practice which falls below the thresholds for referral to the GMC or PCT list management powers.
20.	Steps should be taken to ensure that every prescription generated by a GP can be accurately attributed to an individual doctor. Only then will the data resulting from the monitoring of prescribing information constitute a reliable clinical governance tool.
21.	Regular monitoring of GPs' prescribing should be undertaken by PCTs. Special attention should be paid to the prescribing of controlled drugs by GPs. Doctors who have had a problem of drug misuse in the past or who are suspected of having a current problem should be subject to close scrutiny. When a restriction is placed on a doctor's prescribing powers, this information must be made available to those who need to know, especially pharmacists.
22.	The Department of Health (DoH) should make provision for a national system for monitoring GP patient mortality rates. The system should be supported by a well organised, consistent and objective means of investigating those cases where a GP's patient mortality rates signal as been above the norm.
23.	Every GP practice should keep a death register in which the particulars of the deaths of patients of the practice should be recorded for use in audit and for other purposes.

No.	**Shipman Report 5**
	Recommendations
24.	PCTs should undertake reviews of the medical records of deceased patients, either on a routine periodic basis (if resources permit) or on a targeted basis limited to those GPs whose performance gives rise to concern.
25.	The purpose of GP appraisal must be made clear. A decision must be taken as to whether it is intended to be a purely formative (i.e. education) process or whether it is intended to serve several purposes: part formative, part summative (i.e. pass/fail) and/or part performance management.
26.	If appraisal is intended to be a clinical governance tool, it must be ‘toughened up’. If that is to be done, the following steps will be necessary. Appraiser should be more thoroughly trained and accredited following some form of test or assessment. Standards for appraisal should be set and there should be nationally agreed core verifiable information supplied by the PCT both to the appraiser and appraisee.
27.	The Family Health Services Authority (Special Health Authority) or its proposed successor, the NHS Litigation Authority, should collect and analyse information relating to the use made by PCTs of their list management powers. Such analysis would assist the DOH in providing guidance to PCTs.
28.	The Government should consider the feasibility of providing a financial incentive for the achievement of GP practice accreditation by means of a scheme similar to that operated by the Royal College of General Practitioners in Scotland.
29.	The policy of the DoH and PCTs should be to focus on the resolution of the problems inherent in single-handed and small practices. More support and encouragement should be given to GPs running single-handed and small practices. In return, more should be expected of such GPs in terms of group activity and mutual supervision.
30.	PCTs should be willing and able to provide advice to GP practices on good recruitment practice and should also be willing to offer support in drafting job specifications and advertisements. They should be prepared, if requested, to assist in sifting applications and in making the necessary checks on applicants before the interview stage.
31.	A standard reference form should be developed for use in connection with appointments to GP practices. PCTs should insist that a reference is obtained from the doctor’s previous employer or PCT. In the case of a PCT, the reference should be signed by the medical director or Clinical Governance Lead.

No.	Shipman Report 5
	Recommendations
32.	When recruiting a new member, GP practices should canvass and take account of the views of their patients about the kind of doctor the practice needs.
33.	PCTs should keep a separate file for each individual GP on their lists. That file should hold all material relating to the doctor which could have any possible relevance to clinical governance. If a doctor moves from one PCT to another, the file should be sent to the new PCT.
34a.	Every GP practice should have a written policy, setting out the procedure to be followed by a member of the practice staff who wishes to raise concerns, in particular concerns about the clinical practice or conduct of a healthcare professional within the practice.
34b.	Staff should be encouraged to bring forward any concerns they may have openly, routinely, and without fear of criticism. If unable to raise concerns he should be able to approach a person designated by the PCT for the purpose. The contact details of that person should appear in the written policy.
35.	The written policy should contain details of organisations from which staff can obtain free independent advice. If the 'single portal' is created, in whatever form, the policy should set out contact details of that also.
36.	It should be a statutory requirement for all private healthcare organisations to have a clear written policy for the raising of concerns. Steps should be taken to foster in the private sector the same culture of openness that is being encouraged in the NHS.
37.	Consideration should be given to amending the Public Interest Disclosure Act 1998 in order to give greater protection to persons disclosing information, the disclosure of which is in the public interest.
38.	Written policies setting out procedures for raising concerns in the healthcare sector should be capable of being used in relation to persons who do not share a common employment.
39.	There should be some national provision (probably a telephone helpline) to enable any person, whether working within heath care or not, to obtain advice about the best way to raise a concern about a healthcare matter and about the legal implications of doing so. It might be possible to link this helpline with the single portal previously referred to.

No.	**Shipman Report 5**
	Recommendations
40.	There should be a central database containing information about every doctor working in the UK. This should be accessible to the officers of NHS bodies and to accredited employers in the private sector, as well as to other bodies with a legitimate interest.
41.	The database would contain, or provide links to, information held by the GMC, the Criminal Records Bureau (CRB) and the NHS Counter Fraud and Security Management Service. It would also contain records of disciplinary action by employers, details of list management action by PCTs any adverse reports following the investigation of complaint, adverse findings by the Health Care Commission/Ombudsman and details of any finding of negligence in a clinical negligence action. Doctors should be able to access their own entries.
42.	Private sector employers should be required to provide relevant information as a condition of registration with the Healthcare Commission. Deputising services should also be required to provide information and should be able to access the database through the relevant PCT.
43.	Information about unsubstantiated allegations or concerns should not be included on the central database. Instead, the doctor’s entry on the database should be flagged to indicate that confidential information is held by a named body.
44.	GPs should be required to disclose to the relevant PCT the fact that a clinical negligence claim has been brought against them, the gist of the allegation made and, when the time comes, the outcome of the claim." A failure by a doctor to make full declarations to a PCO as required by the Regulations 2004 should be regarded as misconduct of sufficient gravity to warrant referral to the GMC.
45.	The GMC should adopt a policy of tiered disclosure to apply to all persons seeking information about a doctor.
46.	The first tier should relate to information which is relevant to the doctor’s current registration status, together with certain information about his/her past fitness to practise (FTP) history. First tier information should be posted on the GMC website... and should also be disclosed to anyone who requests any information about the doctor’s registration...
47.	Disclosure of information at the second tier should be made to any person who makes a request about a doctor’s FTP history. All information which has at any time been in the public domain should remain available to enquirers at the second tier for as long as the doctor remains on the register.

No.	Shipman Report 5
	Recommendations
48.	In all cases where a GP's registration is subject to conditions, or where s/he has resumed practice after a period of suspension or erasure, patients of any practice in which the GP works should be told. A letter of explanation which has been approved by the PCT should be sent to all patients...
49.	The GMC should ensure that its publications contain accurate and readily understandable guidance as to the types of case that do and do not fall within the remit of its FTP procedures.
50.	There must be complete separation of the GMC's casework and governance functions at the investigation stage of the new FTP procedures and this must be reflected in the Rules.
51.	The adjudication stage of the FTP procedures must be undertaken by a body independent of the GMC. This body should appoint and train lay and medically qualified panellists and take on the task of appointing case managers, legal assessors and any necessary specialist advisers.
52.	Consideration should be given to appointing a body of full-time, or nearly full-time, panellists who could sit on the FTP panels of all the healthcare regulatory bodies.
53.	"The GMC should adopt clear, objective tests to be applied by decision-makers at the investigation and adjudication stages of the FTP procedures. The tests that I recommend are set out at paragraphs 25.63 and 25.67-25.68. The tests should be incorporated into the Medical Act 1983 and/or the Rules..."
54.	The Medical Act 1983 should be amended to add a further route by which there might be a finding of impairment of fitness to practise, namely 'deficient clinical practise'.
55.	Urgent steps should be taken to develop standards, criteria and thresholds so that decision-makers will be able to reach reasonably consistent decisions at both the investigation and the adjudication stages of the FTP procedures and on restoration applications.
56.	The Council for the Regulation of Healthcare Professionals (now known as the Council for Healthcare Regulatory Excellence (CRHP/CHRE)) should be invited to set up a panel of professional and lay people (similar in nature to the Sentencing Advisory Panel)...
57.	Steps should be taken to ensure that FTP panels determining cases in which issues of deficient professional performance arise apply a standard which is no lower than that set for admission to general practice.

No.	**Shipman Report 5**
	Recommendations
58.	Rule 4 of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (the November 2004 Rules), which sets out the test to be applied by the Registrar on receipt of an allegation, should be amended to give greater clarity.
59.	The November 2004 Rules should be amended to make formal provision for the GMC routinely to communicate with employers and with primary care organisations (PCOs) before deciding what action should be taken in response to an allegation and giving the GMC power to require from the doctor the necessary details to enable it to make such communication....
60.	Where a doctor has committed a criminal offence in respect of which a court has imposed a conditional discharge, that offence should be dealt with by the GMC in the same way as if it were a criminal conviction.
61.	The November 2004 Rules should be amended so as to give case examiners, and Investigation Committee (IC) panels in cases where the case examiners have disagreed, the power to direct investigations.
62.	Case examiners should be advised that they should not take mitigation into account when making their decisions and that they should consult a lawyer if they are in any doubt as to whether the available evidence is such that there is a realistic prospect of proving the allegation
63.	The November 2004 Rules should be amended to give case examiners, and Investigation Committee (IC) panels in cases where the case examiners have disagreed, the power to direct that an assessment of a doctor’s performance and/or health should be carried out.
64.	The GMC should develop an abridged performance assessment to be used as a screening tool in any case in which an allegation is made which potentially calls into question the quality of a doctor’s clinical practice.
65.	In order to avoid doctors undergoing multiple performance assessments, the GMC should investigate the development of a modular assessment.
66.	The November 2004 Rules should be amended to include a provision whereby reports of performance assessments should be disclosed by the GMC to doctor’s employers or PCOs as soon as possible after receipt.
67.	The power to send letters of advice should be incorporated into the Rules and clear criteria for the sending of such letters should be prepared.
68.	The GMC should reconsider its proposals for the issuing of warnings at the investigation stage.

No.	Shipman Report 5
	Recommendations
69.	Rule 28 of the November 2004 Rules, which provides for the cancellation of hearings before a FTP panel, should be amended so as to provide that a decision to cancel must be taken by an IC panel and that the reasons for the cancellation must be formally recorded...
70.	There should be regular monitoring and audit of the number of applications to cancel FTP panel hearings and of the decisions to cancel and the reasons for those applications and decisions. Those reasons should be scrutinised with a view to taking steps to minimise the number of cases in which referrals are subsequently cancelled.
71.	If the GMC pursues its present intention to extend the use of voluntary undertakings to cases other than those raising issues of adverse health or deficient performance, the disposal of such cases should take place in public at the adjudication stage and not in private.
72.	The November 2004 Rules should be amended to make provision for the revival of closed allegations. The usual ‘cut-off’ period should be five years but it should be possible, in exceptional circumstances and in the interests of patient protection, to reopen a case at any time.
73.	Reviews of investigation stage decisions should be carried out by an independent external commissioner. The circumstances in which a review may take place should be extended to cover decisions of the Registrar to reject an allegation rather than to refer it to a case examiner.
74.	The November 2004 Rules should be amended so as to provide that the arrangements for the obtaining and consideration of health assessments and for the management and supervision of doctors who are the subject of voluntary undertakings relating to health assessments...
75.	The November 2004 Rules should be amended so as to provide that the arrangements for the obtaining and consideration of performance assessments and for the management and supervision of doctors who are the subject of voluntary undertakings relating to performance should be directed by a medically qualified case examiner...
76.	There should be an explicit power in the Rules to allow the GMC to undertake any further investigations it considers necessary after a case has been referred to a FTP panel and before the panel hearing.
77.	In the event that the GMC retains control of the adjudication stage, the GMC committee charged with governance of the adjudication stage should audit the work of case managers. Case management should apply to cases with a performance element.

No.	Shipman Report 5
	Recommendations
78.	FTP panellists should be warned that they should exercise caution about drawing adverse inferences from a failure to comply with case management orders.
79.	In the event that the GMC retains control of the adjudication stage, it should appoint a number of legally qualified chairmen who should, as an experiment or pilot, preside over the more complex FTP panel hearings...
80.	As part of their training, FTP panellists should be advised about their discretion to admit hearsay evidence and other forms of evidence not admissible in a criminal trial…
81.	The GMC should reopen its debate about the standard of proof to be applied by FTP panels. It should consider introducing a rule that the civil standard of proof should apply unless the doctor faces an allegation of misconduct which also amounts to a serious criminal offence.
82.	The GMC should abandon its intention to notify doctors, at the same time as sending notice of referral of their case to a FTP panel, of the outcome it will be seeking at the FTP panel hearing.
83.	FTP panels should be required to give brief reasons for their main findings of fact.
84.	Rule 17(5)(b) of the November 2004 Rules (which permits a FTP panel, on receipt of a report of a health or performance assessment, to refer the allegation back into the investigation stage for consideration of voluntary undertakings) should be revoked.
85.	Rule 17(2)(j) of the November 2004 Rules should be amended to make clear what types of further evidence should be received before a FTP panel decides whether a doctor's fitness to practise is impaired….
86.	The Medical Act 1983 should be amended to permit a FTP panel to issue a warning in a case where it has found that a doctor's fitness to practice is impaired but not to a degree justifying action on registration.
87.	Rule 17(2)(m) of the November 2004 Rules, which permits a FTP panel to take into account written undertakings entered into by a doctor when deciding how to deal with the doctor's case, should be revoked. If it is to be retained, the rule should be amended to make clear that undertakings can be taken into account only at the stage of deciding on sanction...

No.	Shipman Report 5
	Recommendations
88.	Throughout the period that a doctor's registration is subject to conditions imposed by a FTP panel or to voluntary undertakings, someone within the GMC (preferably a case examiner) should take responsibility for the doctor's progress and for ensuring that he is compiling with conditions imposed or undertakings given.
89.	In every case where a doctor is continuing to practise subject to conditions or voluntary undertakings, a professional supervisor should be appointed to oversee and report on the doctor's progress and on his/her compliance with the conditions or undertakings...
90.	Any breach of a condition imposed by a FTP panel or of a voluntary undertaking (save for the most minor breach) should result in the doctor being referred back (or referred) to a FTP panel so that consideration can be given to imposing a sanction.
91.	The November 2004 Rules should be amended to ensure that there is at least one review hearing in all cases where a period of suspension or conditions on registration have been imposed, unless there are exceptional reasons why no such hearing should take place.
92.	The arrangements set out in the 2003 draft Rules, whereby any necessary gathering of evidence in preparation for a review hearing would be undertaken by a specially appointed case examiner, should be reinstated.
93.	In all but exceptional cases, a doctor whose registration has been suspended should be required to undergo an objective assessment of his/her fitness to practise before being permitted to return to practice. That assessment should be considered by a FTP panel...
94.	The GMC's primary role should be one, not of remediation of doctors, but of protection of patients. If a doctor who is subject to conditions or voluntary undertakings undergoes an assessment in the circumstances described above, and the assessment reveals that he does not meet the required standard consideration should be given to taking the steps necessary to remove the doctor from practice...
95.	The arrangements set out in the 2003 draft Rules, whereby any necessary gathering of evidence in preparation for a restoration hearing should be undertaken by a specially appointed case examiner, should be reinstated.
96.	Every doctor whose application for restoration to the register has reached the second stage of the procedure should be required to undergo an objective assessment of every aspect of his/her fitness to practise. The doctor should not be restored to the register unless he has met the required standard

No.	**Shipman Report 5**
	Recommendations
97.	Doctors who are restored to the register should be required to have a mentor whose task it will be to monitor, and report to the GMC on, their progress in practice.
98.	A thorough investigation of the circumstances underlying allegations of misconduct involving drug abuse should be conducted. The full facts should be established, including the circumstances in which the abuse began.
99.	The GMC should commission research into drug abusing doctors and their outcomes following supervision under the health procedures.
100.	Every aspect of the FTP procedures in which either doctors or makers of allegations have direct interest should be set out in the Rules. In addition, the GMC should publish a FTP manual, containing all its relevant Rules and its guidance for panellists...
101.	Clear statistical information should be collected and published by the GMC. The GMC should publish an annual report which should amount to a transparent statement of the year's activities in respect of the FTP procedures.
102.	The GMC should carry out audits of various aspects of its procedures, in addition to its other routine auditing activities.
103.	The arrangements for revalidation should be amended so that revalidation comprises, as required by section 29A of the Medical Act 1983, an evaluation of an individual doctor's fitness to practise.
104.	The annual report referred to at 101 above should include clear statistical information about the number of applications for revalidation and their outcomes. It should amount to a transparent statement of the year's revalidation activities.
105.	In three to four year's time, there should be a thorough review of the operation of the new FTP procedures, to be carried out by an independent organisation. This task should be undertaken by or on the instructions of the CRHP/CHRE.
106.	The GMC's constitution should be reconsidered, with view to changing its balance, so that elected medical members do not have an overall majority. Medical and lay members who are to be appointed (by the Privy Council) should be selected for nomination to the privy council.

No.	**Shipman Report 5**
	Recommendations
107.	The GMC should be directly accountable to Parliament and should publish an annual report which should be scrutinised by a Parliamentary Select Committee.
108.	Section 29 of the National Health Service Reform and Health Care Professions Act 2002 should be amended so as to clarify that the Act provides for the CRHP/CHRE to appeal against ‘acquittals’ and findings of no impairment of fitness to practise, as well as in respect of sanctions which it believes were unduly lenient.
109.	There should in the future be a review of the powers of the CRHP/CHRE with a view to ascertaining whether any extension of its powers and functions is necessary in order to enable it to act effectively to ensure that patients are sufficiently protected by the GMC

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APPENDIX E – TERMS OF REFERENCE of DHSSPS SHIPMAN PROGRAMME BOARD

Background

1. The 3rd, 4th and 5th Shipman Inquiry Reports were published between July 2003 and December 2004. These reports presented a major challenge to all UK Health Departments to determine how best to implement the numerous recommendations in ways that were timely and effective, thus securing maximum public confidence in professional performance and service provision.

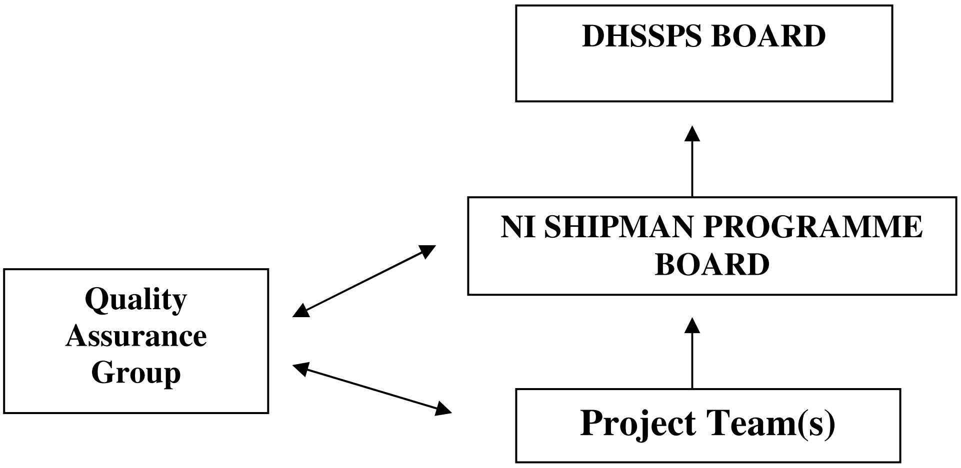
2. The focus of the DHSSPS response to these Shipman Inquiry Reports is to consider the recommendations in the context of local implications, acknowledging that there are different HPSS structures, local policies, procedures, and legislation in place, which is different to other parts of the United Kingdom.

Process

3. In 2005, the DHSSPS Shipman Programme Board was convened to oversee production of a timely and effective local implementation plan. Its remit was to co-ordinate and facilitate: -

   - a review of relevant Shipman inquiry recommendations and their applicability to health and social care in Northern Ireland;
   - liaison with national and local organisations and groups, involved in the wider clinical and social care governance agenda; and
   - development of an appropriate review mechanism to ensure that all elements of the Plan are implemented within their specified timeframes.

4. The following structure was put in place to aid in the development of a DHSSPSNI response:



5. The Programme Board was jointly chaired by the Chief Medical Officer and the Deputy Secretary of the Department, Mr Andrew Hamilton. Membership comprised a range of internal and external stakeholders. The external stakeholders played an important role in promoting awareness of the issues and will facilitate implementation of the recommendations in the future. The Programme Board reported to the Departmental Board and also provided regular updates to the Best Practice, Best Care Implementation Steering Group.

6. Within the Project Team, Core Team members had an intensive and continuous role in developing the final document.

7. The role of the Quality Assurance Group was to take receipt of and provide comment on Project Team papers produced in draft prior to submission to the Programme Board for signing off as acceptable products. The Quality Assurance Group represented the interests of additional external stakeholders.

8. Administrative support was provided by the Primary and Community Care Directorate, DHSSPS, who ensured that there was good communication across work streams.

9. The second phase which will focus on the actual implementation of the recommendations is outside the remit of this project, other than to establish the review mechanism for ensuring effective implementation.

Membership of Steering Group
Mr Andrew Hamilton (Co-chair) - Deputy Secretary, DHSSPS
Dr Michael McBride – Chief Medical Officer, DHSSPS
Dr Ian Carson (Co-chair) – Deputy/Acting Chief Medical Officer (until Apr 2006)
Ms Christine Jendoubi - Primary & Community Care Directorate, DHSSPS
Mr Noel McCann - Planning and Performance Management, (until Nov 2006)
Mr David Bingham - Human Resources Directorate, DHSSPS
Dr Norman Morrow - Chief Pharmaceutical Officer, DHSSPS
Mr Martin Bradley - Chief Nursing Officer, DHSSPS
Mrs Doreen Wilson - Chief Dental Officer (until Sept 2006)
Dr Paula Kilbane – Chief Exec., Eastern Health and Social Services Board
Ms Ann Bowen - Pharmaceutical Society of Northern Ireland
Dr Brian Dunn - BMA (GPC)
Mrs Stella Burnside – Chief Exec., Reg. & Quality Improvement Authority
Dr Colin Fitzpatrick - National Clinical Assessment Service Advisor (NI)
Prof Alastair Scotland - National Clinical Assessment Service (GB)
Mr John Knape – Royal College of Nursing (Northern Ireland)
Ms Lynne Cairns – Southern Health and Social Services Council
Ms Elaine Way – former Chief Executive, Altnagelvin HSS Trust

Membership of Core Team

Dr Maura Briscoe (project lead) - Medical and Allied Group, DHSSPS
Mr John Farrell - Primary & Community Care Directorate, DHSSPS
Dr Kathryn Booth - Medical and Allied Group, DHSSPS
Mr Gerry Gault – Directorate Information Systems, DHSSPS
Dr Michael Mawhinney - Pharmaceutical Advice & Services, DHSSPS
Mr Joe Gault - Pharmaceutical Advice & Services, DHSSPS
Ms Diane Taylor - Education & Training, HR Directorate, DHSSPS
Mr Donncha O'Carolan - Dental Group, DHSSPS
Mrs Margaret O'Hagan - Nursing & Midwifery Group, DHSSPS
Ms Michelle McCorry - Pharmaceutical Advice & Services, DHSSPS
Mr Jonathan Bill - Planning and Perf. Management Directorate, DHSSPS
Dr Heather Neagle - Medical and Allied, DHSSPS
Secretariat - Primary & Community Care Directorate, DHSSPS

APPENDIX F

EQUALITY AND HUMAN RIGHTS IMPLICATIONS

1.0 Introduction

Section 75 of the Northern Ireland Act 1998 requires all public authorities, in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity:

- Between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- Between men and women generally;
- Between persons with a disability and persons without; and
- Between persons with dependants and persons without.

In addition, without prejudice to the above, a public authority is also required, in carrying out its functions, to have due regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

2.0 Human Rights

The Human Rights Act 1998 came into force in October 2000, giving further effect to the rights enshrined in the European Convention on Human Rights. It is important that human rights issues are adequately addressed in the implementation of this action plan. For example, it is acknowledged that when underperformance is alleged or identified, individuals have a right to have a fair assessment undertaken within a reasonable timeframe; however, the safety of the public is of paramount importance.

The main articles which are likely to be relevant to this action plan are Article 6 (right to a fair trial), Article 8 (right to respect for private and family life), Article 10 (freedom of expression), and Article 14 (prohibition of discrimination in enjoyment of Convention rights).

3.0 Purpose of discussion

On the 19th July 2006, the project team met to consider the equality implications of the DHSSPS response to recommendations contained in Shipman Inquiry Reports 3, 4 and 5, having due regard to Section 75 of the NI Act 1998 and the Department's commitment to promote equality of opportunity.

4.0 Discussion

The Group considered the screening criteria as set out in paragraph 4.2 of the Department's Equality Scheme.

4.1 Is there any evidence of higher or lower participation or uptake by different groups?

The document has positive benefits for all services users irrespective of their classification under Section 75 and there is no adverse differential participation by any group.

The focus of the entire report is on the promotion of quality and safety for service users, the public, and HPSS staff by enhancing legislation, systems and procedures, professional performance and by promoting a culture of quality improvement and learning through clinical and social care governance.

4.2 Is there any evidence that different groups have different needs, experience, issues and priorities in relation to the particular policy?

The issues addressed in this report and action plan are global ones and do not specifically impact on groups with different needs, for example, lower socioeconomic groups, different genders or younger people. Systems changes are designed to improve public protection across all groups, especially, for example, those at greater risk in society as a consequence of age, social circumstances or disability. Public information will be provided to highlight changes in the current systems, for example, in relation to changes to improve governance in the use of controlled drugs.

There is no differential or adverse impact on any group as a consequence of this report or action plan, for example,

Men and women generally;
Persons of different marital status;
Person of different religious beliefs;
Persons with or without dependents;
Persons of different political opinions;
Persons of different racial groups;
Persons of different sexual orientation

4.3 Is there an opportunity to better promote equality of opportunity or good relations by altering policy or working with others in government or the community at large?

Within this report and action plan, there is a clear message from the Department that quality of service, patient safety and public confidence are high priorities. There are opportunities within this policy and action plan to promote good relations and to work with other government departments, both locally and nationally, especially in relation to enhanced death certification processes, improved governance in use of controlled drugs and improved professional regulation and performance.

4.4 How will this impact on complementary policy areas?

This report and action plan are complementary to other local and national policy areas on quality and safety and improving public confidence in service provision. For example;

Review of Public Administration, which has as a core principle improvement in quality and safety;
Reform and modernisation of HPSS services (as above)
Best, Practice Best Care (2001):
Safety First: A Framework for Sustainable Improvement in the HPSS (2006) - the DHSSPS safety policy and action plan. Part of this action plan is to develop a response to Shipman Inquiry recommendations.
Good Doctors, Safer Patients (DH London)
The Regulation of Non Medical Health Care Professions.

5.0 Conclusion

The group concluded that there was no adverse effect on one or more equality groups through development of this document. No potential differential impact has been identified. The action plan is designed to promote quality and safety of care, systems and legislative changes to give greater public protection.

The Group considered that there was no need to complete a full equality impact assessment; however, there remained a need to ensure appropriate and ongoing monitoring of equality implications during the course of implementation of the action plan.

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Challenging behaviour: a unified approach

Clinical and service guidelines for supporting people with learning disabilities who are at risk of receiving abusive or restrictive practices

College Report CR144
June 2007

Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists

Approved by Central Executive Committee: March 2007

Due for review: 2012

‘Instead of responding to the person we typically react to the behaviour’

‘Most of what passes as assessment seems to be denial about the mutuality of our common condition’

Herb Lovett

‘Our job is not to fix people, but to design effective environments’

Rob Horner

‘Difficult behaviours are messages which can tell us important things about a person and the quality of his or her life’

David Pitonyak

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Foreword

I am very pleased to have been asked to write the foreword to this important publication. One of the most important principles underpinning the *Valuing People* White Paper is that all aspects of the policy apply to all people with learning disabilities. Although we have made some good progress over the past 5 years, there is evidence that people with the most complex needs have not been benefiting as much as others from the changes in services, ways of working and, most importantly, culture and attitudes. This was neither the intention of the policy, nor is it a natural consequence of an initiative fundamentally concerned with people's rights as citizens and their place in society. To the contrary, it is arguably the extent of our success in meeting the needs of those who are most challenging to support that should be the measure of our achievements. When I was managing services in London in the late 1980s and early 1990s, one of the most rewarding achievements was to see how people who had previously been 'written off' by services could achieve a positive place in society (including paid employment) as a result of creative and courageous work by local staff (in partnership with the Special Development Team from what is now the Tizard Centre).

In this context, I particularly welcome the move to redefine the use of the phrase 'challenging behaviour'. The way in which that terminology has become a label to describe either a diagnosis or a problem owned by an individual has become an obstacle to the provision of appropriate and effective support. The real challenge to abilities and capacities is to those responsible for planning, commissioning, managing and providing services for people with such complex needs. It has been our historic failure to do that successfully that has resulted in people being excluded from mainstream society and segregated into inappropriate services. The acceptance of that ownership by ourselves rather than attributing the outcome to the individual's behaviour is an important step towards achieving better outcomes for all people.

Those outcomes could and should include participation in all aspects of life and society. In order to do that, appropriate investment in skilled health professionals is an essential but not the only component. If support to people who challenge services is interpreted as only being the business of the National Health Service, then achieving those wider goals and aspirations will be impossible. Partnership between all people concerned with the lives of people with learning disabilities and a shared vision to end the exclusion from mainstream society of people who are described as challenging services is the only effective way forward. I hope that this document is widely used as an important contribution towards that aspiration.

Rob Greig
National Director: Learning Disabilities

Purpose of this report

This report is the result of a joint working group of the learning disability faculties of the British Psychological Society and the Royal College of Psychiatrists, in consultation with the Royal College of Speech and Language Therapists.

Although there are many good examples of integrated and multidisciplinary working between health professionals in the field of learning disability, there are often, in the background, dynamics that tend towards a splitting of professional groups and what then appear to be polarised and antagonistic views and approaches. Yet, in the increasing joint working between the professions, it is clear that we share more common ground than we have differences and that our greatest effectiveness is when we work in close and coordinated collaboration.

One of the main functions of learning disability teams in the UK is to work with people with a learning disability whose behaviour presents a challenge. Considerable resources of professional time, support, managerial planning, strategic thinking and research have been committed over the past two decades or more to the development of service responses to the challenges presented by a significant number of people with learning disabilities. Though effective responses are essentially multidisciplinary and involve a wide range of individuals including carers and families, it has tended to be the professions of clinical psychology and learning disability psychiatry that have taken the lead in the development of theoretical and clinical paradigms, models of service provision, planning, and research.

There is a growing interest in the concept of ‘complexity’ in healthcare and it can be seen that challenging behaviour presents a complex and often paradoxical entity. The term was originally developed to describe the interaction between the behaviour of a person with a learning disability and the environment around them (see Chapter 3). Thus the term incorporates a multiplicity of biological and psychological characteristics, predisposing, precipitating and maintaining factors in the individual, the carers and the environment that cannot be conceptualised in terms of linear or simple cause-and-effect models. These multiple factors and the systems in which they operate are all interrelated and cannot be readily analysed or understood without reference to the others. ‘New conceptual frameworks that incorporate a dynamic, emergent, creative, and intuitive view of the world must replace traditional “reduce and resolve” approaches to clinical care and service organisation’ (Elsek & Greenhalgh, 2001).

One of the paradoxes in this complexity is the balancing of the need for consistent standards of evidence-based practice with an analysis and response to the unique circumstances and structures in existence for the individual at a particular point in time.

It is with these concepts in mind that this report has been produced, with the following aims:

- to revise and develop the interpretation of the term challenging behaviour
- to bring together relevant, available, evidence-based practice with a consensus of clinical opinion and experience
- to provide a unified framework for good practice in multidisciplinary clinical and social interventions
- to encourage the development of creative, flexible and effective responses to individuals who present behavioural challenges
- to provide guidance for service developers and commissioners
- to inform and empower service users and their carers
- to provide a set of standards of good practice against which service provision can be benchmarked and audited
- to promote the development of comprehensive and effective local services and to reduce the number of individuals who are failed by the current service provision
- to provide a framework for training of health and social care professionals and paid support staff and carers
- to guide future research and development.

The unifying principle is to improve the quality of life of people whose behaviour challenges services.

Within the constraints of time and practicality it has not been possible to produce a report that addresses every aspect of challenging behaviour across the whole spectrum of age and degree of learning disability. Our main focus has been upon adults who are vulnerable to restrictive interventions and abuse as a consequence of their limited capacity to make choices for themselves about where they live or work, and how they are supported. Specifically we have not addressed the needs of children, older people or those who commit offences (forensic). We readily acknowledge that the issues for these groups are integrally related to the groups covered in this report; for example, behaviour that is severely challenging in adults is likely to have its origins in childhood and early intervention to prevent 'challenging careers' is essential. There are, however, fundamental concepts and principles that are applicable to all population groups and the services that work with them. Not least, the core framework of creating capable environments as a response to challenging behaviour is one that should be universal in this field. The needs of particular groups may be the work of further publications or of more localised responses to the guidance given in this report.

The report was produced through the combined work of the members of the working group and drew on a number of key publications already in existence or in preparation at the time; we have also carried out a wide-ranging consultation process (see Acknowledgements). Although the disciplines of psychology and psychiatry were originally tasked to provide the main guidance for the working group focus and process, we have also sought the particular expertise of speech and language therapy, being aware that there is a body of professional research in this area. Challenging behaviour, however, requires a multidisciplinary and multi-agency approach and therefore this report has also been produced with the intention that it will be relevant and useful to a wide range of health and social care professionals, family and paid carers, service providers and commissioners. In order to achieve its aims, this document needs to be alive, active and responsive. It is intended to provoke action as much as to inform, to encourage local and national debate, analysis, review and response. It aims to instigate further thought and guidance for the groups of people with learning disabilities whose needs are not addressed specifically in this report.

Finally, the report hopes to complement other publications and guidance in this area and overall to further a reinvigorated and unified approach to supporting people whose behaviour is experienced as challenging. The importance of this is particularly emphasised following the Healthcare Commission reports into services in Cornwall Partnership NHS Trust (Commission for Healthcare Audit and Inspection, 2006) and Sutton and Merton Primary Care Trust (Commission for Healthcare Audit and Inspection, 2007).

Executive summary

This report concerns standards of clinical practice in supporting people with learning disabilities who present behavioural challenges. It unites the clinical theory and practice of health professions that have specific models for the assessment and management of challenging behaviour. The fundamental unifying principle is to improve the quality of life for people whose behaviour challenges others.

The report focuses primarily on adults with moderate to severe learning disabilities, although the broad principles outlined are applicable to children and adults of all degrees of intellectual disability. People with learning disabilities who present behavioural challenges are often marginalised, stigmatised, disempowered and excluded from mainstream society.

The term challenging behaviour has become distorted from its original meaning, and has come to be misused as a diagnostic label. The report redefines challenging behaviour, building on past definitions and focusing on the responses that the behaviour evokes in others, including those that are punitive or restrictive.

There is a diversity of learning disability policy throughout the UK. Despite shared commitments to support ordinary lives in the community and to a range of generic and specialist supports, there has been a growth in the provision of long-stay residential provision in the independent/private sector and in the number of individuals in out-of-area placements.

LEGISLATION

UK legislation varies between the different legislatures and is continually changing. Clinicians must remain informed on how this affects their practice. Professionals making treatment decisions for adults with learning disabilities are guided both by the law and by professional guidelines. The development and enactment of mental capacity legislation is clarifying the principle of best interests and the process of decision-making for adults who lack capacity.

People who pose severe behavioural challenges are more likely to be subjected to procedures which are directly or indirectly regulated by legislation, i.e. detention and treatment under the provision of the Mental Health Act 1983, informal detention of incapacitated people (Bournewood; Department of Health 2006*a*), physical interventions, seclusion.

FOCUSING ON THE INDIVIDUAL

Challenging behaviour is socially constructed and is a product of an interaction between the individual and their environment. Assessment and intervention must therefore address the person, the environment and the interaction between the two.

Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.

The person with a learning disability may be expressing unhappiness in their current environment through their behaviour and clinicians may be expected to provide interventions in environments that are inadequate to meet the person's needs. A balance must be struck between best practice and pragmatic measures to pre-empt a crisis that could have more deleterious impact on the individual. In less than optimal circumstances, the clinician may need to adopt a strong clinical advocacy role.

A comprehensive assessment should address: a functional assessment of behaviour, underlying medical and organic factors, psychological/psychiatric factors, communication and social/environmental factors. Detailed functional assessment and diagnosis are both integral features of an assessment of challenging behaviour and should lead to a clear formulation of the presenting problem.

Interventions should be delivered in a person-centred context and a framework of positive behavioural support. They should include proactive and reactive strategies. Interventions described include psychotherapy, communication, positive programming, physical and/or medical and psychopharmacological.

It is important that all interventions be routinely evaluated for their effectiveness; those that are more thoroughly evaluated are more likely to show a positive outcome.

Communication and feedback between professionals, carers and service users, and the timely sharing of information is an essential component at all stages of care.

CAPABLE ENVIRONMENTS

Challenging behaviour is more likely to be encountered in the family home, in small scale community settings or in environments that are poorly organised and unable to respond well to the needs of the person. It has been shown that people who present behavioural challenges can be effectively supported in ordinary housing in the community. When an individual's living situation breaks down it is generally not the behaviour but rather the service response that is the critical determinant.

There is often a mismatch between the level of need of people with learning disabilities and the range of available service provision with the capacity to work with behavioural challenges. As a result, out-of-area placements are widely used as a solution, at the expense of local resource development.

There may also be a mismatch between the expectations of professional staff and of staff providing direct support to individuals in community settings; the latter saying that professionals do not understand the constraints under which they work and produce advice that they cannot implement. Clinicians report that staff are unable to carry out necessary assessments and interventions.

To improve services for people who present behavioural challenges and to enable them to remain in their own homes and communities requires the creation and support of capable environments. Competency-based training and professional support is required for all carers together with the promotion of creative solutions to the challenges faced.

The quality of staff support provided should be focused on enabling the individual to engage in meaningful activity and relationships at home and in the community. Staff should be skilled and well-organised to deliver active support.

CREATIVE COMMISSIONING

Commissioners should have a clear basis on which to develop and select competent providers. An alternative route to market development may be through the establishment of personal budgets and independent brokerage. They need to manage the market they have created in order to sustain the capacity of local services to meet the needs of everyone with learning disabilities. This involves encouraging service providers to cooperate, underpinning service competence through training and service development and reshaping specialised challenging behaviour services to support effective local placements. There are not enough services that can provide skilled support in each local area and commissioners therefore have an important role in developing the new kinds of services that will be required.

Services need to be refashioned to give closer integration between care managers, care standards inspectors and members of community learning disability teams or specialist challenging behaviour teams. Staff training and support to local services should be a core role of specialist health professionals and clarity over outcomes and clearly defined service provision should increase the quality of services available to people who challenge services.

Commissioners will need to be aware of best practice in intervention, the outcomes achieved by interventions (and these may be broader than behavioural change) and the difficulties in predicting how long an intervention will take, as intervention is complex and may involve many different parties.

FUTURE DIRECTIONS

Future work needs to address the issues of challenging behaviour and early intervention in children.

The service user perspective needs to be emphasised and it is hoped to achieve this through the development of a charter outlining what standards of service provision people should expect.

A set of good practice standards is provided against which local services and stakeholders can audit and evaluate their current service provision and to assist in service planning and development.

A number of other initiatives are suggested for joint professional working, research, evaluation and audit.

Definitions and scope

This document is concerned with standards of clinical practice and how best to support people with learning disabilities who also present challenging behaviour. In practice both of these terms, challenging behaviour and learning disability, are applied with wide variation and inconsistency and often in ways that are idiosyncratic to service geography and structure, professional backgrounds and theoretical perceptions.

People with learning disabilities do not constitute a uniform group. Epidemiologically and diagnostically, the definitions of mental retardation in the *ICD–10 Classification of Mental and Behavioural Disorders* (World Health Organization) or *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV; American Psychiatric Association, 1994) are generally used. In practice, however, the eligibility criteria for access to services vary considerably and do not adhere to consistent operational definitions. However, it is generally accepted that the common criteria of learning disability centre on significant impairment of intellectual and social functioning that occurs before adulthood.

The focus of this report is primarily on adults with moderate to severe learning disabilities. The rationale behind this is to focus the scope of the guidance to those circumstances where it is likely that the individuals themselves may be excluded from receiving other forms of intervention and support aimed at ameliorating challenging behaviour.

This report also focuses on guidance to professionals and services. It does not include the additional guidance that will be necessary for work with forensic populations (where additional specific psychological techniques would need to be included); or the additional guidance necessary for working with people with significant depression, anxiety, anger management difficulties etc., all of these would also require additional guidance, much of which is now being dealt with within the National Institute for Clinical Excellence frameworks. This is not to say that the guidance regarding medication, behavioural intervention, environmental support and commissioning is not relevant to these additional groups. Its focus, however, remains on those people who are more likely to be excluded from the broader range of psychological and psychiatric interventions.

We acknowledge that there will be specific issues of diagnosis, aetiologies, treatment options, and legal frameworks for children and older adults. However, we believe that there are fundamental principles, values and guidance that are applicable across all groups who present behaviours that are challenging.

We believe that it is also important to note that people with learning disabilities who present challenging behaviours are often marginalised, stigmatised, disempowered and excluded from mainstream society. They suffer similar disadvantages to other groups who are discriminated against in society for reasons of ethnic origin, religion or sexuality for example. It is important to be particularly aware of those who are also from minority or stigmatised groups and may be doubly disadvantaged.

Challenging behaviour is a term that was originally adopted from use in the USA by The Association for Severe Handicaps (TASH), where it had been introduced in order to transfer the demands for change from the individual with severe behaviour problems to the organisation around them. The challenge was to carers, services and professionals to find more effective ways of understanding the origins and meaning of a person's behaviour and to find creative ways of responding to this challenge in order that the behaviour ceased to fulfil the same function and would therefore diminish. The most widely used, formalised definition has been that of Emerson:

> 'culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities'. (Emerson, 1995)

All behaviour has meaning or function and does not occur in isolation. There are likely to be a number of underlying causes of a behaviour that are a challenge to others. As well as functional determinants, precipitants and maintaining factors, aetiologies may include:

- physical: discomfort, pain, malaise, physiological disturbance (e.g. thyroid disorders)
- mental illness: mood disorders, psychosis, anxiety, obsessive–compulsive disorders
- neuropsychiatric disorders: epilepsy, Gilles de la Tourette syndrome, attention-deficit hyperactivity disorder (ADHD), dementia
- pervasive developmental disorders: autism
- phenotype-related behaviours: Prader-Willi syndrome, Lesch-Nyhan syndrome, Williams syndrome
- psychological trauma: reaction to abuse or loss
- communication difficulties: hearing loss, unclear communication, insufficient vocabulary or means of expression, difficulties understanding communication of others.

Through attempts to define the term challenging behaviour more consistently for the purposes of service provision, service development and research, the emphasis has moved away from its origins as a socially determined concept to a diagnostic entity. Attempts have been made to define challenging behaviour in terms of the behavioural characteristics, aetiologies, quantifiable frequencies or severities. As a result, the term in practice has been increasingly used as a diagnostic label, a means of describing groups of individuals or groups of behaviours. It has also been used to describe specialist services or service elements and professional roles, with the result that people with learning disabilities become labelled by association. The temporal and situational elements of the term also seem to have been lost; rather than challenging behaviour being a description of an interaction in a certain place at a certain time, the term becomes diffuse (if one aspect of a person's behaviour is challenging then all their abnormal behaviours receive the same label) and lasting ('once a challenging behaviour always a challenging behaviour'). The attribution for responsibility for the behaviour and therefore for its change has unfortunately gravitated away from carers, services and professionals back to the individual.

One of the reasons for the adoption of the term challenging behaviour was to provide a reminder that severely problematic or socially unacceptable behaviour should be seen as a challenge to services rather than a manifestation of psychopathological processes. In order to respond to this challenge, services need to promote positive behavioural development, reduce the occurrence of damaging behaviour and maintain people's access to a decent quality of life despite continuing behavioural difficulties.

It is our belief that there needs to be a firm reaffirmation of the term in its original context and a clear shift of emphasis back to the responsibilities for change being with the systems around the individual. We believe that 'challenging behaviour' is a socially constructed and dynamic concept. In order for an individual's behaviour to be viewed as challenging, a judgement is made that this behaviour is dangerous, frightening, distressing or annoying and that these feelings invoked in others are in some way intolerable or overwhelming. The impact on others, and therefore the characteristics of the observer(s) have to be incorporated in the application and understanding of the term challenging behaviour.

We propose the adoption of a modified definition that builds on that of Emerson:

> Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.

Quality of life and physical safety of the person and those around them is a focal concept of this definition. It has also moved from thinking in terms of the qualitative aspects of the behaviour of the person, to those of the responses of individuals and services. The actual nature of the behaviours therefore should be defined separately, for example: self-injury, assault, socially inappropriate behaviour. We believe that behaviour should be regarded as challenging when responses that are neglectful, socially and morally unacceptable, abusive or restrictive are being used to manage it; particularly so when basic human rights are being contravened (Commission for Healthcare Audit and Inspection, 2006, 2007).

Thus the prevalence of challenging behaviour can be conceptualised within such parameters as

- number of individuals excluded from local services
- number of individuals in 'out of area' placements
- number of individuals not receiving day services, employment opportunities, education, respite or home support
- service responses involving
  - seclusion
  - restraint
  - locked doors
  - abuse
- clinical responses involving
  - inappropriate prescribing of drug treatments
  - punitive and aversive behavioural interventions
  - risk avoidance rather than risk management.

It is clear therefore that the label of challenging behaviour becomes less appropriate once the consequences and the responses of others change to being non-punitive, non-restrictive and socially enabling rather than restricting. The nature and even the severity and frequency of the behaviour may remain unchanged and yet it ceases to be seen as challenging when carers, professionals and services are able to respond in positive, inclusive and enabling ways. An analogy can be drawn with a chronic medical condition such as insulin-dependent diabetes; the control of blood sugar and the avoidance of the complications of the condition require daily and lifelong treatment with insulin and appropriate adjustments to diet and lifestyle. While this treatment is available and able to be adhered to the individual can usually live a normal life, however, in the absence of these daily supports the condition represents a significant threat to their health, well-being and survival.

SCOPE

The underlying factors in an individual's behaviour that challenges others may have a range of aetiologies and may be complex. The individuals on whom they impact and the contexts in which they occur are also varied. Family and paid carers are usually those who primarily have responsibility for supporting the individual who presents challenges. The responsibility for designing interventions and support packages has tended to be within health services for people with learning disabilities and also within specialist groups or individuals within those services. Clinical psychologists, psychiatrists, speech and language therapists, learning disability nurses and occupational therapists have been in the forefront of service provision and development. There are many other individuals from different professional backgrounds however who work with people who present challenges and have acquired skills and experience in this area, for example psychotherapists, art therapists, physiotherapists and social workers.

This document aims therefore to have relevance to all professionals who work with people with learning disabilities, although it is written primarily from the perspective of clinical psychologists and psychiatrists and with a significant contribution from speech and language therapists. Our process of consultation has endeavoured to incorporate a wider view, although we accept that it is unlikely that we have been all-inclusive and hope that this document will promote further discussion, research and contributions to future revision.

The focus of the definition of challenging behaviour is on service and systemic responses. This report will aim therefore, above all, to inform and guide those who are policy makers and those who provide and commission services for people with learning disabilities in the statutory, voluntary and independent sectors. Our intention is that organisations that are charged with purchasing, commissioning or regulating services will use the standards outlined in the document in order to assess the appropriateness and quality of the services for which they are responsible.

CONTEXT

UK LEARNING DISABILITY POLICY

The context of service provision for people with learning disabilities has been changing. With the closure of large hospital institutions, the emphasis for professional intervention has moved to a community, multidisciplinary and multi-agency base, with an intent to utilise mainstream health services wherever possible and with the lead for specialist learning disability services coming from the local authority. Working with individuals who present challenging behaviour has to take place in the context of their home, their daily activities and support networks. These involve carers and supporters from a variety of backgrounds and employing agencies. Although the NHS long-stay hospital provision has almost disappeared, there has been a growth in the provision of a wide variety of residential and long-stay care, particularly in the independent sector. This growth may bring with it potential compromises to the values and principles of enabling people with learning disabilities to live ordinary, non-segregated lives.

Some of the biggest challenges have been in the sustained development and provision of specialist services or service elements, and in the training and support available to families, carers, advocates or non-specialist professionals. When families want to continue to care for the person at home, they are frequently faced with a lack of practical, financial, specialist, responsive or flexible supports that would enable this to happen. Too often the only real alternative is for the relative they are caring for to leave the family home, whether or not they wish this to happen.

Supporting people who challenge services needs to be seen within the current policy context, primarily national but also local. National policy has also undergone changes within the past 20 years with the devolution, in varying degrees, of responsibilities for health and social care provision to national administrations in Wales, Scotland and Northern Ireland.

England and Scotland have seen the launch and implementation of high profile national strategies for people with a learning disability, *Valuing People* (Department of Health, 2001) and *The Same as You?* (Scottish Executive Health Department, 2000).

Valuing People aims 'to provide new opportunities for children and adults with learning disabilities to live full and independent lives as part of their local communities'. It also recognises that one of the major issues for learning disability services is the provision and commissioning of services for those who present challenging behaviour.

The Same as You? emphasises that while challenging behaviour services should not be separate from general provision for people with learning disabilities, it is important to recognise the need for a range of specialist clinical services and treatments to be available including psychotherapy, cognitive–behavioural approaches and behaviour analysis; 'the aim of the specialist services should be to support mainstream services and to help people stay in their own homes as far as possible'.

The Welsh Assembly Government responded to the report of an advisory group on learning disability, *Fulfilling the Promises* (National Assembly for Wales, 2001), by restating its commitment to the All Wales Strategy of 1983 and its update in 1994. In August 2004 the Assembly issued Section 17 Guidance on Service Principles and Service Responses for Adults with Learning Disabilities. The principle for people with challenging behaviour states that 'People with learning disabilities who present challenging behaviour should receive evidenced-based care and treatment appropriate to their needs in their home or as close as possible to their home, irrespective of the severity of the level of challenge'. The service responses again emphasise the need for specialist expertise to support the work of learning disability and mainstream services.

Although they highlight the importance of services for people who show challenging behaviour and reaffirm commitment to their provision and development, these strategies do not contribute anything new or innovative in the field. Indeed, by highlighting challenging behaviour as a separate entity, paradoxically they may have contributed further to a lack of integration of understanding and approach, and an emphasis on symptoms rather than cause. Too often challenging behaviour has become regarded as synonymous with risk and thus services have become structured to reflect a hierarchy of risk management or risk containment. This hierarchy often ascends from the level of basic core skills within members of multidisciplinary teams, through specialist practitioners, specialist teams, assessment and treatment units up to low and medium secure units and forensic provision. Service responses to challenging behaviour are often, therefore determined primarily by the nature and availability of fixed resources and, again, the challenge is located within the individual who is then judged against eligibility or admission criteria for these services. Perversely, the nature and degree of challenging behaviour may also become labelled in terms of the nature of the service response e.g. 'he is a forensic problem', 'her challenging behaviour can only be managed in a medium-secure unit', 'they need to be on the challenging behaviour ward'.

CHALLENGING BEHAVIOUR POLICY

Following the publication of *Facing the Challenge* by the Kings Fund (Blunden & Allen, 1987) and *Meeting the Challenge* (Allen *et al*, 1991) one of the most influential drivers of strategic change has been the Mansell Report, *Services For People With Learning Disabilities And Challenging Behaviour Or Mental Health Needs* (Department of Health, 1993). More recent learning disability strategies have not fully addressed the vital connection between challenging behaviour and mental health, emphasising instead issues of access to generic provision for all health needs; challenging behaviour has remained, without clear direction, within the specialist remit of learning disability services. Also lost is the charter for people with learning disabilities who have challenging behaviour or mental health needs contained in Appendix 4 of the Mansell Report (Department of Health, 1993) which states that:

- standards and charters applying to other people shall also apply to people with learning disabilities and challenging behaviour or mental health needs
- services will ensure that each person is treated as a full and valued member of their community, with the same rights as everyone else and with respect for their culture, ethnic origin and religion
- services will be individually tailored, flexible and responsive to changes in individual circumstances and delivered in the most appropriate local situation
- services will strive to enable people to live in ordinary homes and enjoy access to services and facilities provided for the general community
- services will be provided by appropriately trained, qualified and experienced staff who will help the people they serve to develop fully in all aspects of their lives
- services will be delivered in the least restrictive manner capable of responding to individual need
- services will strive to continually improve, using the latest research to provide the best treatment, care and support.

BRITISH PSYCHOLOGICAL SOCIETY: CLINICAL PRACTICE GUIDELINES

The British Psychological Society (2004) published guidance for clinical psychologists who provide psychological interventions to people with learning disabilities who also display behaviours that severely challenge services. Although aimed at psychologists, and drawing largely on the evidence-base contained in the psychology literature, it was intended that other professionals, service providers and purchasers may also find them helpful in clarifying what to expect from psychologists. Many of the guidelines contained in the document are equally applicable to other professionals and they have provided the impetus for this collaborative report, which aims to build on the evidence-base, by producing a consensus position statement on best practice for those clinicians who provide services to this group of people. The guidelines are not fully reproduced in this report but contain a more extensive review of the evidence base with respect to positive behavioural support and applied behavioural analysis. This report recommends that these guidelines are adhered to as appropriate in clinical practice.

Legislation

England, Ireland, Scotland and Wales have differing legislation and this legislation is in a continual process of change. All clinicians need to keep themselves informed as to how current local legislation and related practice guidelines affect their own practice. For the sake of brevity, this chapter is based on legislation that covers England and Wales. Clinicians in other jurisdictions will need to interpret the principles outlined in this section in light of their own national legislative framework.

CONSENT TO TREATMENT AND BEST INTERESTS

Professionals deciding on the appropriate treatment for adults with learning disabilities are guided by both the requirements of the law (and supplementary codes of practice or guidance) and of professional practice guidelines. The implementation of the Mental Capacity Act in 2007 and the Code of Practice 2007 (Department for Constitutional Affairs, 2007) has clarified the position in relation to decision-making on behalf of incapacitated adults.

The law in relation to treatment is based on the principle that 'every person being of adult years and sound mind has a right to determine what shall be done with his own body' (Per Cardozo [1914]). This principle of autonomy is fundamental, whereby people have the right to refuse treatment, even if others think it will benefit them. However, many individuals with learning disabilities and challenging behaviour would not be able to exercise such autonomy, as they might lack decision-making capacity. Those who lack capacity have been defined as:

> '...a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'. (Mental Capacity Act 2005)

The Mental Capacity Act has further defined incapacity as:

> '...a person is unable to make a decision for himself if he is unable:
> (a) to understand the information relevant to the decision
> (b) to retain that information
> (c) to use or weigh that information as part of the process of making the decision, or
> (d) to communicate his decision (whether by talking, using sign language or any other means.)' (Mental Capacity Act 2005).

In relation to decisions about treatment for mental disorder, the Mental Health Act 1983 allows for treatment to be given for mental disorder (to those detained) under part IV (sections 56–64). The Mental Capacity Act allows for the majority of other decisions to be made on behalf of an incapacitated adult.

There is also a presumption of capacity, and anyone wishing to treat a person has to prove lack of capacity before proceeding to treat without consent. This places requirements on those treating individuals who present challenging behaviour to assess capacity in relation to the decision that needs to be made. There is a requirement that information is presented in a way that is accessible to the person, and that simplified language, visual aids or other communication methods should be used if appropriate. Clinicians will therefore have to present information about medication or psychological interventions in a way which is accessible to the individual, assess whether or not they have understood and can remember it and whether they have used the information to arrive at a decision. The decision should be voluntary.

If the person does not have capacity to consent, then any treatment must be in their 'best interests':

> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)
>
> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
>
> (c) the other factors that he would be likely to consider if he were able to do so. (Mental Capacity Act 2005)

The 'best interests' provisions also place an obligation on the clinician to consult those involved in the care of the person (which can be both family and carers), anyone appointed by the court as a deputy for the person, and anyone appointed by the person themselves. This encompasses more than medical best interests, and also considers emotional, social and welfare issues. They should also be the 'least restrictive alternative' for the person; this can be particularly relevant for people who present behavioural challenges, as it is recognised that they may be placed in more restrictive environments and may have a more restricted range of opportunities available to them. The Code of Practice to the Mental Capacity Act 2007 provides more guidance on the issue of best interests.

INFORMAL DETENTION OF INCAPACITATED PEOPLE

Another significant issue is the extent to which any placement might be sufficiently restrictive that it could be considered to amount to a deprivation of liberty for that individual. The case law on this issue derives from a ruling in the European Court of Human Rights, known as the Bournewood judgment (HL v. United Kingdom). This highlighted that detained patients have an automatic right of review of their detention, those who are not detained but unable to exercise their right to leave however do not have the same protection. The Mental Capacity Act is being amended to ensure that these rights are clear in law.

There are also implications for the treatment of incapacitated people in relation to the nature of the services in which they are placed, in that services that are unnecessarily restrictive of an individual's freedom could be in breach of the European Convention on Human Rights; this could include practices such as locking doors and restrictive care practices. It is likely that people whose behaviour is challenging could be especially susceptible to such regimes, and professionals may also need to pay attention to these issues when considering placements or, indeed, providing clinical input to such placements.

PHYSICAL INTERVENTIONS

It is suggested that approximately half of people with learning disabilities whose behaviour is challenging will have physical interventions used on them at some point in their lives (Emerson, 2003). In the absence of a lawful reason, using force, or threatening to use force, could give rise to a criminal charge, as could locking someone in their room. The Mental Capacity Act defines the unlawfulness, and the appropriate penalties for actions of ill-treatment or neglect.

A physical intervention in relation to challenging behaviour is described by the British Institute for Learning Disabilities (Harris *et al*, 1996) as

> 'A method of responding to the challenging behaviour of people with learning disability and/or autism which involves some degree of direct physical force which limits or restricts the movement or mobility of the person concerned.'

They define three types of physical intervention

- direct physical contact between a member of staff and a service user: for example holding a person's arms and legs to stop them attacking someone
- the use of barriers such as locked doors to limit freedom of movement: for example placing door catches or bolts beyond the reach of service users
- materials or equipment that restricts or prevents movement: for example placing splints on a person's arms to restrict movement.

It is recognised that there may be occasions where the risk posed by an individual's behaviour necessitates the use of physical intervention as a reactive management strategy. Those individuals who possess capacity should be fully involved in planning all aspects of their care. In situations where the individual lacks capacity a care plan should be constructed which is considered to be in the best interests of that person and which utilises the least restrictive alternatives.

Clinicians working with individuals with learning disabilities whose behaviour is challenging are less likely to be required to participate in physical interventions involving direct physical contact, but may be required to advise on their use. They may also be involved in risk assessment regarding restricting an individual's freedom of movement and may be involved in interventions with individuals who self-injure where restraint is being considered as an option. The importance of acting in the best interests of the person and of ensuring that the other, less intrusive means are tried before resorting to physical interventions has been emphasised in a number of reports (British Psychological Society, 2004; National Patient Safety Agency 2004; Royal College of Psychiatrists, 2005).

The Department of Health/Department for Education and Skills guidance (2002) outlines the requirements when physical intervention are planned and these include

- agreement by the multidisciplinary team, including consultation with others as appropriate
- put in writing, together with the behavioural plan (they should never be the only plan for managing behaviour)
- be supervised by appropriately trained staff
- be recorded, so that the circumstances of any physical intervention and methods used can be monitored.

This guidance also emphasises that the physical interventions should

- be used as infrequently as possible
- be in the best interests of the service user
- be part of a broader treatment strategy
- not cause injury
- maintain the person's dignity.

In addition, The Mental Health Act Code of Practice (Department of Health & Welsh Office, 1999) provides guidance for the use of restraint within in-patient mental health settings. This contains similar recommendations in as much as the purpose of restraint is for an emergency response to end or reduce danger; should be individually planned; only used as a last resort; and should use the minimum amount of force for only as long as is necessary. The code recognises that situations may arise whereby non-compulsory detained individuals might need to be restrained as an emergency. If this occurs, especially on a repeated basis, consideration should be given to whether formal detention under the Mental Health Act is appropriate.

The Mental Capacity Act provides protection to carers from liability in regard to certain acts performed in connection with the personal care, healthcare and treatment of a person lacking capacity. The use of restraint is permitted only under specific circumstances and carers will be provided with protection from liability providing they believe that the restraint was necessary in order to prevent harm to the person lacking capacity and that the restraint was proportionate. This section does not allow the restraint in order to prevent harm coming to another person; Jones (2005) noted, however, that the common law could allow for the prevention of assault on another. Clinicians should be guided by the Department of Health/ Department for Education and Skills guidance (2002) and the Mental Capacity Act Code of Practice.

Seclusion

The Mental Health Act Code of Practice (1999) also contains guidance on the use of seclusion, defining seclusion as 'supervised confinement in a room, which may be locked'. The Code states that it should be used as a last resort and for the shortest period of time and not be used as a punishment or threat, as part of a treatment programme, because of shortage of staff or where there is any risk of suicide or self-harm.

The Department of Health/Department for Education and Skills guidance (2002) clearly states that the use of seclusion outside the Mental Health Act should only be considered in exceptional circumstances and should always be proportional to the risk presented. The guidance also makes a useful distinction between seclusion and withdrawal, whereby withdrawal is removal of a person from a situation that causes anxiety or distress to a location where they can be continuously observed and supported until they are ready to resume their usual activities. Seclusion should similarly be considered to be a physical intervention, and its use outside the Mental Health Act should not occur.

PLACEMENT BREAKDOWN

Section 35 of the Mental Capacity Act provides for the appointment of an independent mental capacity advocate if there is to be a change in the provision of accommodation to a service user. These provisions apply if there is no one else available to consult. The change in accommodation must be for a specified length of time, and does not apply if the person is accommodated under the provisions of the Mental Health Act.

Focusing on the person

The term challenging behaviour is socially constructed. It represents the interaction of both individual and environmental factors, and the relationship between them. Any assessment and intervention for challenging behaviour must include these three elements (see Fig. 1).

Individual factors include
- degree and nature of learning disability
- sensory or motor disabilities
- mental health problems
- physical problems, including pain and/or discomfort
- communication difficulties, personal history of relationships and experiences.

Environmental factors will include the characteristics of services:
- number of staff
- training and experience of staff
- consistency of staff provision and approach
- the working relationship with the client
- working relationship between staff
- quality of the material environment
- opportunities available
- ability of the service to understand and respond to unique needs of individuals

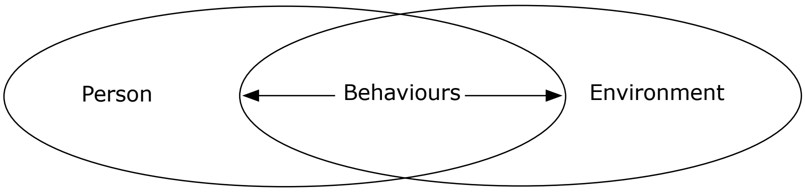

Fig. 1 The relationship between the elements of assessment and intervention in challenging behaviour.

A poor fit between the individual's needs and their environment may result in limited opportunities to
- gain social attention
- escape from or avoid excessive demands

- gain access to preferred activities or objects
- gain alternative forms of sensory feedback
- reduce arousal and anxiety by other means
- exert choice or control over environment
- understand and communicate with the person.

Individual risk factors (such as communication difficulties or a history of abuse) are widespread among people with learning disabilities; environmental risk factors (such as poorly organised and inadequately trained staff) are widespread among services. To design effective supports for people who challenge services, these factors need to be considered on an individual basis within a context that is based on strong ethical standards and values.

Where individuals are cared for in environments that do not respond appropriately to their needs, challenging behaviours are likely to develop and then remain in the person's repertoire. Many people encountered by clinicians who have been asked to intervene in their challenging behaviour are unhappy in their current environment and are powerless to do anything about it other than expressing their plight through their behaviour. Clinicians need to be aware that they may be expected to provide interventions in environments that are inadequate to meet the person's needs. They must strike a balance between best practice and pragmatic measures to pre-empt a crisis that could have more deleterious impact on the individual. A detailed functional assessment may help to demonstrate why the behaviour is occurring, and hence what needs to be altered in order to bring about service change. In considering interventions in less than optimal circumstances, the clinician may need to adopt a strong 'clinical advocacy' role, through communication with the relevant agencies, commissioners and regulators, in order to try to bring about the necessary environmental changes.

A CONTEXT FOR DELIVERING INDIVIDUALISED SUPPORTS

People with learning disabilities are generally disempowered and potentially vulnerable to abuse or neglect. Their lack of power reduces their ability to challenge poor practice and restricts their access to redress. In order to support this group of people a strong set of ethical standards and values is required.

Effective and ethical work must focus on individual needs and circumstances; person-centred values have been adopted as the cornerstone of *Valuing People, The Same as You?* and the Welsh Assembly Government's response to *Fulfilling the Promises*. This approach is not only important in terms of values but also outcomes for interventions. The Department of Health (2006*b*) White Paper *Our Health, Our Care, Our Say* sets out the Government's policy of designing services around the individual. Failure to individualise an assessment of the function of a person's behaviour can potentially lead to increases in the severity of a problem behaviour. For example, two of the common functions of challenging behaviour are social contact and social avoidance. These are opposites and to provide the same response to the behaviour, regardless of the person and the context, could result in completely different outcomes.

Within this document, we promote the approach that is increasingly referred to as positive behavioural support (Carr *et al*, 2002). This approach has emerged from three main sources

- applied behaviour analysis
- the normalisation/inclusion movement
- person-centred values.

Positive behavioural support integrates the following components into a cohesive approach

- comprehensive lifestyle change
- a lifespan perspective
- ecological validity
- stakeholder participation
- social validity
- systems change
- multi-component intervention
- emphasis on prevention
- flexibility in scientific practices
- multiple theoretical perspectives.

ASSESSMENT

Assessment is the process of collecting and evaluating relevant information about the person, the social, interpersonal and physical environment, as well as the behaviour that is challenging. Information about the person should include medical and psychological/psychiatric factors.

The purposes of assessment are

- to collect enough information to lead to a coherent formulation or diagnosis
- to lead to an intervention plan which fits the person and their environment, and leads to an improvement in their quality of life
- to establish a baseline that enables subsequent evaluation of effectiveness.

The focus of the assessment should be determined by the impact of the behaviour on the individual and those around them, including

- the degree of physical harm to the person and others
- the risk of loss of access to opportunities for development and participation
- the levels of distress being experienced by the person and others
- the capacity and motivation for change in the person and in their environment.

WHAT SHOULD BE ASSESSED?

The British Psychological Society's clinical practice guidelines on challenging behaviour (British Psychological Society, 2004) and the report on the use of medication for the management of behaviour disorders among adults with a learning disability (Deb *et al*, 2006) provide detailed frameworks for the assessment of challenging behaviours. In summary, an assessment should address both the individual and their behaviour in the context of

- underlying medical and organic factors (including medical examination and investigations)

- psychological and psychiatric factors
- social and environmental factors
- the interaction of these factors.

PRE-ASSESSMENT AND PRELIMINARY RISK EVALUATION

Before any clinician begins to carry out an assessment of a person's challenging behaviour, they should perform a pre-assessment. This preliminary information gathering shapes the initial focus of an intervention and will include information that will assist the risk screening process, the setting of priorities and provides some direction for the subsequent assessment. The information should be provided by someone who knows the person well. If there is continuing family involvement, family members should be consulted.

Pre-assessment information should include

- descriptions of the challenging behaviour
- circumstances in which the behaviour occurs
- frequency and severity of the behaviour
- sensory impairments
- the person's communication style
- communication typically used by other people
- specific disabilities, including aetiology of intellectual impairment
- medical problems
- current medication
- setting in which the person lives/works
- previous interventions
- risks to the person or to others
- existing risk management strategies
- capacity to consent to current and potential interventions.

RISK ASSESSMENT

Risk is an inherent and fundamental aspect of behaviour that is described as challenging and its assessment and management should therefore be an integral part of all aspects of intervention and support. Although there tends to be greater concern regarding risks of physical harm to others and/or to the individual, there are significant risks to loss of the various elements that make up quality of life (rights, choice, independence, citizenship, participation, inclusion etc.). Risk assessment should constitute a specific, documented component of the process. There should be an agreed multidisciplinary and multi-agency framework for description and evaluation of risk. This should include

- a precise description of the behaviours including frequency, duration and intensity and an indication of who or what is at risk
- identification of any behavioural precursors displayed by the individual that may indicate the probability of escalation of risk
- identification of aspects of the environment that are associated with increased likelihood of the behaviour.

The identification of these indicators should lead to planned early intervention aimed at diffusing and altering the course of potential incidents.

The risk assessment must be mindful of the person's aspirations and wishes as documented in their person-centred plan. Risk assessment should not be used as an excuse to adopt a 'risk averse' stance that then severely restricts a person's life further, with the potential consequence of inadvertently increasing their level of risk (Allen, 2002).

There may be rare situations where the risk assessment indicates that support staff will need to physically intervene in order to manage risk (see chapter on legislation).

Clearly, in an emergency situation it may not be possible to carry out a full and detailed assessment before having to initiate some intervention to protect the individual or others (LaVigna & Willis, 2002). Documentation in such circumstances should detail what information was obtained to validate the intervention, a projected timescale for the emergency measures and a clear indication of when and how a full assessment will be completed.

ASSESSING THE FUNCTION OF BEHAVIOUR

FUNCTIONAL ASSESSMENT

This is a specific behaviour-analytic procedure, where structured observation and other methods of assessment (for example interview of people in frequent contact with the person or use of standardised questionnaires) are employed to generate hypotheses about the challenging behaviour, antecedents which might be acting as stimuli for the behaviour and consequences which may be reinforcing it. These hypotheses are then tested out by experimental trial in either a real life or a more controllable analogue setting. The hypotheses that can be supported by experimental evidence are then used to derive interventions to reduce or eliminate the challenging behaviour.

It is essential that an assessment attempts to establish the function of challenging behaviours, in order to determine the correct basis for an intervention. The terms functional assessment and functional analysis are used interchangeably by some clinicians. Generally, functional assessment is a more inclusive term that refers to a range of approaches to establish the function of the behaviour, while functional analysis refers to more structured techniques that may include manipulating antecedents and consequences in order to establish their functional relationships (for example analogue assessment, Iwata *et al*, 1990).

The evidence-base supports the use of functional analysis for interventions where the primary focus is the reduction or elimination of severely challenging behaviours in people with moderate, severe or profound learning disabilities. A correlation has been found between carrying out a functional analysis and successful outcome, measured by reduced challenging behaviour (Scotti *et al*, 1991; Didden *et al*, 1997; Ager & O'May, 2001). This should therefore be the approach of choice where challenging behaviour is severe and the most urgent target for intervention.

A functional analysis should follow three stages (Horner, 1994; Repp, 1994; Toogood & Timlin, 1996)

- stage 1 – hypothesis development: interviews or rating are used to generate hypotheses or rule out areas for further investigation
- stage 2 – hypothesis testing: direct observation and more detailed interviews are used to assess the accuracy of the hypotheses and identify contextual factors
- stage 3 – hypothesis refining: either experimental analysis is used to refine the working hypothesis or there is a direct move to intervention

strategies that are used to check the accuracy of the hypothesis about the function of the behaviour.

ASSESSMENT OF PHYSICAL DISORDER

In some individuals, challenging behaviour may be associated with a physical disorder, particularly one that causes pain or physical discomfort. This may commonly include

- headaches and migraine
- cerebrovascular and epilepsy-related events
- earache and toothache
- eyesight disorders
- gut-related pain: gastro-oesophageal reflux, colic, peptic ulcers and constipation
- urinary tract infections and prostatism
- bone and joint pain
- neoplasms
- wounds and fractures.

Clinicians should actively consider the role of possible physical disorders and/or the iatrogenic effects of treatment and whether a more detailed physical assessment is merited; referral for further assessment and investigations should be supported where necessary.

ASSESSMENT OF PSYCHIATRIC DISORDER

In some individuals, challenging behaviour may be associated with psychiatric disorder (Borthwick-Duffy, 1994). Different types of mental health problems may lead to different patterns of behaviour and consequently a variability of challenges both between individuals and within the same person. For example depression may be associated with apathy, withdrawal and self-neglect or it may lead to severe agitation, irritability and repeated attempts at self-harm or suicide. Mania on the other hand may be associated with uncontrollable overactivity, impulsiveness and recklessness, irritability, sexual disinhibition, aggression and violence. Individuals with a cyclical or bipolar mood disorder therefore may present a variety of behavioural challenges at different times and for varied durations.

Xenitidis *et al* (2001) presented schematically the relationship between challenging behaviour and psychiatric disorders across the spectrum of intellectual ability. This indicates that not all people with a learning disability will show behaviour that is challenging; not all people who present behaviour that is challenging have a learning disability; there is an overlap between autism and psychiatric disorder, but neither necessarily leads to behaviour that is challenging (see Fig. 2).

Emerson *et al* (1999) outlined three ways in which psychiatric disorders may be associated with behaviours that present a challenge; we have developed these and added a fourth:

1. Behaviour as the symptomatic presentation of a psychiatric disorder: psychiatric disorders may present in atypical ways among people with highly restricted linguistic and adaptive behaviours: for example some forms of self-injurious behaviour may constitute the atypical

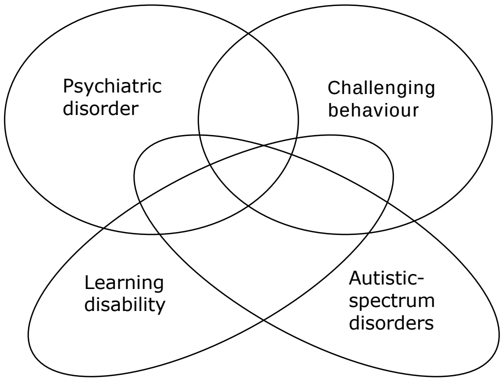

Fig. 2 Relationship between psychiatric disorder and challenging behaviour.

presentation of obsessive–compulsive disorder among people with severe learning disability (King, 1993).

2. Behaviour as a secondary feature of a psychiatric disorder: a range of problem behaviours, including aggression and self-injury may occur as secondary features of affective disorders among people with severe learning disability (Sovner & Hurley, 1983; Reid 1992), for example somatic symptoms such as headache and abdominal pain, agitation, and disturbances of physiological functions such as sleep, appetite and bowel movements may occur in people with severe learning disabilities who are depressed and unable to express their feelings verbally (Reid, 1992).
3. As a motivational basis for the expression of previously established behavioural patterns: The presence of a psychiatric disorder might establish the conditions for certain behavioural responses that themselves become reinforced and maintained by other environmental or internal factors. Apathy and low motivation in depression, for example, may be associated with an unwillingness to participate in educational or social activities. The avoidance of these activities may be negatively reinforcing, or the comfort of remaining at home with carers may positively reinforce this withdrawal from previous activities. Previous association of challenging behaviour with positively or negatively reinforcing events may lead to an increase in these behaviours at times of mental ill health.
4. As an iatrogenic effect of medication: medication for the treatment of psychiatric disorder may result in unwanted effects. These may include: akathisia from neuroleptics, disinhibition from benzodiazepines, selective serotonin reuptake inhibitor- (SSRI-)induced anxiety, excessive sedation and constipation. When a person with learning disabilities also has a mental health problem (dual diagnosis) it is essential to have a clear understanding of the emotional, cognitive and behavioural impact of the psychiatric disorder on the person with a learning disability.

Psychiatric disorders such as acute psychosis, depression, anxiety disorders and phobias should always be considered in a person with a learning disability who shows behaviour problems. Conditions such as autism (Bhaumik *et al*, 1997) and attention-deficit hyperactivity disorder (ADHD) (Biederman, 2005) are more common among adults with learning disability compared with their peers without learning disabilities. Both autistic disorders and ADHD are associated with high rates of behaviour problems.

The assessment process should also consider enduring abnormalities of personality that result in difficulties in interpersonal, occupational and social functioning; examples being borderline, paranoid or dissocial personality disorders. The term personality disorder however should be used with care; it can be used pejoratively in people whose behaviours are intractable, are considered socially unacceptable, or invoke strong emotional responses in others. Although it may be used to describe a pattern of behaviour in people with mild to moderate learning disability it is more difficult to be applied conceptually in adults with severe and profound learning disability.

The assessment and diagnosis of psychiatric disorders in people with learning disabilities can be complex and difficult and, in the UK, is usually the domain of psychiatrists in the specialty of learning disability. It is essential to note, however, that this process is not solely the domain of psychiatrists. A thorough approach to diagnosis and formulation should bring together relevant information, observations and specific assessments from a range of sources and clinical disciplines. Careful distinction should be made between behaviours associated with the symptoms of psychiatric disorder and those related to the underlying developmental disorder. Changes in behaviour, where clear symptoms and signs of psychiatric disorder are not evident, should not be assumed to be due to a psychiatric disorder. Guidelines exist for the assessment and diagnosis of mental health problems in people with a learning disability (Deb *et al*, 2001; see also http://www.estiacentre.org). For example, an adult with learning disabilities who appears to be having a conversation with themselves or is raising their fist at unseen 'objects' should not be assumed to be experiencing hallucinations unless there is further, more detailed evidence that can distinguish this as a hallucinatory phenomenon rather than a behaviour that is consistent with the individual's cognitive or developmental level. Similarly, the disorders of communication and behaviour in autism, if taken at face value and without an understanding of the underlying neuropsychological processes, could be mistaken for thought disorder, hallucinations or delusions. Clinicians and carers should also be aware of the phenomenon of 'diagnostic overshadowing', the tendency to attribute behavioural patterns to the person's pre-existing learning disability, thereby failing to consider the presence of a psychiatric disorder superimposed on the person's learning disability.

The clinical team should also be aware of other contributory psychological and emotional factors that may initiate and/or perpetuate behaviour problems. For example

- bereavement
- psychological trauma
- specific environmental stressors (new, ongoing or recurrent)
- relationship difficulties
- loss of self esteem
- isolation.

ASSESSMENT OF COMMUNICATION

There is clearly a link between communication difficulties and challenging behaviour. Desrochers *et al* (1997) found that only 32% of service users whose behaviour severely challenged and were referred to challenging behaviour services were able to communicate most or all wants and desires. Research has shown that challenging behaviours typically increase in frequency, intensity or duration when communication difficulties increase (Talkington *et al*, 1971; Chamberlain *et al*, 1993; Cheung *et al*, 1995; Bott, 1997). Most research to date has focused on the link between expressive communication skills and challenging behaviour but the role of understanding is also vital. For example challenging behaviour may result from the individual not understanding what is expected of them (Clarke-Kehoe & Harris, 1992; Bradshaw, 1998, 2002; Kevan, 2003).

Communication must be viewed within a partnership (Bartlett & Bunning, 1997) in both assessments and interventions, where the contributions of both the person presenting challenging behaviour and their communication partners are included.

A detailed communication assessment is needed to give information about the communication skills of the individual, their communication environment (including the communication partners) and the ways in which these are utilised within their daily lives (Bradshaw, 2002; Royal College of Speech and Language Therapists, 2003). This should also include an assessment of hearing skills.

There are also some specific communication considerations within a functional assessment; for example, considering the role that communication may have played within an analysis of antecedents, behaviours and consequences.

ASSESSMENT IN AUTISM

The principles above also apply to understanding the behaviour of people with autism. It is essential that an objective and comprehensive assessment of all individual and environmental factors is carried out. Assumptions should not be made about the experiences, perceptions, understandings or beliefs of the individual; many of the projections clinicians may make based on their own internal experiences about sensations, communication, social rewards and routines, are inappropriate or inaccurate when applied to people with autism.

Autism is a neurodevelopmental disorder and its 'causes' are associated with a wide range of neuropsychological and interactional difficulties that vary between individuals. Thus the clinician actively needs to consider evidence of sensory as well as processing and motor anomalies; such factors as sensory overload, for example, can produce extreme behavioural changes.

Although communication difficulties may be easily diagnosed, it is often difficult to assess the person's specific difficulties; which is why communication problems are a common aetiological factor of challenging behaviour in people with autism. Communication difficulties can also severely hamper the elucidation of physical and mental health problems.

In addition, the assumption that the person desires social interaction can be erroneous since many people with autism have interests and fascinations that do not include interacting with people other than to help with these interests.

FORMULATION AND DIAGNOSIS

Formulation is best regarded as an hypothesis, or set of interconnected hypotheses, about the nature of the presenting problem and its development. It usually contains informed 'ideas' about causal or functional relationships between variables / events and the central problem. It has two main functions

- to guide clinical intervention within an explicit rationale
- to aid the establishment of criteria for evaluation of the intervention.

> Functional assessment and diagnosis are both integral features of the assessment of challenging behaviours that should be carried out by all clinicians, either individually or in collaboration.

Formulation is a component of both psychological and psychiatric interventions. It occurs as part of the process of assessment, diagnosis and treatment planning, in psychiatric and psychotherapeutic practice. The establishment of a diagnosis of psychiatric illness, pervasive developmental disorder, behavioural phenotype or specific cognitive impairments should not in any way limit or unduly dominate all other factors in a complete functional assessment.

There is no one single 'correct' way to carry out a formulation; method and form will depend upon the context, the theoretical model being utilised, and the particular purpose of the formulation (Harper & Moss, 2003).

Psychiatric diagnosis is sometimes viewed as an unnecessary 'double stigmatisation' of the person already stigmatised by a label of learning disability. This view is untenable since appropriate psychiatric diagnosis based on a comprehensive assessment of all aspects of the individual can enhance the assessment process and help to clarify possible aetiological factors, prognosis and the nature of interventions and expected outcomes.

INTERVENTIONS

Interventions should be delivered in a person-centred context. While the detailed assessment and formulation process outlined above should result in clear intervention strategies, these must be tailored to the individual, their personal characteristics, environment and available resources for support. Multi-agency and multidisciplinary involvement should occur in close partnership with families and other carers. Detailed information concerning the nature and outcome of previous interventions should be obtained and taken into account.

A number of therapeutic modalities are described below which may be delivered in combination (e.g. medication and family therapy). Whenever possible, interventions should be introduced one at a time in order to enable clearer evaluation of outcome. Depending on the findings of the risk assessment described above, the therapeutic interventions may need to take place in an environment in which safety and security can be offered.

Within the positive behavioural support framework, the plan should include both proactive strategies for reducing the likelihood of the occurrence of the behaviour, and reactive plans for managing the behaviour when it does occur (Allen *et al*, 2005).

PROACTIVE STRATEGIES

Proactive strategies address the goodness of fit between the individual and their environment. These strategies would be expected to reduce the frequency, intensity or duration of the challenging behaviour by either

- adjusting aspects of the environment in order that they are more supportive, or
- attempting to address individual factors such as skills and tolerances via systematic skills building, or
- addressing physical health problems via medical intervention.

REACTIVE STRATEGIES

Reactive strategies are designed to deal with specific incidents. This may involve

- early intervention when signs are present that challenging behaviour may be about to occur. This will involve identification of environmental triggers known to be associated with the behaviour and behavioural precursors that might indicate that the individual may be becoming agitated. The aim here would be to diffuse the situation in order to prevent escalation of the behaviour
- physical management of the individual in order to ensure the safety of all those involved. This would be a last resort and thus a relatively rare occurrence and be in keeping with the relevant legal frameworks and principles of good practice reported elsewhere in this document.

PSYCHOTHERAPEUTIC INTERVENTIONS

The underlying aetiology of challenging behaviour may relate to psychological trauma, such as a past or ongoing history of abuse, losses or bereavement (Hollins & Esterhuyzen, 1997), problems in sexuality and intimate relationships, intra-familial and inter- and/or intra-personal conflict. While interventions may initially focus on the immediacy of the challenges being presented, it is also essential to understand and to work to resolve some of these underlying conflicts or traumas. The importance of these aetiological factors in people with learning disabilities has increasingly been recognised (Sequeira & Hollins, 2003).

Psychotherapeutic interventions, having for many years been denied to people with learning disabilities, are increasingly being validated as applicable and effective (Royal College of Psychiatrists, 2003). Cognitive behavioural approaches either individually or in groups have been applied to problems of anxiety, anger, aggression and offending; psychodynamic approaches may be effective in reducing psychological distress and interpersonal problems and increasing self-esteem as well as reducing offending behaviour (Hollins & Sinason, 2000; Beail, 2003; Wilner, 2005). Although much of the current evidence-base relates to people with mild learning disabilities, many clinicians are adapting cognitively based interventions in order to make them more available to people with more significant learning disabilities.

The group analytic approach in particular has been used extensively in generic forensic mental health settings and has also been applied with offenders with learning disabilities in secure settings (Xenitidis, 2005). Moreover as the role of personality disorder is increasingly being explored in adults with learning disabilities (Flynn *et al*, 2002) psychodynamic formulations and psychotherapeutic interventions are likely to become more widely used.

Families and carers can encounter personal and interpersonal stressors and conflicts that may benefit from psychotherapeutic intervention and support using family, systemic or group analytic models. The services, agencies and wider organisational structures involved in supporting individuals who present severe challenges may also become dysfunctional and thereby contribute to the failure to meet the challenges presented by the individual. Systemic, organisational or other psychotherapeutic approaches can contribute to recognising and addressing these issues at this wider level (Baum & Lyngaard, 2006).

Assessments and interventions for supporting the individual with challenging behaviour should therefore always consider the potential role of psychotherapeutic models in enabling formulation and/or diagnosis and treatment at a number of levels.

COMMUNICATION INTERVENTIONS

There are a number of communication-focused approaches to challenging behaviour which have been reported in the literature (Bradshaw, 1998; Brown, 1998; Chatterton, 1998; Dobson *et al*, 1999; Thurman, 2001). These have typically attempted to improve the communication skills of both the person with a learning disability and/or their communication partners and communication environments. This may include interventions designed to increase the communication skills of the individual, for example

- increasing the effectiveness of existing communication skills (e.g. increasing clarity of communication)
- teaching the individual more ways of communicating (additional/ vocabulary or forms of communication such as signs or symbols)

and/or the skills of the communication partners, for example

- improving recognition and understanding of the individual's communication skills (both in terms of what they understand and how they express themselves)
- assisting communication partners to provide appropriate models of communication
- facilitating communication partners' use of appropriate forms of communication, such as use of signs, symbols and objects, in addition to spoken communication
- structuring partner communication so that it is within the individual's understanding

and the wider communication environment, for example

- promoting good listening environments (e.g. reducing distractions and background noise)
- providing individuals with opportunities to take part in a range of communication acts (e.g. to ask questions, comment etc.)
- increasing the amount of good quality communication.

Communication-based interventions may also be challenging behaviour-specific, such as those found within the literature on functional communication training. Once the function(s) of behaviours have been assessed, attempts are then made to replace these behaviours with a functionally equivalent communicative response. For example, teaching the person to use a Makaton sign for 'break' to replace behaviour that serves the function of avoiding demands. Such interventions have been shown to reduce the level of behaviours that are challenging (Carr & Durand 1985; Carr *et al* 1991; Durand & Carr, 1991; Carr, 1994; Carr *et al*, 1994).

POSITIVE PROGRAMMING

One of the central components of positive behavioural support (Horner *et al*, 1990) is to enable the person to engage in meaningful activities and relationships. Changes in a person's quality of life are both an intervention and a measure of the effectiveness of an intervention. Interventions are frequently delivered through, and in partnership with, a range of different mediators (families, support workers etc; Lucyshyn *et al*, 1997). Mediators need to be both skilled in the delivery of positive interventions, and organised and supported in such ways that they can support people positively.

Specific approaches to 'positive programming' may be required if mediators are to be supported to deliver positive interventions. One such approach is active support (Jones *et al*, 1999) a package of procedures which includes activity planning, support planning and training for providing effective assistance. Such approaches have been shown to increase the levels of assistance that individuals receive and their engagement in everyday activities.

PHYSICAL AND/OR MEDICAL INTERVENTIONS

If assessment indicates that a behaviour is a consequence of an underlying medical condition (for example chest infection, dehydration, epilepsy) that requires medication or other physical treatment, then this should be addressed promptly within the treatment plan and reassessment made in the light of response to treatment. There is good evidence that common and treatable medical conditions often go undiagnosed and untreated in people with learning disabilities (Hatton *et al*, 2002).

PSYCHO-PHARMACOLOGICAL INTERVENTIONS

A medication treatment plan should be drawn up that explicitly addresses the following

- the name of the medication and who is to prescribe it
- a clear indication of how dosage will be titrated cautiously according to individual response and susceptibility to side-effects
- whether physical examination and investigations are required prior to treatment and as part of ongoing monitoring
- desired outcome of treatment, assessment methods and timescales
- Potential adverse effects, including effects on quality of life of the individual and their carers, how these adverse effects should be monitored and the action to take if they occur.

