Appendix 9 HEALTH ECONOMICS REPORT .......... Error! Bookmark not defined.
Appendix 10 QUALITY CRITERIA FOR MAIN STUDY DESIGNS ...................... 359
Appendix 11 CRITICAL APPRAISAL OF MANAGEMENT OF IMMINENT VIOLENCE: CLINICAL PRACTICE GUIDELINES TO SUPPORT MENTAL HEALTH SERVICES .............................................................. 361
Appendix 12 SUMMARY OF ST GEORGE'S REPORT ON RCPSYCH GUIDELINE .............................................................................................................. 365
Appendix 13 CRITICAL APPRAISAL OF BREAKING THE CIRCLES OF FEAR: A REVIEW OF THE RELATIONSHIP BETWEEN MENTAL HEALTH SERVICES AND AFRICAN AND CARIBBEAN COMMUNITIES ......................... 366
Appendix 14 REPORT ON FOCUS GROUPS .......... Error! Bookmark not defined.
Appendix 15 PEER REVIEWERS ................................................................. 453

Appendix 9

Health Economics Searches, Evidence Tables and References

This appendix first presents the searches, and then summarises the findings by search topic. The list of reviewed papers is at the end in section 9.12.

9.1 The searches

9.1.2 Databases and initial search strategies

The databases searched for the heath economic evidence are: Medline, Embase, OHE HEED, and NHS EED. Searches were not conducted for the separate topics, but one search was designed to cover all material, and the search completed by 28/1/03. Below are the search terms and strategies for each database, and the number of hits.

Medline (1)

#1 (de escalat$.tw or de fus$.tw or exp Restraint/ Physical or restrain$.ti or coerc$.ti or seclu$.ti or constrain$.ti or tranquili$.ti) and (exp Mental Disorders or psychiatrist$.ti or paranoi$.ti or schizo$.ti or anxio$.ti or mani$.ti or depress$.ti or psychiatric inpatient$.ti) and (economic evaluations and quality of life search filters- see cbmeconfil and cbmqolfil on the Medline database)

OR

#2 (violen$.ti or disturb$.ti or anger$.ti or rage$.ti or intimidat$.ti or aggress$.ti or danger$.ti or attack$.ti or threat$.ti or combative$.ti or assault$.ti) and (exp Mental Disorders or psychiatrist$.ti or paranoi$.ti or schizo$.ti or anxio$.ti or mani$.ti or depress$.ti or psychiatric inpatient$.ti) and (economic evaluations and quality of life search filters- see cbmeconfil and cbmqolfil on the Medline database)

#3 #1 OR #2
#4 (de escalat$.tw or de fus$.tw or exp Restraint/ Physical or restrain$.ti or coerc$.ti or seclu$.ti or constrain$.ti or tranquili$.ti) and (violent$.ti or disturb$.ti or anger$.ti or rage$.ti or intimidat$.ti or aggress$.ti or danger$.ti or attack$.ti or threat$.ti or combative$.ti or assault$.ti) and (exp Mental Disorders or psychiatric$.ti or paranoid$.ti or schizo$.ti or anxio$.ti or mani$.ti or depress$.ti or psychiatric inpatient$.ti)

#5 #3 OR #4 = 196 hits.

**Medline (2)**

(psychiatric inpatient$.tw OR inpatient$.tw OR psychiatric$.tw OR psycho$.tw OR schizophen$.tw OR anxi$.tw OR depress$.tw OR hyster$.tw OR mani$.tw OR personality disorder$.tw OR bi polar$.tw OR exp Mental Disorder OR mental disorder$.tw)

AND

(brief psychiatric rating scale$.ti OR bprs$.ti OR basis 32$.ti OR overt agitation severity scale$.ti OR behaviour symptom identification scale$.tw OR overt aggression scale$.ti OR child behaviour checklist$.ti OR mmpi$. OR vrin$.ti OR devereux scale$.ti OR assessment inventory$.ti OR dissociative experience scale$.ti OR staff observation aggression scale$.ti OR soas$.ti)

AND

(violent$.tw OR aggress$.tw OR agitat$.tw OR rage$.tw OR anger$.tw OR angry$.tw OR disturb$.tw) = 132 hits

**Embase (1)**

#1 (de escalat* or de fus* or restrain* or coerc* or seclu* or constrain* or tranquili*) and (psychiatric inpatient* or mental disorder*) and (economic* or cost* or fee* or charge* or budget* or pric* or quality of life or life quality or quality adjusted life year or well being)

OR

#2 (violent* or disturb* or anger or rage* or intimidat* or aggress* or danger* or attack* or threat* or combative or assault*) and (mental disorder* or psychiatric inpatient*) and (economic* or cost* or fee* or charge* or budget* or pric* or quality of life or life quality or quality adjusted life year or well being)

#3

#1 OR #2

#4 (de escalat* or de fus* or restrain* or coerc* or seclu* or constrain* or tranquili*) and (violent* or disturb* or anger or rage* or intimidat* or aggress* or danger* or attack* or threat* or combative or assault*) and (mental disorder* or psychiatric inpatient*)

#5 #3 OR #4 193 Hits
Embase (2)

(violent* or aggress* or agitat* or rage* or anger or angry or disturb* or angry) and (psychiatric inpatient* or inpatient* or psychiatr* or psychos* or schizophen* or anxi* or depress* or hyst* or mani* or personality disorder* or bi polar* or mental disorder*) and (brief psychiatric rating scale* or bprs or basis 32 or overt agitation severity scale* or behaviour symptom identification scale* or overt aggression scale* or child behaviour checklist* or mmpi* or vrin* or devereux scale* or assessment inventory or dissociative experience scale* or staff observation aggression scale* or soas) in TI) = 45 hits

OHE HEED (due to a fault in the system, this database does not allow any complex searching):

Search term- ‘psychiatric inpatient’ = 12 hits.

NHS EED (very complex searching and long search terms cannot be used on this database. The database automatically truncates terms):

(de escalate OR seclude OR restrain OR medicate OR coerce) AND (violent OR disturbed OR aggressive) OR (psychiatric inpatient OR mental disorder) = 152 hits

Grand total: 678 hits

9.1.2. Sifting of the results

Given the expectation that there will be few economics studies that addressed any of the topics, no strict criteria were used other than (a) that the study addresses violence in inpatient psychiatric settings, and (b) that the study has an economic or an evaluative component, or (c) that the study aims to quantify different degrees of violent behaviour. Comments and letters were excluded. Of the 678 articles identified in the initial search, around 80 were of any relevance to criterion (a). This was further narrowed down to 29 papers by (b) and (c), and these were ordered for review. A further 6 were identified from other sources and ordered. Section 9.11 lists the 35 papers reviewed from this initial search.

Judging from the titles/abstracts, the distribution of these papers is as follows (n = 37 since some papers correspond to more than one category):

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>7</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

9.1.3. An additional search on rapid tranquilisation

The initial health economics search resulted in only one study on rapid tranquilisation, which was a comment (and therefore excluded), and did not result in any of the studies identified in the NICE Guideline on Schizophrenia. Therefore, an additional search was carried out, using the same databases, and the following strategies.
Medline

1  Violence/ (12961)  
2  violen$.tw. (13530)  
3  disturb$.tw. (90012)  
4  anger.tw. (3921)  
5  angry.tw. (853)  
6  rage$.tw. (969)  
7  intimidat$.tw. (302)  
8  aggress$.tw. (52942)  
9  danger$.tw. (21806)  
10  attack$.tw. (45101)  
11  threat$.tw. (40380)  
12  combative.tw. (119)  
13  assault$.tw. (3820)  
14  or/1-13 (264773)  
15  Emergency Services, Psychiatric/ (1291)  
16  (psychiatric adj3 emergenc$).tw. (1181)  
17  ((rapid$ or acute or short-acting or fast-acting or emergenc$ or urgent) adj3 (sedat$ or tranquil$)).tw. (550)  
18  ((chemical$ or pharmacological) adj3 restrain$).tw. (250)  
19  (acute adj3 agitation).mp. [mp=title, abstract, cas registry/ec number word, mesh subject heading] (83)  
20  Haloperidol/ (11688)  
21  haloperidol.tw. (11589)  
22  PROMAZINE/ (624)  
23  promazine.tw. (309)  
24  LORAZEPAM/ (1770)  
25  lorazepam.tw. (1897)  
26  DIAZEPAM/ (14402)  
27  diazepam.tw. (13357)  
28  FLUNITRAZEPAM/ (2314)  
29  flunitrazepam.tw. (2508)  
30  CLONAZEPAM/ (1696)  
31  clonazepam.tw. (2035)  
32  MIDAZOLAM/ (4119)  
33  midazolam.tw. (4970)  
34  PROCHLORPERAZINE/ (630)  
35  prochlorperazine.tw. (415)  
36  exp Benzodiazepines/ (39331)  
37  benzodiazepine$.tw. (18293)  
38  exp BENZODIAZEPINONES/ (28453)  
39  benzodiazepinone$.tw. (22)  
40  CHLORPROMAZINE/ (11061)  
41  chlorpromazine.tw. (7270)  
42  CLOPENTHIXOL/ (278)  
43  clopenthixol.tw. (143)  
44  neuroleptic$.tw. (14027)  
45  or/15-44 (87756)  
46  economics/ (25927)  
47  exp "costs and cost analysis"/ (103775)  
48  economic value of life/ (6987)  
49  exp economics, hospital/ (12123)  
50  exp economics, medical/ (9573)  
51  economics, nursing/ (3585)  
52  economics, pharmaceutical/ (1151)  
53  exp models, economic/ (3256)  
54  exp "fees and charges"/ (20793)  
55  exp budgets/ (7883)
Embase

