

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



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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
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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 Health 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.

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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 health 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 stigmatisation 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 may be 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) *Ninth 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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NIMHE is part of the Modernisation Agency at the Department of Health

Front cover image by Owen Turner

34200 1p 5k Feb 04 (XXX)