Although psycho-pharmacological treatments have been widely used in the management of behaviour there is a meagre evidence-base for their effectiveness; there are very few studies comparing different medications for the management of specific behaviour problems. Specific treatments cannot therefore be recommended for specific behaviour problems.

It is however appropriate to consider medication as an important component in the management of psychiatric disorders and aetiological or contributory psychiatric symptoms. Thus an underlying depression may require treatment with antidepressants, a cyclical mood disorder with mood stabilisers or a psychotic disorder with an antipsychotic drug. Obsessive–compulsive disorder, panic or generalised anxiety that results in or exacerbates challenging behaviour may benefit from treatment with an SSRI. High levels of arousal and anxiety contributing to aggression in an individual with autism may respond to the tranquillising or anxiolytic effects of an antipsychotic or to other drugs used in the treatment of anxiety (Einfield, 2001).

Pharmacological treatment in people who present challenging behaviour should only be initiated following a thorough process of assessment, diagnosis and formulation that has clearly established either

- that an identifiable psychiatric disorder is present

or

- that there are significant psychiatric symptoms

and

- these are an aetiological or contributory factor in the behaviour which is presenting a challenge

and

- the medication proposed can be expected to improve the psychiatric disorder or symptoms identified (if the medication is not licensed for the disorder then there must be an established literature giving a rationale for the proposed medication).

Other factors to be taken into account should include

- inadequate response to other non-drug interventions
- likely speed of response to different interventions
- significant risk or evidence of harm and/or distress to the individual
- significant risk or evidence of harm and/or distress to others
- high frequency and/or severity of behaviour problems
- good response to previous drug interventions
- possibility of greater effectiveness of, or enhanced ability to deliver, other interventions as a result of drug treatment.

Medication should not be planned and delivered in isolation, it should be an integral part of a comprehensive intervention strategy and should be regarded as adjunctive or complementary to other non-drug interventions planned and delivered by various members of the multidisciplinary team (Deb *et al*, 2006, see http://www.ld-medication.bham.ac.uk). It is important to bear in mind that medication may be recommended by a psychiatrist but prescribed by an individual’s general practitioner. The initiation, discontinuation or alteration of medication may therefore occur without the specialist team’s knowledge. It is essential that there is active dialogue between the responsible clinicians in primary, secondary and specialist health services.

Prior to initiating medication the prescribing clinician, in consultation with the person, their family and carers and other members of the multidisciplinary team, should therefore address the following

- what range of management options has been considered?
- what medication is the individual already prescribed?
- have there been any past adverse reactions to medication?
- does the formulation include a clear rationale for the proposed drug treatment?
- what is the likely effectiveness of the proposed treatment?
- is there a clear, objective method of assessment of outcome and adverse effects?

- have issues of capacity and consent been fully taken into account and recorded?
- is the proposed treatment in the best interests of the individual, considering all alternative interventions?
- is the proposed treatment and its implementation consistent with relevant legal frameworks?
- is the dose and planned duration of treatment within British National Formulary and other good practice prescribing guidelines and dose recommendations?

As well as the general intervention documentation described above, a medication treatment plan must be written that explicitly addresses the following

- the name of the medication and who is to prescribe it
- how the dose should be titrated, and over what period of time
- whether physical examination and investigations are needed prior to treatment and as part of the ongoing monitoring
- potential adverse effects, including effects on quality of life of the individual and their carers, how these adverse effects should be monitored and what action should be taken if they should occur.

The use of medication makes it even more important that the intervention plan clearly records

- the working formulation including rationale for medication
- desired outcome of treatment, assessment methods and timescales
- consent to treatment (if the person lacks capacity to consent, then the rationale for its administration and the views of others).

There are occasions where the intensity of an individual’s behavioural disturbance (aggression, anxiety, agitation) may require urgent intervention for the protection of the individual or of others. In these circumstances clinicians should follow an established ‘rapid tranquillisation policy’ for example those produced by the National Institute for Clinical Excellence (2005) or the Bethlem and Maudsley Prescribing Guidelines (Taylor *et al*, 2001), modified if necessary to take account of increased vulnerability of people with learning disabilities to adverse effects of medication. Such interventions, however, should be followed immediately by a multidisciplinary review and assessment as outlined above to determine the longer-term role of drug interventions for the individual.

INITIATING INTERVENTION PLANS

Before commencing any intervention, it is important to bring together all the elements of assessment described above into a coherent and concise treatment plan. This plan should be developed and agreed by the multidisciplinary team, the individual and carers. The relevant roles and responsibilities of all involved, including a named professional and process for coordination, should be clarified, documented and agreed.

EVALUATION

Clinicians are under an ethical obligation to measure the impact of their interventions on the target behaviour, because the nature of challenging behaviour is such that, by definition, there is a threat to the health and well-being of the person concerned or those close to him or her.

All interventions should be routinely evaluated for their effectiveness and this evaluation should be planned at the point of initiation of the intervention. There is evidence to suggest that those that are more thoroughly evaluated are more likely to demonstrate a positive outcome (Scotti *et al*, 1991; Didden *et al*, 1997).

An evaluation will usually repeat baseline measures from the start of an intervention and look for any evidence of change. The measurement of challenging behaviour alone, is an inappropriately narrow focus and as a minimum, the evaluation should consider

- the severity, frequency and duration of the target challenging behaviour
- the person's quality of life and range of activities or opportunities
- the person's development of positive skills and abilities
- the person's well-being and satisfaction with the intervention
- the well-being and satisfaction of carers or family members in close contact with the person.

Adverse effects of the intervention should also be carefully monitored. Follow-up assessments should always consider withdrawal of medication (if medication has been a component of the intervention strategy) and be incorporated with an introduction of alternative non-drug managements.

The clinician needs to make a specific evaluation of those factors that he or she is attempting to change. If an intervention attempts to teach new skills, for example, then the acquisition of those new skills should be measured. If the intervention is hoping to change an environment, then measures of the environment need to be taken before and after the intervention.

The evaluation should also include a review of the initial formulation. There is significant evidence that demonstrates the potential persistence of challenging behaviour over long periods of time. It is, therefore, essential that progress is monitored repeatedly over extended time periods, thus allowing

- measurement of the impact of interventions
- early identification of potential deterioration or relapse.

Work on relapse prevention with people with learning disabilities is at a very early stage but the literature suggests that relapse is a very real problem, 'patterns of severe challenging behaviour do not simply disappear' (Anderson *et al*, 1993).

COMMUNICATION AND FEEDBACK

Communication between professionals, carers and service users, and the timely sharing of information is an essential component of care. Many services have guidelines on the timeliness and content of reports and letters, which need to be adhered to as an essential element of good practice. It is likely that many people will be the subject of the care programme approach or some other system of care coordination and it is essential that such mechanisms are properly utilised.

The term 'feedback' should also be understood more broadly to include verbal and informal communication. Feedback should be provided at several stages, as follows

- at the end of the assessment period and when the formulation has been produced
- following interventions, whether or not these are successful
- when there is a substantial revision to the formulation or the proposed intervention plan
- on completion of work with the individual or care team.

Feedback should also be given to the person with learning disabilities in an understandable and respectful form.

People involved in the assessment or intervention should receive regular and routine feedback, as should the referrer and other important people in the life of the person with learning disabilities. This, of course, is dependent upon appropriate consideration of issues of confidentiality (see below).

There is some evidence for the effectiveness of presenting feedback in different modalities or formats. Visual presentations, for example, may be important for people with autism (Clements, 1987; Mesibov *et al*, 1988). The use of video feedback to help a person understand their own behaviour can also be helpful.

The most important factor in providing feedback for staff and families appears to be 'goodness of fit' with the environment, recognising the skills, preferences and styles of the people with whom one is communicating. For example, the use of visual representations (graphs, bar charts, pie charts or scatter plots) can be very helpful for some people, while others find numbers or narrative easier.

Clinicians must ensure that they respect the confidentiality of the person with learning disabilities when they are giving feedback. It is particularly important for clinicians working with people who are not socially valued and often not seen as active agents in their own lives to be mindful of the requirement to respect confidentiality. There is anecdotal evidence to suggest that breaches of confidentiality are more likely to occur with more disabled and more disadvantaged groups of people.

Sometimes clinicians are perplexed about whether family members or paid carers should be provided with personal information about the person with learning disabilities. The following factors should be considered

- the person with a learning disability should be asked, where possible, what information they do or do not wish to have shared with other specified people. It is important to allow for the tendency of people with learning disabilities to be acquiescent to requests of this sort in assessing consent to sharing information
- partnership working with close family members is often of central importance in the life of a person with learning disabilities. The clinician needs to consider this when making a decision to share or to withhold information. It is likely to be necessary to work alongside the family to strengthen relationships so that they can offer mutual trust, safety and the capacity for development
- there is no obligation to pass on information unless there is a serious risk to a person or others. A parent, for example, does not have a right to know everything about their adult son or daughter
- where there is a serious risk to the person with a learning disability or others, the clinician has an obligation to share information with those who need to know in order that they can take steps to protect others or themselves

- it may be helpful to consider what information would be shared in similar circumstances if the person did not have a learning disability.

As well as providing feedback to others, the clinician should also ask for feedback from others on his or her own performance, establishing a two-way process that can modify or improve their clinical practice, personal development and professional revalidation.

INTERVENING IN 'LESS THAN OPTIMAL' SERVICES: CLINICAL ADVOCACY

Given the nature of challenging behaviour, appropriate intervention will usually involve some combination of changing the situation the person is in (for example who they live with, how staff support them, what they do) and intervention with the person themselves (for example developing functionally equivalent alternatives to challenging behaviour or treating underlying mental health problems). If services are poorly set up (for example too many people living together, not enough staff, too far from shops and amenities) then the environmental aspects of change may include redesigning the service.

In practice, clinicians may often be asked to intervene in services that are ill-conceived, badly set up, under-resourced, and where staff or managers are not sufficiently skilled or motivated to implement effective means of working with people. The services may, for example

- not be able to provide all the support that is required
- be unable or unwilling to carry out recommended interventions
- have poor levels of knowledge or skills
- have a high staff turnover
- be using aversive or punitive measures to control the individual.

It may also be the case that services or organisations do not change despite interventions, reports or advice.

In these 'less than optimal' situations, clinicians face a dilemma; if they recommend interventions which they believe represent best practice in addressing the problem, they may not be carried out or not carried out sufficiently well. Intervention may become discredited, staff demoralised and potentially the clinician is blamed for unrealistic expectations. The person receiving services suffers from inadequate and incompetent intervention and may end up gaining a reputation of 'being beyond help' when in fact it is services that have failed them.

On the other hand, if clinicians acknowledge the deficiencies of the service they are working with, they may need to propose pragmatic interventions which deal with the short-term crisis but leave the underlying problems untouched. The service, and the commissioners and care managers who assess and plan for the individual, are therefore not enabled to learn from the problem and develop the service, so that the risk is that the problem will recur again and again. The individual person receives less effective intervention than they need and may suffer more restrictive intervention than would be needed in a better situation.

Given scarce resources and the urgency of the request for help, clinicians may feel that they have to 'do something' and may end up delivering less than optimal interventions themselves; for example, medication being prescribed in the absence of other interventions as a result of these being unavailable or undeliverable in the particular setting. Alternatively they may refuse to intervene in settings that are unsafe or unable to change. Neither approach should be acceptable; professional ethics and codes of practice make it clear that as well as a duty to do their best to meet the needs of the individual, the clinician has a duty to point out when they believe that the client is suffering unduly as a result of service deficiencies or bad practice (Royal College of Psychiatrists, 2004; British Psychological Society, 2006). Facing this dilemma, clinicians have two responsibilities – these are not alternatives: both have to be done:

- to do their best with the resources that are available to meet the needs of the person concerned
- to draw to the attention of the responsible authorities that the service the person is receiving is unsatisfactory, to indicate in what respects it is deficient and to spell out the negative consequences of these deficiencies on the quality of life of the person concerned.

A role of 'clinical advocate' may need to be adopted in which the clinician, within the appropriate boundaries of confidentiality, works together with the service user to ensure that their needs are clearly outlined and communicated to relevant managers, commissioners or inspectorates. A detailed, recorded, functional assessment, formulation and diagnosis, together with a risk assessment are vital in not only highlighting individual, environmental and systemic issues, but also the impact on the individual and those around them, of a failure to respond appropriately and adequately to their needs.

Clinical advocacy must not be confused with 'shroud waving'. The clinician does not refuse responsibility for trying to help the person, nor do they make general claims beyond that which the evidence supports. They maintain a degree of objectivity at the same time as illuminating the personal and human facets of the situation that the person is challenging. Where possible, more than one potential solution should be sought in order to help those responsible for managing, developing and commissioning services to find creative and flexible responses within the system in which they work.

We acknowledge that this is a difficult area and one where clinicians need to maintain appropriate and safe boundaries in their clinical relationship with the service user. They may also need to make service providers and commissioners aware of their professional duty to point out problems with the way services are set up and run. However, clinicians cannot escape this responsibility. They will often be the most highly-trained resource the service user has and their potential influence is considerable.

Capable environments

In recent years, increasing numbers of people whose behaviour challenges services have moved from institutional settings to a range of places in the community (Mansell *et al*, 2002). Demonstration projects have shown that people can be well supported in the community (Felce *et al*, 1994; Mansell, 1994, 1995; Horner *et al*, 1996; Mansell *et al*, 2001), but the learning from these has not become embedded nationally as models for service delivery. Three problems commonly exist

- family support and local placements can break down, and there are rarely local alternatives or supports that are of sufficient quality
- out-of-area placements then become the most likely alternative. A study in the West Midlands, for example, shows a steep rise in the number of people placed out-of-area in recent years (Ritchie *et al*, 2005, p.45). Such placements are often both expensive, and a long way from the person's family and community (Mitra & Alexander, 2003; Beadle-Brown *et al*, 2006)
- despite the national requirements for inspection and monitoring, there still exist institutional services where restrictive and abusive practices persist (Commission for Healthcare Audit and Inspection, 2006, 2007). These are often in larger settings where every resident demonstrates behavioural challenges (Robertson *et al*, 2004)

Where these problems exist in a locality at a significant level, they can produce two further consequences

- the process of care planning can become overwhelmed by crises and short-term reactive responses which are almost entirely concerned with finding placements to take people whose existing arrangements have broken down
- the overall cost of services increases, since the new placements for people whose behaviour is challenging are able to command higher fees. Despite these higher costs, the new placements are often of poorer quality, not only because they often remove people from their local communities, but also in terms of care practices (Emerson *et al*, 1992; Robertson *et al*, 2004).

REASONS FOR BREAKDOWN, OUT-OF-AREA PLACEMENT AND POOR QUALITY SERVICES

It is important to recognise that the reason for the breakdown of local placements is generally not the behaviour itself. Local services can successfully support people who present a wide range of challenges (Mansell *et al*, 2002). Rather, the reason lies in the way typical services respond to people who present challenges.

As outlined in the previous chapter (Focusing on the person), the term 'challenging behaviour' is socially constructed. The term represents the interaction of both individual and environmental factors, and the relationship between them (see Fig.1).

When people are supported in services that are unable to respond appropriately to their needs, it is more likely that the person will develop patterns of behaviour that are then responded to in ways that will maintain that behaviour. If services are poorly organised, it is more likely that they will be challenged by the behaviours and that the behaviours will then persist (Department of Health, 1993).

In the past, there have been some naïve beliefs that simply by discharging people from institutional settings into community placements, there would be an increase in their opportunities, and a consequent decrease in behaviours that challenge. A change of model by itself is insufficient to bring about a change of behaviour (Emerson & Hatton, 1994).

Another persistent belief is that behaviour can be eliminated through appropriate biomedical or psychological treatment alone. Biomedical interventions may be effective in changing behaviours where the underlying cause has a physical basis that is amenable to medication (Deb *et al*, 2006). Successful psychological interventions (British Psychological Society, 2004) are frequently not maintained, due to a lack of the required level of consistency by the support team (Oliver *et al*, 1987).

Rather than relying on attempts to alter a person's behaviour by changing service models, or through 'treatment', it is evident that commissioners and managers should be designing services that promote a person's quality of life in spite of the intensity or frequency of their behaviour.

Staff teams should not be looking for quick solutions to what may be lifelong patterns of behaviour. They need to be trained, supported and managed in such a way that they can promote positive interactions that may bring about increased participation, independence, choice and inclusion within local communities. Limitations in 'placement competence' appear to reflect a lack of training, or relevance of training, and 'practice leadership' (Mansell, 1996; Jones *et al*, 1999), as well as a lack of knowledge (Hastings, 1996), value conflicts (McGill & Mansell, 1995) and different perceptions by front-line staff about the priorities in their work (Mansell & Elliott, 2001). The rhetoric of 'treatment', in which challenging behaviour is seen as entirely located within the individual and amenable to medical or psychological treatment, actually helps perpetuate unsophisticated support for individuals presenting challenging behaviour in residential care or in their family homes. The requirement for staff to work in skilled and well-organised ways is diminished by the belief that the problem lies in the person and that they can be cured, usually somewhere else.

At this point in the development of community-based services, commissioners are typically paying for large numbers of residential care places that can support individuals who do not present particular challenges, and only a few places that can support people with more complex needs (and these places are not always of good quality). There is a mismatch between the level of need in the population of people with learning disabilities and the range of available provision. Fig. 3 illustrates how, for an increasing level of need for responsive, resourced and skilled support and intervention, there is not an equivalent capacity to deliver these in the majority of services. Within a small service sector there is a concentration of skills and resources only for those who present the greatest challenge (or risk) or who have been rejected by local services. In the majority of local community-based service provision, the capacity and capability to respond appropriately to behavioural challenges is generally low. When a certain threshold of tolerability is exceeded then a specialist and resource intensive solution is sought, increasingly within the independent sector and away from the individual's place of origin.

SUPPORT FOR PLACEMENTS

In the situation described above, people who may present a significant challenge to services which are not really staffed, trained and organised to respond to their needs are likely to be excluded. The ideological commitment to supporting people in the community, so widely evident in learning disability services, breaks down under pressure.

Even if the services concerned wished to continue to support individuals presenting major challenges, there is often not enough capacity to do so. Within staff teams, there is typically little expertise. Most staff are untrained, staff turnover is high, and what training people have received is likely to have been restricted to reactive management methods rather than proper preventive and ecological strategies. Once challenging behaviour escalates to a frequent, severe problem the staff may not be able to cope.

The major source of the expertise needed to work with people presenting challenging behaviour is located in professionals, typically employed by the health service and organised in multi-professional teams. These teams include nurses, psychologists, speech and language therapists,

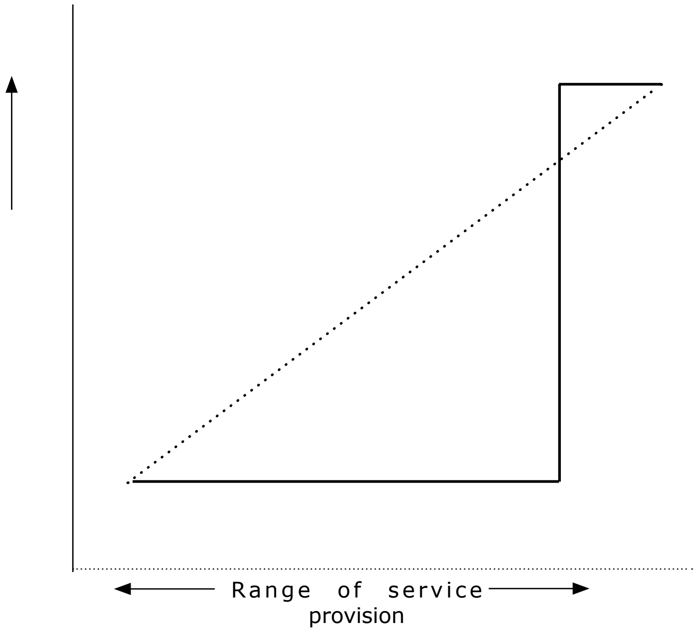

Fig. 3 Need and capability in services for people with learning disabilities. ——— , capability of service to respond; ………… , individual demand on service

physiotherapists, psychiatrists, occupational therapists, social workers and other therapists. There are major shortages of some of these groups.

Yet these professionals face substantial problems even where they do exist. Basing their approach on recent research and development, they expect to analyse the challenging behaviour in the situation in which it is occurring and develop a package of intervention components which include

- ecological manipulation: managing the situation to avoid triggering challenging behaviour while still supporting people to engage in meaningful activity and relationships
- positive programming: helping the individual learn functionally equivalent alternatives to challenging behaviour to get what they need
- direct treatment: responding to the challenging behaviour in a way that will reduce its functional effectiveness
- reactive management: how to work with the person safely during episodes of challenging behaviour (Donellan *et al*, 1988).

This kind of approach requires careful, consistent, sustained implementation by staff, often over many days or weeks. They will need to work together as a team, to understand the principles underlying the professionals' recommendations so that they can sensibly adapt to changing circumstances, to manage their interaction with the focal service user and record events and incidents.

Given the level of training, turnover and the prevailing ethos in learning disability services, staff are rarely able to respond to these demands. A common reaction therefore is a kind of stand-off. Staff providing direct support to people with learning disabilities often say that professionals do not understand the practical constraints they face and generate action plans that are impossible to implement. Meanwhile, clinicians report that staff are simply not able to carry out necessary assessments and intervention (Beadle-Brown *et al*, 2006). They may lower their expectations but thereby run the risk of their plans being ineffective.

Difficulties of implementation are exacerbated during periods when the individual's behaviour is most challenging. Questions then arise about the ability of the staff team to sustain the action plan. Once a few staff have been injured or incapacitated there may not be enough skilled staff within the team to carry on. Nor can help usually be found from other local services because of the scarcity of expertise of the level required and the inability to deploy staff between different providers. The gap between relatively unsophisticated and effective services is too great to be bridged, especially in a crisis.

Given these difficulties, providers often feel that they have no choice but to exclude individuals from their services. Facing a shortage of services that will take people with serious challenging behaviour, care managers are then often obliged to place people in settings out-of-area, away from any local links the person may have.

SPECIALIST CHALLENGING BEHAVIOUR PLACEMENTS

Once their existing placements break down, people are often moved to special 'challenging behaviour' services. These may be assessment and treatment services, of which there are estimated to be about 60 in England. This arrangement reflects the dominant 'treatment' paradigm in which particularly complex individuals are referred to more specialised services, which group people with more challenging problems together and deploy rarer expertise to assess, treat and if not cure, at least ameliorate people's problems to the extent that they can return to less specialised services.

In some cases the greater skill and organisation in the special unit is indeed effective at helping to reduce the severity and impact of the individual's challenging behaviour. This might be because of particular clinical skills (Murphy & Clare, 1991; Mansell *et al*, 1994*a*) identifying the causes of challenging behaviour and the best ways of responding to it. It might also more simply reflect better training and organisation of staff, so that they provide a more consistent approach than was possible in the former placement.

In these cases the issue then becomes how easy it is to transfer the knowledge and skill of the staff in the specialist service to the person's original home since, in most cases, maintenance of improvement will require changes in how staff there provide support. This requires exactly the same kind of organisation as when external professionals advise staff, and faces all the same problems described above. Thus, in practice, units for the short-term assessment and treatment of challenging behaviour often face difficulties in providing a way back for individuals, who become de facto long-term residents (Beadle-Brown *et al*, 2006) and clinicians report concerns as to whether some specialist units do in fact offer greater skill and organisation themselves or rather simply refer to their local learning disability teams following admission.

In units that are partly or wholly providing long-term care, there is an uneasy relationship between the ideology of short-term assessment and treatment, and providing support to people in their long-term home. The focus on assessment and treatment can mean that insufficient attention is given to the quality of people's lives throughout the day, with a primary focus for staff attention on control and on challenging behaviour. Practices which might be tolerable for a short stay are not acceptable when people are more-or-less permanent residents, and there is a risk that the environment and staff practices degenerate to a lowest common denominator because of the wide variety of challenging behaviour that occurs over time. Thus, for example, furnishings become barren as individuals damage them and they are not replaced for reasons of health and safety, behaviour management or economy; resident access to their rooms and communal spaces is controlled and choice is reduced to fit in with the regime. In so far as special units are separate, geographically, organisationally and socially, from ordinary learning disability services and the wider community, isolation and norm drift can occur. There is evidence that special challenging behaviour units, and other residential services which group together people whose behaviour challenges services, provide less good quality of care than community services (Mansell, 1994, 1995; Robertson *et al*, 2002; Mansell *et al*, 2003).

Excluding people from their home and sending them to a special challenging behaviour unit also risks creating several perverse incentives at service system level for the providers of support and accommodation to people with learning disabilities. It can confirm the reputation of the individual concerned as 'impossible', making it harder to set up a new placement locally. Potentially, it rewards weak management and training and represents a failed opportunity for developing the capacity and skill of local services. It could reward a strategy of allowing situations to worsen, rather than taking preventative action as early as possible, and it perpetuates 'passing the buck' as a service response.

If present arrangements continue, one might expect to see the growth of new institutions for people with learning disabilities. Although there are now only 700 people with learning disabilities living in NHS long-stay hospitals, there are 3700 places in private nursing homes and hospitals, many of which will be for people who present challenging behaviour (Department of Health, 2004).

STRATEGIES FOR IMPROVING SERVICES

CREATING CAPABLE ENVIRONMENTS

How might services be improved to enable people with learning disabilities who present challenging behaviour to remain in their own homes and communities, in services which provide a good quality of life? Providing more resources for the existing arrangements is not necessarily going to help; more specialist teams and units would not address the reasons why existing teams and units have limited effectiveness. The analysis presented above offers some obvious alternative indications for action to improve services. Fundamentally, the aim of service providers and commissioners should be to increase the capability and capacity of the environments in which people ordinarily live, in order to enable them to respond appropriately to individual need.

The focus of the challenge presented by the behaviour(s) of an individual can be conceptualised as occurring at the interface between the characteristics of the environment in which the individual lives and the services available. The capacity and/or competence of the environment to respond to challenging behaviour is determined by a number of factors among which we would see the following as being salient

- organisational structure
- appropriateness of response
- flexibility of response
- delivery of service
  - staff number
  - staff skills
  - staff deployment
- attitudes and attributions (culture and values)
- stability and focus.

Within this environment there should be a range of skills available, ranging from those core skills held by all carers, support staff and professionals, to those highly specialised skills in the fields of mental and physical health, psychological therapies, communication and behavioural skills.

A model of competency-based training can be applied to skills acquisition by support staff. Skills related to the understanding, assessment and management of challenging behaviour can be developed in the same way as that described for psychological therapies in the NHS (National Health Service Executive, 1996):

- type A: fundamental – those integral to all work with people with learning disabilities. This may include basic understandings of person-centred approaches, psychological and/or behavioural interventions, signs and symptoms of mental illness, values and principles of understanding and supporting people whose behaviour is challenging.

- type B: specialised – specific skills in the assessment, diagnosis/formulation and management of mental and behaviour disorders and how they may underlie challenging behaviours. All learning disability psychiatrists, psychologists, speech and language therapists, nurses and other members of the multidisciplinary health team should possess these skills to different degrees.
- type C: highly specialised – specialised skills in the assessment, formulation and management of challenging behaviours. These can be held by a variety of professionals with specific experience and training and may be delivered as part of specialist challenging behaviour services.

The point of intersection of these two parameters, capacity/competence and skills, is where the focus of interaction with the individual with a learning disability is located. It is at this locus that we concentrate our efforts to understand the person and the meaning of their behaviour through

- listening and asking questions ('Why are you doing this?', 'Why do you think he/she is doing this?', 'Why is this happening?', 'What are you/we doing in response to this?')
- communication assessments and interventions
- person-centred approaches
- assessment, formulation/diagnosis, intervention
- psychotherapeutic interventions
- risk assessment
- multidisciplinary and inter-agency collaboration.

For any particular individual, the balance of skills that are required must be titrated according to need, and this will be always changing over time.

The drivers behind service development will be pushing towards a greater degree of competence and capacity in the environment, with more skills being delivered through type A interventions; currently we find low competence/capacity environments with maximum reliance on highly specialised services. This aim can be expressed in a reconstruction of Fig. 3, see Fig. 4 where capability parallels need.

It is important to note that this does not express an intent to reduce the numbers of professionals with specialist skills. On the contrary, in order for there to be greater competence and capacity within services and agencies, it is essential that there is a highly skilled specialist workforce to deliver advice, support, training and supervision in addition to specific interventions and therapeutic work with individuals, carers and families. In this model, the role of specialist practitioners should be more focused, validated and strengthened.

PROMOTING CREATIVE SOLUTIONS

Capacity and competence in the person's environment are essential, but the nature of the concept of challenging behaviour begs a further quality – that of creativity. In the original sense of the term, the challenge of a particular behaviour was aimed at those around the person, carers, professionals and services to find alternative ways of responding to the behaviour. It is, therefore, clear that the greater the challenge then the more likely that people will need to

- find more creative responses and solutions
- overturn traditional or longstanding responses

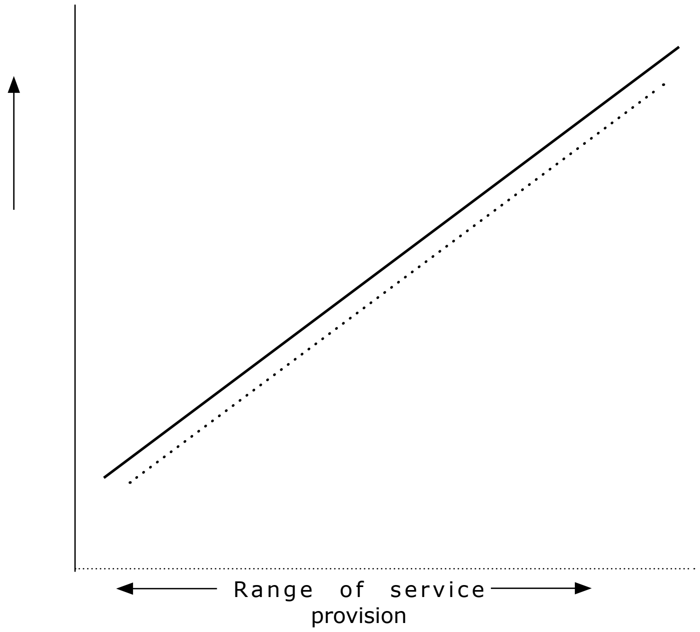

Fig. 4 Aim for capability to parallel need. ——— , capability of service to respond; ………… , individual demand on service.

- adopt counter-intuitive ideas
- question the necessity for the established reputation and practice around the individual
- take managed risks
- adopt a greater flexibility of roles and responsibilities
- establish creative and unconventional working partnerships between individuals, community supports, voluntary and statutory agencies, professionals.

Many emergency placements are made at times when it is not easy to enlist the assistance of people who might be able to find and provide more creative responses. Faced with a breakdown of an individual's support and with limited resources, time and clear paths of access to a range of options, clinicians and managers often have to adopt restrictive or custodial solutions of admission to hospital, assessment and treatment units or out-of-area placements. More creative and person-centred solutions cannot be rapidly conjured up at short notice; services and living environments therefore need to be in a state of 'creative preparedness'. Day-to-day operation should be based on principles and practice that expands the range of

- activities
- community links and participation
- networks of friends and supporters
- links between statutory and non-statutory services
- people able to provide support both in the short and long term.

Potential solutions to a placement breakdown might include, for example

- deployment of support workers to engage the individual in activities outside the home until the crisis has abated or to enable less time to be spent in the home on a daily basis

- deployment of support workers or extra skilled staff into the individual's home to work through a crisis
- extra skilled leadership or support for staff to help in 'getting back on track'
- a weekend hotel break for the individual (or for family)
- staying with tolerant or skilled friends
- borrowing a caravan or flat for a holiday break
- using a local flat or house before it is permanently occupied
- using a designated respite care home.

To support such an approach, services need to adopt new ways and principles of working. These should allow for example

- flexibility in recruitment and deployment of a range of skilled staff
- a focus on enriching the capabilities of the immediate environment rather than a reliance on specialist services
- planning realistic futures with individuals rather than leading a life of surprises
- building spare capacity into service growth and individual care plans
- working in an integrated manner with a range of service provision for an individual who crosses the conventional statutory and non-statutory sector boundaries
- clear 'rules' about not taking an individual's home away while they are in assessment/treatment or respite facilities
- Proactive risk management plans for predictable crises.

PERSON-CENTREDNESS

When thinking about the skills of carers and professionals, service structures and provision, it becomes easy to overlook the individual at the heart of all this activity. Experience would suggest that individuals who present severe challenges are less likely to have supports that are tailored to individual preferences and choices. Of course, it can also be argued that it is the failure to deliver such individualised supports that may lead to the occurrence of challenging behaviour.

It is essential that those planning and delivering support and packages of care should consider what a 'good enough' service would feel like to the service user. We assume that such a service would be constructed firmly around the individual's

- likes, dislikes, aspirations
- preferred social activities
- valued activities
- communication style
- friendships and other social relationships
- integration and participation in community activities, relationships and supports
- validating and non-aversive, non-punitive support from others
- physical, psychological and spiritual well-being
- sense of 'home'.

FOCUS ON CARE PRACTICES

The service community (the people commissioning and planning services, providing them, working in them and using them) needs to recognise that challenging behaviour is relatively common in services for people with learning disabilities and that it is unlikely to disappear as the result of short-term treatment. The implication is that the present model, in which support is almost entirely provided by unqualified and unskilled staff, relying on a small amount of specialist services to help them or deal directly with the most challenging individuals, needs to be replaced.

The pervasive ideology of treatment, moving people around in the belief that they can be 'fixed' somewhere else, is inappropriate. What is required is that a much greater proportion of staff are sufficiently skilled so that they can support people to live well in the community, even if they present challenges in terms of their behaviour.

Although this might seem a radical departure from a well-entrenched model, it is in fact one expression of a general shift that is required in social care services. Across all client groups, the populations now using community services have many more disabilities than those who were using them 20 or 30 years ago and they have complex needs which demand considerable skill as well as common sense and humanity in the staff who work in these services.

If the goal is to support the individual in achieving as good a quality of life as possible in spite of their problems, this has implications for the kind of support provided by staff, and their training, management and organisation. It requires individually tailored placements, which may involve living with two or three other people, but which are not 'challenging behaviour homes'. Whether these are people's own homes (e.g. through the 'supported living' movement) or small group homes they should provide a homely, comfortable and individualised environment.

The quality of staff support provided should be focused on enabling the individual to engage in meaningful activity and relationships at home and in the community, and staff should be skilled and well-organised to deliver what is called active support (Mansell *et al*, 1987, 1994*a*, 2005; Jones *et al*, 1996; Mansell, 1998).

Within this context of good preventative practice, through providing skilled active support, placements will need to address challenging behaviour through methods of positive behavioural support (Koegel *et al*, 1996). This involves developing individual skills, especially communication skills, and rendering them differentially effective over challenging behaviour through contingent reinforcement (McGill, 1993; British Psychological Society, 2004).

This implies changes in the training and status of staff in order to achieve and retain the expertise required. Whereas current training policy is focused only on achieving the most basic level of training (Department of Health, 2002), services that can support people with a wider range of needs require staff with more advanced training who can follow a career providing skilled support to people with learning disabilities. It also implies changes in regulatory practice to focus on the quality of support offered to people (Commission for Social Care Inspection, 2004) and to detect the early signs of decay in care practices which lead to placement breakdown (Mansell *et al*, 1994*a*, *b*).

Creative commissioning

MATCHING PURCHASING STRATEGY TO NEED

The requirements for good support for individuals give commissioners a clear basis on which to develop and select competent providers. Most directly, the requirement for more skilled support could be reflected in service specifications and monitored through contract compliance arrangements. Given evidence of the very limited developmental role now played by local authority social services in respect of learning disability services (Cambridge *et al*, 2005), an alternative route to developing the market may be through personal budgets and independent brokerage (Department of Health, 2005).

However needs are specified there are not enough services that can provide the level of skilled support required in each local area. Commissioners therefore have an important role in developing the new kinds of services that will be required. This might include direct facilitation through recognition, help and financial reward to bring new service providers into the local market, or to shape up existing service providers to be able to provide the level of support needed. There are documented examples of this approach (Mansell *et al*, 2001) and recently the 'In Control' project set out to build individualised support arrangements around individuals, including people with complex needs, in the context of personal budgets (Duffy *et al*, 2004). Developing sufficient skilled support locally will also require commissioners to manage the incentives for provider competence, so that services which really do provide more skilled support are treated differently from those that do not.

Recognising the fragmented nature of service provision, it is also important to encourage provider cooperation and mutual support. For example, if a particular service enters a difficult period in which several staff are injured, it is important that they can call on other staff of comparable levels of skill to help get through the difficulties. At present, services tend to work in isolation and even if staff could be borrowed from other local providers, they would be unlikely to have the knowledge and skill required in the more specialised service. Small-scale services have to work together if they are to be sustainable.

RE-FASHION 'CHALLENGING BEHAVIOUR' SERVICES

Instead of functioning as a route for taking over service provision to individuals in crisis, challenging behaviour services need to use their specialist skills to help managers in the provider network lead their staff in the provision of effective local services. This requires closer coordination between the people paying for services, the managers providing services and the professional specialists advising on the support people need, to ensure that advice is both practical and is acted upon.

This might be achieved in at least three ways

- there could be closer integration between care managers, care standards inspectors and members of community learning disability teams or more specialised challenging behaviour teams. These different external sources of advice, help and control could work together (in the way that they do, for example, in adult protection investigations) so that advice to service providers is clear, consistent and authoritative
- many of the skills and the expertise to carry out assessments, interventions and proactive risk management plans exist within the clinical staff employed within the NHS. Staff training and support to local services in different sectors should be a core role of specialist health professionals
- the extension of personal budgets could allow individuals (or individual trusts, or other representatives) to decide for themselves whether the specialist advice they pay for is useful and whether the support staff they employ follow it. Present proposals for the extension of direct payments and personal budgets (Department of Health, 2005) do not include health services but this would be a logical development of present policy.

When placements enter crisis, people whose behaviour is challenging are likely to be excluded, often to specialised challenging behaviour assessment and treatment units. These units serve multiple functions, including assessment, treatment, respite for the individual or others and a 'holding area' while new placements are sought. Part of the strategy should therefore be to replace the 'one-stop shop' of challenging behaviour units with a wide range of tailored options to meet these multiple needs. In particular, help will be required to find or create new options for housing and support locally. For as long as sufficiently skilled services are scarce, the expertise of challenging behaviour support teams is likely to be needed to help in this task.

Instead of regarding challenging behaviour as a clinical problem located within a minority of individuals, commissioners should recognise that challenging behaviour is relatively widespread and persistent. Services need to be configured in order to support people in spite of potential or actual challenging behaviour and this means that commissioners need to choose services in which staff have the expertise to do so.

Commissioners also need to manage the market they have created in order to sustain the capacity of local services to meet the needs of everyone with learning disabilities. This involves encouraging service providers to cooperate, underpinning service competence through training and service development and reshaping specialised challenging behaviour services to support effective local placements.

Whether commissioning can meet this challenge remains to be seen. Cambridge (1999) suggests that commissioning in learning disability services has failed to realise its potential. Increasing enthusiasm among policymakers for direct payments and personal budgets may reflect a view that commissioning by local authorities is unlikely to meet the needs of disabled people. However, although increased personalisation may reduce the need for some aspects of service selection and design at the individual level, it will not remove the need for the population-level work of developing and coordinating sufficient services in each locality.

FUTURE COMMISSIONING ARRANGEMENTS

In 2005 new funding arrangements for the NHS were introduced, which are likely to impact on the commissioning and provision of specialist psychological and psychiatric services for people who present behavioural challenges.

At the time of writing, it is intended that services provided by the NHS will be subject to a national tariff. Each provider will then have to match their services against this benchmark cost, and services that are significantly over the base tariff will presumably have to either cut costs or justify them. These tariffs are not yet available for services for people with learning disabilities whose behaviour is challenging and an alternative method of costing may be developed.

Whatever form of costing is decided upon, however, services will be more accountable in terms of their cost and their outcomes. Funding is likely to be on a contracted basis, and sourced through primary care trusts (PCTs) and practice-based commissioning. The financial imperatives may drive commissioning to the cheapest provider (and the NHS will face competition from voluntary and private sector providers). Services therefore will need to be able to demonstrate both value for money and effectiveness. They will need to promote high standards demonstrating high-quality evidence-based interventions, effective outcomes and at a cost that appears to be broadly in line with other services.

Providers of psychological and psychiatric services to people whose behaviour is challenging will therefore need to demonstrate that they are achieving good outcomes. This is difficult to achieve in work which usually requires input and support from a range of other individuals and organisations. They will also need to gain contracts from commissioners, as purchasing of services will no longer automatically go to the local NHS provider. Those services which either do not deliver good outcomes or fail to meet other contractual requirements may lose their funding, while those services which do achieve good outcomes, at a reasonable cost, are more likely to grow and expand.

Clarity over outcomes and clearly defined service provision should increase the quality of services available to people presenting challenging behaviour. However, difficulties may occur if one provider has a contract via the NHS arrangement, but circumstances arise where it can not be properly delivered. This is not an infrequent occurrence in delivering services to this client group and specialist services have usually retained the right to withdraw their services if the advised treatment is not being implemented. This may be more difficult to do in the new contracting arrangements, or it may be that the intervention will take longer (and therefore cost more) with consequent impact on overall contract activity. Commissioners will, therefore, need to be aware of

- best practice in intervention
- the outcomes achieved by the intervention (and these may be broader than behavioural change)
- the difficulties in predicting how long an intervention will take, as it depends on many others to implement.

Future directions

Compared with most other areas of work with people who have learning disabilities, there is an extensive evidence-base to guide professionals who support people whose behaviour is seen as challenging. However, there are significant issues around implementation of best practice, as is evidenced by the number of people who have to be referred to out-of-area placements when their local services are unable to support them. The purpose of this section is to identify some of the areas of practice that have not been fully addressed within this document, or where future research is required in order to create a context for successful professional practice.

AREAS NOT ADDRESSED IN THIS DOCUMENT

The main focus of this document has been on adults who have limited capacity or ability to exercise choice over their interactions with the environment. This has therefore excluded children and many people who may fall within the forensic services. Much of this document may be of relevance to professionals who work with children or offenders, however their needs should be fully considered in a future report. In addition, functional assessment and functional analysis are approaches that are applicable to many different client groups, not just to people with learning disabilities.

In particular, it is recognised that there needs to be an emphasis on early intervention and preventative work. There is an evidence-base that suggests that once patterns of behaviour have developed, and environmental responses have become entrenched, it is difficult to bring about lasting change without extensive interventions. Challenging behaviour may be a lifelong problem and there needs to be a greater emphasis on lifelong planning across services. Within services for adults, there is a recognition that by the time of transition into adult services, many children have unnecessarily been moved into large scale, out-of area residential care, and that interventions are too rarely based upon the principles of positive behavioural support. Many adults are also in out-of-area placements, and services are actively seeking to bring them back. This document could be useful in assisting in the transition process and in the quality monitoring of both existing and planned placements, as well as in developing new services.

This report has been written by professionals, primarily for professionals. Although there has been consultation with both service users and carers in its development, it has not been our intention to address the content specifically to them. Instead, our aim is to work with service user and family carer groups in the near future to prepare a charter that outlines 'what should you expect your local services to look like if they are meeting the standards set out in this report?'

IMPLEMENTATION

By itself, this document is unlikely to bring about significant improvements in services for people who present behavioural challenges. Locally tailored multidisciplinary implementation plans are required in order to develop these guidelines into local care pathways. It is neither possible nor appropriate to dictate the details of such pathways, as they will be determined by existing local service strengths and gaps. However, the good practice standards (see Appendix 1) should provide a framework for local teams to review themselves and agree their own pattern of service delivery. This process should include all local stakeholders, including carers, service users, providers, commissioners, professionals, regulatory bodies etc. Local teams should ensure that they have in place a service delivery plan that includes all the elements addressed within this report.

Currently, most residential accommodation support to people is provided through systems that are regulated in England by the Commission for Social Care Inspection (CSCI), the Care Standards Inspectorate for Wales (CSIW), and the Care Commission in Scotland. Generally psychiatrists and psychologists do not directly influence these bodies. A policy paper, 'Best Practice Guidance on the Operation and Management of Registered Care Homes for People with Learning Disability Who Present Significant Challenges' was written by the National Care Standards Commission (NCSC) (2003), the forerunner to CSCI. It is important that there is consistency between our groups. It may be possible for clinicians to work with colleagues in the various inspection bodies to develop a process for challenging behaviour accreditation.

Other specific areas of work that could potentially influence the implementation of 'best practice' include

- collaboration with service users and family carers. Partnership models such as the family partnership approach (Davis *et al*, 2002) offer ideas for implementing change in collaboration with a range of carers, paid and unpaid. Albin *et al* (2002) have highlighted some of the difficulties of transferring interventions based on positive behavioural support from the clinic or research environment into people's natural environments. This requires further specific work
- NICE guidance development. There is currently a lack of NICE guidance relating directly to people with learning disabilities though, unless specifically excluded, all NICE guidance should be considered to be applicable across the range of intellectual ability. The development of guidance on psychological and physical treatments or management strategies for behaviours that are challenging could prove useful though, in a field of great heterogeneity of individual characteristics, aetiologies etc., such guidance should aim to facilitate a range of approaches rather than be narrowly restrictive
- training of support/care staff. There is a need for new support workers to be able to 'hit the ground running' when they start to work with people who challenge. In an area of high staff turn over, there is a need for a rolling programme of competency-based training, including responding to potentially violent situations. The

current LDAF and NVQ models of staff training do not place sufficient emphasis on training staff, from their first day of employment, in methods that will enable them to fully support people who challenge. It is to be hoped that the new learning disability qualifications training models that are being developed by the Valuing People support team and skills for care will address this.

Professionals using this document will have a significant role in teaching and training others. Carers and support staff will have a major role in delivering the interventions described, and we will need to provide ongoing training and support to both develop and maintain services that can meet the complex needs described in this document. Allen *et al* (2005) draw attention to some of the reasons for positive behavioural support not being used more widely. These include the limited training opportunities and commissioners' reluctance to specify that staff have such training.

- Core skills and training for professional staff. Professional training for psychologists, psychiatrists, speech and language therapists and other members of the multidisciplinary team, at all levels, including ongoing professional development should be developing a strong and clear focus on core skills and demonstrable competences in working with people who present behavioural challenges. Current changes in professional training regulation and monitoring provides opportunities for building new training approaches and methods of evaluation.
- New commissioning/purchasing models. The growth of individualised budgets can be viewed as a means of introducing greater individuality, flexibility and creativity of service purchasing and delivery. Where people can have control of who they purchase to support them, there may be concerns about the nature and standards of training, supervision and support that those individuals might have in supporting people with behavioural challenges.
- 'Payment by results'. It is difficult to envisage how this will work in learning disability services as a whole, in the absence of examples of its operation or piloting elsewhere. In the model of defining and responding to challenging behaviour as laid out in this document it is not immediately apparent how one might conceptualise activity, case-mix and healthcare resource groups. It is essential that clinicians engage with this process at an early stage in order to assist in finding meaningful parameters to describe and quantify healthcare activity and to avoid a regression to the use of challenging behaviour as a diagnostic term.

FURTHER JOINT WORK BETWEEN PROFESSIONS

It is hoped that the production of this report represents the early steps in a developing programme of joint professional working at both national and local levels that should include

- further development of guidance on the appropriate and specific uses of psychotropic medication
- the development and description of integrated models of diagnosis and formulation, for example bio-behavioural or bio-psychosocial models. Effort should be made to bring together models that may, at times, appear to be in opposition to one another

- the description and demonstration of the characteristics of effective multidisciplinary working
- acknowledging that providing input to social care settings should be a core role for clinicians, we need to be clearer on how we work with and influence services that are not delivered within the NHS (for example how do clinicians influence training plans, philosophy, values, therapeutic approaches etc. in residential care homes within the independent sector?)
- addressing workforce issues including implementation of 'New Ways of Working' and 'New Types of Workers' initiatives
- the further development of psychotherapeutic approaches, extending the potential benefit to families, carers and those with greater degrees of intellectual impairment, for whom these may not be currently the prime intervention of choice
- addressing issues of abuse perpetrated against, rather than by people with learning disabilities who present severe behavioural challenges; considering how we should investigate and protect against abuse in such vulnerable people.

RESEARCH, EVALUATION AND AUDIT

More collaborative and inter-disciplinary activity is needed in research evaluation and audit to look at

- the development of a set of outcome measures for interventions in the assessment and management of the behavioural challenges of people with learning disabilities. Particular focus should be placed on measuring the outcomes of interventions with carers, staff teams and other systems
- the establishment of a current evidence-base around effective interventions, based on good single case methodology and generally building up a research evidence base from clinical practice
- the prevention of unnecessary out-of-area placements, including how best to provide effective supports to families and local care systems. This may include a cost-benefit analysis of preventing unnecessary out-of-area placements that addresses outcomes for people, financial cost of placing people away from their communities, and the lost opportunities for investing locally in services that might support other people who present challenges.

References

Ager, A. & O'May, F. (2001) Issues in the definition and implementation of 'best practice' for staff delivery of interventions for challenging behaviour. *Journal of Intellectual and Developmental Disability*, **26**, 243–256.

Albin, R.W., Dunlap, G. & Lucyshyn, J.M. (2002) Collaborative research with families on positive behavior support. In *Families and Positive Behavior Support: Addressing Problem Behavior in Family Contexts* (ed. J. M. Lucyshyn, G. Dunlap & R. W. Albin), pp. 373–389. P. H. Brookes.

Allen, D. (2002) Devising individualised risk management plans. In *Ethical Approaches to Physical Interventions. Responding to Challenging Behaviour in People with Intellectual Disabilities* (ed. D. Allen), pp. 71–88. BILD Publications.

Allen, D., Banks, R. & Staite, S (1991) *Meeting the Challenge – Some UK Perspectives on Community Services for People with Learning Difficulties and Challenging Behaviour*. Kings Fund.

Allen, D., James, W., Evans, J., *et al* (2005) Positive behavioural support: Definition, current status and future directions. *Learning Disability Review*, **10**, 4–11.

American Psychiatric Association (1994) Diagnostic and Statistical Manual for Mental Disorders (DSM–IV). APA.

Anderson, J. L., Albin, R. W., Mesarols, R. A., *et al* (1993). Issues in providing training to achieve comprehensive behavioural support. In *Communicative Alternatives to Challenging Behaviour* (eds J. Reichel & D. P. Wacker), pp. 317–342. P. H. Brookes.

Bartlett, C. & Bunning, K. (1997) The importance of communication partnerships: A study to investigate the communicative exchanges between staff and adults with learning disabilities. *British Journal of Learning Disabilities*, **25**, 148–153.

Baum, S. & Lyngaard, H. (2006) *Intellectual Disabilities – A Systemic Approach*. Karnac

Beadle-Brown, J., Mansell, J.L., Whelton, B., *et al* (2006) People with learning disabilities in 'out-of-area' residential placements: 2. Reasons for and effects of placement. *Journal of Intellectual Disability Research*, **50**, 845–856.

Beail, N. (2003) What works for people who have mental retardation: critical commentary on cognitive-behavioural and psychodynamic psychotherapy. *Mental Retardation*, **41**, 468–472.

Bhaumik, S., Branford, D., McGrother, C., *et al* (1997) Autistic traits in adults with learning disabilities. *British Journal of Psychiatry*, **170**, 502–506.

Biederman, J. (2005) ADHD – a selective overview. *Biological Psychiatry*, **57**, 1215–1220.

Blunden, R. & Allen, D. (1987) *Facing the Challenge: An Ordinary Life for People with Learning Difficulties and Challenging Behaviour*. Kings Fund.

Borthwick-Duffy, S.A. (1994) Prevalence of destructive behaviours. In *Destructive Behaviour in Developmental Disabilities: Diagnosis and Treatment* (eds T. Thompson & D. B. Gray). Sage.

Bott, C., Farmer, R. & Rhode, J. (1997) Behaviour problems associated with lack of speech in people with learning disabilities. *Journal of Intellectual Disability Research*, **41**, 3–7.

Bradshaw, J. (1998) Assessing and intervening in the communication environment. *British Journal of Learning Disabilities*, **26**, 62–66.

Bradshaw, J. (2002) The management of challenging behaviour within a communication framework. In *Management of Communication Needs of People with Learning Disability* (eds S. Abudarham & A. Hurd), pp. 246–275. Whurr Publishers.

British Psychological Society (2004) *Challenging Behaviours: Psychological Interventions for Severely Challenging Behaviours Shown by People with Learning Disabilities*. British Psychological Society.

British Psychological Society (2006) *Code of Ethics and Conduct*. British Psychological Society.

Brown, L. (1998) Carer communication – making the change. *Speech and Language Therapy in Practice*, (Summer), 4–7.

Cambridge, P. (1999) More than just a quick fix? The potential of joint commissioning in services for people with learning disabilities. *Research Policy and Planning*, **17**, 12–22.

Cambridge, P., Carpenter, J., Forrester-Jones, R., *et al* (2005) The state of care management in learning disability and mental health services twelve years into community care. *British Journal of Social Work*, **35**, 1039–1062.

Carr, E. G. (1994) Emerging themes in the functional analysis of problem behavior. *Journal of Applied Behavior Analysis*, **27**, 393–399.

Carr, E. G. & Durand, V. M. (1985) Reducing behavior problems through functional communication training. *Journal of Applied Behavior Analysis*, **18**, 111–126.

Carr, E. G., Taylor, J. C. & Robinson, S. (1991) The effects of severe behavior problems in children on the teaching behavior of adults. *Journal of Applied Behavior Analysis*, **24**, 523–535.

Carr, E. G., Levin, L., Mcconnachie, G., *et al* (1994) *Communication-based Intervention for Problem Behavior: A User's Guide for Producing Positive Change*. P. H. Brookes.

Carr, E. G., Dunlap, G., Homer, R. H., *et al* (2002) Positive behaviour support: evolution of an applied science. *Journal of Positive Behaviour Interventions*, 4, 4–16, 20.

Chamberlain, L., Cheung, C., M. & Jenner, L. (1993) Preliminary findings on communication and challenging behaviour in learning difficulty. *British Journal of Developmental Disabilities*, **39**, 118–125.

Chatterton, S. (1998) An investigation of speech and language therapy to improve the communication environment of people with severe learning disabilities who have communication difficulties and behaviours that challenge services. *Journal of Learning Disabilities for Nursing, Health and Social Care*, **2**, 203–211.

Cheung, C., M., Jenner, L., Chamberlain, L., *et al* (1995) One year follow up pilot study on communication skill and challenging behaviour. *European Journal of Psychiatry*, **9**, 83–95.

Clarke-Kehoe, A. & Harris, P. (1992) It's the way that you say it. *Community Care*, **923**, 21–22.

Clements, J. (1987) *Severe Learning Disability and Psychological Handicap*. Wiley.

Commission for Healthcare Audit and Inspection (2006) *Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust*. Commission for Healthcare Audit and Inspection.

Commission for Healthcare Audit and Inspection (2007) *Investigation into the Service for People with Learning Disabilities Provided by Sutton and Merton Primary Care Trust*. Commission for Healthcare Audit and Inspection.

Commission for Social Care Inspection (2004) *Inspecting for Better Lives: Modernising the Regulation of Social Care*. Commission for Social Care Inspection.

Davis, H., Day, C. & Bidmead, C. (2002) *Parent Adviser Training Manual*. Psychological Corporation.

Deb, S., Matthews, T., Holt, G., *et al* (eds) (2001) *Practice Guidelines for the Assessment and Diagnosis of Mental Health Problems in Adults with Intellectual Disability. European Association for Mental Health in Mental Retardation (EAMHMR)*. Pavilion Press.

Deb, S., Clarke, D. & Unwin, G. (2006) *Using Medication to Manage Behaviour Problems Among Adults with a Learning Disability*. University of Birmingham, Royal College of Psychiatrists, Mencap.

Department for Constitutional Affairs (2007) *Mental Capacity Act 2005. Code of Practice*. DCA

Department of Health (1993) *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (*The Mansell Report*). TSO (The Stationery Office).

Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. TSO (The Stationery Office).

Department of Health (2002) *Care Homes for Younger Adults and Adult Placements: National Minimum Standards: Care Homes Regulations*. TSO (The Stationery Office).

Department of Health (2004) *Health and Personal Social Services Statistics for England*. TSO (The Stationery Office).

Department of Health (2005) *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England*. TSO (The Stationery Office).

Department of Health (2006*a*) Bournewood Briefing Sheet. Department of Health.

Department of Health (2006*b*) *Our Health, Our Care, Our Say: A New Direction for Community Services*. TSO (The Stationery Office).

Department of Health/Department for Education and Skills (2002) G*uidance on Restrictive Physical Interventions for People with Learning Disability and Autistic Spectrum Disorder, in Health, Education and Social Care Settings*. Department of Health.

Department of Health & Welsh Office (1999) C*ode of Practice to the Mental Health Act 1983*. TSO (The Stationery Office).

Desrochers, M. N., Hile, M. G. & Williams-Moseley, T. L. (1997) surveys of functional assessment procedures used with individuals who display mental retardation and severe problem behaviors. *American Journal of Mental Retardation*, **101**, 535–546.

Didden, R., Duker, P.C., & Korzilius, H. (1997) Meta-analytical study on treatment effectiveness for problem behaviours with individuals who have mental retardation. *American Journal of Mental Retardation*, **101**, 387–399.

Dobson, S., Stanley, B. & Maley, L. (1999) An integrated communication and exercise programme in a day centre for adults with challenging behaviours. *British Journal of Learning Disabilities*, **27**, 20–24.

Donellan, A. M., LaVigna, G. W., Negri-Shoultz, N., *et al* (1988) *Progress Without Punishment: Effective Approaches for Learners with Behavior Problems*. Teachers College Press.

Duffy, S., Casey, J., Poll, C., *et al* (2004) *In Control: A National Programme To Change The Organisation Of Social Care In England So That People Who Need Support Can Take More Control Of Their Own Lives And Fulfil Their Role As Citizens*. Mencap.

Durand, V. M. & Carr, E. G. (1991) Functional communication training to reduce challenging behavior: Maintenance and application in new settings. *Journal of Applied Behavior Analysis*, **24**, 251–264.

Einfield, S.L. (2001) Systematic management approach to pharmacotherapy for people with learning disabilities. *Advances in Psychiatric Treatment*, **7**, 43–49.

Elsek, P.E., Greenhalgh, T. (2001) The challenge of complexity in health care. *BMJ*, **323**, 625–628.

Emerson, E. (2003) The prevalence and use of reactive management strategies in community-based services in the UK. In *Ethical Approaches To Physical Interventions. Responding To Challenging Behaviour In People With Intellectual Disabilities* (ed. D. Allen). BILD publications

Emerson, E. & Hatton, C. (1994) *Moving Out: Relocation from Hospital to Community*. TSO (The Stationery office).

Emerson, E., Beasley, F., Offord, G., *et al* (1992) An evaluation of hospital-based specialized staffed housing for people with seriously challenging behaviours. *Journal of Intellectual Disability Research*, **36**, 291–307.

Emerson, E., Moss, S. & Kiernan, C. (1999) The relationship between challenging behaviour and psychiatric disorder in people with severe developmental disabilities. In *Psychiatric and Behavioural Disorders in Developmental Disabilities and Mental Retardation*. (ed. N. Bouras). Cambridge University Press.

Felce, D. & Lowe, K. & de Paiva, S. (1994) Ordinary housing for people with severe learning disabilities and challenging behaviours. In *Severe Learning Disabilities and Challenging Behaviours: Designing High Quality Services* (eds E. Emerson, P. McGill & J. Mansell), pp. 97–118. Chapman & Hall.

Flynn, A., Matthews, H. & Hollins, S. (2002) Validity of the diagnosis of personality disorder in adults with learning disability and severe behavioural problems. *British Journal of Psychiatry*, **180**, 543–546.

Harper, D., & Moss, D. (2003) A different kind of chemistry? Reforming 'formulation'. *Clinical Psychology*, **25**, 6–10.

Harris, J., Allen, D., Cornick, M., Jefferson, A., *et al* (1996) *Physical Interventions. A Policy Framework*. British Institute of Learning Disabilities.

Hastings, R. P. (1996) Staff strategies and explanations for intervening with challenging behaviours. *Journal of Intellectual Disability Research*, **40**, 166–175.

Hatton, C., Elliott, J. & Emerson, E. (2002) *'Key Highlights' Of Research Evidence On The Health Of People With Learning Disabilities*. Institute for Health Research, Lancaster University (commissioned by the Valuing People Support Team, Department of Health).

Hollins, S., & Esterhuyzen, A. (1997) Bereavement and grief in adults with learning disabilities. *British Journal of Psychiatry*, **170**, 497–501.

Hollins, S., Esterhuyzen, A. & Sinason, V. (2000) Psychotherapy, learning disabilities and trauma: new perspectives. *British Journal of Psychiatry*, **176**, 32–36.

Horner, R. H. (1994) Functional assessment: contributions and future directions. *Journal of Applied Behaviour Analysis*, **27**, 401–404.

Horner, R. H., Dunlap, G., Koegel, R. L., *et al* (1990) Toward a technology of 'non-assertive' behavioural support. *Journal of the Association for Persons with Severe Handicaps*, 15, 125–132.

Horner, R. H., Close, D. W., Fredericks, H. D. B., *et al* (1996) Supported living for people with profound disabilities and severe problem behaviors. In *Persons with Disabilities who Challenge the System* (eds D. H. Lehr & F. Brown). P. H. Brookes.

Iwata, B. A., Bollmer, T. R. & Zarcone, J. R. (1990) The experimental (functional) analysis of behavior disorders: methodology, applications, and limitations. In *Perspectives on the Use of Non-Aversive and Aversive Interventions for Persons with Developmental Disabilities* (eds A. C. Repp & N. Singh), pp. 301–330. Sycamore Press.

Jones, E., Perry, J., Lowe, K., *et al* (1996) *Active Support: A Handbook for Planning Daily Activities and Support Arrangements for People with Learning Disabilities. Booklet 1: Overview*. Welsh Centre for Learning Disabilities Applied Research Unit.

Jones, E., Perry, J., Lowe, K., *et al* (1999) Opportunity and the promotion of activity among adults with severe intellectual disability living in community residences: the impact of training staff in active support. *Journal of Intellectual Disability Research*, 43, 164–178.

Jones, R. (2005) *Mental Capacity Act Manual* (1st edn). Sweet and Maxwell

Kevan, F. (2003) Challenging behaviour and communication difficulties. *British Journal of Learning Disabilities*, **31**, 75–80.

King, B. H. (1993) Self-injury by people with mental retardation: A compulsive behaviour hypothesis. *American Journal on Mental Retardation*, **98**, 93–112.

Koegel, L. K., Koegel, R. L. & Dunlap, G. (1996) *Positive Behavioral Support: Including People With Difficult Behavior In The Community*. P. H. Brookes.

LaVigna, G. & Willis, T. (2002) Counter-intuitive strategies for crisis management within a non-aversive framework. In *Ethical Approaches To Physical Interventions. Responding To Challenging Behaviour In People With Intellectual Disabilities* (ed. D. Allen). BILD publications.

Lucyshyn, J. M., Albin, R. W., & Nixon, C. D. (1997) Embedding comprehensive behavioural support in family ecology: An experimental single case analysis. *Journal of Consulting and Clinical Psychology*, **65**, 241–251.

Mansell, J. (1994) Specialized group homes for persons with severe or profound mental retardation and serious problem behaviour in England. *Research in Developmental Disabilities*, **15**, 371–388.

Mansell, J. (1995) Staffing and staff performance in services for people with severe or profound learning disability and serious challenging behaviour. *Journal of Intellectual Disability Research*, **39**, 3–14.

Mansell, J. (1996) Issues in community services in Britain. In *Deinstitutionalization and Community Living: Intellectual Disability Services in Britain, Scandinavia and the USA* (eds J. Mansell & K. Ericsson), pp. 49–63. Chapman & Hall.

Mansell, J.(1998) Active support (editorial). *Tizard Learning Disability Review*, **3**, 4–6.

Mansell, J., & Elliott, T. (2001) Staff members' prediction of consequences for their work in residential settings. *American Journal on Mental Retardation*, **106**, 424–447.

Mansell, J., Felce, D., Jenkins, J., *et al* (1987) *Developing Staffed Housing For People With Mental Handicaps*. Costello.

Mansell, J., J., Hughes, H. & McGill, P. (1994*a*) Maintaining local residential placements. In *Severe Learning Disabilities and Challenging Behaviour: Designing High-Quality Services* (eds E. Emerson, P. McGill & J. Mansell), pp. 260–281. Chapman & Hall.

Mansell, J., J., McGill, P. & Emerson, E. (1994*b*) Conceptualising service provision. In *Severe Learning Disabilities and Challenging Behaviour: Designing High-Quality Services* (eds E. Emerson, P. McGill & J. Mansell). Chapman & Hall.

Mansell, J., J., McGill, P. & Emerson, E. (2001) Development and evaluation of innovative residential services for people with severe intellectual disability and serious challenging behaviour. In *International Review of Research in Mental Retardation* (ed L. M. Glidden), pp. 245–298. Academic Press.

Mansell, J., Ashman, B., Macdonald, S., *et al* (2002) Residential care in the community for adults with intellectual disabilities: needs, characteristics and services. *Journal of Intellectual Disability Research*, **46**, 625–633.

Mansell, J., Beadle-Brown, J., Macdonald, S, *et al* (2003) Functional grouping in residential homes for people with intellectual disabilities. *Research in Developmental Disabilities*, **24**, 170–182.

Mansell, J., Beadle-Brown, J., Ashman, B., *et al* (2005) *Person-centred Active Support: A Multi-media Training Resource For Staff To Enable Participation, Inclusion And Choice For People With Learning Disabilities*. Pavilion.

McGill, P. (1993) Challenging behaviour, challenging environments, and challenging needs. *Clinical Psychology Forum*, **56**, 14–18.

McGill, P. & Mansell, J. (1995) Community placements for people with severe and profound learning disabilities and serious challenging behaviour: Individual illustrations of issues and problems. *Journal of Mental Health*, **4**, 183–198.

Mesibov, G. B., Schaffer, B. & Schopler, E. (1988) *Individualised Assessment And Treatment For Autistic And Developmentally Disabled Children. 4: Adolescent And Adult Psycho-educational Profile*. ProEd.

Mitra, I. & Alexander, R. (2003) Out-of-area placements: implications of psychiatric services in learning disability. *Psychiatric Bulletin*, **27**, 382–385.

Murphy, G. H. & Clare, I. C. H. (1991) MIETS: A service option for people with mild mental handicaps and challenging behaviour or psychiatric problems: 2 Assessment treatment and outcome for service users and service effectiveness. *Mental Handicap Research*, **4**, 180–206.

National Assembly for Wales (2001) *Fulfilling the Promises. Proposal for a Framework for Services for People with Learning Disabilities*. National Assembly for Wales.

National Care Standards Commision (2003) *Best Practice Guidance on the Operation and Management of Registered Care Homes for People with Learning Disabilities who Present Significant Challenges*. National Care Standards Commision.

National Patient Safety Agency (2004) *Understanding the Patient Safety Issues for People with Learning Disabilities*. NPSA.

NHS Executive (1996) *NHS Psychotherapy Services in England: Review of Strategic Policy*. Department of Health.

Oliver, C., Murphy, G. & Corbett, J. (1987) Self-injurious behaviour in people with mental handicap: a total population study. *Journal of Mental Deficiency Research*, **31**, 147–162.

Reid, A. H. (1992) *The Psychiatry of Mental Handicap*. Blackwell.

Repp, A. C. (1994) Comments on functional analysis procedures for school-based behaviour problems. *Journal of Applied Behaviour Analysis*, **27**, 409–411.

Ritchie, F., Goodman, N., Nix, J., *et al* (2005) *'Out Of Area, Out Of Sight?' Review Of Out Of Area Placement Arrangements Made By Social Services And Health For People With Learning Disabilities From The West Midlands*. Birmingham and The Black Country Strategic Health Authority and West Midlands South Strategic Health Authority.

Robertson, J., Emerson, E., Pinkney, L., *et al* (2002) *Quality & Costs of Community – Based Residential Supports for People with Learning Disabilities and Challenging Behaviour*. Institute of Health Research, University of Lancaster.

Robertson, J., Emerson, E. & Pinkney, L. (2004) Quality and costs of community-based residential supports for people with mental retardation and challenging behavior. *American Journal of Mental Retardation*, **109**, 332–344.

Royal College of Psychiatrists (2004) Good Psychiatric Practice (2nd edn) (College Report CR125). Royal College of Psychiatrists.

Royal College of Psychiatrists (2005) *The Evidence Base for the Management of Imminent Violence in Learning Disability Settings* (Occasional Paper OP57). Royal College of Psychiatrists.

Royal College of Speech and Language Therapists (2003) *Speech and Language Therapy Provision for Adults with Learning Disabilities* (Position Paper). Royal College of Speech and Language Therapists.

Scotti, J. R., Evans, I. M., Meyer, L. H., *et al* (1991) A meta-analysis of intervention research with problem behaviour: treatment validity and standards of practice. *American Journal of Mental Retardation*, **96**, 233–256.

Scottish Executive, Health Department (2000) *The Same As You? A Review Of Services For People With Learning Disabilities*. TSO (The Stationery Office).

Sequeira, H. & Hollins, S. (2003) Clinical effects of sexual abuse on people with learning disability: Critical literature review. *British Journal of Psychiatry*, **182**, 13–19.

Sovner, R. & Hurley, D.A. (1983) Do the mentally retarded suffer from affective illness? *Archives of General Psychiatry*, **40**, 61–67.

Talkington, L. W., Hall, S. & Altman, R. (1971) Communication deficits and aggression in the mentally retarded. *American Journal of Mental Deficiency*, **76**, 235–237.

Taylor, D., McConnell, D., McConnell, H., *et al* (2001) *The South London and Maudsley NHS Trust, 2001 Prescribing Guidelines* (6th edn). Martin Dunitz.

Thurman, S. (2001) Challenging Communication. *Mental Health Care*, **41**, 203–206.

Toogood, S. & Timlin, K. (1996) The functional assessment of challenging behaviour: a comparison of informant-based, experimental and descriptive methods. *Journal of Applied Research in Intellectual Disabilities*, **9**, 206–222.

Willner, P. (2005) The effectiveness of psychotherapeutic interventions for people with learning disabilities: a critical overview. *Journal of Intellectual Disability Research*, **49**, 73–85.

World Health Organization (1993) *The ICD–10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. WHO.

Xenitidis, K., Russell, A. Murphy, D. (2001) Management of people with challenging behaviour. *Advances in Psychiatric Treatment*, **7**, 109–116.

Xenitidis, K., Barnes, J., White, J. (2005) Forensic psychotherapy for adults with learning disabilities: an inpatient group-analytic group. *Group Analysis*, **38**, 427–438.

HL v. United Kingdom [2004].

Per Cardozo J. in Scloendorff v. Society of new York Hospital [1914] 211NY 125.

Appendix

GOOD PRACTICE STANDARDS FOR SERVICE RESPONSES TO CHALLENGING BEHAVIOUR– SELF ASSESSMENT CHECKLIST

This framework is designed to be used by senior professionals (clinicians, social workers, managers, commissioners and those responsible for inspection and review) who have responsibility within a defined area or population for the provision of services to people with learning disabilities whose behaviour severely challenges services. It is a self-assessment checklist that should be used to establish the extent to which local processes and practices reflect 'best practice' as described in more detail elsewhere in this document.

The standards should be reviewed against the current position and practices that are followed by services. Users, advocates and carers should also be involved in the review process. The standards apply to people living in family homes, and health and social care provision (within the statutory and independent sectors). They also apply when out-of-area placements have been purchased by the relevant authorities.

The checklist should be reviewed in a multidisciplinary/multi-agency setting with the aim of achieving a consensus view about how local services compare with good practice standards. The team that carries out the review of standards should ensure that they have the appropriate membership to achieve a broad view of services. Different teams may be required to review different subsets of standards as outlined in the table following the checklist. A joint action plan should be developed to address any areas of need or to build on current good practice.

Table 1 Standards for service provision

	Current position		
Standard	**Green**	**Amber**	**Red**
1. Assessments and interventions are delivered within the current legal framework, by taking full account of the care programme approach, Mental Capacity Act, Mental Health Act, Bournewood ruling, Health and Safety at Work Act, CSCI guidance etc.	There are clear written processes in place to ensure that all practices meet current legal requirements. These will include: ■ people who require assessment or treatment under the MHA have access to appropriate local facilities ■ clear health and social care pathways incorporate assessment of capacity, in line with the Mental Capacity Act ■ a local advisory group with clear terms of reference, to consider issues of best interest for people who lack capacity ■ explicit multidisciplinary processes using standard national policies (e.g. care programme approach) is used ■ there is a published local adult protection policy that service users, clinicians, carers can access ■ Where people have out-of-area placements purchased for them, the purchasing authority regularly checks that the provider also achieves these standards.	Progress has been made to fully achieve 4–6 of these criteria.	Only 1–3 of these criteria have been achieved.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
2. A detailed risk assessment is carried out with individuals who present severely challenging behaviour to ensure that interventions are appropriately and systematically targeted.	There is an agreed written process for carrying out individualised risk assessments. It includes at least the following criteria: ■ a multidisciplinary process. ■ a statement of philosophy that addresses 'the least restrictive alternative'. ■ clarity about what triggers an assessment. ■ risk assessment informs a written management plan that identifies: ☐ individuals' level of risk and risk factors ☐ clarity about individual professionals' responsibilities and actions ☐ a clear process for reviewing plans. ■ where people move between services, up-to-date risk assessments are shared between purchasers and providers.	Systematic risk assessments and management plans are in place, with 3–5 of the criteria being met.	There are no formal processes in place to ensure a systematic approach to risk management.
3. For each person who presents severely challenging behaviour, there is a written assessment that takes account of relevant factors about the person, their environment and the behaviour.	There is an agreed multidisciplinary assessment care pathway in place for all people whose behaviour presents severe challenges. It will include sufficient information to: 1. exclude/treat biological factors that contribute to the person's behaviour 2. lead to a coherent formulation and, where appropriate, a psychiatric diagnosis 3. lead to an intervention plan which fits the person and their environment 4. provide a baseline so that the effectiveness of any intervention can be subsequently measured.	Multidisciplinary assessments are in place for most people, but there are no agreed care pathways or standards in place to ensure that these are systematically carried out.	There is a limited multidisciplinary approach to assessments, with most assessments being uni-professional.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
4. There is a multifaceted written formulation that takes account of possible diagnosis, psychological and relationship factors. This formulation has been developed from the assessment, and leads to an appropriate intervention.	For each person who presents severe challenges, there is an agreed written multidisciplinary formulation that includes each of the following components: ■ hypotheses about how/why the behaviour has developed ■ rationale for any psychiatric diagnosis ■ psychological and relationship factors ■ integration of behavioural, biological, communication and environmental factors ■ hypotheses about how the behaviour is being maintained ■ clear links between the formulation and intervention.	For some people who present severe challenges the written formulation meets these standards, but this is not the norm for all people.	Generally, professionals who assess an individual will develop their own uni-professional assessments, formulations or diagnoses, and this will not be coordinated into an agreed multidisciplinary formulation.
5. There is clear evidence that the intervention has person-centred approaches at its core.	In addition to any pharmacological, psychological, and/or behavioural interventions, each person has a written person-centred plan that describes how the person will be supported in ways that address their rights, inclusion, choice and independence. It will address the factors that contribute to the person's challenging behaviour. There is evidence that the plans are implemented by support teams.	Most people have a person-centred plan in addition to any 'treatment' but evidence of implementation is limited.	There is little evidence of a person-centred plan at the core of the person's care.

Table 1 *Continued*

Standard	Current position Green	 Amber	 Red
6. Interventions are written down, are derived from the formulation and include: ■ primary preventative strategies, and ■ early crisis intervention strategies.	Each person has a written multidisciplinary care plan that details strategies that include: ■ clarity about how the interventions are derived from the formulation ■ ways to enhance the person's quality of life ■ promotion of the 'least restrictive alternative' ■ appropriate 'talking treatments' can be accessed when so indicated by the formulation ■ potential triggers for the behaviour are identified and addressed ■ clarity about how staff/carers should respond to the target behaviour ■ a clear rationale for any psychoactive medication, and the circumstances under which p.r.n. medication is to be used ■ evidence of a skills-based, psychoeducational or other positive strategy aimed to help the person to manage their own behaviour ■ clarity about how any physical intervention or restrictive practice should be used how and when they will be reviewed ■ clarity that the interventions are informed by the evidence-base of effectiveness.	Many intervention plans meet this standard but there is not a systematic approach to the development of multidisciplinary written care plans that address preventative and crisis intervention strategies.	There is no process to ensure that all intervention plans meet this standard, and few do.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
7. There is clarity about how 'crises' will be managed, with clear links to mental health and other services when required.	There are clear written protocols for managing crises, including those that might occur 'out-of-hours' in the person's usual place of residence or work. These include: ■ processes for providing additional support to carers in the person's usual place of residence ■ access to a responsive emergency and out-of-hours on-call assessment service ■ access to mental health services, including in-patient beds, if admission is required ■ register or database of people most at risk of requiring out-of-hours support ■ written risk management plans (possibly as part of care programme approach process), identifying proactive actions to be taken to support people identified as being at significant risk of crises ■ a process to ensure effective communication of crisis management plan to all appropriate people.	Generally staff/ carers can access some out-of-hours crisis service, but responses are not comprehensive, and there are few clear protocols across different services.	Responses to out-of-hours crises are patchy, with regular disagreements between services about issues of responsibility.
8. Each person whose behaviour challenges services will have their care coordinated within a clear system.	There is a clear inter-agency care coordination system that ensures that all people who present severe challenges have: ■ a named care coordinator ■ a written multidisciplinary care plan ■ a system that ensures regular care reviews ■ care programme approach process in place for those with additional mental health needs. Where out-of-area placements are purchased, the purchasing authority ensures that multidisciplinary care is coordinated in the placement, and that there is a named person in the purchasing authority who is responsible for ensuring the quality of the care received	Elements of a multidisciplinary care coordination process are in place, but it is not systematically available to everyone who presents severe challenges.	Care planning is generally uni-professional, with few multidisciplinary coordinated processes.

Table 1 *Continued*

	Current position		
Standard	**Green**	**Amber**	**Red**
9. Effective processes will be used to ensure that <u>everyone</u> supporting the person has the necessary skills and knowledge to carry out the intervention.	Within an authority there is a multi-agency training strategy that provides systematic competency-based training for care staff. This is based on a clear value-base that promotes positive strategies and ensures that care staff who are required to implement any physical interventions or restrictive practices are appropriately trained. There are processes to ensure that staff have the required skills.	Individual service providers have their own challenging behaviour training plans, but these are not systematic in the way they are delivered or evaluated.	Training for care staff is generally uncoordinated, with many untrained staff supporting people who present severe challenges.
10. The interventions will be fully evaluated in terms of the behaviour and the impact of the behaviour on the person’s quality of life and on others.	There are processes in place to ensure that care plans for people who present severe challenges are systematically evaluated across the authority by managers or appropriate professionals. This will include monitoring of: ■ the impact of the intervention on the targeted behaviour ■ the impact on the person’s quality of life ■ the use of physical interventions, restrictive practices and psychotropic medications.	Most service providers systematically evaluate the quality and effectiveness of their interventions, but this is not a universal process within the authority.	There are no systematic evaluation processes across the authority. Less than half of the service providers evaluate the quality or effectiveness of their interventions, and even these are generally unsystematic.
11. There is a system in place across an authority for auditing the standards for service provision that are described in these guidelines.	The partnership/management board has a clear process across the services that it has responsibility for commissioning or purchasing, to ensure that all these standards are being met.	There are processes to ensure that at least some of these standards are being met across all services in an authority.	There is no mechanism within an authority to ensure the service standards are being met.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
Availability of long-term supports			
12. People who present severely challenging behaviour have equality of access to a comprehensive range of local social and health service provision.	People presenting challenges have access to: ■ housing ■ support at home ■ meaningful day-time activity, education or work ■ advocacy ■ generic and specialist healthcare.	Some people presenting challenges have all these service elements in place but others do not	Arrangements typically exclude at least one of these elements
13. The full range of service options is available locally to everyone, including those who present challenges.	All levels of support are available to people challenging services within different housing and service configurations, for example family home, direct payments or personalised budgets as well as residential homes.	Some people have high levels of support while living in their own home, but this is not available to everyone.	There is only token availability of high levels of support to people living in their own home.
14. The competence of local services within the statutory, private and voluntary sectors, matches the needs of the people being supported.	Commissioners purchase local support and housing in which staff support is sufficiently skilled to (a) provide activity and personal growth and development for the individual and (b) prevent or minimise challenging behaviour. This is for people: ■ with minimal, latent or emerging challenging behaviour ■ presenting moderate levels of challenge ■ with the most complex or enduring problems.	Up to 10% of housing and support placements for people fail each year because of problems responding to challenging behaviour.	More than 10% of housing and support placements for people fail each year because of problems responding to challenging behaviour.
15. Mechanisms are in place to ensure that out-of-area placements reflect individual choices.	People placed out-of-area (or their advocates, where appropriate) can choose to move back to local services which are at least as good as the ones they are coming from.	Some people placed out-of-area (or their advocates, where appropriate) can choose to move back to local services but others cannot (whether due to cost or quality).	People placed out-of-area (or their advocates, where appropriate) have no choice whether to move back to their local area or not.

Table 1 *Continued*

Standard	**Current position**		
	Green	**Amber**	**Red**
16. Services are commissioned that ensure that family carers are supported locally.	Local services are available to all families that support members who present challenges (including the most serious challenges) such as ■ respite ■ day activity, work or education.	Local services exclude people who present challenges but fund alternatives out-of-area.	Local services exclude people who present challenges without alternatives.
Access to specialist help			
17. Specialised multidisciplinary professional advice is readily available locally for everyone presenting a challenge.	Every person presenting a challenge has access to a specialist assessment of their situation and their behaviour which is multidisciplinary and which: ■ checks for psychiatric or other biomedical causes ■ identifies possible functions of learned behaviour ■ takes account of weaknesses or problems in placement organisation ■ provides initial assessment within X weeks and completed within Y weeks.	More than 25% of assessments are incomplete or late.	More than 50% of assessments are incomplete or late.
18. Highly specialised professional advice is available for people who present the most complex challenges.	People presenting the most complex challenges have access to assessment by highly specialised experts in challenging behaviour (e.g. special behaviour support teams), within a multidisciplinary team.	Highly specialised advice available but only by purchase from out-of-area, or uni-professionally.	No highly specialised professional advice available locally.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
19. Assessment and treatment units are used appropriately.	Assessment and treatment units are only used for this purpose. They use contracts that specify the specific purpose of the stay, its maximum length, a binding undertaking that the referring agency will provide local services at the end of this period and a specification of how the gains made in the unit will be transferred to and maintained in the local placement.	More than 10% of residents in assessment and treatment units have completed treatment (such as crisis management or emergency placement) but have not returned to the community.	More than 25% of residents in assessment and treatment units have completed treatment, or are there for other reasons (such as crisis management or emergency placement), but have not returned to the community.
20. Mental health services are available to all.	Local mental health services have taken the lead in reviewing their provision to people with learning disabilities, using the NIMHE greenlight toolkit. Local mental health services are readily available to people with learning disabilities who have mental health problems. Psychiatric care of people with learning disabilities is an integrated part of local mental health services.	Local mental health services only serve some people with learning disabilities who have mental health problems. Psychiatric care of people with learning disabilities has some links with local mental health services.	Local mental health services routinely exclude people with learning disabilities who have mental health problems. Psychiatric care of people with learning disabilities is separate from local mental health services.
Individualisation			
21. People presenting challenges have person-centred plans.	Each person presenting challenges has an effective person-centred plan including a ‘circle of support’ beyond service personnel.	Only people presenting moderate levels of challenge have an effective person-centred plan including a circle of support’beyond service personnel.	Only people presenting the most complex challenges have an effective person-centred plan including a circle of support beyond service personnel.

Table 1 *Continued*

Standard	Current position		
	Green	**Amber**	**Red**
22. Commissioners and professionals have effective systems to review everyone who is out-of-area or is likely to be at risk of their local service breaking down.	There is a process agreed between commissioners and professionals that ensures: ■ knowledge about the needs of, and plans for, everyone who is placed out-of-area ■ review system for the ongoing appropriateness of out-of-area placements for each person ■ knowledge about people who live locally but are most at risk of placement breaking down ■ contingency plans available for those most at risk of local placement breaking down.	There is some knowledge about the ongoing appropriateness of out-of-area placements, and some planning to address inadequacies of placements. Local ‘placement breakdown’ planning is in place for a few people.	There is only limited knowledge about people who are placed out-of-area, and few active systems are in place to prevent local service breakdown.
23. There is an agreed Partnership Board (or other commissioning body) strategy to promote local services for people who present severe challenges.	Partnership Board has an agreed strategy that addresses all the standards outlined in this document.	Multi-agency strategies are in place to meet most standards outlined in this document. There is an agreed process to address the others.	Agreement has been reached on how to achieve some of these standards.

WHO WILL BE INVOLVED IN REVIEWING THE STANDARDS?

The purpose of the chart illustrated in Table 2 is to offer suggestions as to the possible composition of teams that will be involved in reviewing local standards. Different review teams may be required to audit different subsets of standards. The completed table is not intended to be prescriptive, and local circumstances will dictate who should be involved (the last column can be used as a local checklist).

Table 2 Team members who might be involved in reviewing different standards

Standard	Specialist challenging behaviour team	Prac-titioners in CLDTs	Specialist residential providers	Hospitals including ATUs	Social services care managers	Commissioners	Inspection teams	Users/carers	Other
1. Legal framework	✓	✓	✓	✓	✓	✓	✓	✓	
2. Risk assessment	✓	✓	✓	✓	✓	✓	✓	✓	
3. Written assessment	✓	✓	✓	✓	✓	?	✓	✓	
4. Written formulation	✓	✓	✓	✓	✓	?	✓	✓	
5. Person-centred approaches	✓	✓	✓	✓	✓	?	✓	✓	
6. Written intervention plan	✓	✓	✓	✓	✓	?	✓	✓	
7. Crisis management	✓	✓	✓	✓	✓	✓	✓	✓	
8. Care coordination	✓	✓	✓	✓	✓	✓	✓	✓	
9. Trained support staff	✓	✓	✓	✓	✓	✓	✓	✓	
10. Evaluate outcomes	✓	✓	✓	✓	✓	✓	✓	✓	
11. Auditing of standards	✓	✓	✓	✓	✓	✓	✓	✓	
12. Equality of access to local provision	x	x	✓	x	✓	✓	x	✓	
13. Full range of services	x	x	✓	x	✓	✓	x	✓	
14. Competence of services matches people's need	x	x	✓	x	✓	✓	x	✓	

Table 2 Team members who might be involved in reviewing different standards

Standard	Specialist challenging behaviour team	Prac-titioners in CLDTs	Specialist residential providers	Hospitals including ATUs	Social services care managers	Commissioners	Inspection teams	Users/ carers	Other
15. Out-of-area placements reflect individual choice	x	x	x	x	✓	✓	✓	✓	
16. Commissioned services support people locally	✓	✓	✓	✓	✓	✓	✓	✓	
17. Access to local MD specialised advice	✓	✓	✓	✓	✓	✓		✓	
18. Access to highly specialised advice	✓	✓	✓	✓	✓	✓		✓	
19. Appropriate use of ATUs	✓	x	x	✓	✓	✓	✓	✓	
20. Availability of mental health services	✓	✓	x	✓	✓	✓	✓	✓	
21. Person-centred plans	✓	✓	✓	✓	✓	✓	✓	✓	
22. Review of people out-of-area	✓	x	x	x	x	✓	✓	✓	
23. Agreed commissioning strategy	✓	✓	✓	✓	✓	✓	✓	✓	

Composition of team reviewing standards ………………………………………………………………………………..

Standards to be reviewed ………………………………………………………………………………………………

Coordinator responsible for carrying out review…………………………………………………………………………

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Mental Capacity Act 2005 Deprivation of liberty safeguards

TSO

Mental Capacity Act 2005

Deprivation of liberty safeguards

Code of Practice to supplement the main
Mental Capacity Act 2005 Code of Practice

Ministry of Justice

Mental Capacity Act 2005

Deprivation of liberty safeguards

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Foreword by Ivan Lewis and Edwina Hart MBE

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Assembly Government

The Mental Capacity Act 2005 (‘the Act’) provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. It introduced a number of laws to protect these individuals and ensure that they are given every chance to make decisions for themselves. The Act came into force in October 2007.

The Government has added new provisions to the Act: the deprivation of liberty safeguards. The safeguards focus on some of the most vulnerable people in our society: those who for their own safety and in their own best interests need to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty, but who lack the capacity to consent.

The deprivation of a person’s liberty is a very serious matter and should not happen unless it is absolutely necessary, and in the best interests of the person concerned. That is why the safeguards have been created: to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities.