#49 #14 and #48 (217 records)
#48 #43 and #47 (3986 records)
#47 #44 or #45 or #46 (202916 records)
#46 ((economic* or pharmacoeconomic* or pharmaco-economic* or price* or pricing*) in ti) and (PY=1985-2002) (9160 records)
#45 ((cost*) in TI) and (PY=1985-2002) (20835 records)
#44 explode 'economic-aspect' / all subheadings (197794 records)
#43 #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42 (150895 records)
#42 neuroleptic-agent (6073 records)
#41 explode 'neuroleptic-agent' / all subheadings (81262 records)
#40 clopenthixol (413 records)
#39 'clopenthixol-' / all subheadings (361 records)
#38 chlorpromazine (17720 records)
#37 'chlorpromazine-' / all subheadings (17077 records)
#36 benzodiazepine-derivative (3981 records)
#35 explode 'benzodiazepine-derivative' / all subheadings (66446 records)
#34 prochlorperazine (2631 records)
#33 'prochlorperazine-' / all subheadings (2382 records)
#32 midazolam (11355 records)
#31 'midazolam-' / all subheadings (10800 records)
#30 clonazepam (8428 records)
#29 'clonazepam-' / all subheadings (8265 records)
#28 flunitrazepam (5812 records)
#27 'flunitrazepam-' / all subheadings (4905 records)
#26 diazepam (34376 records)
#25 'diazepam-' / all subheadings (32582 records)
#24 lorazepam (8473 records)
#23 'lorazepam-' / all subheadings (8339 records)
#22 promazine (973 records)
#21 'promazine-' / all subheadings (943 records)
#20 haloperidol (25784 records)
#19 'haloperidol-' / all subheadings (24729 records)
#18 (chemical* or pharmacological) near3 (restrain*) (96 records)
#17 (rapid* or acute or short-acting or fast-acting or emergenc* or urgent) near3 (sedat* or tranquilili*) (291 records)
#16 'emergency-health-service' / all subheadings (5685 records)
#15 psychiatric near3 emergenc* (791 records)
#14 #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 (226226 records)
#13 assault* (3482 records)
#12 combative (91 records)
#11 threat* (33214 records)
#10 attack* (39311 records)
#9 danger* (18326 records)
#8 aggress* (46334 records)
#7 intimidat* (188 records)
#6 rage (972 records)
#5 anger (551 records)
#4 anger (3917 records)
#3 disturb* (72608 records)
short-term management of violent (disturbed) behaviour in adult psychiatric in-patient and accident and emergency settings guideline

# 2 violen* (12949 records)
# 1 explode 'violence-'/ all subheadings (20296 records)

NHS EED

clophenthixol or chlorpromazine or benzodiapene or prochlorperazine or midazolam or clonazepam or flunitrazepam or diazepam or lorazepam or promazine or haloperidol OR (chemical or pharmacological) and restrain OR rapid sedation or acute sedation or short-acting sedation or fast acting sedation or emergency sedation or urgent sedation or tranquil*= 51 Hits.

Grand total: 336 hits

These searches resulted in 336 hits, of which 25 were in the context of violent behaviour in inpatient psychiatric settings. Judging from the titles and abstracts, 4 papers were identified as possible economic studies. These 4 studies were included in the Schizophrenia Guideline.

9.2 Environmental Concerns and Alarm Systems

Of the 2 papers identified as addressing environment, both are evaluations and give descriptions of outcomes but lack input data (ie. these are not cost-effectiveness studies). These are summarised below. A 3rd paper on environment was not available. There were no papers with economic analyses of alarm systems.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>category</td>
<td>environment</td>
</tr>
<tr>
<td>population/country</td>
<td>1000-bed maximum-security forensic psychiatric hospital for men, US.</td>
</tr>
<tr>
<td>intervention</td>
<td>Total quality management to reduce meal time violence (change procedure, introduce plastic disposable cutlery, play music chosen by music therapist, therapeutic communication training for food service staff).</td>
</tr>
<tr>
<td>outcome measure</td>
<td>Incidence of violence (40% reduction); incidence of weapon attacks with silverware (100% reduction); meal procedure staff time (70 nursing staff hours / day); staff compensation pay (up to 24% reduction).</td>
</tr>
<tr>
<td>cost measure/year</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>comments</td>
<td>Can be revisited under staff training ??</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>category</td>
<td>environment</td>
</tr>
<tr>
<td>population/country</td>
<td>Psychiatric unit of community hospital, US.</td>
</tr>
<tr>
<td>intervention</td>
<td>Violence prevention program based on OSHA (Occupational Health and Safety Administration) recommendation.</td>
</tr>
<tr>
<td>outcome measure</td>
<td>Workers’ compensation payments for assaults (up to 70% reduction).</td>
</tr>
<tr>
<td>cost measure/year</td>
<td>Extra staff/personnel cost mentioned by no levels/figures given.</td>
</tr>
<tr>
<td>comments</td>
<td>Can be revisited under staff training.</td>
</tr>
</tbody>
</table>
9.3 Prediction: Antecedents, Warning Signs and Risk Assessment

9.3.1. The literature review

The search has identified 8 papers on prediction, summarised below. None of them are economic evaluations.

<table>
<thead>
<tr>
<th>Category</th>
<th>Population/Country</th>
<th>Intervention</th>
<th>Outcome Measure</th>
<th>Cost Measure/Year</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prediction</td>
<td>Danish psychiatric hospital</td>
<td>1-year prospective descriptive study.</td>
<td>Correlation between SOAS and diagnosis, by sex.</td>
<td>?</td>
<td>“There was a strong association between the use of coercive measures and violent behaviour (abstract)” Full paper not yet in file.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Category</th>
<th>Population/Country</th>
<th>Intervention</th>
<th>Outcome Measure</th>
<th>Cost Measure/Year</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prediction [review]</td>
<td>- violence over time is often “predictable” - best predictors are historical eg. Revised Psychopathy Checklist (PCL-R) - actuarial methods outperform clinical judgement eg. Violence Risk Appraisal Guide (VRAG) - no clear evidence on what really reduces violence - some exceptions in area of behavioural programs and staff training</td>
<td>None (although mentions staff training costs possibly being outweighed by benefits)</td>
<td>No evaluation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

McNiel and Binder. Relationship between preadmission threats and later violent behavior by acute psychiatric inpatients. *Hospital and Community Psychiatry*. 1989

<table>
<thead>
<tr>
<th>Category</th>
<th>Population/Country</th>
<th>Intervention</th>
<th>Outcome Measure</th>
<th>Cost Measure/Year</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prediction</td>
<td>Patients on admission; university based, locked, short-term inpatient psychiatric unit, middle class catchment area, US</td>
<td>Retrospective study of relationship between 2 wk preadmission threats of violence and violent behaviour within 3 days of acute hospitalisation. $n = 253$</td>
<td>Cross tab of verbal threats and assault-related events; by diagnosis (schizophrenia, mania, other); chi-square tests; highly significant prediction for schizophrenia patients, less for others; victim of violence can be other than those initially intended</td>
<td>None</td>
<td>No evaluation</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Category</th>
<th>Population/Country</th>
<th>Prediction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/Country</td>
<td>Patients from private and state psychiatric hospital, US</td>
<td>Prediction</td>
</tr>
</tbody>
</table>
### Intervention Test of a theoretical model retrospectively explaining violence by antecedent variables (history of violence, diagnosis, length of hospitalisation) and mediating variables (intimidation, interpersonal control, accommodation). \( n = 156 \).

- **Outcome measure**: 60% of aggression explained by intimidation and interpersonal control, length of hospitalisation, history of violence, and bipolar affective syndrome.
- **Cost measure/year**: None.
- **Comments**: “Aggression” of the model is about aggressive behaviour patterns over time, as opposed to specific incidents of violence. No evaluation.

### Sheridan et al, Precipitants of violence in a psychiatric inpatient setting. *Hospital & Community Psychiatry*, 1990

- **Category**: Prediction
- **Population/Country**: 367-bed acute and chronic psychiatric division, Veterans Affairs Medical Centre, US
- **Intervention**: Retrospectively recorded external/internal events preceding incidents of restraint, from both patient and staff point of view; see if patient attitude to restraint experience had correlation with further violent behaviour in 3-month period.
- **Outcome measure**: No relationship between patient attitude to restraint and subsequent violence found.
- **Cost measure/year**: None.
- **Comments**: Has no comparator, how often do these “precedents” happen and yet not lead to violent behaviour? No evaluation.

### Sloore, Use of the MMPI in the prediction of dangerous behavior, *Acta Psychiatrica Belgica*, 1988

- **Category**: Prediction [review]
- **Population/Country**: A review of the correlation between certain personalities and their likelihood of violent behaviour.
- **Intervention**: None.
- **Outcome measure**: Prediction of violence over time, not of an incident. No evaluation.


- **Category**: Prediction
- **Population/Country**: Corrections-based inpatient psychiatric hospital, US
- **Intervention**: (Retrospective?) correlation between PAI and Overt Aggression Scale.
- **Outcome measure**: Significant but low correlation (<0.3) found.
- **Cost measure/year**: None.
- **Comments**: Not clear whether the correlation was PAI before an incidence and OAS after the incidence. No evaluation.


- **Category**: Prediction
- **Population/Country**: 20-bed PICU, Veterans hospital, US
- **Intervention**: Prospective study of correlation between Brief Psychiatric Rating Scale and violent behaviour in schizophrenia patients within 8 days of admission \( n = 207 \).
9.3.2. Health economic comments on prediction

None of the reviewed studies are economic evaluations, but a very simplified net benefit analysis will build upon:

Net benefit of a true positive prediction = - R + AL - CI
Net benefit of a true negative prediction = - R
Net benefit of a false positive prediction = - R - CI
Net benefit of a false negative prediction = - R - AL

Where:
R: resource use for predicting (eg. staff training, monitoring for indicators, etc)
AL: the averted loss associated with the prevented violence
CI: the cost of early intervention (eg. extra staff time and inconvenience to the patient of observation)

Overall net benefit of prediction (combined with a 100% effective early intervention) will depend on the above information, and the sensitivity/specificity of the prediction. But many studies only report sensitivity, ignoring specificity.

Assuming R is negligible, evidence-based guidance on prediction will require information on AL and CI. Reality is more complicated than the above. For example, the sensitivity of the prediction may well be correlated with the magnitude of the possible violent behaviour, and thus with AL, and at the same time the early preventive intervention may become less effective, more labour intensive, or more intrusive to the patient.

9.4 De-escalation Techniques

Of the 2 papers identified as addressing de-escalation, neither are evaluations. Both are summarised below.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>category</td>
<td>de-escalation</td>
</tr>
<tr>
<td>population/country</td>
<td></td>
</tr>
<tr>
<td>intervention</td>
<td></td>
</tr>
<tr>
<td>outcome measure</td>
<td>Paper not relevant. (In-depth interviews of psychiatric nurses in the US. Indicates what an experienced nurse goes through during successful de-escalation, but does not investigate which of these factors might also be shared with failed de-escalation.)</td>
</tr>
<tr>
<td>cost measure/year</td>
<td></td>
</tr>
<tr>
<td>comments</td>
<td></td>
</tr>
<tr>
<td>Paterson, Leadbetter, and McComish. De-escalation in the management of aggression and violence.</td>
<td></td>
</tr>
</tbody>
</table>
9.5 Physical Interventions and Seclusion

The health economics literature search has identified 15 papers on seclusion and/or restraint, summarised below. None of them are economic evaluations.

**Bjørkly, Open-area seclusion in the long-term treatment of aggressive and disruptive psychotic patients, an introduction to a ward procedure, Psychological Reports, 1995**

<table>
<thead>
<tr>
<th>Category</th>
<th>Seclusion &amp; restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/country</td>
<td>8-bed special secure unit, county hospital, Norway; psychotic patients criminal + civil; staff-to-patient ratio 3.5</td>
</tr>
<tr>
<td>Intervention</td>
<td>Therapeutic “open-area seclusion” debriefing</td>
</tr>
<tr>
<td>Outcome Measure</td>
<td>Reality re-orientation; staff attitudes</td>
</tr>
<tr>
<td>Cost Measure/year</td>
<td>None.</td>
</tr>
<tr>
<td>Comments</td>
<td>Therapeutic, as opposed to administrative sanction / safety procedure. No evaluation.</td>
</tr>
</tbody>
</table>

**Bornstein, The use of restraints on a general psychiatric unit. Journal of Clinical Psychiatry, 1985**

<table>
<thead>
<tr>
<th>Category</th>
<th>Seclusion &amp; restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/country</td>
<td>Acute psychiatric unit, 2 large general hospitals, US</td>
</tr>
<tr>
<td>Intervention</td>
<td>9-month prospective study of all restrained patients during the course of hospitalisation.</td>
</tr>
<tr>
<td>Outcome Measure</td>
<td>Percentage restraint by background characteristics. 75 episodes of restraint per 1000 admissions; Men / young / single or divorced more likely; race and insurance type not relevant; more serious psychiatric illness; staffing pattern relevant.</td>
</tr>
<tr>
<td>Cost Measure/year</td>
<td>None.</td>
</tr>
<tr>
<td>Comments</td>
<td>No evaluation.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Category</th>
<th>Seclusion &amp; restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/country</td>
<td>Inpatient psychiatric setting / US</td>
</tr>
<tr>
<td>Intervention</td>
<td>Behavioural consultation; use of monitoring system; review of treatment plan if &gt;6 applications or &gt;72hrs seclusion/restraint utilization per month</td>
</tr>
<tr>
<td>Outcome Measure</td>
<td>Mean seclusion/restraint utilization per month across patients: 62% drop 6 months before vs 6 months after implementation.</td>
</tr>
<tr>
<td>Cost Measure/year</td>
<td>Not mentioned (presumably, staff training &amp; time).</td>
</tr>
<tr>
<td>Comments</td>
<td>Spill over benefits beyond reduction in violent behaviour expected. No economic evaluation.</td>
</tr>
</tbody>
</table>

### Category: Seclusion & restraint

<table>
<thead>
<tr>
<th>Population/Country</th>
<th>Inpatient schizophrenic unit, US. 100 consecutive admissions. DSM-III schizophrenia or schizoaffective disorder. Post seclusion interview about episode within 48hrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>n = 26; younger and less prior contact with inpatient mental health facilities more likely to be secluded; sex and race irrelevant. Patient views on seclusion: seclusion room needed on unit to control disruptive aggressive patient behaviors; seclusion makes patients feel angry and sad, and not protected or safe.</td>
</tr>
<tr>
<td>Outcome Measure</td>
<td>None.</td>
</tr>
<tr>
<td>Cost Measure/Year</td>
<td>No evaluation.</td>
</tr>
</tbody>
</table>

**Hodgkinson. The use of seclusion. Medicine, Science, and the Law**

<table>
<thead>
<tr>
<th>Category</th>
<th>Seclusion &amp; restraint [review]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/Country</td>
<td>Literature review on patterns of seclusion and patient attitudes. Who is secluded, for what, for how long. Variation in practice.</td>
</tr>
<tr>
<td>Intervention</td>
<td>No evaluation. Need for clear guidelines on management strategies.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Category</th>
<th>Seclusion &amp; restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/Country</td>
<td>Psychiatric unit of a District General Hospital, UK</td>
</tr>
<tr>
<td>Intervention</td>
<td>Differentiated levels of nursing observation &amp; supervision.</td>
</tr>
<tr>
<td>Outcome Measure</td>
<td>None (incidence after implementation reported but no baseline provided, and therefore useless).</td>
</tr>
<tr>
<td>Cost Measure/Year</td>
<td>None.</td>
</tr>
<tr>
<td>Comments</td>
<td>No evaluation.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Category</th>
<th>Seclusion &amp; restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/Country</td>
<td></td>
</tr>
<tr>
<td>Intervention</td>
<td></td>
</tr>
<tr>
<td>Outcome Measure</td>
<td></td>
</tr>
<tr>
<td>Cost Measure/Year</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td>Not included (letter on van Rybroek et al, PADS, below).</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Category</th>
<th>Seclusion &amp; restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population/Country</td>
<td>7 nurses in closed wards of psychiatric teaching hospital, Australia.</td>
</tr>
<tr>
<td>Intervention</td>
<td>Interview of nurses with qualitative analysis.</td>
</tr>
<tr>
<td>Outcome Measure</td>
<td></td>
</tr>
<tr>
<td>Cost Measure/Year</td>
<td></td>
</tr>
<tr>
<td>Comments</td>
<td>No evaluation.</td>
</tr>
</tbody>
</table>