The new provisions in the Act set out the legal framework of the deprivation of liberty safeguards. This Code of Practice is formally issued by the Lord Chancellor as a Code of Practice under the Mental Capacity Act 2005. It provides guidance and information for those implementing the deprivation of liberty safeguards legislation on a daily basis. In some cases, this will be paid staff, in others those who have been appointed in law to represent individuals who lack capacity to make decisions for themselves (such as deputies or donees of a Lasting Power of Attorney).

Because of this broad audience, the Code of Practice has been written so as to make it as user-friendly as possible – like the main Mental Capacity Act 2005 Code of Practice, issued in April 2007. We are grateful to all those who commented on earlier drafts of the Code to help it achieve that goal.

Ivan Lewis

Edwina Hart

Introduction

The Mental Capacity Act 2005 ('the Act'), covering England and Wales, provides a statutory framework for acting and making decisions on behalf of people who lack the capacity to make those decisions for themselves. These can be small decisions – such as what clothes to wear – or major decisions, such as where to live.

In some cases, people lack the capacity to consent to particular treatment or care that is recognised by others as being in their best interests, or which will protect them from harm. Where this care might involve depriving vulnerable people of their liberty in either a hospital or a care home, extra safeguards have been introduced, in law, to protect their rights and ensure that the care or treatment they receive is in their best interests.

This Code of Practice helps explain how to identify when a person is, or is at risk of, being deprived of their liberty and how deprivation of liberty may be avoided. It also explains the safeguards that have been put in place to ensure that deprivation of liberty, where it does need to occur, has a lawful basis. In addition, it provides guidance on what someone should do if they suspect that a person who lacks capacity is being deprived of their liberty unlawfully.

These safeguards are an important way of protecting the rights of many vulnerable people and should not be viewed negatively. Depriving someone of their liberty can be a necessary requirement in order to provide effective care or treatment. By following the criteria set out in the safeguards, and explained in this Code of Practice, the decision to deprive someone of their liberty can be made lawfully and properly.

How does this Code of Practice relate to the main Mental Capacity Act 2005 Code of Practice?

This document adds to the guidance in the main Mental Capacity Act 2005 Code of Practice ('the main Code'), which was issued in April 2007, and should be used in conjunction with the main Code. It focuses specifically on the deprivation of liberty safeguards added to the Act. These can be found in sections 4A and 4B of, and Schedules A1 and 1A to, the Act.

Though these safeguards were mentioned in the main Code (particularly in chapters 6 and 13), they were not covered in any detail. That was because, at the time the main Code was published, the deprivation of liberty safeguards were still going through the Parliamentary process as part of the Mental Health Bill.[1]

Although the main Code does not cover the deprivation of liberty safeguards, the principles of that Code, and much of its content, are directly relevant to the deprivation of liberty safeguards. It is important that both the Act and the main Code are adhered to whenever capacity and best interests issues, and the deprivation of liberty safeguards, are being considered. The deprivation of liberty safeguards are in addition to, and do not replace, other safeguards in the Act.

How should this Code of Practice be used?

This Code of Practice provides guidance to anyone working with and/or caring for adults who lack capacity, but it particularly focuses on those who have a 'duty of care' to a person who lacks the capacity to consent to the care or treatment that is being provided, where that care or treatment may include the need to deprive the person of their liberty. This Code of Practice is also intended to provide information for people who are, or could become, subject to the deprivation of liberty safeguards, and for their families, friends and carers, as well as for anyone who believes that someone is being deprived of their liberty unlawfully.

In this Code of Practice, as throughout the main Code, references to 'lack of capacity' refer to the capacity to make a particular decision at the time it needs to be made. In the context of the deprivation of liberty safeguards, the capacity is specifically the capacity to decide whether or not to consent to care or treatment which involves being kept in a hospital or care home in circumstances that amount to a deprivation of liberty, at the time that decision needs to be made.

What is the legal status of this Code of Practice?

As with the main Code, this Code of Practice is published by the Lord Chancellor, under sections 42 and 43 of the Mental Capacity Act 2005. The purpose of the main Code is to provide guidance and information about how the Act works in practice.

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[1] The Mental Health Bill was used as a vehicle to amend the Mental Capacity Act 2005 in order to introduce the deprivation of liberty safeguards. The Bill became the Mental Health Act 2007 following completion of its Parliamentary passage.

Both this Code and the main Code have statutory force, which means that certain people are under a legal duty to have regard to them. More details can be found in the Introduction to the main Code, which explains the legal status of the Code and who should have regard to it.

In addition to those for whom the main Code is intended, this Code of Practice specifically focuses on providing guidance for:

- people exercising functions relating to the deprivation of liberty safeguards, and
- people acting as a relevant person's representative[2] under the deprivation of liberty safeguards (see chapter 7).

Scenarios used in this Code of Practice

This Code of Practice includes boxes within the main text containing scenarios, using imaginary characters and situations. These are intended to help illustrate what is meant in the main text. They should not in any way be taken as templates for decisions that need to be made in similar situations. Decisions must always be made on the facts of each individual case.

Alternative formats and further information

This Code of Practice is also available in Welsh and can be made available in other formats on request.

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[2] A 'relevant person' is a person who is, or may become, deprived of their liberty in accordance with the deprivation of liberty safeguards.

Contents

1 What are the deprivation of liberty safeguards and why were they introduced?

The deprivation of liberty safeguards were introduced to provide a legal framework around the deprivation of liberty. Specifically, they were introduced to prevent breaches of the European Convention on Human Rights (ECHR) such as the one identified by the judgment of the European Court of Human Rights (ECtHR) in the case of *HL v the United Kingdom*[3] (commonly referred to as the 'Bournewood' judgment). The case concerned an autistic man (HL) with a learning disability, who lacked the capacity to decide whether he should be admitted to hospital for specific treatment. He was admitted on an informal basis under common law in his best interests, but this decision was challenged by HL's carers. In its judgment, the ECtHR held that this admission constituted a deprivation of HL's liberty and, further, that:

- the deprivation of liberty had not been in accordance with 'a procedure prescribed by law' and was, therefore, in breach of Article 5(1) of the ECHR, and
- there had been a contravention of Article 5(4) of the ECHR because HL had no means of applying quickly to a court to see if the deprivation of liberty was lawful.

To prevent further similar breaches of the ECHR, the Mental Capacity Act 2005 has been amended to provide safeguards for people who lack capacity specifically to consent to treatment or care in either a hospital or a care home[4] that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the Mental Health Act 1983 is not appropriate for the person at that time. These safeguards are referred to in this Code of Practice as 'deprivation of liberty safeguards'.

What are the deprivation of liberty safeguards?

1.1 The deprivation of liberty safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the ECHR in a hospital or care home, whether placed under public or private arrangements. They do not apply to people detained under the Mental Health Act 1983. The safeguards exist to provide a proper legal process and suitable

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[3] (2004) Application No: 00045508/99

[4] Throughout this document, the term 'care home' means a care home registered under the Care Standards Act 2000.

protection in those circumstances where deprivation of liberty appears to be unavoidable, in a person's own best interests.

1.2 Every effort should be made, in both commissioning and providing care or treatment, to prevent deprivation of liberty. If deprivation of liberty cannot be avoided, it should be for no longer than is necessary.

1.3 The safeguards provide for deprivation of liberty to be made lawful through 'standard' or 'urgent' authorisation processes. These processes are designed to prevent arbitrary decisions to deprive a person of liberty and give a right to challenge deprivation of liberty authorisations.

1.4 The deprivation of liberty safeguards mean that a 'managing authority' (i.e. the relevant hospital or care home – see paragraph 3.1) must seek authorisation from a 'supervisory body' in order to be able lawfully to deprive someone of their liberty. Before giving such an authorisation, the supervisory body must be satisfied that the person has a mental disorder[5] and lacks capacity to decide about their residence or treatment. The supervisory body could be a primary care trust, a local authority, Welsh Ministers or a local health board (LHB) (see paragraph 3.3).

1.5 A decision as to whether or not deprivation of liberty arises will depend on all the circumstances of the case (as explained more fully in chapter 2). It is neither necessary nor appropriate to apply for a deprivation of liberty authorisation for everyone who is in hospital or a care home simply because the person concerned lacks capacity to decide whether or not they should be there. In deciding whether or not an application is necessary, a managing authority should carefully consider whether any restrictions that are, or will be, needed to provide ongoing care or treatment amount to a deprivation of liberty when looked at together.

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[5] As defined in section 1 of the Mental Health Act 1983, a mental disorder is any disorder or disability of the mind, apart from dependence on alcohol and drugs. This includes all learning disabilities. The distinction in the Mental Health Act 1983 between learning disabilities depending on whether or not they are associated with abnormally aggressive or seriously irresponsible behaviour is not relevant.

1.6 The deprivation of liberty safeguards cover:

- how an application for authorisation should be applied for
- how an application for authorisation should be assessed
- the requirements that must be fulfilled for an authorisation to be given
- how an authorisation should be reviewed
- what support and representation must be provided for people who are subject to an authorisation, and
- how people can challenge authorisations.

Who is covered by these safeguards?

1.7 The safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them from harm and appears to be in their best interests. A large number of these people will be those with significant learning disabilities, or older people who have dementia or some similar disability, but they can also include those who have certain other neurological conditions (for example as a result of a brain injury).

1.8 In order to come within the scope of a deprivation of liberty authorisation, a person must be detained in a hospital or care home, for the purpose of being given care or treatment in circumstances that amount to a deprivation of liberty. The authorisation must relate to the individual concerned and to the hospital or care home in which they are detained.

1.9 For the purposes of Article 5 of the ECHR, there is no distinction in principle between depriving a person who lacks capacity of their liberty for the purpose of treating them for a physical condition, and depriving them of their liberty for treatment of a mental disorder. There will therefore be occasions when people who lack capacity to consent to admission are taken to hospital for treatment of physical illnesses or injuries, and then need to be cared for in circumstances that amount to a deprivation of liberty. In these circumstances, a deprivation of liberty authorisation must be applied for. Consequently, this Code of Practice must be followed and applied in acute hospital settings as well as care homes and mental health units.

1.10 It is important to bear in mind that, while the deprivation of liberty might be for the purpose of giving a person treatment, a deprivation of liberty authorisation does not itself authorise treatment. Treatment that is proposed following authorisation of deprivation of liberty may only be given with the person's consent (if they have capacity to make the decision) or in accordance with the wider provisions of the Mental Capacity Act 2005. More details of this are contained in paragraphs 5.10 to 5.13 of this Code.

1.11 The safeguards cannot apply to people while they are detained in hospital under the Mental Health Act 1983. The safeguards can, however, apply to a person who has previously been detained in hospital under the Mental Health Act 1983. There are other cases in which people who are – or could be – subject to the Mental Health Act 1983 will not meet the eligibility requirement for the safeguards. Chapter 13 of the main Code contains guidance on the relationship between the Mental Capacity Act 2005 and the Mental Health Act 1983 generally, as does the Code of Practice to the Mental Health Act 1983 itself. Paragraphs 4.40 to 4.57 of the present Code explain the relationship of the deprivation of liberty safeguards to the Mental Health Act 1983, and in particular how to assess if a person is eligible to be deprived of their liberty under the safeguards.

1.12 The safeguards relate only to people aged 18 and over. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered – such as the existing powers of the court, particularly those under section 25 of the Children Act 1989, or use of the Mental Health Act 1983.

When can someone be deprived of their liberty?

1.13 Depriving someone who lacks the capacity to consent to the arrangements made for their care or treatment of their liberty is a serious matter, and the decision to do so should not be taken lightly. The deprivation of liberty safeguards make it clear that a person may only be deprived of their liberty:

- in their own best interests to protect them from harm
- if it is a proportionate response to the likelihood and seriousness of the harm, and
- if there is no less restrictive alternative.

1.14 Under no circumstances must deprivation of liberty be used as a form of punishment, or for the convenience of professionals, carers or anyone else. Deprivation of liberty should not be extended due to delays in moving people between care or treatment settings, for example when somebody awaits discharge after completing a period of hospital treatment.

Are there any cultural considerations in implementing the safeguards?

1.15 The deprivation of liberty safeguards should not impact in any different way on different racial or ethnic groups, and care should be taken to ensure that the provisions are not operated in a manner that discriminates against particular racial or ethnic groups. It is up to managing authorities and supervisory bodies to ensure that their staff are aware of their responsibilities in this regard and of the need to ensure that the safeguards are operated fairly and equitably.

1.16 Assessors who carry out deprivation of liberty assessments to help decide whether a person should be deprived of their liberty (see chapter 4) should have the necessary skills and experience to take account of people's diverse backgrounds. Accordingly, they will need to have an understanding of, and respect for, the background of the relevant person. Supervisory bodies must take these factors into account when appointing assessors and must seek to appoint the most suitable available person for each case.

1.17 Interpreters should be available, where necessary, to help assessors to communicate not only with the relevant person but also with people with an interest in their care and treatment. An interpreter should be suitably qualified and experienced to enable them to provide effective language and communication support in the particular case concerned, and to offer appropriate assistance to the assessors involved. Information should be made available in other languages where relevant.

1.18 Any decision about the instruction of Independent Mental Capacity Advocates (see paragraphs 3.22 to 3.28) or relevant person's representatives (see chapter 7) should take account of the cultural, national, racial or ethnic background of the relevant person.

Where do the safeguards apply?

1.19 Although the Bournewood judgment was specifically about a patient who lacked capacity to consent to admission to hospital for mental health treatment, the judgment has wider implications that extend to people who lack capacity and who might be deprived of their liberty either in a hospital or in a care home.

1.20 It will only be lawful to deprive somebody of their liberty elsewhere (for example, in their own home, in supported living arrangements other than in a care home, or in a day centre) when following an order of the Court of Protection on a personal welfare matter. In such a case, the Court of Protection order itself provides a legal basis for the deprivation of liberty. This means that a separate deprivation of liberty authorisation under the processes set out in this Code of Practice is not required. More information about applying to the Court of Protection regarding personal welfare matters is given in chapter 10.

How do the safeguards apply to privately arranged care or treatment?

1.21 Under the Human Rights Act 1998, the duty to act in accordance with the ECHR applies only to public authorities. However, all states that have signed up to the ECHR are obliged to make sure that the rights set out in the ECHR apply to all of their citizens. The Mental Capacity Act 2005 therefore makes it clear that the deprivation of liberty safeguards apply to both publicly and privately arranged care or treatment.

How do the safeguards relate to the rest of the Mental Capacity Act 2005?

1.22 The deprivation of liberty safeguards are in addition to, and do not replace, other safeguards in the Mental Capacity Act 2005. This means that decisions made, and actions taken, for a person who is subject to a deprivation of liberty authorisation must fulfil the requirements of the Act in the same way as for any other person. In particular, any action taken under the deprivation of liberty safeguards must be in line with the principles of the Act:

- A person must be assumed to have capacity to make a decision unless it is established that they lack the capacity to make that decision.

- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

These principles are set out in chapter 2 of the main Code and explained in more detail in chapters 3 to 6 of the same document. Paragraph 5.13 of the main Code contains a checklist of factors that need to be taken into account in determining a person's best interests.

2 What is deprivation of liberty?

There is no simple definition of deprivation of liberty. The question of whether the steps taken by staff or institutions in relation to a person amount to a deprivation of that person's liberty is ultimately a legal question, and only the courts can determine the law. This guidance seeks to assist staff and institutions in considering whether or not the steps they are taking, or proposing to take, amount to a deprivation of a person's liberty. The deprivation of liberty safeguards give best interests assessors the authority to make recommendations about proposed deprivations of liberty, and supervisory bodies the power to give authorisations that deprive people of their liberty.

This chapter provides guidance for staff and institutions on how to assess whether particular steps they are taking, or proposing to take, might amount to a deprivation of liberty, based on existing case law. It also considers what other factors may be taken into account when considering the issue of deprivation of liberty, including, importantly, what is permissible under the Mental Capacity Act 2005 in relation to restraint or restriction. Finally, it provides a summary of some of the most important cases to date.

Further legal developments may occur after this guidance has been issued, and healthcare and social care staff need to keep themselves informed of legal developments that may have a bearing on their practice.

What does case law say to date?

2.1 The European Court of Human Rights (ECtHR) has drawn a distinction between the deprivation of liberty of an individual (which is unlawful, unless authorised) and restrictions on the liberty of movement of an individual.

2.2 The ECtHR made it clear that the question of whether someone has been deprived of liberty depends on the particular circumstances of the case. Specifically, the ECtHR said in its October 2004 judgment in *HL v the United Kingdom*:

> 'to determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of

implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.'

2.3 The difference between deprivation of liberty and restriction upon liberty is one of degree or intensity. It may therefore be helpful to envisage a scale, which moves from 'restraint' or 'restriction' to 'deprivation of liberty'. Where an individual is on the scale will depend on the concrete circumstances of the individual and may change over time. For more information on how the Act defines restraint, see paragraphs 2.8–2.12.

2.4 Although the guidance in this chapter includes descriptions of past decisions of the courts, which should be used to help evaluate whether deprivation of liberty may be occurring, each individual case must be assessed on its own circumstances. No two cases are likely to be identical, so it is important to be aware of previous court judgments and the factors that the courts have identified as important.

2.5 The ECtHR and UK courts have determined a number of cases about deprivation of liberty. Their judgments indicate that the following factors can be relevant to identifying whether steps taken involve more than restraint and amount to a deprivation of liberty. It is important to remember that this list is not exclusive; other factors may arise in future in particular cases.

- Restraint is used, including sedation, to admit a person to an institution where that person is resisting admission.
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts and residence.
- A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate.
- A request by carers for a person to be discharged to their care is refused.
- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control.

There is more information on some relevant cases at the end of this chapter (paragraphs 2.17–2.23).

How can deprivation of liberty be identified?

2.6 In determining whether deprivation of liberty has occurred, or is likely to occur, decision-makers need to consider all the facts in a particular case. There is unlikely to be any simple definition that can be applied in every case, and it is probable that no single factor will, in itself, determine whether the overall set of steps being taken in relation to the relevant person amount to a deprivation of liberty. In general, the decision-maker should always consider the following:

- All the circumstances of each and every case
- What measures are being taken in relation to the individual? When are they required? For what period do they endure? What are the effects of any restraints or restrictions on the individual? Why are they necessary? What aim do they seek to meet?
- What are the views of the relevant person, their family or carers? Do any of them object to the measures?
- How are any restraints or restrictions implemented? Do any of the constraints on the individual's personal freedom go beyond 'restraint' or 'restriction' to the extent that they constitute a deprivation of liberty?
- Are there any less restrictive options for delivering care or treatment that avoid deprivation of liberty altogether?
- Does the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty, even if individually they would not?

What practical steps can be taken to reduce the risk of deprivation of liberty occurring?

2.7 There are many ways in which providers and commissioners of care can reduce the risk of taking steps that amount to a deprivation of liberty, by minimising the restrictions imposed and ensuring that decisions are taken with the involvement of the relevant person and their family, friends and carers. The processes for staff to follow are:

- Make sure that all decisions are taken (and reviewed) in a structured way, and reasons for decisions recorded.

- Follow established good practice for care planning.
- Make a proper assessment of whether the person lacks capacity to decide whether or not to accept the care or treatment proposed, in line with the principles of the Act (see chapter 3 of the main Code for further guidance).
- Before admitting a person to hospital or residential care in circumstances that may amount to a deprivation of liberty, consider whether the person's needs could be met in a less restrictive way. Any restrictions placed on the person while in hospital or in a care home must be kept to the minimum necessary, and should be in place for the shortest possible period.
- Take proper steps to help the relevant person retain contact with family, friends and carers. Where local advocacy services are available, their involvement should be encouraged to support the person and their family, friends and carers.
- Review the care plan on an ongoing basis. It may well be helpful to include an independent element, possibly via an advocacy service, in the review.

What does the Act mean by 'restraint'?

2.8 Section 6(4) of the Act states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person's freedom of movement, whether they are resisting or not.

2.9 Paragraphs 6.40 to 6.48 of the main Code contain guidance about the appropriate use of restraint. Restraint is appropriate when it is used to prevent harm to the person who lacks capacity and it is a proportionate response to the likelihood and seriousness of harm. Appropriate use of restraint falls short of deprivation of liberty.

2.10 Preventing a person from leaving a care home or hospital unaccompanied because there is a risk that they would try to cross a road in a dangerous way, for example, is likely to be seen as a proportionate restriction or restraint to prevent the person from coming to harm. That would be unlikely, in itself, to constitute a deprivation of liberty. Similarly, locking a door to guard against immediate harm is unlikely, in itself, to amount to a deprivation of liberty.

2.11 The ECtHR has also indicated that the duration of any restrictions is a relevant factor when considering whether or not a person is deprived of their liberty. This suggests that actions that are immediately necessary to prevent harm may not, in themselves, constitute a deprivation of liberty.

2.12 However, where the restriction or restraint is frequent, cumulative and ongoing, or if there are other factors present, then care providers should consider whether this has gone beyond permissible restraint, as defined in the Act. If so, then they must either apply for authorisation under the deprivation of liberty safeguards (as explained in chapter 3) or change their care provision to reduce the level of restraint.

How does the use of restraint apply within a hospital or when taking someone to a hospital or a care home?

Within a hospital

2.13 If a person in hospital for mental health treatment, or being considered for admission to a hospital for mental health treatment, needs to be restrained, this is likely to indicate that they are objecting to treatment or to being in hospital. The care providers should consider whether the need for restraint means the person is objecting (see paragraph 4.46 of this Code for guidance on how to decide whether a person is objecting for this purpose). A person who objects to mental health treatment, and who meets the criteria for detention under the Mental Health Act 1983, is normally ineligible for an authorisation under the deprivation of liberty safeguards. If the care providers believe it is necessary to detain the person, they may wish to consider use of the Mental Health Act 1983.

Taking someone to a hospital or a care home

2.14 Transporting a person who lacks capacity from their home, or another location, to a hospital or care home will not usually amount to a deprivation of liberty (for example, to take them to hospital by ambulance in an emergency.) Even where there is an expectation that the person will be deprived of liberty within the care home or hospital, it is unlikely that the journey itself will constitute a deprivation of liberty so that an authorisation is needed before the journey commences. In almost all cases, it is likely that a person can be lawfully taken to a hospital or a care home under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.

2.15 In a very few cases, there may be exceptional circumstances where taking a person to a hospital or a care home amounts to a deprivation of liberty, for example where it is necessary to do more than persuade or restrain the person for the purpose of transportation, or where the journey is exceptionally long. In such cases, it may be necessary to seek an order from the Court of Protection to ensure that the journey is taken on a lawful basis.

How should managing authorities avoid unnecessary applications for standard authorisations?

2.16 While it is unlawful to deprive a person of their liberty without authorisation, managing authorities should take into consideration that unnecessary applications for standard authorisations in cases that do not in fact involve depriving a person of liberty may place undue stress upon the person being assessed and on their families or carers. Moreover, consideration must always be given to the possibility of less restrictive options for delivering care or treatment that avoid deprivation of liberty altogether.

Examples of case law

2.17 To provide further guidance, the following paragraphs contain short descriptions of what appear to be the significant features of recent or important cases in England and Wales and the ECtHR dealing with deprivation of liberty. Remember that:

- these descriptions are for guidance only
- only the courts can authoritatively determine the law; and
- the courts are likely to give judgments in cases after this guidance is issued. Staff will need to keep up to date and take account of further relevant legal developments.

Cases where the courts found that the steps taken did not involve a deprivation of liberty

2.18 *LLBC v TG* (judgment of High Court of 14 November 2007)

TG was a 78-year-old man with dementia and cognitive impairment. TG was resident in a care home, but was admitted to hospital with pneumonia and septicaemia. While he was in hospital, there was a dispute between the local authority and TG's daughter and granddaughter about TG's future. The daughter and granddaughter wanted TG to live with them, but the local authority believed that TG needed 24-hour care in a residential care home.

The council obtained an order from the court, directing that TG be delivered to the care home identified as appropriate by the council. Neither the daughter nor granddaughter was informed that a court hearing was taking place. That order was subsequently changed and TG was able to live with his daughter and granddaughter.

TG's daughter and granddaughter claimed that the period of time he had spent at the care home amounted to a deprivation of his liberty.

The judge considered that there was no deprivation of liberty, but the case was borderline. The key factors in his decision included:

- The care home was an ordinary care home where only ordinary restrictions of liberty applied.
- The family were able to visit TG on a largely unrestricted basis and were entitled to take him out from the home for outings.
- TG was personally compliant and expressed himself as happy in the care home. He had lived in a local authority care home for over three years and was objectively content with his situation there.
- There was no occasion where TG was objectively deprived of his liberty.

The judge said:

'Whilst I agree that the circumstances of the present case may be near the borderline between mere restrictions of liberty and Article 5 detention, I have come to the conclusion that, looked at as a whole and having regard to all the relevant circumstances, the placement of TG in Towerbridge falls short of engaging Article 5.'

2.19 *Nielsen v Denmark (ECtHR; (1988) 11 EHRR 175)*

The mother of a 12-year-old boy arranged for his admission to the state hospital's psychiatric ward. The boy had a nervous disorder and required treatment in the form of regular talks and environmental therapy. The treatment given, and the conditions under which it was administered, was appropriate. The duration of treatment was 5½ months. The boy, however, applied to the ECtHR, feeling that he had been deprived of his liberty.

The restrictions placed on the applicant's freedom of movement and contacts with the outside world were not much different from restrictions that might be imposed on a child in an ordinary hospital. The door of the ward was locked to prevent children exposing themselves to danger or running around disturbing other patients. The applicant was free to leave the ward with permission and to go out if accompanied by a member of staff. He was able to visit his family and friends, and towards the end of his stay to go to school.

The Court held:

'The restrictions imposed on the applicant were not of a nature or degree similar to the cases of deprivation of liberty specified in paragraph (1) of Article 5. In particular, he was not detained as a person of unsound mind. …. Indeed, the restrictions to which the applicant was subject were no more than the normal requirements for the care of a child of 12 years of age receiving treatment in hospital. The conditions in which the applicant stayed thus did not, in principle, differ from those obtaining in many hospital wards where children with physical disorders are treated.'

It concluded:

'the hospitalisation of the applicant did not amount to a deprivation of liberty within the meaning of Article 5, but was a responsible exercise by his mother of her custodial rights in the interests of the child.'

2.20 *HM v Switzerland (ECtHR; (2002) 38 EHRR 314)*

An 84-year-old woman was placed indefinitely in a nursing home by state authorities. She had had the possibility of staying at home and being cared for there, but she and her son had refused to co-operate with the relevant care association, and her living conditions had subsequently deteriorated. The state authorities placed her in the home in order to provide her with necessary medical care and satisfactory living conditions and hygiene.

The woman was not placed in the secure ward of the home but was free to move within the home and to have social contacts with the outside world. She was initially undecided as to what solution she preferred and, after moving into the home, the applicant had agreed to stay there. However, she subsequently applied to the courts saying that she had been deprived of her liberty.

The Court held that she had not been deprived of her liberty:

‘Bearing these elements in mind, in particular the fact that [the authorities] had ordered the applicant’s placement in the nursing home in her own interests in order to provide her with the necessary medical care and satisfactory living conditions and standards of hygiene, and also taking into consideration the comparable circumstances of *Nielsen v Denmark* [see case summary above], the Court concludes that in the circumstances of the present case the applicant’s placement in the nursing home did not amount to a deprivation of liberty within the meaning of Article 5(1), but was a responsible measure taken by the competent authorities in the applicant’s best interests.’

Cases where the courts have found that the steps taken involve a deprivation of liberty

2.21 *DE and JE v Surrey County Council (SCC) (*High Court judgment of 29 December 2006)

DE was a 76-year-old man who, following a major stroke, had become blind and had significant short-term memory impairment. He also had dementia and lacked capacity to decide where he should live, but was still often able to express his wishes with some clarity and force.

DE was married to JE. In August 2003, DE was living at home with JE. There was an occasion when JE felt that she could not care for DE, and placed him on a chair on the pavement in front of the house and called the police. The local authority then placed him in two care homes, referred to in the judgment of the court as the X home and the Y home.

Within the care homes, DE had a very substantial degree of freedom and lots of contact with the outside world. He was never subject to physical or chemical restraint.

DE repeatedly expressed the wish to live with JE, and JE also wanted DE to live with her. SCC would not agree to DE returning to live with, or visit, JE and made it clear that if JE were to persist in an attempt to remove DE, SCC would contact the police. DE and JE applied to the courts that this was a deprivation of his liberty.

In his judgment, Justice Munby said:

‘The fundamental issue in this case … is whether DE has been and is deprived of his liberty to leave the X home and whether DE has been and is deprived of his liberty to leave the Y home. And when I refer to leaving the X home and the Y home, I do not mean leaving for the purpose of some trip or outing approved by SCC or by those managing the institution; I mean leaving in the sense of removing himself permanently in order to live where and with whom he chooses, specifically removing himself to live at home with JE.’

He then said:

‘DE was not and is not “free to leave”, and was and is, in that sense, completely under the control of [the local authority], because, as [counsel for DE] put it, it was and is [the local authority] who decides the essential matters of where DE can live, whether he can leave and whether he can be with JE.’

He concluded:

‘The simple reality is that DE will be permitted to leave the institution in which [the local authority] has placed him and be released to the care of JE only as and when, – if ever; probably never, – [the local authority] considers it appropriate. [The local authority’s] motives may be the purest, but in my judgment, [it] has been and is continuing to deprive DE of his liberty.’

2.22 *HL v United Kingdom (ECtHR; (2004) 40 EHRR 761)*

A 48-year-old man who had had autism since birth was unable to speak and his level of understanding was limited. He was frequently agitated and had a history of self-harming behaviour. He lacked the capacity to consent to treatment.

For over 30 years, he was cared for in Bournewood Hospital. In 1994, he was entrusted to carers and for three years he lived successfully with his carers. Following an incident of self-harm at a day centre on 22 July 1997, the applicant was taken to Bournewood Hospital where he was re-admitted informally (not under the Mental Health Act 1983).

The carers wished to have the applicant released to their care, which the hospital refused. The carers were unable to visit him.

In its judgment in *HL v the United Kingdom*, the ECtHR said that:

‘the key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements from the moment he presented acute behavioural problems on July 22, 1997 to the date when he was compulsorily detained on October 29, 1997.

‘His responsible medical officer (Dr M) was clear that, had the applicant resisted admission or tried to leave thereafter, she would have prevented him from doing so and would have considered his involuntary committal under s. 3 of the 1983 Act; indeed, as soon as the Court of Appeal indicated that his appeal would be allowed, he was compulsorily detained under the 1983 Act. The correspondence between the applicant’s carers and Dr M reflects both the carer’s wish to have the applicant immediately released to their care and, equally, the clear intention of Dr M and the other relevant health care professionals to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence; the applicant would only be released from hospital to the care of Mr and Mrs E as and when those professionals considered it appropriate. … it was clear from the above noted correspondence that the applicant’s contact with his carers was directed and controlled by the hospital, his carers visiting him for the first time after his admission on 2 November 1997.

‘Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave.’

2.23 *Storck v Germany (ECtHR; (2005) 43 EHRR 96)*

A young woman was placed by her father in a psychiatric institution on occasions in 1974 and 1975. In July 1977, at the age of 18, she was placed again in a psychiatric institution. She was kept in a locked ward and was under the continuous supervision and control of the clinic personnel and was not free to leave the clinic during her entire stay of 20 months. When she attempted to flee, she was shackled. When she succeeded one time, she was brought back by the police. She was unable to maintain regular contact with the outside world.

She applied to the courts on the basis that she had been deprived of her liberty. There was a dispute about whether she consented to her confinement.

The Court noted:

‘the applicant, on several occasions, had tried to flee from the clinic. She had to be shackled in order to prevent her from absconding and had to be brought back to the clinic by the police when she managed to escape on one occasion. Under these circumstances, the Court is unable to discern any factual basis for the assumption that the applicant – presuming that she had the capacity to consent – agreed to her continued stay in the clinic. In the alternative, assuming that the applicant was no longer capable of consenting following her treatment with strong medication, she cannot, in any event, be considered to have validly agreed to her stay in the clinic.’

2.24 These cases reinforce the need to carefully consider all the specific circumstances of the relevant individual before deciding whether or not a person is being deprived of their liberty. They also underline the vital importance of involving family, friends and carers in this decision-making process: a significant feature of a number of the cases that have come before the courts is a difference of opinion or communication issue between the commissioners or providers of care and family members and carers.

3 How and when can deprivation of liberty be applied for and authorised?

There are some circumstances in which depriving a person, who lacks capacity to consent to the arrangements made for their care or treatment, of their liberty is necessary to protect them from harm, and is in their best interests.

Deprivation of liberty can be authorised by supervisory bodies (primary care trusts (PCTs), local authorities, Welsh Ministers or local health boards (LHBs). To obtain authorisation to deprive someone of their liberty, managing authorities have to apply for an authorisation following the processes set out in this chapter.[6] Once an application has been received, the supervisory body must then follow the assessment processes set out in chapter 4 before it can authorise deprivation of liberty. It should be borne in mind that a deprivation of liberty authorisation does not, in itself, give authority to treat someone. This issue is covered in paragraphs 5.10 to 5.13.

In the vast majority of cases, it should be possible to plan in advance so that a standard authorisation can be obtained before the deprivation of liberty begins. There may, however, be some exceptional cases where the need for the deprivation of liberty is so urgent that it is in the best interests of the person for it to begin while the application is being considered. In that case, the care home or hospital may give an urgent authorisation for up to seven days (see chapter 6).

How, in summary, can deprivation of liberty be authorised?

3.1 A **managing authority** has responsibility for applying for authorisation of deprivation of liberty for any person who may come within the scope of the deprivation of liberty safeguards:

- In the case of an NHS hospital, the managing authority is the NHS body responsible for the running of the hospital in which the relevant person is, or is to be, a resident.

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[6] If a person is lawfully deprived of liberty in a care home or hospital as **a consequence of an order of the Court of Protection**, there is no need to apply for an authorisation. However, once the order of the Court of Protection has expired, for lawful deprivation of liberty to continue authorisation must be obtained by following the processes set out in this chapter.

- In the case of a care home or a private hospital, the managing authority will be the person registered, or required to be registered, under part 2 of the Care Standards Act 2000 in respect of the hospital or care home.

3.2 If a healthcare or social care professional thinks that an authorisation is needed, they should inform the managing authority. This might be as a result of a care review or needs assessment but could happen at any other time too. (See chapter 9 for guidance on action to take if there is a concern that a person is already being deprived of their liberty, without authorisation.)

3.3 A **supervisory body** is responsible for considering requests for authorisations, commissioning the required assessments (see chapter 4) and, where all the assessments agree, authorising the deprivation of liberty:

- Where the deprivation of liberty safeguards are applied to a person in a hospital situated in England, the supervisory body will be:
  - if a PCT commissions[7] the relevant care or treatment (or it is commissioned on the PCT's behalf), that PCT
  - if the Welsh Ministers or an LHB commissions the relevant care and treatment in England, the Welsh Ministers, or
  - in any other case, the PCT for the area in which the hospital is situated.
- Where the deprivation of liberty safeguards are applied to a person in a hospital situated in Wales, the supervisory body will be the Welsh Ministers or an LHB **unless** a PCT commissions the relevant care and treatment in Wales, in which case the PCT will be the supervisory body.

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[7] Guidance on establishing the responsible commissioner can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466

- Where the deprivation of liberty safeguards are applied to a person in a care home, whether situated in England or Wales, the supervisory body will be the local authority for the area in which the person is ordinarily resident. However, if the person is not ordinarily resident in the area of any local authority (for example a person of no fixed abode), the supervisory body will be the local authority for the area in which the care home is situated.[8]

3.4 There are two types of authorisation: standard and urgent. A managing authority must request a standard authorisation when it appears likely that, at some time during the next 28 days, someone will be accommodated in its hospital or care home in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights. The request must be made to the supervisory body. Whenever possible, authorisation should be obtained in advance. Where this is not possible, and the managing authority believes it is necessary to deprive someone of their liberty in their best interests **before** the standard authorisation process can be completed, the managing authority must itself give an urgent authorisation and then obtain standard authorisation within seven calendar days (see chapter 6).

3.5 The flowchart at Annex 1 gives an overview of how the deprivation of liberty safeguards process should operate.

How should managing authorities decide whether to apply for an authorisation?

3.6 Managing authorities should have a procedure in place that identifies:

- whether deprivation of liberty is or may be necessary in a particular case
- what steps they should take to assess whether to seek authorisation

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[8] To work out the place of ordinary residence, the usual mechanisms under the National Assistance Act 1948 apply (see http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Ordinaryresidence/DH_079346). Any unresolved questions about the ordinary residence of a person will be handled by the Secretary of State or by the Welsh Ministers. Until a decision is made, the local authority that received the application must act as the supervisory body. After the decision is made, the local authority of ordinary residence must become the supervisory body. Regulations 17 to 19 of the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 set out, for England, arrangements that are to have effect while any question as to the ordinary residence of a person is determined in a case in which a local authority has received a request for a standard authorisation or a request to decide whether there is an unauthorised deprivation of liberty.

- whether they have taken all practical and reasonable steps to avoid a deprivation of liberty
- what action they should take if they do need to request an authorisation
- how they should review cases where authorisation is or may be necessary, and
- who should take the necessary action.

A flowchart that can be used to help develop such a procedure is at Annex 2.

What is the application process?

3.7 A managing authority must apply for a standard authorisation. The application should be made in writing to the supervisory body. A standard form is available for this purpose.

3.8 In England, the request from a managing authority for a standard authorisation must include:

- the name and gender of the relevant person
- the age of the relevant person or, where this is not known, whether the managing authority reasonably believes that the relevant person is aged 18 years or older
- the address at which the relevant person is currently located, and the telephone number at the address
- the name, address and telephone number of the managing authority and the name of the person within the managing authority who is dealing with the request
- the purpose for which the authorisation is requested
- the date from which the authorisation is sought, and
- whether the managing authority has given an urgent authorisation and, if so, the date on which it expires.

3.9 A request for a standard authorisation must also include, if it is available or could reasonably be obtained by the managing authority:

- any medical information relating to the relevant person's health that the managing authority reasonably considers to be relevant to the proposed restrictions to their liberty
- the diagnosis of the mental disorder (within the meaning of the Mental Health Act 1983 but disregarding any exclusion for persons with learning disability) from which the relevant person is suffering

- any relevant care plans and needs assessments
- the racial, ethnic or national origins of the relevant person
- whether the relevant person has any special communication needs
- details of the proposed restrictions on the relevant person's liberty
- whether it is necessary for an Independent Mental Capacity Advocate (IMCA) to be instructed
- where the purpose of the proposed restrictions to the relevant person's liberty is to give treatment, whether the relevant person has made an advance decision that may be valid and applicable to some or all of that treatment
- whether there is an existing standard authorisation in relation to the detention of the relevant person and, if so, the date of the expiry of that authorisation
- whether the relevant person is subject to any requirements of the Mental Health Act 1983, and
- the name, address and telephone number of:
  - anyone named by the relevant person as someone to be consulted about their welfare
  - anyone engaged in caring for the person or interested in their welfare
  - any donee of a Lasting Power of Attorney ('donee') granted by the person
  - any deputy appointed for the person by the court, and
  - any IMCA who has already been instructed.

If there is an existing authorisation, information that has not changed does not have to be resupplied.

3.10 In Wales, the request from a managing authority for a standard authorisation must include:

- the name of the relevant person
- the name, address and telephone number of the managing authority
- the reasons why the managing authority considers that the relevant person is being or will be detained in circumstances which amount to a deprivation of liberty
- the reasons why the managing authority considers that the relevant person satisfies the qualifying requirements
- details of any urgent authorisation

- information or documents in support of why the relevant person satisfies the qualifying requirements
- the name, address and telephone number of any person who has an interest in the welfare of the relevant person, and
- details of any relevant valid and applicable advance decision.

Where should applications be sent?

3.11 If the application is being made by a care home, the application must be sent to the local authority for the area in which the relevant person is ordinarily resident. If the relevant person is not ordinarily resident in the area of any local authority (for example, is of no fixed abode), if the care home does not know where the person currently lives, or if the person does not live in England or Wales, the application should be sent to the local authority in whose area the care home is located.

3.12 When the application is being made by a hospital:

- if the care is commissioned by a PCT, the application should be sent to that PCT
- if the care is commissioned by the Welsh Ministers, the application should be sent to the LHB for the area in which the relevant person is ordinarily resident
- if the care is commissioned by an LHB, the application should be sent to that LHB, and
- in any other case (for example, care that is commissioned privately), the application should be sent to the PCT for the area in which the relevant hospital is situated.

3.13 An application sent to the wrong supervisory body can be passed on to the correct supervisory body without the managing authority needing to reapply. But the managing authority should make every effort to establish which is the correct supervisory body to minimise delays in handling the application. (Footnote 8 explains how place of ordinary residence is determined and how disputes about the place of ordinary residence will be resolved.)

3.14 The managing authority must keep a written record of each request made for a standard authorisation and the reasons for making the request.

Who should be informed that an application has been made?

3.15 The managing authority should tell the relevant person's family, friends and carers, and any IMCA already involved in the relevant person's case, that it has applied for an authorisation of deprivation of liberty, unless it is impractical or impossible to do so, or undesirable in terms of the interests of the relevant person's health or safety. Anyone who is engaged in caring for the relevant person or interested in their welfare, or who has been named by them as a person to consult, must be given the opportunity to input their views on whether deprivation of liberty is in the best interests of the relevant person, as part of the best interests assessment (see paragraphs 4.58 to 4.76), as far as is practical and appropriate. The views of the relevant person about who to inform and consult should be taken into account.

3.16 The managing authority must notify the supervisory body if it is satisfied that there is no one who should be consulted in determining the relevant person's best interests, except those providing care and treatment for the relevant person in a professional capacity or for remuneration. In such a case, the supervisory body must instruct an IMCA to represent and support the relevant person before any assessments take place (see paragraphs 3.22 to 3.27 regarding the rights and role of an IMCA instructed in these circumstances).

What action does the supervisory body need to take when it receives an application for authorisation?

3.17 When it receives an application for authorisation of deprivation of liberty, the supervisory body must, as soon as is practical and possible:

- consider whether the request is appropriate and should be pursued, and
- seek any further information that it requires from the managing authority to help it with the decision.

If the supervisory body has any doubts about proceeding with the request, it should seek to resolve them with the managing authority.

3.18 Supervisory bodies should have a procedure in place that identifies the action they should take, who should take it and within what timescale. As far as practical and possible, they should communicate the procedure to managing authorities and give them the relevant contact details for making an application. The flowchart at Annex 3 summarises the process that a supervisory body should follow on receipt of a request from a managing authority for a standard deprivation of liberty authorisation.

Can an application for authorisation be made in advance?

3.19 A standard authorisation comes into force when it is given, or at any later time specified in the authorisation. Paragraph 3.4 refers to the timescales for initially applying for authorisations: 28 days are allowed so that authorisations can usually be sought as part of care planning (such as planning of discharge from hospital). There is no statutory limit on how far in advance of the expiry of one authorisation a fresh authorisation can be sought. Clearly, however, an authorisation should not be applied for too far in advance as this may prevent an assessor from making an accurate assessment of what the person's circumstances will be at the time the authorisation will come into force.

3.20 If a supervisory body considers that an application for an authorisation has been made too far in advance, it should raise the matter with the managing authority. The outcome may be an agreement with the managing authority that the application should be withdrawn, to be resubmitted at a more appropriate time.

What happens when the managing authority and the supervisory body are the same organisation?

3.21 In some cases, a single organisation will be both supervisory body and managing authority – for example, where a local authority itself provides a residential care home, rather than purchasing the service from another organisation. This does not prevent it from acting in both capacities. However, in England the regulations specify that in such a situation the best interests assessor cannot be an employee of the supervisory body/managing authority, or providing services to it. For example, in a case involving a local authority care home, the best interests assessor could be an NHS employee or an independent practitioner. (See paragraphs 4.13 and 4.60 for full details of who can be a best interests assessor.) There are similar provisions for Wales.

When should an IMCA be instructed?

3.22 If there is nobody appropriate to consult, other than people engaged in providing care or treatment for the relevant person in a professional capacity[9] or for remuneration, the managing authority must notify the supervisory body when it submits the application for the deprivation of liberty authorisation. The supervisory body must then instruct an IMCA straight away to represent the person. It is particularly important that the IMCA is instructed quickly if an urgent authorisation has been given, so that they can make a meaningful input at a very early stage in the process. (See paragraph 3.28 for other stages in the deprivation of liberty safeguards process when an IMCA must or may be instructed.)

3.23 Chapter 10 of the main Code ('What is the new Independent Mental Capacity Advocate service and how does it work?') describes the wider rights and role of an IMCA. Supervisory bodies should follow the guidance in that chapter in identifying an IMCA who is suitably qualified to represent the relevant person. However, it is also important to note that an IMCA instructed at this initial stage of the deprivation of liberty safeguards process has additional rights and responsibilities compared to an IMCA more generally instructed under the Mental Capacity Act 2005. IMCAs in this context have the right to:

- as they consider appropriate, give information or make submissions to assessors, which assessors must take into account in carrying out their assessments
- receive copies of any assessments from the supervisory body
- receive a copy of any standard authorisation given by the supervisory body
- be notified by the supervisory body if they are unable to give a standard authorisation because one or more of the deprivation of liberty assessments did not meet the qualifying requirements
- receive a copy of any urgent authorisation from the managing authority
- receive from the managing authority a copy of any notice declining to extend the duration of an urgent authorisation
- receive from the supervisory body a copy of any notice that an urgent authorisation has ceased to be in force, and

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[9] A friend or family member is **not** considered to be acting in a professional capacity simply because they have been appointed as the person's representative for a previous authorisation.

- apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with a matter relating to the giving or refusal of a standard or urgent authorisation (in the same way as any other third party can).

The assessment and authorisation processes are described in chapters 4 and 5.

3.24 IMCAs will need to familiarise themselves with the relevant person's circumstances and to consider what they may need to tell any of the assessors during the course of the assessment process. They will also need to consider whether they have any concerns about the outcome of the assessment process.

3.25 Differences of opinion between an IMCA and an assessor should ideally be resolved while the assessment is still in progress. Where there are significant disagreements between an IMCA and one or more of the assessors that cannot be resolved between them, the supervisory body should be informed before the assessment is finalised. The supervisory body should then consider what action might be appropriate, including perhaps convening a meeting to discuss the matter. Wherever possible, differences of opinion should be resolved informally in order to minimise the need for an IMCA to make an application to the Court of Protection. However, an IMCA should not be discouraged from making an application to the Court of Protection should they consider it necessary. (Chapter 15 of the main Code ('What are the best ways to settle disagreements and disputes about issues covered in the Act?') contains general guidance about the resolution of disputes arising under the Act.)

3.26 An IMCA will also need to consider whether they have any concerns about the giving of an urgent authorisation (see chapter 6), and whether it would be appropriate to challenge the giving of such an authorisation via the Court of Protection.

3.27 Once a relevant person's representative is appointed (see chapter 7), the duties imposed on the IMCA cease to apply. The IMCA may, however, still apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with the giving of a standard authorisation; but, in doing so, the IMCA must take account of the views of the relevant person's representative.

Other circumstances in which an IMCA must or may be instructed

3.28 An IMCA must also be instructed during gaps in the appointment of a relevant person's representative (for instance, if a new representative is being sought – see paragraphs 7.34 to 7.36). In addition, an IMCA may be instructed at any time where:

- the relevant person does not have a paid 'professional' representative
- the relevant person or their representative requests that an IMCA is instructed to help them, or
- a supervisory body believes that instructing an IMCA will help to ensure that the person's rights are protected (see paragraphs 7.37 to 7.41).

4 What is the assessment process for a standard authorisation of deprivation of liberty?

When a supervisory body gives a standard authorisation of deprivation of liberty, the managing authority may lawfully deprive the relevant person of their liberty in the hospital or care home named in the authorisation.

This chapter describes the assessments that have to be undertaken in order for a standard authorisation to be given. It also sets out who is eligible to undertake the assessments.

What assessments are required before giving a standard authorisation?

4.1 As soon as the supervisory body has confirmed that the request for a standard authorisation should be pursued, it must obtain the relevant assessments to ascertain whether the qualifying requirements of the deprivation of liberty safeguards are met. The supervisory body has a legal responsibility to select assessors who are both suitable and eligible. Assessments must be completed within 21 days for a standard deprivation of liberty authorisation, or, where an urgent authorisation has been given, before the urgent authorisation expires.

4.2 The assessments (described in paragraphs 4.23 to 4.76) are:

- age assessment (paragraphs 4.23 and 4.24)
- no refusals assessment (paragraphs 4.25 to 4.28).
- mental capacity assessment (paragraphs 4.29 to 4.32)
- mental health assessment (paragraphs 4.33 to 4.39)
- eligibility assessment (paragraphs 4.40 to 4.57), and
- best interests assessment (paragraphs 4.58 to 4.76).

Standard forms are available for completion by each of the assessors.

4.3 If the person being assessed is not currently in the supervisory body's area, the supervisory body should seek, as far as is practical and possible, to arrange to use assessors based near where the person currently is.

Using equivalent assessments

4.4 The Act states that where an 'equivalent assessment' to any of these assessments has already been obtained, it may be relied upon instead of obtaining a fresh assessment.

4.5 An equivalent assessment is an assessment:

- that has been carried out in the last 12 months, not necessarily for the purpose of a deprivation of liberty authorisation (where the required assessment is an age assessment, there is no time limit on the use of an equivalent assessment)
- that meets all the requirements of the deprivation of liberty assessment,
- of which the supervisory body is satisfied that there is no reason to believe that it is no longer accurate, and
- of which the supervisory body has a written copy.

An example would be a recent assessment carried out for the purposes of the Mental Health Act 1983, which could serve as an equivalent to a mental health assessment.

4.6 Great care should be taken in deciding to use an equivalent assessment and this should not be done routinely. The older the assessment is, even if it took place within the last 12 months, the less likely it is to represent a valid equivalent assessment (unless it is an age assessment). For example, only a very recent mental capacity assessment would be appropriate where capacity is known to fluctuate, since one of the principles of the Act is that a person must be assumed to have capacity unless it is established that they lack capacity.

4.7 If an equivalent best interests assessment is used, the supervisory body must also take into account any information given, or submissions made, by the relevant person's representative or an Independent Mental Capacity Advocate (IMCA) instructed under the deprivation of liberty safeguards.

4.8 Supervisory bodies should record the reasons why they have used any equivalent assessment. A standard form is available for this purpose.

When must assessments take place?

4.9 The regulations for England[10] specify that all assessments required for a standard authorisation must be completed within 21 calendar days from the date on which the supervisory body receives a request from a managing authority. The regulations for Wales specify that all assessments required for a standard authorisation must be completed within 21 days from the date the assessors were instructed by the supervisory body.

4.10 However, if an urgent authorisation is already in force, the assessments must be completed before the urgent authorisation expires. The regulations for Wales specify that, where the managing authority has given itself an urgent authorisation and applies for a standard authorisation, the assessors must complete the assessments within five days of the date of instruction.

4.11 Urgent authorisations may be given by managing authorities for an initial period not exceeding seven days. If there are exceptional reasons why it has not been possible to deal with the request for a standard authorisation within the period of the urgent authorisation, they may be extended **by the supervisory body** for up to a further seven days. It is for the supervisory body to decide what constitutes an 'exceptional reason', taking into account all the circumstances of an individual case.

4.12 Supervisory bodies must keep a record of all requests for standard authorisations that they receive and should acknowledge the receipt of requests from managing authorities for standard authorisations.

How should assessors be selected?

4.13 The six assessments do not have to be completed by different assessors. In fact, it is highly unlikely that there will be six separate assessors – not least because it is desirable to minimise the burden on the person being assessed. However, each assessor must make their own decisions, and to ensure that an appropriate degree of objectivity is brought to the assessment process:

- there **must** be a minimum of two assessors
- the mental health and best interests assessors **must** be different people

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[10] The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008.

- the best interests assessor can be an employee of the supervisory body or managing authority, but **must not** be involved in the care or treatment of the person they are assessing nor in decisions about their care
- a potential best interests assessor should not be used if they are in a line management relationship with the professional proposing the deprivation of liberty or the mental health assessor
- none of the assessors may have a financial interest in the case of the person they are assessing (a person is considered to have a financial interest in a case where that person is a partner, director, other office-holder or major shareholder of the managing authority that has made the application for a standard authorisation)
- an assessor **must not** be a relative of the person being assessed, nor of a person with a financial interest in the person's care. For this purpose, a 'relative' is:
    a. a spouse, ex-spouse, civil partner or ex-civil partner
    b. a person living with the relevant person as if they were a spouse or a civil partner
    c. a parent or child
    d. a brother or sister
    e. a child of a person falling within definitions a, b or d
    f. a grandparent or grandchild
    g. a grandparent-in-law or grandchild-in-law
    h. an aunt or uncle
    i. a sister-in-law or brother-in-law
    j. a son-in-law or daughter-in-law
    k. a first cousin, or
    l. a half-brother or half-sister.

  These relationships include step-relationships
- where the managing authority and supervisory body are both the same body (see paragraph 3.21), the supervisory body may not select to carry out a best interests assessment a person who is employed by the body, or providing services to it, and
- the supervisory body should seek to avoid appointing assessors in any other possible conflict of interests situations that might bring into question the objectivity of an assessment.

4.14 Other relevant factors for supervisory bodies to consider when appointing assessors include:

- the reason for the proposed deprivation of liberty
- whether the potential assessor has experience of working with the service user group from which the person being assessed comes (for example, older people, people with learning disabilities, people with autism, or people with brain injury)
- whether the potential assessor has experience of working with people from the cultural background of the person being assessed, and
- any other specific needs of the person being assessed, for example communication needs.

4.15 Supervisory bodies should ensure that sufficient assessors are available to meet their needs, and must be satisfied in each case that the assessors have the skills, experience, qualifications and training required by regulations to perform the function effectively. The regulations also require supervisory bodies to be satisfied that there is an appropriate criminal record certificate issued in respect of an assessor. It will be useful to keep a record of qualified assessors and their experience and availability. Supervisory bodies should consider making arrangements to ensure that assessors have the necessary opportunities to maintain their skills and knowledge (of legal developments, for example) and share, audit and review their practice.

4.16 Assessors act as individual professionals and are personally accountable for their decisions. Managing authorities and supervisory bodies must not dictate or seek to influence their decisions.

4.17 There is no reason in principle why interviews, examinations and fact-finding required as part of any deprivation of liberty safeguards assessment cannot serve more than one purpose, in order to avoid unnecessary burdens both on the person being assessed and on staff. However, if this does happen, all purposes of the interview or examination should be made clear to the relevant person, and to any family members, friends, carers or advocates supporting them.

Protection against liability

4.18 Nobody can or should carry out an assessment unless they are protected against any liabilities that might arise in connection with carrying out the assessment. Individual assessors will need to satisfy themselves, and any supervisory body that selects them as an assessor, that they are appropriately covered by either employers' or personal insurance.

What is the assessment process?

4.19 As indicated in paragraph 4.2, there are six assessments that must be conducted before a supervisory body can give an authorisation.

4.20 The assessments are set out in the order in which it will normally be most appropriate to complete them. In particular, it is recommended that the best interests assessment, which is likely to be the most time-consuming, is not started until there is a reasonable expectation that the other five qualifying requirements will be met.

4.21 But, ultimately, it is for the supervisory body to decide on the order in which the assessments should be undertaken and, in the light of the time available to complete the overall assessment process, the extent to which they should be undertaken to separate or simultaneous timescales. The supervisory body's decision about how many assessors will undertake the assessments (see paragraph 4.13) will also be a relevant factor.

4.22 The following paragraphs explain the assessment process.

Age assessment

4.23 The purpose of the age assessment is simply to confirm whether the relevant person is aged 18 or over. This is because, as paragraph 1.12 explains, the deprivation of liberty safeguards apply only to people aged 18 or over. For people under the age of 18, a different safeguards process applies. In most cases, this is likely to be a fairly straightforward assessment. If there is any doubt, age should be established by a birth certificate or other evidence that the assessor considers reliable. Where it is not possible to verify with any certainty whether a person is aged 18 or over, the assessor should base the assessment on the best of their knowledge and belief.

4.24 This assessment can be undertaken by anybody whom the supervisory body is satisfied is eligible to be a best interests assessor.

No refusals assessment

4.25 The purpose of the no refusals assessment is to establish whether an authorisation to deprive the relevant person of their liberty would conflict with other existing authority for decision-making for that person.

4.26 The following are instances of a conflict that would mean that a standard authorisation could not be given:

- If the relevant person has made **an advance decision to refuse treatment** that remains valid and is applicable to some or all of the treatment that is the purpose for which the authorisation is requested, then a standard authorisation cannot be given. See sections 24 to 26 of the Mental Capacity Act 2005 and chapter 9 of the main Code ('What does the Act say about advance decisions to refuse treatment?') for more information about advance decisions and when they are valid and applicable. Remember too that the deprivation of liberty authorisation does not, in itself, provide authority to treat the person (see paragraphs 5.10 to 5.13 of this Code).
- If any part of the proposal to deprive the person of their liberty (including any element of the care plan) would be in conflict with a **valid decision of a donee or a deputy** made within the scope of their authority, then a standard authorisation cannot be given. For example, if a donee or deputy decides that it would not be in the best interests of the relevant person to be in a particular care home, and that decision is within the scope of their authority, then the care plan will need to be reviewed with the donee or deputy.

4.27 If there is any such conflict, the no refusals assessment qualifying requirement will not be met and a standard authorisation for deprivation of liberty cannot be given.

4.28 The no refusals assessment can be undertaken by anybody that the supervisory body is satisfied is eligible to be a best interests assessor.

Mental capacity assessment

4.29 The purpose of the mental capacity assessment is to establish whether the relevant person lacks capacity to decide whether or not they should be accommodated in the relevant hospital or care home to be given care or treatment. The assessment refers specifically to the relevant person's capacity to make this decision at the time it needs to be made. The starting assumption should always be that a person has the capacity to make the decision.

4.30 Sections 1 to 3 of the Act set out how a person's capacity to make decisions should be determined. Chapter 4 of the main Code ('How does the Act define a person's capacity to make a decision and how should capacity be assessed?') gives further guidance on ways to assess capacity. When assessing the capacity of a person being considered for the deprivation of liberty safeguards, these guidelines should be followed.

4.31 The regulations for England specify that the mental capacity assessment can be undertaken by anyone who is eligible to act as a mental health or best interests assessor. In deciding who to appoint for this assessment, the supervisory body should take account of the need for understanding and practical experience of the nature of the person's condition and its impact on decision-making.

4.32 Supervisory bodies may wish to consider using an eligible assessor who already knows the relevant person to undertake this assessment, if they think it would be of benefit. This will primarily arise if somebody involved in the person's care is considered best placed to carry out a reliable assessment, using their knowledge of the person over a period of time. It may also help in reducing any distress that might be caused to the person if they were assessed by somebody they did not know.

Mental health assessment

4.33 The purpose of the mental health assessment is to establish whether the relevant person has a mental disorder within the meaning of the Mental Health Act 1983. That means any disorder or disability of mind, apart from dependence on alcohol or drugs. It includes all learning disabilities. This is not an assessment to determine whether the person requires mental health treatment.

4.34 A distinction can be drawn between the mental health assessment and the mental capacity assessment:

- Although a person must have an impairment or disturbance of the functioning of the mind or brain in order to lack capacity, it does not follow that they automatically have a mental disorder within the meaning of the Mental Health Act 1983.
- The objective of the mental health assessment is to ensure that the person is medically diagnosed as being of 'unsound mind' and so comes within the scope of Article 5 of the European Convention on Human Rights.

4.35 In both England and Wales, the regulations specify that:

- the mental health assessment must be carried out by a doctor, and
- the assessing doctor has to either be approved under section 12 of the Mental Health Act 1983, or be a registered medical practitioner with at least three years' post-registration experience in the diagnosis or treatment of mental disorder, such as a GP with a special interest. This includes doctors who are automatically treated as being section 12 approved because they are approved clinicians under the Mental Health Act 1983.

4.36 To be eligible to undertake assessments, in England a doctor will need to have completed the standard training for deprivation of liberty mental health assessors. Except in the 12 month period beginning with the date the doctor has successfully completed the standard training, the regulations for England also require the supervisory body to be satisfied that the doctor has, in the 12 months prior to selection, completed further training relevant to their role as a mental health assessor. In Wales, a doctor will need to have completed appropriate training and have appropriate skills and experience.

4.37 Supervisory bodies must consider the suitability of the assessor for the particular case (for example, whether they have experience relevant to the person's condition).

4.38 As with the mental capacity assessment, supervisory bodies may wish to consider using an eligible assessor who already knows the relevant person to undertake this assessment, if they think it would be of benefit.

4.39 The mental health assessor is required to consider how the mental health of the person being assessed is likely to be affected by being deprived of their liberty, and to report their conclusions to the best interests assessor. The mental health and best interests assessments cannot be carried out by the same person.

Eligibility assessment

4.40 This assessment relates specifically to the relevant person's status, or potential status, under the Mental Health Act 1983.

4.41 A person is not eligible for a deprivation of liberty authorisation if:

- they are detained as a hospital in-patient under the Mental Health Act 1983, or

- the authorisation, if given, would be inconsistent with an obligation placed on them under the Mental Health Act 1983, such as a requirement to live somewhere else. This will only affect people who are on leave of absence from detention under the Mental Health Act 1983 or who are subject to guardianship, supervised community treatment or conditional discharge.

4.42 Where the proposed authorisation relates to a care home, or to deprivation of liberty in a hospital for non-mental health treatment, the eligibility assessment will simply be a matter of checking that authorisation would not be inconsistent with an obligation placed on the person under the Mental Health Act 1983.

4.43 When a person is subject to guardianship under the Mental Health Act 1983, their guardian can decide where they are to live, but cannot authorise deprivation of liberty and cannot require them to live somewhere where they are deprived of liberty unless that deprivation of liberty is authorised.

4.44 Occasionally, a person who is subject to guardianship and who lacks capacity to make the relevant decisions may need specific care or treatment in a care home or hospital that cannot be delivered without deprivation of liberty. This may be in a care home in which they are already living or in which the guardian thinks they ought to live, or it may be in a hospital where they need to be for physical health care. It may also apply if they need to be in hospital for mental health care. The process for obtaining a deprivation of liberty authorisation and the criteria to be applied are the same as for any other person.

4.45 If the proposed authorisation relates to deprivation of liberty in a hospital **wholly or partly for the purpose of treatment of mental disorder**, then the relevant person will not be eligible if:

- they object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder, **and**
- they meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983 (unless an attorney or deputy, acting within their powers, had consented to the things to which the person is objecting).

4.46 In many cases, the relevant person will be able to state an objection. However, where the person is unable to communicate, or can only communicate to a limited extent, assessors will need to consider the person's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained (see paragraphs

5.37 to 5.48 of the main Code for guidance on how to do this). If there is reason to think that a person would object if able to do so, then the person should be assumed to be objecting. Occasionally, it may be that the person's behaviour initially suggests an objection, but that this objection is in fact not directed at the treatment at all. In that case, the person should **not** be taken to be objecting.

4.47 Assessors should always bear in mind that their job is simply to establish whether the person objects to treatment or to being in hospital: whether that objection is reasonable or not is not the issue.

4.48 Even where a person does not object and a deprivation of liberty authorisation is possible, it should not be assumed that such an authorisation is invariably the correct course. There may be other factors that suggest that the Mental Health Act 1983 should be used (for example, where it is thought likely that the person will recover relevant capacity and will then refuse to consent to treatment, or where it is important for the hospital managers to have a formal power to retake a person who goes absent without leave). Further guidance on this is given in the Mental Health Act 1983 Code of Practice.

4.49 The eligibility assessor is not required to decide (or even consider) whether an application under the Mental Health Act 1983 would be in the person's best interests.

4.50 If the proposed authorisation relates to deprivation of liberty in a hospital **wholly or partly for the purpose of treatment of mental disorder**, then the person will also not be eligible if they are:

- currently on leave of absence from detention under the Mental Health Act 1983
- subject to supervised community treatment, or
- subject to conditional discharge,

in which case powers of recall under the Mental Health Act 1983 should be used.

4.51 People on leave of absence from detention under the Mental Health Act 1983 or subject to supervised community treatment or conditional discharge are, however, eligible for the deprivation of liberty safeguards if they require treatment in hospital for a physical disorder.

Who can conduct an eligibility assessment?

4.52 The regulations for England specify that the eligibility assessment must be completed by:

- a mental health assessor who is also a section 12 doctor, or
- a best interests assessor who is also an approved mental health professional (AMHP).

4.53 The assessment cannot be carried out by a non-section 12 doctor, even if they are qualified to be a mental health assessor, nor by a non-AMHP, even if they are qualified to be a best interests assessor. This will ensure that the eligibility assessor is sufficiently familiar with the Mental Health Act 1983, which will be particularly important in cases in which it appears that the powers available under the Mental Health Act 1983 may be more appropriate than the deprivation of liberty safeguards.

4.54 The eligibility assessment will often be carried out by the best interests assessor but, where this is not the case, the eligibility assessor must request the best interests assessor to provide any relevant eligibility information that the best interests assessor may have, and the best interests assessor must comply with this request.

What happens when people are assessed as ineligible?

4.55 If the eligibility assessor believes that the relevant person is not eligible, but (on the basis of the report of the best interests assessor) that they should nevertheless be deprived of liberty in their best interests, the eligibility assessor should immediately inform the supervisory body.

4.56 In the case of someone already subject to the Mental Health Act 1983, the eligibility assessor should inform the supervisory body with a view to contact being made with the relevant responsible clinician (i.e. the clinician in overall charge of the person's treatment) or, if the person is subject to guardianship, the relevant local social services authority. Otherwise, the assessor or supervisory body should take steps to arrange for the person to be assessed further with a view to an application being made for admission to hospital under the Mental Health Act 1983. Assessors will need to be familiar with local arrangements for doing this.

4.57 In some cases, even before the eligibility assessment is undertaken, it may be known that there is a chance that the person will have to be assessed with a view to an application under the Mental Health Act 1983 because the eligibility assessment might conclude that they are ineligible for a deprivation of liberty authorisation. In such cases, steps should be taken, where practical and possible, to arrange assessments in a way that minimises the number of separate interviews or examinations the person has to undergo.

Best interests assessment

4.58 The purpose of the best interests assessment is to establish, firstly, whether deprivation of liberty is occurring or is going to occur and, if so, whether:

- it is in the best interests of the relevant person to be deprived of liberty
- it is necessary for them to be deprived of liberty in order to prevent harm to themselves, and
- deprivation of liberty is a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm.

4.59 The best interests assessor is the person who is responsible for assessing what is in the best interests of a relevant person.

4.60 In both England and Wales, the best interests assessment must be undertaken by an AMHP, social worker, nurse, occupational therapist or chartered psychologist with the skills and experience specified in the regulations. In England, this includes at least two years' post-registration experience. In England, the supervisory body must also be satisfied that the assessor:

- is not suspended from the register or list relevant to the person's profession
- has successfully completed training that has been approved[11] by the Secretary of State to be a best interests assessor
- except in the 12 month period beginning with the date the person has successfully completed the approved training, has, in the 12 months prior to selection, completed further training relevant to their role as a best interests assessor, and

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[11] Approved courses can be found at: http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm

- has the skills necessary to obtain, evaluate and analyse complex evidence and differing views and to weigh them appropriately in decision-making.

4.61 Section 4 of the Mental Capacity Act 2005 sets out the best interests principles that apply for the purpose of the Act. Chapter 5 of the main Code ('What does the Act mean when it talks about "best interests"?') explains this in more detail, and, in particular, paragraph 5.13 of the main Code includes a checklist of factors that need to be taken into account in working out what is in a person's best interests. These principles and guidance apply equally to working out a person's best interests for the purpose of the deprivation of liberty safeguards. However, when it comes to best interests around deprivation of liberty, additional factors apply, including:

- whether any harm to the person could arise if the deprivation of liberty does not take place
- what that harm would be
- how likely that harm is to arise (i.e. is the level of risk sufficient to justify a step as serious as depriving a person of liberty?)
- what other care options there are which could avoid deprivation of liberty, and
- if deprivation of liberty is currently unavoidable, what action could be taken to avoid it in future.

Establishing whether deprivation of liberty is occurring

4.62 The first task of a best interests assessor is to establish whether deprivation of liberty is occurring, or is likely to occur, since there is no point in the assessment process proceeding further if deprivation of liberty is not at issue. If the best interests assessor concludes that deprivation of liberty is **not** occurring and is not likely to occur, they should state in their assessment report to the supervisory body that deprivation of liberty is not in the person's best interests because there is obviously a less restrictive option available. The best interests requirement will therefore not be met in such a case.

4.63 To establish whether deprivation of liberty is occurring, or is likely to occur, the best interests assessor must consult the managing authority of the hospital or care home where the person is, or will be, accommodated and examine any relevant needs assessments and care plans prepared for the person. The best interests assessor must consider whether the care plan and the manner in which it is being, or will be, implemented constitutes a deprivation of liberty. If not, then no deprivation of liberty authorisation is required for that care plan.

4.64 The managing authority and supervisory body must provide the best interests assessor with any needs assessments or care plans that they have undertaken or which have been undertaken on their behalf.

The best interests assessment process

4.65 If the best interests assessor considers that deprivation of liberty is occurring, or is likely to occur, they should start a full best interests assessment. In line with section 4(7) of the Act this involves seeking the views of a range of people connected to the relevant person to find out whether they believe that depriving the relevant person of their liberty is, or would be, in the person's best interests to protect them from harm or to enable them to follow the care plan proposed. The best interests assessor should, as far as is practical and possible, seek the views of:

- anyone the person has previously named as someone they want to be consulted
- anyone involved in caring for the person
- anyone interested in the person's welfare (for example, family carers, other close relatives, or an advocate already working with the person), and
- any donee or deputy who represents the person.

4.66 This may mean that the best interests assessor needs to explain key aspects of the care plan and what it aims to do to the people being consulted. The best interests assessor should then take the views received into account as far as is practical and appropriate. It is essential that the best interests assessor provides an independent and objective view of whether or not there is a genuine justification for deprivation of liberty, taking account of all the relevant views and factors.

4.67 The best interests assessor must state in their assessment the name and address of every interested person whom they have consulted in carrying out the assessment.

4.68 Family and friends may not be confident about expressing their views: it is the responsibility of the best interests assessor to enable them to do so – using support to meet communication or language needs as necessary.

Scenario: Consulting around best interests

Mr Simpson is 60 and has dementia with particularly poor short-term memory, which clinicians agree is most likely to be related to chronic excessive alcohol intake. After initial treatment in hospital, he has been admitted to a care home – a decision which he consented to.

However, though he had the mental capacity to consent to hospital admission, he has no insight into his dementia. He is unable to understand the health and safety implications of continuing to drink, and will do so heavily whenever he has access to alcohol and the money to buy it.

Scenario: Consulting around best interests *(continued)*

Although Mr Simpson had no access to alcohol in hospital, there is a pub within walking distance of the care home, which he visits and drinks in. When he returns to the home intoxicated, his behaviour can be very distressing and potentially dangerous to other residents. The care home staff believe that if this continues, there may be no other option than to return him to hospital under the Mental Health Act 1983.

The care home staff have asked Mr Simpson to drink only in moderation, but this has not proved successful; and the landlord has been asked not to serve him more than one drink but has refused to do so. The manager of the home is now considering a care plan to prevent Mr Simpson from leaving the home without an escort, and to prevent visits from friends who bring alcohol. He believes this would be in Mr Simpson's best interests.

As the pub is open all day, if this new care plan was adopted, Mr Simpson would be stopped from going out at all without an escort, even though he often goes to the shops and the park as well as the pub. Staffing levels are such that an escort would only be available on some days and for limited periods.

Mr Simpson's daughter, his closest relative, is concerned that these restrictions are excessive and would amount to a deprivation of liberty. She believes that having a drink and socialising in the pub is her father's 'only remaining pleasure', and is sure that, if he still had capacity, he would choose to carry on drinking, regardless of the health risks.

She requests a best interests meeting to consider whether a less restrictive care plan could still meet his needs.

At this meeting, Mr Simpson's community mental health nurse confirms that Mr Simpson is likely to lack capacity in relation to this particular issue, and advises that if he continues to drink to excess his dementia is likely to advance rapidly and his life expectancy will be reduced. However, small amounts of alcohol will not be significantly harmful.

Scenario: Consulting around best interests *(continued)*

The consensus is that the proposed restrictions would severely limit Mr Simpson's ability to maintain social contact and to carry on the life he has been used to, and that this would amount to deprivation of liberty. Bearing in mind his daughter's view, it is felt that it would not be in Mr Simpson's best interests to prevent him from having any alcohol at all. However, in view of the health risks and the likelihood that he would otherwise have to be detained in hospital, it would be in Mr Simpson's best interests to ensure that he does not get intoxicated. (The possibility of limiting his access to his money would be unacceptable since he retains the capacity to decide how to spend it in other ways.)

Discussion then focuses on ways of minimising restrictions so that he is still able to visit the pub, but drinks in moderation. The care home key worker says that when she has gone to the pub with Mr Simpson he has been fully co-operative and has had just one drink before coming back with her. It is therefore agreed that the home will provide an escort for him to visit the pub at least three times a week, and the shops and the park at other times, and that his daughter will be able to take him out at any time.

It is agreed that care home staff (in consultation with his daughter) will review Mr Simpson's care plan in two months' time and, if it is felt that increased restrictions are required, consider whether it is then necessary to request an authorisation for deprivation of liberty.

4.69 The best interests assessor must involve the relevant person in the assessment process as much as is possible and practical, and help them to participate in decision-making. The relevant person should be given the support needed to participate, using non-verbal means of communication where needed (see paragraphs 3.10 and 3.11 of the main Code) or the support of speech and language therapists. It may also help to involve others whom the relevant person already trusts and who are used to communicating with the relevant person.

4.70 The best interests assessor will need to consider the conclusions of the mental health assessor about how the person being assessed is likely to be affected by being deprived of their liberty. If the proposed care would involve the person being moved, then the assessor should consider the impact of the upheaval and of the journey itself on the person.

4.71 If the best interests assessment supports deprivation of liberty in the care home or hospital in question, the assessor must state what the maximum authorisation period should be in the case concerned. This must not exceed 12 months. The assessor should set out the reasons for selecting the period stated. This decision will be based on the information obtained during the consultation process – but should also reflect information from the person's care plan about how long any treatment or care will be required in circumstances that amount to a deprivation of liberty. It should also take into account any available indication of how likely it is that the relevant person's circumstances will change, including the expected progression of the illness or disability. The underlying principle is that deprivation of liberty should be for the minimum period necessary so, for the maximum 12-month period to apply, the assessor will need to be confident that there is unlikely to be a change in the person's circumstances that would affect the authorisation within that timescale.

The report of the best interests assessor

4.72 The best interests assessor must provide a report that explains their conclusion and their reasons for it. If they do not support deprivation of liberty, then their report should aim to be as useful as possible to the commissioners and providers of care in deciding on future action (for example, recommending an alternative approach to treatment or care in which deprivation of liberty could be avoided). It may be helpful for the best interests assessor to discuss the possibility of any such alternatives with the providers of care **during the assessment process**.

4.73 If the best interests assessor does not support deprivation of liberty, it would be good practice for their report to be included in the relevant person's care plan or case notes, to ensure that any views about how deprivation of liberty can be avoided are made clear to the providers of care and all relevant staff on an ongoing basis.

4.74 The best interests assessor may recommend that conditions should be attached to the authorisation. For example, they may make recommendations around contact issues, issues relevant to the person's culture or other major issues related to the deprivation of liberty, which – if not dealt with – would mean that the deprivation of liberty would cease to be in the person's best interests. The best interests assessor may also recommend conditions in order to work towards avoiding deprivation of liberty in future. But it is not the best interests assessor's role to specify conditions that do not directly relate to the issue of deprivation of liberty.

4.75 Conditions should not be a substitute for a properly constructed care plan (see paragraph 2.7 on good practice for care planning). In recommending conditions, best interests assessors should aim to impose the minimum necessary constraints, so that they do not unnecessarily prevent or inhibit the staff of the hospital or care home from responding appropriately to the person's needs, whether they remain the same or vary over time. It would be good practice for the best interests assessor to discuss any proposed conditions with the relevant personnel at the home or hospital before finalising the assessment, and to make clear in their report whether the rejection or variation of recommended conditions by the supervisory body would significantly affect the other conclusions they have reached.

4.76 Where possible, the best interests assessor should recommend someone to be appointed as the relevant person's representative (see chapter 7). The assessor should be well placed, as a result of the consultation process, to identify whether there is anybody suitable to take on this role. The appointment of the relevant person's representative cannot take place unless and until an authorisation is given. However, by identifying someone to take on this role at an early stage, the best interests assessor can help to ensure that a representative is appointed as soon as possible.

Scenario: Application for standard authorisation

Mrs Jackson is 87 years old and lives by herself in an isolated bungalow in a rural area. Over the past few years, staff at her local health centre have become increasingly concerned about her wellbeing and ability to look after herself. Her appearance has become unkempt, she does not appear to be eating properly and her house is dirty.

The community mental health team have attempted to gain her trust, but she is unwilling to engage with them. She has refused care workers entry to her home and declined their help with personal hygiene and household chores.

Because it is believed that she is a potential risk to herself, she is admitted to psychiatric hospital under section 2 of the Mental Health Act 1983 for assessment of her mental disorder.

Scenario: Application for standard authorisation *(continued)*

Following the assessment, it is felt that Mrs Jackson requires further treatment for mental disorder. An application is made for her detention to be continued under section 3 of the Mental Health Act 1983. She is prescribed antipsychotic medication, but this seems to have little effect on her behaviour. She remains extremely suspicious of people to the point of being delusional. She is assessed as potentially having mild dementia, most probably of the Alzheimer type, but because there is no obvious benefit from anti-dementia medication, further treatment for mental disorder is felt unnecessary.

Mrs Jackson insists that she wishes to return to her own home, but given past failed attempts to gain her acceptance of support at home and her likely future mental deterioration, transfer to a care home is believed to be most appropriate.

A best interests meeting is held by the mental health team to consider her future care and placement, and the team's approved social worker and the instructed IMCA are invited. The meeting concludes that Mrs Jackson does not have sufficient mental capacity to make an informed decision on her stated wish to return home. There is no advance decision in existence, no Lasting Power of Attorney or court deputy appointed and no practical way of contacting her immediate family.

An appropriate care home is identified. A care plan is developed to give Mrs Jackson as much choice and control over her daily living as possible. However, it is felt that the restrictions still necessary to ensure Mrs Jackson's wellbeing will be so intense and of such duration that a request for a standard deprivation of liberty authorisation should be made by the care home manager (the relevant managing authority).

The best interests assessor agrees that the proposed course of action is in Mrs Jackson's best interests and recommends a standard authorisation for six months in the first instance.

What guidelines are there relating to the work of assessors?

Access to records

4.77 All assessors may, at any reasonable time, examine and take copies of:

- any health record
- any record of, or held by, a local authority that was compiled in accordance with a social services function, and
- any record held by a care home

which they consider may be relevant to their assessment. Assessors should list in their assessment report what records they examined.

Recording and reporting assessments

4.78 As soon as possible after carrying out their assessments, assessors must keep a written record of the assessment and must give copies of their assessment report(s) to the supervisory body. The supervisory body must in turn give copies of the assessment report(s) to:

- the managing authority
- the relevant person and their representative, and
- any IMCA instructed

at the same time that it gives them copies of the deprivation of liberty authorisation or notification that an authorisation is not to be given (see paragraphs 5.7 and 5.18 respectively).

5 What should happen once the assessments are complete?

If all the assessments in the standard authorisation assessment process indicate that the relevant person meets all the qualifying requirements, then the supervisory body will give a deprivation of liberty authorisation. If any of the qualifying requirements are not met, however, different actions will need to be taken, depending on the circumstances of the individual case.

This chapter identifies potential outcomes of the assessment process and offers guidance on what should happen next.

What action should the supervisory body take if the assessments conclude that the person meets the requirements for authorisation?

5.1 If all the assessments conclude that the relevant person meets the requirements for authorisation, and the supervisory body has written copies of all the assessments, it must give a standard authorisation. A standard form is available for this purpose.

5.2 The supervisory body cannot give a standard authorisation if any of the requirements are not fulfilled.

5.3 The supervisory body must set the period of the authorisation, which may not be longer than that recommended by the best interests assessor (see paragraph 4.71).

5.4 When the supervisory body gives a standard authorisation, it must do so in writing and must state the following:

- the name of the relevant person
- the name of the relevant hospital or care home
- the period during which the authorisation is to be in force (which may not exceed the period recommended by the best interests assessor)
- the purpose for which the authorisation is given (i.e. why the person needs to be deprived of their liberty)

- any conditions subject to which the authorisation is given (see paragraph 5.5), and
- the reason why each qualifying requirement is met.

5.5 The supervisory body may attach conditions to the authorisation. Before deciding whether to give the authorisation subject to conditions, the supervisory body must consider any recommendations made by the best interests assessor (see paragraph 4.74). Where the supervisory body does not attach conditions as recommended by the best interests assessor, it should discuss the matter with the best interests assessor in case the rejection or variation of the conditions would significantly affect the other conclusions the best interests assessor reached in their report.

5.6 It is the responsibility of the supervisory body to appoint a representative for the relevant person (see chapter 7).

5.7 As soon as possible after giving the authorisation, the supervisory body must give a copy of the authorisation to:

- the managing authority
- the relevant person
- the relevant person’s representative
- any Independent Mental Capacity Advocate (IMCA) involved, and
- every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment.

The supervisory body must also keep a written record of any standard authorisation that it gives and of the matters referred to in paragraph 5.4.

5.8 The managing authority must take all practical and possible steps to ensure that the relevant person understands the effect of the authorisation and their rights around it. These include their right to challenge the authorisation via the Court of Protection, their right to request a review, and their right to have an IMCA instructed, along with the process for doing so (see paragraphs 7.37 to 7.41). Appropriate information must be given to the relevant person both orally and in writing. Any written information must also be given to the relevant person’s representative. This must happen as soon as possible and practical after the authorisation is given.

How long can an authorisation last?

5.9 A deprivation of liberty should last for the shortest period possible. The best interests assessor should only recommend authorisation for as long as the relevant person is likely to meet all the qualifying requirements. The authorisation may be for quite a short period. A short period may, for example, be appropriate if:

- the reason that the deprivation of liberty is in the person's best interests is because their usual care arrangements have temporarily broken down, or
- there are likely to be changes in the person's mental disorder in the relatively near future (for example, if the person is in rehabilitation following brain injury).

What restrictions exist on authorisations?

5.10 A deprivation of liberty authorisation – whether urgent or standard – relates solely to the issue of deprivation of liberty. It does not give authority to treat people, nor to do anything else that would normally require their consent. The arrangements for providing care and treatment to people in respect of whom a deprivation of liberty authorisation is in force are subject to the wider provisions of the Mental Capacity Act 2005.

5.11 This means that any treatment can only be given to a person who has not given their consent if:

- it is established that the person lacks capacity to make the decision concerned
- it is agreed that the treatment will be in their best interests, having taken account of the views of the person and of people close to them, and, where relevant in the case of serious medical treatment, of any IMCA involved
- the treatment does not conflict with a valid and applicable advance decision to refuse treatment, and
- the treatment does not conflict with a decision made by a donee of Lasting Power of Attorney or a deputy acting within the scope of their powers.

5.12 In deciding what is in a person's best interests, section 4 of the Act applies in the same way as it would if the person was not deprived of liberty. The guidance in chapter 5 of the main Code on assessing best interests is also relevant.

5.13 Life-sustaining treatment, or treatment to prevent a serious deterioration in the person's condition, may be provided while a decision in respect of any relevant issue is sought from the Court of Protection. The need to act in the best interests of the person concerned will continue to apply in the meantime.

Can a person be moved to a different location under a standard authorisation?

5.14 If a person who is subject to a standard authorisation moves to a different hospital or care home, the managing authority of the new hospital or care home must request a new standard authorisation. The application should be made **before** the move takes place.

5.15 If the move has to take place so urgently that this is impossible, the managing authority of the new hospital or care home will need to give an urgent authorisation (see chapter 6).

5.16 The only exception is if the care regime in the new facility will not involve deprivation of liberty.

5.17 These arrangements are not an alternative to applying the provisions of sections 38 and 39 of the Act regarding change of residence.

What happens if an assessment concludes that one of the requirements is not met?

5.18 If any of the assessments conclude that one of the requirements is not met, then the assessment process should stop immediately and authorisation may not be given. The supervisory body should:

- inform anyone still engaged in carrying out an assessment that they are not required to complete it
- notify the managing authority, the relevant person, any IMCA involved and every interested person consulted by the best interests assessor that authorisation has not been given (a standard form is available for this purpose), and
- provide the managing authority, the relevant person and any IMCA involved with copies of those assessments that have been carried out. This must be done as soon as possible, because in some cases different arrangements will need to be made for the person's care.

5.19 If the reason the standard authorisation cannot be given is because the eligibility requirement is not met, it may be necessary to consider making the person subject to the Mental Health Act 1983. If this is the case, it may be possible to use the same assessors to make that decision, thereby minimising the assessment processes.

What are the responsibilities of the managing authority and the commissioners of care if a request for an authorisation is turned down?

5.20 The managing authority is responsible for ensuring that it does not deprive a person of their liberty without an authorisation. The managing authority must comply with the law in this respect: where a request for an authorisation is turned down, it will need to review the relevant person's actual or proposed care arrangements to ensure that a deprivation of liberty is not allowed to either continue or commence.

5.21 Supervisory bodies and other commissioners of care will need to purchase care packages in a way that makes it possible for managing authorities to comply with the outcome of the deprivation of liberty safeguards assessment process when a request for a standard authorisation is turned down.

5.22 The actions that both managing authorities and commissioners of care should consider if a request for an authorisation is turned down will depend on the reason why the authorisation has not been given:

- If the best interests assessor concluded that the relevant person was not in fact being, or likely to be, deprived of liberty, no action is likely to be necessary.
- If the best interests assessor concluded that the proposed or actual deprivation of liberty was not in the relevant person's best interests, the managing authority, in conjunction with the commissioner of the care, will need to consider how the care plan could be changed to avoid deprivation of liberty. (See, for example, the guidance on practical ways to reduce the risk of deprivation of liberty in paragraph 2.7.) They should examine carefully the reasons given in the best interests assessor's report, and may find it helpful to discuss the matter with the best interests assessor. Where appropriate, they should also discuss the matter with family and carers. If the person is not yet a resident in the care home or hospital, the revised care plan may not involve admission to that facility unless the conditions of care are adapted to be less restrictive and deprivation of liberty will not occur.

- If the mental capacity assessor concluded that the relevant person **has** capacity to make decisions about their care, the care home or hospital will need to consider, in conjunction with the commissioner of the care, how to support the person to make such decisions.
- If the relevant person was identified as not eligible to be subject to a deprivation of liberty authorisation, it may be appropriate to assess whether an application should be made to detain the person under the Mental Health Act 1983.
- If the relevant person does not have a mental disorder as defined in the Mental Health Act 1983, the care plan will need to be modified to avoid a deprivation of liberty, since there would be no lawful basis for depriving a person of liberty in those circumstances.
- Where there is a valid refusal by a donee or deputy, or an applicable and valid advance decision (see paragraphs 4.25 to 4.28), alternative care arrangements will need to be made. If there is a question about the refusal, a decision may be sought from the Court of Protection.
- If the person is under 18, use of the Children Act 1989 may be considered.

5.23 Working out what action should be taken where a request for a standard deprivation of liberty authorisation is turned down in respect of a ‘self-funder’ may present particular problems, because the managing authority may not be able to make alternative care arrangements without discussing them with those controlling the funding, whether relatives of the person concerned or others. The desired outcome should be the provision of a care regime that does not constitute deprivation of liberty.

5.24 Where the best interests assessor comes to the conclusion that the best interests requirement is not met, but it appears to the assessor that the person being assessed is already being deprived of their liberty, the assessor must inform the supervisory body and explain in their report why they have reached that conclusion. The supervisory body must then inform the managing authority to review the relevant person’s care plan immediately so that unauthorised deprivation of liberty does not continue. Any necessary changes must be made urgently to stop what would be an unlawful deprivation of liberty. The steps taken to stop the deprivation of liberty should be recorded in the care plan. Where possible, family, friends and carers should be involved in deciding how to prevent the unauthorised deprivation of liberty from continuing. If the supervisory body has any doubts about whether the matter is being satisfactorily resolved within an appropriately urgent timescale, it should alert the inspection body (see chapter 11).

6

When can urgent authorisations of deprivation of liberty be given?