**Myers. Seclusion: a last resort measure, Perspectives in Psychiatric Care, 1990**

<table>
<thead>
<tr>
<th>category</th>
<th>Seclusion &amp; restraint / Rapid tranquillisation [comment].</th>
</tr>
</thead>
<tbody>
<tr>
<td>population/country</td>
<td></td>
</tr>
<tr>
<td>intervention</td>
<td></td>
</tr>
<tr>
<td>outcome measure</td>
<td></td>
</tr>
<tr>
<td>cost measure/year</td>
<td></td>
</tr>
<tr>
<td>comments</td>
<td></td>
</tr>
</tbody>
</table>

### Ryden et al, Relationships between aggressive behavior in cognitively impaired nursing home residents and use of restraints, psychoactive drugs, and secured units. *Archives of Psychiatric Nursing*, 1999

<table>
<thead>
<tr>
<th>category</th>
<th>Seclusion &amp; restraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>population/country</td>
<td>Nursing home, US. 203 cognitive impaired residents.</td>
</tr>
<tr>
<td>intervention</td>
<td>None.</td>
</tr>
<tr>
<td>outcome measure</td>
<td>Ryden Aggression Scale, Mini-Mental State Examination; frequency of restraints, seclusion and psychotropic drugs; by use of antipsychotics, anxiolytics and antidepressants.</td>
</tr>
<tr>
<td>cost measure/year</td>
<td>None.</td>
</tr>
<tr>
<td>comments</td>
<td>No evaluation. Significantly lower physical aggression scores found in those receiving antidepressants.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>category</th>
<th>Seclusion &amp; restraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>population/country</td>
<td>Inpatients in 20-bed regional secure unit, large psychiatric hospital, UK.</td>
</tr>
<tr>
<td>intervention</td>
<td>Retrospective study of pattern of seclusion.</td>
</tr>
<tr>
<td>outcome measure</td>
<td>Total admissions/yr, proportion secluded, time of incident; correlation between medication, trigger factors, diagnosis.</td>
</tr>
<tr>
<td>cost measure/year</td>
<td>None.</td>
</tr>
<tr>
<td>comments</td>
<td>No evaluation. “Consistent and regular occurrence over a five-year period of practice may suggest that seclusion of some disturbed patients will inevitably continue to be used as an effective intervention.”</td>
</tr>
</tbody>
</table>

### Soloff et al, Seclusion and restraint in 1985: a review and update. *Hospital & Community Psychiatry*, 1985

<table>
<thead>
<tr>
<th>category</th>
<th>Seclusion &amp; restraint [review]</th>
</tr>
</thead>
<tbody>
<tr>
<td>population/country</td>
<td>Literature review to identify indicators for the use of seclusion and restraint.</td>
</tr>
<tr>
<td>intervention</td>
<td>Setting, population, incidence, demographics, diagnosis, precipitant, duration.</td>
</tr>
<tr>
<td>outcome measure</td>
<td>None.</td>
</tr>
<tr>
<td>cost measure/year</td>
<td>None.</td>
</tr>
</tbody>
</table>
comments
No evaluation. Incidence varies by composition of patient population and treatment philosophy of unit. Occasional use as administrative / punitive sanction.

Tardiff. Emergency control measures for psychiatric inpatients. Journal of Nervous and Mental Disease, 1981

category Observation; Seclusion & restraint; Rapid tranquillisation

population/country US; psychiatric inpatients; schizophrenia, depression, psychotic organic brain syndrome, mental retardation, other non-psychotic disorders

intervention Correlation between experience of control measures in past 1 month and age / sex / race / length of stay / primary diagnosis

outcome measure Chi squared tests indicate correlation between control measures and age / length of stay / primary diagnosis, but not with sex and race.

cost measure/year None.

comments No evaluation. Claims that use of control measures are “justified” because of observed correlations. However, not obvious whether correlations are enough to justify.


category Seclusion & restraints

population/country Forensic unit in mental health institute, US. Repetitively aggressive psychiatric patients.

intervention Ambulatory restraint procedure for repetitively aggressive patients after release from seclusion to avoid social distancing; full access to ward activity/milieu is made possible without provoking fear in other patients and staff.

outcome measure None. List of indications given. No complaints from patients.

cost measure/year None.

comments No evaluation. Looks at how to reintegrate after seclusion. PADS can help “produce a more humane atmosphere in a maximum security environment”.

9.6 Rapid Tranquillisation

9.6.1. Overall results

The additional search has identified 4 papers on rapid tranquillisation. Of these, 2 are economic evaluations and 2 are cost analyses.


category Rapid tranquillisation

population/country PICU, NHS hospital, UK; 83 patients, 45% schizophrenia

intervention None: retrospective baseline description of costs

outcome measure None.

cost measure/year Fixed costs / semi-fixed costs / variable costs; total / per patient-year; no break down by drugs used.

comments No evaluation: not clear if proposed “protocol” was in effect when study was carried out.


category Rapid tranquillisation
Thus, one (Hyde et al, 1998) of the two reviewed studies is a cost minimisation study of zuclopenthixol acetate and haloperidol; i.e. the effectiveness of the two drugs are assumed to be the same, and the study compares the costs of these two interventions. The second study (Lauriet et al, 1997) is a cost consequence study of the same two drugs; i.e. both the outcomes and the costs of the two drugs are compared, where the various outcome indicators are not collapsed into, or represented by, a single variable. Both studies employ the health system’s perspective, and only consider direct medical costs. Neither study look at longer-term effects. The two studies are compared to each other in the following section.

9.6.2. The two economic evaluation studies on rapid tranquillisation

The table below presents a head to head comparison of the two economic evaluations on rapid tranquillisation

<table>
<thead>
<tr>
<th>Population/Country</th>
<th>PICU, NHS hospital, UK; inpatients with diagnosis of schizophrenia, mania, manic depression, substance misuse or other acute psychosis</th>
<th>Laurier et al, 1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Zuclopenthixol acetate vs. haloperidol for rapid tranquillisation</td>
<td>Every effort to control psychotic symptoms; degree of sedation; frequency of extrapyramidal symptoms</td>
</tr>
<tr>
<td>Outcome measure</td>
<td>Assumed same.</td>
<td>Derived from retrospective baseline description of direct costs.</td>
</tr>
<tr>
<td>Cost measure/year</td>
<td>Nursing staff costs, medical staff costs, damage to property, injury to people, drug prices (BNF)</td>
<td>Direct medical costs</td>
</tr>
<tr>
<td>Comments</td>
<td>Cost minimisation study: include in review</td>
<td>Cost consequence analysis, based on modelling. Include in review.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Zuclopenthixol acetate IM vs. haloperidol IM</td>
<td>Zuclopenthixol acetate IM vs. haloperidol IM</td>
</tr>
<tr>
<td>Outcome measure</td>
<td>Control of psychotic symptoms; degree of sedation; frequency of extrapyramidal symptoms</td>
<td>Control of psychotic symptoms; degree of sedation; frequency of extrapyramidal symptoms</td>
</tr>
<tr>
<td>Cost measure/year</td>
<td>Direct medical costs</td>
<td>Direct medical costs</td>
</tr>
<tr>
<td>Comments</td>
<td>Cost consequence analysis, based on modelling. Include in review.</td>
<td>Cost consequence analysis, based on modelling. Include in review.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Canadá: schizophrenic patients hospitalised subsequent to A&amp;E visit</td>
<td>A&amp;E in a Canadian hospital; patients with DSM-IV diagnosis of schizophrenia and who were treated with haloperidol</td>
</tr>
<tr>
<td>Outcome measure</td>
<td>Zuclopenthixol acetate IM vs. haloperidol IM</td>
<td>None. RETROSPECTIVE BASELINE DESCRIPTION OF DIRECT COSTS.</td>
</tr>
<tr>
<td>Cost measure/year</td>
<td>Control of psychotic symptoms; degree of sedation; frequency of extrapyramidal symptoms</td>
<td>Mean cost of emergency room stay; GP/psychiatrist time, medication, bed</td>
</tr>
<tr>
<td>Comments</td>
<td>Control of psychotic symptoms; degree of sedation; frequency of extrapyramidal symptoms</td>
<td>No evaluation; not clear if population/context is relevant.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Country / Setting</th>
<th>UK; PICU</th>
<th>Canada; 1 psychiatric 1 general hospital; and literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of Study</td>
<td>Dec 94 - Jan 96 from single PICU</td>
<td>1992 - 94 for costs from 2 hospitals</td>
</tr>
<tr>
<td>Patients</td>
<td>Inpatients with diagnosis of schizophrenia, mania, manic depression, substance</td>
<td>Schizophrenic patients hospitalised subsequent to A&amp;E visit</td>
</tr>
</tbody>
</table>

Thus, one (Hyde et al, 1998) of the two reviewed studies is a cost minimisation study of zuclopenthixol acetate and haloperidol; i.e. the effectiveness of the two drugs are assumed to be the same, and the study compares the costs of these two interventions. The second study (Lauriet et al, 1997) is a cost consequence study of the same two drugs; i.e. both the outcomes and the costs of the two drugs are compared, where the various outcome indicators are not collapsed into, or represented by, a single variable. Both studies employ the health system’s perspective, and only consider direct medical costs. Neither study look at longer-term effects. The two studies are compared to each other in the following section.