Wherever possible, applications for deprivation of liberty authorisations should be made before the deprivation of liberty commences. However, where deprivation of liberty unavoidably needs to commence before a standard authorisation can be obtained, an urgent authorisation can be given which will make the deprivation of liberty lawful for a short period of time.

This chapter contains guidance on the rules around urgent authorisations.

When can an urgent authorisation be given?

6.1 A managing authority can itself give an urgent authorisation for deprivation of liberty where:

- it is required to make a request to the supervisory body for a standard authorisation, but believes that the need for the person to be deprived of their liberty is so urgent that deprivation needs to begin before the request is made, or
- it has made a request for a standard authorisation, but believes that the need for a person to be deprived of liberty has now become so urgent that deprivation of liberty needs to begin before the request is dealt with by the supervisory body.

This means that an urgent authorisation can never be given without a request for a standard authorisation being made simultaneously. Therefore, before giving an urgent authorisation, a managing authority will need to have a reasonable expectation that the six qualifying requirements for a standard authorisation are likely to be met.

6.2 Urgent authorisations should normally only be used in response to sudden unforeseen needs. However, they can also be used in care planning (for example, to avoid delays in transfer for rehabilitation, where delay would reduce the likely benefit of the rehabilitation).

6.3 However, an urgent authorisation should not be used where there is no expectation that a standard deprivation of liberty authorisation will be needed. Where, for example:

- a person who lacks capacity to make decisions about their care and treatment has developed a mental disorder as a result of a physical illness, and
- the physical illness requires treatment in hospital in circumstances that amount to a deprivation of liberty, and
- the treatment of that physical illness is expected to lead to rapid resolution of the mental disorder such that a standard deprivation of liberty authorisation would not be required,

it would not be appropriate to give an urgent authorisation simply to legitimise the short-term deprivation of liberty.

6.4 Similarly, an urgent deprivation of liberty authorisation should not be given when a person is, for example, in an accident and emergency unit or a care home, and it is anticipated that within a matter of a few hours or a few days the person will no longer be in that environment.

6.5 Any decision to give an urgent authorisation and take action that deprives a person of liberty must be in the person's best interests, as set out in section 4 of the Mental Capacity Act 2005. Where restraint is involved, all actions must comply with the additional conditions in section 6 of the Act (see chapter 6 of the main Code).

6.6 The managing authority must decide the period for which the urgent authorisation is given, but this must not exceed seven days (see paragraphs 6.20 to 6.28 regarding the possible extension of the seven-day period). The authorisation must be in writing and must state:

- the name of the relevant person
- the name of the relevant hospital or care home
- the period for which the authorisation is to be in force, and
- the purpose for which the authorisation is given.

A standard form is available for a managing authority to use to notify a supervisory body that it has given an urgent authorisation.

6.7 Supervisory bodies and managing authorities should have a procedure in place that identifies:

- what actions should be taken when an urgent authorisation needs to be made
- who should take each action, and
- within what timescale.

What records should be kept about urgent authorisations?

6.8 The managing authority must keep a written record of any urgent authorisations given, including details of why it decided to give an urgent authorisation. They must give a copy of the authorisation to the relevant person and any IMCA instructed, and place a copy in the relevant person's records. The managing authority must also seek to ensure that, as far as possible, the relevant person understands the effect of the authorisation and the right to challenge the authorisation via the Court of Protection. Appropriate information must be given both orally and in writing.

6.9 The managing authority should, as far as possible and appropriate, notify the relevant person's family, friends and carers when an urgent authorisation is given in order to enable them to offer informed support to the person.

6.10 The processes surrounding the giving and receiving of urgent authorisations should be clearly recorded, and regularly monitored and audited, as part of a managing authority's or supervisory body's governance structure.

Who should be consulted before giving an urgent authorisation?

6.11 If the managing authority is considering depriving a person of liberty in an emergency and giving an urgent authorisation, they must, as far as is practical and possible, take account of the views of anyone engaged in caring for the relevant person or interested in their welfare. The aim should be to consult carers and family members at as early a stage as possible so that their views can be properly taken into account before a decision to give an urgent authorisation is taken.

6.12 The steps taken to involve family, friends or carers should be recorded in the relevant person's records, along with their views. The views of the carers will be important because their knowledge of the person will put them in a good position to gauge how the person will react to the deprivation of their liberty, and the effect it will have on their mental state. It may also be appropriate to consult any staff who may have some involvement in the person's case.

6.13 The ultimate decision, though, will need to be based on a judgement of what is in the relevant person's best interests. The decision-maker from the managing authority will need to be able to show that they have made a reasonable decision based on their professional judgement and taking account of all the relevant factors. This is an important decision, because it could mean the deprivation of a person's liberty without, at this stage, the full deprivation of liberty safeguards assessment process having taken place. The decision should therefore be taken at a senior level within the managing authority.

Scenario: Urgent authorisation followed by short-term standard authorisation

Mr Baker is 75, widowed and lives near his only family – his daughter. He is admitted to hospital having been found by his daughter on his kitchen floor. He is uncharacteristically confused and is not able to give a reliable history of what has happened. He has a routine physical examination, as well as blood and urine investigations, and is diagnosed as having a urinary tract infection. He is given antibiotics, but his nursing care is complicated by his fluctuating confusion. Once or twice he removes his clothes and walks through the ward naked, and at times he tries to leave the ward, unaware that he is in hospital, and believing that he is late for an important work meeting. During more lucid moments, however, he knows where he is and accepts the need for investigation and treatment in hospital.

The responsible consultant, in consultation with ward nursing staff and Mr Baker's daughter, feels that it would be in his best interests to place him in a side room to protect his dignity, and restrict his movements to ensure he remains on the ward.

However, after two days, his confusion appears to worsen: he starts having hallucinations and has to be restrained more often by staff to prevent him leaving the ward. After assessment by a doctor from the liaison psychiatry team, Mr Baker is prescribed antipsychotic medication for his own and other patients' safety. He does not resist taking this medication. The likely benefits and possible side effects are discussed with his daughter and, on balance, the medication is felt to be in his best interests in order to continue his medical investigations.

Scenario: Urgent authorisation followed by short-term standard authorisation *(continued)*

Staff become concerned about the level of restriction of liberty Mr Baker is now subject to. In particular, they are concerned about the duration of the restrictions; the fact that Mr Baker no longer has lucid intervals when he can give his consent to ongoing care and treatment in hospital; and the physical restraint that is still being required on occasion.

After discussion between the ward manager and Mr Baker's daughter, the managing authority gives an urgent authorisation and submits a request for a standard authorisation to the supervisory body (PCT). A best interests assessor is appointed, and the liaison psychiatrist provides the mental health and mental capacity assessments. In making all the deprivation of liberty safeguards assessments to see whether the qualifying requirements are met, it is considered that although restraint is being used, this does not mean he is objecting having regard to all the circumstances, so he is not ineligible and a standard authorisation is given.

Can a person be moved into care under an urgent authorisation?

6.14 There may be cases in which managing authorities are considering giving an urgent authorisation to enable them to move the relevant person to a new type of care. This may occur, for example, when considering whether to admit a person living at home or with relatives into a hospital care regime that would deprive them of their liberty, and when the need for admission appears to be so urgent that there would not be enough time to follow the standard authorisation process.

6.15 For some people, such a change of location may have a detrimental effect on their mental health, which might significantly distort the way they come across during any assessment process. In such a case, managing authorities should consider whether giving the urgent authorisation and admitting the person to hospital would outweigh the benefits of leaving the person in their existing location, where any assessment of their needs might be more accurate. This will involve looking carefully at the existing care arrangements and consulting with any carers involved, to establish whether or not the person could safely and beneficially be cared for in their home environment while the assessment process takes place. Where the relevant person is already known to statutory care providers, for example the community mental health team or social services, it will be important to involve them in this decision-making process. The relevant person's GP may also be an important source of knowledge about the person's situation, and may be able to offer a valuable opinion when the appropriateness of moving the person into a different care setting is under consideration.

What happens at the end of an urgent authorisation period?

6.16 An urgent authorisation will terminate at the end of the period for which it is given. As noted above, this is normally a maximum of seven days, but in exceptional circumstances an urgent authorisation can be extended to a maximum of 14 days **by the supervisory body**, as explained in paragraphs 6.20 to 6.28.

6.17 An urgent authorisation will terminate before this time if the standard authorisation applied for is given.

6.18 An urgent authorisation will also terminate if a managing authority receives notice from the supervisory body that the standard authorisation will not be given. It will not then be lawful to continue to deprive the relevant person of their liberty.

6.19 The supervisory body must inform the relevant person and any IMCA instructed that the urgent authorisation has ended. This notification can be combined with the notification to them of the outcome of the application for standard authorisation.

Scenario: Considering an urgent authorisation

Mr Watson is 35. He has autism and learning disabilities. He lives in the family home with his parents. Although he is well settled and generally calm at home, Mr Watson sometimes becomes disturbed when in an unfamiliar and crowded environment.

While his parents are away for a couple of days, and Mr Watson is in the care of a paid carer, he has an accident at home. His carer is concerned that he may have broken his arm and takes him to the A&E department at the local hospital, where it is decided that his arm needs to be X-rayed to check for a break. The outcome is that there is no break, just bad bruising, so there is no medical need to admit him.

Scenario: Considering an urgent authorisation *(continued)*

However, because of the pain he is in and the crowded environment, Mr Watson has become very agitated to the extent that hospital security personnel feel a need to control him physically. The carer tries to restrain him and lead him outside where she says he is likely to be more settled and calm down.

Because restraint is being used, the A&E doctor wonders whether it his duty to use an urgent authorisation or other measure to detain Mr Watson in hospital if he believes it is in his best interests.

He consults a liaison psychiatry nurse, who reassures him that such restraint is permitted under the Mental Capacity Act 2005 where it is necessary to prevent harm to the person himself and so long as it is a proportionate response. The nurse assists the carer with gentle restraint to take Mr Watson to a quieter area. She suggests the doctor phone Mr Watson's parents for further information, and obtains painkillers for Mr Watson.

The doctor speaks to Mr Watson's parents, who believe that Mr Watson does not have the mental capacity to decide on his care and treatment in the current circumstances. They have experienced similar situations many times, and are confident that Mr Watson will calm down once he is back in his home environment. They state that if any more detailed assessment of his mental state is required it should take place there, in the company of the carer whom they know and trust. They reassure the doctor that Mr Watson is highly unlikely to present a danger to himself, his carer or the general public.

The doctor decides that it will be in Mr Watson's best interests to return home with his carer.

How and when can an urgent authorisation be extended?

6.20 If there are exceptional reasons why the request for a standard authorisation cannot be dealt with within the period of the original urgent authorisation, the managing authority may ask the supervisory body to extend the duration of the urgent authorisation for a maximum of a further seven days. The managing authority must keep a written record of the reason for making the request and must notify the relevant person, in writing, that they have made the request. Standard forms are available for managing authorities to request the extension of an urgent authorisation from a supervisory body and for supervisory bodies to record their decision in response to such a request.

6.21 Unless the duration of the urgent authorisation is extended by the supervisory body, or a standard authorisation is given before the urgent authorisation expires, the authority to deprive the person of liberty will cease once the urgent authorisation period has expired. It is therefore essential that any request for an extension of an urgent authorisation is made promptly. This will necessitate good communication between the managing authority and the supervisory body regarding the progress of the standard authorisation assessment process. Particular care may need to be taken where an urgent authorisation is due to expire over the weekend or on a bank holiday, when appropriate people at the managing authority and supervisory body may not be immediately available.

6.22 The supervisory body may only extend the duration of the urgent authorisation if:

- the managing authority has made a request for a standard authorisation
- there are exceptional reasons why it has not yet been possible to make a standard authorisation, and
- it is essential for the deprivation of liberty to continue while the supervisory body makes its decision.

6.23 Extensions can only be granted for exceptional reasons. An example of when an extension would be justified might be where:

- it was not possible to contact a person whom the best interests assessor needed to contact
- the assessment could not be relied upon without their input, and
- extension for the specified period would enable them to be contacted.

6.24 It is for the supervisory body to decide what constitutes an ‘exceptional reason’, but because of the seriousness of the issues involved, the supervisory body’s decision must be soundly based and defensible. It would not, for example, be appropriate to use staffing shortages as a reason to extend an urgent authorisation.

6.25 An urgent authorisation can only be extended once.

6.26 The supervisory body must notify the managing authority of the length of any extension granted and must vary the original urgent authorisation so that it states the extended duration. The supervisory body must also keep a written record of the outcome of the request and the period of the extension.

6.27 The managing authority must give a copy of the varied urgent authorisation to the relevant person and any IMCA instructed, and must seek to ensure that, as far as possible, the relevant person understands the effect of the varied authorisation and the right to challenge the authorisation via the Court of Protection. The appropriate information must be given both orally and in writing.

6.28 If the supervisory body decides not to extend the urgent authorisation, it must inform the managing authority of its decision and the reasons for it. The managing authority must give a copy of the notice to the relevant person and any IMCA involved.

7 What is the role of the relevant person's representative?

Once a standard deprivation of liberty authorisation has been given, supervisory bodies must appoint the relevant person's representative as soon as possible and practical to represent the person who has been deprived of their liberty.

This chapter explains the role of the relevant person's representative and gives guidance on their selection and appointment.

What is the role of the relevant person's representative?

7.1 The supervisory body must appoint a relevant person's representative for every person to whom they give a standard authorisation for deprivation of liberty. It is important that the representative is appointed at the time the authorisation is given or as soon as possible and practical thereafter.

7.2 The role of the relevant person's representative, once appointed, is:

- to maintain contact with the relevant person, and
- to represent and support the relevant person in all matters relating to the deprivation of liberty safeguards, including, if appropriate, triggering a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection.

This is a crucial role in the deprivation of liberty process, providing the relevant person with representation and support that is independent of the commissioners and providers of the services they are receiving.

7.3 The best interests principle of the Act applies to the relevant person's representative in the same way that it applies to other people acting or making decisions for people who lack capacity.

How should managing authorities work with the relevant person's representative?

7.4 As soon as possible and practical after a standard deprivation of liberty authorisation is given, the managing authority must seek to ensure that the relevant person and their representative understand:

- the effect of the authorisation
- their right to request a review (see chapter 8)
- the formal and informal complaints procedures that are available to them
- their right to make an application to the Court of Protection to seek variation or termination of the authorisation (see chapter 10), and
- their right, where the relevant person does not have a paid 'professional' representative, to request the support of an Independent Mental Capacity Advocate (IMCA) (see paragraphs 7.37 to 7.41).

7.5 When providing information to the person and their representative, the managing authority should take account of the communication and language needs of both the person and their representative. Provision of information should be seen as an ongoing responsibility, rather than a one-off activity.

Who can be the relevant person's representative?[12]

7.6 To be eligible to be the relevant person's representative, a person must be:

- 18 years of age or over
- able to keep in contact with the relevant person, and
- willing to be appointed.

The person must not be:

- financially interested in the relevant person's managing authority (a person is considered to be financially interested where that person is a partner, director, other office-holder or major shareholder of the managing authority)

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[12] Requirements relating to the eligibility, selection and appointment of relevant person's representatives are covered in regulations. The regulations for England are The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008. The regulations for Wales are The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) (Wales) Regulations 2008.

- a relative of a person who has a financial interest in the relevant person's managing authority (paragraph 4.13 explains what is meant by 'relative')
- employed by, or providing services to, the care home in which the person relevant person is residing
- employed by the hospital in a role that is, or could be, related to the treatment or care of the relevant person, or
- employed to work in the relevant person's supervisory body in a role that is, or could be, related to the relevant person's case.

7.7 The appointment of the relevant person's representative is in addition to, and does not affect, any appointment of a donee or deputy. Similarly, the functions of the representative are in addition to, and do not affect, the authority of any donee, the powers of any deputy or any powers of the court. A donee or deputy may themselves be appointed as the relevant person's representative if they meet the eligibility criteria set out in paragraph 7.6.

7.8 There is no presumption that the relevant person's representative should be the same as the person who is their nearest relative for the purposes of the Mental Health Act 1983, even where the relevant person is likely to be subject simultaneously to an authorisation under these safeguards and a provision of the Mental Health Act 1983. This is because the relevant person's representative is not selected in the same way as the nearest relative under the Mental Health Act 1983, nor do they perform the same role. However, there is nothing to stop the relevant person's representative being the same as their nearest relative under the Mental Health Act 1983.

When should the relevant person's representative be identified?

7.9 The process of identifying a representative must begin as soon as possible.

7.10 Normally, this should be when the best interests assessor is appointed – even if one or more of the other assessments has not yet been completed. This is because the best interests assessor must, as part of the assessment process, identify if there is anyone they would recommend to become the relevant person's representative. The best interests assessor should discuss the representative role with the people interviewed as part of the assessment.

7.11 This does leave a risk that the process to identify a representative might begin in cases where authorisation is not given. Nevertheless, it is important that the process begins, so that the representative can be appointed immediately the authorisation is given or as soon as possible and practical thereafter.

How should the relevant person's representative be selected?

7.12 The best interests assessor should first establish whether the relevant person has the capacity to select their own representative and, if so, invite them to do so. If the relevant person has capacity and selects an eligible person (according to the criteria set out in paragraph 7.6), the best interests assessor must recommend that person to the supervisory body for appointment.

7.13 Alternatively, if the relevant person lacks capacity and there is a donee or deputy with the appropriate authority, the donee or deputy may select the person to be recommended as the relevant person's representative, again subject to the criteria set out in paragraph 7.6. If a donee or deputy selects an eligible person, then the best interests assessor must recommend that person to the supervisory body for appointment.

7.14 It is up to the best interests assessor to confirm whether any representative proposed by the relevant person, a donee or a deputy is eligible. If the best interests assessor decides that a proposed representative is not eligible, they must advise the person who made the selection and invite them to make a further selection.

7.15 If neither the relevant person, nor a donee or deputy, selects an eligible person, then the best interests assessor must consider whether they are able to identify someone eligible who could act as the relevant person's representative.

7.16 In making a recommendation, the assessor should consider, and balance, factors such as:

- Does the relevant person have a preference?
- If they do not have the capacity to express a preference now, is there any written statement made by the relevant person when they had capacity that indicates who they may now want to be their representative?

- Will the proposed representative be able to keep in contact with the relevant person?
- Does the relevant person appear to trust and feel comfortable with the proposed representative?
- Would the proposed representative be able to represent the relevant person effectively?
- Is the proposed representative likely to represent the relevant person's best interests?

In most cases, the best interests assessor will be able to check at the same time that the proposed representative is willing to take on the role.

7.17 It should not be assumed that the representative needs to be someone who supports the deprivation of liberty.

7.18 The best interests assessor must not select a representative where the relevant person, if they have the capacity to do so, or a donee or a deputy acting within the scope of their authority, states they are not content with that selection.

7.19 If the best interests assessor is unable to recommend anybody to be the relevant person's representative, they must notify the supervisory body accordingly. The supervisory body must then itself identify an eligible person to be appointed as the representative. In doing so, the supervisory body may select a person who:

- would be performing the role in a professional capacity
- has satisfactory skills and experience to perform the role
- is not a family member, friend or carer of the relevant person
- is not employed by, or providing services to, the relevant person's managing authority, where the relevant person's managing authority is a care home
- is not employed to work in the relevant person's managing authority in a role that is, or could be, related to the relevant person's case, where the relevant person's managing authority is a hospital
- is not employed to work in the supervisory body that is appointing the representative in a role that is, or could be, related to the relevant person's case, and
- the supervisory body is satisfied that an appropriate criminal record certificate has been issued in respect of.

7.20 The supervisory body may pay a person they select to be the relevant person's representative in the circumstances set out in paragraph 7.19. This service could be commissioned, for example, through an advocacy services provider, ensuring that the service provides effective independent representation for the relevant person.

7.21 When selecting a suitable representative for the relevant person, the best interests assessor or supervisory body should pay particular attention to the communication and cultural needs of the relevant person.

How should the relevant person's representative be appointed?

7.22 The supervisory body must invite, in writing, the person recommended by the best interests assessor to become the relevant person's representative. If the best interests assessor does not recommend anyone, then the supervisory body should identify and appoint someone to undertake the role. If the person is willing to become the representative, the supervisory body must formally appoint them. If the person refuses, a further eligible person must be identified and invited to become the representative. This process must continue until an eligible person is appointed.

7.23 The appointment of the relevant person's representative by the supervisory body must be in writing and set out the role and responsibilities of the relevant person's representative. The letter of appointment should also state the name of the appointed person and the date of expiry of the appointment, which must be for the period of the standard authorisation that has been given. The supervisory body must send copies of the written appointment to:

- the appointed person
- the relevant person
- any donee or deputy of the relevant person
- any IMCA involved
- every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment, and
- the managing authority of the relevant hospital or care home.

7.24 The relevant person's representative must confirm to the supervisory body in writing that they are willing to accept the appointment and have understood their roles and responsibilities in respect of the relevant person.

How should the work of the relevant person's representative be supported and monitored?

7.25 It is important that the representative has sufficient contact with the relevant person to ensure that the relevant person's best interests are being safeguarded. In order to fulfil their role, therefore, the representative will need to be able to have face-to-face contact with the relevant person. That means that the care home or hospital should accommodate visits by the representative at reasonable times. The name of the person's representative should be recorded in the person's health and social care records.

7.26 Managing authorities and supervisory bodies should inform the relevant person's representative about sources of support and information available to help them in the role, including how to access the support of an IMCA (see paragraphs 7.37 to 7.41).

7.27 If the representative has insufficient contact with the relevant person, for whatever reason, the person may effectively be unable to access important review and appeal rights. For this reason, if the representative does not maintain an appropriate level of contact with the person, the managing authority will need to consider informing the supervisory body. When the managing authority is reviewing the person's care plan, it should consider whether the representative is in sufficient contact with the relevant person to offer effective support. Records kept by managing authorities about frequency of contact will support this consideration.

7.28 Because the appropriate levels and methods of contact between a relevant person and their representative will vary from case to case, this is a matter about which the managing authority will need to exercise discretion. If the managing authority has any concerns, it may be best to raise the matter with the representative initially to see whether any perceived problems can be resolved informally. If after this the representative still does not maintain what the managing authority considers to be an appropriate level of contact with the relevant person, then the managing authority should notify the supervisory body.

When can the appointment of the relevant person's representative be terminated?

7.29 The appointment of the relevant person's representative will be terminated in any of the following circumstances:

- The standard authorisation comes to an end and a new authorisation is not applied for or, if applied for, is not given.
- The relevant person, if they have capacity to do so, objects to the representative continuing in their role and a different person is selected to be their representative instead.
- A donee or deputy, if it is within their authority to do so and the relevant person lacks the capacity to decide, objects to the representative continuing in their role and a different person is selected to be the representative instead.
- The supervisory body becomes aware that the representative is no longer willing or eligible to continue in the role.
- The supervisory body becomes aware that the relevant person's representative is not keeping in touch with the person, is not representing and supporting them effectively or is not acting in the person's best interests.
- The relevant person's representative dies.

7.30 If the supervisory body becomes aware that the representative may not be keeping in touch with the person, is not acting in the relevant person's best interests, or is no longer eligible, it should contact the representative to clarify the position before deciding whether to terminate the appointment.

7.31 When the appointment of the relevant person's representative ends, the supervisory body must give notice to all those listed in paragraph 7.23. This notice should be given as soon as possible, stating when the appointment ended and the reason why.

7.32 When the appointment of a relevant person's representative ends but the lawful deprivation of liberty continues, the supervisory body must appoint a suitable replacement to be the relevant person's representative as soon as possible and practical after they become aware of the vacancy. As before, a person qualified to be a best interests assessor should make a recommendation to the supervisory body and the supervisory body should take account of any such recommendations.

7.33 If the reason for the termination of the former representative's appointment is that they are no longer eligible, the views of the former representative on who might replace them should be sought. The person identified as most suitable should then be invited to accept the appointment. This process should continue until an eligible person is willing to accept appointment.

What happens when there is no relevant person's representative available?

7.34 A person who is being deprived of their liberty will be in a particularly vulnerable position during any gaps in the appointment of the relevant person's representative, since there may be nobody to represent their interests or to apply for a review on their behalf. In these circumstances, if there is nobody who can support and represent the person (other than a person engaged in providing care and treatment for the relevant person in a professional capacity or for remuneration), the managing authority must notify the supervisory body, who must instruct an IMCA to represent the relevant person until a new representative is appointed.

7.35 The role of an IMCA instructed in these circumstances is essentially the same as that of the relevant person's representative. The role of the IMCA in this situation ends when the new relevant person's representative is appointed.

7.36 At any time when the relevant person does not have a representative, it will be particularly important for supervisory bodies to consider exercising their discretion to carry out a review if there is any significant change in the person's circumstances.

When should an IMCA be instructed?

7.37 Both the person who is deprived of liberty under a standard authorisation and their representative have a statutory right of access to an IMCA. It is the responsibility of the supervisory body to instruct an IMCA if the relevant person or their representative requests one. The intention is to provide extra support to the relevant person or a family member or friend acting as their representative if they need it, and to help them make use of the review process or access the Court of Protection safeguards. Where the relevant person has a paid 'professional' representative (see paragraphs 7.19 and 7.20), the need for additional advocacy support should not arise and so there is no requirement for an IMCA to be provided in those circumstances.

7.38 The role of the IMCA is to help represent the relevant person and, in particular, to assist the relevant person and their representative to understand the effect of the authorisation, what it means, why it has been given, why the relevant person meets the criteria for authorisation, how long it will last, any conditions to which the authorisation is subject and how to trigger a review or challenge in the Court of Protection. The IMCA can also provide support with a review (see chapter 8) or with an application to the Court of Protection (see chapter 10), for example to help the person to communicate their views.

7.39 The IMCA will have the right to make submissions to the supervisory body on the question of whether a qualifying requirement should be reviewed, or to give information, or make submissions, to any assessor carrying out a review assessment. Both the person and their representative must be told about the IMCA service and how to request an IMCA.

7.40 An IMCA must be instructed whenever requested by the relevant person or their representative. A request may be made more than once during the period of the authorisation. For example, help may be sought at the start of the authorisation and then again later in order to request a review.

7.41 In addition, if the supervisory body has reason to believe that the review and Court of Protection safeguards might not be used without the support of an IMCA, then they must instruct an IMCA. For example, if the supervisory body is aware that the person has selected a representative who needs support with communication, it should consider whether an IMCA is needed.

8

When should an authorisation be reviewed and what happens when it ends?

When a person is deprived of their liberty, the managing authority has a duty to monitor the case on an ongoing basis to see if the person's circumstances change – which may mean they no longer need to be deprived of their liberty.

The managing authority must set out in the care plan clear roles and responsibilities for monitoring and confirm under what circumstances a review is necessary. For example, if a person's condition is changing frequently, then their situation should be reviewed more frequently.

This chapter explains the duties of managing authorities and supervisory bodies in relation to reviewing cases, and what happens when an authorisation ends. The review process is set out in flowchart form at Annex 4.

When should a standard authorisation be reviewed?

8.1 A standard authorisation can be reviewed at any time. The review is carried out by the supervisory body.

8.2 There are certain statutory grounds for carrying out a review. If the statutory grounds for a review are met, the supervisory body must carry out a review. If a review is requested by the relevant person, their representative or the managing authority, the supervisory body must carry out a review. Standard letters are available for the relevant person or their representative to request a review. There is also a standard form available for the managing authority to request a review. A supervisory body can also decide to carry out a review at its own discretion.

8.3 The statutory grounds for a review are:

- The relevant person no longer meets the age, no refusals, mental capacity, mental health or best interests requirements.
- The relevant person no longer meets the eligibility requirement because they now object to receiving mental health treatment in hospital and they meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983 (see paragraphs 4.45 to 4.48).

- There has been a change in the relevant person's situation and, because of the change, it would be appropriate to amend an existing condition to which the authorisation is subject, delete an existing condition or add a new condition.
- The reason(s) the person now meets the qualifying requirement(s) is(are) different from the reason(s) given at the time the standard authorisation was given.

8.4 Different arrangements apply if the person no longer meets the eligibility requirement because they have been detained under the Mental Health Act, or become subject to a requirement under that Act that conflicts with the authorisation. (See paragraphs 8.19 to 8.21 regarding the short-term suspension of a standard authorisation.)

8.5 A managing authority must request a review if it appears to it that one or more of the qualifying requirements is no longer met, or may no longer be met.

What happens when a review is going to take place?

8.6 The supervisory body must tell the relevant person, their representative and the managing authority if they are going to carry out a review. This must be done either before the review begins or as soon as possible and practical after it has begun. A standard form is available for this purpose.

8.7 The relevant person's records must include information about any formal reviews that have been requested, when they were considered, and the outcome. These records must be retained by the supervisory body.

8.8 Deprivation of liberty can be ended before a formal review. An authorisation only **permits** deprivation of liberty: it does not mean that a person **must be** deprived of liberty where circumstances no longer necessitate it. If a care home or hospital decides that deprivation of liberty is no longer necessary then they must end it immediately, by adjusting the care regime or implementing whatever other change is appropriate. The managing authority should then apply to the supervisory body to review and, if appropriate, formally terminate the authorisation.

How should standard authorisations be reviewed?

8.9 When a supervisory body receives a request for a review, it must first decide which, if any, of the qualifying requirements need to be reviewed. A standard form is available for recording this decision.

8.10 If the supervisory body concludes that none of the qualifying requirements need to be reviewed, no further action is necessary. For example, if there has been a very recent assessment or review and no new evidence has been submitted to show that the relevant person does not meet the criteria, or that circumstances have changed, no review is required.

8.11 If it appears that one or more of the qualifying requirements should be reviewed, the supervisory body must arrange for a separate review assessment to be carried out for each of these requirements.

8.12 The supervisory body must record when a review is requested, what it decides to do (whether it decides to carry out a review or not) and the reasons for its decision.

8.13 In general, review processes should follow the standard authorisation processes – so supervisory bodies should conduct the assessments outlined in chapter 4 of this Code of Practice for each of the qualifying requirements that need to be reviewed.

8.14 Where the supervisory body decides that the best interests requirement should be reviewed solely because details of the **conditions** attached to the authorisation need to be changed, and the review request does not include evidence that there is a significant change in the relevant person's overall circumstances, there is no need for a full reassessment of best interests. The supervisory body can simply vary the conditions attached to the authorisation as appropriate. In deciding whether a full reassessment is necessary, the supervisory body should consider whether the grounds for the authorisation, or the nature of the conditions, are being contested by anyone as part of the review request.

8.15 If the review relates to any of the other requirements, or to a significant change in the person's situation under the best interests requirement, the supervisory body must obtain a new assessment.

8.16 If the assessment shows that the requirement is still met, the supervisory body must check whether the reason that it is met has changed from the reason originally stated on the authorisation. If it has, the supervisory body should make any appropriate amendments to the authorisation. In addition, if the review relates to the best interests requirement, the supervisory body must consider whether any conditions should be changed following the new assessment.

Scenario: The review process

Jo is 29 and sustained severe brain damage in a road traffic collision that killed her parents. She has great difficulty in verbal and written communication. Jo can get very frustrated and has been known to lash out at other people in the nursing care home where she now lives. At first, she regularly attempted to leave the home, but the view of the organisation providing Jo's care was that such a move would place her at serious risk, so she should be prevented from leaving.

Jo was assessed under the deprivation of liberty safeguards and an authorisation was made for six months. That authorisation is not due to end for another three months. However, Jo has made huge progress at the home and her representative is no longer sure that the restrictions are necessary. Care home staff, however, do not think that her improvement reduces the best interests requirement of the deprivation of liberty authorisation.

Jo is assisted by her representative to request a review, in the form of a letter with pictures. The pictures appear to describe Jo's frustration with the legal processes that she perceives are preventing her from moving into her own accommodation.

The supervisory body appoints a best interests assessor to coordinate the review. The best interests assessor considers which of the qualifying requirements needs to be reviewed and by whom. It appears that the best interests assessment, as well as possibly the mental health and mental capacity assessments, should be reviewed.

To assess Jo's mental capacity and her own wishes for the best interests assessment, the best interests assessor feels that specialist help would be beneficial. A speech and language therapist meets with Jo and uses a visual communication system with her. Using this system, the therapist is able to say that in her view Jo is unlikely to have capacity to make the decision to leave the care home. The mental health assessment also confirmed that Jo was still considered to have a mental disorder.

Scenario: The review process *(continued)*

The best interests assessor was uncertain, however, whether it was still in Jo's best interests to remain under the deprivation of liberty authorisation. It was not possible to coordinate full updated assessments from the rehabilitation team, who knew her well, in the time limits required. So, because the care home believed that the standard authorisation was still required, and it was a complex case, the best interests assessor recommended to the supervisory body that two conditions should be applied to the standard authorisation:

- assessments must be carried out by rehabilitation specialists on Jo's clinical progress, and
- a full case review should be held within one month.

At this review meeting, to which Jo's representative and the best interests assessor were invited, it was agreed that Jo had made such good progress that deprivation of liberty was no longer necessary, because the risks of her having increased freedom had reduced. The standard authorisation was therefore terminated, and a new care plan was prepared which focused on working towards more independent living.

What happens if any of the requirements are not met?

8.17 If any of the requirements are not met, then the authorisation must be terminated immediately.

8.18 The supervisory body must give written notice of the outcome of a review and any changes that have been made to the deprivation of liberty authorisation to:

- the managing authority and the care home or hospital itself
- the relevant person
- the relevant person's representative, and
- any Independent Mental Capacity Advocate (IMCA) involved.

Short-term suspension of authorisation

8.19 There are separate review arrangements for cases in which the eligibility requirement ceases to be met for a short period of time for reasons other than that the person is objecting to receiving mental health treatment in hospital. For example, if the relevant person is detained as a hospital in-patient under the Mental Health Act 1983, the managing authority must notify the supervisory body, who will suspend the authorisation.

8.20 If the relevant person then becomes eligible again within 28 days, the managing authority must notify the supervisory body who will remove the suspension. If no such notice is given within 28 days, then the authorisation will be terminated. Standard forms are available for managing authorities to notify supervisory bodies about the need for suspension of an authorisation, or that a suspension should be lifted.

8.21 If the person ceases to meet the eligibility requirement because they begin to object to receiving mental health treatment in hospital and they meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983, a review should be started immediately (see paragraph 8.3).

Is a review necessary when the relevant person's capacity fluctuates?

8.22 Guidance about people with fluctuating or temporary capacity is contained in paragraphs 4.26 and 4.27 of the main Code. In the context of deprivation of liberty safeguards, where a relevant person's capacity to make decisions about the arrangements made for their care and treatment fluctuates on a short-term basis, a balance needs to be struck between:

- the need to review and terminate an authorisation if a person regains capacity, and
- spending time and resources constantly reviewing, terminating and then seeking fresh deprivation of liberty authorisations as the relevant person's capacity changes.

8.23 Each case must be treated on its merits. Managing authorities should keep all cases under review: where a person subject to an authorisation is deemed to have regained the capacity to decide about the arrangements made for their care and treatment, the managing authority must assess whether there is consistent evidence of the regaining of capacity on a longer-term basis. This is a clinical judgement that will need to be made by a suitably qualified person.

8.24 Where there is consistent evidence of regaining capacity on this longer-term basis, deprivation of liberty should be lifted immediately, and a formal review and termination of the authorisation sought. However, it should be borne in mind that a deprivation of liberty authorisation carries with it certain safeguards that the relevant person will lose if the authorisation is terminated. Where the regaining of capacity is likely to be temporary, and the authorisation will be required again within a short period of time, the authorisation should be left in place, but with the situation kept under ongoing review.

Scenario: Fluctuating capacity

Walter, an older man with severe depression, is admitted to hospital from a care home. He seems confused and bewildered, but does not object. His family are unable to look after him at home, but they would prefer him to go into a different care home rather than stay in hospital. However, there is no alternative placement available, so when the assessment concludes that Walter lacks capacity to make decisions about his care and treatment, the only option seems to be that he should stay on the ward,

Because the care regime in the ward is extremely restrictive – Walter is not allowed to leave the hospital and his movement within the hospital is restricted for his own safety – ward staff think that they need to apply for a deprivation of liberty authorisation which is subsequently given.

However, over time Walter starts to experience lucid passages, during which he expresses relief at being on the ward rather than in the care home. A review meeting is convened and the participants agree that Walter now sometimes has capacity to make decisions about the arrangements made for his care and treatment. As this capacity fluctuates, it is decided, in consultation with his family, that the deprivation of liberty authorisation should remain in place for the time being.

Walter remains on the ward and his progress is such that his family feel they could look after him at home. Walter seems happy with this proposal and the consultant psychiatrist with responsibility for his care agrees to this. The deprivation of liberty authorisation is reviewed and terminated.

What happens when an authorisation ends?

8.25 When an authorisation ends, the managing authority cannot lawfully continue to deprive a person of their liberty.

8.26 If the managing authority considers that a person will still need to be deprived of liberty after the authorisation ends, they need to request a further standard authorisation to begin immediately after the expiry of the existing authorisation.

8.27 There is no statutory time limit on how far in advance of the expiry of one authorisation the managing authority can apply for a renewal authorisation. It will need to be far enough in advance for the renewal authorisation to be given before the existing authorisation ends (but see paragraphs 3.19 and 3.20 about not applying for authorisations too far in advance).

8.28 Once underway, the process for renewing a standard authorisation is the same as that for obtaining an original authorisation, and the same assessment processes must take place. However, the need to instruct an IMCA will not usually arise because the relevant person should at this stage have a representative appointed.

8.29 When the standard authorisation ends, the supervisory body must inform in writing:

- the relevant person
- the relevant person's representative
- the managing authority, and
- every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment.

9 What happens if someone thinks a person is being deprived of their liberty without authorisation?

It is a serious issue to deprive someone of their liberty without authorisation if they lack the capacity to consent. If anyone believes that a person is being deprived of their liberty without authorisation, they should raise this with the relevant authorities.

If the conclusion is that the person is being deprived of their liberty unlawfully, this will normally result in a change in their care arrangements, or in an application for a deprivation of liberty authorisation being made.

This chapter explains the process for reporting concerns and for assessing whether unauthorised deprivation of liberty is occurring. The flowchart at Annex 3 summarises the process that a supervisory body should follow when it receives a request from somebody other than the managing authority to examine whether or not there is a current unauthorised deprivation of liberty.

What action should someone take if they think a person is being deprived of their liberty without authorisation?

9.1 If the relevant person themselves, any relative, friend or carer or any other third party (such as a person carrying out an inspection visit or a member of an advocacy organisation) believes that a person is being deprived of liberty without the managing authority having applied for an authorisation, they should draw this to the attention of the managing authority. A standard letter is available for this purpose. In the first instance, they should ask the managing authority to apply for an authorisation if it wants to continue with the care regime, or to change the care regime immediately. Given the seriousness of deprivation of liberty, a managing authority must respond within a reasonable time to the request. This would normally mean within 24 hours.

9.2 It may be possible for the managing authority to resolve the matter informally with the concerned person. For example, the managing authority could discuss the case with the concerned person, and perhaps make some adjustment to the care arrangements so that concerns that a deprivation of liberty may be occurring are removed. However, if the managing authority is unable to resolve the issue with the concerned person quickly, they should submit a request for a standard authorisation to the supervisory body.

9.3 If the concerned person has raised the matter with the managing authority, and the managing authority does not apply for an authorisation within a reasonable period, the concerned person can ask the supervisory body to decide whether there is an unauthorised deprivation of liberty. They should:

- tell the supervisory body the name of the person they are concerned about and the name of the hospital or care home, and
- as far as they are able, explain why they think that the person is deprived of their liberty.

A standard letter is available for this purpose.

9.4 In such circumstances, the supervisory body must select and appoint a person who is suitable and eligible to carry out a best interests assessment to consider whether the person is deprived of liberty.

9.5 The supervisory body does not, however, need to arrange such an assessment where it appears to the supervisory body that:

- the request they have received is frivolous or vexatious (for example, where the person is very obviously not deprived of their liberty) or where a very recent assessment has been carried out and repeated requests are received, or
- the question of whether or not there is an unauthorised deprivation of liberty has already been decided, and since that decision, there has been no change of circumstances that would merit the question being considered again.

The supervisory body should record the reasons for their decisions. A standard form is available for this purpose.

9.6 The supervisory body must notify the person who raised the concern, the relevant person, the managing authority of the relevant hospital or care home and any IMCA involved:

- that it has been to asked to assess whether or not there is an unauthorised deprivation of liberty
- whether or not it has decided to commission an assessment, and
- where relevant, who has been appointed as assessor.

What happens if somebody informs the supervisory body directly that they think a person is being deprived of their liberty without authorisation?

9.7 If a person raises concerns about a potential unauthorised deprivation of liberty directly with the supervisory body, the supervisory body should immediately arrange a preliminary assessment to determine whether a deprivation of liberty is occurring. The supervisory body should then immediately notify the managing authority, rather than asking the concerned person to contact the managing authority themselves, to ask them to request a standard authorisation in respect of the person who is possibly deprived of liberty. The supervisory body should agree with the managing authority what is a reasonable period within which a standard authorisation should be requested (unless the managing authority is able to resolve the matter informally with the concerned person as described in paragraph 9.2). If the managing authority does not submit an application within the agreed period, and the matter has not been resolved informally, the supervisory body should follow the process set out in paragraphs 9.3 to 9.6 to assess whether unlawful deprivation of liberty is occurring. Even if the concerned person prefers to deal directly with the managing authority, the supervisory body should monitor what happens very closely to ensure that no unlawful deprivation of liberty may be occurring without proper action being taken.

How will the assessment of unlawful deprivation of liberty be conducted?

9.8 An assessment of whether an unlawful deprivation of liberty is occurring must be carried out within seven calendar days. Although the assessment must be completed by somebody who is suitable and eligible to carry out a best interests assessment, it is not a best interests assessment as such. The purpose of the assessment is simply to establish whether unlawful deprivation of liberty is occurring.

9.9 The person nominated to undertake the assessment must consult the managing authority of the relevant hospital or care home, and examine any relevant needs assessments and care plans to consider whether they constitute a deprivation of liberty. They should also speak to the person who raised the concern about why they believe that the relevant person is being deprived of their liberty and consult, as far as is possible, with the relevant person's family and friends. If there is nobody appropriate to consult among family and friends, they should inform the supervisory body who must arrange for an IMCA to be instructed to support and represent the person. A standard form is available for the assessor to record the outcome of their assessment.

What happens once the assessment has been conducted?

9.10 There are three possible outcomes of this assessment. The assessor may conclude that:

- the person is not being deprived of their liberty
- the person is being lawfully deprived of their liberty because authorisation exists (this, though, is an unlikely outcome since the supervisory body should already be aware if any authorisation exists, thus rendering any assessment in response to a third party request unnecessary), or
- the person is being deprived of their liberty unlawfully.

9.11 The supervisory body must notify the following people of the outcome of the assessment:

- the concerned third party who made the request
- the relevant person
- the managing authority of the relevant hospital or care home, and
- any IMCA involved.

A standard form is available for this purpose.

9.12 If the outcome of the assessment is that there is an unauthorised deprivation of liberty, then the full assessment process should be completed as if a standard authorisation for deprivation of liberty had been applied for – unless the managing authority changes the care arrangements so that it is clear that there is no longer any deprivation of liberty.

9.13 If, having considered what could be done to avoid deprivation of liberty, the managing authority decides that the need to continue the deprivation of liberty is so urgent that the care regime should continue while the assessments are carried out, it must give an urgent authorisation and seek a standard authorisation within seven days. The managing authority must supply the supervisory body with the same information it would have had to include in a request for a standard authorisation.

9.14 If the concerned person does not accept the outcome of their request for assessment, they can apply to the Court of Protection to hear their case. See chapter 10 for more details of the role of the Court of Protection.

10 What is the Court of Protection and when can people apply to it?

To comply with Article 5(4) of the European Convention on Human Rights, anybody deprived of their liberty in accordance with the safeguards described in this Code of Practice is entitled to the right of speedy access to a court that can review the lawfulness of their deprivation of liberty. The Court of Protection, established by the Mental Capacity Act 2005, is the court for this purpose. Chapter 8 of the main Code provides more details on its role, powers and responsibilities.

When can people apply to the Court of Protection about the deprivation of liberty safeguards and who can apply?

Applying before an authorisation is given

10.1 The relevant person, or someone acting on their behalf, may make an application to the Court of Protection **before** a decision has been reached on an application for authorisation to deprive a person of their liberty. This might be to ask the court to declare whether the relevant person has capacity, or whether an act done or proposed to be done in relation to that person is lawful (this may include whether or not the act is or would be in the best interests of the relevant person). It is up to the Court of Protection to decide whether or not to consider such an application in advance of the decision on authorisation.

Applying after an authorisation has been given

10.2 Once a standard authorisation has been given, the relevant person or their representative has the right to apply to the Court of Protection to determine any question relating to the following matters:

- whether the relevant person meets one or more of the qualifying requirements for deprivation of liberty
- the period for which the standard authorisation is to be in force
- the purpose for which the standard authorisation is given, or
- the conditions subject to which the standard authorisation is given.

10.3 Where an urgent authorisation has been given, the relevant person or certain persons acting on their behalf, such as a donee or deputy, has the right to apply to the Court of Protection to determine any question relating to the following matters:

- whether the urgent authorisation should have been given
- the period for which the urgent authorisation is to be in force, or
- the purpose for which the urgent authorisation has been given.

10.4 Where a standard or urgent authorisation has been given, any other person may also apply to the Court of Protection for permission to take the relevant person's case to court to determine whether an authorisation should have been given. However, the Court of Protection has discretion to decide whether or not to consider an application from these people.

10.5 Wherever possible, concerns about the deprivation of liberty should be resolved informally or through the relevant supervisory body's or managing authority's complaints procedure, rather than through the Court of Protection. Chapter 15 of the main Code ('What are the best ways to settle disagreements and disputes about issues covered in the Act?') contains general guidance on how to settle disputes about issues covered in the Mental Capacity Act 2005. The review processes covered in chapter 8 of this Code also provide a way of resolving disputes or concerns, as explained in that chapter.

10.6 The aim should be to limit applications to the Court of Protection to cases that genuinely need to be referred to the court. However, with deprivation of liberty at stake, people should not be discouraged from making an application to the Court of Protection if it proves impossible to resolve concerns satisfactorily through other routes in a timely manner.

How should people apply to the Court of Protection?

10.7 Guidance on the court's procedures, including how to make an application, is given in the Court of Protection Rules and Practice Directions issued by the court.[13]

10.8 The following people have an automatic right of access to the Court of Protection and do not have to obtain permission from the court to make an application:

- a person who lacks, or is alleged to lack, capacity in relation to a specific decision or action

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[13] There will usually be a fee for applications to the court. Details of the fees charged by the court and the circumstances in which fees may be waived or remitted are available from the Office of the Public Guardian (http://www.publicguardian.gov.uk/)

- the donor of a Lasting Power of Attorney to whom an application relates, or their donee
- a deputy who has been appointed by the court to act for the person concerned
- a person named in an existing court order[14] to which the application relates, and
- the person appointed by the supervisory body as the relevant person's representative.

10.9 All other applicants must obtain the permission of the court before making an application. (See section 50 of the Mental Capacity Act 2005, as amended.) This can be done by completing the appropriate application form.

What orders can the Court of Protection make?

10.10 The court may make an order:

- varying or terminating a standard or urgent authorisation, or
- directing the supervisory body (in the case of a standard authorisation) or the managing authority (in the case of an urgent authorisation) to vary or terminate the authorisation.

What is the role of the Court of Protection in respect of people lacking capacity who are deprived of their liberty in settings other than hospitals or care homes?

10.11 The deprivation of liberty safeguards relate only to circumstances where a person is deprived of their liberty in a hospital or care home. Depriving a person who lacks capacity to consent to the arrangements made for their care or treatment of their liberty in other settings (for example in a person's own home, in supported living arrangements other than in care homes or in a day centre) will only be lawful following an order of the Court of Protection on a best interests personal welfare matter (see paragraph 6.51 of the main Code).

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[14] Examples of existing court orders include orders appointing a deputy or declarations made by the court in relation to treatment issues.

10.12 In such a case, application to the Court of Protection should be made before deprivation of liberty begins. A Court of Protection order will then itself provide a legal basis for the deprivation of liberty. A separate deprivation of liberty authorisation under the processes set out in this Code will not be required.

Is legal aid available to support applications to the Court of Protection in deprivation of liberty safeguards cases?

10.13 Legal aid will be available both for advice and representation before the Court of Protection.

11 How will the safeguards be monitored?

The deprivation of a person's liberty is a significant issue. The deprivation of liberty safeguards are designed to ensure that a person who lacks capacity to consent to the arrangements made for their care or treatment is suitably protected against arbitrary detention. In order to provide reassurance that the safeguards processes are being correctly operated, it is important for there to be an effective mechanism for monitoring the implementation of the safeguards.

Who will monitor the safeguards?

11.1 Regulations[15] will confer the responsibility for the inspection process of the operation of the deprivation of liberty safeguards in England on a new regulator, the Care Quality Commission, bringing together functions from the existing Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission. The new body will be established during 2008, subject to the passage of the relevant legislation through Parliament, and is expected to be fully operational by 2009/10 in line with the deprivation of liberty safeguards coming into force.

11.2 In Wales, the functions of monitoring the operation of the deprivation of liberty safeguards will fall to Welsh Ministers. These functions will be performed on their behalf by Healthcare Inspectorate Wales and the Care and Social Services Inspectorate Wales.

What will the inspection bodies do and what powers will they have?

11.3 The inspection bodies for care homes and hospitals will be expected to:

- monitor the manner in which the deprivation of liberty safeguards are being operated by:
  - visiting hospitals and care homes in accordance with their existing visiting programme

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[15] Draft regulations for England will be consulted upon later. Welsh Ministers are currently considering how they will use their regulation-making powers for Wales.

  - interviewing people accommodated in hospitals and care homes to the extent that they consider it necessary to do so, and
  - requiring the production of, and inspecting, relevant records relating to the care or treatment of people accommodated in hospitals and care homes
- report annually, summarising their activity and their findings about the operation of the deprivation of liberty safeguards. In England this report will be made to the Secretary of State for Health, and in Wales the report will be made to the Welsh Ministers. It will be for each monitoring body to decide whether there should be a deprivation of liberty safeguards specific report or whether the report should form part of a wider report on the monitoring body's activities.

11.4 The inspection bodies will have the power to require supervisory bodies and managing authorities of hospitals or care homes to disclose information to them.

11.5 The inspection process will not cover the revisiting of individual assessments (other than by way of a limited amount of sampling).

11.6 The inspection process will not constitute an alternative review or appeal process. However, if the inspection body comes across a case where they believe deprivation of liberty may be occurring without an authorisation, they should inform the supervisory body in the same way as any other third party may do.

11.7 The inspection bodies will look at the deprivation of liberty protocols and procedures in place within managing authorities and supervisory bodies. The aim is to use a small amount of sampling to evaluate the effect of these protocols and procedures on individual cases. Monitoring should take place at a time when the monitoring body is visiting the care home or in-patient setting as part of routine operations, not as an exception.

11.8 Supervisory bodies and managing authorities should keep their protocols and procedures under review and supervisory bodies should assess the nature of the authorisations they are giving in light of their local population. This information may be relevant to policy decisions about commissioning care and support services.

Checklists

Key points for care homes and hospitals (managing authorities)

- Managing authorities need to adapt their care planning processes to incorporate consideration of whether a person has capacity to consent to the services which are to be provided and whether their actions are likely to result in a deprivation of liberty.
- A managing authority must not, except in an urgent situation, deprive a person of liberty unless a standard authorisation has been given by the supervisory body for that specific situation, and remains in force.
- It is up to the managing authority to request such authorisation and implement the outcomes.
- Authorisation should be obtained from the supervisory body in advance of the deprivation of liberty, except in circumstances considered to be so urgent that the deprivation of liberty needs to begin immediately. In such cases, authorisation must be obtained within seven calendar days of the start of the deprivation of liberty.
- A managing authority must ensure that they comply with any conditions attached to the authorisation.
- A managing authority should monitor whether the relevant person's representative maintains regular contact with the person.
- Authorisation of deprivation of liberty should only be sought if it is genuinely necessary for a person to be deprived of liberty in their best interests in order to keep them safe. It is not necessary to apply for authorisations for all admissions to hospitals and care homes simply because the person concerned lacks capacity to decide whether to be admitted.

Key points for local authorities and NHS bodies (supervisory bodies)

Checklist

- Supervisory bodies will receive applications from managing authorities for standard authorisations of deprivation of liberty. Deprivation of liberty cannot lawfully begin until the supervisory body has given authorisation, or the managing authority has itself given an urgent authorisation.
- Before an authorisation for deprivation of liberty may be given, the supervisory body must have obtained written assessments of the relevant person in order to ensure that they meet the qualifying requirements (including that the deprivation of liberty is necessary to protect them from harm and will be in their best interests).
- Supervisory bodies will need to ensure that sufficient assessors are available to meet the needs of their area and that these assessors have the skills, qualifications, experience and training to perform the function.
- Authorisation may not be given unless all the qualifying requirements are met.
- In giving authorisation, the supervisory body must specify its duration, which may not exceed 12 months and may not be for longer than recommended by the best interests assessor. Deprivation of liberty should not continue for longer than is necessary.
- The supervisory body may attach conditions to the authorisation if it considers it appropriate to do so.
- The supervisory body must give notice of its decision in writing to specified people, and notify others.
- The supervisory body must appoint a relevant person's representative to represent the interests of every person for whom they give a standard authorisation for deprivation of liberty.
- When an authorisation is in force, the relevant person, the relevant person's representative and any IMCA representing the individual have a right at any time to request that the supervisory body reviews the authorisation.

Key points for managing authorities and supervisory bodies

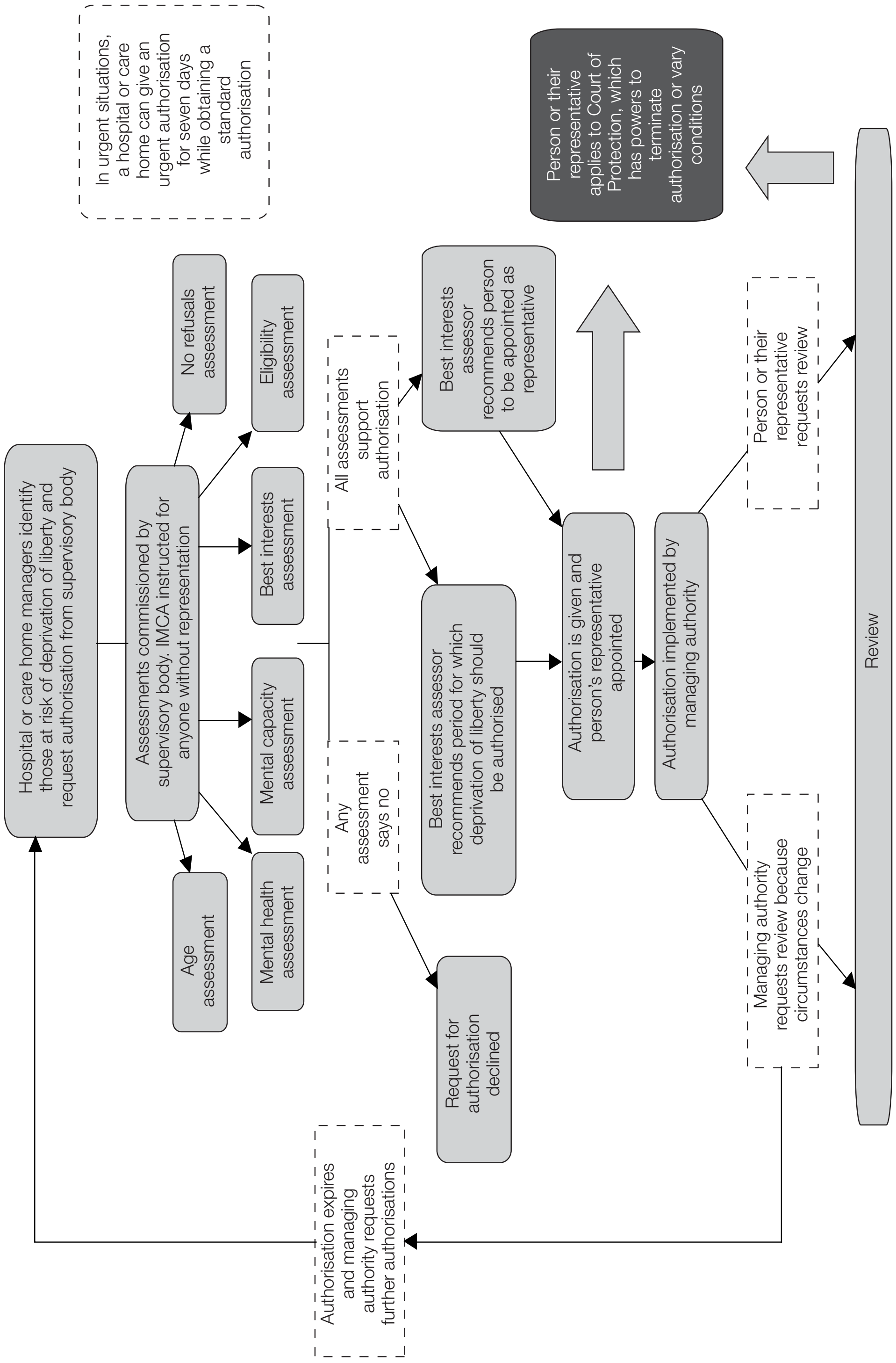
In addition to the above, both managing authorities and supervisory bodies should be aware of the following key points:

- An authorisation may last for a maximum period of 12 months.
- Anyone engaged in caring for the person, anyone named by them as a person to consult, and anyone with an interest in the person's welfare must be consulted in decision-making.
- Before the current authorisation expires, the managing authority may seek a fresh authorisation for up to another 12 months, provided it is established, on the basis of further assessment, that the requirements continue to be met.
- The authorisation should be reviewed, and if appropriate revoked, before it expires if there has been a significant change in the person's circumstances. To this end, the managing authority will be required to ensure that the continued deprivation of liberty of a person remains necessary in the best interests of the person.
- A decision to deprive a person of liberty may be challenged by the relevant person, or by the relevant person's representative, by an application to the Court of Protection. However, managing authorities and supervisory bodies should always be prepared to try to resolve disputes locally and informally. No one should be forced to apply to the court because of failure or unwillingness on the part of a managing authority or supervisory body to engage in constructive discussion.
- If the court is asked to decide on a case where there is a question about whether deprivation of liberty is lawful or should continue to be authorised, the managing authority can continue with its current care regime where it is necessary:
  - for the purpose of giving the person life-sustaining treatment, or
  - to prevent a serious deterioration in their condition while the court makes its decision.
- The complete process of assessing and authorising deprivation of liberty should be clearly recorded, and regularly monitored and audited, as part of an organisation's governance structure.
- Management information should be recorded and retained, and used to measure the effectiveness of the deprivation of liberty processes. This information will also need to be shared with the inspection bodies.

Annexes

Annex 1

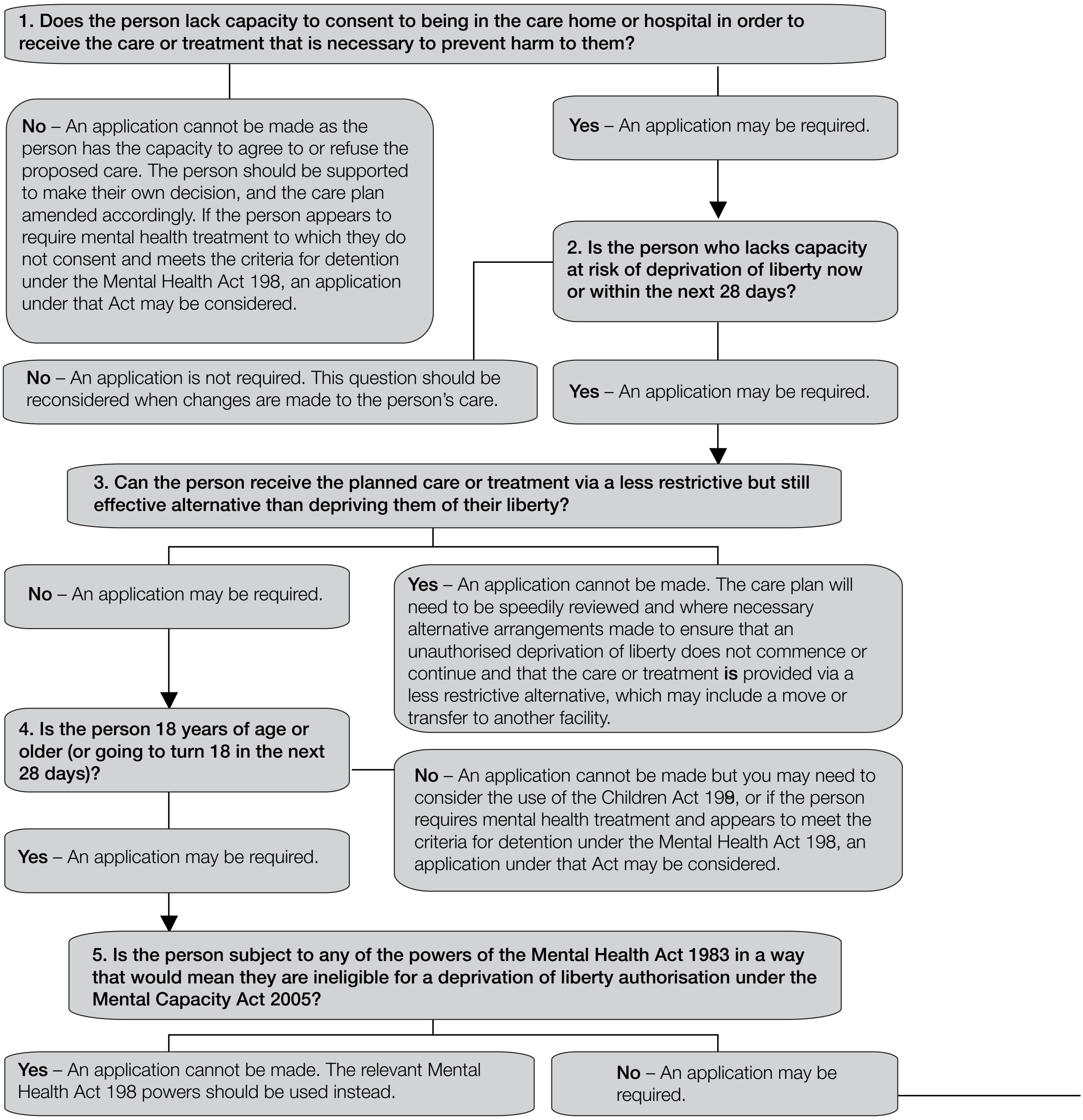
Overview of the deprivation of liberty safeguards process



Annex 2

What should a managing authority consider before applying for authorisation of deprivation of liberty?

These questions are relevant **both** at admission **and** when reviewing the care of patients and residents. By considering the following questions in the following order, a managing authority will be helped to know whether an application for authorisation is required.



1. Does the person lack capacity to consent to being in the care home or hospital in order to receive the care or treatment that is necessary to prevent harm to them?

No – An application cannot be made as the person has the capacity to agree to or refuse the proposed care. The person should be supported to make their own decision, and the care plan amended accordingly. If the person appears to require mental health treatment to which they do not consent and meets the criteria for detention under the Mental Health Act 198, an application under that Act may be considered.

Yes – An application may be required.

2. Is the person who lacks capacity at risk of deprivation of liberty now or within the next 28 days?

No – An application is not required. This question should be reconsidered when changes are made to the person's care.

Yes – An application may be required.

3. Can the person receive the planned care or treatment via a less restrictive but still effective alternative than depriving them of their liberty?

No – An application may be required.

Yes – An application cannot be made. The care plan will need to be speedily reviewed and where necessary alternative arrangements made to ensure that an unauthorised deprivation of liberty does not commence or continue and that the care or treatment **is** provided via a less restrictive alternative, which may include a move or transfer to another facility.

4. Is the person 18 years of age or older (or going to turn 18 in the next 28 days)?

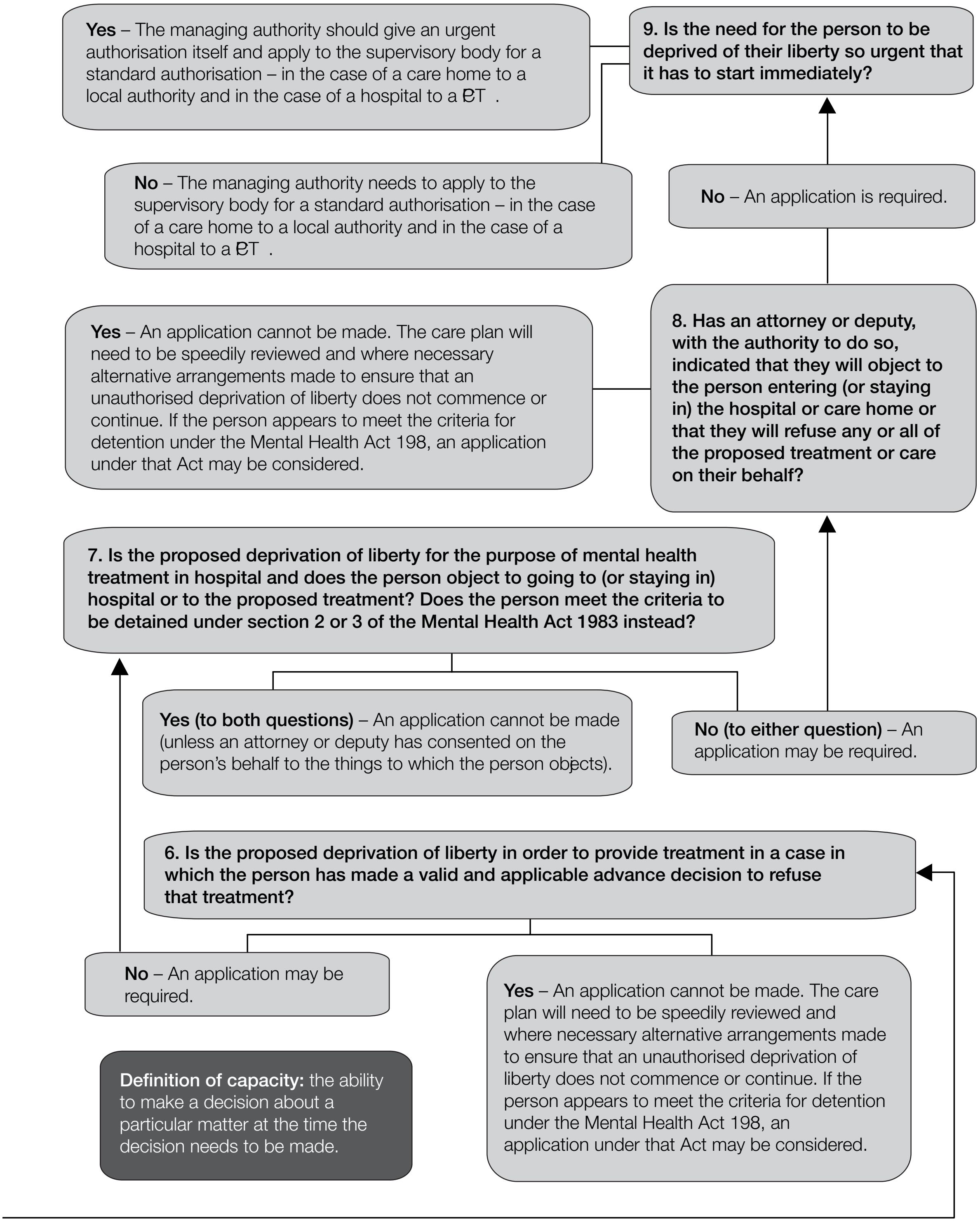
No – An application cannot be made but you may need to consider the use of the Children Act 1989, or if the person requires mental health treatment and appears to meet the criteria for detention under the Mental Health Act 198, an application under that Act may be considered.

Yes – An application may be required.

5. Is the person subject to any of the powers of the Mental Health Act 1983 in a way that would mean they are ineligible for a deprivation of liberty authorisation under the Mental Capacity Act 2005?

Yes – An application cannot be made. The relevant Mental Health Act 198 powers should be used instead.

No – An application may be required.



Yes – The managing authority should give an urgent authorisation itself and apply to the supervisory body for a standard authorisation – in the case of a care home to a local authority and in the case of a hospital to a PCT .

9. Is the need for the person to be deprived of their liberty so urgent that it has to start immediately?

No – The managing authority needs to apply to the supervisory body for a standard authorisation – in the case of a care home to a local authority and in the case of a hospital to a PCT .

No – An application is required.

Yes – An application cannot be made. The care plan will need to be speedily reviewed and where necessary alternative arrangements made to ensure that an unauthorised deprivation of liberty does not commence or continue. If the person appears to meet the criteria for detention under the Mental Health Act 198, an application under that Act may be considered.

8. Has an attorney or deputy, with the authority to do so, indicated that they will object to the person entering (or staying in) the hospital or care home or that they will refuse any or all of the proposed treatment or care on their behalf?

7. Is the proposed deprivation of liberty for the purpose of mental health treatment in hospital and does the person object to going to (or staying in) hospital or to the proposed treatment? Does the person meet the criteria to be detained under section 2 or 3 of the Mental Health Act 1983 instead?

Yes (to both questions) – An application cannot be made (unless an attorney or deputy has consented on the person's behalf to the things to which the person objects).

No (to either question) – An application may be required.

6. Is the proposed deprivation of liberty in order to provide treatment in a case in which the person has made a valid and applicable advance decision to refuse that treatment?

No – An application may be required.

Yes – An application cannot be made. The care plan will need to be speedily reviewed and where necessary alternative arrangements made to ensure that an unauthorised deprivation of liberty does not commence or continue. If the person appears to meet the criteria for detention under the Mental Health Act 198, an application under that Act may be considered.

Definition of capacity: the ability to make a decision about a particular matter at the time the decision needs to be made.

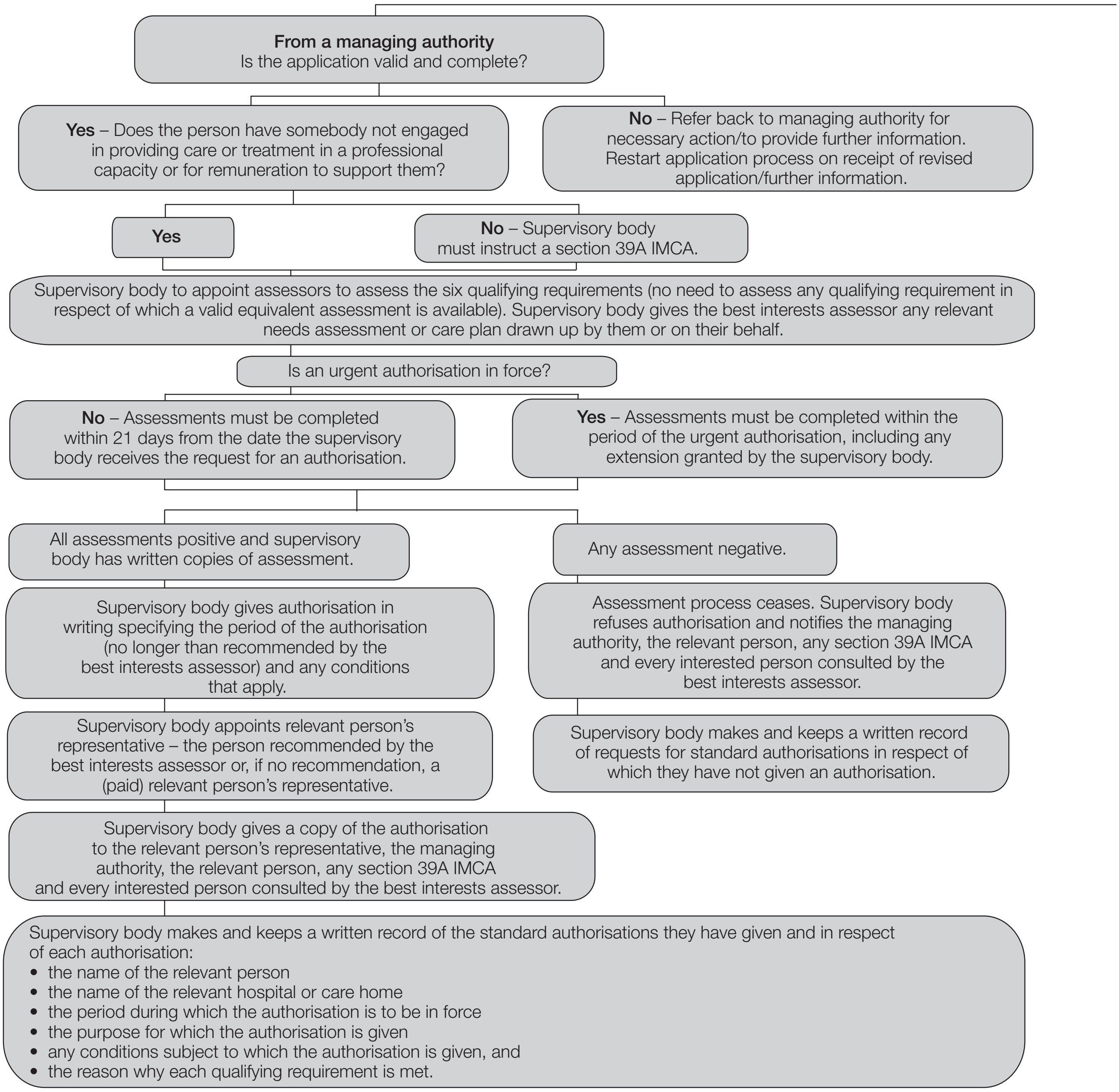
NB: An authorisation only relates to deprivation of liberty and does not give authority for any course of treatment.

Annex 3

Supervisory body action on receipt of a request from:

a) a managing authority for a standard deprivation of liberty authorisation

b) somebody other than a managing authority (an eligible person) to determine whether or not there is a current unauthorised deprivation of liberty



From a managing authority
Is the application valid and complete?

Yes – Does the person have somebody not engaged in providing care or treatment in a professional capacity or for remuneration to support them?

No – Refer back to managing authority for necessary action/to provide further information. Restart application process on receipt of revised application/further information.

Yes

No – Supervisory body must instruct a section 39A IMCA.

Supervisory body to appoint assessors to assess the six qualifying requirements (no need to assess any qualifying requirement in respect of which a valid equivalent assessment is available). Supervisory body gives the best interests assessor any relevant needs assessment or care plan drawn up by them or on their behalf.

Is an urgent authorisation in force?

No – Assessments must be completed within 21 days from the date the supervisory body receives the request for an authorisation.

Yes – Assessments must be completed within the period of the urgent authorisation, including any extension granted by the supervisory body.

All assessments positive and supervisory body has written copies of assessment.

Supervisory body gives authorisation in writing specifying the period of the authorisation (no longer than recommended by the best interests assessor) and any conditions that apply.

Supervisory body appoints relevant person's representative – the person recommended by the best interests assessor or, if no recommendation, a (paid) relevant person's representative.

Supervisory body gives a copy of the authorisation to the relevant person's representative, the managing authority, the relevant person, any section 39A IMCA and every interested person consulted by the best interests assessor.

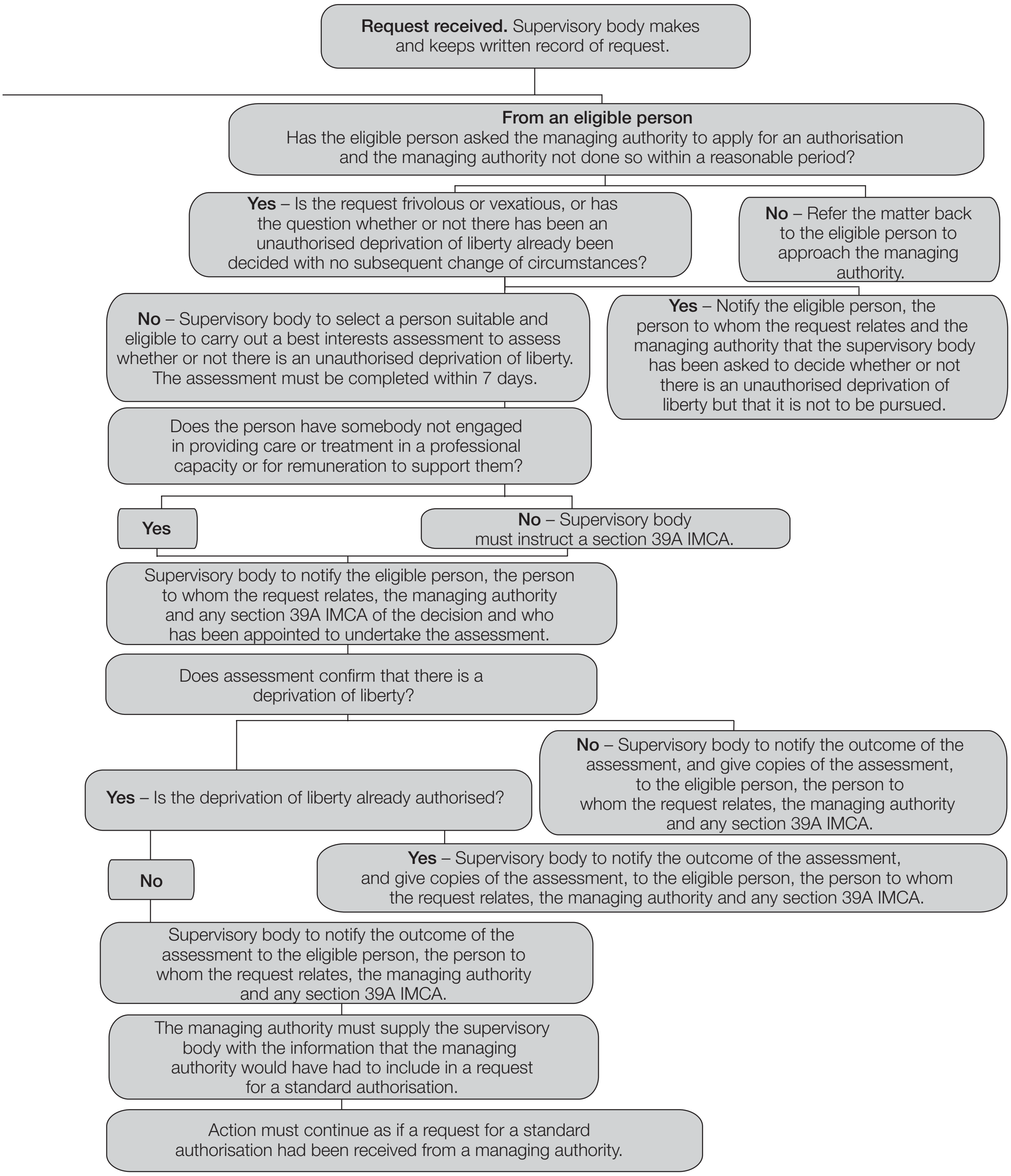
Supervisory body makes and keeps a written record of the standard authorisations they have given and in respect of each authorisation:

- the name of the relevant person
- the name of the relevant hospital or care home
- the period during which the authorisation is to be in force
- the purpose for which the authorisation is given
- any conditions subject to which the authorisation is given, and
- the reason why each qualifying requirement is met.

Any assessment negative.

Assessment process ceases. Supervisory body refuses authorisation and notifies the managing authority, the relevant person, any section 39A IMCA and every interested person consulted by the best interests assessor.

Supervisory body makes and keeps a written record of requests for standard authorisations in respect of which they have not given an authorisation.



Request received. Supervisory body makes and keeps written record of request.

From an eligible person
Has the eligible person asked the managing authority to apply for an authorisation and the managing authority not done so within a reasonable period?

Yes – Is the request frivolous or vexatious, or has the question whether or not there has been an unauthorised deprivation of liberty already been decided with no subsequent change of circumstances?

No – Refer the matter back to the eligible person to approach the managing authority.

No – Supervisory body to select a person suitable and eligible to carry out a best interests assessment to assess whether or not there is an unauthorised deprivation of liberty. The assessment must be completed within 7 days.

Yes – Notify the eligible person, the person to whom the request relates and the managing authority that the supervisory body has been asked to decide whether or not there is an unauthorised deprivation of liberty but that it is not to be pursued.

Does the person have somebody not engaged in providing care or treatment in a professional capacity or for remuneration to support them?

Yes

No – Supervisory body must instruct a section 39A IMCA.

Supervisory body to notify the eligible person, the person to whom the request relates, the managing authority and any section 39A IMCA of the decision and who has been appointed to undertake the assessment.

Does assessment confirm that there is a deprivation of liberty?

Yes – Is the deprivation of liberty already authorised?

No – Supervisory body to notify the outcome of the assessment, and give copies of the assessment, to the eligible person, the person to whom the request relates, the managing authority and any section 39A IMCA.

No

Yes – Supervisory body to notify the outcome of the assessment, and give copies of the assessment, to the eligible person, the person to whom the request relates, the managing authority and any section 39A IMCA.

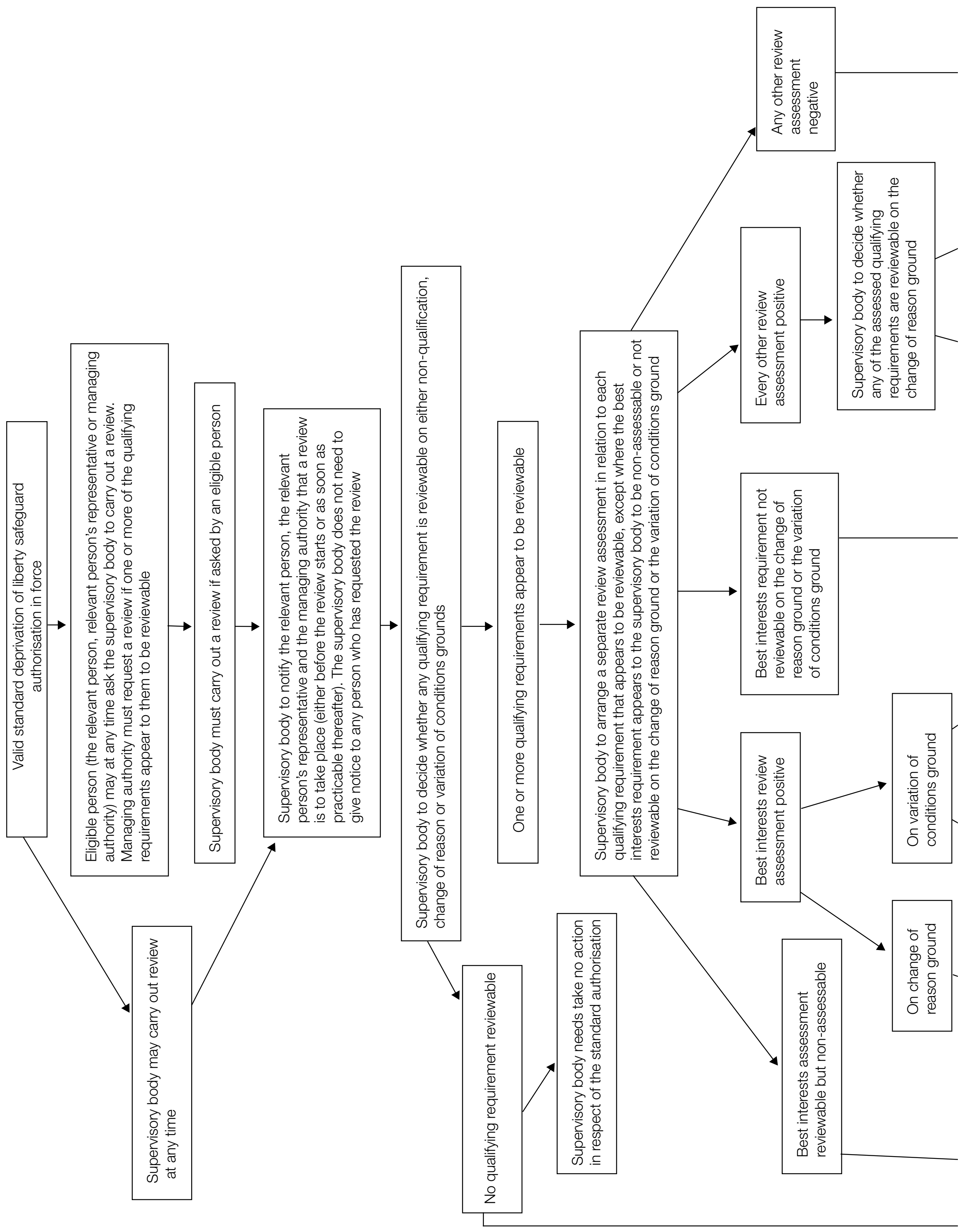
Supervisory body to notify the outcome of the assessment to the eligible person, the person to whom the request relates, the managing authority and any section 39A IMCA.

The managing authority must supply the supervisory body with the information that the managing authority would have had to include in a request for a standard authorisation.

Action must continue as if a request for a standard authorisation had been received from a managing authority.

Annex 4

Standard authorisation review process



Valid standard deprivation of liberty safeguard authorisation in force

Eligible person (the relevant person, relevant person's representative or managing authority) may at any time ask the supervisory body to carry out a review. Managing authority must request a review if one or more of the qualifying requirements appear to them to be reviewable

Supervisory body may carry out review at any time

Supervisory body must carry out a review if asked by an eligible person

Supervisory body to notify the relevant person, the relevant person's representative and the managing authority that a review is to take place (either before the review starts or as soon as practicable thereafter). The supervisory body does not need to give notice to any person who has requested the review

Supervisory body to decide whether any qualifying requirement is reviewable on either non-qualification, change of reason or variation of conditions grounds

No qualifying requirement reviewable

Supervisory body needs take no action in respect of the standard authorisation

One or more qualifying requirements appear to be reviewable

Supervisory body to arrange a separate review assessment in relation to each qualifying requirement that appears to be reviewable, except where the best interests requirement appears to the supervisory body to be non-assessable or not reviewable on the change of reason ground or the variation of conditions ground

Any other review assessment negative

Every other review assessment positive

Supervisory body to decide whether any of the assessed qualifying requirements are reviewable on the change of reason ground

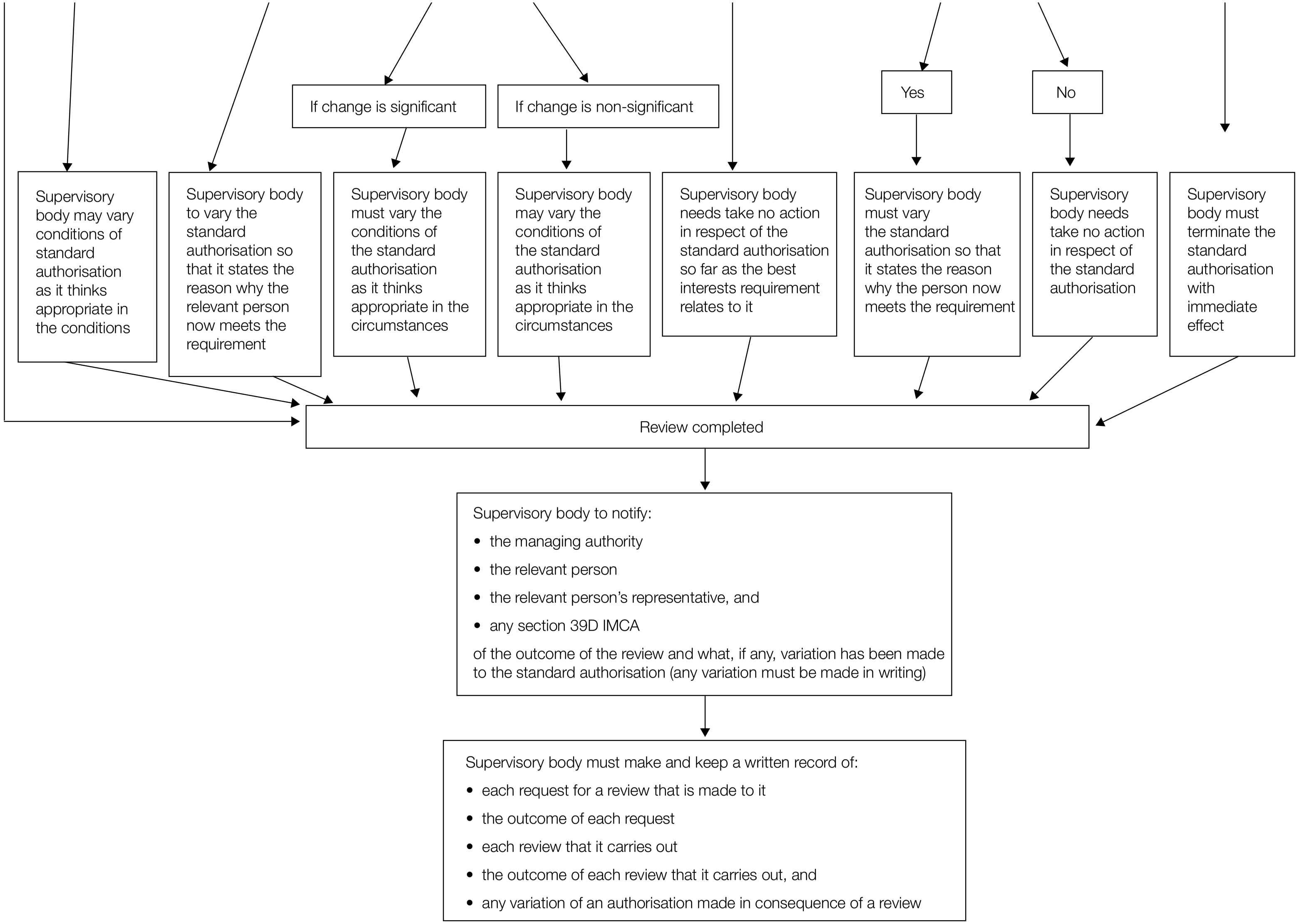
Best interests requirement not reviewable on the change of reason ground or the variation of conditions ground

Best interests review assessment positive

On variation of conditions ground

On change of reason ground

Best interests assessment reviewable but non-assessable



Supervisory body to notify:

- the managing authority
- the relevant person
- the relevant person’s representative, and
- any section 39D IMCA

of the outcome of the review and what, if any, variation has been made to the standard authorisation (any variation must be made in writing)

Supervisory body must make and keep a written record of:

- each request for a review that is made to it
- the outcome of each request
- each review that it carries out
- the outcome of each review that it carries out, and
- any variation of an authorisation made in consequence of a review

Key words and phrases used in the Code of Practice

The table below is not a full index or glossary. Instead, it is a list of key terms used in this Code of Practice. References in bold indicate particularly valuable content for that term.

Advance decision to refuse treatment	A decision to refuse specified treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment. Specific rules apply to advance decisions to refuse life sustaining treatment.	4.26
Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.	2.7
Age assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether the relevant person has reached age 18.	**4.23–4.24**
Approved mental health professional	A social worker or other professional approved by a local social services authority to act on behalf of a local social services authority in carrying out a variety of functions.	4.52, 4.53, 4.60
Assessor	A person who carries out a deprivation of liberty safeguards assessment.	**Chapter 4 (all)** 1.16–1.17, 3.21, 5.22, 9.10 Best interests, and appointing a relevant person's representative: 7.10–7.23
Best interests assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether deprivation of liberty is in a detained person's best interests, is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm.	**4.58–4.76** Best interests, and appointing a relevant person's representative: 7.10–7.23

Bournewood judgment	The commonly used term for the October 2004 judgment by the European Court of Human Rights in the case of *HL v the United Kingdom* that led to the introduction of the deprivation of liberty safeguards.	**Introduction to chapter 1** 1.19, 2.2, 2.22
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.	Throughout
Care home	A care facility registered under the Care Standards Act 2000.	Throughout
Care Quality Commission	The new integrated regulator for health and adult social care that, subject to the passage of legislation, will take over regulation of health and adult social care from 1 April 2009.	Chapter 11
Carer	Someone who provides unpaid care by looking after a friend or neighbour who needs support because of sickness, age or disability. In this document, the term carer does not mean a paid care worker.	Throughout
Children Act 1989	A law relating to children and those with parental responsibility for children.	1.12, 5.22
Conditions	Requirements that a supervisory body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the best interests assessor.	**4.74–4.75** 5.5 Review of: 8.14, 8.16
Consent	Agreeing to a course of action – specifically in this document, to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.	Throughout
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.	**Chapter 10**
Deprivation of liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.	**Chapter 2** Throughout

Deprivation of liberty safeguards	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.	Throughout
Deprivation of liberty safeguards assessment	Any one of the six assessments that need to be undertaken as part of the standard deprivation of liberty authorisation process.	**Chapter 4**
Deputy	Someone appointed by the Court of Protection with ongoing legal authority, as prescribed by the Court, to make decisions on behalf of a person who lacks capacity to make particular decisions.	4.26, 4.65, 5.11, 5.22, 7.7, 7.13–7.15, 7.18, 7.23, 7.29, 10.3, 10.8
Donee	Someone appointed under a Lasting Power of Attorney who has the legal right to make decisions within the scope of their authority on behalf of the person (the donor) who made the Lasting Power of Attorney.	3.9, 4.26, 4.65, 5.11, 5.22, 7.7, 7.13–7.15, 7.18, 7.23, 7.29, 10.3, 10.8
Eligibility assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.	**4.40–4.57**
European Convention on Human Rights	A convention drawn up within the Council of Europe setting out a number of civil and political rights and freedoms, and setting up a mechanism for the enforcement of the obligations entered into by contracting states.	Chapter 1, Chapter 2
European Court of Human Rights	The court to which any contracting state or individual can apply when they believe that there has been a violation of the European Convention on Human Rights.	Introduction to Chapter 1, 2.1–2.2
Guardianship under the Mental Health Act 1983	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local authority or a private individual approved by the local authority.	4.43, 4.44

Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 and is not the same as an ordinary advocacy service.	**3.22–3.28, 7.34–7.41** 3.16, 4.7, 5.7–5.8, 5.18, 6.8, 6.19, 6.27–6.28, 7.4, 7.23, 7.26, 8.18, 8.28, 9.6, 9.9
Lasting Power of Attorney	A Power of Attorney created under the Mental Capacity Act 2005 appointing an attorney (donee), or attorneys, to make decisions about the donor's personal welfare, including health care, and/or deal with the donor's property and affairs.	10.8
Life-sustaining treatment	Treatment that, in the view of the person providing health care, is necessary to keep a person alive.	5.13
Local authority	In the deprivation of liberty safeguards context, the local council responsible for social services in any particular area of the country.	1.4, 2.18, 2.21, 3.3, 3.11, 3.21, 4.77
Local health board (LHB)	Local health boards cover the same geographic areas as local authorities in Wales. They work alongside their respective local authorities in planning long-term strategies for dealing with issues of health and wellbeing in their areas.	1.4, 3.3
Main Code	The Code of Practice for the Mental Capacity Act 2005.	Throughout
Managing authority	The person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty.	**1.4–1.5, 3.1** Throughout
Maximum authorisation period	The maximum period for which a supervisory body may give a standard deprivation of liberty authorisation, which must not exceed the period recommended by the best interests assessor, and which cannot be for more than 12 months.	4.71
Mental Capacity Act 2005	Legislation that governs decision-making for people who lack capacity to make decisions for themselves or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.	Throughout

Mental capacity assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether a person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant hospital or care home for the purpose of being given care or treatment.	4.29–4.32
Mental disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.	1.4, 1.7, 1.9, 3.9, 4.33–4.35, 4.45, 4.50, 5.9, 5.22, 6.3
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It covers detention in hospital for mental health treatment, supervised community treatment and guardianship.	**4.33–4.57** 1.1, 1.11–1.12, 2.13, 4.5, 5.19, 5.22, 7.8, 8.3, 8.19–8.21
Mental health assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether a person has a mental disorder.	**4.33–4.39**
No refusals assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether there is any other existing authority for decision-making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or donee appointed under a Lasting Power of Attorney.	**4.25–4.28**
Qualifying requirement	Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.	4.1
Relevant hospital or care home	The hospital or care home in which the person is, or may become, deprived of their liberty.	Throughout
Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.	Throughout
Relevant person's representative	A person, independent of the relevant hospital or care home, appointed to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the operation of the deprivation of liberty safeguards.	**Chapter 7**

Restraint	The use or threat of force to help carry out an act that the person resists. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.	2.8–2.15
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.	Chapter 2
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.	**Chapter 8**
Standard authorisation	An authorisation given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in the relevant hospital or care home.	**Chapter 4** Throughout
Supervised community treatment	Arrangements under which people can be discharged from detention in hospital under the Mental Health Act 1983, but remain subject to the Act in the community rather than in hospital. Patients on supervised community treatment can be recalled to hospital if treatment in hospital is necessary again.	4.41, 4.50, 4.51
Supervisory body	A primary care trust, local authority, Welsh Ministers or a local health board that is responsible for considering a deprivation of liberty request received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.	**1.4, 3.3** Throughout
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.	Chapter 9

Urgent authorisation	An authorisation given by a managing authority for a maximum of seven days, which may subsequently be extended by a maximum of a further seven days by a supervisory body, that gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.	**Chapter 6** Throughout

Royal College
of Nursing

“Let’s talk about restraint”

Rights, risks and responsibility

Royal College of Nursing

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"Let's talk about restraint"

Rights, risks and responsibility

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Introduction

This guidance is applicable to all settings where nursing care is provided. It replaces *Restraint revisited – rights, risks and responsibility; guidance for nursing staff*. While again it has been written for all nursing staff, distinctions are made, where appropriate, between the roles and responsibilities of registered nurses, nursing students, and health care assistants. It also sets out what support and guidance nursing staff should expect their employing organisation to provide. In addition, it may be helpful to regulators and inspectors of health and social care.

This guidance is intended for nurses working with adults, with examples and case studies particularly geared towards the care of older people.

Whilst this guidance is directed at nurses, except in emergencies, decisions about restraint need to be made after discussion, wherever possible, with the older person, their relatives and friends, as partners in care. It is important to involve the whole care team, including other professionals and agencies that may be helping to support the older person. Whilst we have used the term 'clients' in this publication, it should be noted that this term is interchangeable with 'patients'.

Our aims

This guidance aims to help nursing staff to:

- Understand what restraint is
- Provide person-centred care that minimises the need for restraint
- Understand the legal and ethical frameworks relevant to restraint
- Know what to do if they suspect inappropriate or abusive use of restraint
- Understand the circumstances in which restraint may be legally or ethically appropriate
- Understand how to minimise the risks if restraint is used.

While this document cannot provide all the answers, its aim is to give nursing staff a framework for decision-making that helps them to provide the best possible care for every older person in their care.

What is restraint?

Whilst a basic definition of restraint might be 'restricting movement' or 'restricting liberty', many nursing interventions may restrict unintended movement – for example, plaster casts to stop a client accidentally displacing a fracture – or may unintentionally restrict movement – for example, a nursing home locked at night to protect residents and staff from intruders.

According to established international definitions, included within *Showing restraint: challenging the use of restraint in care homes* (Counsel and Care UK, 2002), restraint is defined as 'the intentional restriction of a person's voluntary movement or behaviour.' In this context, 'behaviour' means planned or purposeful actions, rather than unconscious, accidental or reflex actions. An alternative plain English definition is 'stopping a person doing something they appear to want to do.'

Types of restraint

- Physical restraint involves one or more members of staff holding the person, moving the person, or blocking their movement to stop them leaving.

- Mechanical restraint involves the use of equipment. Examples include specially designed mittens in intensive care settings; everyday equipment, such as using a heavy table or belt to stop the person getting out of their chair; or using bedrails to stop an older person from getting out of bed. Controls on freedom of movement – such as keys, baffle locks and keypads – can also be a form of mechanical restraint.
- Technological surveillance – such as tagging, pressure pads, closed circuit television, or door alarms – is often used to alert staff that the person is trying to leave or to monitor their movement. Whilst not restraint in themselves, they could be used to trigger restraint, for example through physically restraining a person who is trying to leave when the door alarm sounds. These methods are increasingly being included within an individual agreed plan of care, provided they operate within organisational policy, clear guidance and risk assessment.
- Chemical restraint involves using medication to restrain. This could be regularly prescribed medication – including that to be used as required – over-the-counter medication, or illegal drugs.
- Psychological restraint can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.

If an action fits the definition of restraint, it is not automatically unacceptable or wrong. Malicious and abusive use of restraint can occur, but even for the vast majority of caring and conscientious nurses, decisions about restraint are not easy or straightforward. A discussion of the ethical, legal, practical, and professional issues follows, to help nurses understand the difference between unacceptable or abusive restraint and the rare circumstances in which restraint may be justified or positively required, to help strike the right balance between independence and safety.

It is not possible to give a list of what kind of equipment, physical holding, or medication constitutes restraint, as it depends upon the circumstances. A piece of equipment, physical hold, or medication may equal restraint in some circumstances, but not others.

Is it restraint or not? Some examples

Following treatment in hospital for a heart condition, a client develops dangerously high blood pressure levels. As part of her treatment, she is heavily sedated within a critical care environment. This does not fit the definition of restraint, as the sedation is being given to treat her illness, not to control her behaviour.

Following admission to hospital with a heart condition, a client who also has dementia is unable to settle, and constantly wanders. After two nights with little rest, his legs have become very oedematous, and there is a concern that his constant movement is exacerbating his heart condition. Sedation is prescribed. This may fit the definition of restraint, as the sedation is directed at controlling the client's behaviour. However, it is likely to be justified if the ethical and legal principles set out later in this guidance are met.

An older person has been admitted to a care home for a period of respite. He is very unsettled at night, finding it hard to sleep. He constantly walks around the home looking for his wife. Staff find it difficult to support this client and ask the GP to prescribe sedation. This could fit the definition of restraint, and is unlikely to be justified. Alternative ways of supporting the client to settle, such as conversation and reassurance, could be found.

Following a series of strokes, an older person in a rehabilitation hospital needs help from nurses and a hoist to get out of bed. He is also unable to communicate his needs. He is restless at night, has muscle spasms, and is at risk of falling out of bed. Nurses decide bedrails would be in his best interest, to reduce the risk of an accidental fall. This does not fit the definition of restraint, as the bedrails are not controlling his behaviour or preventing him from doing something he wants to do.

An older person is admitted to a care home after treatment for a hip fracture that occurred in her own home. The older person is unsteady when mobilising, and often forgets to use her walking frame. Her relatives are very worried a second hip fracture could result in fatality. They ask nurses to put bedrails up to prevent her from getting out of bed alone to use the toilet at night. This could fit the definition of restraint, as the older person appears to want to get out of bed. It is unlikely to be justified as alternative methods of reducing the risk of further falls – and so reassuring her relatives – could be found.

When might restraint be used?

Adults who may be at risk can be justifiably restrained in some cases, in the following circumstances:

- Displaying behaviour that is putting themselves at risk of harm
- Displaying behaviour that is putting others at risk of harm
- Requiring treatment by a legal order, for example, under the Mental Health Act 2007
- Requiring urgent life-saving treatment
- Needing to be maintained in secure settings.

This applies to individuals being cared for by nurses working in all types of settings, including continuing care, mental health, forensic, critical care and care in the community.

While abuse or restraint can occur in institutions, it may also happen in people's own homes. Nurses working in hospitals, care homes, or the community who suspect restraint is being used abusively – whether through information a client or carer discloses to them, or by what they have observed – should report the information to their employer. If a nurse believes there is a risk of harm to a client, they are required to report poor practice as set out in the NMC Code of conduct.

Bear in mind that legislation and national guidance is always subject to change. Nurses have a professional responsibility to keep themselves up-to-date with any changes that may affect their area of practice.

Next this guidance examines the ethical and legal frameworks that can help nurses to decide if restraint is unavoidable.

Restraint outside the UK

Vest, belt or cuff devices specifically designed to stop people getting out of beds or chairs are in relatively common use in hospital and care home settings in many countries outside the UK, including in Europe, the USA and Australia. These devices are not acceptable in the UK. Nurses employed in the UK should make sure they understand standards of acceptable practice. Employers should ensure that nursing staff are aware of this RCN guidance.

Restraint as a last resort

In most circumstances restraint can be avoided by positive changes to the provision of care and support for the older person. It should be noted that a person with capacity to consent might request items, such as lap belts or bedrails, to enhance their feeling of safety and/or security. Whilst this may not accord with a nurse's recommendation, an individual's choice should be acknowledged and included in a care plan and risk assessment.

When a client cannot give informed consent, nurses should always explain what they are doing, seeking their understanding and agreement. A study suggests that even clients who were delirious when restrained, later remembered and valued nurses' explanations of what was happening to them, particularly reassurances that nurses were trying to keep them safe (Minnick, Leipzig and Johnson, 2001).

An example of good practice

Recent design principles to help clients with dementia have led to the development of small family-orientated households that support 12 older people, with a ratio of one member of staff to five clients. Through a design that excludes corridors – which can often be confusing for people with memory impairment – these units help clients to live more independently, be involved in purposeful activity and have safe access to a secure garden.

Cues for behaviour, memory and reality are provided within the design, helping people with dementia to maximise their independence, reducing their reliance on others. An open plan environment enables staff to observe residents without high levels of intrusion. Meanwhile a 'no uniform' policy removes the constant reminder that staff are different from clients.

The creation of a comfortable, relaxed environment where individuals feel valued, confident and safe reduces incidences of older people trying to leave the building or presenting with challenging behaviour, which may often lead to restraint. In addition, staff who try to understand the underlying reasons for a person's behaviour, and what that person is attempting to communicate, are more likely to help clients in distress.

In essence, a combination of well-considered environmental features and a workforce that has developed person-centred care reduces the need for inappropriate restraint.

Appendix One provides links to good practice resources to help nurses avoid the need for restraint by providing positive care environments. Topics include:

- Person-centred care of older people with mental health needs
- Freedom and risk in care homes
- Prevention of violence and aggression
- Preventing suicide and self-harm
- Client experience in critical care settings
- Meeting the needs of older people with dementia in acute care
- Prevention and treatment of delirium
- Dignity in care
- Falls prevention.

Ethical issues

To help meet the needs of its members, the RCN is currently developing a comprehensive ethics strategy. This acknowledges that every nursing decision has an ethical dimension, and that ethics and ethical decision-making abilities are applicable to all aspects of nursing in all areas of practice.

Basic ethical concepts underpinning nursing practice include:

- **Obligations and duties** – identifying our moral obligations to other people can help us determine what we should do in a given situation
- **Avoiding harm** – perhaps the most essential ethical concept and the basis for good practice
- **Assessing the consequences of action** – the ethically appropriate action may be determined by calculating its potential benefits and harm
- **Autonomy and rights** – respect for the individual's rights to make their own decisions and respect for the rights of others
- **Best interests** – identifying and acting in the best interests of others is a commonly applied means of ethically justifying an action or decision
- **Values and beliefs** – from which we may formulate ethical principles.

Resolving an ethical problem is rarely straightforward and can be challenging to all concerned. In terms of making decisions about physical restraint, it is often difficult to avoid harm, as both restraining or not restraining could bring about harm. Nurses have obligations to all those in their care and, if allowing one person freedom of action causes harm to others, decision-makers need to strike a balance between the consequences of applying or not applying restraint.

Making an ethical decision

– a case study

Sarah works in a care home. Although one resident, Mrs Green, suffers from Alzheimer's disease, she usually appears very happy to live there. Mrs Green has a slight temperature and a visit from her GP has been requested. In the meantime, Mrs Green becomes very agitated, and attempts to leave the home, apparently believing it is many years ago and her small children are at home alone. Sarah has tried to reassure Mrs Green, telephoning her daughter to ask her to visit the nursing home, but in her anxiety Mrs Green is pushing past her to go out of the front door.

Sarah has professional, legal and ethical obligations towards Mrs Green. She foresees that, in these circumstances, it is unlikely she can avoid some degree of harm occurring. She is aware that either preventing Mrs Green from leaving the care home, or allowing her to go out alone, will result in harm. In assessing the consequences of her actions, Sarah concludes that, as Mrs Green is unable to look after her own safety and could come to serious harm if allowed to leave the home unaccompanied, restraining Mrs Green's movements, although distressing, is likely to be the least harmful action.

Preventing Mrs Green from leaving overrides her right to freedom. However, this must be balanced against her right to be free from physical harm. Mrs Green is currently unable to make an autonomous decision about whether she should leave; therefore it is acceptable that Sarah makes a carefully considered ethical decision on her behalf. Sarah can ethically justify her actions, as she is acting in Mrs Green's best interests.

In order to minimise Mrs Green's distress, Sarah calls another staff member to accompany Mrs Green on a walk outside to wait for her daughter's arrival, reassuring her that her family are safe and on their way to meet her at the home.

The use of restraint as a first line response is not conducive to a positive social environment. If people feel enabled to do things, rather than prevented from following their desires, they are more likely to be in a better state of emotional well-being over time. Making decisions about the best course of action can be difficult. As part of their training and continuing professional development, nurses need to discuss real and theoretical dilemmas. Except in emergencies, individual decisions about restraint and policies or guidance should be discussed within multi-disciplinary teams, with the involvement of the older person and their carers, as far as possible.

Legal issues for nurses

While this guidance cannot give legal advice, it can outline broad requirements under law. Nurses have different obligations relating to their different roles – in other words, they have those belonging to any member of the public, and those relating to their professional or contractual duty of care.

The law that would cover restraint comes from both criminal and civil law. Different Acts of Parliament may apply in each UK country. Relevant Acts of Parliament that impact on the law relating to restraint include:

- Offences Against the Person Act 1861
- Mental Capacity Act 2005
- Adults with Incapacity (Scotland) Act 2000
- Human Rights Act 1998.

When is restraint justified in law?

Situations in which restraint can be justified include where the client gives informed and voluntary consent as part of a planned programme of care. In other cases, the nurse may have a professional duty of care to restrain a client to protect that client from a greater risk of harm, or to avoid a foreseeable risk of harm occurring to others. In a situation where a nurse or other person is being attacked or is at risk of physical harm, it is possible to justify the use of restraint as self defence.

Mental Capacity Act 2005

The Act creates and clarifies the common law on consent in England and Wales. A similar Act exists in Scotland-Adults with Incapacity (Scotland) Act 2000 where the principles are similar. A short summary of the key provisions of the Mental Capacity Act 2005 is set out in this document. A fuller set of materials on the application of each Act is given in the useful material section.

The Mental Capacity Act 2005 affects everyone aged 16 and over and provides a statutory framework to empower and protect people who may not be able to make some decisions for themselves, for example, people with dementia, learning disabilities, mental health problems, stroke or head injuries.

The Mental Capacity Act 2005 lays down five principles that relate to the protection of capacity and each must be respected in relation to the provision of healthcare:

1. A person must be assumed to have capacity unless it is established that he lacks capacity
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of actions.

The Mental Capacity Act 2005 sets out the legal definition of the status of an individual who lacks capacity. A person is unable to make a decision for himself if he is unable

a) to understand the information relevant to the decision

b) to retain that information

c) to use or weigh that information as part of the process of making the decision, or

d) to communicate his decision (whether by talking, using sign language or any other means).

The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as being competent and able to make the decision.

In a situation where restraint is being considered for a client who lacks capacity, the Mental Capacity Act 2005 does allow for treatment to be provided as long as this is in the best interests of the individual. The Act requires that the following factors must be considered before any action is taken for the person lacking capacity:

a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)

b) the beliefs and values that would be likely to influence his decision if he had capacity, and

c) the other factors that he would be likely to consider if he were able to do so.

The Mental Capacity Act 2005 sets out the conditions in which an act may be planned that would constitute restraint of a client who lacks capacity. Restraint is defined in the Act as action that uses, or threatens to use, force to secure the doing of an act which the client resists, or restricts the client's liberty of movement, whether or not the client resists.

This legal authority to restrain a client is allowed only if the following three conditions are satisfied:

- The client lacks capacity in relation to the matter in question
- The nurse reasonably believes that it is necessary to do the act in order to prevent harm to the client
- The act is a proportionate response to a) the likelihood of the client's suffering harm and b) the seriousness of that harm.

A new Court of Protection has been created which can decide the lawfulness of any act done or yet to be done in relation to that person, including any omission or course of conduct. It is possible that where nurses are working in settings in which restraint is a real possibility for clients who lack capacity, that some challenge may be made to the Court of Protection about the potential for forms of restraint to be declared unlawful. Good record keeping and sound policy development will be considered by the Court of Protection in such cases to assess whether the three conditions have been met.

Consent

Consent is the legal means by which the person gives a valid authorisation for treatment or care. This could include giving consent to an agreed form of restraint. The legal basis of consent is identical to the professional requirement that consent is needed before carrying out any treatment. The case law on consent has established three requirements which must all be satisfied before any consent given by a person can be sufficient:

- The consent should be given by someone with mental capacity
- Sufficient information should be given to the person
- The consent must be freely given.

Professionals who are personally regulated have professional accountability under their Code of Conduct to ensure that while caring for clients they are assured they have been given information about their condition and understand the risks and implications of any proposed restraint. A failure to obtain valid consent could also lead to professional misconduct as ensuring consent is valid is inherent to the regulatory codes of professional conduct.

Consent must be freely given and no threats or implied threats used. Coercion or manipulation of the client would tend to imply that consent has not been obtained voluntarily. In this situation, even where the client signs

Abuse of restraint
– two case studies

1. An older people's specialist nurse visited a client in a care home. Although the home appeared to be very caring, she was concerned that staff seemed overly protective. She was surprised to see many residents in special chairs, which appeared to be restricting their freedom to move independently. The nurse contacted her employer's POVA lead to talk through her concerns. After discussions between agencies, the care home was provided with support to update its practices, enabling it to strike the right balance between safety and freedom for individual residents. More frequent unannounced inspections have also been introduced.

2. A community psychiatric nurse (CPN) made an assessment visit to a new client who had a diagnosis of Alzheimer's. The nurse was concerned to find that the client's daughter routinely locks him alone in his bedroom, while she attends a part-time job. The daughter is convinced that this is the best way to keep him safe, and is unwilling to consider alternatives. The CPN discussed the situation with the multi-disciplinary team and his employer's POVA lead. After an emergency case conference, an arrangement was made whereby the daughter accepts a day care place and carers for her father. This arrangement is closely monitored, with plans in place to intervene if the daughter returns to locking her father in his room.

a consent form, the consent will have been obtained in an unlawful manner and the consent will not be valid.

The Protection of Vulnerable Adults (POVA)

POVA is a statutory system that requires employers to refer care workers directly to the Secretary of State who can impose a 10-year workforce ban on anyone who has been assessed as being unfit to work with adult or child service users. In addition to nurses, it applies to those employed in care homes, independent hospitals and domiciliary care agencies, as well as those who provide personal care in someone's own home, It requires health care providers and local authorities to have systems in place to act, when allegations are made that adults who are defined as vulnerable, through their need for support or care, are at risk of physical, sexual, financial, verbal or psychological abuse. This includes systems to exclude care workers who have been identified as perpetrators of abuse, from further employment with vulnerable people.

The law and restraint
– a case study

Tom is an adult with significant learning difficulties and care needs, who lives in a group home. He has been unwell for several days and when his GP visits, he suspects Tom has developed type 1 diabetes. Tom is close to collapse, needing urgent hospital care and treatment for dehydration and ketoacidosis. While waiting for an ambulance to arrive, Tom's GP tries to establish intravenous access, but Tom dislikes needles and does not co-operate. Staff from the home who are familiar to Tom try to reassure him, explaining in simple language the importance of the treatment, but Tom is unable to grasp the seriousness of his illness. The GP asks staff at the care home to hold Tom's arms still, while he finds a vein, explaining this needs to be done as soon as possible, as delays in treatment will expose Tom to risk of death or significant brain damage.

This is likely to be legally justified. No assumption has been made that Tom lacks capacity simply because of his learning disability and, given the emergency, as much as possible has been done to help Tom understand the situation, however he appears to lack capacity, as he cannot understand that his illness is life-threatening. Members of staff present have discussed the issues as much as is reasonable in an emergency. Delaying while they consult relatives or an advocate would not be reasonable in these circumstances. The nurses and GP believe holding Tom whilst they establish intravenous access – even if this causes distress and is done against Tom's wishes – is justified in Tom's best interests, to reduce the risk of greater harm from treatment delays.

The Government is repealing the POVA, and its equivalent system for children, POCA, and replacing it with the Safeguarding Vulnerable Groups Act 2006 in England and Wales, with similar legislation in other countries. This introduces a new vetting and barring scheme for those who work with children and vulnerable adults. The statutory duty on employers remains, but there is also a fine of £5,000 for failing to make the statutory referral. The new scheme covers health and social care services and is scheduled to be introduced from autumn 2008.

While abuse or restraint can occur in institutions, it may also happen in people's own homes. Nurses working in hospitals, care homes, or the community who suspect restraint is being used abusively - whether through information a client or carer discloses to them, or by what they have observed - should report the information to their employer. However there is no requirement for a nurse to make a POVA related referral; in fact the scheme does not allow this unless a nurse is also an employer. If a nurse believes there is a risk of harm to a client, they are required to report poor practice to the NMC, under clause 8.2 of the Code of Conduct.

Bear in mind that legislation and national guidance is always subject to change. Nurses have a professional responsibility to keep themselves up-to-date with any changes that may affect their area of practice.

Human Rights Act and Mental Health Act

The Human Rights Act (1998) sets out clear guidance on the freedom of the individual. The use of restraint must be justified by a clear rationale. This should explain why other considerations are believed to override individual freedom of action.

Like any member of the public, under common law nurses can use reasonable force to prevent harm to themselves or others. This public duty is most likely to be used in response to violence and aggression from a client; as a justification for restraining a client to protect staff from harm; or to protect other clients or members of the public. The Human Rights Act 1998 does not apply to care homes run by independent providers, but does apply to NHS settings.

You may find it helpful to consult *Human rights in healthcare: a framework for local action*, produced by the Department of Health in 2007. You can download this publication from the Department of Health's website:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/

The Mental Health Act 1983. At the time this guidance was being prepared, amendments to the Mental Health Act were still being debated. Nurses should ensure they are aware of the powers and responsibilities they hold under any updated legislation.

Civil Law

If a nurse restrains a client without a sound professional and legal basis, the client may bring a civil claim against the nurse in negligence and make a claim for compensation for any harm suffered as a result of the restraint. Where any client can show that he or she has suffered harm- which can be physical or psychological- which was directly caused by the restraint and which was foreseeable, the courts will have to assess any professional standards that existed at the time to see whether the restraint was reasonable. If the actions of the nurse fell below those standards it is possible that a claim in negligence will succeed. The facts of each case will be important and a review will take place of the length of time that the restraint lasted and the amount of force used. Both factors will be need to be justified to show that they are both reasonable and professionally accepted.

It is important that any use of restraint should be reasonably anticipated and steps taken to record this fully in the clinical records. If the nature of the restraint is such that only named staff can undertake this, it would be advisable that their full names and job title are clearly recorded. If training is needed for a particular form of restraint, each healthcare professional should keep a clear record of that training.

Criminal Law

Restraining another person without their consent may be a criminal activity. The nurse who carries out an unlawful restraint may face criminal prosecution that could lead to a fine or imprisonment depending on the severity of the restraint. It is important that whenever restraint is used by a nurse, it is in accordance with accepted professional standards that are justified in the particular circumstance. Any prosecution under criminal law will consider whether the restraint amounted to an offence under an Act of Parliament that could include assault, unlawful detention, ill treatment or willful neglect.

Contracts of employment often set out the limits of a

If restraint is used – three case studies

New management took over a residential care home where some residents had confusion or dementia. Previous policy had been to keep all exits locked. After reviewing the residents' needs, and discussing the issues with all the care team, it was decided it would be much less restrictive if the garden gates could be secured, while doors into the garden could be fitted with new handles that were easier to open. The front door was fitted with a lock that could be opened from the inside, while technology was installed that rang a portable buzzer, carried by a nurse on duty, when the door was opened. This practice fulfils the requirement that if restraint is used, it should be the least restrictive option.

Managers of a unit providing intensive support for adults with significant mental health needs knew that, despite the skills of their staff, including their training in therapeutic care, occasions may arise when physical restraint would be needed to protect clients from harming themselves or others. To ensure this would be done as safely as possible, they provided extensive theoretical and practical training, with clear roles and responsibilities, planning and debriefs. They also devised a process for continual revision and updating of plans for assessing and reducing the risks involved in using restraint. This practice fulfils the requirement that if restraint is used, it should be as safe as possible.

Although no longer needing sedation for therapeutic reasons, a client recovering from a head injury in intensive care became very agitated, attempting to remove equipment that his survival depended upon. Although the emergency was managed, with further sedation used as a chemical restraint, plans were made to gradually reduce this sedation as soon as possible, with staff attempting to manage his care through positive alternatives to restraint. This practice fulfils the requirement that if restraint is used, it should be for as short a time as possible.

nurse's practice, and require nurses to adhere to locally approved policies, procedures or protocols relevant to restraint. This might include detailing how decisions on restraint in different circumstances are to be made, who is responsible, and other requirements, such as having undertaken competency-based training, and the carrying out of risk assessment to reduce the possibility of unintended harm before using restraint. Requirements on documenting decision-making and actions taken are likely to be covered both by professional standards and contracts of employment.

Restraint of children and young people

Anyone working with children or young people is advised to consult the RCN's guidance on *Restraining, holding still and containing children and young people: guide for good practice* (2003) and the BMA's *Consent, Rights and Choices in Health Care for Children and Young People* (2001). This sets out the rights of the child, and the legal framework surrounding those rights, including the Human Rights Act 1998 and the European Convention on the Rights of the Child 1989.

Building exit controls

Units or homes providing support and care for adults may have a variety of controls on how people can enter or leave the building. These include:

- Buildings which are locked constantly – fire exits can be opened but are alarmed
- Buildings where a receptionist controls everyone going in and out
- Doors which require a number code before they can be opened
- Doors with 'baffle handles' that are difficult for a person with cognitive impairment to open
- Doors painted to resemble bookcases with the intention of distracting someone from recognising and using the door
- Stripes and pattern changes on flooring near doorways intended to direct the person away from this area
- Tagging systems that raise an alarm if a tagged person approaches the door
- 'Loop' building designs that encourage a person to walk in circles, never finding the front door
- CCTV installed to observe all exits.

Is this restraint?

Providers of buildings-based services have a responsibility to maintain safety for everyone who is visiting, staying, living or working there, including securing the building from intruders. However, there may also be an assessed need to prevent an older person who is a resident or client from leaving, in order to protect their safety and well-being. This needs to be done in the most dignified way possible. Often subtle design changes in buildings, décor and doors can distract a person from leaving. Nurses need to ensure that they sit on planning committees for new buildings and security design, ensuring that research-based design methods are used.

What support should employers provide?

Organisations, as well as the individual members of staff within them, have a duty of care. To help ensure restraint is not used abusively, and that nurses and other staff are supported in making appropriate decisions about restraint, employers should provide:

- A policy or guidance for staff on the use of restraint
- A multi-disciplinary approach to individual care

Developing a policy on restraint in critical care – a case study

A client who was being cared for in ICU had been sedated on a ventilator for some time. Their condition had improved and they were being weaned off both sedation and the ventilator. However, clearly the client still had no capacity to consent and was manifesting behaviour that was likely to cause themselves harm – for example, by pulling out IV lines. Following organisational protocol, a second senior medical and nursing opinion was sought. This was explained to the client's family. A decision to use mittens was taken to bridge the time between when the sedative drugs were wearing off and the client regained their capacity and was no longer a danger to themselves. The decision was recorded in the client's medical and nursing notes and reviewed at least twice daily.

In this case it was felt more beneficial to use mittens to prevent harm, rather than sedating the client thereby increasing the risk of further harm. Providing purpose-made mittens was an important risk reduction, in comparison to improvised bandaging.

planning, including regular planned reviews of care

- A system for reporting incidents where clients or staff were harmed, or could have been harmed, and learning from them
- Clear channels for raising concerns about possible abuse of restraint
- Access to independent advocates for clients
- Risk assessment procedures, so that risks involved in using restraint can be anticipated and reduced
- Appropriate education, including clinical supervision, reflective practice, learning from best practice, and competency based training
- Regular audit related to restraint, including benchmarking against other comparable organisations
- Dementia care training and awareness for staff in all services.

Employers should also ensure that:

- Nursing students or health care assistants are not put in the position of making decisions about restraint because of a lack of qualified nurses.
- Nurses are not pressured to comply with a request from a person's relative to restrain them, when it is not in their client's best interests.

Restraint should never be used solely to reduce workload. Employers should never put nurses in a position where they resort to restraint because there are too few staff or resources to provide safe care.

Employers in different environments may have specific responsibilities, for example the National Minimum Standards for care homes require the registered person to ensure restraint is used solely when it is the only practicable method of ensuring a resident's welfare – Regulation 13(7) – and that use of restraint is recorded – Regulation 13(8).

'Restraint doesn't happen here' – what the National Patient Safety Agency (NPSA) says

"We were concerned to find occasional reports to the National Patient Safety Agency where nurses had let delirious or suicidal clients get into very risky situations, because they thought it was in all circumstances wrong to stop a client doing what they wanted to do, or had been unsure whether to assist in life saving treatment because a client – although clearly lacking capacity through head injury or delirium – was not co-operating.

"To find out more, we contacted lead nurses in a variety of health care settings to ask if they had policies on restraint. Many organisations shared thoughtful, practical and client-centred policies, but some replied that they most certainly did not have policies on restraint, because they would not tolerate restraint in their organisation in any circumstances. One person even returned the questionnaire on restraint with a cover note saying 'in response to your questions on elder abuse...'

"It appeared that both some individual nurses and some organisations were working to the assumption that restraint was never justified in any circumstances, and autonomy was the only ethical principle they needed to follow. But if an organisation takes the position 'it doesn't happen here' any problems just get hidden. And if staff don't have a clear understanding of the circumstances where restraint is justified or positively required, they won't be able to recognise the circumstances where restraint is wrong or abusive."

Martin Fletcher, Chief Executive, NPSA

Individual responsibilities

With the help of their employers, colleagues, and managers, and the advice and resources within this guidance, nursing staff should ensure that they:

- Understand what restraint is
- Provide person-centred care that minimises the need for restraint
- Understand the legal and ethical frameworks relevant to restraint
- Know what to do if they suspect inappropriate or abusive use of restraint
- Understand the circumstances in which restraint may be legally or ethically required
- Understand how to minimise the risks if restraint is used.

The use of restraint is always an emotive issue, involving challenging and difficult decisions about care. Nurses need to discuss and debate the issues, and work with colleagues to develop caring, practical solutions that suit individual clients.

Appendix One

Resources for good practice that will help avoid the need for restraint

TOPICS	SUGGESTED RESOURCES
Freedom and risk in care homes	*Residents taking risks, minimising the use of restraint: a guide for care homes* (2001) and *Showing restraint: challenging the use of restraint in care homes* (2002). Both produced by the charity, Counsel and Care UK, these are excellent plain English discussions of ethical, practical and legal issues of risk and restraint that are useful in all settings, not just care homes. Visit: www.counselandcare.org.uk
Meeting the needs of older people with dementia in acute care	*Let's respect toolkit*. Primarily for health care staff who care for older people with mental health needs in acute hospitals. Priced at £25, to order visit: www.olderpeoplesmentalhealth.csip.org.uk/lets-respect.html *Who cares wins: improving the outcome for older people admitted to the general hospital: guidelines for developing liaison mental health services for older people* (2005). Produced by the Royal College of Psychiatrists and endorsed by the Alzheimer's Society, British Geriatrics Society and the RCN. Available at: www.alzheimers.org.uk/Working_with_people_with_dementia/PDF/WhoCaresWins.pdf A resource for caring for people with memory problems on medical and surgical wards. Available at: www.changeagentteam.org.uk/index.cfm?pid=250
Guidance on ethics and freedom for family and friends of people with dementia	*Making difficult decisions*, published by the Alzheimer's Society www.alzheimers.org.uk Priced at £7, to order contact: 01753 535751.
Prevention and treatment of delirium	*Prevention, diagnosis and management of delirium in older people. National guidelines. Concise guidance to good practice number 6* (2006) published by Royal College of Physicians. Priced at £7 and available at www.rcplondon.ac.uk/pubs/brochure.aspx?e=142
Dignity in care	The Government's *Dignity in care* campaign, launched in February 2007. This sets out a 10-point challenge for high quality services. Access at: www.dh.gov.uk
Falls prevention	National Institute for Health and Clinical Excellence (NICE) guidance on *The assessment and prevention of falls in older people*, published in 2004. Access at: www.nice.org.uk National Service Framework for Older People. Access at the Department of Health's website: www.dh.gov.uk *Slips, trips and falls in hospital* – the third report from the Patient Safety Observatory, published in 2007 by the NHS National Patient Safety Agency. Access at: www.npsa.nhs.uk/pso
Prevention of elder abuse	Protection of vulnerable adults – a wealth of guidance and information is available at the Department of Health's website: www.dh.gov.uk Action on Elder Abuse (AEA) is a charity working to protect, and prevent the abuse of vulnerable older adults. Visit: www.elderabuse.org.uk *Enough is enough* campaign, run by charity, Help the Aged. Find out more at: www.helptheaged.org.uk
Safe use of bedrails	*Using bedrails safely and effectively*, issued February 2007. NHS National Patient Safety Agency: www.npsa.nhs.uk/alerts

Appendix Two

Restraint guidance in specialised settings

These are other sources of guidance. Please note that listing here does not imply the RCN endorses all content. These documents also include substantial information on strategies to avoid the use of restraint.

SETTING	GUIDANCE
Children and young people	*Restraining, holding still and containing children and young people; guidance for nursing staff*. Updated in 2003 and available at www.rcn.org.uk
Critical Care	British Association of Critical Care Nurses position statement on the use of restraint in adult critical care units, *Nursing in Critical Care*, 2004, vol 9 No 5, pages 199-211.
Neuroscience	Guidelines on use of restraint in neuroscience settings, *Nursing Times*, June 2005 Vol 101 No 23, pages 28-29.

References

Counsel and Care UK (2002) *Showing restraint: challenging the use of restraint in care homes*. London: Counsel and Care UK.

Minnick A, Leipzig, RM, Johnson ME (2001) Elderly patients' report of physical restraint devices in intensive care units. *American Journal of Critical Care* 10 168-171.

Royal College of Nursing (2003) *Restraining, holding still and containing children and young people; guidance for nursing staff*. London: RCN.

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MÄNNYSTRIE O
Poustie, Resydènter Heisi
an Fowk Siccar

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Chief Executive of HSC Trusts
Chief Executive of HSC Board (for cascade to GPs and other relevant practitioners)
Chief Executive of PHA
Chief Executive of RQIA (for cascade to private hospitals, clinics and other relevant establishments and agencies)
Chief Executive of PCC
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Our Ref: HSC/MHDP – MHU 1 /10 - **revised**

Date: 14 October 2010

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance

Purpose

1. The purpose of this circular is to provide interim guidance on the principles to be applied by those involved in taking decisions about an individual's care or treatment that may result in the deprivation of that individual's liberty. The guidance is issued pursuant to the European Court of Human Rights (ECtHR) judgement in 2004 in the "Bournewood" case (see Annexe 1) and is therefore an important element in the protection of Human Rights of patients as required under the European Convention of Human Rights. The guidance is intended as an interim solution based on the current legislative framework, the Mental Health (Northern Ireland) Order 1986 (the Order) and best practice, pending the introduction of new mental capacity legislation in Northern Ireland.

2. The guidance is intended for use by staff working in hospital and/or community care settings across all HSC organisations and relevant independent sector organisations where an individual may be subject to deprivation of their liberty.

A copy of this circular has been placed on the Department's website (www.dhsspsni.gov.uk).

3. This guidance revokes and replaces Circular Letter HSC/MHDP – MHU 1/10: DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance, issued by the Department on 1 March 2010.

The Case

4. Attached (annexe 1) is a summary of the Bournewood judgement which involved HL, a man who had autism and learning disabilities who was admitted to Bournewood Hospital for treatment. HL eventually took proceedings to the ECHR against the UK government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirement of Article 5(4) of the ECHR. The summary conclusions of the ECHR are important and are attached.

Deprivation of Liberty

5. The European Court found that HL had been deprived of his liberty within the meaning of Article 5(1) of the Convention. It is important to note that the judgement does not concern the treatment of incapacitated patients generally. It was only concerned with the question of deprivation of liberty of an incapacitated person.

6. The European Court's judgement does not, therefore, mean that incapacitated patients admitted to hospital or to care homes are automatically deprived of their liberty, even if staff would prevent them leaving unescorted for their own safety.

7. There must be particular factors which provide the "degree" and "intensity" to render the situation one of deprivation of liberty. The factors might relate for example, to the type of care being provided, its duration, its effects and the ways in which admission came about.

8. In this case, the European Court said that:

   > "the key factor in this present case [is] that the healthcare professionals treating and managing the applicant exercised complete and effective control over his care and movements".

   and, noting that HL had been resident with his carers for over three years the Court went on to say that

   > " the clear intention of Dr M and the other relevant health care professionals [was] to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence: the applicant would only be released from hospital to the care of Mr and Mrs E as and when professionals considered it appropriate (paragraph 91).

9. Accordingly the Court found that "the concrete situation was that the applicant was under continuous supervision and control and was not free to leave" (paragraph 91).

10. The Court attached particular importance to the fact that HL had a settled home with his paid carers to which he was prevented from returning and that his contact with those carers was (to some extent) restricted by the staff of the hospital. The court did not consider the issue of whether the ward was "locked" or "lockable" to be determinative.

Lack of Procedural Safeguards

11. The European Court did not find that HL's rights had been breached simply because he was admitted to hospital on the basis of common law doctrine of necessity (i.e. in his "best interests"), rather than under specific statutory provisions (e.g. the Mental Health Order).

12. However, the Court did find that the absence of procedural safeguards surrounding his admission failed to protect him against "arbitrary deprivation of liberty on grounds of necessity and, consequently, (failed) to comply with the essential purpose of article 5(1) of the Conventions".

13. In this latter respect, the European Court was clearly influenced by the "lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" when contrasted with "the extensive network of safeguards applicable to psychiatric committals covered by the (Mental Health Act 1983). Paragraph 120 is of relevance.

14. The European Court also said:

> "the nomination of a representative of a patient who could make certain objections and applications on his/her behalf is a procedural protection accorded to those committed involuntarily under the 1983 Act and which would be of equal importance for patients who are legally incapacitated and have, as in the present case, extremely limited communication abilities" (paragraph 120)

By which it presumably had in mind the role of the nearest relative under current mental health legislation.

15. Above all, although it did not question their good faith, the Court seems to have been concerned that the hospital's health care professionals were able to assume "full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit" (paragraph 21).

16. The Court did not say that HL should have been formally detained under the Mental Health Act. Nor, in the Department's view, does the judgement mean that procedural safeguards for people in HL's position must be identical to those patients detained under the current mental health legislation. However, it is accepted that to avoid further violations of Article 5(1), new procedural safeguards are required for patients who are not formally detained, but who are, in effect, deprived of their liberty in the best interests under common law doctrine.

Breach of Article 5(4)

17. The European Court also found a violation of his rights under Article 5(4) of the convention.

Next Steps

The following paragraphs outline the next steps to be taken by DHSSPS, HSC organisations and relevant independent sector organisations.

Proposals for new procedural safeguards

18. The Department will bring forward new safeguards in law via the proposed Mental Capacity (Health, Welfare and Finance) Bill.

Interim steps that might be taken by HSC bodies and relevant independent sector organisations.

19. Until these safeguards are established in law, the effect of the Bournewood Judgement is that it would be unlawful for an HSC body (without the prior authorisation of the High Court) to arrange or provide care or treatment for an incapacitated patient in a way that amounted to deprivation of liberty within the meaning of Article 5 of the Convention unless the patient were detained under the Mental Health (NI) Order 1986.

20. Nonetheless, the HSC will need to continue to provide care and treatment for incapacitated patients, and it is important that neither the safety of those patients nor the quality of the care they receive is jeopardised during the interim period, both for their good, and, it follows, the care and protection of other patients.

21. Pending the development of new safeguards described above, HSC bodies will want to consider what steps they can take in the short-term to protect incapacitated people against the risk of arbitrary deprivation of liberty and minimise the risk of successful legal challenges.

22. The Department suggests that HSC bodies and relevant independent sector organisations will want to ensure they have systems in place so that when making arrangements to provide care to an incapacitated person which involves a restriction on the liberty of that person, consideration is given as to whether what they are proposing amounts in practice to a deprivation of that person’s liberty within the meaning of Article 5 of the Convention, taking into account the range of factors identified by the Court set as described above and also contained within (a) to (f) in the Bournewood Judgement attached. The same question will need to be asked when reviewing the circumstances of those people who they have already placed who may, in practice, be deprived of their liberty.

23. If patients are considered to be deprived of their liberty (or at risk of it), consideration should always be given to alternatives to ensure that they get adequate care but which falls short of deprivation of liberty. In particular, HSC bodies and independent sector organisations will want wherever possible, to avoid situations in which professionals may be said to take “full and effective control” over patients care and liberty.

24. Elements of good practice which are likely to assist in this, and in avoiding the risk of legal challenge, may include:

- ensuring that decisions are taken (and reviewed) in a structured way, which includes safeguards against arbitrary deprivation of liberty. There should, for example, be a proper assessment of whether the patient lacks capacity to decide whether or not to accept the care proposed, and that decisions should be taken on the basis of proper medical advice by a person properly qualified to make the judgement.

- effective, documented care planning and record keeping for such patients, including appropriate and documented involvement of family, friends, carers (both paid and unpaid) and others interested in their welfare and safety.

- ensuring that alternatives to admission to hospital or residential care are considered and that any restrictions placed on the patient while in hospital or residential care should be kept to the minimum necessary in all the circumstances of their case.

- ensuring appropriate information is given to patients themselves and to family, friends and carers. This would include information about the purpose and reasons for the patient's admission, proposals to review the care plan and the outcome of such reviews and the way in which they can challenge decisions (e.g. through the relevant complaints procedure). The involvement of local advocacy services, where these are available, should be encouraged to support patients and their families, friends and carers.

- taking proper steps to help patients retain contact with family, friends and carers, with proper consideration given to the views of these people. If, exceptionally, there are good clinical reasons why that is not in the patient's best interests, those reasons should be properly documented and explained to the people they affect.

- ensuring both the assessment of capacity and the care plan are kept under review. It may be helpful to include an independent element in the review. Depending on the circumstances, this might be achieved by involvement of social work or community health staff, or by seeking a second medical (or other appropriate clinical) opinion either from within the HSC Body/independent organisation, or elsewhere. Such a second opinion will be particularly important where family members, carers or friends do not agree with the organisation's decisions. But, even where there is no dispute, an organisation must ensure its decision making stands up to scrutiny.

25. If it is concluded that there is no way of providing appropriate care which does not amount to deprivation of liberty, then consideration will have to be given to using the formal powers of detention in the Mental Health (NI) Order 1986. However it is important to remember that:

- nothing in the judgement changes the requirements in the Mental Health Order which must be met before patients can be detained. It should not therefore be assumed that all patients who are to be subject to restrictions which may amount to deprivation of liberty can be detained under the Order. (For example, it would be unlawful to detain patients under the Order if their mental disorder does not warrant detention in hospital, although reception into guardianship under the Order might be appropriate in some cases).

- there are dangers in using the Order simply to be "on the safe side". Although it provides procedural safeguards, the use of the Mental Health Order will not necessarily be welcomed by their family, friends or carers, given the stigma that is often (wrongly) perceived to attach to it. Moreover, a significant increase in the use of the Mental Health Order will inevitably put considerable further pressure on approved social workers, the availability of second opinion appointed doctors (SOADs) and on the operation of the Mental Health Review Tribunal (MHRT).

Action Required

26. I should be grateful if Trust Chief Executives would bring this guidance to the attention of all relevant personnel; ensure the principles it contains are embedded into Trust's procedures; and, confirm to me by **10 December 2010** that this has been done.

Yours sincerely

[SIGNED]

DR MAURA BRISCOE
Director of Mental Health and Disability Policy

Annex 1

The Bournewood Judgement

The Bournewood judgement refers to the European Court of Human Rights' decision in the case of "H.L. v the UK" (published on 5th October 2004).

The case involved H.L, a man who suffered from autism and learning disabilities, who was admitted to Bournewood hospital for treatment under the common law doctrine of necessity. H.L lacked the capacity to consent or object to being admitted and detained for treatment. Although H.L. did meet the criteria for detention under the Mental Health Act 1983 (the 1983 Act) he was not formally detained because he was compliant and did not resist admission and was, therefore, admitted as an "informal patient".

This approach was taken in compliance with the Code of Practice drawn up under the 1983 Act. Chapter 2 of that Code specifically provided that, "if at the time of admission, the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal. The decision to admit a mentally incapacitated patient informally should be made by the doctor in charge of the patient's treatment in accordance with what is in the patient's best interests and is justifiable on the basis of the common law doctrine of necessity".

H.L. applied, by his carers, to the High Court for leave to apply for judicial review of the hospital/Health Trust's decision to admit him, for a writ of habeas corpus and for damages for false imprisonment and assault. The Court held that, although the 1983 Act provided a comprehensive statutory regime for those formally admitted to psychiatric care, section 131(1) of that Act preserved the common law jurisdiction in respect of informal patients. It concluded that H.L. had not been "detained" but had been informally admitted and that the requirements of the common law principle of necessity had been satisfied. The application was therefore refused.

H.L appealed and the Court of Appeal held that he had been detained by the hospital/Trust and that the right to detain a patient for treatment for mental disorder was to be found only in the 1983 Act, which excluded the application of the common law doctrine of necessity. It considered that section 131(1), which preserved the right to admit a patient informally, applied only to a patient who had the capacity to and did consent to his/her admission. The Court of Appeal therefore held that, since H.L. had been admitted for treatment without his consent and without the other formalities required by the 1983 Act, his detention was unlawful.

The hospital/Trust then appealed to the House of Lords, which unanimously allowed the appeal.

H.L. then took proceedings to the ECtHR against the UK Government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that the procedures available to him as an informal patient for the review of the legality of his detention (judicial review plus a writ for habeas corpus) did not satisfy the requirements of Article 5(4) of the ECHR.

The relevant parts of Article 5 are set out below.

Article 5 - Right to liberty and security

Article 5(1):
Everyone has the right to liberty and security of person. No one shall be deprived of his liberty *save* in the following cases and in accordance with a procedure prescribed by law.

Article 5(1)(e):
The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts or vagrants.

(The case of *Winterwerp v Netherlands* (1979) set out the criteria which must be satisfied in order to lawfully deprive a person of his/her liberty on the basis of unsoundness of mind, namely: the person concerned must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder.)

Article 5(4):
Everyone who is deprived of his/her liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his/her detention shall be decided speedily by a court and his/her release ordered, if the detention is not lawful.

European Court of Human Rights considerations

The ECtHR had to consider whether H.L. had in fact been detained: and, if so, whether that detention was lawful (i.e. whether detaining H.L in his own best interests under the common law doctrine of “necessity” complied with Article 5(1)); and also whether sufficient safeguards existed to comply with Article 5(4).

The ECtHR concluded that:

- H.L. had in fact been detained and, therefore, the right to liberty in Article 5(1) had been engaged.

  The Court considered that the question as to whether there has been a deprivation of liberty or a restriction upon a person’s liberty depends on the particular circumstances of the individual case and “account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question”. It stated that “the distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of nature or substance”. It considered the facts of HL’s case and concluded that he had been detained because he was constantly under supervision, was not free to leave and because “the health care professionals treating and managing him exercised complete and effective control over his care and movements”.

- HL’s detention under the common law doctrine of necessity in his own best interests was unlawful under the ECHR, as it did not comply with Article 5(1): i.e. it lacked procedural safeguards which are required to protect against the risk of arbitrary deprivation of liberty.

The ECtHR considered the common law under which H.L was detained. It noted particularly "the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" in contrast with the extensive safeguards available to persons who are compulsorily detained under the Mental Health Act 1983. It also noted the lack of the following attributes which would be necessary to ensure compliance with Article 5(1):

a) Formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions;

b) A requirement to fix the exact purpose of admission (e.g. for assessment or for treatment);

c) Limits in terms of time, treatment or care which should attach to the person's admission;

d) Specific provision requiring continuing clinical assessment of the persistence of a disorder warranting detention;

e) A requirement to nominate or appoint a representative of a patient who could make certain objections and applications on his/her behalf; and

f) Arrangements to enable the person (or his/her representative) to have access to a court/body with judicial character to have the lawfulness of the detention and/or any decision relating to deprivation of liberty reviewed and dealt with within a reasonable period of time.

The Court concluded that "this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5(1)".

- HL's detention was also contrary to Article 5(4) because he was unable to take proceedings by which the lawfulness of his detention could have been challenged and decided quickly by a court.

  The ECtHR considered that HL's application for leave to apply for judicial review of the decision to admit and detain, including a writ of habeas corpus, did not provide H.L. with an adequate means to challenge his deprivation of liberty. Therefore, Article 5(4) of the ECHR was breached.

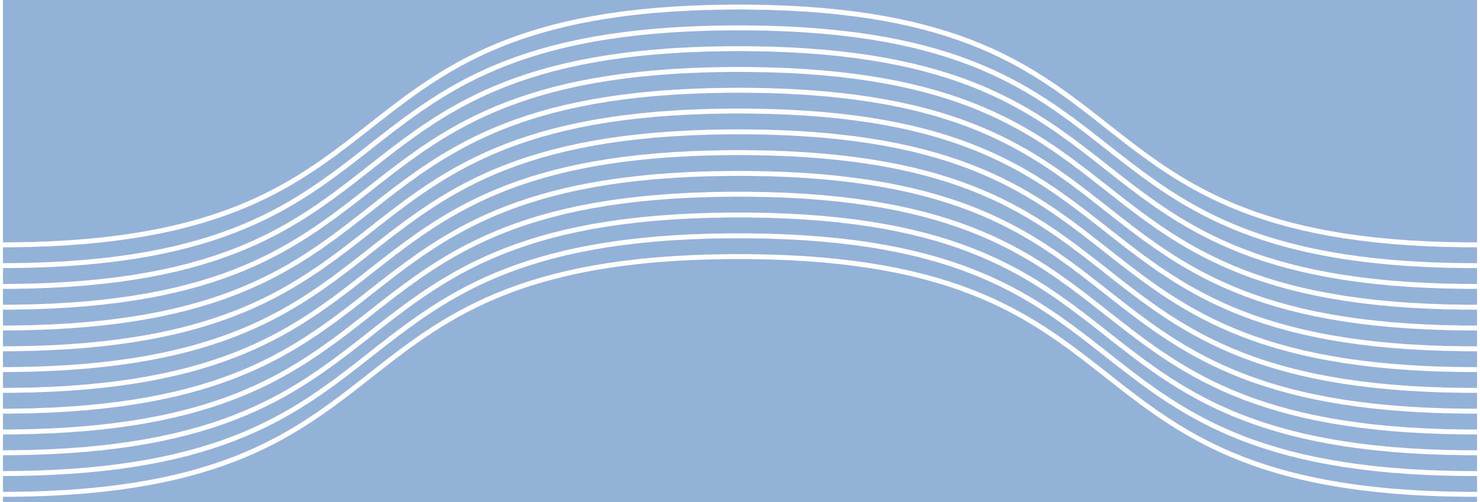
The ECtHR formally held that Articles 5(1) and 5(4) of the ECHR were violated by the UK Government.

South London and Maudsley NHS
NHS Foundation Trust

South West London and St George's NHS
Mental Health NHS Trust

Recovery is for All

Hope, Agency and Opportunity in Psychiatry



A Position Statement by Consultant Psychiatrists

December 2010

Recovery is for All

Hope, Agency and Opportunity in Psychiatry

A Position Statement by Consultant Psychiatrists

South London and Maudsley NHS Foundation Trust

South West London and St George's Mental Health NHS Trust

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FOREWORD

Recovery focused services are a central component to making our mental health services fit for the twenty-first century. Whilst the concepts of Recovery is not new, as psychiatrists we need to rethink how we work alongside, in partnership with, people who use our services to enable them to get on with life from the point when they first access services.

As clinicians we are not abandoning our traditional medical skills of assessment, diagnosis and treatment. However, the challenge for us is to look beyond clinical recovery and to measure effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the individual service user and their family. We need to continually ask ourselves are we helping or hindering a person in their recovery.

A central tenant of NHS policy is showing us that a recovery focused approach, in particular shared decision making, needs to become the norm: *no decision about me without me*[1]. Research shows us that shared decision making in mental health has the potential to improve mental health care as it impacts on quality of life, autonomy, choice and health outcomes.

Our primary interest should be to take the principles and concepts of Recovery and to look at ways in which our practices and all our services across both Trusts can be orientated to facilitate Recovery in people who use them.

This position statement is the result of joint working between our two mental health trusts. In particular, we are indebted to Dr Jed Boardman and Dr Mark Potter for leading this work across the two organisations. We believe *Recovery is for All: Hope, Agency and Opportunity in Psychiatry* provides the conceptual and practical framework for psychiatrists to turn the vision of recovery focused mental health services into reality. We wholly endorse the recommendations within this position statement and as medical directors will provide the leadership to implement recovery focused practice across psychiatry within our respective organisations.

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[1] Department of Health (2010) *Equity and Excellence: Liberating the NHS*. The Stationery Office, Norwich.

POSITION STATEMENT

BACKGROUND

This position statement was developed following a joint workshop on Recovery for consultant psychiatrists in two London NHS Trusts, the South West London and St George's Mental Health NHS Trust and the South London and Maudsley NHS Foundation Trust. A smaller group of consultants was given the task of developing a coherent view of Recovery and of summarising the key factors that support the relevance of Recovery principles for the practice of clinicians and the future development of mental health services. The group was comprised of clinicians from the major specialities of psychiatry: General Adult Psychiatry, Older Adults, Child and Adolescent, Forensic, Addictions and Learning Disabilities. The full document provides the detailed background to our deliberations, including sections on the incorporation of the principles of Recovery into the main psychiatric specialities. In this section we set out our core arguments as to the central importance of the principles and values of Recovery to the future practice of Psychiatry and how we would like to see these incorporated into the development of mental health services.

Integrating the ideas of Recovery into the practice of mental health professionals and into mental health services is a central component to making our services fit for the twenty-first century. As senior professionals in mental health services we believe that we should play a major part in leading this change and supporting the needs and wishes of service users to live a more fulfilling life.

WHAT IS RECOVERY?

A helpful and succinct definition is:

> *"… a deeply personal, unique process of changing one's attitudes, values, feelings goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."*
> (Anthony, 1993).

There is no set model of Recovery and it is better to speak about Recovery ideas or concepts. This means that:

- Recovery is about individualised approaches and, as the definition suggests, it is about having a satisfying and fulfilling life, *as defined by each person*.
- Recovery does not necessarily mean 'clinical recovery' (usually defined in terms of symptoms and cure) - it does mean 'social recovery' – building a life beyond illness without necessarily achieving the elimination of the symptoms of illness.
- Recovery is often described as a journey, with its inevitable ups and downs, and people often describe themselves as being *in* Recovery rather than Recover*ed.*

Recovery can be seen as a process and can be most helpfully defined by three core concepts:

- ***Hope***. Hope is a central aspect of Recovery as Recovery is probably impossible without hope. It is essential to sustaining motivation and supporting expectations of an individually fulfilled life.

- ***Agency***. This refers to people gaining a sense of control. Recovery means service users taking control over their own problems, the services they receive, and their lives. It is concerned with self-management, self-determination, choice and responsibility.

- ***Opportunity***. This links Recovery with social inclusion and thus peoples' participation in a wider society. People with mental health problems wish to be part of communities; to be a valued member of and contribute to those communities; and have access to the opportunities that exist within those communities.

THE IMPORTANCE OF RECOVERY PRINCIPLES FOR PSYCHIATRY

The principles and values of Recovery ideas have been formulated by, and for, service users to describe their own experiences. It is service users that "do Recovery". Professionals (and mental health services) can influence Recovery and Recovery journeys in that they can impede them, but they can also facilitate them. It is this idea of the facilitation of Recovery that must be central to the role of professionals.

It is clear that Recovery is not an intervention, it is not what professionals do to people. It is a description of the processes underlying the struggle of people with mental health problems to live meaningful and satisfying lives. Thus, for professionals, our primary interest should be to take the principles and concepts of Recovery and to look at ways in which our practices and services could be orientated to facilitate Recovery in the people who use them.

If Recovery ideas are to have an impact then professionals and others working in mental health services need to understand what Recovery means and, in partnership with service users and others, actively support their implementation across services.

This will mean a shift in the relationship between professionals and service users to one with a greater emphasis on partnership. It represents a transfer of the authority to define and recognise Recovery away from the professional to the individual.

The principles and values of Recovery overlap with other key concepts such as empowerment, self-management, disability rights, social inclusion and rehabilitation. As clinicians we should be concerned with how these concepts can steer the future direction of services.

Recovery can also be seen as a values-led approach which is focused on social and personally-valued outcomes. As such, it can provide an important orientation for practice, practitioners and services, and is consistent with the guiding values of all the healing professions. In this way it has clear relevance for psychiatry and psychiatric practice. Central to these values is the collaboration and partnership with many others within and beyond professional boundaries.

WHY SHOULD PSYCHIATRISTS SUPPORT THE IMPLEMENTATION OF RECOVERY PRINCIPLES?

The fundamental reason for supporting their implementation is because that is what service users want. This has the potential to provide them with an enhanced experience of mental health services, to improve the quality of those services and to improve the outcomes of people who use those services.

In addition, their implementation has the potential to improve the working lives of mental health professionals and the satisfaction they obtain from their daily work. The Recovery approach offers an exciting re-evaluation of practice for psychiatrists, allowing us to work in partnership with service users to improve their lives.

The challenge to mental health professionals is to look beyond clinical recovery and to measure effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the individual service user and their family, i.e. those of personal Recovery.

Other reasons for supporting the implementation of Recovery principles include:

- *Outcomes of severe mental illness* - The evidence about the prospects for people diagnosed with a severe mental illness is reasonably encouraging. Whilst clinical recovery is possible for people with schizophrenia, the evidence also points to the fact that people can also enter a process of personal Recovery beyond, and in the presence of, ongoing symptoms and difficulties.

- *Historical developments in mental health services* - In the United Kingdom over the past 60 years we have moved from an asylum-based system to one of community services. The first national plan and standards for adult mental health services (the National Service Framework) in England ended in 2009. This means that there is presently an opportunity to develop Recovery-orientated practice and services.

- *Policy developments* - Recovery ideas are now a core part of Department of Health Policy and are supported by other mental health professional bodies in the UK. The development in English national policy, *New Horizons* (HM Government, 2009), offered the opportunity to make Recovery-orientated practice the core of our mental health services. For the new government, the White paper, *Liberating the NHS*, with it's clear focus on service user experience (quality) and shared decision making – *no decision about me without me* (Department of Health, 2010) there remains a central place in policy for Recovery-orientated practice. There is also international interest – and national plans relating to Recovery in several countries including New Zealand, USA, and Ireland.

- *Professional developments* - The profession of medicine is becoming more collaborative, with a greater emphasis on shared decision making, self-care and patient choice, and greater recognition of the contribution of service users as experts in their own conditions. Psychiatry is a core medical discipline.

- *Evidence for the benefits of working in a Recovery-orientated way* - There is evidence for the effectiveness of a number of specific interventions which most people agree would support a 'Recovery approach' and which can be examined in terms of their effectiveness in producing Recovery-relevant outcomes. Successful interventions which have particularly good evidence for their effectiveness include those that aim to improve employment outcomes and empowerment. To these we may add interventions involving Peer support and self management.

OPPORTUNITIES ASSOCIATED WITH RECOVERY-ORIENTATED PRACTICE AND SERVICES

The shift of to a greater collaborative clinical relationship between professionals and service users and the greater focus on personal Recovery provides opportunities that can bring future benefits to service users, professionals, families and carers. There are several ways in which this may be advantageous:

- *Personal Recovery places greater value on the personal knowledge of the individual*. This highlights the presence of two experts in the clinical encounter – the clinician with their technical knowledge and the service user with their expertise by experience; the value of both professional and personal knowledge. This may provide greater job satisfaction for professionals as well as improved engagement of service users in the management of their own problems.
- *Personal Recovery places greater emphasis on the personal priorities of the service user rather than on the professionally defined best interests of the service user*. For clinicians, this emphasises the values underpinning their work and helps them understand their role. For service users this may lead to better outcomes and is more likely to enable them to live the lives they want to lead.

- *The introduction of personal Recovery priorities provides a more balanced and evidence-based approach to treatment*. Our major treatments are not as effective as we often think and the limitations to our standard approaches can be supplemented by a Recovery-orientated practice.

- *Personal Recovery approaches can readdress the historically subordinate interests of people with mental illness in society*. It provides a means of empowering service users and reasserting their rights and citizenship with the potential of providing greater social inclusion and a potential role for clinicians in helping promote this.

CONCLUSIONS

We conclude that Recovery ideas should form the guiding principles to govern the future development of mental health services and that this has benefits for both service users and practitioners. There is a need to transform training and clinical practice, mental health services and culture to create practices and services that are Recovery-orientated and support service users in their Recovery journeys.

The key ideas of Recovery, *Hope, Agency and Opportunity* should run through mental health practice and services, providing the central ideas to guide the day to day practice of mental health professionals and the organisation and culture of our mental health services. These ideas and values need to be translated into practice in order to guide the development of Recovery-orientated mental health services across all psychiatric specialities.

We believe that:
Recovery is probably the most important new direction for mental health services. It represents the convergence of a number of ideas (empowerment, self-management, disability rights, social inclusion and rehabilitation) under a single heading that signals a new direction for mental health services which is supported by service users, authoritative professional bodies, mental health policy and key leaders in mental health around the world.

- Recovery ideas should form the guiding principles to govern the future development of mental health services.

- Recovery ideas should provide the basis for the future direction of psychiatric practice and be applied across the major sub-specialities of psychiatry.

- The adoption of Recovery ideas by mental health services has profound advantages for service users and can improve the quality of mental health services, the experience of service users by expanding and improving the outcomes of for service users.

- The uptake of Recovery ideas has the potential to improve not only the practice of psychiatry but also the satisfaction and working lives of practitioners.

- Psychiatrists, in partnership with service users, other professionals and agencies, should take a leadership role in advocating for changes that address the limitations and barriers for people with mental health problems to live in hope, exercise greater choice and control and to have access to a greater range of opportunities to live a life that they value and choose.

We recommend:

- A greater emphasis be placed on Recovery, and its implications for practice, in the education and training of psychiatrists at the undergraduate and postgraduate levels and in our continuing professional development. This includes the development of the skills, knowledge and support to promote successful self-care, self-management and self-directed care.

- Changes to the practise of psychiatrists to give greater prominence to the principles of Recovery and to the development of an emphasis on partnership between doctor and service user.

- A Recovery-orientation be built into the annual appraisal process to stress the importance of changing practice in our professional development and to assess professional practice against the standards and values of a Recovery-orientated approach.

- The delivery of services which address not only the improvement of symptomatic outcomes for people, but also social outcomes. These should be given priority when commissioning specific services.

- The development of best practice guidelines that give priority to a range of approaches to support Recovery goals and planning that emphasises *hope, agency and opportunity*.

- The development of a culture throughout mental health provider and commissioning organisations in which Recovery principles are embedded and supported by, for example, managerial practices, risk policies, recruitment, training and service delivery.

- A change to the way in which service users participate in their own treatment and involvement in mental health services, which places greater emphasis on partnership and the active involvement of services in such roles as trainers and peer professionals.

- A review of the current mental health workforce which highlights the role of people with lived experience of mental health problems as peer specialists.

SUPPORTING RATIONALE AND EVIDENCE FOR THE IMPORTANCE OF RECOVERY

This section provides a longer discussion of the arguments and evidence for the importance of Recovery principles and values for the future development of mental health practice and services.

INTRODUCTION

This paper is concerned with the importance of the ideas and principles of Recovery for the future practice of psychiatry. It emphasises the need to examine how we might alter our practices and services to become 'Recovery-orientated'. We first cover the generic arguments for the importance of Recovery and then examine the implications for a range of sub-specialities: Forensic Psychiatry, Addictions, Older Adults, Child and Adolescent Psychiatry and Learning disabilities.

BACKGROUND

In 2009, the South West London and St George's Mental Health NHS Trust and the South London and Maudsley Mental Health Foundation Trust organised a joint workshop for Consultant Psychiatrists on Recovery. The workshop was set up to inform consultants about the latest thinking and practice associated with Recovery, to explore their views about the relevance of Recovery to clinical practice and to understand the role of psychiatrists in Recovery-orientated services. When setting up the workshop the Recovery Leads from both Trusts were aware of the strides already made in their own organisations in developing services that were consistent with the ideas of Recovery, but also the apparent scepticism, and sometimes cynicism, about the Recovery approach. However, it was clear to both Trusts that the ideas of Recovery have a central role to play in the future improvement of the quality of mental health services and that Consultant Psychiatrists must have a key leadership role in promoting these developments.

Over 60 consultants from a range of specialities attended and gave their views on the ideas of Recovery and the ways in which their clinical practice could incorporate these ideas. Whilst there was discussion and argument about how these ideas may be incorporated into clinical practice, a consensus emerged that Recovery orientated practice was important to the way professionals practice and the organisation of mental health services. It was clear that, not only could the orientation of mental health services and practice improve the quality of service user experience and outcomes, but that this could also improve the quality of the working lives of clinicians.

One outcome of the workshop was to direct a small group of consultants, from different psychiatric specialities, to produce a written statement outlining the importance of Recovery ideas for the future of practice and services and outlining some ways in which these may change. This Position Statement and its supporting rationale is the result of the group's attention to that task.

This section of the paper provides a background to the ideas and concepts of Recovery, a general consideration of its importance and the way they may be incorporated into mental health practice and services. In addition, the implications for some of the psychiatric sub-specialities are considered, including Child and Adolescent Psychiatry, Older Adults, Forensic Psychiatry, Addictions and Learning Disabilities.

WHAT IS RECOVERY?

Recovery is probably the most important new direction for mental health services. It represents the convergence of a number of ideas – empowerment, self-management, disability rights, social inclusion and rehabilitation - under a single heading that signals a new direction for mental health services which is supported by service users, authoritative sources, English mental health policy and key leaders in mental health around the world.

Much has been written on this subject, and there are many definitions of Recovery, but one succinct definition has been formulated by Anthony (1993):

> *"… a deeply personal, unique process of changing one's attitudes, values, feelings goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."*

This definition highlights the fact that Recovery is about having a satisfying and fulfilling life, *as defined by each person* (Slade 2009, Repper & Perkins, 2003). It represents a shift in who has authority to define and recognise Recovery away from the professional and to the individual.

Whilst some people refer to a 'Recovery model', it is probably better to speak about Recovery ideas or concepts. A model would suggest that there is a Recovery manual somewhere that should be applied to all people to fix them and the opposite is in fact true. Recovery is about individualised approaches.

It is clear from this that Recovery does not necessarily mean 'clinical recovery' which is usually defined in terms of symptoms and cure. Rather, it means 'social recovery'; building a life beyond illness without necessarily achieving the elimination of symptoms of illness. This concept of Recovery can also be applied to people with long-term conditions or disabilities, for example, diabetes, asthma, arthritis. People often describe Recovery as a journey; it may have ups and downs. A period of illness does not necessarily mean that Recovery stops, it may in fact be part of the longer term process of learning and developing an understanding of the illness. Some people, particularly those who experience long term problems say that Recovery is about regaining control and for some it means Recovery from the impact of an illness. People often describe themselves as being *in* Recovery rather than Recover*ed.* This is a fundamentally different understanding of what Recovery means from the traditional clinical sense of Recovery as measured and evaluated by the clinician. Input from mental health services is just part of Recovery journey. Recovery as discussed here can mean both recovery from the condition and recovery of a life worth living. These can be both independent and interdependent.

Recovery can be seen as a process, the components of which include: finding and maintaining hope, re-establishing a positive identity, building a meaningful life, and taking responsibility and control (Andresen et al, 2006). Some suggested principles of Recovery are shown in *Box 1*. This may be boiled down to three core concepts that define Recovery: *Hope, Agency and Opportunity*.

Hope

Hope is a central aspect of Recovery and some would say that Recovery is impossible without hope. It is central to sustaining motivation and supporting expectations of an individually fulfilled life - if you can’t see the possibility of a decent future for yourself then what is the point in trying? Relationships are central to hope, as we all know that it is difficult to believe in yourself if everyone around you thinks you will never amount to very much, and when you find it hard to believe in yourself, you need others to believe in you

Agency

This refers to people gaining a sense of control. In this sense Recovery involves service users taking control over their own problems, the services they receive, their life and destiny. For example, control over the way they understand what has happened to them, their problems and the help they receive, what they do in their lives and their dreams and ambitions. Recovery is concerned with self-management, self-determination, choice and responsibility.

Opportunity

The idea of opportunity links us with the idea of social inclusion and is concerned with participation in a wider society. Social inclusion is important for Recovery as people with mental health problems wish to be part of communities, not apart from them. They wish to be a valued member of those communities, to have access to the opportunities that exist in those communities, and to have the opportunity to contribute to those communities.

Recovery can also be seen as a values-led approach focused on social and personally-valued outcomes. In this way it offers hope or goals for people and an orientation for practice, practitioners and services. An approach based on the values of Recovery overlaps significantly with the guiding values of all the healing professions and in this way has clear relevance for psychiatry and psychiatric practice. Central to these values are collaboration and partnership with many others within, and beyond, professional boundaries.

BOX 1. THE PRINCIPLES OF RECOVERY

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.
- Hope is central to Recovery and can be enhanced by each person seeing how they can have more active control over their lives ('agency') and by seeing how others have found a way forward.
- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. There is no 'one size fits all'.
- The helping relationship between clinicians and service users moves away from being expert / patient to being 'coaches' or 'partners' on a journey of discovery. Clinicians are there to be "on tap, not on top".
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.
- Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.
- The language used and the stories and meanings that are constructed have great significance as mediators of the Recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.
- The development of Recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.
- Family and other supporters are often crucial to Recovery and they should be included as partners wherever possible. However, peer support is central for many people in their Recovery.

Sources: Shepherd, G., Boardman, J., & Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health. (Adapted from Recovery – Concepts and Application by Laurie Davidson, the Devon Recovery Group).

IS RECOVERY POSSIBLE?

Why should we believe that Recovery is possible? The *evidence* about the prospects for people diagnosed with a severe mental illness is reasonably encouraging. Almost half can realistically look forward to 'clinical recovery' and less than a quarter are likely to remain severely socially disabled. The empirical evidence comes from studies examining the long-term outcomes of people with schizophrenia. A meta-analysis of over 100 studies revealed that more than 20% of participants showed complete social recovery following a first psychotic episode (economic and residential independence and low social disruption) and a further 20% showed partial recovery (Warner, 2004). When international studies are added, particularly from India and Hong Kong, a similar pattern is seen, with outcomes being particularly favourable in the developing world (Warner, 2009).

Here it is clear that clinical recovery is possible for people with schizophrenia. We may undervalue clinical recovery even if the evidence for this is more favourable than we often believe. However, this evidence also points to the fact that people can also enter a process of personal Recovery beyond that and in the presence of ongoing symptoms and difficulties.

WHY SHOULD WE BE INTERESTED IN RECOVERY?

Psychiatrists and others working in mental health services do not ‘do’ Recovery. Recovery is what service users ‘do’. As psychiatrists we should be concerned with how we can facilitate Recovery or, at least, not hinder it. Nevertheless, if Recovery ideas are to have an impact then professionals and others working in mental health services need to understand what Recovery means and, in partnership with service users and others, actively support its implementation across services. This will require us to think about changing the way we work; about changing the structure and organisation of our services; and about changing the culture of our organisations in order to make our services more ‘Recovery-orientated’. Recovery ideas and Recovery-orientated practice has the potential to radically transform mental health services for the better and to alter traditional power relationships.

Historical developments mean that there is presently an opportunity to develop Recovery-orientated services. In the United Kingdom over the past 60 years we have moved from an asylum-based system to one of community services. The first national plan and standards for adult mental health services (the National Service Framework) in England ended in 2009. This means that there is presently an opportunity to develop Recovery-orientated practice and services.

Recovery ideas are now a core part of Department of Health Policy and are supported by other mental health professional bodies in the UK. The development in English national policy, *New Horizons* (HM Government, 2009), offered the opportunity to make Recovery-orientated practice the core of our mental health services. For the new government, the White paper, *Liberating the NHS*, with it’s clear focus on service user experience (quality) and shared decision making – *no decision about me without me* (Department of Health, 2010) there remains a central place in policy for Recovery-orientated practice. There is also international interest – and national plans relating to Recovery in several countries including New Zealand, USA, and Ireland.

In addition, the profession of medicine is changing. It is becoming more collaborative, with a greater emphasis on shared decision making, self-care and patient choice, and greater recognition of the contribution of service users as experts in their own conditions. Psychiatry may be ahead of this trend, but should be careful not get left behind.

The challenge to mental health professionals is, therefore, to look beyond clinical recovery and to measure effectiveness of treatments and interventions in terms of the impact of these on the goals and outcomes that matter to the individual service user and their family, i.e. personal Recovery (Craig, 2008).

BENEFITS OF RECOVERY

We are clear that Recovery is not an intervention. It is not what professionals do to people, but rather it is a description of processes underlying the struggle of people with mental health problems to live meaningful and satisfying lives.

It would thus be unhelpful to ask the question, *does Recovery work?* However, we can examine the possible benefits of working in a Recovery-orientated way. In addition, on the basis of the literature, we can try to specify a set of conditions within mental health services that will make 'Recovery' more likely and can therefore examine the effectiveness of a number of specific interventions which most people agree would support a 'Recovery approach'. In this way we can examine them in terms of their effectiveness in producing Recovery-relevant outcomes.

For example, in adults of working age, two areas have particularly good evidence for their effectiveness: improving employment outcomes and empowerment (Warner, 2009). To these we may add interventions involving intentional peer support and self management.

Improving employment outcomes

There is strong evidence, from random-controlled trials undertaken in several different countries, for the effectiveness of 'Individual Placement and Support' ('IPS'), a specific approach to vocational rehabilitation. IPS has been shown to achieve employment rates 2-3 times better than traditional alternatives such as interview training and sheltered workshops. More than half of those receiving IPS achieved successful placement in paid employment, compared with only 20-25% of controls. Those supported by IPS worked significantly more hours, had higher earnings and better job tenure. The higher rates of employment resulting from IPS also have positive long-term benefits in terms of improved confidence and wellbeing and reduced reliance on mental health services (Sainsbury Centre for Mental Health, 2009a).

Empowerment

One means of empowerment is through the involvement of service users in key decisions regarding their treatment and management. There is extensive evidence that a reduced sense of empowerment is associated with lower self-esteem, higher sense of stigma, poorer quality of life and a range of negative outcomes (Warner, 2009). Evidence in this area comes from three approaches. First, the *shared decision making* model for medication management developed by Deegan & Drake (2006). Research shows us that shared decision making in mental health has the potential to improve mental health care as it impacts on quality of life, autonomy, choice and health outcomes (Simon *et al.*, 2009). Another approach is through the use of *Joint Crisis Plans* (JCP), sometimes known as advance directives, to cover arrangements for admission to hospital which can reduce involuntary admissions and improve service users sense of control of their mental health problems (Henderson *et al.*, 2004; 2008). Finally, the use of an educational approach (rather than a therapeutic approach) to *illness-management and Recovery*, is designed to provide people with severe mental illness with the information and skills necessary to manage their illness effectively and work towards achieving personal Recovery goals (Mueser et al, 2002). The benefits for service users include an increased their knowledge of illness, coping skills, personal goal identification and attainment.

Peer support

This concerns the use of others with lived experience of mental health problems acting as workers who directly help others with similar problems. There are now a number of trials and studies of peer support interventions (Chinman *et al.*, 2008) which show that appropriately trained and supported peers can increase service users' satisfaction; their sense of control (self-efficacy), empowerment and movement towards Recovery. They can also help the person expand their social networks, gain hope and become more involved in their own care. Evidence shows that peer support specialists working within mental health services and alongside professionals can reduce length of hospital admissions and support earlier discharge (Slade, 2009).

Self management

Through an educational approach service users can learn more about their conditions and make supported decisions based on this learning. Self management aims to enable people to develop practical tools of everyday living in order for them to make daily decisions that will maintain or improve their health. Self management has developed from supporting people who have long term health conditions and has begun to be applied to people who experience mental health conditions. Two streams of mental health self management have developed, condition specific self management (Rinaldi, 2002) and generic self management (Lawn et al, 2007; Cook et al, 2009). Evaluation of this work is still in its infancy and there remains a need for more systematic research in this area.

THE OPPORTUNITIES ASSOCIATED WITH RECOVERY-ORIENTATED PRACTICE AND SERVICES

There does seem to be evidence for benefits that are associated with some aspects of Recovery-orientated practice. But there are other opportunities associated with this approach that can bring future benefits to service users, professionals, families and carers. These are mainly associated with shifting the clinical relationship between professionals and service users to make it more collaborative and by focusing more on personal Recovery.

There are several ways in which this may be advantageous (Slade, 2009):

1. Personal Recovery places greater value on the personal knowledge of the individual. There are two experts in the encounter between clinicians and service users – the clinician with their technical knowledge and the service user with their expertise by experience. These two experts should work in partnership and value both professional and personal knowledge. This encourages clinicians to work in a different way and can result in greater job satisfaction for professionals as well as improved engagement of service users in the management of their own problems.

2. Personal Recovery places greater emphasis on the personal priorities of the service user than on the professionally defined best interests of the individual. For clinicians, this helps in being clearer about the need to place emphasis on the values underpinning the application of rational scientific knowledge, and enhances the understanding of their roles. For service users the delivery of care which uses socially inclusive and Recovery orientated approaches in line with their preferences and choice, is likely to lead to better outcomes as we saw above. Working with service users' preferences and choices as far as possible, is more likely to enable them to live the lives they want to lead.

3. Our major treatments are not as effective as we often think. The introduction of personal Recovery priorities provides a more balanced and evidence-based approach to treatment. We have some evidence for drugs, psychotherapeutic approaches and types of services which have benefits for clinical outcomes, but this evidence shows the limitations to these approaches and they need to be supplemented by additional efforts. Recovery-orientated practice can help to supplement our usual approaches. Valuing of social outcomes and ways of achieving these can improve the outcomes for service users especially when they may need to learn to live with continuing symptoms and fluctuating conditions.

4. Historically, the interests of people with mental illness in society have been subordinate, with resultant personal and collective harm to them. Personal Recovery readdresses this and provides a means of empowering service users and reasserting their rights and citizenship. The benefits here of their greater social inclusion for service users and the role of clinicians in helping promote this. This means attending to the rights of people with mental ill-health, to citizenship, equality and justice, and stigma and discrimination, and to the status of people with mental health problems in society.

The Recovery approach represents a paradigm shift in the relationship between the individual and psychiatrist. Current practice focuses on evidence based medicine, encouraged by professional groups and health provider organisations. However, although this is vital to providing high quality patient care, it is led by professionals. A Recovery approach will allow a more equal dialogue between professionals and service users and perhaps offer more innovative care. The shift that is required is one from professionals doing things ‘to’ people to supporting them to ‘do’ things for themselves, how they like and in their own way. Thus, rather than being the subject of treatment, the person would become the object in directing their own life, albeit with treatment and support. This represents a shift from being ‘patient’ to being active, and from being seen as the source of problems to becoming the source for solutions. This shift places a central emphasis on education.

There is evidence for the efficacy of service user led Recovery particularly in the field of self help and user led groups. Organisations such as Alcoholics Anonymous have comparable outcomes to professionally led services (Project Match Research Group, 1997).

OBSTACLES TO RECOVERY-ORIENTATED PRACTICE

There are some often repeated arguments against a Recovery-orientated practice (Davidson et al, 2006; Shepherd et al, 2008) which may reflect criticisms based on an anxiety about new approaches and of change. There may also be a lack of knowledge about the evidence behind a Recovery approach, for example a recent survey of junior psychiatrists shows they tend to be rather paternalistic and pessimistic about the prospective of Recovery for people diagnosed with schizophrenia (Ng et al, 2008) despite the research evidence which shows that Recovery from schizophrenia is possible (Warner, 2009, 2010).

Some of these arguments are:

There is nothing new in the idea we have been doing it for years

To some degree the ideas of Recovery are not new, but they have not been driving our practice; much of what we do and the institutional design of services, often hinders Recovery and does not give adequate opportunity for service users voices to be heard. Recovery is sufficiently distinctive to justify its inclusion as a new concept and to explore its implications.

Recovery adds to the burden of the professional

If Recovery ideas replace the existing traditional 'assessment-treatment-cure' ideologies in mental health services then it may not add to the burden of professionals. There is however, an obvious danger of adding to staff workloads if Recovery-oriented care were simply to be 'added on'. If Recovery ideas are integrated, the assessment process would focus more on things the service user wants to achieve. Interventions would be collaboratively agreed and would target these goals. Successful attainment of the goals would replace 'cure', though, in practice this might well be the same thing. This is a reworking of what staff do rather than an add-on or complete replacement and may eliminate unnecessary tasks and assist in achieving greater job satisfaction.

Recovery means the person is cured

Recovery is about the person and their life, what happens to their 'illness' is a different question. 'Cure' and 'Recovery' are not the same thing, but active treatment can play a role in the Recovery process. Treatment and gaining an understanding of oneself and one's illness go hand-in-hand with Recovery. 'Insight' is less important than how the person evaluates different aspects of their life.