9.6.2. The two economic evaluation studies on rapid tranquillisation

The table below presents a head to head comparison of the two economic evaluations on rapid tranquillisation

<table>
<thead>
<tr>
<th>Type of Study</th>
<th>Cost minimisation; prospective, sequential</th>
<th>Cost consequence analysis; based on modelling.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country / Setting</td>
<td>UK; PICU</td>
<td>Canada; 1 psychiatric 1 general hospital; and literature</td>
</tr>
<tr>
<td>Year of Study</td>
<td>Dec 94 - Jan 96 from single PICU</td>
<td>1992 - 94 for costs from 2 hospitals</td>
</tr>
<tr>
<td>Patients</td>
<td>Inpatients with diagnosis of schizophrenia, mania, manic depression, substance</td>
<td>Schizophrenic patients hospitalised subsequent to A&amp;E visit</td>
</tr>
</tbody>
</table>
misuse or other acute psychosis

<table>
<thead>
<tr>
<th>interventions</th>
<th>IM zuclopenthixol acetate (Z) vs. IM haloperidol (H) for rapid tranquillisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>dosage per injection</td>
<td>Z 25-150 mg; H 5-30 mg (dosage per incident not reported)</td>
</tr>
<tr>
<td></td>
<td>Z 50-200 mg; H 7-12 mg (dosage per incident not reported)</td>
</tr>
<tr>
<td>sample size</td>
<td>Z 26; H 16</td>
</tr>
<tr>
<td></td>
<td>N/A for outcomes; 44 for costs</td>
</tr>
<tr>
<td>outcome measures</td>
<td>Effectiveness implicitly assumed same;</td>
</tr>
<tr>
<td></td>
<td>side effects (drowsiness, tremor, rigor, dystonia, akathisia, visual disturbances</td>
</tr>
<tr>
<td></td>
<td>and oro-facial movements) recorded</td>
</tr>
<tr>
<td></td>
<td>Control of psychotic symptoms; degree of sediment; frequency of extrapyramidal</td>
</tr>
<tr>
<td></td>
<td>symptoms</td>
</tr>
<tr>
<td>source of outcome data</td>
<td>Primary data collection in 1 hospital</td>
</tr>
<tr>
<td></td>
<td>Review of trial literature</td>
</tr>
<tr>
<td>cost measures</td>
<td>Direct costs: nursing staff costs, medical staff costs, damage to property,</td>
</tr>
<tr>
<td></td>
<td>injury to people, drug prices</td>
</tr>
<tr>
<td></td>
<td>Direct costs: basic hospital stay, drugs, physician visits, diagnostic tests,</td>
</tr>
<tr>
<td></td>
<td>nursing care</td>
</tr>
<tr>
<td>source of cost data</td>
<td>Primary data collection in 1 hospital</td>
</tr>
<tr>
<td></td>
<td>Z: review of trial literature;</td>
</tr>
<tr>
<td></td>
<td>H: primary data collection from 2 hospitals</td>
</tr>
<tr>
<td>duration of study</td>
<td>Entire episodes</td>
</tr>
<tr>
<td></td>
<td>9 days from A&amp;E admission</td>
</tr>
<tr>
<td>other considerations</td>
<td>Collected data on staff attitude towards the two drugs.</td>
</tr>
<tr>
<td></td>
<td>Model built around the number of injections required. Source of this info is</td>
</tr>
<tr>
<td></td>
<td>the literature for Z and primary data for H.</td>
</tr>
<tr>
<td>main results</td>
<td>- Side effects comparable</td>
</tr>
<tr>
<td></td>
<td>- Drug cost per patient 8 times higher for Z (GBP23 vs. GBP3)</td>
</tr>
<tr>
<td></td>
<td>- Special nursing cost per patient 2 times lower for Z (386:794)</td>
</tr>
<tr>
<td></td>
<td>- Total cost per patient 2 times lower for Z (469:863)</td>
</tr>
<tr>
<td></td>
<td>- 20/21 staff preferred Z over H</td>
</tr>
<tr>
<td></td>
<td>- Similar control of symptoms</td>
</tr>
<tr>
<td></td>
<td>- Similar side effects</td>
</tr>
<tr>
<td></td>
<td>- More frequent injections with H</td>
</tr>
<tr>
<td></td>
<td>- Incremental cost of 50mg Z against 50mg H is CAD21-25.</td>
</tr>
<tr>
<td></td>
<td>- Largest cost component basic hospital stay; similar for both drugs.</td>
</tr>
<tr>
<td></td>
<td>- Next cost component is nursing.</td>
</tr>
<tr>
<td>sensitivity analysis</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>- Incremental cost of 100mg Z against 50mg H is CAD44-48.</td>
</tr>
<tr>
<td></td>
<td>- Z at either dosage may have cost savings depending on distribution of number</td>
</tr>
<tr>
<td></td>
<td>of injections required.</td>
</tr>
<tr>
<td>comments</td>
<td>- Results reported per patient during study period as opposed to per incidence</td>
</tr>
<tr>
<td></td>
<td>(which may not be same).</td>
</tr>
<tr>
<td></td>
<td>- Distribution of no. of injections seems counterintuitive.</td>
</tr>
<tr>
<td></td>
<td>- Not clear why baseline case compares equal dosage of two drugs.</td>
</tr>
</tbody>
</table>

The conclusion to be drawn from the Hyde study is relatively straightforward; zuclopenthixol acetate IM was found to be more cost effective than haloperidol IM. The interpretation of the Laurier study is less so. There are some points that need clarification:

(1) The distribution of the number of injections required implies that the expected number of injections per incident is 1.93 for zuclopenthixol acetate IM and 1.97-2.05 for haloperidol IM; ie. they are about the same. Given that the frequency of injections is much higher for haloperidol IM, this implies that patients given haloperidol IM reach the point at which they need no further injections much earlier on than those given zuclopenthixol acetate IM. TheAbstract and Introduction of the paper mentions that zuclopenthixol acetate IM can be administrated “once every 2 to 3 days” as opposed to “more than once daily” for haloperidol IM. This suggests that an average course of treatment (consisting of 2 dosages of either drug) would take 4-6
days with zuclopenthixol acetate IM while it will be over within a day with haloperidol IM.

(2) However, this is in stark contrast to what is reported in the paper as the results of the review of the trial literature, where effectiveness of the two drugs are concluded to be comparable. None of this is discussed in the paper.

(3) It may be possible that the patient population and/or the practice pattern of the two sources (trial literature for zuclopenthixol acetate IM and primary data for haloperidol IM) were entirely different.

(4) Given that the average dosage per injection for zuclopenthixol acetate IM is much larger (5 times in the Hyde study, possibly 10 times or more in the Laurier study), it is highly misleading that the incremental cost of zuclopenthixol acetate IM against haloperidol IM is reported for the same 50mg dosage for both (and then for 100mg of zuclopenthixol acetate IM against 50mg of haloperidol IM). Combined with the expected number of injections per incidence of 2 derived above, the implied dosage per incidence is 100-400mg for zuclopenthixol acetate IM and 14-24mg for haloperidol IM. A more appropriate comparison may well leave no scope for cost savings by zuclopenthixol acetate IM.

Assuming the number of injections are correct, the conclusion to draw from the Laurier study is that zuclopenthixol acetate IM is less cost effective than haloperidol IM; it takes 4 to 6 times longer to work, and rarely leads to cost savings. On the other hand, taking the effectiveness reviews to be correct, the conclusion to draw still remains that zuclopenthixol acetate IM is less cost effective than haloperidol IM; the two drugs are comparable in terms of effectiveness, but costs are (likely to be) higher for zuclopenthixol acetate IM under more realistic dosages. Both contradict the conclusions of the Hyde study. Since the Laurier study does not report the break down of the costs, the source of this contradiction is not clear.