Recovery means the introduction of new services

A Recovery-orientation may not need a widescale introduction of new services. What is required is an adjustment of our approaches to re-emphasise the priorities of service users. We need to make existing services work more effectively, more directly driven by the needs of those who use them and with a clear Recovery-orientation. It may appear that key factors in a service user's Recovery are outside the scope of traditional psychiatric care, though this should not negate the benefits of a Recovery-orientated approach which engenders hope and promotes control.

Recovery services are neither cost-effective nor evidence based

As we have indicated, evidence does exist to support the introduction of Recovery ideas. Here we need to consider a range of evidence, from first person accounts to randomised controlled trials. First person accounts have immediate validity, but controlled trial evidence, for example on the effectiveness of models for the communication of information about schizophrenia, approaches to the self-management of symptoms, effective help for families and friends, effective approaches for gaining and retaining open employment, may all be used to support people in their Recovery journeys. In addition, there are both health and social benefits. Feeling more 'in control' of one's life and finding a meaning beyond illness are outcomes with important health consequences (Wagner et al, 2001).

Recovery approaches devalue the role of the professional

Professional input remains important but a Recovery-orientation places it in a different context. Professionals bring important expertise to the process of Recovery - expertise regarding effective treatment interventions, the functioning of groups, issues of engagement and conceptual frameworks to assist with the development of services and systems. In this context professionals do not stop being 'professional'. Professionals will remain a key source of advice and support for service users and may be the most important '*holders of hope'*. In Recovery-oriented services, professional expertise and authority is not given automatic primacy over the views of service users (or families and/or carers). Instead, they enter a dialogue in which their contribution is placed within the context of negotiated agreements about care. In general, people with long-term conditions do better when offered interventions that help to develop their skills, knowledge and confidence to actively participate in managing their illnesses over time (Wagner et al, 2001).

Recovery increases providers exposure to risk and liability

Risk is inherent in all mental health services and in Recovery-oriented services risk will remain. However it is sometimes necessary to take risks in order to learn and grow. A Recovery-orientated service will require a change in our emphasis from risk avoidance to constructive and creative risk taking. We must seek to differentiate between the risks that must be minimised (self-harm, harm to others) and the risks which people have a right to experience. Recovery ideas do swing the pendulum a bit more towards the latter, encouraging opportunities for growth and change (the 'dignity of risk') but, of course, this must be done in a responsible way. The majority of risk is actually shared and the different stakeholders therefore have to be clear about what risk they are actually carrying. The skill then is of being risk aware but focused on safety planning in an increasingly collaborative approach that promotes people taking responsibility themselves for ensuring their safety with service supports. If an individual chooses to ignore clearly documented professional advice then they carry the risk; if a professional commits an act which clearly contradicts their 'duty of care', then they are responsible. Either way, the risk is not being appropriately managed and it is certainly not helpful if professionals think that they carry the sole responsibility for how people live their lives.

CHANGING OUR APPROACHES: PRACTICE, SERVICES AND ORGANISATIONAL CULTURE

Three areas need to change in order to put Recovery ideas into practice: the way we practice, the organisation of our mental health services and the culture of our mental health services.

Role of professionals

Psychiatrists have always placed emphasis on the importance of the 'doctor-patient' relationship and have harnessed this important dynamic in the healing process. They possess what might be called 'basic' therapeutic skills, including empathy, acceptance and mutual affirmation and are also sensitive human beings who may sometimes need to use their life experiences to inform their work. They therefore have a wide range of skills, significantly beyond the delivery of a narrow, 'bio-medical' model. Working in a Recovery-orientated way does not mean we need to abandon our traditional medical skills of assessment, diagnosis and treatment, but some of us do need to develop a more Recovery-orientated approach to our practice. This change of emphasis puts these traditional skills in the service of supporting people in their Recovery and directed towards achieving goals valued by them. Our knowledge of medicine can also come into play as we know that people with mental health problems often receive sub-optimal physical health care and their experience of well-being is poor.

The fundamental change has to be with the quality of the partnership in which the psychiatrist operates in a different role and behaves more like a personal coach: *"…offering professional skills and knowledge, while learning from and valuing the patient, who is an 'expert by experience"* (Roberts & Wolfson, 2004, page 41). Coaching has a future focus, thinking of the person in terms of future potential and not their past. This is a shift from a professional who is seen as remote and in a position of expertise and 'authority'. To facilitate this shift we may consider there to be two 'experts' in the consulting room: the medical expert who offers professional skills and knowledge, while learning from, and valuing, the service user (the 'expert by experience'). As a coach, we may aim to provide the service user with resources (information, skills, networks, and support) to manage their own condition as far as possible and help them get access to resources they need to live their lives.

During our training we develop a range of therapeutic skills and, for a Recovery-orientated approach, these may be formulated in terms of the ability to work with the service user and significant others to formulate a shared understanding of the problem and a positive, forward-looking plan, which is implemented with clear, structured feedback regarding progress.

One example is when discussing diagnosis. Psychiatrists are often in the position of informing service users of their psychiatric diagnosis and in turn service users are on the receiving end of this news. For some, receiving a diagnosis can be helpful – it can serve to enable service users and their families to gain a better understanding of their condition and begin to make sense of the symptoms they are experiencing. For others, receiving a diagnosis can be perceived as receiving bad news or a cause uncertainty where a diagnosis is changed. Faulkner (1998) has defined bad news that healthcare professionals deliver as '*information that could radically change the life of the recipient*'.

Psychiatrists may have valid reasons for not talking about potentially stigmatising diagnostic labels but these reasons have to be balanced against the benefits of the individuals increased understanding of their symptoms and condition, the ability for both to participate in shared decision making about treatment options, interventions that may be helpful with getting on with life and in planning for the future. Service users expect us as psychiatrists to provide information about their conditions, including the actual diagnosis. The failure to provide clear information, even if the service user or carer will be distressed by it or not understand the consequences, may ultimately heighten anxieties and minimise opportunities for their Recovery.

There is limited research on delivering difficult or bad news in psychiatry, but we may be able to learn from our Oncology colleagues (Cleary et al, 2009). Baile et al (2000) have developed a practical six step protocol (SPIKES) for delivering bad news to cancer patients which can be used across different medical settings including psychiatry. The overarching aims of the protocol are fourfold: to determine the service user's understanding and expectations; to give relevant information in a manner appropriate for that person; to provide support to the service user in order to reduce the negative emotional consequences of the news; and to collaborate in the development of a treatment plan.

Box 2 illustrates an adaptation of the SPIKES protocol for delivering bad news for psychiatrists and other mental health professionals.

BOX 2: PROTOCOL FOR BREAKING BAD NEWS

SPIKES: A Six-Step Protocol for Breaking Bad News

SPIKES	Dos	Don'ts
Setting ↓	Establish the right **Setting**: Allocate adequate time for the encounter. Ensure service user privacy. Agenda set with the service user.	~~**Interruptions**~~
Perception ↓	Find out what the service user's **Perception** and understanding of his or her problem is. Pay attention to the service user's words. Make a mental note of the discrepancies between medical facts and service user's perspective.	~~**Assumptions**~~
Invitation ↓	Obtain a clear **Invitation** by the service user to give the information: "Are you the sort of person who wants all the details on their problem?"	~~**Blunt disclosure**~~
Knowledge ↓	Use the service user's current understanding of his or her problem as a starting point to provide **Knowledge** and medical facts. Use the same level of language as the service user uses and work with their frame of reference (**Perception**) for how they attribute and make sense of their problems (e.g. social, biological, trauma, spiritual etc). Give the information in small chunks. Check for service user understanding at each step.	~~**Medical jargon**~~
Empathy ↓	Be **Empathic**: "This must be very hard for you." Recognise that crying and anger are normal responses when receiving bad news. Provide realistic hope: "People can and do live meaningful, valued satisfying lives with the condition."	~~**Destroy hope**~~
Strategy	Explain your treatment **Strategy** and discuss self management strategies. Encourage the service user's participation in decision-making. Summarise main points; answer questions. Negotiate next contact. Remember receiving bad news often provokes an emotional response. Help the service user to process the information both emotionally and cognitively. You may need to recap and explore the service user's **Perception** at the next contact.	~~**Ignore service user input**~~

Adapted by Rinaldi & Potter from Baile, et al. (2000). SPIKES--A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer. *Oncologist, 5*(4), 302-311.

In addition, the list of *10 Shared Capabilities* for inclusive practice may be helpful for psychiatrists (NIMHE, 2004; Department of Health, 2007a). These capabilities underpin the '*New Ways of Working'* initiative, and include: working in partnership, respecting diversity, challenging inequality, identifying individual needs and strengths, promoting safety, and responsible risk-taking (Department of Health, 2007b). We will also need to adopt practical ways of conducting service user centred interactions and utilise useful pointers such as the Sainsbury Centre's *10 top tips for Recovery-oriented practice* (Box 3).

These overlap with the key competencies and emphasise the importance of prioritising the service users goals wherever possible and demonstrating a belief that they can be achieved ('maintaining hope and optimism'). Additionally, Recovery-oriented approaches also use a combination of professional help, self-help and non-mental health resources (such as friends, families, employers, education bodies) to enable the service user achieve their goals. We may need to turn traditional priorities upside down and set our sights away from cure, to being able to lead an ordinary life.

Box 3: Ten Top Tips For Recovery-Orientated Practice

A. Understand Recovery

1. Help the person identify and prioritise their personal goals for Recovery (not the professional's goals)

2. Demonstrate a belief in the person's existing strengths in relation to the pursuit of these goals.

3. Be able to identify examples from your own lived experience, or that of other service users, which inspires and validates hope.

4. Accept that the future is uncertain and that setbacks will occur, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations.

B. Know how to collaborate

5. Encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies etc.).

6. Listen to what the person wants in terms of therapeutic interventions, e.g. psychosocial treatments, alternative therapies, joint crisis planning etc. Show that you have listened.

7. Behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together.

8. Indicate a willingness to 'go the extra mile' to help the person achieve their goals.

C. Have a broad view

9. Pay particular attention to the importance of goals which take the person out of the traditional sick role and enable them to serve and help others.

10. Identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of these goals.

Source: Shepherd, G., Boardman, J., & Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Service changes

Recovery-orientated mental health services must be well organised services that deliver evidence based treatments that meet the needs of service users. They must also facilitate individual Recovery and the range of outcomes valued by service users: the normal social outcomes of something to do, somewhere to live and someone to love, and also their valued health outcomes (Charles Fraser quoted in Dunn, 1999, page viii). They should be designed to achieve both health and social outcomes in partnership with service users.

Personalisation within health and social care services represents a significant change in how services need to operate. Personalisation means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. One means of achieving this is through a Personal Budget where a person with a mental health problem can use an allocation of money to design and purchase support to meet their social care needs. Emerging evidence shows that people with mental health problems may have the most to gain from increased choice and control over their support arrangements (Glendinning et al, 2008). The piloting of Personal Health Budgets began in mid 2009. A Personal Health Budget helps service users to get the services they need to achieve their desired health outcomes. Service users with a Personal Health Budget are told how much money they have available for their care and support. They are then given help and support to use this money to buy services that best meet their needs. Service users are able to take as much control over the way in which this money is spent as is appropriate for them. There are currently 21 sites piloting personal health budgets for people with mental health problems.

The multidisciplinary team approach forms the bedrock of modern, adult mental health services. One of the key rationales for teams is that they can provide access to the range of specialist skills and expertise necessary to provide a more complete assessment of needs and a comprehensive plan of treatment and management for people with multiple and complex problems. From a Recovery-orientated perspective, these teams should contain the complete range of necessary skills covering all the areas that are likely to have an effect on illness and outcomes include finances, housing, employment, and social integration. We should also try to ensure that service users and their families and/or carers are included as part of this team viewing the establishment of these collaborative partnerships as central to the role of modern professionals. There should be a range of workers within the teams encompassing welfare advisors, employment specialists, housing and resettlement officers, as well as a significant number of mental health workers who have had experience of mental ill-health to act as Peer Professionals (Ashcraft and Anthony, 2005; Rinaldi 2009). This transformation of the current workforce is a key challenge to the provision of Recovery-orientated services (Sainsbury Centre for Mental Health, 2009b).

We should be particularly concerned to use evidence-based interventions that improve both clinical outcomes and social outcomes, such as family interventions for conduct disorder and related behavioural disorders in children, early intervention in first episode psychosis, supported employment for people with schizophrenia, and contingency management in addictions.

Professionals also have a key role in addressing stigmatising attitudes, which are usually based on a mixture of ignorance, prejudice and behavioural discrimination. For example, by contributing to staff education (addressing ignorance), facilitating direct face-to-face meetings between service users and staff in these agencies who hold these attitudes (addressing prejudice), and identifying illegal discriminatory behaviour. Doctors continue to be held in high esteem by the general public and putting their weight behind these kinds of initiatives at a local level can be extremely powerful.

Organisational culture

Ten key organisational challenges for mental health services in England to deliver Recovery-orientated services have been developed (Sainsbury Centre for Mental Health, 2009) and are summarised in *Box 4*.

BOX 4: MAKING ORGANISATIONS MORE RECOVERY-ORIENTATED

TEN KEY ORGANISATIONAL CHALLENGES

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, service user-led education and training programmes
3. Establishing a ‘Recovery Education Centre’ to drive the programmes forward
4. Ensuring organisational commitment, creating the ‘culture’
5. Increasing ‘personalisation’ and choice
6. Changing the way we approach risk assessment and management
7. Redefining service user involvement
8. Transforming the workforce
9. Supporting staff in their Recovery journey
10. Increasing opportunities for building a life ‘beyond illness’.

Source: Sainsbury Centre for Mental Health (2009) *Implementing Recovery. A new framework for organisational change*. Position Paper. London: Sainsbury Centre for Mental Health.

A Recovery-orientated culture needs to run through our mental health services and Recovery values need to become embedded in every management process in the organisation including recruitment, supervision, appraisal, audit, planning and operational policies. These values also need to be reflected in the publicly stated principles and values of the organisation. This requires leadership from the top (Board level) as well as commitment from the middle levels of management and practitioners at the front line. Outcomes for the organisation should be based on Recovery-oriented goals. These necessary changes need to be understood by commissioners of services and commissioned through co-production between the commissioners and the local service providers (Shepherd et al, 2010).

This culture must value the input of service users, families and carers, and redefine service user involvement to create a more equal partnership. Involvement of service users, families and carers should not only be in the planning of their own care but also in the planning of services and an active participation in research. Service users are central to providing training for staff and peer professionals can act a ‘champions for change’.

Risk policies must change to support positive risk taking and an emphasis on managing risk when this involves ordinary risk taking, such as letting people have control of their finances or whether or not they go to work. Whilst we need to continue to do careful risk assessments and, at times, intervene when we think the person themselves or others are at serious risk of harm, we should support people to take risks which may enhance their personal Recovery. Human resource strategies must change to open up further job opportunities in the workforce for people who have experienced mental ill-health.

Recovery-oriented services must have strong strategic relationships with the necessary range of social care agencies, for example housing, employment and community networks. These strategic alliances must be based not just on good working relationships between individual practitioners, but also mutually agreed strategic plans which recognise the contribution of each agency working together. Such ‘partnership agreements’ need clear, realistic goals, transparent commitment of resources and agreed methods for monitoring progress so that both sides can be satisfied that the partnership is working effectively.

Overall, the Recovery approach offers an exciting re-evaluation of practice for psychiatrists, allowing us to work in partnership with service users to improve lives (Roberts and Hollins, 2007).

RECOVERY AND THE MAIN PSYCHIATRIC SUB-SPECIALITIES

The arguments put forward above to support the importance of Recovery and its ideas to psychiatry have been largely generic and have been mainly applied to adults of working age. However, we believe that the ideas and principles of Recovery apply across all the mental health specialities, although they may need to be adapted and applied in different ways to suit each of these areas. In this appendix we have included sections examining the application of Recovery to the main sub-specialities of the psychiatry of Older Adults, Children and Adolescents, Addictions, Forensic Psychiatry and Learning Disabilities.

OLDER ADULTS

RECOVERY INCLUDES MENTAL HEALTH OF OLDER PEOPLE

The importance of helping people with mental health problems and their families, carers and friends to retain and recover meaning and purpose in life is not restricted to 'adults of working age' who have functional mental health problems. The central concepts of Recovery (hope, agency and opportunity) apply as much to Older People's Mental Health Services as they do to working age adults. Old Age Psychiatrists, especially in Multi Disciplinary Teams, are prey to an extreme form of Physician's Negative Bias – we often complain that we develop large caseloads of the 'unrecovered and incurable' and have developed cynicism and experienced a loss of hope over the years.

The emerging literature on Recovery in Older People's Mental Health Services has been reviewed by Hill et al (2010) where they explored in some detail the similar but parallel paths of development of Recovery in Rehabilitation services and Person Centred Care in the care of people with dementia (see table 1). They note the shared origins from the work of Tuke in the 18th century and Rogers in the 20th century concerning identity and personhood and re-emphasise the importance of relationships and social context. Many Old Age Psychiatrists have rightly been sceptical about the use of the term Recovery in the management of people with Dementia, indeed the word may need to be used with caution in this context. However, several commentators have noted the similarity between the principles of Recovery and Tom Kitwood's work on Dementia Care Mapping (Kitwood, 1997). Hill and colleagues explore social engagement and avoidance of segregation, both important factors in improving social inclusion and made clear links between the work of Goffman (1974) and Kitwood (1997). The development of assisted housing schemes which enable people with dementia to live independently with assistive technology and community support are important service developments. The changing role of professionals to that of 'mentor, coach, support, advocate and ambassador' is encouraged, as are changes in the involvement and support offered to families and informal carers. The use of tools to encourage the development of care plans that are meaningful to and owned by service users and their families is important.

The implications of the values implicit in an approach based on the principles of Recovery are profound and the challenge to implement them successfully is significant both for professionals and for society at large. Some of the principles have already been embodied in Government Policy and there have been international developments. *'Everybody's Business'* (Care Services Improvement Partnership, 2005). This guide to the development of integrated mental health services for older people - stresses the importance of respect and dignity and the principles that must underlie services: a person-centred approach, improving quality of life, meeting complex needs in a co-ordinated way and promoting age equality.

"Staying mentally and physically active gives a sense of purpose and personal worth to people, as well as enabling people to make an effective contribution to their communities. Participating in valued activities can also provide an opportunity for social contact. Hobbies and leisure activities, lifelong learning, as well as volunteering, employment, and engagement in the development or delivery of local services should all be supported." (*Everybody's Business*, page 13)

Overall, there is a need to look at 'whole systems' change. Despite the continued debate about the semantics of the word Recovery a 'curious convergence' between the principals of Recovery and Person Centred Care can be identified (*Table 1*).

TABLE 1: COMPARABLE PRINCIPLES IN RECOVERY-ORIENTATED PRACTICE AND PERSON-CENTRED CARE

Recovery (CSIP, RCPsych & SCIE, 2007; Sainsbury Centre for Mental Health, 2008)	**Person-Centred Care** (Kitwood, 1997, McCormack, 2004; Brooker, 2007)
Recovery is fundamentally about a set of values related to human living applied to the pursuit of health and wellness	A value base that asserts the absolute value of all human lives regardless of age or cognitive ability
The helping relationship between clinicians and patients moves away from being expert/patient to being 'coaches' or 'partners' on a journey of discovery	The need to move beyond a focus on technical competence and to engage in authentic humanistic caring practices that embrace all forms of knowing and acting, in order to promote choice and partnership in care decision-making
Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying roles in society	People with dementia need an enriched environment which both compensates for their impairment and fosters opportunities for personal growth
People do not recover in isolation. Family and other supporters are often crucial to Recovery and should be included as partners wherever possible	Recognises that all human life, including that of people with dementia, is grounded in relationships
Recovery approaches give positive value to cultural, religious, sexual and other forms of diversity as resources and supports for wellbeing and identity	An individualised approach – valuing uniqueness. Accepting differences in culture, gender, temperament, lifestyle, outlook, beliefs, values, commitments, taste and interests

The literature on using a Recovery approach to the nursing of people with dementia has been reviewed by Adams (2009) who similarly finds much that is useful and suggests a convergence of ideas in the promotion of wellbeing in people with dementia. Dementia may signal the end of life, but it is not immediately fatal. If people are to make the most of the lives that are left to them then it is living with, rather than dying from dementia that is critical. As with people of all ages who develop other terminal physical illnesses, the challenge becomes one of living as valued and meaningful a life as possible:

- doing the things you value for as long as possible
- preserving a sense of personhood
- celebrating who you are and what you have achieved in life
- leaving a legacy for future generations (the gift of history)
- preparing 'advance statements 'recording likes, dislikes, preferences so that others know when you are unable to tell them.

A diagnosis of dementia has a profound impact not only on the individual, but also on those who are close to them. Essentially, the challenge of 'Recovery' from a diagnosis of dementia involves families discovering new sources of value and meaning for themselves, in their loved one and in their relationship with them.

Recovery principles point to the need for a wider view of the service user than that of the purely bio-psychological orientation. Partnership working with Social Services is familiar to most Old Age Psychiatrists although substantial progress still needs to be made in this area. To provide comprehensive services and really promote inclusion multidisciplinary teams need to have access to knowledge about Welfare Benefits and sound relationships with Housing, Leisure Services and the Voluntary Sector.

Doctors have a leadership role in addressing issues of stigma, ignorance, prejudice and discrimination. Speaking to staff in other agencies, sharing our knowledge in service user forums, challenging ignorance and taking action where there is discrimination are all part of our role.

Older people's services in both the South West London and St George's (SWLSTG) and South London and Maudsley (SLAM) Trusts have taken on the challenge. At SWLSTG, following a series of qualitative interviews with older age service users, an action plan for the implementation of Recovery-orientated practice in older people's services was developed for both older people with functional mental health problems and those with dementias. The action plan was framed around the three headings of *Hope, Control and Opportunity*. As part of this, a series of publications are being produced. The first has been published for people with dementia and their families, 'Living well with dementia: An introduction to coping positively with dementia'. At SLAM a group of clinicians have obtained a research grant to investigate our understanding of what Recovery means for older people with mental health problems and to evaluate a training programme for frontline staff in the concepts of Recovery and Social Inclusion over a three year period. From 2010 onwards all frontline teams will receive team based Recovery training. There are also plans to offer training in 'coaching conversations' for staff to improve their communications skills.

Mental Health Older Age Clinicians at SWLSTG have produced materials that will be published on the Trust intranet. These include information on life review work, "advanced care directives" for people with dementia, and a booklet specifically for people with dementia which uses the principles of the Recovery model to talk about coping with dementia at the point of diagnosis. The booklet has also been published. Currently planning is needed to ensure the dissemination of the materials and also a training strategy to ensure that the concepts are incorporated into everyday practice.

A Recovery-orientated approach in older people's services now needs to move from rhetoric to a reality in the way we provide our services. Embracing Recovery-orientated practice is important for older people with mental health problems if we are to enable the people who use our services to have sources of meaning and value, to be a part of their communities and contribute to those communities throughout their lives.

CHILDREN AND ADOLESCENTS

RECOVERY AND BUILDING RESILIENCE WITHIN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

Recovery and social inclusion are important for everyone, including children and young people. *Every Child Matters* (Department for Education and Skills, 2003) identified five outcomes for every child and young person: to be healthy, to be safe, to enjoy and achieve, to make a positive contribution to society and to achieve economic well-being. These outcomes are universal ambitions for every child and young person, regardless of their background or circumstances, including those who have experienced mental health difficulties. Furthermore, these outcomes have much in common with the hopes and principles of Recovery.

The term 'Recovery' has raised some challenges for those who work in child and adolescent mental health as it could be taken to imply an approach to mental health care that lacks a developmental perspective. Recovery can be taken to mean a return to what has been before which, for young people and their families is not an option.

Whereas an adult may have confidence in who they are, a young person is still developing, discovering and exploring. A young person who has experienced mental health difficulties will be changing and recovering at the same time. It may be hard for them to feel that they are at a point of recovery as they are likely to come out developmentally different to how they were before.

A term which has been used by CAMHS professionals is *Resilience*, which can be broadly understood as a positive adaptation in circumstances where difficulties, whether personal, familial or environmental, are so significant that there would be an expectation that a person's cognitive or functional abilities would be impaired (Newman, 2002). Resilience is based on positive approaches with a focus on the strengths of the individual, growth and development. A key protective factor for children who have experienced severe adversity is the ability to recognise positive experiences, rather than focusing solely on the negative, and the ability to use these insights as a platform for affirmation and growth (Newman, 2002).

What is apparent with both the concepts and principles associated with Recovery and Resilience is the considerable overlap. The related concepts of hope, optimism, and future planning are key elements of both Resilience and Recovery approaches. The notion of the Recovery process as non-linear (acceptance of setbacks) is compatible with the characterisation of Resilience as changing over time. The explicit Recovery focus on peer support is also entirely compatible with a movement towards more central roles for families and the development of formal youth networks. In addition, Recovery can occur without professional intervention and resilient responses by children may often arise naturally, and may not always need to be stimulated by professional interventions.

Within South West London and St George's Mental Health Trust, a working group has been established to address what adopting Recovery-orientated practice means within CAMHS. The three key areas of the Recovery approach of hope, agency and opportunity have been translated by the group for CAMHS and linked to the five outcomes of Every Child Matters. This work will be carried forward by the Trust-wide CAMHS Forum.

ADDICTIONS

RECOVERY IN ADDICTION

Recovery has long been a core concept in the treatment of addiction. Often this has been narrowly defined with a focus on abstinence from illicit substances. The American Society of Addiction Medicine has described Recovery as a process of overcoming both physical and psychological dependence on a psychoactive drug with a commitment to abstinence based sobriety (Steindler, 1998). More recently the concept of Recovery has broadened after pressure from user led mutual aid groups and advocacy services. In 2007 the Betty Ford Institute Consensus Panel developed the definition of Recovery as “a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship”. Sobriety refers to abstinence from alcohol and other non prescribed drugs, personal health refers to improved quality of personal life and citizenship encompasses living with regard and respect for those around you as defined by validated instruments (Betty Ford Institute Consensus Panel, 2007).

The definition of Recovery needs to encompass several factors to make it a meaningful concept for treatment and health services. Firstly, as a lived experience by individuals and families, secondly as a concept connecting Recovery communities, thirdly as a measurable outcome that allows researchers and health services to quantify it, and finally as a goal or vision for health services (White 2007).

Many services see people with chronic addiction problems exacerbated by mental illness and social marginalisation. These individuals may have been accessing treatment such as methadone maintenance programmes or alcohol services with a long history of continued illicit use or relapse into alcohol. In addition there is increasing coercion for service users accessing addiction services led by the courts using alcohol treatment orders or drug restriction requirements instead of custodial sentences. As a consequence the concept of recovering (White 2007) is also important; a person may not have achieved abstinence but making steps towards that goal.

Many drug services focus on a model of harm reduction and medical stabilisation. In addition commissioners of substance misuse services often focus on narrow outcomes and fund services based on targets such as waiting list times and 12 week retention in treatment which neglects the Recovery strategy. Furthermore the Treatment Outcome Profile in Addiction (TOP) (Marsden et al, 2008) focuses on wider outcomes such as level of drug use, offending behaviour, general health, employment, education and housing, but again these are markers of improvement as defined by services, not the individual service user themselves. Though, in 2010, the National Treatment Agency has incorporated Recovery including reintegration into society for problem drug users in the standards for commissioners of addiction services (NTA, 2010).

In applying the three concepts of Recovery hope, agency and opportunity, psychiatrists can take a lead in promoting the model and incorporating current features of addiction treatment within a Recovery framework.

Hope

Hope is integral to mutual aid societies such as Alcoholics Anonymous and Narcotics Anonymous etc., as these organisations successfully promote self facilitation and engender hope. The use of narrative provides support from peers and 12 step facilitation therapy delivered by services can promote the use of fellowship organisations. More recently the National Treatment Agency has started to incorporate key principles of Recovery in its guidance articulating a vision of Recovery to staff, service users and commissioners. This vision of services includes instilling hope, repairing damaged lives and building social capital (Mitcheson, 2009).

Agency

People with drug and alcohol problems are often stigmatised by both health services and the wider society. This substantially reduces an individual's sense of control over and ability to manage their life. This is exacerbated by addiction where a person's life becomes controlled by a substance of dependence. There is evidence of treatment options than can improve an individual's agency within addiction.

Contingency management is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking or drug use. Consequently, it utilises social, recreational, familial, and vocational re-enforcers to assist service users in the Recovery process (Petry, 2000).The NTA is currently piloting this using financial rewards to promote appointment attendance, vaccination and clean urine testing. The initial evidence indicates this approach to be very successful in promoting positive behaviour and also encouraging service users to spend the money they earn in a way that promotes their Recovery e.g. equipment for a college course.

The ITEC (International Treatment Effectiveness Project) and BTEI (Birmingham Treatment Effectiveness Initiative) aim to improve treatment effectiveness to do this by making the delivery of psychosocial interventions both easier and clearer, and promoting organisational improvements. These approaches improve the quality of care planning through the use of a simple manual based on a cognitive approach known as 'node-link mapping'. This is a technique for discussing issues with service users and visualising them in a series of 'maps'. It can therefore help clients and key workers to clarify and focus on an issue and Recovery goals (NTA, 2009).

Opportunity

The concept of citizenship and participation in wider society is vital to Recovery in addiction and the use of peer support workers can facilitate opportunity. Recovering addicts are often core to rehabilitation programmes and voluntary sector organisations, providing treatment and support. Peer support has less of a tradition in statutory services but this is changing as both the voluntary sector and NHS start working in partnership.

Recovery is a core concept within addiction services both in the narrow sense of sobriety and abstinence, as well as within wider health improvements and societal involvement. The challenge is to incorporate Recovery in all its facets such as citizenship and hope in a milieu when services are measured on specific outcomes. As psychiatrists we can articulate this view in dialogue with service users, commissioners and staff.

FORENSIC

RECOVERY IN FORENSIC PSYCHIATRY

The three pillars of Recovery - *Hope, Agency and Opportunity* – apply to forensic psychiatry. Developing hope for the service user, opportunity for care providers/clinicians and ultimately control for the service user such that they can develop their individual capacities. Recovery does not, in this regard, disempower the doctor but instead inspires them through the application and development of these three pillars. Perhaps hope is not just for the service user but also for the clinician.

Undoubtedly the application of the concepts of recovery within forensic services has challenges as a result of the involvement of Ministry of Justice, MAPPA and other statutory services such as Probation. Comments from service users such as “I don’t have to do what my doctor tells me”, or “I don’t have to live where I am told” are understandable but are not going to be possible within forensic services. Nevertheless even though the implementation of recovery-orientated practice may be more complicated, it may be a valuable way of operationalising forensic practice and how to affect change in the service user.

Working in a recovery approach regains compassion as a central part of the interface between clinician and service user. The similarities between humanism and recovery are recognised (Roberts and Wolfson, 2004). Recovery-orientated practice is just as applicable within forensic services as it is in other mental health services. Forensic services need to be particularly interested to consider whether and how detention and compulsion could be routes to personal recovery (Roberts et al, 2008).

> *“The therapeutic purpose of detaining someone and treating them against their will is to achieve the gradual handing back of choice and control in ways that are safe and to enable them to resume responsibility for themselves.”*
> (Roberts et al, 2008, pages 173-174)

Recovery-orientated practice within forensic psychiatry promotes the normalisation of service users and also promotes their social inclusion. Examples of such practice involves theatre, museum and football trips that allows greater equalisation between staff and service users and will ultimately promote reality testing and community reintegration leading to increased safety and respect for security.

Importantly, recovery-orientated practice is not a treatment but a collaborative approach which promotes hope and hope inspiring relationships. If we are to really promote hope then we need to help service user to accommodate what has happened, help them see they are more than a ‘forensic patient’ and help them to see that a decent life is possible. The role of peer support in forensics is vital.

It is important to remember that personal recovery is not about the absence of illness. For example, some service users might see steps towards their Recovery as the achievement of moving out of high dependency care or sharing responsibility about managing acute relapse of illness. For others engaging in those activities that give their lives meaning within the service (spirituality, education or work) and for others retaining links with their communities maybe seen as part of a person’s recovery.

One of the criticisms of recovery-orientated practice is its capacity to be at times woolly or opaque. Within forensic psychiatry recovery is considered an essential part of modern practice in that it allows the empowerment of service users and aims to maximise people's strengths and abilities. The evidence base for recovery in forensics is developing, but we should not just be concerned about evidence based practice but also practice-based evidence, which means learning from what you are doing. In this regard service users contribute to practise-based evidence as experts.
Within forensic services the management of risk is paramount. If a person harms themselves or other people, or is vulnerable to abuse from others, then this severely restricts their possibilities for rebuilding a meaningful and valued life. However, pursuing opportunities necessarily involves taking the risk of being unsuccessful. Our task is to support people in taking such risks and help them to build on failures that do occur rather than protecting them from the possibility of failure. We need to embrace recovery-orientated practice and worry less about the perceived risk of inclusion. Through such an approach a service user is more likely to turn to their clinician with whom they have an effective working relationship at the point of challenge rather than withdrawal. Encouraging and supporting service users to develop personal recovery plans (or WRAP) along with developing and negotiating advance directives within the parameters that society sets is one way to enable service users to maximise choice and control over the treatments, interventions and support they receive.

There is often concern about giving service users greater choice and control but service users tell us that it is often the small things that make the biggest difference: People having their own appointments diaries; having a choice of time to get up, therapy, activities, how to use 1:1 sessions. Within both Trust's service users have been developing portfolios which include certificates of treatments completed, risk assessments, such as the HCR-20, assessment reports and vocational skills certificates. Portfolios are held by the service user and taken to Tribunals and CPA reviews. They demonstrate to the service user and others how their health is improving.

In addition, at SLAM, a five-item quick questionnaire has been collaboratively developed with service users and Amy Batson and Timothy Green measuring ideas of hope and control for the service user. In particular, this questionnaire develops the concept of inter-dependency which perhaps is a central factor for affective recovery for the mentally disordered offender. Inter-dependency is about shared responsibility and collaboration within a care programme towards safe and effective release to the community. Inter-dependency recognises the input of other bodies, such as the Ministry of Justice, but ultimately concludes how the service user, not just a clinical team, is responsible for ensuring the safety of others. At South West London service users who have moved on from services have been encourage to write personal accounts of their recovery journeys. A collection of these personal accounts has been published and is widely available to all service users, their family, friends and carers and staff within the forensic service. Ex-service users are invited to come back, run groups and provide role models for existing service users to see there is life after forensic services

We have moved forward but need to move further to encourage service users to be involved in the development of their care plans and in the assessment and management of their risk assessments. Working collaboratively, based on shared decision making, promotes a more positive working alliance that promotes hope, shares risk and the management of crisis.

Recovery as an approach to service delivery is helpful for forensic services as it ultimately operationalises relational security.

In conclusion there is minimal difference between recovery processes within forensic psychiatry compared to generic services. Recovery emphasises the importance of parameters within forensic clinical practise and encourages a healthy shift away from punitive concepts that have become increasingly dominant in forensic services. Although public enquiries into homicides have given rise to concerns around service users being given too much independence, ultimately such worries are misplaced. Recovery promotes the concept that control and responsibility has to be shared between clinician and service user. This undoubtedly assists in the ‘management of trust’.

LEARNING DISABILITY

RECOVERY IN LEARNING DISABILITY SERVICES

In parallel with the developments in generic mental health services, the services for people with learning disabilities over the last 30 years has moved from institutional to community care. This shift has been underpinned by overt and strong philosophies which have profound similarities to the principles and values of Recovery, including Normalisation (Wolfensberger, 1972), Social Role Valorisation (Wolfensberger, 1983), Ordinary Living (King's Fund, 1980), Service Accomplishments (O'Brien, 1989), Needs Assessments and Essential Lifestyle Planning / Person Centred Planning (PCP) principles and approaches.

Government policy over the past decade for people with learning disabilities (Department of Health, 2001; 2005) has several aspects of the Recovery approach and has put independence, choice and inclusion at the heart of its developments. The 'Valuing People' Strategy (VPS) set out aspirational values for the future lives and service delivery for all people with learning disabilities: rights as citizens, inclusion in local communities, choices in daily life and real chances for independence. In this approach, the appropriateness of mainstream primary care, secondary care, mental health, social care and other services for people with learning disabilities should be determined through multi-professional/inter-agency individual needs-led Person Centred Planning (PCP) principles and approaches. The All Wales Strategy for the Development of Services for Mentally Handicapped People (launched in 1983) was pioneering in its commitment to enable people with learning disabilities to have "normal patterns of life within the community, to be treated as individuals and to receive additional help and support from the communities in which they live and from professional services in developing their maximum potential".

Despite the aspirations of policy, many people with learning disabilities and mental health needs will still require access to specialist, community-based, out-patient, inpatient and secure mental health learning disabilities services. These people include those with moderate to profound learning disabilities and limited verbal communication skills and those with continuing complex mental health (and other) needs including those with severe enduring mental illness, personality disorders, challenging or offending behaviours, autism, dementia, complex genetic and neuropsychiatric disorders including epilepsy. Given the important role that mental health services play in the lives of many people with learning disabilities, it is essential that they, along with their partners in social and independent sector services, take up and adapt the principles of Recovery in the development of their services and practice.

In some localities, people with learning difficulties and mental health needs access mainstream and specialist mental health services with varying degrees of social and service inclusion planning, facilitation or joint working with learning difficulty services. Examples of these include service users with borderline or mild learning difficulties and co-morbidities such as major mental health problems, Asperger's syndrome, ADHD, alcohol and substance misuse, early onset dementias, and head injuries with or without challenging and offending behaviours.

The problem of access to basic services, especially main stream services, is particularly pertinent for people with learning disabilities. O'Brien (1989) highlighted the difficulties experienced in achieving and sustaining social inclusion, suggesting that prejudice towards people with severe disabilities is perpetuated by their exclusion from “ordinary classrooms, workplaces and homes”. In what have come to be known as *O’Brien’s five accomplishments*, he defines the quality of supported lives of people with learning disabilities in relation to valued inclusive experiences of growing in relationships, contributing, making choices, having the dignity of valued social roles, and sharing ordinary places and environments. These accomplishments are phrased in terms of exclusion, rather than inclusion, and each accomplishment is seen as “challeng(ing) and strengthen(ing) the relationship between people with disabilities and other community members” (O’Brien, 1989).

If Recovery is about having a satisfying and fulfilling life *as defined by each person* then it has the same relevance to those using and working in Learning Disability services as it does for mainstream mental health services. Learning disability includes the presence of significantly reduced ability to understand new or complex information or to learn new skills with a reduced ability to cope independently. It is a life-long condition in which the person needs extra help to maximise their abilities and access opportunities. Nonetheless, people with learning disabilities can lead full and rewarding lives (as many already do) but others find themselves socially excluded due to stigmatisation and the subsequent discrimination.

For people with learning disabilities a full clinical recovery may not always be achievable. The principles of Recovery recognise service users as experts in their own conditions and the emphasis is not just on the clinical recovery but on what happens in the wider part of their lives. The potential benefits for the individual are to improve their social outcomes in terms of employment, to strengthen their social network and relationship with the wider society. The economic benefits may be in keeping service users less in need of mental health services and increasing their opportunities for paid employment. Recovery means not necessarily a change in service but a change in our practice of working in partnership with service users to improve both their clinical and social outcomes. In order to support the Recovery of service users, mental health practitioners must work much more in partnership with the wider community services and networks.

The three core concepts of Recovery provide an ideal summary of principles for people with learning disabilities.

Hope

Hope and motivation to achieve more fulfilling lives is crucial to the well-being of service users with learning disabilities including those making the Recovery from severe mental ill-health and it is essential for their families and carers. The personal qualities of staff are important in encouraging a positive approach and working together as partners in the service user’s Recovery.

Agency

Advocacy and self empowerment have grown in the lives of people with learning disabilities and have become more evident over recent years so giving people with learning disabilities more control over their daily lives with increased independence and choice. The involvement of service users and carers in the delivery and planning of services has increased, for example, through local partnership boards (Department of Health, 2001; 2009). The personalisation agenda is increasingly being incorporated into services for people with learning disabilities for example through a *person centred approach* looking to improve outcomes in terms of social inclusion, empowerment and equality.

People with learning disabilities require greater control of their lives, improved access to health care and to have more fulfilled lives in their local community including friendships and relationships. Presently, less than 10% of people with learning disabilities have jobs.

Opportunity

A strong values base related to social inclusion has underpinned service development for people with learning disabilities over the past 30 years. People with learning disabilities have rights as citizens; they want to participate in their local communities, to have choices in daily life and to experience real chances for independence. They require access to appropriate mainstream primary and secondary physical and mental health care. Health and Social care and other services should be determined through principles and approaches which are needs-led and patient-centred in a multi-professional and inter-agency manner.

The opportunity to have more socially inclusive lives will require support to service users but also a recognition that we need to challenge the beliefs of wider society. Recovery for people with learning disabilities will need to emphasise the importance of relationships, access to a diverse range of social and leisure activities and opportunities for fulfilling occupational lives.

The ideas of Recovery are key to improving the life chances of people with learning disabilities by promoting social inclusion with the ideas of agency and opportunity being essential to achieving better outcomes for people with learning disabilities and severe mental ill-health.

REFERENCES

Adams, T. (2010) The applicability of a recovery approach to nursing people with dementia. *International Journal of Nursing Studies* (in press).

Andresen, R., Caputi, P., Oades, I. (2006) Stages of Recovery instrument: development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry*, 40, 972–980.

Anthony, W.A. (1993) recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal* 16, 11-23.

Ashcraft, L. & Anthony, W.A. (2005) A Story of Transformation: An Agency Fully Embraces Recovery. *Behavioural Healthcare Tomorrow,* 14**,** 12–22.

Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES - A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer. *Oncologist, 5*(4), 302-311.

Betty Ford Institute Consensus Panel (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment* 33, 221-228

Brooker, D. (2007) *Person-centred dementia care: Making services better*. London: Jessica Kingsley Publishers.

Care Services Improvement Partnership (2005) *Everybody's Business. Integrated mental health service for older adults: a service development guide*. London: CSIP

Chinman, M., Lucksted,A., Gresen, R., Davis, M., Losonczy, M., Sussner, B. & Martone, L. (2008) Early Experiences of Employing Consumer-Providers in the VA. *Psychiatric Services*, 59, 1315-1321.

Cleary, M., Hunt, G. E., & Horsfall, J. (2009). Delivering Difficult News in Psychiatric Settings. *Harvard Review of Psychiatry* 17, 5, 315 - 321.

Commission for Social Care Inspection (CSCI) (2008) *See me, not just the dementia: Understanding people's experiences of living in a care home*. London: CSCI.

Cook, J. A., Copeland, M. E., Hamilton, M. M., Jonikas, J. A., Razzano, L. A., Floyd, C. B., et al. (2009). Initial Outcomes of a Mental Illness Self-Management Program Based on Wellness Recovery Action Planning. *Psychiatric Services, 60*(2), 246-249.

Craig, T.J.K.. (2008) Recovery: Say what you mean and mean what you say. *Journal of Mental Health* 17, 2, 125-128.

Davidson, I., O'Connell, M., Tondora, J. et al. (2006) The ten top concerns about recovery encountered in mental health system transformation. *Psychiatric Services*, 57, 640–645.

Deegan, P.E. & Drake, R.E. (2006) Shared Decision Making and Medication Management in the Recovery Process. *Psychiatric Services* 57, 1636-1639.

Department for Education and Skills (2003) *Every Child Matters. The National Service Framework for Children and Young People*, London: DfES

Department of Health (2001) *The National Service Framework for Older People: modern standards and service models.* London: Department of Health.

Department of Health (2001) *The Expert Patient: A new approach to chronic disease management for the 21st century*. London: Department of Health.

Department of Health. (2001). *A New Strategy for Learning Disability for the 21st Century*. The Stationery Office, London.

Department of Health (2005) *Valuing People: the story so far… A new strategy for Learning Disability for the 21st Century – Long Report*. London: Department of Health

Department of Health (2007a) *Capabilities for Inclusive Practice*. London: Department of Health. (www.socialinclusion.org.uk).

Department of Health (2007b) *Mental Health: New ways of working for everyone, Progress report.* London: Department of Health.

Department of Health. (2009). *Valuing People Now: A New Three-Year Strategy for people with learning disabilities.* The Stationery Office, London.

Department of Health (2010) *Equity and Excellence: Liberating the NHS*. The Stationery Office, Norwich.

Dunn, S. (1999) *Creating Accepting Communities. Report of the Mind Inquiry into social exclusion and mental health problems*. London: Mind.

Faulkner, A. (1998) *When the news is bad: A guide for health professionals*. Cheltenham: Stanley Thornes Ltd.

Glendinning, C., Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008) *Evaluation of the Individual Budgets Pilot Programme: Final Report*. York: Social Policy Research Unit, University of York.

Goffman, E. (1974) *Stigma: Notes on the Management of Spoiled Identity*. Penguin, Harmondsworth

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K. & Szmukler, G. (2004) Effect of joint crisis plans on use of compulsory treatment in psychiatry: a single blind randomised controlled trial. *British Medical Journal*, **329**, 136 - 138.

Henderson, C., Flood, C., Leese, M., Thornicroft, G., Sutherby, K. & Szmukler, G. (2008) Views of service users and providers on joint crisis plans. *Social Psychiatry Psychiatric Epidemiology*. Published online 4 October 2008. DOI 10.1007/s00127-008-0442-x

Hill, L. Roberts, G., Wildgoose, J., Hahn, S., Perkins, R., (2010) Recovery and person-centred care in dementia: common purpose, common practice? *Advances in Psychiatric Treatment*, 16, 288-298.

HM Government. (2009). *New Horizons: A shared vision for mental health*. London: Department of Health.

Kitwood,T., (1997) Dementia Reconsidered. Oxford: Oxford University Press.

Lawn, S., Battersby, M. W., Pols, R. G., Lawrence, J., Parry, T., & Urukalo, M. (2007). The Mental Health Expert Patient: Findings from a Pilot Study of a Generic Chronic Condition Self-Management Programme for People with Mental Illness. *International Journal of Social Psychiatry, 53*(1), 63-74.

Marsden J, Farrell M, Bradbury C, Dale-Perera A, Eastwood B, Roxburgh M & Taylor S (2008). Development of the treatment outcomes profile. *Addiction* 103 (9): 1450 – 1460

McCormack, B. (2004) Person-centredness in gerontological nursing: an overview of the literature, *Journal of Clinical Nursing*, 13, 3a, 31-38.

Mueser, K.T., Corrigan, P.W., Hilton, D.W. Tanzman, B., Schaub, A., Gingerich, S., Essock, S.M., Tarrier, N., Morey, B., Vogel-Scibilia, S. & Herz, M.I. (2002) Illness, Management and Recovery: A Review of the Research, *Psychiatric Services*, **53**, 1272-1284.

Mitcheson, L. (2009) mapping the routes to recovery. NTA resources to support psychosocial interventions. Presentation: drugs and alcohol today exhibition. Found at www.nta.nhs.uk/areas/workforce/docs/Drugs_and_alcohol_today_mapping_routes_to_recovery.ppt#258,1,Mapping the Routes to Recovery: NTA resources to support implementation of psychosocial interventions. Accessed 5th January 2010

National Institute for Mental Health in England (2004) *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce*. London: Department of Health.

National Treatment Agency (2009). Routes to recovery: ITEP and BTEI new approaches to psychosocial intervention. London: NTA.

National Treatment Agency (2010). Commissioning for Recovery. London: NTA.

Newman, T. (2002) *Promoting resilience: A Review of Effective Strategies for Child Care Services*. Centre for Evidence-Based Social Services, University of Exeter: Barnardo's.

Ng, R.M.K., Pearson, V., & Chen, E.Y.H. (2008). What does recovery from schizophrenia mean? Perceptions of psychiatrists. *International Journal of Culture and Mental Health* 1(1), 73-84.

O'Brien, J. (1989) *What's worth working for? Leadership for better quality human services.* Lithonia, Georgia: Responsive systems associates, Inc.

Paccaloni M, Moretti F, Zimmermann C (2005) Giving information and involving in treatment: what do psychiatrists think? A review. *Epidemiologia e psichiatria sociale* 14:198–216.

Petry, N.M. (2000). A comprehensive guide for the application of contingency management procedures in standard clinic settings. *Drug & Alcohol Dependence* 58; 9-25.

Project Match Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH Post-treatment drinking outcomes. *Journal of Studies on Alcohol 58*(1), 7-29.

Repper, J. & Perkins, R. (2003) *Social Inclusion and Recovery. A Model for Mental Health Practice.* London: Balliere Tindall.

Rinaldi, M. (2009) *Peer support specialists within mental health services: A brief review*. London: South West London & St George's Mental Health NHS Trust.

Rinaldi, M. (2002). Manic Depression and Self Management. In R. Ramsey, Page, A., Goodman, T. & Hart, D. (Ed.), *Changing Minds: Our Lives and Mental Illness*. London: Gaskell.

Roberts, G. & Hollins, S. (2007) Recovery: our common purpose? *Advances in Psychiatric Treatment*, 13, 397-399.

Roberts, G. & Wolfson, P. (2004) The rediscovery of recovery: open to all. *Advances in Psychiatric Treatment* 10, 37–49

Roberts, G., Dorkins, E., Wooldridge, J., Hewis, E. (2008) Detained – what's my choice? *Advances in Psychiatric Treatment*, 14, 172 – 180.

Rogers, CR. (1951) *Client-centred Therapy – Its current Practices, Implications and Theory*. Boston: Houghton Mifflin.

Royal College of Psychiatrists (2008a) *Rethinking risk to others in mental health services*. College Report 150. London: Royal College of Psychiatrists.

Royal College of Psychiatrists, Mental Health Network, NHS Confederation & London School of Economics and Political Science (2009) *Mental health and the economic downturn. National priorities and NHS solutions*. Occasional Paper OP70 London: Royal College of Psychiatrists.

Sainsbury Centre for Mental Health (2009) *Implementing Recovery. A new framework for organisational change*. Position Paper. London: Sainsbury Centre for Mental Health.

Sainsbury Centre for Mental Health (2009c) *Commissioning what Works: The economic and financial case for supported employment. Briefing paper 41.* London: The Sainsbury Centre for Mental Health.

Shepherd, G., Boardman, J., & Slade, M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Shepherd, G., Boardman, J. & Burns, M. (2010) *Implementing Recovery. A methodology for organisational change*. London: Sainsbury Centre for Mental Health.

Simon, D., Willis, C.E. & Harter, M. (2009) Shared decision-making in mental health. In A. Edwards & G.Elwyn (Eds.) *Shared decision-making in health care: Achieving evidence-based patient choice* (2nd edition pp.269-276). Oxford: Oxford University Press.

Slade, M. (2009) *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*. Cambridge: Cambridge University Press.

Social Care Institute for Excellence (SCIE) (2006) Practice Guide 2: Assessing the mental health needs of older people.

Steindler, M.S. (1998). Addiction Terminology. (In A.W Graham, T.K. Schultz & B.B. Wilford (Eds) *Principles of addiction medicine* (pp1301- 1304) 2nd ed. Chevy Chase, MD: American Society of Addiction medicine, Inc.

Wagner, E.H., Austin, B.T., Davis, C. et al (2001) Improving chronic illness care: translating evidence into action. *Health Affairs (Milwood)* 20, 64-78.

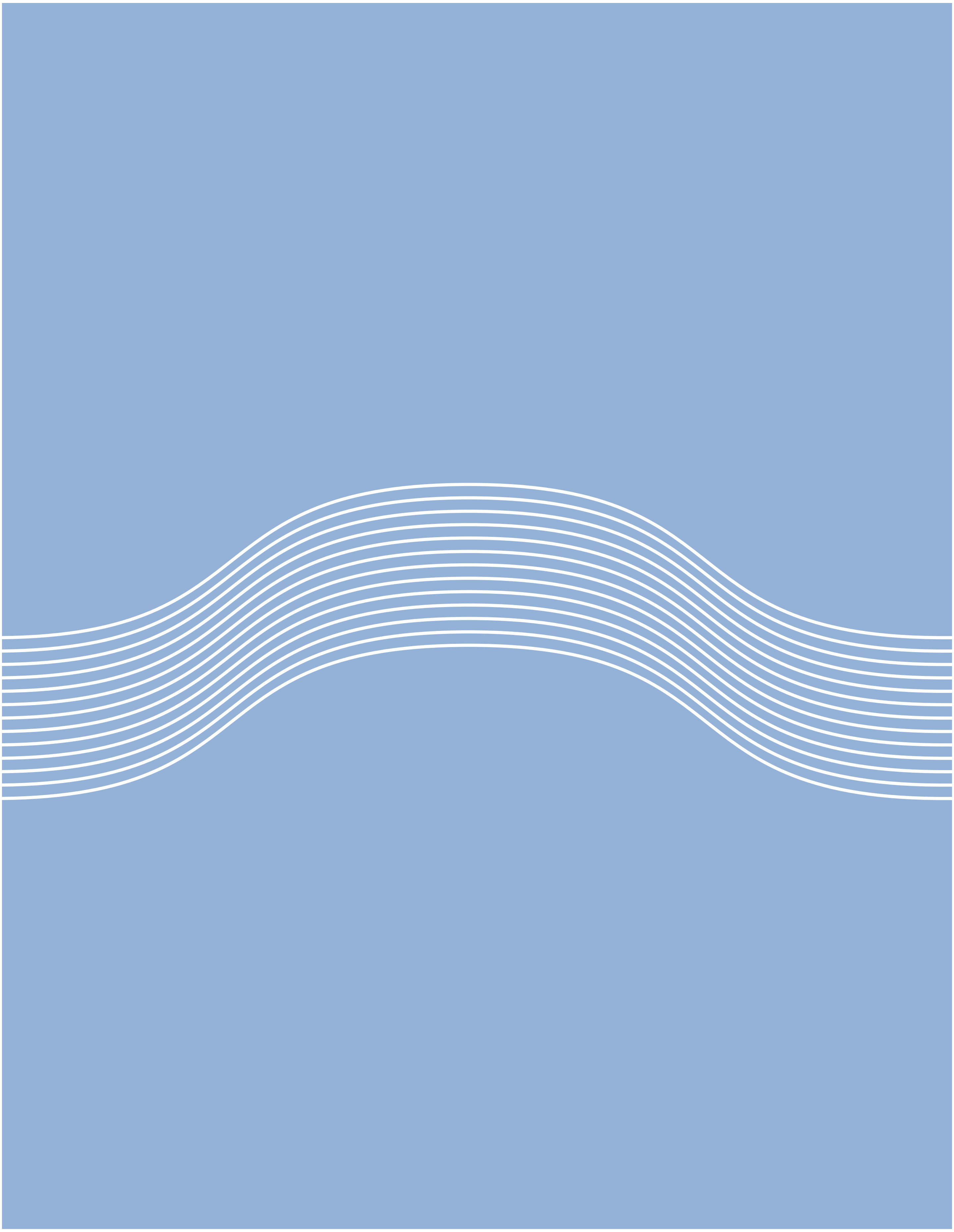
Warner, R. (2009) Recovery from Schizophrenia and the Recovery Model. *Current Opinion in Psychiatry* 22, 374 – 380.

Warner, R. (2010) Does the scientific evidence support the recovery model. *The Psychiatrist* 34, 3-5.

White, W. L. (2007) Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment* 33, 229-241.

Wolfensberger, W. (1972) *The principle of Normalization in human services*. Toronto: National Instititute on Mental Retardation.

Wolfensberger, W. (1983) Social role valorisation: A proposed new term for the principle of normalization. *Mental Retardation*, 21(6), 234-239.



Department of Health

Transforming care:

A national response to Winterbourne View Hospital

Department of Health Review:
Final Report

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	For Information
Gateway Reference	18348
Title	Transforming care: A national response to Winterbourne View Hospital: Department of Health Review Final Report
Author	Department of Health
Publication Date	**December 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, GPs, Directors of Children's SSs
Circulation List	Medical Directors, PCT PEC Chairs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, Communications Leads, Emergency Care Leads, Voluntary Organisations/NDPBs
Description	The report sets out the governments final response to the events at Winterbourne View hospital. It sets out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging.
Cross Ref	Department of Health Review: Winterbourne View Hospital: Interim Report Winterbourne View Review: Concordat: A Programme of Action
Superseded Docs	N/A
Action Required	N/A
Timing	**N/A**
Contact Details	Mental Health, Disability and Equality Department of Health Room 313A Richmond House 79 Whitehall SW1A 2NS
For Recipient's Use	

Transforming care: A National response to Winterbourne View Hospital

Department of Health Review: Final Report

Contents

Ministerial Foreword

The scandal that unfolded at Winterbourne View is devastating.

Like many, I have felt shock, anger, dismay and deep regret that vulnerable people were able to be treated in such an unacceptable way, and that the serious concerns raised by their families were ignored by the authorities for so long.

This in-depth review, set up in the immediate aftermath of the Panorama programme in May 2011, is about the lessons we must learn and the actions we must take to prevent abuse from happening again.

It is also about promoting a culture and a way of working that actively challenges poor practice and promotes compassionate care across the system.

First and foremost, where serious abuse happens, there should be serious consequences for those responsible.

At Winterbourne View, the staff had committed criminal acts, and six were imprisoned as a result. However, the Serious Case Review showed a wider catalogue of failings at all levels, both from the operating company and across the wider system.

When failure occurs, repercussions should be felt at all levels of an organisation. Through proposed changes to the regulatory framework, we will send a clear message to owners, Directors and Board members: the care and welfare of residents is your active responsibility, so expect to be held to account if abuse or neglect takes place.

Yet Winterbourne View also exposed some wider issues in the care system.

There are far too many people with learning disabilities or autism staying too long in hospital or residential homes, and even though many are receiving good care in these settings, many should not be there and could lead happier lives elsewhere. This practice must end.

We should no more tolerate people being placed in inappropriate care settings than we would people receiving the wrong cancer treatment. That is why I am asking councils and clinical commissioning groups to put this right as a matter of urgency.

Equally, we should remember that not everything will be solved through action driven from the centre. Stories of poor care are a betrayal of the thousands of care workers doing extraordinary things to support and improve people’s lives.

And while stronger regulation and inspection, quality information and clearer accountability are vital, so too is developing a supportive, open and positive culture in our care system.

I want staff to feel able to speak out when they see poor care taking place as well as getting the training and support they need to deal with the complex and challenging dilemmas they often face.

For me, this is the bigger leadership and cultural challenge that this scandal has exposed – and answering it will mean listening and involving people with learning disabilities and their families more than ever before.

As much as Winterbourne View fills us all with sorrow and anger, it should also fire us up to pursue real change and improvement in the future. It is a national imperative that there is a fundamental culture change so that those with learning disabilities or autism have exactly the same rights as anyone else to the best possible care and support. This Review is a key part of making that happen.

NORMAN LAMB
Minister of State for Care and Support

Joint Foreword

This report lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. Our shared objective is to see the health and care system get to grips with past failings by listening to this very vulnerable group of people and their families, meeting their needs, and working together to commission the range of services and support which will enable them to lead fulfilling and safe lives in their communities.

The Concordat which accompanies this report sets out our commitment to work together, with individuals and families, and with the groups which represent them, to deliver real change, improve quality of care and ensure better outcomes. Together we will set the strategic direction and measure progress. This requires real system leadership across all sectors, including elected councillors as well as across health and care to reduce inequalities.

The new health and care system brings a greater opportunity for people to work together more creatively to develop local innovative solutions. We commit to doing this.

	Sarah Pickup	
Sir David Nicholson KCB CBE	Sarah Pickup	Councillor David Rogers
Chief Executive **NHS Commissioning Board**	President **Association of Directors of Adult Social Services**	Chair, Community Wellbeing Board **Local Government Association**

Executive summary

1. The abuse revealed at Winterbourne View hospital was criminal. Staff whose job was to care for and help people instead routinely mistreated and abused them. Its management allowed a culture of abuse to flourish. Warning signs were not picked up or acted on by health or local authorities, and concerns raised by a whistleblower went unheeded. The fact that it took a television documentary to raise the alarm was itself a mark of failings in the system.

2. This report sets out steps to respond to those failings, including tightening up the accountability of management and corporate boards for what goes on in their organisations. Though individual members of staff at Winterbourne View have been convicted, this case has revealed weaknesses in the system's ability to hold the leaders of care organisations to account. This is a gap in the care regulatory framework which the Government is committed to address.

3. The abuse in Winterbourne View is only part of the story. Many of the actions in this report cover the wider issue of how we care for children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging.

4. CQC's inspections of nearly 150 other hospitals and care homes have not found abuse and neglect like that at Winterbourne View. However, many of the people in Winterbourne View should not have been there in the first place, and in this regard the story is the same across England. Many people are in hospital who don't need to be there, and many stay there for far too long – sometimes for years.

5. The review has highlighted a widespread failure to design, commission and provide services which give people the support they need close to home, and which are in line with well established best practice. Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals.

6. For many people however, even the best hospital care will not be appropriate care. People with learning disabilities or autism may sometimes need hospital care but hospitals are not where people should live. Too many people with learning disabilities or autism are doing just that.

7. This is the wider scandal that Winterbourne View revealed. We should no more tolerate people with learning disabilities or autism being given the wrong care than we would accept the wrong treatment being given for cancer.

8. Children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging can be, and have a right to be, given the support and care they need in a community-based setting, near to family and friends. Closed institutions, with people far from home and family, deny people the right care and present the risk of poor care and abuse.

9. The Department of Health review drew on:

   - a criminal investigation with 11 individuals prosecuted and sentenced;
   - the Care Quality Commission review of all services operated by Castlebeck Care, the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes;
   - the NHS South of England reviews of serious untoward incident reports and the commissioning of places at Winterbourne View hospital;
   - an independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012; and
   - the experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.

10. An interim report was published on 25 June 2012. This final report of the review can be published now that the criminal proceedings have concluded.

Programme of Action

11. This report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

12. The Government's Mandate to the NHS Commissioning Board[1] says:

    "The NHS Commissioning Board's **objective** is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people." (para 4.5)

13. We expect to see a fundamental change. This requires actions by many organisations including government. In summary, this means:

    - all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014;
    - by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning

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[1] http://www.dh.gov.uk/health/2012/11/nhs-mandate/

disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out at **Annex A**;
- as a consequence, there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals;
- a new NHS and local government-led joint improvement team, with funding from the Department of Health, will be created to lead and support this transformation;
- we will strengthen accountability of Boards of Directors and Managers for the safety and quality of care which their organisations provide, setting out proposals during Spring 2013 to close this gap;
- CQC will strengthen inspections and regulation of hospitals and care homes for this group of people. This will include unannounced inspections involving people who use services and their families, and steps to ensure that services are in line with the agreed model of care; and
- with the improvement team we will monitor and report on progress nationally.

14. A full account of these actions, together with a range of further actions to support improvement of services – including, for instance, steps to improve workforce skills, and strengthening safeguarding arrangements – is set out in Parts 4-8. A timeline of the detailed actions is at **Annex B**.

15. Alongside this report, we are publishing a **Concordat** agreed with key external partners. It sets out a shared commitment to transform services, and specific actions which individual partners will deliver to make real change in the care and support for people with learning disabilities or autism with mental health conditions or behaviour that challenges.

16. This report focuses on the need for change, but there are places which already get this right. This shows that the change we intend to make is achievable. Alongside this report, we are publishing examples of good practice which demonstrate what can – and should be – done for all.

Part 1: Introduction

1.1 This Department of Health review responds to criminal abuse at Winterbourne View hospital revealed by the BBC Panorama programme in May 2011. It is equally concerned with the care and support experienced by all children, young people and adults with learning disabilities or autism who also have mental health conditions or behave in ways that are often described as challenging. For the purposes of this report, we describe this vulnerable group of people as “people with challenging behaviour”.

1.2 There are currently an estimated 3,400 people in NHS-funded learning disability inpatient beds of which around 1,200 are in assessment and treatment units (usually known as A&T units)[2].

1.3 This report builds on the evidence and issues set out in the interim report published in June 2012[3].

1.4 The picture from investigations and reviews, and from people who use services, their families, and the groups which represent them[4] is of good services in some places, but too often they fall short. Too many people do not receive good quality care. The review found widespread poor service design, failure of commissioning, failure to transform services in line with established good practice[5], and failure to develop local services and expertise to provide a person-centred and multidisciplinary approach to care and support.

1.5 Starting now and by June 2014, we must – and we will – transform the way services are commissioned and delivered to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support for all people with challenging behaviour.

1.6 This is not easy. Developing the right range of services locally to build up necessary expertise is a complex task – though that will be made easier with pooled budgets. But there is clear – and readily available – guidance and evidence for what works[6]. That guidance has been available for years. There are no excuses for local health and care

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[2] There is poor quality data about the numbers of people with challenging behaviour. In the interim report we focused on the 1,200 beds in A&T units in the CQC Count me in Census 2010. In this report we have used the larger estimate of 3,400 people in NHS funded inpatient beds (from the same census). This is because some people may be in rehabilitation or other types of unit which provide A&T services and we also want to avoid inpatient services simply re-badging themselves.

[3] *Department of Health Review: Winterbourne View Hospital:Interim Report Interim Report:* (June 2012) http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[4] see summaries of engagement with people with learning disabilities and families published alongside this report at www.dh.gov.uk/learningdisabilities

[5] see *Services for People with Learning disability and challenging behaviour or mental health needs* 2007, Prof Jim Mansell. http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicandgudiance/dh_080129

[6] see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129 Examples of good practice are published at http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

commissioners failing to come together to commission and design the services which will enable most people to live safely with support in their communities and prevent unnecessary admissions to hospital. There are no excuses for continuing to commission the wrong model of care.

1.7 The programme for change described below draws on actions in the interim report[7] to which external delivery partners have already committed. A more detailed action plan will be agreed and monitored by the national Learning Disability Programme Board chaired by the Minister of State for Care and Support. The Board will measure progress against milestones, monitor risks to delivery, and challenge partners, to ensure all of these commitments are delivered.

1.8 In addition to this monitoring, the Department of Health will publish a progress report in one year, and again as soon as possible following 1 June 2014, to ensure that the steps set out in this report are achieved.

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[7] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

Part 2: Winterbourne View hospital

2.1 When the interim report of this review was published in June, we were unable to comment on what happened in Winterbourne View hospital as criminal proceedings against former members of staff had not completed. Subsequently, all 11 individuals charged have pleaded guilty to all charges and have been sentenced (with custodial sentences for six former staff). The Crown Prosecution Service treated these offences as disability hate crimes, crimes based on ignorance, prejudice and hate, and brought this aggravating factor to the attention of the court in sentencing.

2.2 We now have a very detailed and compelling picture of the serious abuse suffered by patients at Winterbourne View hospital and the systematic way in which staff abused patients and misused restraint as punishment for what staff saw as bad behaviour.

2.3 The Serious Case Review (SCR) commissioned by South Gloucestershire Council Adult Safeguarding Board published on 7 August 2012 gives a compelling and comprehensive chronology of events at the hospital and we do not intend to duplicate that here.[8]

2.4 But now we have that picture, along with other reports shared as evidence to the SCR including reports from the police, the CQC, and the review by NHS South of England of commissioning of services at Winterbourne View hospital, we are able to draw firm conclusions about what went wrong.

2.5 Opened in December 2006, Winterbourne View was a private hospital owned and operated by Castlebeck Care Limited. It was designed to accommodate 24 patients in two separate wards and was registered as a hospital with the stated purpose of providing assessment and treatment and rehabilitation for people with learning disabilities. By the time the hospital was closed in June 2011, the majority of patients (73%) had been admitted to the hospital under Mental Health Act powers. Although thirteen were informal patients at admission, six of these were then detained under Mental Health Act powers after admission. On average, it cost £3,500 per week to place a patient in Winterbourne View.

2.6 Forty-eight patients had been referred to Winterbourne View by 14 different English NHS commissioners (there had also been a few placements from Wales); meaning that there was no one commissioner with a lead or strong relationship with the hospital. Similarly, South Gloucestershire Council, in whose area the hospital was located, was not party to the majority of referrals to Winterbourne View hospital.

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[8] South Gloucestershire Safeguarding Adults Board *Winterbourne View Hospital: A Serious Case Review* by Margaret Flynn (2012) http://www.southglos.gov.uk/Pages/Article%20Pages/Community%20Care%20-%20Housing/Older%20and%20disabled%20people/Winterbourne-View-11204.aspx

2.7 This also meant that although a significant minority of patients were local to the hospital **almost half of the patients at Winterbourne View were placed far away from their homes**. Of 48 patients:

- 13 were referred by commissioners located within 20 miles;
- a further 12 patients were referred by commissioners between 20 and 40 miles away;
- 14 patients were referred by commissioners between 40 and 120 miles away; and
- 9 patients were referred by commissioners more than 120 miles away.

2.8 For just under half of the people in Winterbourne View, the main reason for referral was management of a crisis – suggesting a real lack of planning for crises or local responsive services for people with this type of support need.

2.9 **People were staying at Winterbourne View hospital for lengthy periods**. The average length of stay at Winterbourne View was around 19 months but some patients had been there more than three years when the hospital closed – and this in a hospital which was open for less than five years.

2.10 There is little evidence of urgency in considering discharge and move-on plans for Winterbourne View patients. It is worth noting for instance that 10 patients detained under Mental Health Act powers remained in Winterbourne View after their period of detention ended – in one case for a further 18 months.

2.11 One of the most striking issues is the **very high number of recorded physical interventions** at Winterbourne View (ie of patients being physically held to prevent danger to themselves or others). The Serious Case Review notes that Castlebeck Care Ltd recorded a total of 558 physical interventions between 2010 and the first quarter of 2011, an average of over 1.2 physical interventions per day. One family provided evidence that their son was restrained 45 times in 5 months, and on one occasion was restrained “on and off” all day. It is very difficult to see how such high numbers of interventions could possibly be seen as normal.

2.12 Opportunities to pick up poor quality of care were repeatedly missed by multiple agencies. For instance:

- Winterbourne View patients attended NHS Accident and Emergency services on 78 occasions while Winterbourne View was open but there was no process in place for linking these so that an overall picture emerged;
- Between January 2008 and May 2011 police were involved in 29 incidents concerning Winterbourne View patients;
- Between January 2008 and May 2011, 40 safeguarding alerts were made to South Gloucestershire Council but these were treated as separate incidents. 27 were allegations of staff to patient assaults, 10 were patient on patient assaults and three were family related incidents.

2.13 The Serious Case Review provides evidence **of poor quality healthcare**, with routine healthcare needs not being attended to – for instance there were widespread dental problems and "most patients were plagued by constipation". Many patients were being given anti-psychotic and anti-depressant drugs without a consistent prescribing policy.

2.14 The Serious Case Review also sets out very clearly that for a substantial portion of the time in which Winterbourne View operated, families and other visitors were not allowed access to the wards or individual patients' bedrooms. This meant there was very little opportunity for outsiders to observe daily living in the hospital and enabled a **closed and punitive culture to develop on the top floor of the hospital**. Patients had limited access to advocacy and complaints were not dealt with.

2.15 There is strong and compelling evidence of **real management failure at the hospital.** The Serious Case Review says that on paper Castlebeck's policies, procedures, operational practices and clinical governance were impressive. The reality was very different:

- for much of the period in which Winterbourne View operated, there was **no Registered Manager** (even though that is a registration requirement);
- approaches to staff recruitment and training did not demonstrate a strong focus on quality. For example, staff job descriptions did not highlight desirability of experience in working with people with learning disabilities or autism and challenging behaviour – nor did job descriptions make any reference to the stated purpose of the hospital;
- there is little evidence of staff training in anything other than in restraint practices;
- although structurally a learning disability nurse-led organisation, it is clear that Winterbourne View had, by the time of filming by Panorama, become dominated to all intents and purposes by support workers rather than nurses**;** and
- there was very high staff turnover and sickness absence among the staff employed at the hospital.

2.16 All this suggests **that managers at the hospital and the parent company, as well as commissioners, regulators and adult safeguarding, had a number of opportunities to pick up indications that there were real problems at Winterbourne View, but failed to do so.**

2.17 The very high number of recorded restraints, high staff turnover, low levels of training undertaken by staff, the high number of safeguarding incidents and allegations of abuse by staff – all could have been followed up by the **hospital itself or by Castlebeck Care Ltd,** but were not to any meaningful extent. This failure by the provider to focus on clinical governance or key quality markers is striking, and a sign of an unacceptable breakdown in management and oversight within the company.

2.18 Equally it is striking that **adult safeguarding** systems failed to link together the information. NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts – some commissioners were aware of concerns – and failures to follow up concerns when commissioners became aware of them.

2.19 Despite the high cost of places at Winterbourne View (on average £3,500 per week) **commissioners** do not seem to have focused much on quality, or on monitoring how the hospital was providing services in line with its registered purpose – ie. assessing the needs of individuals and promoting their rehabilitation back home. The lack of any substantial evidence that people had meaningful activity to do in the day, the way in which access by outsiders to wards was restricted, reports of safeguarding alerts (where these were shared with commissioners) should have been followed up rigorously, but were not. **This amounts to a serious failure of commissioning**.

2.20 The **CQC** acknowledged that they did not respond to the Winterbourne View hospital whistleblower and that neither they nor their predecessor organisations followed up on the outcomes of statutory notifications – and clearly failed to enforce the requirement for there to be a registered manager.

2.21 The **Mental Health Act Commissioner** was notified on more than one occasion of incidents, and in its annual report in May 2008 referenced the need for action to improve – but it was not followed up.

2.22 The **Police** have acknowledged that they took explanations from staff at face value. Avon and Somerset Constabulary police were involved in 29 incidents concerning Winterbourne View patients. Eight of the reported incidents were associated with staff using physical restraint on patients. The Police secured the successful prosecution of one member of staff prior to the Panorama programme.

What happened to people at Winterbourne View

2.23 Patients at Winterbourne View hospital were subject to horrific and sustained abuse, ill-treatment and neglect. The Serious Case Review has thrown down a challenge to health and social care commissioners to ensure that the individual patients and their families get the support they need to recover from their experience. The Department of Health supports that challenge.

> *Out of Sight: Stopping the abuse of people with a learning disability pr*ovides an update on what happened to Simon, one of the patients at Winterbourne View.
>
> Simon's Mum said:
> *Simon is now back living near us, and he is loving every minute of his life. He is at the same residential care home he was in before he was sent away, but the service has been adapted so that it meets his needs. They have done this by developing a flat for him adjoining the care home, where he lives with his support team. It is his own space, an oasis of quiet and calm.'*
>
> *Simon's package of care now costs about half as much as it did for him to be in Winterbourne View. The staff he has now have been wonderful and are truly dedicated. I know that not only is Simon happy, he is safe."*

2.24 But we know that not every one who was at Winterbourne View has had the same experience as Simon. Indeed, the second Panorama programme broadcast on 29 October 2012 showed that some others who had suffered abuse have continued to be moved to hospitals far from home.

2.25 DH asked NHS South of England to coordinate follow up on what happened to the 48 English NHS patients who had been in Winterbourne View hospital. In March 2012:

- 26 former patients had moved into a range of social care supported arrangements and 22 patients were in various inpatient facilities;
- 19 had been subject to a safeguarding alert in their new location;

- 27 people had required support related to the trauma experienced at Winterbourne View hospital.

2.26 This exercise was repeated in September 2012. At that point:

- Additional hospital discharges had taken place with 32 former patients in a range of social care settings and 16 patients in inpatient setting.
- there were initial safeguarding alerts or active safeguarding procedures for six people at the time of the exercise.

2.27 Whilst one cannot generalise from such a small group of patients, the fact that two thirds of those in Winterbourne View are now in social care supported arrangements gives a strong indication of what is possible.

2.28 DH will continue to seek assurance about what has happened to this group of people.

Part 3: The picture beyond Winterbourne View

3.1 The events at Winterbourne View triggered a wider review of care across England for people with challenging behaviour. This included a programme of CQC inspections of nearly 150 learning disability services[9] together with engagement by the Department of Health to seek the experiences and views of people with learning disabilities and people with autism – some of whom had experienced care in hospital settings – as well as families, organisations who represent the interests of this group of people, professionals and providers.

3.2 The interim report of the Department of Health review published in June 2012[10] set out the findings:

- too many people were placed in hospitals for assessment and treatment and staying there for too long;
- they were experiencing a model of care which went against published Government guidance that people should have access to the support and services they need locally, near to family and friends;
- there was widespread poor quality of care, poor care planning, lack of meaningful activities to do in the day and too much reliance on restraining people; and
- all parts of the system have a part to play in driving up standards.

3.3 The interim report identified concerns about the quality of person centred planning, involvement of people and families in developing their care plan, and in ensuring personalised care and support.

3.4 In addition, the interim report summarised published good practice guidance including the 1993 Mansell report, updated and revised in 2007[11], which emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs or challenging behaviour; and
- that services/support should be provided locally where possible.

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[9] The summary CQC report was published in June 2012. http://www.cqc.org.uk/public/reports-surveys-and-reviews/themed-inspections/review-learning-disability-services

[10] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[11] *Services for people with learning disabilities and challenging behaviour or mental health needs* October 2007, Professor Jim Mansell – see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

3.5 Three examples of good practice – Salford, Tower Hamlets and Cambridgeshire – were published alongside the interim report.[12]

3.6 As a first step to driving redesign, the interim report set out the model of care which practice demonstrates will give the best quality of life and support and improve outcomes. This is summarised in here and set out in detail at **Annex A.**

3.7 In summary, the norm should always be that children, young people and adults live in their own homes with the support they need for independent living within a safe environment. Evidence shows that community-based housing enables greater independence, inclusion and choice, and that challenging behaviour lessens with the right support. People with challenging behaviour benefit from personalised care, not large congregate settings[13]. Best practice is for children, young people and adults to live in small local community-based settings.

3.8 Where children, young people and adults need specialist support the default position should be to put this support into the person's home through specialist community teams and services, including crisis support.

- the individual and her/his family must be at the centre of all support - services designed around them and with their involvement, highly individualised and person-centred across health and social care (including access to personal budgets and personal health budgets where appropriate);
- people's homes should be in the community, supported by local services;
- people need holistic care throughout their life, starting in childhood;
- when someone needs additional support it should be provided as locally as possible; and
- when someone needs to be in hospital for a short period, this should be in small inpatient settings as near to their home as possible.

3.9 This means that people with challenging behaviour should only go into specialist hospital settings exceptionally and where there is good evidence that a hospital is the best setting to enable necessary assessment and treatment - not the only available placement. From the beginning, the reason for admission must be clearly stated and families should be involved in decision making. Where an individual lacks capacity and does not have a family to support them, the procedures of the Mental Capacity Act 2005 should be followed to ensure that decisions made are in her/his best interest and, if appropriate, an Independent Mental Capacity Advocate appointed.

3.10 Where someone is admitted to hospital the priority from the start should be rehabilitation and returning home. This requires a strong and continuing relationship between local commissioners and service providers and the hospital, focused on the individual patient's care plan, and a real effort to maintain links with their family and the home community. It also means for example, maintaining the person's tenancy of their home where relevant unless and until a more appropriate home in the community is found. Most of all, it is vital that families are involved in decision-making.

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[12] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

[13] NICE clinical guidelines for autism recommend that if residential care is needed for adults with autism it should usually be provided in small, local community-based units (of no more than six people and with well-supported single person accommodation).

3.11 Sending people out of area into hospital or large residential settings can cause real harm to individuals by weakening relationships with family and friends and taking them away from familiar places and community. It can damage continuity of care. It can also mean putting people into settings which they find stressful or frightening. This can damage mental health or increase the likelihood of challenging behaviour. There should always be clear and compelling reasons for sending any individual out of area. The individual and their family should always be involved and told these reasons. When this does happen, commissioners and the community team from the home area must keep in close contact with the individual and their family as well as the commissioner for the area where the individual is placed to assess progress and plan for their return to their own community.

Good Practice

The **Association of Supported Living** members contributed to a study on good commissioning in which they describe the ingredients to the successful outcomes they had achieved in moving people who at some point have been contained in institutions. Now everyone has a better life in community services which cost less. Prior to changes, costs ranged from £91,000 to £520,000 (for a private secure unit) per annum, following a move to supported living, high end costs reduced from £520,000 to £104,000 per annum.

3.12 The Government's Mandate to the NHS Commissioning Board makes clear that the presumption should always be that services are local and that people remain in their communities.

3.13 This model is achievable. It has been tried and tested and it works. The good practice examples published alongside the Interim Report are community-based and multidisciplinary. They can respond when someone presents with challenging behaviour, responding to that individual, their family, and care and support providers to seek explanations for the behaviour. That enables services working in partnership to develop interventions and support based on an understanding of the individual and their environment. Multidisciplinary approaches are essential because of the complexity of need and the way in which different perspectives contribute to agreeing appropriate interventions.

Part 4: The right care in the right place

4.1 A central part of our plan for action is to ensure that people with challenging behaviour only go into hospital if hospital care is genuinely the best option, and only stay in hospital for as long as it remains the best option. Our plan requires health and care partners to:

a. review all current placements, and support everyone inappropriately in hospital to move to community-based support;

b. in parallel, put in place a locally agreed joint plan to ensure high quality care and support services for all people with challenging behaviour that accord with the right model of care from childhood onwards; and

c. give national leadership and support for local change.

4.2 The patients at Winterbourne View were not listened to or believed when they told people about abuse. Their families were often not involved in decisions about where they were sent, parents and siblings found it increasingly difficult to visit and families' concerns and complaints often were not acted on. This failure to listen to people with challenging behaviour and their families is sadly a common experience and totally unacceptable. It leaves people feeling powerless.

4.3 We expect all actions in this programme to be appropriately informed by the views and needs of people with challenging behaviour and families in line with the NHS Constitution – which can mean providing appropriate advice, information and support. This will happen at all levels, locally and nationally:

- people with learning disabilities and families will be members of the Learning Disability Programme Board;
- CQC will involve self-advocates and families in inspections and in their stakeholder group;
- the NHSCB, LGA, and ADASS will involve them in planning and supporting changes in the way care is developed.

4.4 Changing attitudes to people with challenging behaviour is vital. Tackling disability hate crime is an issue the Department of Health takes very seriously. The Department is already taking steps to improve its understanding of disability hate crime and to deliver better outcomes for patients including those with learning disabilities.

4.a REVIEW ALL CURRENT PLACEMENTS AND SUPPORT EVERYONE INAPPROPRIATELY IN HOSPITAL TO MOVE TO COMMUNITY BASED SUPPORT

4.5 By 1 June 2014 we expect to see a rapid reduction in the number of people with challenging behaviour in hospitals or in large scale residential care - particularly those away from their home area. By that date, no-one should be inappropriately living in a hospital setting. This is a three stage process which involves:

- commissioners making sure they know who is in hospital and who is responsible for them;
- health and care commissioners working together and with partners to review the care people are receiving;
- commissioners working with individuals to agree personal care plans and bringing home or to appropriate community settings all those in hospital[14].

4.6 DH will closely monitor progress in bringing these numbers down. The Government's Mandate to the NHSCB emphasises the expectation for a substantial reduction in reliance on inpatient care for these groups of people.

4.7 Progress in this area will be dependent on developing the range of responsive local services which can prevent admissions to hospital or other large institutional settings and allow any existing patients to be moved to better settings, closer to home. This may involve better use of existing Mental Health services with the right reasonable adjustments, or the commissioning of new, smaller and more local inpatient units where they are needed. But the emphasis should be on designing community services in line with the best practice model. We would expect to see a dramatic and sustained reduction in the number of assessment and treatment units and beds as a result of this shift.

Agreeing who should be reviewed and who is responsible for them

4.8 Commissioners need to make sure they know who is in hospital and who is responsible for them.

Key Actions:

The NHS Commissioning Board will:

- **ensure by 1 April 2013 that all Primary Care Trusts develop local registers of all people with challenging behaviour in NHS-funded care;**

- **make clear to Clinical Commissioning Groups in their handover and legacy arrangements what is expected of them, including:**
    - **maintaining the local register from 1 April 2013; and**
    - **reviewing individuals' care with the Local Authority, including identifying who should be the first point of contact for each individual.**

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[14] For a very small number of people with complex needs, this can be a lengthy process. However, we expect this process to be carried out as quickly as possible. If, by this time, there are a very small number of cases where plans are agreed but not yet fully implemented, progress will be closely monitored.

Reviewing care and agreeing personal care plans

4.9 People should have the right care and support package to meet their individual needs. The care plans of all inpatients with challenging behaviour will be reviewed individually. Commissioners will assess whether they can create a better, community-based support package tailored as far as possible to each individual's needs.

4.10 People with challenging behaviours and their families will have the support they need to ensure they can take an active part in these reviews - being provided with information, advice and independent advocacy, including peer advocacy.

4.11 Personal care plans should be enacted swiftly and safely. In many instances this will require the development of more personalised services in different settings so that individuals can be better supported at home or in the community. Although doing this can take time, the Department of Health expects it to be carried out with pace and a sense of urgency – whilst always putting the interest of the individual first.

4.12 Where responsibility transfers from the NHS to local government, councils should not be financially disadvantaged. The NHS should agree locally how any new burden on local authorities will be met, whether through a transfer of funding or as part of a pooled budget arrangement.

Key Actions

By 1 June 2013, health and care commissioners, working with service providers, people who use services and families will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.

Plans should be put into action as soon as possible, and all individuals should be receiving personalised care and support in the appropriate community settings no later than 1 June 2014.

4b. LOCALLY AGREED PLANS TO ENSURE HIGH QUALITY CARE AND SUPPORT SERVICES WHICH ACCORD WITH THE MODEL OF GOOD CARE

4.13 In parallel with the actions for people currently in hospital, every local area will put in place a locally agreed joint plan to ensure high quality care and support services for all people with challenging behaviour that accords with the model of good care. These plans should ensure that a new generation of inpatients does not take the place of people currently in hospital.

Commissioning the right model of care and challenging poor practice

4.14 We expect commissioners to work together to drive the move from hospital care to good quality local, community-based services, and account for how they do this. This involves:

- better joint working between health and care; and
- using the evidence on good practice.

4.15 Health and care commissioners are accountable for commissioning services to meet identified needs. It is essential that they work together to develop specific plans for improving health and care services for this particular group of people. This goes wider than health and adult social care; in particular, a strategic plan must also include children's services and specialist housing.

Gloucestershire County Council and NHS Gloucestershire have a (joint) strategic commissioning plan which includes bringing people back into the county. *"For at least two years we have had a joint LA & NHS Learning Disability commissioning team (Gloucestershire CC and NHS Gloucestershire). We work from a common plan and as lead commissioner I head up the team of 8 people. We have commissioners from both health and social care. Health team members are directly engaged with complex people including people 100% funded by health and both LA and NHS colleagues work with people placed out of county*".

Referrals for anyone needing additional assessment or treatment also go through this team to a specialist Learning Disability NHS service whose aim is to prevent admission for assessment and treatment. Social care commissioning colleagues in the team also access the NHS A&T service this way. This also means that if anyone's current services need additional resources to avoid breakdown, before the resources are allocated, the specialist NHS Learning Disability service would ensure this is necessary and value for money.

4.16 Local health and care commissioners and services should be commissioning integrated care – care co-ordinated and personalised around the needs of individuals with a presumption that care should be local and that people should stay in their communities. This is more likely to happen if:

- Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) take account of the health and care needs of people with challenging behaviour; and
- health and care commissioners pool budgets.

4.17 Pooled budgets with shared accountabilities are likely to facilitate the development of more integrated care. They may help overcome the lack of strong financial incentives on a single commissioner to invest in community services (eg where the cost of investment in supported living in local communities falls to councils while savings from reduced reliance on hospital services go to NHS commissioners). There should be a clear presumption that budgets should be pooled and that health and wellbeing boards should promote collaborative working and the use of pooled budgets.

4.18 Commissioners need to work with providers of specialist services to ensure that community learning disability teams have the additional, intensive support they need to keep people out of hospital – including in crises. They will also need to have access to local inpatient mental health services where these are genuinely required. This will reduce the need for hospital admissions out of area.

4.19 Finally, there is consensus that large hospital units are outdated and inappropriate and do not provide the care which people with challenging behaviour need. It is our clear expectation that commissioners should not place people in large hospitals. There may be a few people who need inpatient care, but this should be provided in smaller units and as close to home as possible. Any new, small specialist hospitals should only be built where JSNAs show a genuine unmet local need for such provision in a way which is consistent with good models of care. Local commissioners should have oversight of the services available in their areas and take the lead in discussing future need and what additional facilities are required. In addition, CQC will take account of the model of care in its revised guidance about compliance and in the registration and inspection of providers, as part of its new regulatory model.

Key Actions:

By April 2014, CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.

The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint commissioning arrangements.

Evidence on best practice

4.20 Commissioning needs to draw on the evidence of what is best practice in the care of people with challenging behaviour. The Model of Care set out in this report is based on well established evidence. To strengthen the evidence base, NICE is developing further standards and guidelines for this group of people, to go alongside the standards already published on autism clinical pathways.

Key Actions:

By Summer 2015 NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.

By Summer 2016 NICE will publish quality standards and clinical guidelines on mental health and learning disability.

4.21 NICE will also develop new quality standards on child maltreatment. They will focus on the recognition and response to concerns about abuse and neglect and effective interventions. These will support the use of the Government's statutory guidance, *Working Together to Safeguard Children.*[15]

Prioritising children and young people's services

4.22 Children and young people with challenging behaviour can face particular difficulties and crises as they move from child to adult services. Integrating care and support around their needs and ensuring that they have access to the services identified in their agreed care plan is vital.

4.23 For children and young people with special educational needs or disabilities the Mandate to the NHS Commissioning Board sets out the expectation that children will have access to the services identified in their agreed care plan and that parents of children who could benefit will have the option of a personal budget based on a single assessment across health, social care and education. This means:

- integrated planning around the needs of individual children; and
- identifying best outcomes and measuring progress.

4.24 Local health and care commissioners need to plan strategically to develop local services that properly meet the needs of children and young people in the area where they live.

Good practice:

Ealing services for children with additional needs set up "The Intensive Therapeutic & Short Break Service (ITSBS). The service provides a viable model for significantly reducing challenging behaviour and securing home placement stability for a small but significant number of children and young people whose challenging behaviour would otherwise most likely result in a

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[15] https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN-v3.pdf

move to residential placements. Residential placement was avoided for all five young people who had been offered the service between 2008 and 2010. Residential placement has also been avoided for six out of the seven young people who were first offered the service between 2010 and 2011.

Key Actions:

The Department of Health will work with the Department of Education (DfE) to introduce from 2014 a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.

Both Departments will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood. This will report by June 2013.

4.25 Children and young people and their families need to be involved in this work.

4c. NATIONAL LEADERSHIP SUPPORTING LOCAL CHANGE

4.26 While changes to people's lives require action at a local level, with local commissioners and providers working together, change of this scale, ambition and pace requires **national leadership**. To provide leadership and support to the transformation of services locally, the LGA and the NHSCB will develop an improvement programme led by a senior sector manager. This will be in addition to the cross-government programme board.

Key Actions:

The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.

At a national level, from December 2012, the cross-government Learning Disability Programme Board chaired by the Minister of State for Care and Support will lead delivery of the programme of change by measuring progress against milestones, monitoring risks to delivery, and challenging external delivery partners to deliver to plan, regularly publishing updates.

4.27 Social care and health commissioners will be accountable to local populations and will be expected to demonstrate that they have involved users of care and their families in planning and commissioning appropriate local services to meet the needs of people with challenging behaviour. Families and self advocates have an important role to play in challenging local agencies to ensure that people have local services and the optimum model of care. There is a clear need both to challenge localities for failing to redesign services, and to provide practical support to help them do so.

Good Practice

There are many examples of good local practice in this area.

In **Salford,** in the last 5 years 16 people with a learning disability and behaviour that challenges living out of area have returned to their communities.

Beyond Limits have been commissioned by NHS Plymouth (now Devon CCG) to develop local personalised commissioning/provider processes and tailor-made services for people who have experienced long term, multiple placements and institutionalised living because their behaviours have challenged existing services. They are piloting this through facilitating planning for 20 people currently in out of area Specialist Assessment &Treatment Units and then providing support using personal Health Budgets.

4.28 Providers have a key role to play in redesigning service, working closely with commissioners, people who use services and families. The national market development forum within the Think Local Act Personal (TLAP) partnership will work with DH to identify barriers to reducing the need for specialist hospitals and by April 2013 will publish solutions for providing effective local services.

4.29 The Developing Care Markets for Quality and Choice programme will support local authorities to identify local needs for care services and produce market position statements, including for learning disability services.

4.30 The NHSCB will also work with ADASS to develop by April 2013 practical resources for commissioners of services for people with learning disabilities,[16] including:

- model service specifications;
- new NHS contract schedules for specialist learning disability services;
- models for rewarding best practice through the NHS Commissioning for Quality and Innovation (CQUIN) framework; and
- a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.

Key Action:

By March 2013 the NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and adults with challenging behaviour built around the model of care in Annex A.

4.31 DH will ensure health and wellbeing boards have guidance and information to support them to understand the complex needs of people with challenging behaviour.

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[16] This will build on the guidance published in October 2012, *Improving the health and wellbeing of people with learning disabilities: an evidence-based commissioning guide for clinical commissioning groups.* http://www.improvinghealthandlives.org.uk/publications/1134/Improving_the_Health_and_Wellbeing_of_People_with_Learning_Disabilities:_An_Evidence-Based_Commissioning_Guide_for_Clinical_Commissioning_Groups
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Part 5: Strengthening accountability and corporate responsibility for quality of care

5.1 Although 11 former members of staff at Winterbourne View have been sentenced in connection with the abuse of patients, this review has identified weaknesses in the system of accountability where leaders of organisations are not fully held to account for poor quality or for creating a culture where neglect and even abuse can happen.

Quality of care

5.2 **The primary responsibility for the quality of care rests with the providers of that care. Owners, Boards of Directors and Senior managers of organisations which provide care must take responsibility for ensuring the quality and safety of their services**. The requirements set out in law include:

- safe recruitment practices which select people who are suitable for working with people with learning disabilities or autism and behaviour that challenges;
- providing appropriate training for staff on how to support people with challenging behaviour;
- providing good management and right supervision;
- providing leadership in developing the right values and cultures in the organisation;
- having good governance systems in place; and
- providing good information to support people making choices about care and support, including the views of people who use services about their experience.

5.3 We also expect boards to demonstrate good practice and comply with further legal requirements, which include:

- Directors, management and leaders of organisations providing NHS or local authority-funded services must ensure that systems and processes are in place to provide assurance to themselves, service users, families, local Healthwatch and the public that essential requirements are being met and that they deliver high quality and appropriate care;
- the Boards of care providers should understand the quality of the care and support services they deliver; and
- organisations must identify a senior manager or, where appropriate a Director, to ensure that the organisation pays proper regard to quality, safety, and clinical governance for that organisation.

Key Action:

We expect Directors, management and leaders of organisations providing NHS or local authority-funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.

Sanctions to hold Boards to account when the quality of care is unacceptable:

5.4 There must be robust consequences for senior managers or Boards of Directors of services where through neglect the organisations they lead provide poor quality of care or where people experience neglect or abuse.

CQC's enforcement powers

5.5 CQC will take steps to strengthen the way it uses its existing powers to hold organisations to account for failure to meet legal obligations to service users. CQC registers providers at an organisational level. However, its inspections take place at the level at which services are delivered. As a result CQC has not always held organisations to account at a corporate level, but rather at the level of the regulated service. This needs to be addressed.

5.6 While most organisations providing care put in place governance arrangements that support safety and quality, some do not pay sufficient attention to this area. Where the leadership of an organisation allows a culture to develop that does not foster safety and quality in care, the people providing that leadership have to be held to account for the service failings. In the words of the serious case review, "Castlebeck Ltd's appreciation of events… was limited, not least because they took the financial rewards without any apparent accountability."

5.7 This is an unacceptable situation and must change. CQC already has powers to take action:

- CQC is able to take tough enforcement action against organisations that do not meet the registration requirements, including stopping them from providing specific services or operating from specific locations. In the most extreme cases CQC can cancel a provider's registration, stopping it from providing any health or adult social care;
- it is already an offence under the Health and Social Care Act 2008 not to meet the essential levels of safety and quality. This would include, for example, not making suitable arrangements to ensure that service users are safeguarded against the risk of abuse. As well as prosecuting the corporate provider for a failure to meet the registration requirements, CQC can prosecute individual directors or managers where the offence can be proven to have been committed by, or with the consent or connivance of, or attributable to any neglect on the part of that individual.

5.8 It is important that CQC makes full use of its existing powers to hold the corporate body to account. CQC will meet with executives of provider organisations when there are serious concerns about quality and safety issues to discuss their plans to deliver safe and effective care. Since summer 2012, CQC has appointed corporate compliance managers to assess the quality and safety of care of large providers who operate across a large area.

Key Action:

CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.

Fit and proper person test

5.9 CQC will also consider whether it is able to use its existing powers to carry out a fit and proper person test of Board members as part of the registration of providers. One option for this could be to require providers to nominate an individual Board member with responsibility for quality who would be accountable to CQC for the quality of care. If this person did not meet the fit and proper person test, CQC could insist that another Board member is nominated. CQC could not use its existing powers to bar an individual from being a member of the Board, since Directors are not required to register with CQC.

5.10 DH will explore how a stronger fit and proper person test for board members of health and social care providers can be introduced to make it comparable to fit persons' tests in other sectors. This will include looking at:

- the tests applied by the Financial Services Authority, the Premier League and the Charity Commission, which look at an individual's past performance with regards to other regulatory systems;
- prior involvement with other companies which may have had their licences revoked, withdrawn or terminated; and
- if they or any business associated with them, has been suspended or criticised by a regulatory or professional body. Where individuals fail to meet these tests, regulators can deem them to be unsuitable to hold certain positions and organisations face regulatory action or risk being refused registration, where such persons are appointed. DH will examine if a similar approach could be applied to board members of health and social care providers.

Holding corporate bodies to account for poor care

5.11 There can be no excuse for Directors or managers allowing bullying or the sort of abusive culture seen in Winterbourne View. Individuals should not profit from others' misery.

5.12 DH will examine how corporate bodies, their Boards of Directors and financiers can currently be held to account under law for the provision of poor care and the harm experienced by people using those services.

5.13 There are a number of potential criminal offences for which a Board Director or Manager could be prosecuted:

- there are offences under general criminal law. For example, in cases where it is proved that an individual board member or manager has committed an offence against a person or aided and abetted the commission of any offence (such as an assault), then such individuals could also be prosecuted in accordance with general criminal law;
- organisations can be prosecuted for offences under the Corporate Manslaughter and Corporate Homicide Act 2007 if the service provider's organisation is managed in such a way that it caused a person's death. The track record of prosecution in such cases – despite new legislation being introduced expressly to address corporate failure – is thin.

Key Action:

The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps.

We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.

Developing leadership in Boards

5.14 Boards should ensure they have proper governance arrangements in place and take seriously their corporate responsibilities towards the people for whom they provide care. DH will explore with the National Skills Academy and the NHS Leadership Academy options to develop proposals on Board leadership development by March 2013.

Part 6: Tightening the regulation and inspection of providers

6.1 What happened at Winterbourne View raised profound questions about how regulation and inspection was working. As a result of Winterbourne View, and learning from their programme of inspecting nearly 150 learning disability hospitals, CQC is seeking to improve the way it regulates and inspects providers. In particular, CQC is committed to delivering on the recommendations set out in their Internal Management Review[17], the findings of the Serious Case Review, the evaluation of their inspection of nearly 150 learning disability services[18], and any relevant matters from the consultation on their strategy for 2013-16[19] to ensure that its regulation of providers is robust.

6.2 This means:

- checking how services fit with national guidance;
- improving inspection; and
- improving information sharing.

6.3 Providers are already required to have regard to national guidance, as one of the requirements of regulation monitored by CQC. The model of care at Annex A sets out an agreed framework for best practice in this area. CQC will take action to ensure this model of care is considered as part of inspection and registration of relevant services in their new regulatory model which will be implemented in 2013. CQC will also include reference to the model of care in their revised guidance about compliance, which will also be published in 2013. Where services are not provided in line with this model of care, CQC will seek assurance that the provider's approach still delivers care in line with national guidance and legal requirements.

Key Action:

CQC will use existing powers to seek assurance that providers have regard to national guidance and the good practice set out in the model of care at Annex A.

6.4 In addition, CQC will:

- share the information, data and details they have about prospective providers with the relevant CCGs and local authorities through their existing arrangements, who will, in turn, take account of the information and data shared by CQC when making decisions to commission care from the proposed service provider;

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[17] CQC Internal Management Review of the regulation of Winterbourne View (October 2011) http://www.cqc.org.uk/sites/default/files/media/documents/20120730_wv_imr_final_report.pdf

[18] CQC Review of Learning Disability Services (June 2012) http://www.cqc.org.uk/search/apachesolr_search/evaluation%20of%20learning%20disability%20services

[19] CQC, The next phase: Our consultation on our strategy for 2013 to 2016 http://www.cqc.org.uk/sites/default/files/media/documents/cqc_strategy_consultation_2013-2016_tagged.pdf

- take steps now to strengthen the way we use existing powers to hold organisations to account for failures to provide quality care and report on changes to be made from Spring 2013;
- assess whether providers are delivering care consistent with the statement of purpose made at the time of registration, particularly in relation to length of stay and to whether treatment is being offered. Where it is not, CQC will take the necessary action (including, if necessary, enforcement action) to ensure that a provider addresses discrepancies either through changes to its services or changes to its statement of purpose;
- take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place;
- take enforcement action against providers that do not operate effective recruitment procedures to ensure that their staff are suitably skilled, of good character and legally entitled to do the work in question. Operating effective recruitment procedures is a legal requirement and providers must be able to demonstrate to CQC that they have adequate procedures in place. Evidence of effective recruitment can include a provider showing it has requested criminal records checks for eligible employees (including any staff who regularly provide care or treatment) alongside checking references and qualifications. Where a provider has not requested criminal records checks on eligible employees, it will have to assure CQC that its recruitment procedures are still effective and that it can be evidenced that it is reasonable for the check not to have been made. Providers also commit an offence if they knowingly engage a person who is barred in activities such as providing healthcare or personal care. From 2014 the government will commence an explicit duty to check that a person is not barred before engaging them in these activities;
- continue to run the stakeholder group that helped to shape the inspection of 150 learning disability services. It will continue to meet twice yearly and will be chaired by the CQC Chief Executive. CQC will review the role and function of the group as part of that work programme to make sure it continues to provide advice and critique on CQC's inspection and monitoring of providers;
- continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team;
- take a differentiated approach to inspections between different sectors of care provision to ensure the inspections are appropriate to the vulnerability and risk for the different care user groups (subject to the outcome of consultation on its new strategy);
- review, as part of its new strategy, the delivery of its responsibilities under s120 of the Mental Health Act 1983 for the general protection of patients detained under the Act which include wide powers to review the way in which the Act's functions and safeguards are working and investigating complaints by any person detained under the Act.

Key Actions:

CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.

CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance about compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about the proposed changes to the registration process in respect of models of care for learning disability services in 2013.

6.5 From 2013 arrangements for checking criminal records will become quicker and simpler with the introduction of a new service that will make criminal records certificates more portable. When the new service is running, the Department of Health will review the regulatory requirements about criminal records checks and consider whether providers should routinely request a criminal record certificate on recruitment.

6.6 Monitor will begin licensing non-foundation trust providers of NHS funded services from April 2014. Monitor will consider strengthening Board-level governance by including internal reporting requirements in the licensing conditions. This is in line with the recommendations from the Serious Case Review. Monitor and CQC are required to co-operate with each other and share information.

6.7 In its recent consultation document on licence conditions, Monitor proposed two requirements for providers to meet before they could obtain a licence:

- a requirement for them to hold CQC registration; and
- to confirm that their governors and directors, or equivalent people, are fit and proper persons.

6.8 The proposal is that these requirements would also appear in the licence conditions, making them on-going obligations which providers would have to continue to meet in order to continue to hold a licence. Monitor and CQC will be under a legal duty to seek to ensure that the conditions are consistent.

6.9 Ofsted, CQC, Her Majesty's Inspectorate of Constabulary (HMIC), Her Majesty's Inspectorate of Probation and Her Majesty's Inspectorate of Prisons will introduce a new joint inspection of multi-agency arrangements for the protection of children in England from June 2013. This approach, which is currently being piloted, will focus on the effectiveness of local authority and partners' services for children who may be at risk of harm, including the effectiveness of early identification and early help. The inspectorates intend to publish the arrangements for the inspections by April 2013.

6.10 Ofsted is responsible for inspecting children's homes, as well as boarding and residential provision in schools. Under new inspection frameworks published in September 2012 they will make judgements on the overall effectiveness, outcomes for children and young people, quality of care, safeguarding as well as leadership and management. Under the framework inspectors are expected to consider residents views on the service, to observe interactions between staff and children and young people and to obtain the views of relevant parties including social workers and the authorities responsible for placements.

Part 7: Improving quality and safety

7.1 Ensuring that commissioners are commissioning the right services, that organisations are properly accountable, and that regulation is most effective will tackle many of the systemic problems revealed by Winterbourne View. However, the Serious Case Review and the other evidence we have received make it clear that the programme of change must go wider.

7.2 The actions we have described so far are primarily for the Department of Health, commissioners and regulators to lead. However, this wider programme lays much greater weight on the responsibility of providers, professional bodies and others to lead. It covers:

- making best practice normal;
- improving the capacity of the workforce;
- whistleblowing;
- the Mental Health Act and Mental Capacity Act;
- physical restraint;
- medication; and
- improving advocacy.

Making best practice normal

7.3 The fundamental responsibility for providing good quality care rests with providers. Representatives of provider organisations fully accept this. They have agreed to work together to develop options for improving quality, including bringing forward a pledge or code model based on shared principles along the lines of the TLAP Making it Real principles for learning disability providers.

7.4 Providers should involve people with learning disabilities and people with autism and their families in checking the quality of services.

<ins>Good Practice</ins>

Dimensions is a large social care provider that has made stringent efforts to monitor and improve quality and performance. It made a conscious decision to create a Compliance audit team separate from the operational management of services, believing that this tension would enable more objective and rigorous monitoring. The Dimensions Compliance team, together with a team of four Experts by Experience, work across each of the organisation's regions conducting service audits. The audits look at every aspect of the service from regulatory requirements, finance, health and safety and for evidence of better practice, including a two hour observation of staff interacting with the people they are supporting as well as on-going observation throughout the visit. The audit process gives a clear picture of what is happening in individual services and across the organisation, and forms part of the reporting of risk management up through its governance structure, including the people it supports. The new systems are contributing to significant advances in quality and improved outcomes. Dimensions' intention is to promote best practice, ensure that it exceeds compliance requirements and demonstrate robust and rigorous processes of internal scrutiny in line with its vision and values.

7.5 Good practice guidance for the care of adults is well established[20]. And there will be new statutory guidance in relation to children in long-term residential care.

Key Action:

The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care (s85 and s86 of the Children Act 1989) in 2013.

Improving the capability of the workforce

7.6 Recruiting, training and managing the workforce is the responsibility of providers. The events at Winterbourne View highlighted that there are too many front-line staff who have not had the right training and support to enable them to care properly for people with challenging behaviour. This is a theme which has been reinforced by many of the families we have heard from.

7.7 It is crucial that staff who work with people with challenging behaviour are properly trained in essential skills. CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff. Better skills and training are an important part of raising standards overall and we expect providers to ensure the people they employ are properly trained. However, the Department of Health, commissioners and other organisations will play an important role in setting expectations, creating standards and offering advice.

7.8 We expect commissioners to assure themselves that providers are meeting proper training standards. Contracts with learning disability and autism hospitals should be dependent on assurances that staff are signed up to the proposed Code of Conduct which the Department of Health has commissioned from Skills for Health and Skills for care, and minimum induction and training standards for unregistered health and social care assistants are being met.

7.9 From April 2013 Health Education England (HEE) will have a duty to ensure we have an education and training system fit to supply a highly trained and high quality workforce. HEE will work with the Department of Health, providers, clinical leaders, and other partners to improve the skills and capability of the workforce to respond to the needs of people with challenging behaviour and will examine ways to ensure that skills include knowing when and how to raise concerns, (in other words 'whistleblow') including on disability hate crime.

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[20] see *Services for People with Learning Disability and challenging behaviour or mental health needs* 2007, Prof. Jim Mansell, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080129

7.10 HEE will expect that all new entrants are tested for their values and interpersonal skills, and will reach out into schools and colleges to ensure that young people with the right values consider a career in healthcare. HEE will ensure the values set out in the NHS Constitution lie at the heart of all it does.

7.11 It is crucial that staff who work with people with challenging behaviour should be properly trained in essential skills. HEE are committed to ensuring that non-professional members of the workforce (ie bands 1-4) receive continuing development and training to provide a skilled and highly motivated workforce.

7.12 It is not sufficient to have a well-trained workforce. There also needs to be good clinical and managerial leadership. The National Skills Academy for Social Care, on behalf of the Department of Health, published a Leadership Qualities Framework for Adult Social Care in October 2012. This builds on the principle that leaders that demonstrate the right values and behaviours at every level of the sector provide the best foundation for transforming social care.

7.13 There will be concerted effort across the system over the next year to ensure health and care professionals understand and are guided in achieving minimum standards, and aspire to best practice.

Key Actions

CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.

By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach*[21] to support clinicians in community learning disability teams to deliver actions that provide better integrated services.

By April 2013 the Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.

Skills for Care will develop by February 2013 a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour.

Skills for Health and Skills for Care will develop by January 2013 national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.

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[21] The Royal College of Psychiatrists and British Psychological Society and Royal College of Speech and Language Therapists: *A Unified Approach* (2007)

By end 2013 there will be a progress report on actions to implement the recommendations in *Strengthening the Commitment*, the report of the UK Modernising Learning Disability Nursing Review[22].

Confidence in Whistleblowing

7.14 When things go badly wrong, and local management is reluctant to change, members of staff must feel it is safe for them to raise their concerns more widely and that they will be listened to. The interim report of this review set out action already taken to encourage whistleblowing[23]. It also clarified roles within the system:

- **Government:** in ensuring that the legislative framework in the Public Interest Disclosure Act is adequate;
- **Employers**: in supporting staff to raise concerns by having a clear policy in place which makes it clear that staff who raise concerns will be supported and which provides ways to by-pass the immediate line management chain where necessary;
- **CQC**: in monitoring concerns about patient safety raised with it and ensuring that timely referrals are made to the professional regulators where necessary; and
- **Professionals and other health and care workers**: in raising concerns promptly.

7.15 CQC has strengthened its arrangements for responding to concerns that are raised with it by whistleblowers. Whistleblowing concerns are now monitored to ensure they are followed up and thoroughly investigated until completion and the information provided is included in regional risk registers, which list providers where 'major concerns' have been identified.

7.16 The Department of Health funds a free, confidential whistleblowing helpline for NHS and care staff and employers who need advice about raising concerns and for employers on best practice. The service, provided by Mencap, was extended for the first time to staff and employers in the social care sector. Mencap will shortly be announcing a campaign which aims to reduce the gap between those staff who know how to whistleblow and those who would feel comfortable in doing so.

7.17 In March 2012, we revised the NHS Constitution to include an expectation that staff will raise concerns, a pledge that concerns will be acted upon and an undertaking to give clarity around the existing legal rights to raise concerns. It is important that workers know to whom they can raise concerns and all employers should have a clear whistleblowing policy in place.

7.18 Where a doctor has good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, s/he has a duty to put the matter right if possible. Similar duties are laid on other professionals through their codes of conduct. In all cases, professionals must consider the wider implications of failing to report such concerns and the risks to patient safety.

7.19 The Department of Health has asked the LGA and NHSCB to take account of the recommendations of the Serious Case Review on whistleblowing**. Commissioners**

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[22] *Strengthening the Commitment'*http://www.scotland.gov.uk/Publications/2012/04/6465/downloads

[23] http://www.dh.gov.uk/health/2012/06/interimwinterbourne/

should ensure that organisations contracting with the NHS or a local authority include a condition of employment on its workers to report concerns where:

- a criminal offence has been, is being or is likely to be committed;
- a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject;
- a miscarriage of justice has occurred, is occurring or is likely to occur;
- the health or safety of any individual has been, is being or is likely to be endangered;
- the environment has been, is being or is likely to be damaged; or
- information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

Improving safeguarding

7.20 Following consultation, **DfE is revising *Working Together to Safeguard Children*, statutory guidance on how organisations, agencies and individuals working with children should work together to safeguard and promote their welfare**. The guidance will be published in due course.

7.21 Events at Winterbourne View flagged the need to prioritise strengthening adult safeguarding arrangements. The Serious Case Review shows that adult safeguarding systems failed to link information. NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts and failures to follow up concerns when commissioners became aware of them. The Department of Health has already announced its intention to put Safeguarding Adults Boards on a stronger, statutory footing, better equipped both to prevent abuse and to respond when it occurs. By strengthening the safeguarding adults boards arrangements and placing health, NHS and the police as core partners on the boards we will help ensure better accountability, information sharing and a framework for action by all partners to protect adults from abuse.

Key Action:

The Department of Health will revise statutory guidance and good practice guidance to reflect new legislation and address findings from Winterbourne View, to be completed in time for the implementation of the Care and Support Bill (subject to parliamentary approval). In particular:

- **Safeguarding Adults Boards will be put on a statutory footing, subject to parliamentary approval of the Care and Support Bill;**
- **local authorities will be empowered to make safeguarding enquiries, and Boards will have a responsibility to carry out safeguarding adults reviews;**
- **the Safeguarding Adults Board will publish an annual report on the exercise of its functions and its success in achieving its strategic plan; and**
- **the Safeguarding Adults Board core membership will consist of the LA, NHS and Police organisations, convened by the LA. Individual boards will be able to appoint other members in line with local need.**

7.22 Local authorities should ensure that everyone involved in safeguarding is clear about their roles and responsibilities. All local authorities and their local safeguarding partners should ensure they have robust safeguarding boards and arrangements and have the right information-sharing processes in place across health and care to identify and deal with safeguarding alerts. This requires a multi-agency approach including all partners. In recognition of the critical role of information sharing and multi-agency working in delivering successful outcomes for adults and children at risk, the Home Office is working in partnership with the Association of Chief Police Officers (ACPO), the Department of Health and the Department for Education to improve our understanding of the different local multi-agency models in place to support information sharing around safeguarding responses for vulnerable people.

7.23 **Local areas need to work in partnership, including, where necessary with police and criminal justice agencies, to ensure that people returning to communities are supported adequately. This may include working with integrated offender management teams where appropriate**.

7.24 NHS Accident and Emergency (A&E) staff need to be alert to adult safeguarding issues and have a clear understanding of what to do with any safeguarding concerns. The Department of Health will highlight to A&E departments the importance of detecting incidences of re-attendance from the same location /individual in their annual review of Clinical Quality Indicators.

7.25 ACPO recognise the importance of working together with statutory agencies, local authorities and safeguarding partners to enhance the service provided to vulnerable adults. ACPO has reviewed the overall learning from Winterbourne View and will ensure the following:

- the one direct recommendation relating to the police regarding the early identification of trends and patterns of abuse has been fully recognised by Avon & Somerset Police. A specific workstream has been created by the force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally; and
- all associated learning from the review will be incorporated into training and practice, including Authorised Professional Practice.

Applying protections of the Mental Health Act and the Mental Capacity Act

7.26 Nearly three-quarters of people at Winterbourne View hospital (73%) were detained under the Mental Health Act 1983. But it is clear that the principles and safeguards of the Mental Health Act were not properly applied. This was also true for some of the people who were informal patients, who also had their freedom and movement constrained. Some of the people we met said they and their families were given little say in where they were sent. This does not fit with the principles of personalisation in the NHS Constitution or the principles of the Mental Health Act 1983 and Mental Capacity Act 2005.

Key Actions:

The Department of Health will work with CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards (DOLS) provisions to protect individuals and their human rights and will report by Spring 2014.

During 2014 the Department of Health will update the Mental Health Act Code of Practice and this will take account of findings from this review.

Raising understanding of good practice and reducing the use of physical restraint

7.27 Physical restraint should only ever be used as a last resort and never used to punish or humiliate.

7.28 The CQC inspections revealed widespread uncertainty on the use of restraint, with some providers over-reliant on physical restraint rather than positive behaviour support and managing the environment to remove or contain the triggers which could cause someone to behave in a way which could be seen as challenging. In Winterbourne View, bullying, punishment and humiliation were disguised as restraint.

7.29 We need both to take enforcement action where restraint is used improperly or illegally and to clarify and spread better understanding on how to use restraint properly. Where CQC finds evidence of inappropriate or illegal use of restraint it will take enforcement action.

Key Actions:

The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.

With external partners, the Department of Health will publish by the end of 2013 guidance on best practice on positive behaviour support so that the physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.

7.30 This will include:

- a set of agreed values to promote change and raise standards to minimise the use of physical intervention;
- looking at different methods of restraint;
- a training framework for commissioners to enhance the skills of the workforce; and
- identification of information and data needs.

This work will look more widely than people with challenging behaviour and apply to anyone in the health and social care systems who may be subject to physical intervention.

Addressing the use of Medication

7.31 **We have heard deep concerns about over-use of antipsychotic and anti-depressant medicines**. Health professionals caring for people with learning disabilities should assess and keep under review the medicines requirements for each individual patient to determine the best course of action for that patient, taking into account the views of the person if possible and their family and/or carer. Services should have systems and policies in place to ensure that this is done safely and in a timely manner and should carry out regular audits of medication prescribing and management, involving pharmacists, doctors and nurses.

Key Actions:

The Royal College of Psychiatrists, the Royal Pharmaceutical Society and other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotics and anti-depressants.

The Department of Health will explore with the Royal College of Psychiatrists and others whether and how to commission an audit of use of medication for this group. As the first stage of this we will commission, by summer 2013, a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.

Improving information, advice and advocacy

7.32 Good information and advice, including advocacy, is important to help people with challenging behaviour and their families to understand the care available to them and make informed choices. But it is clear that there is a very wide variety in the quality and accessibility of information, advice and advocacy, including peer advocacy and support to self-advocate.

<u>Good Practice</u>

In Dudley the local authority is working with independent advocacy organisations and commissioners to develop a quality framework which we hope will be widely adopted.

Key Actions:

The Department of Health will work with independent advocacy organisations to:

- **identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs; and**
- **drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.**

7.33 It is vital that people who make complaints about their care, or the care of a family member are listened to and are given the support (including advocacy as appropriate) and advice they need to make that complaint. This includes complaints about abuse and disability hate crime.

7.34 The Care and Support White Paper[24] states that all providers are required, by law, to have a clear and effective complaints system, and this is monitored by the CQC. If a provider or local authority does not resolve a complaint to the satisfaction of the user, that person can ask the Local Government Ombudsman to investigate. The Ombudsman will be clearly signposted through the new national information website for care and support.

7.35 The Department of Health accepted the recommendations made by the Equality and Human Rights Commission, which includes putting in place robust and accessible systems so that residents living in institutions can be confident of reporting harassment by staff or other residents.

7.36 The Department for Health is strengthening the ways in which people can give feedback on their care and support. This Government supports the development of websites which allow those who use services and their family or carers, to give feedback to providers and commissioners about any poor, or indeed good practice.

7.37 The Department of Health will work with the LGA and Healthwatch England on involving people with learning disabilities and their families in local Healthwatch organisations. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards, and, for children and young people, Parent Carer Forums. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.

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[24] *Caring for our Future: reforming care and support* , http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

Part 8: Monitoring and reporting on progress

8.1 How will government, the public, people with challenging behaviour and families know we are making progress? Transparency of information and robust monitoring are critical for delivering transformed care and support. This involves:

- auditing current provision;
- developing better information for the future; and
- national monitoring through the Learning Disability Programme Board, including service user and family representation.

Auditing current provision

8.2 In pursuing this review, it became clear that there is a lack of clarity on the number of people with challenging behaviour in hospital settings or who is responsible for them. There have been improvements, but much more needs to be done to establish a baseline.

Key Action:

By March 2013 the Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.

Developing better information systems

8.3 The Department of Health intends to establish key performance indicators (on, for example, numbers of people in hospital, length of stay, incidents of restraint, and number of safeguarding alerts) which will enable the Learning Disability Programme Board and local services to monitor progress.

Action:
The Department of Health, the Information Centre for Health and Social Care and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress from April 2013.

The Department of Health will develop a new learning disability minimum data set to be collected through the Information Centre from 2014/15.

The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.

Monitoring and transparency

8.4 We will monitor progress through the Learning Disability Programme Board. It will also be essential for the process to be transparent and open to scrutiny.

Key Actions:

The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments (Annex B). CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.

Regular updates to the Programme Board will be published on the Department of Health website, with all other papers and minutes for that Board.

The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013 and repeat this by December 2014.

Part 9: Conclusion

9.1 For too long, people with challenging behaviour have – as highlighted by Mencap and the Challenging Behaviour Foundation – been too much out of sight. Although there is ample authoritative guidance across health and care, and examples of good practice around the country, in too many places the needs of this highly vulnerable group of people are not being addressed. It is easy to see why families and groups who support people with challenging behaviour are sceptical about what will happen this time to deliver the transformation of care which people deserve.

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9.2 But we believe that the package of timetabled actions set out in this report and the accompanying Concordat, together with the commitment by national and local leaders to monitor and report on delivery against these will deliver real change. And this will be enabled by the reforms to health and care systems which give greater power to individuals and local communities to develop services which genuinely respond to local needs.

Annex A: The model of care

There are too many people challenging behaviour living in inpatient services for assessment and treatment and they are staying there for too long.

The closure of most long-stay hospitals in the 1980s and 1990s, and the recent closure of NHS campuses, means most people with learning disabilities, including those with behaviours that challenge now live in the community with support. But some still live (for short or longer periods) in NHS funded settings. Assessment and treatment units emerged as the most likely solution to meeting the needs of people with learning disabilities and complex mental health/behavioural issues post-institutional closure. However, there were opposing views between 'building based' services and increasing support to people in their natural communities as the preferred option.

Good practice guidance on supporting people with learning disabilities, autism and those with behaviour which challenge includes the 1993 Mansell report, updated and revised in 2007. Both emphasise:

- the responsibility of commissioners to ensure that services meet the needs of individuals, their families and carers;
- a focus on personalisation and prevention in social care;
- that commissioners should ensure services can deliver a high level of support and care to people with complex needs/challenging behaviour; and
- that services/support should be provided locally where possible.

Evidence shows that community-based housing enables greater independence, inclusion and choice and that challenging behaviour lessens with the right support. The Association of Supported Living's report *There is an Alternative* describes how 10 people with learning disabilities and challenging behaviour moved from institutional settings to community services providing better lives and savings of around £900,000 a year in total.

The CQC *Count me in* 2010 census showed only 2 learning disabled patients on Community Treatment Orders compared to over 3,000 mental health patients – suggesting a greater reliance on inpatient solutions for people with learning disabilities than for other people needing mental health support.

CQC found some people were staying many years in assessment and treatment units. Annex B estimates that, in March 2010, at least 660 people were in A&T in Learning Disability wards for more than 6 months.

This report sets out how the model of care set out in the Mansell reports fits with the new health and care system architecture focusing on key principles, desired outcomes for individuals, and a description of how the model should work in practice.

Key principles

The key principles of high quality services for people with learning disabilities and behaviour which challenges are set out below:

For people:

1. I and my family are at the centre of all support – services designed around me, highly individualised and person-centred;
2. My home is in the community – the aim is 100% of people living in the community, supported by local services;
3. I am treated as a whole person;
4. Where I need additional support, this is provided as locally as possible.

For services:

5. Services are for all, including those individuals presenting the greatest level of challenge;
6. Services follow a life-course approach i.e. planning and intervening early, starting from childhood and including crisis planning;
7. Services are provided locally;
8. Services focus on improving quality of care and quality of life;
9. Services focus on individual dignity and human rights;
10. Services are provided by skilled workers;
11. Services are integrated including good access to physical and mental health services as well as social care;
12. Services provide good value for money;
13. Where inpatient services are needed, planning to move back to community services starts from day one of admission.

Outcomes

A high quality service means that people with learning disabilities or autism and behaviour which challenges will be able to say:

1. I am safe;
2. I am treated with compassion, dignity and respect;
3. I am involved in decisions about my care;
4. I am protected from avoidable harm, but also have my own freedom to take risks;
5. I am helped to keep in touch with my family and friends;
6. Those around me and looking after me are well supported;
7. I am supported to make choices in my daily life;
8. I get the right treatment and medication for my condition;
9. I get good quality general healthcare;
10. I am supported to live safely in the community;
11. Where I have additional care needs, I get the support I need in the most appropriate setting;
12. My care is regularly reviewed to see if I should be moving on.

This is about personalisation, starting with the individual at the centre, living in the community. The first level of support for that individual includes the people, activities and support all people need in their every day lives – family, friends, circles of support, housing, employment and leisure.

Most people with learning disabilities or autism will need more support from a range of sources: their GP or other primary care services, advocacy, a care manager or support worker and could include short breaks. That support may change as needs change, and this will involve assessments of physical or mental health needs or environmental needs (such as loss of a parent, a relationship breakdown, unemployment) to identify what support should be provided.

For people who need further support – including where they have behaviour which challenges – the intensity of support should increase to match need. That should include intensive support services in the community, assessment and treatment services (which could be provided in a safe community setting), and, where appropriate, secure services. But the aim should always be to look to improvement, recovery, and returning a person to their home setting wherever possible.

Responsibility for safety and quality of care depends on all parts of the system working together:

i. **providers** have a duty of care to each individual they are responsible for, ensuring that services meet their individual needs and putting systems and processes in place to provide effective, efficient and high quality care;
ii. **commissioners** (NHS and local authorities) are responsible for planning for local needs, purchasing care that meets people's needs and building into contracts clear requirements about the quality and effectiveness of that care;
iii. **workforce,** including health and care professional and staff who have a duty of care to each individual they are responsible for; and
iv. **system and professional regulators** who are responsible for assuring the quality of care through the discharge of their duties and functions.

To achieve these outcomes a revised model of care as set out below needs to be delivered.

Roles and responsibilities

Good services meeting the needs of everybody must include:

<u>Information</u>

- **Councils, elected councillors, health bodies and all care providers, whether from the public, for-profit or not-for-profit sectors** should provide good quality, transparent, information, advice and advocacy support for individuals, families and carers.

<u>Community based support</u>

- **Councils and health commissioners** should ensure that general services (GPs, hospitals, libraries, leisure centres etc) are user-friendly and accessible to people with learning disabilities/autism so they can access what everyone else can access.

- **Community based mental health services** for this group should offer assertive outreach, 24-hour crisis resolution, a temporary place to go in crisis and general support to deal with the majority of additional support needs at home.
- **Housing** authorities should include a wide range of community housing options - shared, individual, extra care, shared lives scheme, domiciliary care, keyring, respite.
- **Social care commissioners** should ensure the availability of small-scale residential care for those who would benefit from it (eg because they have profound and multiple disabilities).
- **Councils and employment services** should offer support into employment.
- **Councils and providers of services** should enable a range of daytime activities.
- **Councils** should roll out personal budgets for all those who are eligible for care and support including those with profound and multiple disabilities and/or behaviours seen as challenging.
- Where appropriate, **health commissioners** should fund continuing health care.
- **Health and social care commissioners** should focus on early intervention and preventive support to seek to avoid crises (eg behavioural strategies). Where crises occur, they should have rapid response and crisis support on which they can call quickly.

Commissioning, assessment and care planning

- **Health and social care commissioners** should develop personalised services that meet people's needs. Key factors include;
- involving individuals - with support where needed - and families at all stages;
- planning for the whole life course, from birth to old age, starting with children's services;
- developing expertise in challenging behaviour;
- developing partnerships and pooling resources to work together on joint planning and support with integrated services – including:
    - multi-disciplinary teams to perform assessments, care planning, care assessment, care management and review,
    - joint commissioning – ideally with pooled budgets, and
    - shared risk management;
- **Health and social care commissioners** should use all available information from joint strategic needs assessments (JSNAs) and local health and wellbeing strategies to commission strategically **for innovation** and to develop person-centred community based services;
- **Health and social care commissioners** should commission personalised services tailored to the needs of individuals, ensuring a focus on improving that individual's health and well-being and agreed outcomes. Progress towards delivering outcomes should be regularly reviewed;
- **Health and social care commissioners** should start to plan from day one of admission to inpatient services for the move back to community;
- **Health and social care commissioners** should ensure close coordination between the commissioning of specialised services including secure services, and other health and care services;

- **Social care bodies** have ongoing responsibility for individuals, even where they are in NHS-funded acute or mental health services, including working with all partners to develop and work towards delivering a discharge plan;
- **Health and social care commissioners** should audit provision to assess which services are good at supporting people with challenging behaviour (the Health Self Assessment Framework is an effective way to monitor outcomes);
- **Health and social care commissioners** should develop effective links with children's services to ensure early planning at transition and joint services. The SEND Green Paper proposal for an integrated health, education and care plan from 0-25 will also help to ensure that children's services are similarly thinking about a young person's transition to adult services at an early stage.

Service Providers

- **All service providers** (community, residential, health, care, housing – public, for-profit and not-for-profit providers) have a duty of care to the individuals for whom they provide services and a legal duty to refer. This includes ensuring that:
    - people are safe and protected from harm;
    - their health and well-being are supported;
    - their care needs are met;
    - people are supported to make decisions about their daily lives;
    - people are supported to maintain friendships and family links.

Providers should:

- provide effective and appropriate leadership, management, mentoring and supervision. Good leadership is essential in setting the culture and values;
- have a whole organisation approach to Positive Behaviour Support training;
- recruit for values and ensure that staff have training for skills - mandatory training which can include training on value bases when working with people with learning disabilities, positive behaviour support, types of communication including non-verbal communication, active support and engaging in meaningful activities and Mental Capacity requirements. Best practice includes involving people with learning disabilities and families in the training;
- operate good clinical governance arrangements;
- monitor quality and safety of care;
- Work with commissioners to promote innovation – new and different ideas, especially for the most challenging.

Assessment and treatment services

- **Health and care commissioners** are responsible for commissioning assessment and treatment services where these are needed. The focus should be on services (which can be community based) rather than units**.** Where a person is at risk (or is putting others at risk) in a way that community support cannot help and needs to be moved to a safe place, **commissioners** should focus on this being provided close to home.
- **Health and care commissioners** should look to review any placement in assessment and treatment services regularly, and focus on moving the individual on into more appropriate community based services as soon as it is safe for the individual to do so.

- **Social care services** should be closely involved in decisions to admit to assessment and treatment services.
- All **assessment and treatment services providers** must comply with statutory guidance on the use of physical restraint.

<u>Prisons and secure services</u>

- **Social care services** should work closely with prison and secure services to ensure person centred planning and health action planning and to plan for appropriate provision when people move on from prison or secure services.
- **Offender management processes** should include health screening programmes that identify an offender's learning disability and any physical and/or mental health issues.

<u>Workforce</u> should demonstrate that they are providing quality care and support which includes:

- personal and professional accountability;
- training in working with people with complex needs and behaviour which challenges;
- developing good communication and involving advocates and families'
- monitoring an individual's progress and reviewing plans; and
- good understanding of the legislative framework and human rights;
- Taking action to report any concerns identified.

System and professional regulators

As a regulator, the Care Quality Commission (CQC) should:

- monitor whether services are meeting essential standards;
- take enforcement action if a provider is not compliant;
- monitor the operation of the Mental Health Act 1983.

Professional regulators such as the Nursing and Midwifery Council (NMC) and General Medical Council (GMC), have a role to play to protect and promote public safety. They do this by:

- setting and maintaining professional standards;and
- investigating and taking appropriate action where concerns are raised about registrants, which can include the registrant being removed from the register and where appropriate being referred to the Independent Safeguarding Authority (ISA).

The professional regulators have produced a leaflet to help the public to ensure that they receive the care and treatment from professionals who meet the right standards.

Annex B: Timetable of Actions

This Report sets out a range of national actions which the Department of Health and its partners will deliver to lead a redesign in care and support for people with learning disabilities or autism and mental health conditions or behaviours viewed as challenging.

The Department of Health is committed to working with partners to monitor progress, hold all players to account for delivery, and ensure better experiences and improved outcomes for this very vulnerable group of people.

No.	Date	Action
1.	From June 2012	CQC will continue to make unannounced inspections of providers of learning disability and mental health services employing people who use services and families as vital members of the team.
2.	From June 2012	CQC will take tough enforcement action including prosecutions, restricting the provision of services, or closing providers down, where providers consistently fail to have a registered manager in place.
3.	From June 2012	CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff.
4.	From November 2012	The cross-government Learning Disability Programme Board will measure progress against milestones, monitor risks to delivery and challenge external delivery partners to deliver to the action plan of all commitments. CQC, the NHSCB and the head of the LGA, ADASS, NHSCB development and improvement programme will, with other delivery partners, be members of the Programme Board, and report on progress.
5.	From December 2012	The Department of Health will work with the CQC to agree how best to raise awareness of and ensure compliance with Deprivation of Liberty Safeguards provisions to protect individuals and their human rights and will report by Spring 2014.
6.	From December 2012	The Department of Health will, together with CQC, consider what further action may be needed to check how providers record and monitor restraint.
7.	From December 2012	The Department of Health will work with independent advocacy organisations to identify the key factors to take account of in commissioning advocacy for people with learning disabilities in hospitals so that people in hospital get good access to information, advice and advocacy that supports their particular needs.
8.	From December 2012	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy, through strengthening the Action for Advocacy Quality Performance Mark and reviewing the Code of Practice for advocates to clarify their role.
9.	From December 2012	A specific workstream has been created by the police force to identify a process to trigger early identification of abuse. The lessons learnt from the work undertaken will be disseminated nationally. All associated learning from the review will be incorporated into training and practice,

No.	Date	Action
		including Authorised Professional Practice.
10.	From December 2012	The College of Social Work, to produce key points guidance for social workers on good practice in working with people with learning disabilities who also have mental health conditions;
11.	From December 2012	The British Psychological Society, to provide leadership to promote training in, and appropriate implementation of, Positive Behavioural Support across the full range of care settings.
12.	From December 2012	The Royal College of Speech and Language Therapists, to produce good practice standards for commissioners and providers to promote reasonable adjustments required to meet the speech, language and communication needs of people with learning disabilities in specialist learning disability or autism hospital and residential settings.
13.	By end of December 2012	The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. They will involve key partners including DH, ADASS, ADCS and CQC in this work, as well as people with challenging behaviour and their families. The programme will be operating within three months and Board and leadership arrangements will be in place by the end of December 2012. DH will provide funding to support this work.
14.	By end December 2012	By December 2012 the professional bodies that make up the Learning Disability Professional Senate will refresh *Challenging Behaviour: A Unified Approach* to support clinicians in community learning disability teams to deliver actions that provide better integrated services.
15.	By January 2013	Skills for Health and Skills for Care will develop national minimum training standards and a code of conduct for healthcare support workers and adult social care workers. These can be used as the basis for standards in the establishment of a voluntary register for healthcare support workers and adult social care workers in England.
16.	By February 2013	Skills for Care will develop a framework of guidance and support on commissioning workforce solutions to meet the needs of people with challenging behaviour
17.	By March 2013	The Department of Health will commission an audit of current services for people with challenging behaviour to take a snapshot of provision, numbers of out of area placements and lengths of stay. The audit will be repeated one year on to enable the learning disability programme board to assess what is happening.
18.	By March 2013	The NHSCB will work with ADASS to develop practical resources for commissioners of services for people with learning disabilities, including: ▪ model service specifications; ▪ new NHS contract schedules for specialist learning disability services; ▪ models for rewarding best practice through the NHS; commissioning for Quality and Innovation (CQUIN) framework; and ▪ a joint health and social care self-assessment framework to support local agencies to measure and benchmark progress.
19.	By March 2013	The NHSCB and ADASS will develop service specifications to support CCGs in commissioning specialist services for children, young people and

No.	Date	Action
		adults with challenging behaviour built around the model of care in Annex A.
20.	By March 2013	The Joint Commissioning Panel of the Royal College of General Practitioners and the Royal College of Psychiatrists will produce detailed guidance on commissioning services for people with learning disabilities who also have mental health conditions.
21.	By March 2013	The Royal College of Psychiatrists will issue guidance about the different types of inpatient services for people with learning disabilities and how they should most appropriately be used.
22.	By 1 April 2013	The NHSCB will ensure that all Primary Care Trust develop local registers of all people with challenging behaviour in NHS-funded care.
23.	By 1 April 2013	The Academy of Medical Royal Colleges and the bodies that make up the Learning Disability Professional Senate will develop core principles on a statement of ethics to reflect wider responsibilities in the health and care system.
24.	By 1 April 2013	The National Quality Board will set out how the new health system should operate to improve and maintain quality.
25.	By 1 April 2013	The Department of Health will work with key partners to agree how Quality of Life principles should be adopted in social care contracts to drive up standards.
26.	From 1 April 2013	The NHSCB will make clear to CCGs in their handover and legacy arrangements what is expected of them in maintaining local registers, and reviewing individual's care with the Local Authority, including identifying who should be the first point of contact for each individual.
27.	From April 2013	The NHSCB will hold CCGs to account for their progress in transforming the way they commission services for people with learning disabilities/autism and challenging behaviours.
28.	From April 2013	Health Education England will take on the duty for education and training across the health and care workforce and will work with the Department of Health, providers, clinical leaders and other partners to improve skills and capability to respond the needs of people with complex needs.
29.	From April 2013	CQC will take action to ensure the model of care is included as part of inspection and registration of relevant services from 2013. CQC will set out the new operation of its regulatory model, in response to consultation, in Spring 2013.
30.	From April 2013	CQC will share the information, data and details they have about providers with the relevant CCGs and local authorities.
31.	From April 2013	CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration.
32.	From April 2013	Monitor will consider in developing provider licence conditions, the inclusion of internal reporting requirements for the Boards of licensable provider services to strengthen the monitoring of outcomes and clinical governance arrangements at Board level.
33.	From April 2013	The strong presumption will be in favour of pooled budget arrangements with local commissioners offering justification where this is not done. The NHSCB, ADASS and ADCS will promote and facilitate joint

No.	Date	Action
		commissioning arrangements.
34.	From April 2013	The NHSCB will ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism receive safe, appropriate and high quality care. The presumption should always be for services to be local and that people remain in their communities.
35.	From April 2013	Health and care commissioners should use contracts to hold providers to account for the quality and safety of the services they provide.
36.	From April 2013	Directors, management and leaders of organisations providing NHS or local authority funded services to ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care.
37.	From April 2013	The Department of Health, the Health and Social Care Information Centre and the NHSCB will develop measures and key performance indicators to support commissioners in monitoring their progress.
38.	From April 2013	The NHSCB and ADASS will implement a joint health and social care self assessment framework to monitor progress of key health and social care inequalities from April 2013. The results of progress from local areas will be published.
39.	From April 2013	The Department of Health will work with the LGA and Healthwatch England to embed the importance of local Healthwatch involving people with learning disabilities and their families. A key way for local Healthwatch to benefit from the voice of people with learning disabilities and families is by engaging with existing local Learning Disability Partnership Boards. LINks (local involvement networks) and those preparing for Healthwatch can begin to build these relationships with their Boards in advance of local Healthwatch organisations starting up on 1 April 2013.
40.	By Spring 2013	The Department of Health will immediately examine how corporate bodies, their Boards of Directors and financiers can be held to account for the provision of poor care and harm, and set out proposals during Spring 2013 on strengthening the system where there are gaps. We will consider both regulatory sanctions available to CQC and criminal sanctions. We will determine whether CQC's current regulatory powers and its primary legislative powers need to be strengthened to hold Boards to account and will assess whether a fit and proper persons test could be introduced for board members.
41.	From Spring 2013	CQC will take steps now to strengthen the way it uses its existing powers to hold organisations to account for failures to provide quality care. It will report on changes to be made from Spring 2013.
42.	By 1 June 2013	Health and care commissioners, working with service providers, people who use services and families, will review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.
43.	By Summer 2013	Provider organisations will set out a pledge or code model based on shared principles - along the lines of the Think Local Act Personal (TLAP)

No.	Date	Action
		Making it Real principles.
44.	By Summer 2013	The Department of Health, with the National Valuing Families Forum, the National Forum of People with Learning Disabilities, ADASS, LGA and the NHS will identify and promote good practice for people with learning disabilities across health and social care.
45.	By summer 2013	The Department of Health will explore with the Royal College of Psychiatrists and others whether there is a need to commission an audit of use of medication for this group. As the first stage of this, we will commission a wider review of the prescribing of antipsychotic and antidepressant medicines for people with challenging behaviour.
46.	By June 2013	The Department of Health and the Department for Education will work with the independent experts on the Children and Young People's Health Outcomes Forum to prioritise improvement outcomes for children and young people with challenging behaviour and agree how best to support young people with complex needs in making the transition to adulthood.
47.	In 2013	The Department of Health and the Department for Education will develop and issue statutory guidance on children in long-term residential care.
48.	In 2013	The Department of Health and the Department for Education will jointly explore the issues and opportunities for children with learning disabilities whose behaviour is described as challenging through both the SEN and Disability reform programme and the work of the Children's Health Strategy.
49.	In 2013	The Department of Health will work with independent advocacy organisations to drive up the quality of independent advocacy.
50.	In 2013	The Department for Education will revise the statutory guidance *Working together to safeguard Children.*
51.	In 2013	The Royal College of Psychiatrists, the Royal Pharmaceutical Society ad other professional leadership organisations will work with ADASS and ADCS to ensure medicines are used in a safe, appropriate and proportionate way and their use optimised in the treatment of children, young people and adults with challenging behaviour. This should include a focus on the safe and appropriate use of antipsychotic and antidepressant medicines.
52.	By December 2013	The Department of Health will work with the improvement team to monitor and report on progress nationally, including reporting comparative information on localities. We will publish a follow up report by December 2013.
53.	By end 2013	The Department of Health with external partners will publish guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort where the safety of individuals would otherwise be at risk and never to punish or humiliate.
54.	By end 2013	There will be a progress report on actions to implement the recommendations in *Strengthening the Commitment* the report of the UK Modernising learning disability Nursing Review.
55.	By end 2013	CQC will also include reference to the model in their revised guidance about compliance. Their revised guidance abut compliance will be linked to the Department of Health timetable of review of the quality and safety regulations in 2013. However, they will specifically update providers about

No.	Date	Action
		the proposed changes to our registration process about models of care for learning disability services in 2013.
56.	From 2014	The Department of Health will work with the Department for Education to introduce a new single assessment process and Education, Health and Care Plan to replace the current system of statements and learning difficulty assessments for children and young people with special educational needs; supported by joint commissioning between local partners (subject to parliamentary approval). The process will include young people up to the age of 25, to ensure they are supported in making the transition to adulthood.
57.	By April 2014	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area. This could potentially be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) processes.
58.	No later than 1 June 2014	Health and care commissioners should put plans into action as soon as possible and all individuals should be receiving personalised care and support in appropriate community settings no later than 1 June 2014.
59.	In 2014	The Department of Health will update the Mental Health Act Code of Practice and will take account of findings from this review.
60.	By December 2014	The Department of Health will publish a second annual report following up progress in delivering agreed actions.
61.	From 2014/15	The Department of Health will develop a new learning disability minimum data set to be collected through the Health and Social Care Information Centre.
62.	By Summer 2015	NICE will publish quality standards and clinical guidelines on challenging behaviour and learning disability.
63.	By Summer 2016	NICE will publish quality standards and clinical guidelines on mental health and learning disability.

Glossary

ACPO	Association of Chief Police Officers
A & E	Accident and Emergency
A & T	Assessment and Treatment
A4A	Action for advocacy
ADASS	Association of Directors for Adult Social Services
ADCS	Association of Directors of Children's Services
BBC	British Broadcasting Corporation
CCG	Clinical Commissioning Groups
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DfE	Department for Education
DH	Department of Health
DOLS	Deprivation of Liberty Safeguards
EOF	Education Outcomes Framework
GP	General Practitioner
HEE	Health Education England
JHWSs	Joint Health and Wellbeing Strategies
JSNAs	Joint Strategic Needs Assessments
LA	Local Authorities
LD	Learning Disability
LGA	Local Government Association
LINKS	Local involvement networks
NHS	National Health Service
NHSCB	National Health Service Commissioning Board
NICE	National Institute for Health and Clinical Excellence
NQB	National Quality Board
Ofsted	Office for Standards in Education, Children’s Services and Skills
RCGP	Royal College of General Practitioners
RCPsych	Royal College of Psychiatrists
SAB	Safeguarding Adults Boards
SCR	Serious Case Review
TLAP	Think Local Act Personal

Mental Health Commission

Seclusion and Physical Restraint Reduction Strategy

Consultation Report

January 2013

Executive Summary

The Mental Health Commission approved a Draft Seclusion and Physical Restraint Reduction Strategy in November 2011 on the basis that it would issue for wider consultation. The draft strategy consisted of 18 actions which it was proposed to implement to reduce the use of seclusion and physical restraint in approved centres. The 18 actions were grouped into seven intervention categories:

- State Policy and Regulation Change;
- Leadership;
- Staffing;
- Training and Education;
- Patient, Family and Advocate Involvement;
- Using data to monitor seclusion and restraint episodes; and
- Review Procedures/Debriefing.

A written consultation exercise commenced on 12th June 2012 and ran for three months until 12th September 2012. The Commission"s consultation document[1] asked stakeholders to identify the draft actions that they considered should be prioritised for implementation, those actions that they considered appropriate for medium-term implementation and those matters that were suitable for longer term implementation. Stakeholders were also asked to identify those actions that they considered were not suitable to include as part of the final strategy. General views were also sought on the usefulness of the strategy.

Fifty-two respondents made submissions as part of the consultation exercise. Respondents were representative of all major stakeholder groups. We would like to thank everyone who took the time to participate in the consultation.

Responses to Consultation Document Questions

Almost all (97.9%) respondents stated that it would be useful to put a seclusion and physical restraint reduction strategy in place.

Respondents also fed back on the different actions outlined in the draft strategy. This summary outlines stakeholder views on each action using quantitative data and supplementary comments that were presented for each action.

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[1] The consultation document can be accessed at the following web address: http://www.mhcirl.ie/Consultations/Previous_Consultations/

Intervention Category – Policy and Regulation Changes

Action 1 - Linking Service and Safety
More than half (18/33) of respondents stated that this action should be prioritised and over one quarter (9/33) indicated that it was appropriate for medium-term implementation. Five submissions (15.2%) considered that it was suitable for long- term implementation.

A submission from the Project Joint Governance Committee *of Linking Service & Safety* which has responsibility for overseeing its implementation, informed us that they would be "*pleased to provide updates on the implementation of the Linking Service & Safety Strategy*".

Intervention Category: Leadership

Action 2 – Peer to Peer Networking
A majority (21/39) of respondents stated that peer to peer networking was appropriate for medium-term implementation. One quarter (10/39) considered that it should be put in place as a priority action and 15% of respondents (6/39) suggested that it should be realised in the long-term.

Action 3 – Responsibility for Implementation of Strategy
A large majority of over 77% (28/36) of respondents indicated that this action should be prioritised. One in six (8/36) respondents considered that it should be realised as a medium-term action.

Action 4 – Seclusion and Restraint Reduction Plan
A substantial majority of more than nine in ten respondents (34/37) indicated that the development of a seclusion and restraint reduction plan should be prioritised. Three submissions (8.1%) expressed a preference for implementing it in the medium-term.

Action 5 – Demonstrate Commitment to Implement Reduction Plan
Almost eight out of ten (31/39) respondents supported prioritising this action. Seven submissions (18%) indicated that it was appropriate for medium-term implementation.

Action 6 – Examine Feasibility of Removing Seclusion Rooms
Two-fifths (14/36) of respondents considered that it was most appropriate to examine the feasibility of removing seclusion rooms in the long term. Eleven per cent (4/34) of respondents suggested that this action was not suitable to implement. One quarter (9/36) of responses stated that it should be a priority action and the same proportion supported implementing it in the medium-term.

Comments on Leadership Actions
In general, respondents recognised the critical importance of leadership to the success of the strategy. This was reflected in the strong support for prioritising three of the five leadership actions. A recurring theme in several submissions related to where responsibility for implementing these actions was allocated. A large number of respondents stated that it was insufficient to allocate responsibility for actions to senior managers, Clinical Directors and Registered Proprietors. It was suggested that there needed to be more multidisciplinary involvement and a key role assigned to senior nurses in particular.

Reflecting preferences for implementing peer-to-peer networking as a medium-term action, many submissions stated that more consultation with stakeholders was needed before it could be implemented. Many respondents felt that this action assumed that services with low uses of seclusion and restraint were best practice services and that this was erroneous.

Though only one fifth of respondents stated that the proposal to examine the feasibility of removing seclusion rooms was not suitable to include in the strategy, most commentary on this action reflected strong concerns over implementing this action. It was suggested that it was impractical in the absence of alternatives and that it risked alienating staff members and reducing good will towards a strategy.

Intervention Category: Staffing

Action 7 – Call for Exemption from Moratorium on Recruitment
Almost seven out of ten respondents (27/39) considered that a call for an exemption from the Moratorium on Recruitment for the mental health services should be prioritised. Close to one quarter (9/39) of submissions stated that it should be implemented in the medium-term.

Action 8 - Psychiatric Emergency Response Teams (PERTs)
Four out of every ten respondents (16/39) considered that the development of psychiatric emergency response teams (PERTs) should be put in place in the medium term. Just over 10% (4/39) of respondents supported prioritising the action. Eleven (28.2%) submissions considered that this action should be realised in the longer-term. A relatively large proportion (20.5%) of respondents did not support including this action in the strategy.

Action 9 – Staff Rotation
More than one-third (12/33) of submissions indicated that staff rotation should be prioritised. Three out of ten (30.3%) respondents stated that it should be implemented in the medium-term and one quarter (24.2%) considered it appropriate for longer-term implementation.

Comments on Staffing Actions
Comments reflected the strong support for prioritising the action related to a call for an exemption from the Moratorium on Recruitment in the Public Service. It was frequently reported that it was simply not feasible to introduce a strategy if there were further reductions in staffing numbers in services.

Some comments were supportive of the development of PERTS and of the proposal to rotate staff but the majority of commentary identified concerns regarding including these actions in the final strategy. A recurring theme was that there were simply too few staffing resources at present to contemplate putting either action in place. A number of respondents considered that both actions may lead to the deskilling of staff. It was also suggested that PERTS were not suitable for Irish mental health services as they were mainly associated with services in the United States.

Intervention Category: Training and Education

Action 10 – Additional Guidance on Training
More than four out of five (31/39) respondents supported implementing additional guidance on training as a priority. Six respondents (15%) supported implementing this action in the medium term.

Many respondents reflected on the lack of standardised training addressing seclusion and restraint use in Ireland. Staffing and financial shortages were identified as a barrier to realising this action. Others felt that the strategy also needed to address how the prevention and management of violence and aggression are addressed in third level curricula.

Intervention Category: Patient, Family and Advocate Involvement

Action 11 – Assessment Following Admission
Seven out of ten (70.3%) respondents supported implementing this action as a priority. Almost one quarter (9/37) of submissions stated that it should be realised in the medium term.

Action 12 – Advocate and Service User Involvement in Reduction Initiatives
Over one half (20/39) of respondents supported prioritising this action. Almost two-fifths (15/39) of submissions supported implementing this proposal in the medium-term.

Comments on Staffing Actions
Involving service users, family members, carers and advocates in reduction initiatives was almost universally recognised as a welcome development. A number of services commented on their positive experiences of working with service users and advocates currently. Much support for including the action related to an assessment talking place following the admission of a patient, including a risk assessment, was based on the fact that this is already expected of services as a provision of the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre*. Common challenges associated with implementing advance directives were, however, noted.

Intervention Category: Using data to monitor seclusion and restraint episodes

Action 13 – Seclusion and Restraint Reduction Targets
The inclusion of seclusion and restraint reduction targets as a medium-term action was favoured by 36.4% (12/33) of respondents. Around one quarter (8/33) of respondents stated that it should be a priority action and approximately one-fifth (6/33) indicated that it should be realised in the longer term. A relatively large percentage of 21.2% of respondents considered that this action should not be implemented.

Action 14 – Additional Data Analysis on Seclusion and Restraint Episodes
Just under one half (16/35) of respondents wanted to include the action related to the undertaking of additional data analysis on seclusion and restraint use. One quarter (25.7%) of responses supported carrying out this action in the longer term and one sixth (17.1%) stated that it should be prioritised.

Action 15 – Examine Feasibility of Developing Electronic Registers
Just over 44% (15/34) of respondents supported the implementation of this action in the long term. Around one-third (12/34) of respondents considered that this action should be executed in the medium term. Five (14.7%) submissions indicated that it should be a priority action.

Action 16 – Examine Feasibility of Collecting Additional Data on Seclusion and Physical Restraint Use
Close to 42% (13/31) of respondents favoured implementing this action in the medium-term and 38.7% (12/31) stated that it should be included in the strategy as a long term action. One in six (5/31) respondents believed that this action should be prioritised.

There was much less support for prioritising all actions related to the use of data to monitor seclusion and restraint episodes than for all other actions. It was frequently observed that it was more appropriate to consider additional actions initially because data collection was already taking place. Common concerns related to these actions were that they would be difficult to implement because of staff shortages, costs, insufficient ICT systems and poor ICT infrastructure. Commentary on our proposals revealed strong opposition to the proposal to introduce seclusion and restraint reduction targets in particular.

Intervention Category: Review Procedures/Debriefing

Action 17 – Additional Guidance on Debriefing
Almost three-quarters (29/40) of respondents wanted to prioritise the inclusion of additional guidance on debriefing. One quarter (10/40) considered that it should be put in place in the medium term.

Action 18 – Additional Guidance on Review Procedures
A large majority of almost seven in ten (25/36) respondents supported prioritising the inclusion of additional guidance on review procedures. Around one quarter (8/36) of respondents wished to implement this action in the medium term.

A large number of respondents who supported the speedy implementation of guidance on debriefing and review procedures linked their support to the fact that these issues were already covered by guidance outlined in the Commission Rules and a Code of Practice. Debriefing and review procedures were both identified as valuable reflective learning experiences.

Other Comments and Suggestions

The final consultation question asked respondents to indicate any additional comments or suggestions that they had on the strategy. These included:

- **Omissions from the draft strategy** such as the role of the physical environment, the administration of medication and increased staff-to-patient ratios;
- **The scope of the draft strategy**. There was a wish to extend the strategy to other locations where restrictive interventions are used such as penal institutions and settings where services are provided to people with intellectual disabilities;
- **Implementation of the strategy**; Challenges posed by the shortage of resources were noted. Suggestions included a request for clarification on the timeframes associated with each action.
- **The Knowledge Review**. Suggestions were made regarding additional literature that could be perused, in particular literature related to people with intellectual disabilities and older people;
- **Contextual Developments** including the inappropriate placement of some patients in approved centres; and
- Matters which were considered **outside the scope** of the consultation.

Table of Contents

1. Background

1.1 Introduction

The Mental Health Commission regulates seclusion and restraint in Irish approved centres in the form of *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* and the *Code of Practice on the Use of Physical Restraint in Approved Centres*. Linked to this regulatory role, the Commission developed a Draft Seclusion and Physical Restraint Reduction Strategy during 2011. The draft strategy consists of 18 actions which were formulated following the completion of a knowledge review on seclusion and restraint reduction.

In addition to our regulation of the use of seclusion and restraint, the Commission considered it appropriate to develop a strategy for other reasons:

- We already collect data on the use of these interventions and publish annual reports on the extent of their use;
- Doubts persist over the safety and effectiveness of seclusion and restraint and of their impact on patients; and
- Successful seclusion and restraint reduction strategies have been implemented in other countries.

The Mental Health Commission approved the draft strategy in November 2011 on the understanding that it would issue for wider consultation before implementation. This consultation exercise took place from 12th June 2012 until 12th September 2012. This report summarises what we heard during the consultation exercise.

The Commission would like to acknowledge its appreciation to everyone who participated in the consultation exercise. It is clear that a lot of effort and resources were involved in preparing submissions which we are especially grateful for.

1.2 Consultation Process

The consultation required stakeholders to express views on 18 specific actions included in the draft strategy. These were best considered following an examination of the knowledge review which informed the development of the strategy. The Commission therefore considered that a written consultation exercise was the most appropriate means for stakeholders to submit feedback as a detailed consideration of the relevant issues was required. We prepared a consultation document to facilitate the consultation process which can be accessed at the following web address:
http://www.mhcirl.ie/Consultations/Previous_Consultations/

The consultation document includes background information on the development of the draft strategy and specifies the 18 actions that it consists of. Seven consultation questions were included that aimed to elicit respondents‟ views. Stakeholders were asked about the usefulness of putting a strategy in place and to prioritise the different actions. Participants prioritised the draft strategy‟s actions by identifying those that they would prioritise for implementation, actions that they considered were suitable for medium-term implementation and actions that were regarded as appropriate for longer-term implementation. Respondents were also asked to indicate which actions they considered were not suitable to implement.

A three-month period was chosen for the written consultation exercise in order to allow stakeholders sufficient time to consider the consultation document and knowledge review. This is in line with the guidance outlined in the *Framework for Public and Service User Involvement in Health and Social Care Regulation in Ireland (2009),* which was produced by the Health and Social Care Regulatory Forum, of which the Commission is a member. Responses could be returned by email or by post.

Some individuals and organisations made requests to submit feedback after the end date of 12th September 2012 and these were facilitated. Appendix 1 includes details of all of the organisations and groups that made submissions as part of the consultation process.

Details of the consultation were also posted on the Commission‟s website for the duration of the consultation period. Information on the consultation was also provided on the websites of other organisations and included in some health sector publications. All queries received in relation to the consultation were responded to. All submissions were also logged and analysed by the Commission.

1.3 Overview of Respondents

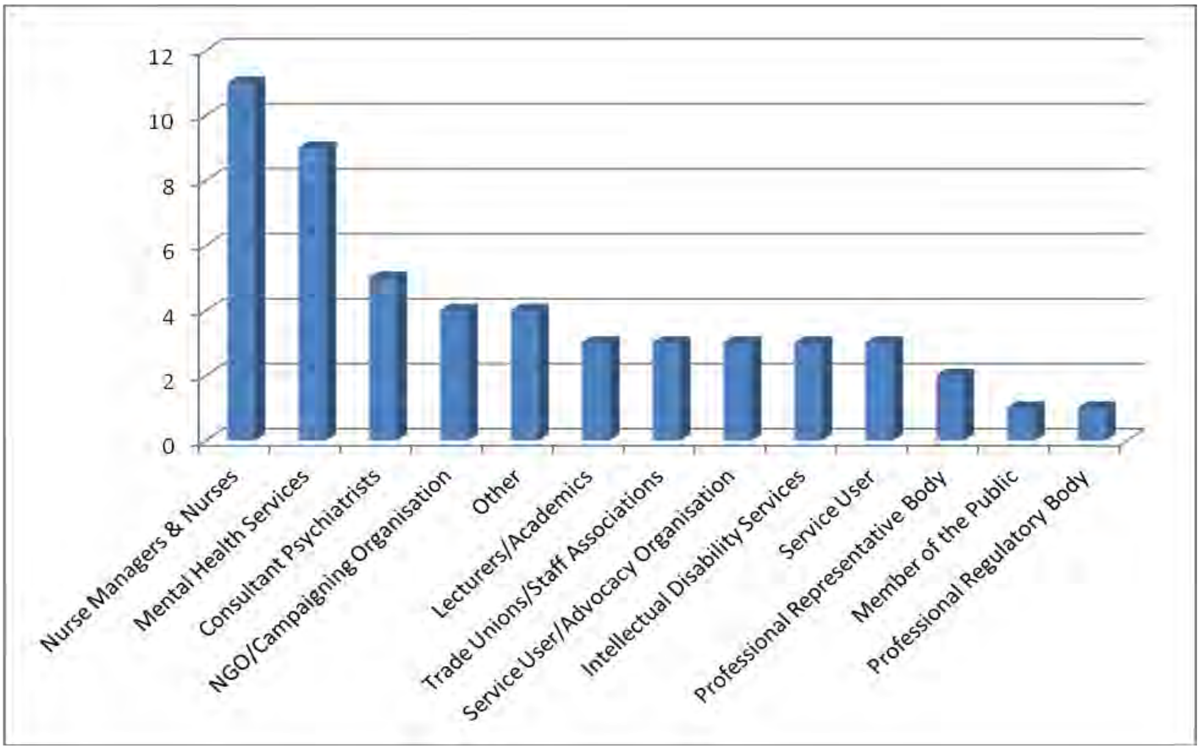
The Commission received 52 responses as part of the consultation. Figure 1 illustrates the breakdown of submissions by a number of respondent type categories. It shows that the largest group from which submissions came were nurse managers and nurses. These 12 respondents included individual nurses, groups of nurses, nurse instructors in the Professional Management of Aggression and Violence (PMAV) and nursing practice/policy development committees.

Submissions made by other respondent types also reflected a nursing focus. Three submissions were made by nurse lecturers and academics, three responses were received from staff associations/trade unions representing nurses and we also received feedback from An Bord Altranais, the professional regulatory body for nurses and midwives.

The second largest number of submissions came from specific mental health services and these also incorporated the views of many nurses. These 9 responses were received from approved centres, general adult mental health services, a mental health service for older people and the national forensic service. Though submissions from services largely reflected the input of nurses and consultant psychiatrists, eight of these nine submissions, nevertheless, included the opinions of other multidisciplinary team members and additional relevant persons. Views were therefore also provided by occupational therapists, social workers, psychologists, behavioural therapists, social care workers, advocates and managers.

Submissions were also made by two intellectual disability services and a joint submission was received on behalf of a mental health service and an intellectual disability service.

Figure 1: Overview of Responses to Consultation by Respondent Type



n = 52

Five consultation submissions were made by individual consultant psychiatrists or groups of consultant psychiatrists. This included one submission from the group of 15 Executive Clinical Directors. The two submissions from professional representative bodies included feedback from the Faculty of General Adult Psychiatry at the College of Psychiatry of Ireland. The other submission from a professional representative body was made on behalf of the Association of Occupational Therapists of Ireland (AOTI) Special Interest Group in Mental Health.

Feedback on the consultation was also provided by four non-governmental organisations (NGOs) or campaigning organisations. These were Mental Health Reform, Amnesty International Ireland, Barnardos and Children in Hospital Ireland.

Three further submissions were made by service user or advocacy organisations. These responses were made on behalf of the National Service User Executive (NSUE), the Irish Advocacy Network (IAN) and Shine. Three responses also came from individual service users.

Of the 52 submissions, 40 were joint submissions and 12 were made by individuals. Joint submissions were either organisational submissions or responses on behalf of a number of people.

2. Consultation Findings

The report presents the findings for all of the questions contained in the consultation document. We first summarise what we heard in responses to the first question as we asked stakeholders to comment on the usefulness of putting a strategy in place.

Findings in respect of the next five questions are then considered together. Questions 2-5 addressed the 18 specific actions included as part of the draft strategy and asked respondents to differentiate between actions by indicating which actions they would prioritise for implementation and which actions they regarded as suitable for medium-term and longer-term implementation. Participants were also asked to identify any actions which were not suitable for implementation. The sixth question in the consultation document asked respondents to explain their responses to each of the above questions. As responses addressed many of the eighteen actions in a number of the above consultation questions, we considered it appropriate to present the consultation feedback from all of the above questions for each action separately.

The findings section concludes by presenting an analysis of responses to the final question where respondents included any other comments and suggestions that they had on the strategy.

Some respondents included feedback on some questions that upon analysis, we felt was more appropriate to consider alongside responses to different questions. The presentation of the findings also reflects this.

2.1 Findings for Consultation Question 1: Usefulness of Strategy

The consultation document's opening question asked respondents: *Do you think it would be useful to put a Seclusion & Physical Restraint Reduction Strategy in place?*

Forty-eight of the 52 submissions included a response to this question. The overwhelming majority (97.9%) of these submissions indicated that it would be useful to put such a strategy in place although some respondents qualified their response by highlighting challenges or necessary pre-requisites before such a strategy could be implemented. Typical responses indicated that "*I definitely think that it would be useful*", that "*A strategy is essential*" and that "*we welcome the strategy*".
"Ideally we would like to see seclusion removed from all acute admission units and fully support the development of a strategy for reduction" – **[Faculty of General Adult Psychiatry, College of Psychiatry of Ireland].**

One service user emphasised that implementing a strategy would be useful "*only if and when individuals are given their human rights entitlements to have a say on their treatments*".

A more complete analysis of responses showed that respondents identified the following benefits of putting a strategy in place:

- A strategy will provide an opportunity to **review current practices** and encourage staff and services to **explore alternative intervention approaches**. The review of seclusion and restraint interventions would allow for a "*critical eye*" to be cast on the use of seclusion and restraint.
- It would **raise awareness** of the use of seclusion and physical restraint. Some respondents considered that a strategy would focus attention on the use of restrictive interventions on **distinct service user populations** which was especially welcome. These distinct populations included people with intellectual disabilities, older people, children and adolescents and persons using forensic mental health services.
- A strategy would encourage a **standardised approach** to the use of seclusion and restraint.
- A number of submissions noted that a strategy would ensure that a **human rights approach to mental health care** would be adopted.
- A reduction strategy should create **a more therapeutic environment** within mental health services.
- A strategy should also facilitate the creation of a **safe caring and work environment**.
- A strategy should lead to **more collaborative working**. This would occur within teams and also with service users.
- A Seclusion and Physical Restraint Reduction Strategy should lead people to **explore the values and beliefs underpinning attitudes to the use of seclusion and restraint**.
- It would correctly **shift focus away from compliance with Rules and Codes towards achieving reductions in the use of both interventions**.
- Reducing the use of seclusion and restraint would assist with **removing stigma** from people who use mental health services. It was suggested that practices such as seclusion and physical restraint could be seen as a confirmation of all society"s fears and stereotypes around mental illness.
- Putting in place such a strategy would **require commitment from senior management** i.e. ownership of the strategy at the highest levels and encourage managers to manage more creatively.
- It provides an **opportunity to improve data collection and analysis**. Some respondents stated that a strategy would allow for more meaningful comparisons to be made between approved centres using restrictive interventions.

Other benefits associated with implementing a strategy which were expressed were that:

- It would reduce the danger of retraumatising service users who have already been subject to traumatic life events;
- It should reduce aggression and violence in services;
- It would highlight the responsibility of the individual practitioner to be accountable for his or her actions;
- It was compatible with the Commission‟s mandate under the Mental Health Act 2001;
- It should lead to a process of continuous quality improvement;
- It should achieve financial savings;
- It should lead to improved patient and staff satisfaction;
- It would complement existing good governance procedures and practice regarding the use of these interventions; and
- It would encourage services to review the environment in which care is provided.

Many submissions highlighted implementation challenges associated with this strategy in their responses to this question. These included a **lack of staffing and financial resources** and **the relevance of some of the actions for Irish psychiatric services** in particular. These issues are considered in more detail in the analysis of comments on specific actions and in the section where we present the findings of the responses to the final question.

Current Involvement in Reduction Initiatives

The Commission found it very useful to receive feedback from respondents on their **current involvement in reduction initiatives** and related good practice initiatives. A submission from a group of consultant psychiatrists in South Tipperary Mental Health Services observed for instance that:

"*In South Tipperary our experience has been that by reviewing, auditing, educating and promoting discussion the use of seclusion and restraint within the service reduced significantly and became more standardised. We also decommissioned seclusion rooms*".

Reflecting on some of the limitations of the literature from the United States, the National Forensic Service noted that their local strategy had addressed some of these shortcomings by including a range of restrictive practices in addition to seclusion and restraint.

The Psychiatric Nurses Association (PNA) recommended that consideration be given to rolling out a seclusion pathway that is in use in Dublin West/South West Mental Health Services. Another respondent commented on his involvement in the implementation of a very successful trauma informed care strategy in an acute patient setting.

The National Federation of Voluntary Bodies also provided details on initiatives that are in place in some of the intellectual disability services provided by its 62 member organisations. These included Multi-Element Behaviour Support Plans (MEBS) and Rights Review Committees.

Finally, the commitment of some services to commence reviewing their use of restrictive interventions immediately was especially welcome.

2.2 Findings for Specific Actions Included as part of Draft Seclusion and Physical Restraint Reduction Strategy

The four questions to which respondents provided most feedback on the draft strategy's individual actions were Consultation Questions 2 to 5. They were as follows:

> *Which actions specified in Section 2 above [which outlined the 18 actions] would you **prioritise for implementation**?*
>
> *Which actions specified in Section 2 above would you regard as suitable for **medium-term implementation**?*
>
> *Which actions specified in Section 2 above would you regard as suitable for **longer-term implementation**?*
>
> *Are there any actions specified in Section 2 that you consider are **not suitable for implementation?***

The sixth question in the consultation document asked respondents to explain their responses to each of the above questions.

Quantitative information is presented which shows how submissions ranked each action in order of priority. It is important to note that the information presented in graphs identifies how each submission ranked each of the draft strategy"s eighteen actions. **The presented data analysis does not distinguish therefore between responses that came from a single respondent and those which were submitted by an organisation or group of respondents.** We consider, however, that the data as presented still allows for an assessment to be made of how key stakeholders assessed the different components of the strategy.

For each action, the quantitative data that we present is accompanied by a summary of written comments and feedback that were also submitted.

2.2.1Intervention Category: Policy and Regulation Changes - Action 1

Action 1

The MHC should request regular updates on the implementation of those aspects of the HSE Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service, *Linking Service and Safety* (HSE, Dec 2008) that relate to seclusion and physical restraint.
Action: MHC
Intervention Category: Policy and regulation changes

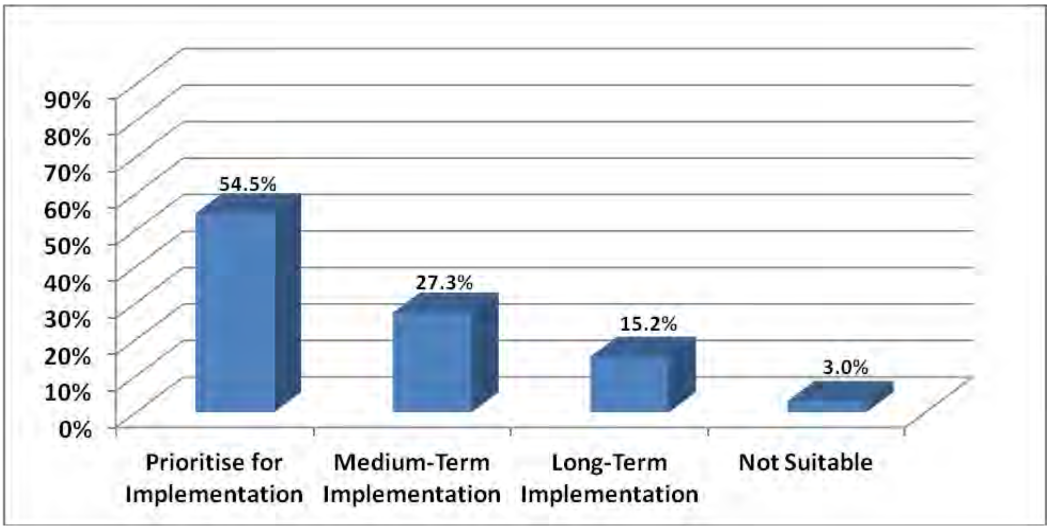
Four of the 34 recommendations set out in the HSE strategy which it has formally adopted as an organisation wide approach to addressing aggression and violence in the workplace are of particular relevance to our draft strategy‟s first action. Recommendations 19 – 22 are set out in Table 1 below.

Table 1: Recommendations 19-22 of HSE Strategy, *Linking Service and Safety*

19.	Proactively aspire to provide services which are „seclusion and restraint minimised‟ at philosophical, organisational and operational levels.
20.	Establish the practice safety and fitness for purpose of physical interventions currently in use as a priority.
21.	The use of physical interventions be subject to standards and regulation at least comparable to those applying to other patient focussed interventions.
22.	Standards governing the training in and the use of physical interventions be developed as a matter of priority.

Thirty-three submissions addressed the first action. Figure 2 indicates how the different submissions prioritised this action. Eighteen or just more than half (54.5%) of these respondents stated that the proposal regarding the request of regular updates on the implementation of *Linking Service and Safety* should be prioritised. More than one quarter (27.3%) of submissions indicated that it was appropriate for medium-term implementation. Five submissions (15.2%) considered that it should be realised in the long- term.

Figure 2: Analysis of Responses to Consultation Questions for Action 1 - ***Linking Service and Safety***



n = 33

Comments on Action 1 – Linking Service and Safety

Submission from Project Joint Governance Committee of *Linking Service and Safety*
We wish to draw attention to a submission that was received from the Project Joint Governance Committee of *Linking Service and Safety*. The Project Joint Governance Committee highlighted ongoing work in relation to Recommendations 21 and 22 in particular. It was acknowledged that the implementation of these recommendations would require engagement with a number of agencies, including the Mental Health Commission. The Commission is a member of the Multi Agency forum whose role is to provide a platform for the Governance Committee to actively consult and collaborate with key stakeholders in implementing key elements of the strategy.

The Project Joint Governance Committee clarified that they "*would be pleased to provide updates on the implementation of the Linking Service & Safety Strategy*".

Support for Action
Other respondents identified the implementation of *Linking Service and Safety* as pivotal to achieving reductions in the use of restrictive interventions. Respondents noted the similarities between the aims of *Linking Service and Safety* and the Commission‟s draft strategy.

Suggested Amendments to Action
A number of respondents suggested changes that should be made to the current wording of the draft actions. It was proposed for instance that:

- The action states that the Commission "*requires updates from the HSE*";

- The action specifies an appropriate timeframe for receipt of these updates and that this should occur on a six-monthly basis;
- *Linking Service and Safety* should be integrated into existing service policies in order to ensure its implementation in a seamless way;
- An "easy read" version of *Linking Service and Safety* should be made available;
- The monitoring of *Linking Service and Safety* should take place by examining the HSE corporate response to the strategy; and
- The action clarifies that the Commission would examine the organisational issues associated with violence and aggression identified in *Linking Service and Safety*.

Challenges to Implementing Action
Respondents who believed that this action should only be implemented in the long-term outlined a variety of different reasons for this view. Concern was expressed that monitoring the implementation of the HSE strategy would perhaps become "*a paper exercise*" and that monitoring the strategy might have no impact if there was no progress implementing *Linking Service and Safety*. There was also a concern that the MHC requests for information would impact on front-line staff who are already obliged to complete a lot of paper work.
One submission noted the slow implementation of the HSE strategy which was linked by the respondent to the Moratorium on Recruitment and Promotion in the Public Services. Finally, one respondent considered that this action was not suitable to implement because it was unlikely to have any impact.

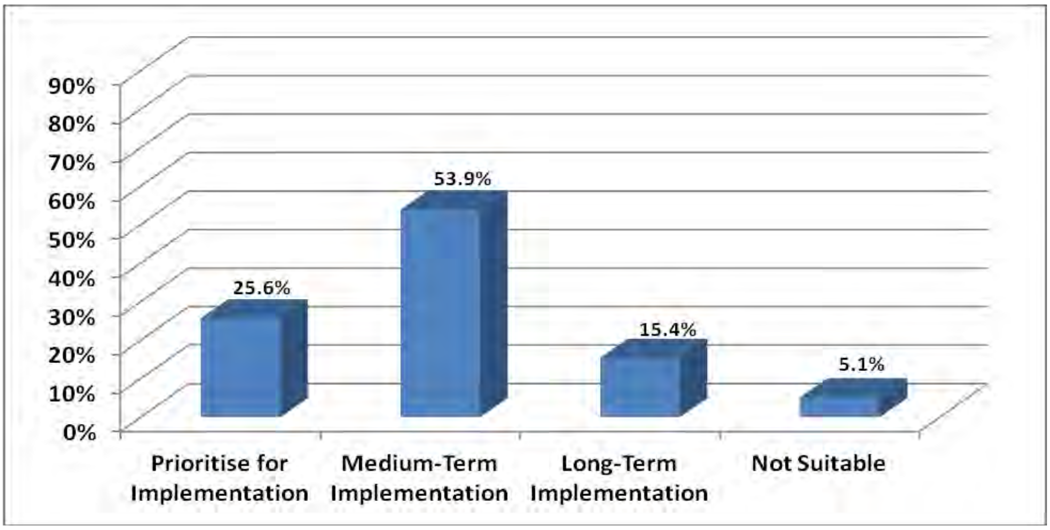
2.2.2 Intervention Category: Leadership - Actions 2-6

Action 2

Peer-to-peer networking should be organised between mental health services with a particular emphasis on creating links between services that report relatively high overall uses of seclusion and physical restraint and services that report relatively low overall uses of seclusion and physical restraint.
Action: HSE & independent mental health service providers
Intervention Category: Leadership

Peer-to-peer networking was commented on by 39 respondents. More than half (53.9%) of submissions stated that the identified action was appropriate for medium-term implementation as can be seen in Figure 3. Ten submissions (25.6%) considered that peer-to-peer networking should be put in place as a priority action and six (15.4%) suggested that it should be realised in the long-term.

Figure 3: Analysis of Responses to Consultation Questions for Action 2 – *Peer to Peer Networking*



n = 39

Comments on Action 2 – *Peer to Peer Networking*

Support for Action
Many respondents commented on the benefits of this particular initiative. It was noted that peer-to-peer networking could help to foster better practice across services as staff could learn from other services where the use of restrictive interventions has reduced. This should occur through discussing and thinking through alternative strategies to seclusion and restraint. One respondent stated that this action should be prioritised because HSE training budgets have been reduced or frozen.