9.6.3. The relevance of the evidence to the present guideline

Firstly, the conclusion of this review for the GDG is that the two economic evaluation studies report contradicting results regarding the cost effectiveness of zuclopenthixol acetate IM relative to haloperidol IM. Therefore, the GDG must decide how much relative weight to give to these two studies. For considerations are the following points. Neither is based on randomised control trials, and both have small sample size (where relevant). The advantages of the Hyde study are: it is UK based, all the data are collected in one institution and therefore more consistent, and the patient population and the circumstance of the study intervention is probably more closely related to that of the Guideline. The disadvantages of this study are that there is no explicit discussion of the equivalence of the two drugs in terms of effectiveness, and it is based in a PICU environment so the results may not be generalisable to other environments. The advantage of the Laurier study is the sensitivity analysis, whilst its major disadvantages are the inconsistency between points (1) and (2) above, and that the population and circumstance of the intervention may be relatively less relevant to our context.
Secondly, the review on clinical effectiveness has concluded that zuclopenthixol acetate IM cannot be recommended for use in rapid tranquillisation under normal circumstances.

Thirdly, zuclopenthixol acetate versus haloperidol is not the only pair for which there is effectiveness evidence. Thus, the contribution of the above evidence to the drafting of recommendations is not very straightforward. The relative cost effectiveness of various drugs (and dosages) used for rapid tranquillisation will depend on the following items:

(a) cost of drug acquisition (and dosage and frequency)
(b) time cost of administering the drug (and frequency)
(c) time cost of nursing the patient
(d) cost of controlling for short term side effects
(e) cost of treating longer term side effects
(f) effectiveness of the rapid tranquillisation
(g) short term side effects
(h) long term side effects

Hyde and Harrower-Wilson (1996) reports a break down of costs associated with violence and aggression in a PICU environment in the UK. The results indicate that, regarding rapid tranquillisation, (a) is much smaller compared to (b) and (c), which jointly make up a large proportion of the cost. This is supported by both of the economic evaluation studies reviewed above*, and Ricard et al (1999) is also in agreement with this. (e) and (h) are important and should not be ignored; if there are no studies addressing these, they should still be taken into account for drafting the GDG recommendation.

(*) The Laurier study reports that cost of basic hospital stay account for 86-87% of total costs for both zuclopenthixol acetate IM and haloperidol IM, followed by nursing costs. In our current context, basic hospital stay can be ignored, since this is not affected by the incidence of violence or the management intervention of choice.

9.7 Training

The health economics literature search has identified 4 papers on staff training, summarised below. Two were irrelevant, and none were economic evaluations.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>category</td>
<td>Environment / staff training</td>
</tr>
<tr>
<td>population/country</td>
<td>Violent patients in general hospital / Australia</td>
</tr>
<tr>
<td>intervention</td>
<td>Violence Management Team: 6 staff on call (1 doctor, 1 nurse, 4 orderlies); special training; verbal placation, physical restraint, sedative medication</td>
</tr>
<tr>
<td>outcome measure</td>
<td>282 calls in 44 months.</td>
</tr>
<tr>
<td>cost measure/year</td>
<td>None.</td>
</tr>
</tbody>
</table>

| Corrigan et al, The effects of interactive staff training on staff programing and patient aggression in a psychiatric inpatient ward. Behavioral Interventions, 1995 |
|---|---|
| category | Staff training |
population/country | Mental Health Centre line level staff \((n = 22)\) / US  
(“extended care ward”, severe mental illness, not developmental disability, post 60-day acute phase)  

intervention | Interactive Staff Training; “to build cohesion among line-level staff members by having them work together to make active decisions about the social learning program [for patients: eg. incentive programs and social skills training programs]”  

outcome measure | Staff and patient participation in social learning programs (both increased).  
Number of physical restraints and aggression related incidents (decreased).  

cost measure/year | None.  
comments | No evaluation.


<table>
<thead>
<tr>
<th>category</th>
<th>Staff training</th>
</tr>
</thead>
</table>
| population/country | Forum piece on psychological interventions, in particular competency-based treatment  

intervention | Competency-based treatment. “Psychologists design behavioural protocols and can train technical, nursing and other staff in observing behaviour, recording precise data, and responding appropriately to maladaptive behavior.”  

outcome measure | “Psychological interventions reduce dangers from aggressive patients and reduce both staff and patient injuries. […] Active programming reduces the need for restrictive procedures and overall patient resistance by utilizing behaviorally sound principles involving patient participation.” No reference given.  

cost measure/year | None.  
comments | No evaluation.

McKeegan et al. Applying behavioural methods in the inpatient setting: Patients with mixed borderline and dependent traits. *Psychosocial Rehabilitation Journal*. 1993

<table>
<thead>
<tr>
<th>category</th>
<th>Staff training</th>
</tr>
</thead>
</table>
| population/country | Two patients with concurrent borderline and dependent personality features / psychiatric hospital / US  

intervention | Behavioral interventions  

outcome measure | Description of case history.  

cost measure/year | None.  
comments | Not relevant. No evaluation.

9.8 Ethnicity, Gender and Other Special Concerns

The following four papers mention race and/or sex as a background characteristic, while none were economic evaluations. These are already summarised elsewhere in this appendix. There were no papers looking at disabilities.


9.9 Staff and Service User Perspectives

The following six papers mention service user or staff attitudes and views, but none are economic evaluations with these as the outcome.

Bjørkly, . Open-area seclusion in the long-term treatment of aggressive and disruptive psychotic patients, an introduction to a ward procedure, *Psychological Reports*, 1995
Hodgkinson. The use of seclusion. *Medicine, Science, and the Law*
Sheridan et al, Precipitants of violence in a psychiatric inpatient setting. *Hospital & Community Psychiatry*, 1990

9.10 Accident and Emergency Settings

There were two papers that refer to A&E, both of which address rapid tranquillisation. The reference to A&E is because that was where the patients were recruited, and not because the papers address the issues of management of violence in the A&E environment in particular. Thus, neither paper is reviewed for this topic. The two papers are:

Laurier et al. Economic evaluation of zuclopenthixol acetate compared with injectable Haloperidol in schizophrenic patients with acute psychosis. *Clinical Therapeutics*. 1997

9.11 Conclusion

To conclude, very few economic studies relevant to this Guideline were identified, and the only two that were found on rapid tranquillisation were on a drug that would not be recommended for routine use based on clinical reasons (zuclopenthixol acetate). Furthermore, since many of the recommendations in this Guideline are related to issues of human rights and/or less tangible non-health benefits, which are very difficult to model, no economic modelling was employed.

9.12 Ordered papers

Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings Guideline


Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings Guideline


9.13 Cost effectiveness of life support training

Q1. Cost benefit analysis for introducing automatic external defibrillators into all wards/environments in which rapid tranquillisation, restraint and or seclusion is used.

Q2. Cost benefit analysis of insisting that all those involved in rapid tranquillisation are qualified at ALS entry level and that, at all times, someone on the ward has full ALS training.

Background

There is evidence indicating that AED in larger commercial airplanes can be cost-effective. The baseline scenario in this context is no medical intervention for at least a couple of hours between onset of cardiac arrest and hand over to paramedics (after landing). Thus a large proportion of survival is attributable to AED.

There is evidence indicating that AED in large stations etc is not necessarily cost-effective (Walker et al, BMJ, 327, 2003). The baseline scenario here is the absence of medical intervention for several minutes (as opposed to hours) between identification of patient and the arrival of paramedics. Thus a much smaller proportion of overall survival is attributable to AED (increased survival at discharge: 2%).

There is no evidence regarding the cost-effectiveness of AED or ALS in psychiatric wards. There are two things to note. First, AED is not appropriate in the context of secondary cardiac arrest under physical restraints, since this is caused by respiratory arrest, does not involve ventricular fibrillation, and therefore defibrillation is not relevant. AED may be relevant in the context of cardiac arrest under rapid tranquillisation, depending on the drug used. (However, this distinction is not reflected in the analysis below.) Second to note is that the baseline scenario in the inpatient context takes place in the presence of nurses (who are BLS qualified), implying that time between onset of cardiac arrest and hand over to cardiac specialists is not wasted in a medical vacuum. This means that, whilst survival rate itself may be higher than in the station context, the marginal benefit attributable to additional training over baseline (BLS) is likely to be smaller. The below analysis assumes a 5% increased rate of survival.

Resuscitation Council (UK) acknowledges that ALS “is intended primarily for those health care professionals who attend cardiac arrests frequently […]. The comprehensive curriculum of the ALS course makes it inappropriate for the majority of health care professionals who attend cardiac arrests rarely but have the potential to be called up on as a first responder. It is difficult to justify the provision of a 2-3 day ALS course for health care professionals who would not expect to put these skills and comprehensive knowledge to use” and instead promotes “Immediate Life Support” training (Soar et al, Resuscitation, 57, 21-6, 2003). This takes a 1-day course at the initial instance, and then half-day revalidation courses every 12 months. The below analysis assumes the ILS revalidation course at a charge of £100.

Assumptions

- Time horizon: life expectancy of AED [7 years]
- Baseline: all nursing staff has BLS training, but no ILS/AED training.
- A ward with 20 beds.
- A ward with 30 staff on the rota [@£20K pa]
- Increased survival rate with AED and/or ILS above BLS [5%]
- Survival [30 years in full health for 99%; 10 years with brain damage for 1%]
- Incidence per ward over 7 years [0.7; at year 4]
- Discount rate for health benefits [3%]

- Purchase price of AED [£3,000]
- Cost of ILS/AED revalidation training [@£100; once 12 months; half-day sessions]
- Medical costs post resuscitation per year based on Walker et al. A&E attendance [@£46], coronary care [1.4 days @£612], general ward [4.2 days @£234].
- Cost of nursing home care for those with brain damage
  
  nursing home bed [@£300 a day]; QOL = 0; LE(a) = 10 years
  
- Discount rate for costs [3%]

### Results under alternative scenarios (present value)

<table>
<thead>
<tr>
<th></th>
<th>Benefits (QALYs)</th>
<th>Costs (£)</th>
<th>Cost (£) / QALY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All the assumptions above</td>
<td>0.62</td>
<td>29,218</td>
</tr>
<tr>
<td>2</td>
<td>increased survival x1.5 OR incidence x1.5</td>
<td>0.93</td>
<td>29,397</td>
</tr>
<tr>
<td>3</td>
<td>increased survival x2 OR incidence x2</td>
<td>1.24</td>
<td>29,426</td>
</tr>
<tr>
<td>4</td>
<td>training charge x0.5</td>
<td>0.62</td>
<td>19,872</td>
</tr>
<tr>
<td>5</td>
<td>training charge x2</td>
<td>0.62</td>
<td>47,909</td>
</tr>
<tr>
<td>6</td>
<td>staff per ward x1.2</td>
<td>0.62</td>
<td>34,540</td>
</tr>
<tr>
<td>7</td>
<td>AED purchase price x0.5</td>
<td>0.62</td>
<td>27,718</td>
</tr>
</tbody>
</table>

### Conclusions

Cost per QALY of ILS training with AED under scenario 1 is around £47,000. For this to be cost effective (i.e. cost per QALY of around £20K or less), multiple factors will have to be significantly, and favourably, different from scenario 1. Scenario 5 suggests that ALS training (where cost of training will be more than twice ILS) is highly unlikely to be cost effective. One problematic (or rather, unrealistic) assumption of the baseline may be that all nursing staff is BLS qualified. However, justification of BLS for all nursing staff can (and probably should) come from elsewhere. If BLS for all nursing staff cannot be justified in a more general context, then ILS for all nursing staff is even less likely to be justified in this context. (An active spread sheet is available from the NCC-NSC on request).

### References

Coady EM (1999), A strategy for nurse defibrillation in general wards, Resuscitation, 42, 183-186


Walker A, Sirel JM, Marsden AK, Cobbe SM, Pell JP (2003), Cost effectiveness and cost utility model of public place defibrillators in improving survival after prehospital cardiopulmonary arrest, *BMJ*, 327:

## Appendix 10 QUALITY CRITERIA FOR MAIN STUDY DESIGNS

<table>
<thead>
<tr>
<th>Study Design</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Systematic reviews</strong></td>
<td>Adequate search strategy</td>
</tr>
<tr>
<td></td>
<td>Inclusion criteria appropriate</td>
</tr>
<tr>
<td></td>
<td>Quality assessment of included studies undertaken</td>
</tr>
<tr>
<td></td>
<td>Characteristics and results of included studies appropriately summarized</td>
</tr>
<tr>
<td></td>
<td>Methods for pooling data</td>
</tr>
<tr>
<td></td>
<td>Sources of heterogeneity explored</td>
</tr>
<tr>
<td><strong>Randomized controlled trials</strong></td>
<td>Study blinded, if possible</td>
</tr>
<tr>
<td></td>
<td>Method used to generate randomization schedule adequate</td>
</tr>
<tr>
<td></td>
<td>Allocation to treatment groups concealed</td>
</tr>
<tr>
<td></td>
<td>All randomized participants included in the analysis (intention to treat)</td>
</tr>
<tr>
<td></td>
<td>Withdrawals/dropouts reasons given for each group</td>
</tr>
<tr>
<td><strong>Cohort studies</strong></td>
<td>All eligible subjects (free of disease/outcome of interest) selected or random sample</td>
</tr>
<tr>
<td></td>
<td>&gt; 80% agreed to participate</td>
</tr>
<tr>
<td></td>
<td>Subjects free of outcomes on interest at study inception</td>
</tr>
<tr>
<td></td>
<td>If groups used: comparable at baseline</td>
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<tr>
<td></td>
<td>Potential confounders controlled for</td>
</tr>
<tr>
<td></td>
<td>Measurement of outcomes unbiased (blinded to group)</td>
</tr>
<tr>
<td></td>
<td>Follow-up sufficient duration</td>
</tr>
<tr>
<td></td>
<td>Follow-up complete and exclusions accounted for (&gt;80% included in final analysis)</td>
</tr>
<tr>
<td><strong>Case control studies</strong></td>
<td>Eligible subjects diagnosed as cases over a defined period of time or defined catchment area or a random sample of such cases</td>
</tr>
<tr>
<td></td>
<td>Case and control definitions adequate and validated</td>
</tr>
<tr>
<td></td>
<td>Controls selected from same population as cases</td>
</tr>
<tr>
<td></td>
<td>Controls representative (individually matched)</td>
</tr>
<tr>
<td></td>
<td>&gt; 80% agreed to participate</td>
</tr>
<tr>
<td></td>
<td>Exposure status ascertained objectively</td>
</tr>
<tr>
<td></td>
<td>Potential confounders controlled for</td>
</tr>
<tr>
<td></td>
<td>Measurement of exposure unbiased (blinded to group)</td>
</tr>
<tr>
<td></td>
<td>Groups comparable with respect to potential confounders?</td>
</tr>
<tr>
<td></td>
<td>Outcome status ascertained objectively</td>
</tr>
<tr>
<td></td>
<td>&gt; 80% selected subjects included in analysis</td>
</tr>
<tr>
<td><strong>Cross-sectional/survey</strong></td>
<td>Selected subjects are representative (all eligible or a random sample)</td>
</tr>
<tr>
<td></td>
<td>&gt; 80% subjects agreed to participate</td>
</tr>
<tr>
<td></td>
<td>Exposure/outcome status ascertained standardized way</td>
</tr>
<tr>
<td><strong>Qualitative</strong></td>
<td>Criteria for selecting sample clearly described</td>
</tr>
<tr>
<td></td>
<td>Methods of data collection adequately described</td>
</tr>
<tr>
<td></td>
<td>Analysis method used rigorous (ie. conceptualised in terms of themes/typologies)</td>
</tr>
</tbody>
</table>
rather than loose collection of descriptive material

evidence of efforts to establish validity (truth value)?

evidence of efforts to establish reliability (consistency)

respondent validation (feedback of data/researcher's interpretation to participants)

interpretations supported by data

<table>
<thead>
<tr>
<th>Studies of diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>independent/blind comparison with a reference ('gold') standard of diagnosis</td>
</tr>
<tr>
<td>diagnostic test evaluated in an appropriate spectrum of patients (those in whom it would be used in practice) selected consecutively</td>
</tr>
<tr>
<td>reference standard applied regardless of the diagnostic test result</td>
</tr>
<tr>
<td>test and reference standards measured independently (blind to each other)</td>
</tr>
<tr>
<td>test validated in a second, independent group of patients</td>
</tr>
<tr>
<td>results of the diagnostic study important</td>
</tr>
<tr>
<td>is the test available, affordable, accurate and precise?</td>
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<table>
<thead>
<tr>
<th>Risk factor studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>eligible cohort of participants</td>
</tr>
<tr>
<td>high participation at baseline and follow up &gt; 70%</td>
</tr>
<tr>
<td>risk factors conceptually relevant</td>
</tr>
<tr>
<td>baseline measurement of risk factors</td>
</tr>
<tr>
<td>reporting of methods, explicit inclusion criteria and demographic information</td>
</tr>
<tr>
<td>adequate length of follow up &gt; 6 months</td>
</tr>
<tr>
<td>measurement of falls as outcome</td>
</tr>
<tr>
<td>statistical methods detailed - adequate reporting for data extraction.</td>
</tr>
<tr>
<td>methods of adjustment for confounding reported</td>
</tr>
</tbody>
</table>
Appendix 11 CRITICAL APPRAISAL OF MANAGEMENT OF IMMINENT VIOLENCE: CLINICAL PRACTICE GUIDELINES TO SUPPORT MENTAL HEALTH SERVICES

AGREE Appraisal Tool (carried out independently by 2 reviewers)

**Title of Document:** Management of imminent violence: clinical practice guidelines to support mental health services (1998).