Other respondents identified their rationale for including peer-to-peer networking as a medium-term objective. Some consultation participants commented that consultation with stakeholders was needed before implementing this action meaning that it was not best suited for immediate implementation. It was also noted that adequate local planning and preparation was firstly needed to ensure that those involved in peer to peer networking had a foundation to work from.

Variations in the Use of Seclusion and Physical Restraint
A recurring theme in comments on this action was concern over interpretations of the variations in the use of seclusion and restraint in Ireland. Several respondents stated that it was erroneous to assume that services with low overall uses of seclusion and restraint were necessarily models of best practice. One respondent reported that he contacted two approved centres in which the use of restraint and seclusion had decreased significantly as reported in the Mental Health Commission‟s annual activity reports. He was told that this was due to the discharge of particular patients and not to the implementation of any reduction initiatives. Two submissions reported that many services in Ireland “*export*” and “*ship*”

challenging patients to other services which skews the data that are collected on the use of these interventions.

Many respondents highlighted factors that contribute to varying levels of seclusion and restraint in services. These included:

- Diverse catchment populations;
- The presence of areas of deprivation;
- The physical environment in approved centres;
- Recording practices;
- Different levels and formats of training;
- Different staffing levels;
- Access to secure units:
- Levels of involuntary admission; and
- The existence of emergency response procedures.

Challenges to Implementing Action

Among the challenges associated with implementing this action were the time that would be required to participate in networking events, staff motivation, and a stated lack of a recognised process to facilitate peer to peer networking.

Respondents also voiced concern that this initiative could be misinterpreted and lead to a league table mentality which risked alienating staff.

Suggestions regarding Implementing Action

Several suggestions were made as to how peer-to-peer networking could be best organised. These included the following proposals:

- The Mental Health Commission should take a lead in this area and highlight examples of good practice;
- An annual forum should be established to report progress and discuss initiatives found useful in reducing seclusion. This was similar to an Australian model that has worked well and it was suggested that the Commission could fund such a forum; and
- The Commission should develop a learning hub to allow good practice to be shared between services; and
- Peer-to-peer networking should match services with similar services in order to ensure that fair comparisons are being made.

Commitments and Proposals from Services

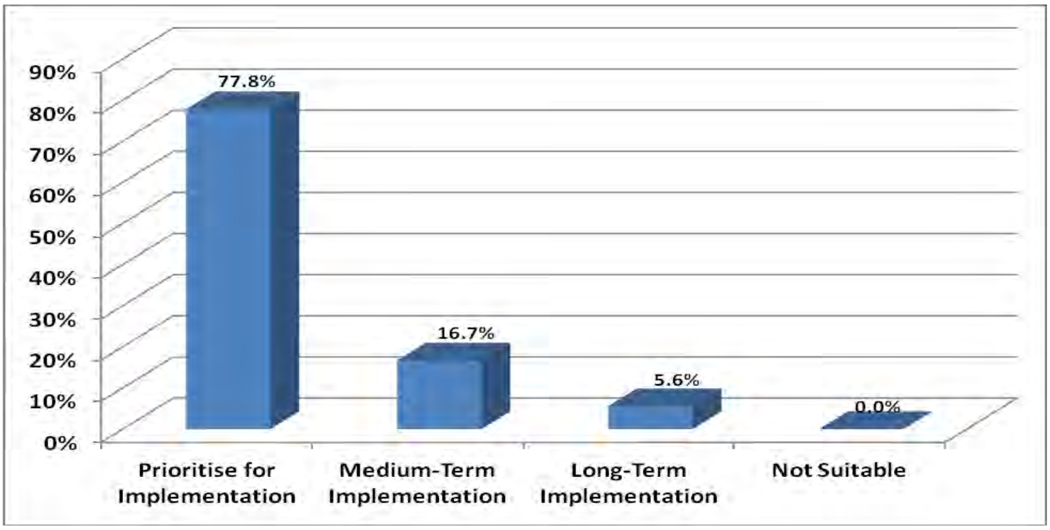
St Joseph‟s Intellectual Disability Service made a specific commitment to establish links with similar services in other jurisdictions as it was acknowledged that there may be no other similar service in Ireland. A submission from a group of psychiatric nurses working in the National Forensic Service proposed that this service should be used as a resource for such networking as they stated that the service has already significantly reduced its use of seclusion and restraint by employing research based interventions.

Action 3

Responsibility should be allocated to HSE senior managers for the implementation of this strategy in all publicly funded mental health services. Responsibility should be allocated for the implementation of this strategy to senior managers within each approved sector in the independent sector that uses seclusion and/or physical restraint.
Action: HSE & independent mental health service providers
Intervention Category: Leadership

Thirty-six submissions addressed this action. Figure 4 shows that a large majority (77.8%) of responses considered that this action should be prioritised. Six submissions (16.7%) suggested that it was appropriate for executing in the medium-term.

Figure 4: Analysis of Responses to Consultation Questions for Action 3 – *Responsibility for Implementation of Strategy*



n = 36

Comments on Action 3 – *Responsibility for Implementation of Strategy*

<u>Allocation of Responsibility to Senior Managers</u>
The vast majority of comments on this action made observations on the allocation of responsibility for implementation to senior managers. Some support was expressed for this with a number of respondents noting for instance that senior management responsibility was necessary to achieve a truly successful outcome and that it would focus attention on the issue at a high level.

Other submissions that expressed support for this idea noted additional requirements to senior management responsibility or qualified the support. Doubt was expressed by some respondents as to the appropriateness of allocating responsibility to senior managers who did not have clinical experience and expertise in the area for example. Two submissions considered that it was not at all clear who was being referred to by the term "*senior managers*" and that the Commission needed to be more specific as to where responsibility for implementation fell.

Many submissions stated that it was not sufficient to allocate responsibility solely to senior managers. It was noted that this risked ignoring the knowledge and skills at all levels of an organisation and the commitment and buy-in required from front-line staff.

"*The identified actions appear to vest leadership roles and responsibilities almost exclusively in clinical directors, registered proprietors, senior managers etc. In doing so it fails to recognise the contribution to leading, managing and implementing change that comes from all mental health professionals*" - **[School of Nursing, Midwifery and Health Systems, University College Dublin].**

Nursing Role in Implementation

A frequent suggestion outlined in submissions was that a senior nurse should have key responsibilities for implementation. This comment was made by individual nurses, groups of nurses, a trade union representing nurses, some mental health services and also by two consultant psychiatrists. This role was variously described as a nurse consultant, a nurse manager, a clinical nurse specialist and an advanced nurse practitioner and one submission suggested that it should be the role of a CNM2. It was also suggested that PMAV trainers could play an important role implementing the strategy.
This comment was typical of these responses:

"*As nurses are the primary group in contact with people experiencing acute mental illness and distress, they are central to organizational commitment, development and implementation of a seclusion and physical restraint reduction strategy*" - **[West and East Galway Mental Health Services in conjunction with the Mental Health Research Cluster, National University of Ireland, Galway.].**

The Commission"s attention was drawn to the existence of such roles in other countries, including Australia, and it was stated that such a role provided the crucial link between senior managers and staff on the ground who have responsibility for such crucial tasks as de-escalation, de-briefing, and training. One respondent suggested that a nurse manager should have responsibility for all aspects of seclusion and restraint in each catchment area in addition to other duties and should be supported by a designated consultant psychiatrist. This had the advantage of not requiring additional resources. Two submissions proposed that each area should have a "*champion*", who was identified as an individual responsible for local implementation and who would be supported by senior management.

Caution regarding Implementing Action

Finally, some respondents introduced a note of caution. Shine noted for example that: "*a commitment for change and leadership of that change is required before any actions can be implemented*". A number of respondents also commented that the strategy could not be implemented quickly.

Action 4

(a) A seclusion and physical restraint reduction plan should be developed for each approved centre that uses seclusion and/or physical restraint. It should:

- Include a mission statement;
- Clearly articulate the approved centre‟s philosophy about seclusion and restraint reduction and the expectations that this places on staff;
- Identify the role of the Clinical Director and senior management in directing the overall plan;
- Describe the roles and responsibilities of all staff and indicates how they will be accountable for their responsibilities;
- Commit senior management to creating a collaborative non-punitive environment to facilitate the reduction of seclusion and restraint in the approved centre;
- Indicate how the approved centre intends to make use of data on seclusion and physical restraint to assist in reducing the use of both interventions;
- Indicate how staff training and education will assist in realising the goal of seclusion and restraint reduction;
- Support clinical audit;
- Be developed in consultation with staff, service users and advocates; and
- Be reviewed on an annual basis.

(b) The Commission should be provided with an update on the implementation of this plan on an annual basis.

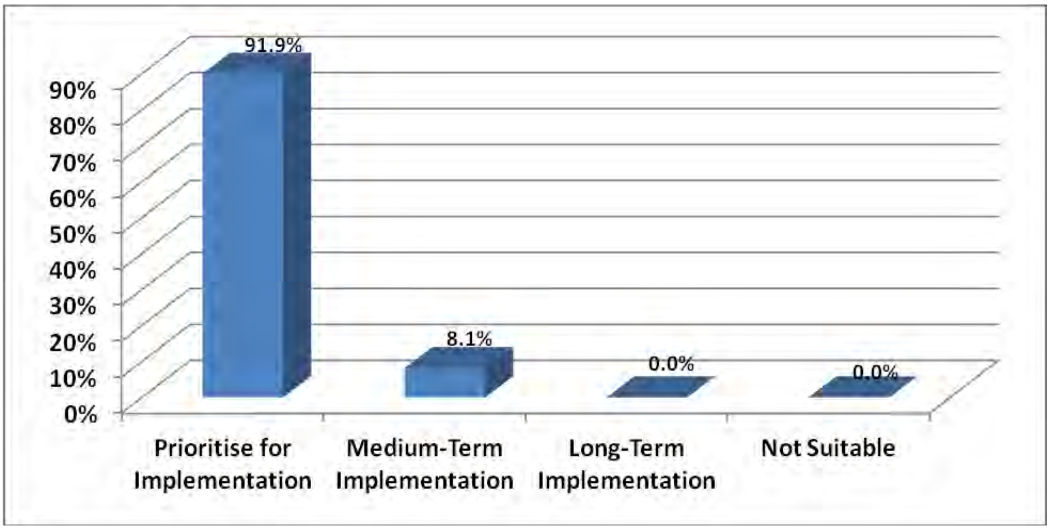
Action: HSE & independent mental health service providers

Intervention Category: Leadership

Forty-two submissions addressed the seclusion and restraint reduction plan. Figure 5 graphs the 37 responses from consultation participants that addressed the two elements of this action as five submissions gave separate rankings for Parts A and/or Part B rather than for the action as a whole. Here, a substantial volume of support emerges for designating this action as a priority. Of the 37 submissions that responded together for Parts A and B, an overwhelming majority (91.9%) indicated that the development of a seclusion and restraint reduction plan should be prioritised. Three submissions (8.1%) deemed that it was appropriate for medium-term implementation.

Of the five submissions that considered Part A separately, four stated that it should be prioritised.

Figure 5: Analysis of Responses to Consultation Questions for Action 4 – *Seclusion and Restraint Reduction Plan*



n = 37

Comments on Action 4 – *Seclusion and Restraint Reduction Plan*

Support for Action
Comments received which addressed the usefulness of implementing this action reflected the broad support for prioritising this action. It was frequently described for example as a "*critical*" or "*essential*" element of any strategy. A submission from the Mid West Mental Health Services insisted that: "*it should happen without delay and be given the attention that any other high risk intervention would be. It is cost neutral and requires only organisational commitment to put in place a system for the plan*".

The description of this action as cost and resource neutral was repeated by a number of respondents. Conversely, one respondent stressed that adequate resources needed to be made available to facilitate this action because of concerns that it may merely result in more administrative work for frontline staff.

Who Develops the Seclusion and Restraint Reduction Plan?
A large number of submissions addressed the issue of who should develop the plan. Many of these comments reflected concerns that had been expressed in relation to where responsibility for implementation of the strategy fell. Some respondents believed that a reduction plan needed to be developed locally by frontline staff. This should ensure that a "*one-size fits all*" approach is not adopted and allow for ownership of the strategy by those tasked with its implementation.

Other submissions proposed that all relevant stakeholders should be involved in the plan"s development, including service users, carers and advocates. In line with other proposals regarding responsibilities for implementation, two submissions proposed that a clinical nurse specialist with key responsibilities for implementing the strategy should be involved in developing the plan.

Suggested Amendments to Action

Many respondents identified specific areas that should be addressed in a service‟s reduction plan. A number of these proposals reflected content which was already set out in the draft action or addressed areas such as reviews and debriefings which are identified in some of the draft strategy‟s other actions. Among the other suggestions made were:

- There should be clear guidelines to assist with preparation of the plan;
- An annual update on the plan‟s implementation was not sufficient. The Commission should receive information bi-annually; and
- The reduction plan should be a regulatory requirement monitored by the Inspectorate of Mental Health Services.

Action 5

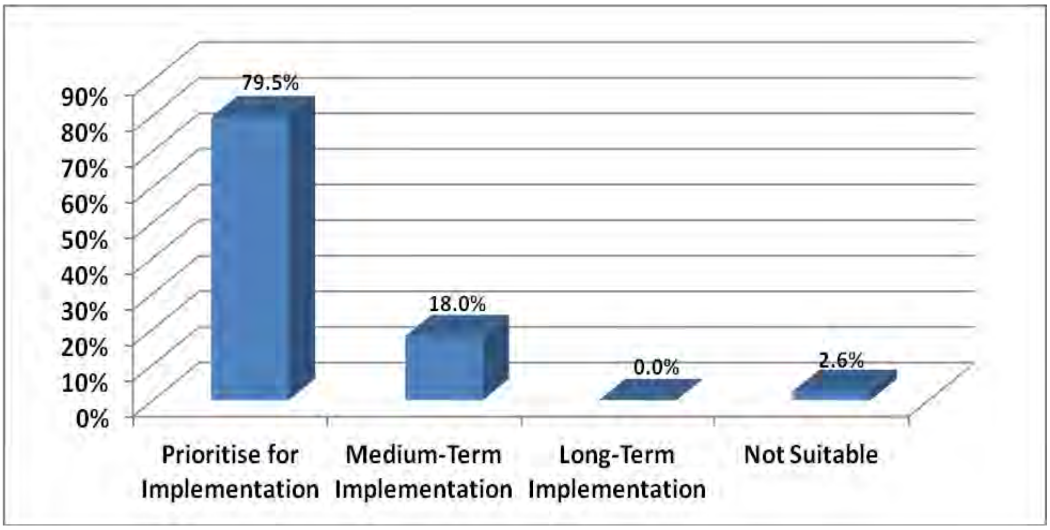
A commitment to the implementation of the seclusion and physical restraint reduction plan should be demonstrated in each approved centre. This should include but is not limited to:

- Making seclusion and physical restraint reduction a standing item on the agenda of multidisciplinary staff meetings;
- Setting up a staff recognition project which recognises staff for their work towards achieving reductions in the use of seclusion and physical restraint on an ongoing basis;
- Clinical leadership communicating to staff that they will be expected to reduce the use of seclusion and physical restraint;
- Reviewing seclusion and physical restraint policies; and
- Formally marking the commencement of the plan‟s implementation.

Action: Clinical Directors and Registered Proprietors
Intervention Category: Leadership

Thirty-nine respondents addressed the fifth action. Figure 6 illustrates that this was another action which a large majority (79.5%) of the 39 submissions addressing it deemed should be implemented as a priority. Of the remaining eight submissions, seven (18%) considered that it should be realised in the medium-term.

Figure 6: Analysis of Responses to Consultation Questions for Action 5 – *Demonstrate Commitment to Implement Reduction Plan*



n = 39

Comments on Action 5 – *Demonstrate Commitment to Implement Reduction Plan*

Support for Action
Many respondents who supported this action saw it as a natural follow-on from the development of a seclusion and restraint reduction plan. It was suggested that it should help ensure that plans would actually be implemented and not become just a paper exercise.

Concerns regarding Implementing Action
The draft action cited examples of how a commitment to implementing a seclusion and restraint reduction plan could be demonstrated. One respondent expressed support for the staff recognition project as it was considered that this would allow staff to take ownership of positive outcomes and recognise good care planning. Three submissions, however, did not support this idea. Consultation participants noted that informal recognition already takes place and that if this was formalised, staff may avoid dealing with crisis situations. Further identified risk was that it would lead to the underreporting of seclusion and restraint and unfairly identify staff. Recognising individual staff members was regarded as inappropriate by another respondent who pointed out that staff should be working as a team to reduce seclusion and physical restraint.

Responses from the nursing sector also voiced strong concerns over the statement included in the action that clinical leaders would tell staff that they would be expected to reduce the use of seclusion and restraint. One respondent noted that this may be used by some Clinical Directors and/or Registered Proprietors to place undue pressure on staff to take unnecessary risks in order to meet unrealistic targets. Another submission did not support the prescriptive nature of the wording used because responsibility was allocated to Clinical

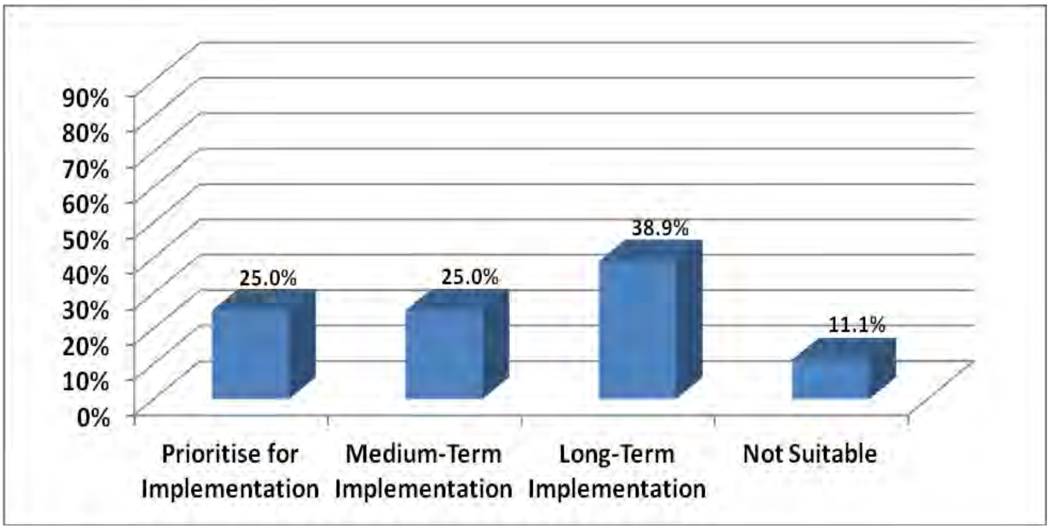
Director and Registered Proprietors in spite of the fact that seclusion and restraint practices are largely the responsibility of mental health nurses.

Action 6

An examination of the feasibility of removing the seclusion room from each approved centre that uses seclusion should be undertaken and a report on its outcome should be forwarded to the Mental Health Commission.
Action: Clinical Directors and Registered Proprietors
Intervention Category: Leadership

There was less support for prioritising this action for implementation than for other actions. Of the 36 submissions that assessed this action, close to two-fifths (38.9%) considered that it should be realised in the longer-term. A little over one in ten submissions (11.1%) suggested that it was not suitable to implement. Support for prioritising this action and for executing it in the medium-term was similar with exactly one quarter of respondents supporting each of these positions.

Figure 7: Analysis of Responses to Consultation Questions for Action 6 – *Examine Feasibility of Removing Seclusion Rooms*



n = 36

Comments on Action 6 – *Examine Feasibility of Removing Seclusion Rooms*

<u>Concerns regarding Implementing Action</u>
Respondents frequently pointed out that the removal of seclusion rooms was desirable but not practical at the moment. The following comments were also received:

- Some services would still require seclusion rooms in emergencies;

- Some patients could suffer if seclusion was not available;
- If seclusion rooms are removed too quickly, staff may feel unsafe in the working environment;
- The reduction in in-patient beds and stricter admission criteria will result in a profile of in-patients for whom seclusion and physical restraint would still be needed as interventions.

Many respondents stated that seclusion rooms could only be removed if adequate alternatives were put in place. Among the necessary alternatives noted were:

- Comfort or relaxation rooms;
- Quiet areas;
- Low stimulus therapeutic environments;
- Adequate education and training and
- Full implementation of *A Vision for Change*, including the Psychiatric Intensive Care Rehabilitation Units.

Comments from Respondents considering the action was not suitable to implement

Although just over one in ten respondents indicated that this action was not suitable to implement, many of the comments received indicated that those who were of this view were strongly opposed to including it in the strategy.

It was suggested that removing seclusion rooms would lead to an increase in the use of seclusion and physical restraint and to some approved centres "exporting" their problems to other areas. The latter risk would lead to an artificial increase in the number of episodes of restrictive interventions in other areas. One submission from a specific mental health service commented on how removing the seclusion room would simply not be feasible at present for that service. The service noted that such a move would give them the highest risk score on the current risk assessment template that they use.

Some submissions cautioned that proceeding with this action could alienate staff members and also reduce goodwill towards the strategy.

Support for Action

Support was nevertheless expressed for this action in other submissions. Some services drew the Commission‟s attention to the absence of seclusion rooms in particular services or elements of a service. It was suggested that a feasibility report could serve as a useful exercise to reflect on practice in a service. One submission which supported prioritising this action suggested that it should be carried out immediately to ensure the timely removal of those seclusion rooms which could be eliminated. Another respondent suggested that it would be appropriate to develop a feasibility report in any areas involving new builds or modifications.

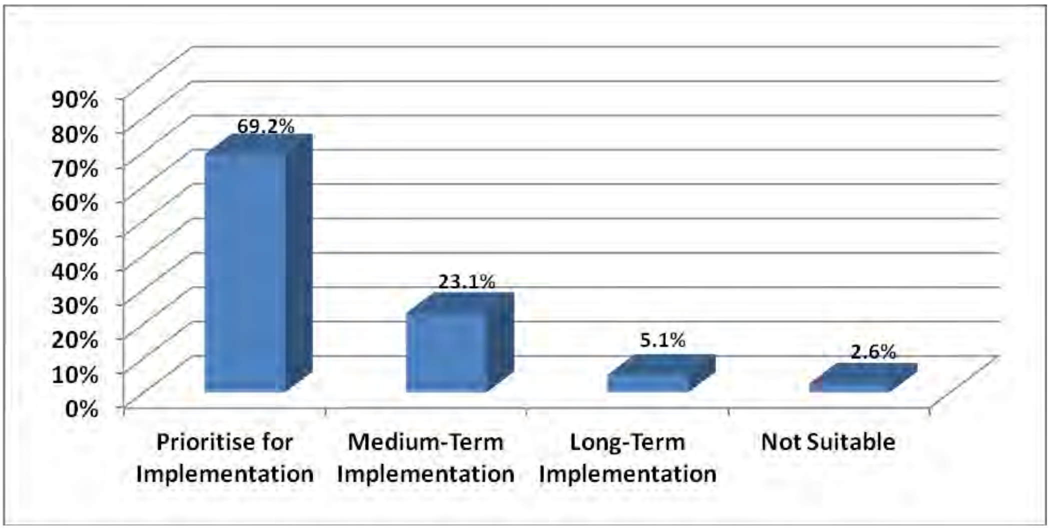
2.2.3 Intervention Category: Staffing - Actions 7-9

Action 7

There should be a call for an exemption from the moratorium on recruitment in the public sector to facilitate the replacement of staff who are retiring from mental health services to ensure that current staff to patient ratios are not further reduced leading to a possible increase in the inappropriate use of seclusion and physical restraint.
Action: MHC & HSE
Intervention Category: Staffing

Figure 8 below shows how the 39 consultation respondents who ranked this action wished it to be prioritised. A clear majority of almost seven out of ten submissions (69.2%) approved of making it a priority action. More than one-fifth (23.1%) of submissions identified it as appropriate for medium-term implementation.

Figure 8: Analysis of Responses to Consultation Questions for Action 7 – *Call for Exemption from Moratorium on Recruitment*



n = 39

Comments on Action 7 – *Call for Exemption from Moratorium on Recruitment*

<u>Support for Action</u>
A large number of comments received on this action point noted that it was a crucial element of any strategy. Typical comments included SIPTU"s statement that an exemption from the moratorium on recruitment is "*essential to allow any improvement in the use of restraint and seclusion*".

Respondents noted that reduced staffing levels often lead to higher risk ratings, made it difficult to maintain good practices and to adequately manage current levels of violence and aggression in approved centres.

Some respondents welcomed this action point on the basis that an end to or exemption from the moratorium on recruitment in the public sector has been and continues to be a priority for their particular service.

Suggested Amendments to Action

Among the suggested amendments to this action outlined by respondents were:

- The Commission should set out appropriate staffing levels for different types of inpatient settings, below which seclusion and restraint are more likely to occur;
- The action should be strengthened. A call for an exemption is not sufficient as more people are leaving the mental health service than are coming in;
- The call from an exemption from the moratorium should also come from the HSE, the College of Psychiatry of Ireland, the National Service Users Executive and the Irish Advocacy Network.

Caution regarding Implementing Action

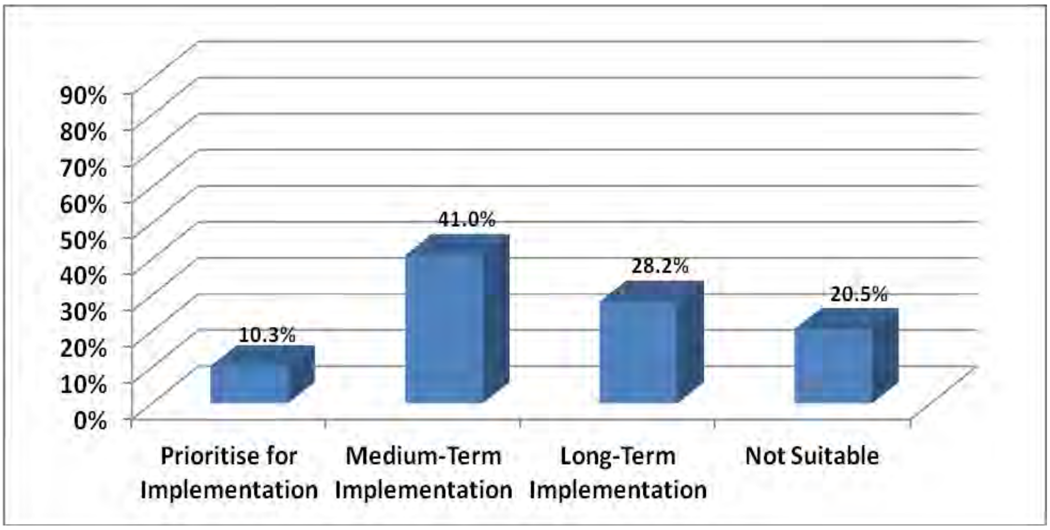
A word of caution with regard to this action was noted by one respondent. It was stated that staff should not be removed from the community to ensure adequate staffing in approved centres.

Action 8

An examination of the feasibility of establishing psychiatric emergency response teams in every approved centre that uses seclusion and/or physical restraint should be undertaken and a report on its outcome should be forwarded to the Mental Health Commission.
Action: Clinical Directors and Registered Proprietors
Intervention Category: Staffing

Compared to many of the draft strategy‟s other actions, consultation responses indicated a low level of support for prioritising this action. Figure 9 below illustrates that just 10.3% of the 39 respondents ranked it as a priority action. Support for implementing this action in the medium term was indicated in 41% of the submissions. Eleven (28.2%) submissions considered that examining the feasibility of establishing psychiatric emergency response teams in approved centres should be realised in the longer-term. One-fifth (20.5%) of responses indicated that such an action was not suitable to implement.

Figure 9: Analysis of Responses to Consultation Questions for Action 8 - *Psychiatric Emergency Response Teams*



n = 39

Comments on Action 8 – *Psychiatric Emergency Response Teams*

Concerns regarding Implementing Action
Almost all comments received in relation to this action identified concerns over including it as part of the strategy. Many of the consultation responses observed that introducing psychiatric emergency response teams at this juncture was not feasible because of the staffing resources that the proposal entailed. The concept implied the availability of additional staff at very short notice which just was not possible at present.
No such teams presently exist in Ireland and establishing them would carry significant training and staffing allocations at a time when finances are stretched in terms of providing the current service – **[Acute Psychiatric Unit, Tallaght, Dublin West/South West Mental Health Services].**

Another respondent pointed to the difficulties experienced finding resources for assisted admissions to highlight the challenges that would be involved.

Additional concerns noted were that:

- The establishment of teams could lead to the deskilling of staff which risked increasing the use of seclusion and restraint;
- PERTS were less appropriate to implement in Ireland where a different context applies than in the USA. In-patient facilities in Ireland are much smaller in size and mechanical restraint is rarely used here;
- Such teams were not appropriate for general hospital units as an emergency response team would consist of the bulk of the available staff.
- PERTS were not appropriate for rural services and geographically dispersed services.

- PERTS were not suitable for older service users and may in fact worsen situations in patients with Behavioral and Psychological Symptoms of Dementia.

Suggested Amendments to Action
Among the amendments to this action that were proposed was a suggestion that the Commission should advocate that all staff should be adequately trained in emergency response and that one member of the nursing team could co-ordinate issues relating to the use of seclusion and restraint at the beginning of each shift.

Emergency Procedures in Ireland
It was helpful for the Commission to hear about emergency procedures that are currently in use in services. St Brendan"s Hospital noted for example that although they do not have an identified team to respond to emergencies, there is a system in place such that responses are received from other units in the approved centre after alarms are activated.

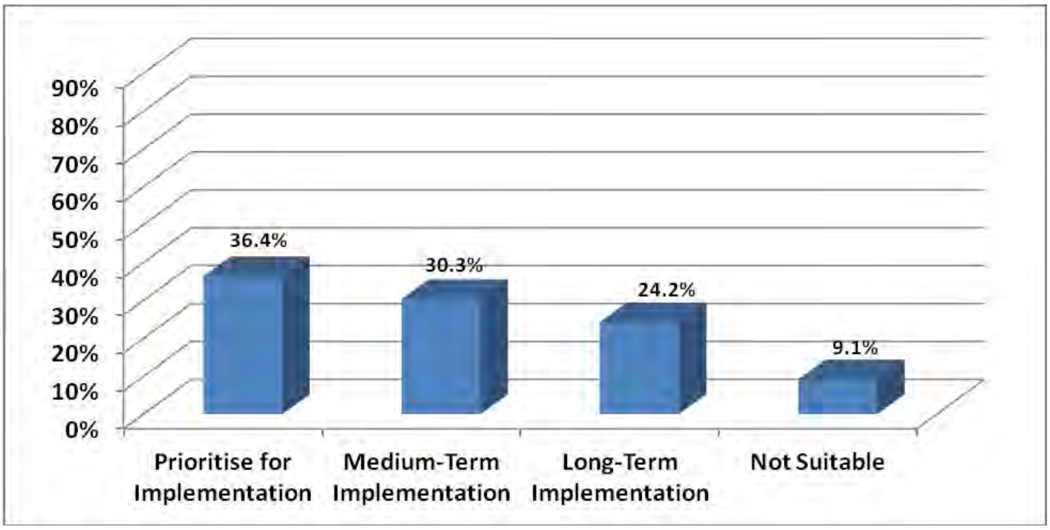
Support for Action
Where support was expressed for including this action as part of the strategy, it was noted that the composition of the emergency response team could be an important safeguard for service users. One respondent noted that this was contingent however on there being multidisciplinary involvement in such teams.

Action 9

Staff rotation should be arranged to ensure that staff are not working continuously with acutely unwell patients.
Action: Senior management and persons with delegated responsibility for staff rostering
Intervention Category: Staffing

An analysis of the views of the 33 consultation participants who ranked this action shows that none of the priority categories were clearly preferred over the others. As illustrated in Figure 10, more than one-third (36.4%) of submissions indicated that staff rotation should be prioritised. Three out of ten (30.3%) respondents stated that it should be implemented in the medium-term and one quarter (24.2%) considered it appropriate for longer-term implementation. Slightly less than one in ten (9.1%) submissions indicated that this action should not be part of a seclusion and restraint reduction strategy.

Figure 10: Analysis of Responses to Consultation Questions for Action 9 – *Staff Rotation*



n = 33

Support for Action
The majority of consultation respodents indicated support for the objective behind staff rotation i.e. preventing staff burnout but they were at the same time cautious about its feasibility at present. Comments from trade unions representing nurses indicated that the current staff shortages within mental health services meant that such an action may not be possible now. The loss of allowances for staff who move to work in other areas was also identfied as an impediment to realising this action in two submissions.

Some respondents infomed the Commission that staff rotation already happens in their service. St Brendan"s Hospital practices rotation for instance in order to prevent staff working continually in an acutely stressful environment.

Risks Associated with Action
A frequent observation made in submissions was that staff rotation risked undermining continuity of care and the development of special skills which are important when working with patients demonstrating challenging behaviour.

Another respondent considered that this action was not appropriate to implement because of its potential to undermine the development of team-working within community teams by disrupting the complement of staff on a regular basis.

A response from the School of Nursing and Midwifery in Trinity College identied a risk that staff rotation could lead to increased stigma by identifying certain sectors of the mental health services as difficult to work in. This submission, and other respondents, suggested that training and education for persons working in acute settings may be more appropriate.

2.2.4 Intervention Category: Training and Education - Action 10

Action 10

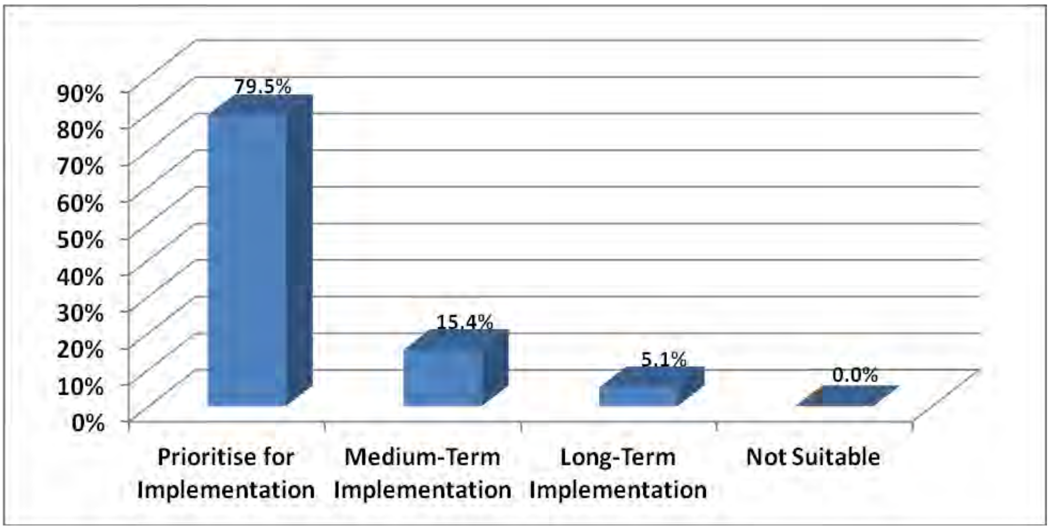
The following Mental Health Commission guidance on training on seclusion and physical restraint should be followed to support achieving compliance with Section 19 of the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (Staff Training) and Section 10 of the *Code of Practice on the Use of Physical Restraint in Approved Centres* (Staff Training).

> *"Each approved centre's policy on training in the use of seclusion and policy on training in the use of physical restraint should address the following:*
> - *attitudes to the use of seclusion and physical restraint;*
> - *crisis management skills including de-escalation and negotiation;*
> - *new models of care including trauma informed care and training in the principles of recovery; and*
> - *the role of (i) policy and regulation (ii) support from the Mental Health Commission (iii) leadership (iv) changes to staffing (v) the involvement of service users, family members and advocates (vi) data (vii) review procedures/debriefing and (viii) medication in reducing the use of seclusion and physical restraint".*

Confirmation that this guidance has been implemented in the approved centre should be forwarded to the Commission six months after the commencement date of this strategy.
Action: Clinical Directors and Registered Proprietors
Intervention Category: Training and Education

Thirty-nine submissions addressed the tenth action. Figure 11 illustrates that a large majority (79.5%) of the 39 submissions considered that it should be implemented as a priority action. Fifteen per-cent of responses stated that it should be realised in the medium term.

Figure 11: Analysis of Responses to Consultation Questions for Action 10 – *Additional Guidance on Training*



n = 39

Comments on Action 10 – *Additional Guidance on Training*

Support for Action
Appropriate training was frequently noted as being critical to the success of the strategy. Respondents drew attention to the importance of skills specified in the guidance, including de-escalation, debriefing and attitudes to the use of seclusion and restraint. Some submissions observed that many of these skills had improved in particular services following the undertaking of specific training.

Standardised Training
By far the most common observation made in relation to this action was that there is currently no standardised national training model related to the management of aggression and violence. There are currently a number of providers offering different training in the area. A standardised approach would be welcomed by many respondents and offer the best means of enusring that specific areas and skills referenced in the draft action can be put in place nationally. It should also assist securing the release of staff to attend such training. *This group should recommend the type of training and the fact that it should be mandatory for all staff of the mental health services* – **[National Service User Executive].**

A number of suggestions were received as to how standardised training should be implemented. Three submissions specifically recommened that PMAV training should be considerd as the standardised training model. It focussed on many of the areas specified in the draft action and had the additional advantage that it could be delivered based on a specific service‟s features and needs.

Other proposals were that the Commission should arrange a best practice conference on seclusion and restraint, at which stakeholders would discuss and agree on a standardised approach. Donegal Mental Health Services offered, where possible, to support the Commission to carry out an audit of existing models of care and training in order to benchmark and develop a national standardised training model.

Additional Suggestions

Respondents made a number of additional suggestions regarding the role of training in reducing the inclidence of seclusion and restraint. These included proposals that:

- The Commission should provide a training programme on "*alternatives to seclusion*";
- There should be national guidance on the regulation of physical intervention programmes and trainers;
- A guidance document should be issued for those who commission training in the area;
- Training should be based on national learning outcomes, be integrated into all professional training curricula and be appropriately accredited;
- Consultant psychiatrists needed training in the area as they are required to authorise episodes of seclusion and restraint;
- Advance nurse practitioners should have a role in delivering training content in the area; and
- A minimum qualification should be established for those who may be involved in the use of seclusion and restraint,

Challenges to Implementing Action

Some respondents commented that releasing staff for training was already difficult and that staff in some services have not received any training. In light of this, executing this action which included additional training would create even further challenges. Challanges related to finding resources to finance additional training were also frequently noted.

Professional Education

Other respondents noted that the whole area of training needed to be considered alongside professional education that takes place in undergraduate and graduate programmes. One submission stated that undergraduate curricula do not address the prevention, management or treatment of challenging or antisocial behaviour in any strategic detail.

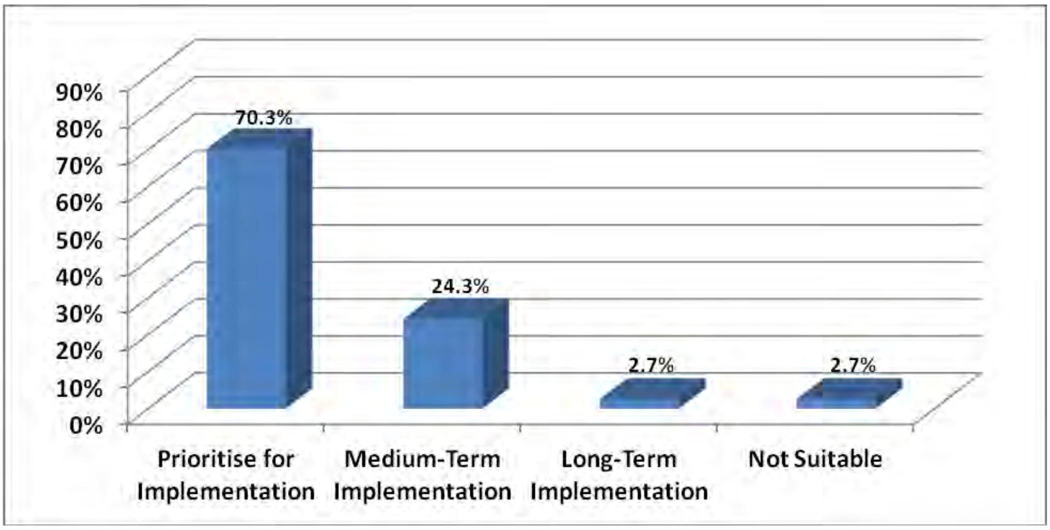
2.2.5 Intervention Category: Patient, Family and Advocate Involvement - Actions 11 & 12

Action 11

Provision 15.1 of the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre* (initial assessment on admission) should be complied with to ensure that that each resident of an approved centre has an adequate assessment following admission, including a risk assessment. This risk assessment should aim to identify individual triggers for each patient and include personally chosen advance directives to be implemented in crisis situations. The outcome of this assessment should be integrated into the patient‟s individual care and treatment plan.
Action: Clinical Directors and Registered Proprietors
Intervention Category: Patient/Family/Advocate Involvement

A large majority (70.3%) of the 37 submissions that assessed this action indicated that it should be implemented as a priority. Almost one quarter (24.3%) of responses supported realising the action in the medium term. Only one (2.7%) submission considered that it should be implemented in the long-term. One respondent (2.7%) stated that it was not suitable to implement.

Figure 12: Analysis of Responses to Consultation Questions for Action 11 – *Assessment Following Admission*



n = 37

Comments on Action 11 – *Assessment Following Admission*

Support for Action

Comments received on this action reflected the large volume of support for its speedy implementation. Among the benefits associated with the action‟s implementation were:

- It assists services to achieve compliance with Commission codes of practice;
- It assists with care planning; and
- It supports a management culture whereby issues are considered proactively rather than reactively.

Suggested Amendments to Action

A number of suggestions to enhance the action were also put forward by consultation participants. These included:

- A pre-admission assessment should accompany each patient;
- The risk assessment should cover early warning signs and indications of relapse;
- An agreed care plan should include approaches to use for violent behaviour, such as Time Out, the use of a Comfort Room and rapid tranquilisation;
- Advance directives selected by patients should be agreed with the primary nurse and be risk assessed; and
- Advance directives need to be balanced with the duty of care;

One respondent stated that responsibility for implementing such an action which was currently assigned to Clinical Directors and Registered Proprietors needed to reflect the reality that nurses are often the staff with responsibility for dealing with advance directives. Another respondent commented that the draft action could not solely be considered as a proposal related to patient, family and advocate involvement. It was felt that it needed to be recognised that this was also a leadership and training issue.

Challenges

Challenges associated with the use of advance directives for some service users were noted. It was felt that adequate consideration needed to be given to a person‟s mental state at the time advance directives are chosen. It was also noted that issues of decision making capacity complicates the use of advance directives for service users with intellectual disabilities. Solutions to the difficulties that are often encountered such as using communication supports and familiar staff were noted however as ways to assist with maximising a service users‟ decision-making capacity.

Action 12

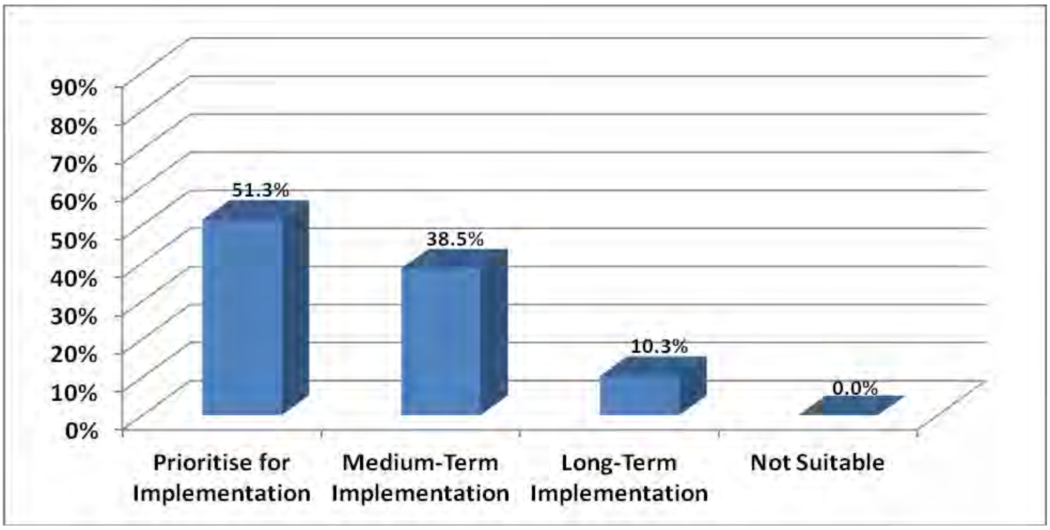
Advocates and service user representative groups should be involved in national, regional and local initiatives to achieve reductions in the use of seclusion and physical restraint. This may include but is not limited to taking part in the development of a seclusion and physical restraint reduction plan and representing patients in debriefing episodes, where appropriate i.e. with the patient"s consent.

Action: IAN, NSUE, MHC & HSE

Intervention Category: Patient/Family/Advocate Involvement

Figure 13 shows that half (51.3%) of the 39 respondents addressing this action considered that it should be prioritised. Almost four in ten (38.5%) submissions supported its implementation in the medium-term. Ten per-cent of respondents indicated that it was appropriate to realise in the longer term.

Figure 13: Analysis of Responses to Consultation Questions for Action 12 – *Advocate and Service User Involvement in Reduction Initiatives*



n = 39

Comments on Action 12 – *Advocate and Service User Involvement in Reduction Initiatives*

<u>Support for Action</u>

Several submissions considered this action to be an essential component of a seclusion and restraint reduction strategy. Some responses from services reflected on the benefits of involving service users and advocates that have already been experienced such as the important role carried out by advocates in providing peer support to residents who have been secluded or physically restrained. A submission from the Multidisciplinary Restrictive

Practices Group based in St Joseph‟s Intellectual Disability Services commented on the work of a parents and friends group which inputs views into the use of restrictive practices and is regarded as "*very useful*". One respondent supported such involvement because it facilitated interpretations of a service user‟s challenging behaviour that were alternative to those supplied by nurses and doctors. One other respondent drew attention to the fact that such involvement is mandated by the UN Convention on the Rights of Persons with Disabilities.

The National Federation of Voluntary Bodies informed us that they wished to explore the development of peer-to-peer support for people with intellectual disability and mental health difficulties.

Suggested Amendments to Action

Among the suggested amendments made regarding this action were:

- Local service user groups should be involved in addition to IAN and NSUE
- Advocate and service user involvement needed to be balanced by the inclusion of staff representative groups in reduction initiatives;
- Service users and advocates could be included in a verification process to ensure that the correct seclusion and restraint procedures were followed; and
- Advocates, carers and family members could be educated about the provisions included in Commission Rules and codes of practice so that they could understand that a structured process is in place which includes the exploration of alternative options before restrictive practices are used.

2.2.6 Intervention Category: Using data to monitor seclusion and restraint episodes - Actions 13-16

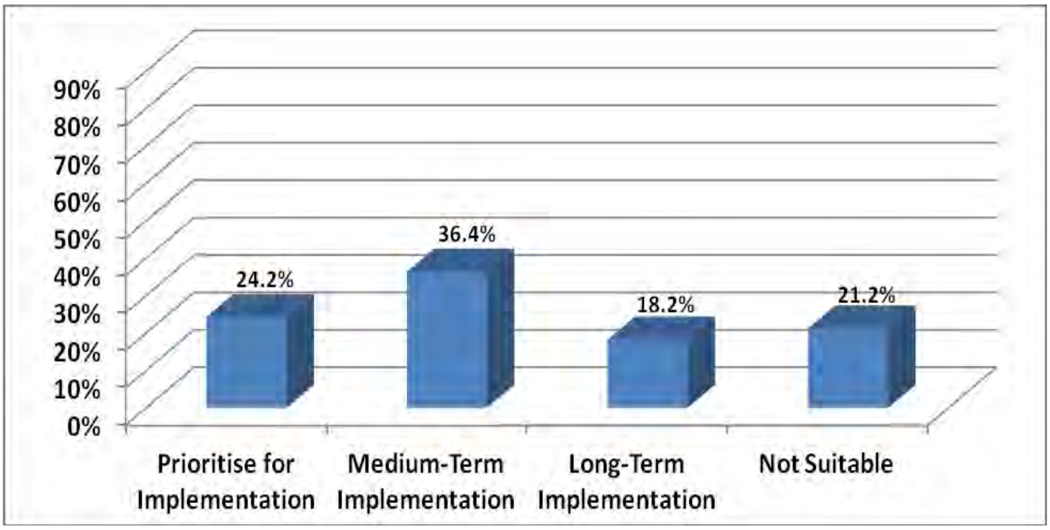
Action 13

Seclusion and physical restraint reduction targets for each approved centre in which seclusion and/or physical restraint are used should be jointly set by the Mental Health Commission and mental health services. These targets should be publicised along with an approved centre‟s progress on reaching the target on the Mental Health Commission website.
Action: MHC, HSE & independent service providers
Intervention Category: Using data to monitor seclusion and restraint episodes

When submissions ranked this action, divergent views were apparent. The most popular option selected was medium-term implementation, which was chosen by 36.4% of respondents whereas support for the other options was more evenly spread. One quarter (24.2%) of the 33 submissions stated that it should be prioritised, one-fifth (21.2%)

considered that it was not suitable to implement and just under one-fifth (18.2%) indicated that it should be realised in the longer term. The proportion of responses that indicated that seclusion and restraint reduction targets were not appropriate to implement as part of the strategy at just over 21% was the highest percentage indicating that any action was not suitable to execute as part of the consultation.

Figure 14: Analysis of Responses to Consultation Questions for Action 13 – *Seclusion and Restraint Reduction Targets*



n = 33

Comments on Action 13 – *Seclusion and Restraint Reduction Targets*

<u>Support for Action</u>
Those respondents who supported prioritising this action noted that data collection and the setting of targets were vital parts of the planning process for launching any strategy.

Other respondents, nevertheless, felt that such an action was more appropriate for medium or longer term implementation because any reduction in the use of restrictive interventions would not happen overnight and that the development of targets was dependent on the realisation of other actions initially, such as those associated with improved data collection. Additional reasons given for identifying this action as a medium term priority were that it posed challenges and needed to be handled sensitively but was still worthwhile to pursue.

<u>Sugessted Amendments to Action</u>
A suggested amendment to the draft action made in three submissions related to the focus of the targets. It was recommended that the targets should also relate to national and local support structures that help those working in mental health services to develop more creative and humane approaches to helping people who are acutely unwell. Another

respondent proposed that an analysis of the reasons for success or otherwise of reduction initiatives should be included alongside published data on targets.

Concerns regarding Implementing Action

Comments noted in numerous submissions regarding this action, however, reflected concerns that it should only proceed in the longer term as well as strong views that it just was not appropriate to implement as part of the strategy. Among the concerns highlighted in submissions were:

- Data returns can be very cyclical and heavily influenced by factors outside of a service‟s control such as the admission of a particularly acutely unwell patient; and the absence of intensive care rehabilitation units;
- A league table mentality could be created which would be inappropriate because many services are so different, catering for specific populations and providing services in radically different physical environments for example;
- Not reaching targets could have a very demoralising impact on staff who were genuinely trying to introduce good practices;
- Targets could lead to the non-reporting of some episodes of seclusion and restraint;
- Managers may focus too much on meeting targets to the detriment of the needs and safety of patients and staff;
- Targets were inappropriate to put in place in the absence of an adequate data collection infrastructure and staffing resources;
- Targets place a focus on ticking boxes when what is really needed in services is a change in vision, culture and practices.

Action 14

Additional data analysis using data collected on the Register for Seclusion and the Clinical Practice Form for Physical Restraint but which are not returned to the Commission should be carried out on a quarterly basis. The additional data which are analysed should support clinical audit and include:

- Seclusion and physical restraint episodes and hours by shift, day, unit and time;
- Seclusion and physical restraint episodes initiated by different staff members.

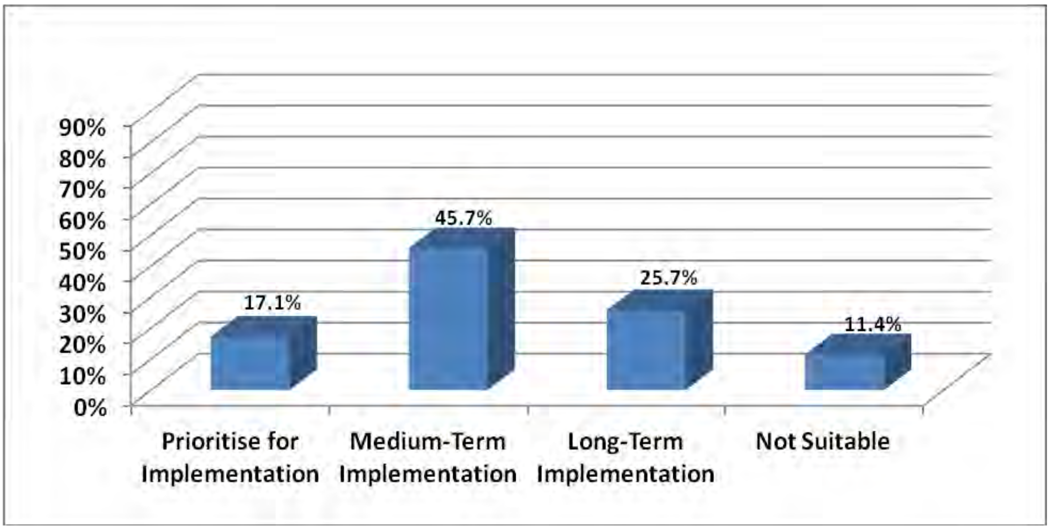
Arising out of this analysis, staff, wards and shifts which are recording high levels of seclusion and physical restraint use and who may benefit from training and education in seclusion and restraint reduction should be identified.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Using data to monitor seclusion and restraint episodes

Thirty-five respondents ranked the draft strategy‟s fifteenth action. Figure 15 shows that the most popular option selected regarding implementing this action was that it should be put in place in the medium-term. Just under one half (45.7%) of submissions considered that this action should be prioritised in this way. One quarter (25.7%) of responses supported realising the collection of additional data in the longer term with one sixth (17.1%) suggesting that it should be implemented as a priority. Just over one in ten (11.4%) submissions stated that it was not suitable to implement.

Figure 15: Analysis of Responses to Consultation Questions for Action 14 – *Additional Data Analysis on Seclusion and Restraint Episodes*



n = 35

Comments on Action 14 – *Additional Data Analysis on Seclusion and Restraint Episodes*

<u>Support for Action</u>
Support for implementing this idea was evident in some submissions from some services. Additional data analysis using information that is already collected was considered a good idea which could influence positive changes in practice. In commenting on why this action should be put in place in the medium term, respondents noted that when other actions were implemented initially, additional data collection made sense to facilitate reporting on the success or otherwise of such initiatives.

<u>Challenges and Concerns regarding Implementing Action</u>
Several consultation responses, nevertheless, pointed out challenges to realising this and other actions associated with the collection and analysis of data. Staff shortages and poor IT systems and infrastructure were the main barriers identified by most respondents.

Data collection is essential but given the lack of electronic systems available to the health service, data collection at the level currently being done is probably all that can be managed in already stressed services – **[Consultant Psychiatrist].**

Many respondents identified concerns related to the draft action‟s proposal to use additional data analysis to identify staff who may benefit from training in the use of the interventions. The difficulties involved in comparing data collected on the use of seclusion and restraint were highlighted again. Other specific comments which were received included:

- Staff should have the necessary resources and infrastructure to enable them to reduce their use of seclusion and physical restraint before their performance in doing so is evaluated and published;
- Identifying particular staff as frequent users of restraint and seclusion may not be positive and could in fact be counterproductive;
- Some staff volunteer to work with particular patients meaning that they would be unfairly associated with episodes of seclusion and restraint;
- Some staff work mainly at night and would not appear in statistics looking at this issue;
- Staff who show up in statistics as frequent initiators of seclusion or restraint may actually be acting appropriately and making correct decisions;
- Data should not be used in a punitive manner; and
- Isolating training to individuals was flawed as all staff should receive training in the area.

A number of submissions took the opportunity to suggest additional data items that could be collected: These include data on:

- The physical characteristics of approved centres;
- If the admission of a person who was secluded/restrained was an assisted admission;
- If medication was administered during a seclusion and restraint episode;
- The last date of training of staff involved in seclusion/restraint;
- The deaths, injuries and costs associated with the use of seclusion and restraint; and
- The levels/degrees of physical restraint used as recognised in PMAV training.

Other proposals made were that the Commission could provide a tool to facilitate the capturing of additional data and that any additional data should be collected and analysed by a clinical nurse with responsibility for seclusion and restraint.

Action 15

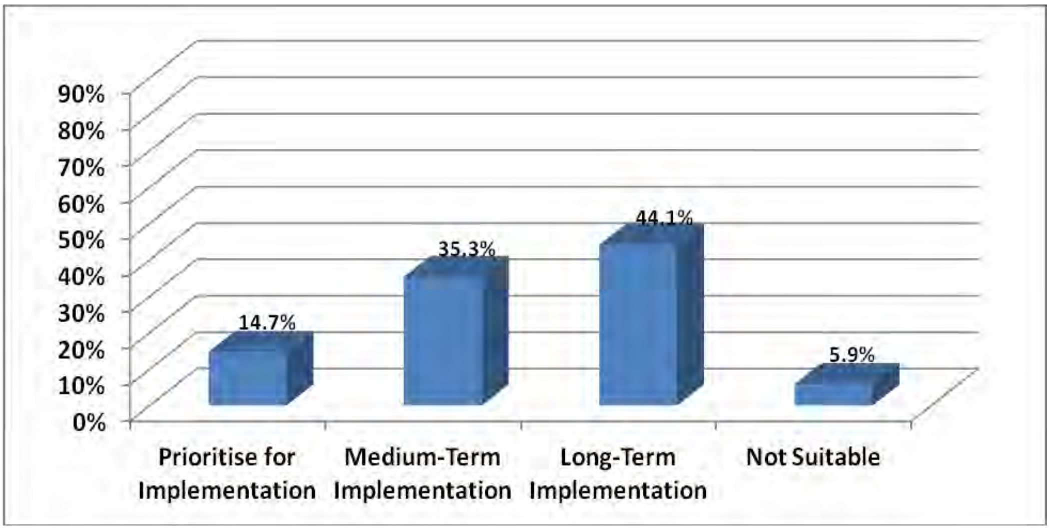
The feasibility of developing electronic versions of the Registers and Clinical Practice form to replace the hard copy format should be examined. This would allow for data returns to be extracted directly from the Registers without manual collation and allow additional data to be reported on, including total seclusion hours.
Action: MHC with assistance from HSE and independent services
Intervention Category: Using data to monitor seclusion and restraint episodes

The draft strategy"s fifteenth action concerned the Register and Clinical Practice Form used to collect data on seclusion and restraint. They also form the basis for the data returns that are made to the Commission on the use of restrictive interventions. It proposes that:
The feasibility of developing electronic versions of the Registers and Clinical Practice form to replace the hard copy format should be examined. This would allow for data returns to be extracted directly from the Registers without manual collation and allow additional data to be reported on, including total seclusion hours.

The draft strategy also proposes that the MHC take responsibility for this action with assistance from the HSE and independent services.

Thirty-four consultation submissions addressed this action. Just over 44% of these submissions supported implementing this action in the long term. More than one-third (35.3%) of respondents considered that this action should be realised in the medium term. Five (14.7%) submissions stated that Action 15 should be prioritised.

Figure 16: Analysis of Responses to Consultation Questions for Action 15 – *Examine Feasibility of Developing Electronic Registers*



n = 34

Comments on Action 15 – *Examine Feasibility of Developing Electronic Registers*

Support for Medium and Longer Term Implementation of Action
Many responses indicated that ideally, this action would be in place in all services as electronic systems facilitate data collection and analysis. In the long run, it was acknowledged that electronic systems should also save time and money. St John of God Hospital noted that they may be able to assist with executing this action because of the service"s use of an electronic mental health information system.

Challenges to Implementing Action
As is the case for all actions related to data collection and analysis, many submissions highlighted challenges associated with implementing this action. The main challenges were:

- Services operating with fewer administrative and clinical staff;
- Access to Information Technology;
- Data Protection Issues; and
- Costs associated with this initiative.

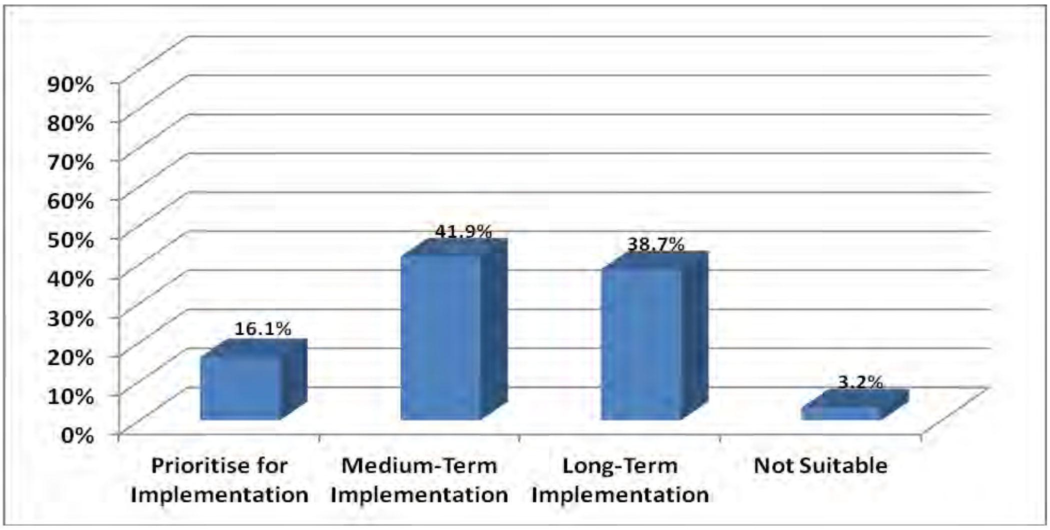
Concern was expressed by one respondent that electronic registers would dilute the meaning associated with recording information on restrictive practices. It was suggested that hard copies of registers should still be completed which could then be integrated with an electronic system.

Action 16

The feasibility of collecting additional data on seclusion and physical restraint use that will assist in monitoring their use and achieving reductions should be examined.
Action: MHC & clinical scientist who is undertaking research into seclusion as part of the MHC/RCSI joint PHD research programme
Intervention Category: Using data to monitor seclusion and restraint episodes

Figure 17 shows that the proportion of submissions indicating support for implementing this action in the medium term and the proportion considering that it should be put it in place in the longer term was close. Almost 42% of respondents stated that it was appropriate for medium-term implementation and 38.7% suggested that it should be included in a reduction strategy as a long term action. One-sixth of respondents believed that this action should be prioritised.

Figure 17: Analysis of Responses to Consultation Questions for Action 16 – ***Examine Feasibility of Collecting Additional Data on Seclusion and Physical Restraint Use***



n = 31

Comments on Action 16 – *Examine Feasibility of Collecting Additional Data on Seclusion and Physical Restraint Use*

Submissions which considered that this action should be put in place speedily noted that the strategy would be assisted by the quick availability of more information. Others observed that as data collection was already taking place, it was more appropriate to consider other actions initially. Challenges related to resources, IT infrastructure and the comparability of data that were noted in respect of other actions were again identified in commentary on this action.

2.2.7 Intervention Category: Review Procedures/Debriefing - Actions 17 & 18

Action 17

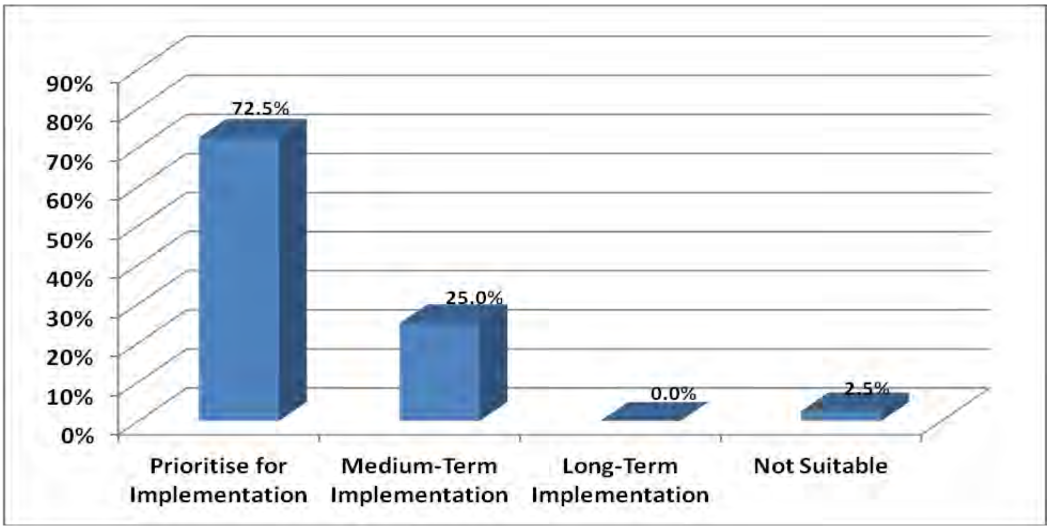
The following Mental Health Commission guidance should be followed to support achieving compliance with Rule 7.4 of the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (Debriefing) and Provision 7.2 of the *Code of Practice on the Use of Physical Restraint in Approved Centres* (Debriefing).

"A debriefing should take place with a resident after an episode of seclusion or physical restraint. A resident's advocate, carer or family member should be granted the opportunity to participate in the debriefing with the resident, or, on his or her behalf, if the resident declines to do so and where he or she consents to the participation of others. A debriefing should include a discussion of the events leading up to the episode of seclusion or physical restraint and address how the use of seclusion or physical restraint can be avoided in the future. The outcome of the debriefing should be documented in the resident's individual care and treatment plan. Approved centres should develop policies and procedures on debriefing that conform to this guidance".

Confirmation that this guidance has been implemented in the approved centre should be forwarded to the Commission six months after the commencement date of this strategy.
Action: Clinical Directors and Registered Proprietors
Intervention Category: Review Procedures/Debriefing

Figure 18 demonstrates that there was large support for prioritising the inclusion of this additional guidance in the strategy. More than seven out of ten (72.5%) respondents ranked the action in this way. One quarter felt that it should be put in place in the medium term.

Figure 18: Analysis of Responses to Consultation Questions for Action 17 – *Additional Guidance on Debriefing*



n = 40

Comments on Action 17 – *Additional Guidance on Debriefing*

Support for Action

The most common response outlined in submissions that wished to prioritise this action was that such additional guidance should be implemented immediately because it addressed issues that services should already be complying with as a result of provisions within Commission Rules and a Code of Practice.

Among the benefits of debriefing noted were:

- It improves practice;
- It facilitates stress reduction for staff; and
- It leads to learning for everyone;

Dialogue between patient and staff (and where appropriate advocates and family) sharing their respective perspective of the events will help improve understanding of all parties and potentially produce alternative solutions in the future – **[Shine]**.

Three submissions emphasised that the wishes of the service users with respect to the involvement of others in the debriefing process had to be respected.

Suggested Amendments to Action

Many proposals were received in relation to this action. Some respondents suggested that the additional guidance should be included directly within the Rules and the Code of Practice in order to give it more weighting than guidance.

The following additional suggestions were made regarding how debriefing could operate more effectively:

- There was a need to highlight the people responsible for the different actions, the timeframes for the completion of debriefing, and the associated documentation which would show that the guidance was being followed;
- Consideration should be given as to what are appropriate professional boundaries and which professionals should appropriately be involved in a therapeutic process; and
- Visual material should be used with service users with an intellectual disability to ensure a more appropriate process.

Four submissions identified a need for staff debriefing which it was felt would recognise that staff often needed support after involvement in a crisis situation.

Clarification Regarding Roles at Debriefing Session

Two respondents sought clarification regarding the role of advocates at the debriefing session. One respondent requested this clarification because they did not regard debriefing as an evidence-based approach. Another respondent asked for clarity around the status of the advocate or service user at the debriefing session. It was considered important that they were regarded as equal participants.

Action 18

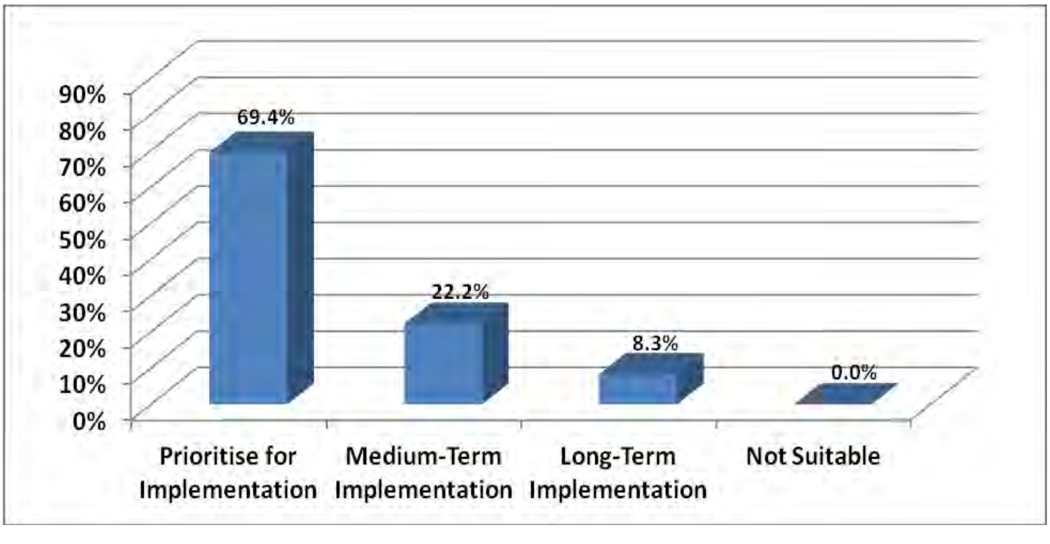
The following Mental Health Commission guidance should be followed to support achieving compliance with Rule 9.3 of the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (Review Procedures) and Provision 10.3 of the *Code of Practice on the Use of Physical Restraint in Approved Centres* (Review Procedures).

"A formal review of an episode of seclusion or physical restraint should take place after the debriefing of the patient, advocate, carer or family member. The staff member who chairs a review meeting should not have been someone who was involved in initiating the episode of seclusion or physical restraint. Approved centres should develop policies and procedures on review procedures that conform to this guidance".

Confirmation that this guidance has been implemented in the approved centre should be forwarded to the Commission six months after the commencement date of this strategy.
Action: Clinical Directors and Registered Proprietors
Intervention Category: Review Procedures/Debriefing

Including the final action as a priority action was supported by a clear majority of the 36 respondents who ranked this action. Almost seven out of ten (69.4%) submissions indicated that it should be prioritised. Eight (22.2%) respondents preferred implementing it in the medium.

Figure 19: Analysis of Responses to Consultation Questions for Action 18 – *Additional Guidance on Review Procedures*



n = 36

Comments on Action 18 – *Additional Guidance on Review Procedures*

Support for Action
Similar reasons for supporting the inclusion of this action as a priority were cited as were noted in relation to the action on debriefing. Putting in place adequate review procedures was frequently described as a valuable reflective and learning experience.

The National Federation of Voluntary Bodies drew the Commission‟s attention to Rights Review Committees (RRC) which have been established by a number of their member organisations. Such committees make a useful distinction between therapeutic interventions and rights restrictions.

Suggested Amendments to Action
Among the suggested changes to the action which were proposed were that:

- The chair of a review meeting should be independent and sufficiently empowered to challenge culture and practice, not just within teams, but also within the approved centre and wider psychiatry; and
- The process of restraint and seclusion, reviews and feedback can be quite emotive and a „no blame‟ culture can lead to improved outcomes.

2.3 Findings for Consultation Question 7: Other Comments or Suggestions

The consultation document‟s final question asked participants:

*Have you any **other comments or suggestions** you wish to make?*

Responses to this question were quite varied and covered a range of issues related to the strategy and to the issue of seclusion and restraint in general. We group the comments under a number of appropriate headings. These include comments relating to:

- Omissions from the draft strategy;
- The scope of the draft strategy;
- Implementation of the strategy;
- Perspectives on the use of Seclusion and Restraint;
- The Knowledge Review;
- Seclusion and Restraint Use among specific populations;
- Contextual Developments;
- Suggested Amendments to Commission Rules and a Code of Practice; and
- Issues that were outside the scope of the consultation.

Omissions

The role of the **physical environment** in promoting relaxation and recovery and therefore to a reduced need to use seclusion and restraint was regularly highlighted. Among the relevant characteristics of approved centres that were noted were:

- The amount of space and light available in the centre;
- The presence of high observation facilities;
- The presence of an adjoining open space such as a garden; and
- Soft furnishings.

Enhancing the environmental design of approved centre (reduced stressors such as crowding, noise etc.) may significantly reduce the need to use seclusion or physical restraint (perhaps the Commission could investigate whether this would be useful and produce standards so that as Approved Centers are replaced and updated more therapeutic, patient centered environments could be constructed) – [**Association of Occupational Therapists of Ireland Special Interest Group in Mental Health]**.

One respondent considered it especially important to comment on the poor physical state of many approved centres.

The administration of medication was a recurring theme in several submissions. This included the use of medication for rapid tranquilisation or what was described by some respondents as chemical restraint. The knowledge review that accompanied the draft strategy acknowledged the evidence that the choice of anti-psychotic medication can influence rates of seclusion and restraint. The Commission considered, however, that it was inappropriate to include an action in the draft strategy related to the use of medication as a restraint in order to achieve reductions in the use of other restrictive interventions.

There was, nevertheless, a request for clarity from a number of respondents as to the status of medication in the strategy. The Psychiatric Nurses Association (PNA) considered that "*the reluctance by the Commission to address the use of medication as part of this strategy not as a means of restraint but sometimes necessary in the treatment of mental illness and distress and therefore must be referred to as a component in this strategy*". Others felt that the appropriate use of medication and in some cases, rapid tranquilisation, reduces the need for seclusion and restraint and the strategy needs to acknowledge this.

Medication is an integral part of the management of acutely unwell patients. It is integral to the treatment of mental illness which may underlie disturbed behaviour. The review was limited in relation to this and needs further consideration, and for its outcomes to be factored into the whole thrust of the document on restraint and seclusion – [**St Vincent's Hospital, Fairview**].

In contrast, other respondents were concerned at the prevalence of the use of medication to restrain patients. Service users reported negative side effects that had been experienced as a result of being administered such medication. Concern was expressed that some services would achieve reductions in the use of seclusion and physical restraint once the strategy commenced by simply administering more medication to patients.

A number of respondents called for clear guidelines or a code of practice to regulate the use of psychotropic medication that is administered to restrain patients. There was also a call for an independent audit of mental health services to assess their use of medication for this purpose.

Other restrictive interventions which can be experienced as restraint and which were not addressed in the strategy were also highlighted. Two respondents felt that the strategy may benefit from viewing restraint in a similar manner as the government initiative, *Towards a Restraint Free Environment in Nursing Homes (2011)*. Its definition of restraint included physical, mechanical, chemical and environmental restraint. Common forms of restrictive practices that other respondents wished to acknowledge were:

- The practice of locking doors;
- Buildings that do not allow much movement or personal privacy; and
- Restrictions on access to personal belongings;

"The National Federation propose that all forms of restraint need to be defined and included comprising chemical, mechanical, environmental and physical restraint accompanied by a strict code of practice monitoring their use with clear guidance on consent.[2] *We also propose that the living situation of the person may be a key factor in the existence of challenging behaviour and a sign of the person's distress"* – **[National Federation of Voluntary Bodies].**

Increased staff-to-patient ratios were recognised as an effective means to reduce the use of restrictive interventions in the literature. We decided, however, that including an action relating to increased staff-to-patient ratios was unrealistic because of the staff shortages in so many services. Some respondents, nevertheless, felt that as it was an evidence informed initiative, it could not be ignored even if it required more resources than some of the other actions. One respondent noted that it was a much more appropriate action than staffing related actions that were included in the draft strategy, such as those related to staff rotation and the development of Psychiatric Emergency Response Teams (PERTs). Mental Health Reform considered that an action related to increased ratios should be included in the strategy in principle and that planning work related to its medium and long-term implementation could commence in the short-term.

Some additional omissions noted by respondents were the following:

- The strategy should address the **harshness of the practice of seclusion and restraint**;
- The strategy needed to more explicitly set out that its goal was also to achieve **decrease in the duration of seclusion and restraint**;
- The reduction strategy should expand its scope from focusing on seclusion and physical restraint to **also include mechanical restraint** and to clearly outline that it aims to completely eradicate the use of mechanical restraint;

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[2] DOHC (October 2011) TOWARDS A RESTRAINT FREE ENVIRONMENT IN NURSING HOMES - A POLICY DOCUMENT

- The strategy needs to more clearly establish that it is about a **shift in practices and a change in culture** and not just about reducing numbers and ticking boxes.

Scope of Strategy

The draft strategy aims to reduce the use of seclusion and physical restraint within approved centres in Ireland. This reflects the scope of the Commission Rules and Code of Practice that govern the use of seclusion and physical restraint. These are interventions that may be used on all residents of approved centres, including children and adolescents.

Suggestions were made that the scope of the strategy should extend to other locations. These included high support units such as Ballydowd Special Care Unit which provides secure residential accommodation for children with serious emotional and behavioural difficulties who are detained under a High Court Order for their safety and welfare. It was also suggested that it would be helpful if the strategy applied to penal institution such as St. Patrick‟s Institution where a number of the children detained there have a dual diagnosis of behavioural and mental health problems.

Frustrations were also expressed that restrictive practices are used in other locations that are not currently subject to statutory inspection. This includes in particular services providing care and treatment to service users with intellectual disabilities in non-approved centre settings. One respondent suggested that the Commission should ask the Inspector of Mental Health Services to carry out an audit of the prevalence of the use of seclusion and physical restraint outside approved centres and make recommendations as to how this should be monitored.

Implementation of Strategy

Respondents frequently addressed how the strategy might be implemented beyond the consideration of the issue in the different draft actions. Challenges to the successful implementation of the strategy were frequently highlighted. There was a widespread concern that the current **shortage of financial and staffing resources** may result in the strategy not being accepted or implemented.

"*There is no comment on funding but the introduction of ICT, audits, staff training, etc. all have resource implications. Many services are firefighting due to staff retirements and lack of resources at present so it is difficult to see how a quality initiative such as this, though very important, can be completed*" – [**SIPTU Health Division**].

On the other hand, some respondents noted that many of the strategy‟s actions were not resource intensive.

There was broad agreement that all actions when finalised should have an agreed **timeframe for implementation**. Different perspectives were offered, however, on what was an appropriate timeframe for implementation of the complete strategy. One respondent considered that a relatively short time frame of around three years should apply because the strategy has been developed during a time of economic constraint. It was then recommended that a review should take place at the end of this timeframe in order to examine actions that were not feasible during the initial period of the strategy. It was still considered essential to prioritise all feasible actions immediately.

The protection of individuals from unnecessary seclusion and restraint is not something that should be delayed. The prohibitions against torture, inhuman and degrading treatment are absolute rights under international human rights law and all feasible actions to prevent the risk of these rights being violated should be undertaken as a matter of priority – [**Mental Health Reform**].

One respondent identified research from Australia which suggested that any seclusion and restraint reduction strategy would require long-term support for a period of at least three to five years.

Some submissions commented on the **role of the Mental Health Commission in implementing the strategy**. It was suggested that the Commission needed to take on more of a leadership role and indicate how it would follow through to ensure delivery of the different actions. One respondent felt that the Commission could also play a leading role in reducing the use of seclusion and restraint by insisting on the provision of resources to provide training for example and recommending capital expenditures to improve the conditions within approved centres. Another submission felt that the Commission‟s leadership role needed to be set out more clearly within the Seclusion and Physical Restraint Reduction Strategy through a strong vision statement.

Other comments addressing the strategy‟s implementation stated that:

- Consideration should be given to including the final strategy or key elements of the strategy in the relevant Rules and Code; and
- The strategy should be implemented through a recognised change model.

Perspectives on the Use of Seclusion and Restraint

A variety of perspectives on the use of seclusion and restraint were put forward by different respondents. Although the vast majority of consultation participants supported the implementation of a reduction strategy, a number of respondents considered that it needed to be fully appreciated that seclusion and restraint were sometimes needed. Other comments which were made were:

- The safety of staff and other patients also needs to be considered;
- Seclusion and restraint are perceived by many service users as punishment;
- Seclusion and restraint can be considered therapeutic approaches; and
- The reduction strategy needed to recognise that seclusion and restraint are quite separate approaches to the management of challenging behaviour.

The Association of Occupational Therapists of Ireland also shared with us their *Best Practice Guidance for Occupational Therapists: Restrictive Practices and People with Intellectual Disabilities".* This provides individual therapists with the information and resources they need to make decisions where they are asked to intervene in restrictive practices.

Knowledge Review

There was a broad welcome and praise for the knowledge review which accompanied the draft strategy. Some respondents, nevertheless, felt that the literature"s focus on research carried out in child and adult in-patient facilities limited its relevance to some approved centres. A submission from a Mental Health Service for Older People considered that as the differing needs of older people had not been adequately considered in informing the strategy, a further review of the literature should be carried out to inform evidence based on this group. A similar suggestion was made by other respondents in respect of literature related to reduction initiatives and people with intellectual disabilities.

Other points noted were that:

- The review did not distinguish adequately between the very different populations of children and adults;
- The knowledge review did not include any literature from the UK; and
- We should be careful interpreting the findings of the knowledge review across jurisdictions and service types.

Seclusion and Restraint Use among Specific Populations

Some respondents focussed particular attention on the issues concerning particular sub-groups on whom seclusion and restraint are used. These included children and adolescents, people with intellectual disabilities, older people and persons using forensic mental health services. In general, respondents considered that specialist approaches were needed for specific populations and that a one-size fits all strategy would not work.

Contextual Developments

A variety of contextual developments were highlighted by consultation participants as important to consider. These included:

- The absence of a coherent management and accountability structure for the public mental health services, including a Director for Mental Health, which is needed to drive the culture change implicit in a reduction strategy; and
- The slow pace of implementation of *A Vision for Change*.

The failure to implement key recommendation of *A Vision for Change* was a source of frustration for many respondents who directly linked inadequate service provision with the high levels of seclusion and restraint in use in some services. This lead in particular to the

inappropriate placement of some patients in approved centres. Some approved centres wish to transfer patients with challenging behaviours to other facilities for instance but cannot because there is no access to a regional secure unit.

The inappropriate placement of many service users with mental illness and intellectual disability in approved centres was also noted. Respondents felt that the implementation of A *Vision for Change*"s recommendations in respect of mental health of intellectual disability teams and the development of intensive care rehabilitation units needed to be immediately prioritised.

Mental Health Commission Rules and Code of Practice Governing the Use of Seclusion and Physical Restraint

Suggested changes were also made by respondents regarding the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* and the *Code of Practice on the Use of Physical Restraint in Approved Centres*. Such amendments would be best considered in the context of a review of any of these documents.

Outside Scope

Several suggestions were received which were beyond the scope of this strategy although related to the issues of seclusion and restraint. Most of these proposals related to matters that could only be changed through amendments to the primary legislation, i.e. the Mental Health Act 2001. They included proposals:

- To designate the *Code of Practice on the Use of Physical Restraint in Approved Centres* as Rules;
- To enhance the protection of rights of individuals regarding restraint and seclusion within the context of the current review of the Mental health Act 2001;
- To make it easier to transfer a patient to the Central Mental Hospital;
- To specify that restraint may only be used for the administration of treatment in exceptional circumstances; and
- To require consideration of whether the status of a voluntary patient should be changed to involuntary before they are secluded or restrained.

The Commission would also like to acknowledge a number of helpful suggestions that were received regarding the **format of the final strategy**.

3. Discussion and Next Steps

This consultation exercise has revealed a huge amount of support for the Commission‟s proposal to implement a seclusion and restraint reduction strategy. The Commission is encouraged by these views and by the large amount of interest in the area that was apparent in the submissions made. We would like to acknowledge that a lot of existing work is already talking place in the area. Many respondents took the time to provide details to us on good practice initiatives that are already in place in services. Others made commitments in relation to implementing reduction initiatives which is especially welcome.

It is clear from quantitative analysis that there is considerable support for immediately implementing certain actions as part of the strategy. More than 90% of respondents consider that a seclusion and restraint reduction plan should be prioritised for implementation for example. Significant support for the speedy implementation of many of our other proposed actions was also evidenced. These included proposals related to guidance on training and guidance on debriefing and assigning responsibility for implementation of the strategy.

Quantitative data analysis also pointed to those actions which respondents are less enthusiastic about implementing. Here, concerns emerged in particular over the proposal to examine the feasibility of removing seclusion rooms from approved centres and actions related to staffing and the use of data to monitor seclusion and restraint.

In addition to quantitative findings, it is also essential to consider the explanatory comments that were fed back to us. These have provided us with a fuller understanding of participant views on areas under consideration. For example, although just one fifth of respondents indicated that they did not consider the action related to the development of psychiatric emergency response teams was suitable to implement, the detailed commentary on this action came almost exclusively from those opposed to this action. An analysis of these comments revealed that those who were opposed to this action had significant concerns.

It is clear to us that there are many challenges associated with putting this strategy in place. As well as cross cutting issues such as a shortage of staffing and financial resources, there are also challenges specific to the implementation of certain actions.

Consultation findings and suggestions made will now be considered in detail by the Commission. We will shortly outline our proposals in relation to the seclusion and physical restraint reduction strategy that we intend to implement in 2013.

4. Appendix - List of Consultation Respondents

1. Acute Psychiatric Unit, Tallaght, Dublin West/South West Mental Health Services
2. Amnesty International Ireland
3. An Bord Altranais
4. Association of Occupational Therapists of Ireland (AOTI) Special Interest Group in Mental Health
5. Barnardos
6. Mr Michael Bambrick, Director of Nursing, West Cork Mental Health Services, Bantry General Hospital, Bantry, Co. Cork.
7. Ms Margaret Brennan, Specialist Mental Health, HSE Dublin North-East
8. Carlow/Kilkenny/South Tipperary Mental Health Services
9. Central Mental Hospital
10. Children in Hospital Ireland
11. Daughter of Charity Intellectual Disability Service
12. Mr Martin Denny, CNM3, South Lee Mental Health Unit, Cork University Hospital
13. Donegal Mental Health Services Nursing
14. Executive Clinical Directors, College of Psychiatry of Ireland
15. Faculty of General Adult Psychiatry, College of Psychiatry of Ireland
16. Galway Mental Health Services Consultant Psychiatrists
17. HSE Mental Health Act Training Group
18. Irish Advocacy Network (IAN) Ltd.
19. Irish Institute of Mental Health Nurses
20. Ms Lisa Kiernan, CNM1, St Patrick‟s University Hospital
21. Kildare/West Wicklow Mental Health Services
22. Mr Graham Malone, CNM1 & PMAV Instructor, Unit One, St Brigid‟s Hospital Complex, Ardee, Co. Louth.
23. Mr Liam Marley, CNM2 & PMAV Instructor, Kerry Mental Health Services
24. Dr. Mia Mc Laughlin, Consultant Psychiatrist, St. Luke‟s Hospital , Kilkenny
25. Mr Patrick Murphy, Staff Nurse & PMAV Instructor, HSE South.
26. North Dublin Mental Health Services
27. Nurse Education Policy Development Committee, Louth/Meath Mental Health Services
28. Member of the Public
29. Mental Health Nursing Forum, School of Nursing & Midwifery, Trinity College Dublin
30. Mental Health Reform

31. Mental Health Services for Older People, Louth/Meath Mental Health Services
32. Mid West Mental Health Services (Clare, Limerick and North Tipperary)
33. Multidisciplinary Restrictive Practice Reduction Group, St Josephs Intellectual Disability Service
34. National Federation of Voluntary Bodies
35. National Service Users Executive (NSUE)
36. Project Joint Governance Committee, Linking Service and Safety
37. Psychiatric Nurses Association (PNA)
38. Psychiatric Nurses Association (PNA) members in the National Forensic Service
39. School of Nursing, Midwifery & Health Systems, University College Dublin
40. Service User 1
41. Service User 2
42. Service User 3
43. Shine
44. SIPTU Health Division
45. South Tipperary Mental Health Services Consultant Psychiatrists
46. St Brendan's Hospital Multidisciplinary Team
47. St John of God Hospital Ltd
48. St John of God Community Services Ltd
49. St Patrick's University Hospital, St Edmundsbury Hospital, Willow Grove Adolescent Unit
50. St Vincent's Hospital, Fairview
51. Dr. Dermot Walsh, Consultant Psychiatrist, Former Inspector of Mental Hospitals
52. West and East Galway Mental Health Services in conjunction with the Mental Health Research Cluster, National University of Ireland, Galway.