**Publisher:** Royal College of Psychiatrists, London. **Developed by:** Royal College of Psychiatrists

### Scope and Purpose (Domain 1)

| 1. The overall objective(s) of the guideline is (are) specifically described. | 4 | 0 | 0 | 0 |
| Comments: The aims of the project are clearly presented (p7). Further information relating to the methodology and scope of the guidelines are also reported in detail. | 4 | 0 | 0 | 0 |

| 2. The clinical question(s) covered by the guideline is (are) specifically described. | 4 | 0 | 0 | 0 |
| Comments: The clinical questions were formulated as “…a set of general hypotheses for each topic” (p22). These hypotheses were based on a series of systematic reviews undertaken for the project. | 4 | 0 | 0 | 0 |

| 3. The patients to whom the guideline is meant to apply are specifically described. | 4 | 0 | 0 | 0 |
| Comments: The target populations and the populations which are excluded from the guideline are specifically described (p18). | 4 | 0 | 0 | 0 |

### Stakeholder Involvement (Domain 2)

| 4. The guideline development group includes individuals from all the relevant professional groups. | 4 | 0 | 0 | 0 |
| Comments: All relevant professional groups were included in formulating the guideline recommendations. | 4 | 0 | 0 | 0 |

| 5. The patients’ views and preferences have been sought. | 4 | 0 | 0 | 0 |
| Comments: Patients’ views were sought through primary research (e.g. focus groups) and as members of both the Work Group and the External Review panel. | 4 | 0 | 0 | 0 |

| 6. The target users of the guideline are clearly defined. | 4 | 0 | 0 | 0 |
| Comments: The target users of the recommendations are reported. These include users, purchasers, managers and clinicians in the mental health services (p18). | 4 | 0 | 0 | 0 |

| 7. The guideline has been piloted among target users. | 4 | 0 | 0 | 0 |
| Comments: The External Review panel (see Appendix 5; p107-8) provided comments and input in relation to the development of the guideline recommendations. There is no reference to a formal piloting of the document. | 4 | 0 | 0 | 0 |

The document was piloted | 4 | 0 | 0 | 0 |
## Rigour of Development (Domain 3)

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<tr>
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<tbody>
<tr>
<td>8. Systematic methods were used to search for the evidence.</td>
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</tr>
<tr>
<td><strong>Comments:</strong> The guideline reports that systematic reviews were completed for each of the topics, an overview of the search strategies is provided and a flow diagram is provided indicating the number of articles retrieved in the search for research evidence. However, the search terms used are not provided and the number of databases searched is inadequate. Searching archives indicates that many areas were thoroughly searched - others less so - weaknesses are acknowledged. Search terms have been located and searches kept.</td>
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<tr>
<td>9. The criteria for selecting the evidence are clearly described.</td>
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</tr>
<tr>
<td><strong>Comments:</strong> The inclusion and rating of evidence is reported. The authors report that they were over-inclusive in the evidence sift, that consideration was given to methodological characteristics and have also provided a table of research study designs that were included. A critical appraisal tool was used to evaluate all articles - copies of these have been kept. Notes on all excluded studies are available.</td>
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<tbody>
<tr>
<td>10. The methods used for formulating the recommendations are clearly described.</td>
<td></td>
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<td>4</td>
</tr>
<tr>
<td><strong>Comments:</strong> There is no description of how the recommendations were generated by the Work Group or how areas of disagreement were resolved. This information can be found in the minutes of the Work Group and in the methods report.</td>
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<tbody>
<tr>
<td>11. The health benefits, side effects and risks have been considered in the formulating the recommendations.</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Comments:</strong> An overriding consideration of the guideline developers for this guideline is the focus on considering the benefits and risks of the recommendations for this topic.</td>
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<tbody>
<tr>
<td>12. There is an explicit link between the recommendations and the supporting evidence.</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Comments:</strong> The authors state that the “…research evidence was insufficient to allow for the generation of evidence-based guideline statements” (p25). The authors further state that the recommendations are based on national guidance documents and the views of patients/carers and health professionals, not specifically on evidence.</td>
<td></td>
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<tbody>
<tr>
<td>13. The guideline has been externally reviewed by experts prior to its publication.</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Comments:</strong> The guideline was reviewed by a large and wide-ranging number of organisations with a vested interest in the content of the guideline recommendations.</td>
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<tbody>
<tr>
<td>14. A procedure for updating the guideline is provided.</td>
<td></td>
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<td>4</td>
</tr>
<tr>
<td><strong>Comments:</strong> It is reported that the recommendations of the guideline should be updated within 5 years (p6). The authors have included a ‘research and lessons learned’ section (pp83-85) which suggests the problems and limitations of updating the guideline. There is no indication that the guideline would not have been updated but NICE are doing it.</td>
<td></td>
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<td>3</td>
</tr>
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</table>

## Clarity and Presentation (Domain 4)

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<tbody>
<tr>
<td>15. The recommendations are specific and unambiguous.</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Comments:</strong> Due to the area of investigation for these guidelines, it is not possible to provide a concrete and precise description of management for all situations and population groups. However, the authors have endeavoured to stipulate, through</td>
<td></td>
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</tbody>
</table>

DRAFT FOR SECOND CONSULTATION JULY 2004  Page 362 of 475
16. The different options for management of the condition are clearly presented.

Comments: The guideline has covered the most pressing issues related to the immediate management of violent behaviour.

17. Key recommendations are easily identifiable.

Comments: The key recommendations in the guideline are easily identifiable and include implementation points for clarification.

18. The guideline is supported with tools for application.

Comments: The guideline is available in a short-form (‘quick reference guide’) for healthcare professionals and the public. Summary documentation is available through the RCPsych website.

### Applicability (Domain 5)

19. The potential organisational barriers in applying the recommendations have been discussed.

Comments: Organisational changes that are required to implement the guideline recommendations are discussed (p71).

20. The potential cost implications of applying the recommendations have been considered.

Comments: There is no discussion or evidence review for the cost implications of the guideline recommendations.

21. The guidelines presents key review criteria for monitoring and/or audit purposes.

Comments: The guideline includes a detailed dissemination and implementation check-lists designed to assist in the uptake of the recommendations.

### Editorial Independence (Domain 6)

22. The guideline is editorially independent from the funding body.

Comments: The document does not include information regarding the funding of the project. However, the document does include information concerning the College Research Units’ ‘Clinical Practice Guidelines Programme’. This information is held in the minutes.

23. Conflicts of interest of guideline development members have been recorded.

Comments: There is no information concerning how conflicts of interest were either resolved or recorded. All interests were declared - this information is held in the minutes and archives.
Overall Assessment

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly recommend</td>
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</tbody>
</table>

**Comments:** Although there are several areas which could have improved the quality of document (e.g. reporting the systematic reviews, reporting of the consensus development processes and inclusion of cost-effectiveness/cost-impact information), the document represents the most comprehensive form of recommendations for the short-term management of violent behaviour in UK inpatient psychiatric settings.

Note: 4 = strongly agree, 1 = strongly disagree.

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Domain 2</th>
<th>Domain 3</th>
<th>Domain 4</th>
<th>Domain 5</th>
<th>Domain 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewer 1</td>
<td>12/12</td>
<td>15/16</td>
<td>19/28</td>
<td>15/16</td>
<td>9/12</td>
</tr>
<tr>
<td>Reviewer 2</td>
<td>12/12</td>
<td>15/16</td>
<td>24/28</td>
<td>15/16</td>
<td>9/12</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>93.75%</td>
<td>76.75%</td>
<td>93.75%</td>
<td>75%</td>
</tr>
</tbody>
</table>
Appendix 12 SUMMARY OF ST GEORGE'S REPORT ON RCPSYCH GUIDELINE

Executive Summary
A set of national clinical guidelines on the management of imminent violence to support mental health services were assessed, using a questionnaire, by six independent appraisers. The assessment was divided between the rigour of the guideline development process, the content and context of the guidelines and their application.

The guidelines scored highly on several aspects of the development process; the search strategy and interpretation of evidence were thorough and comprehensive. However there was disagreement about the adequacy of the methods used for constructing the recommendations. There was also disagreement about the linkage between the recommendations and evidence. Some appraisers commented that the grading of recommendations was not possible because scientific evidence was not available or too weak. Others noted that the guideline group had acknowledged the limitations of validity for some recommendations due to missing evidence. Nevertheless, the majority thought that, on balance the potential biases had been adequately dealt with. A date for the review of the guidelines had been provided (e.g. in five years).

The objectives of the guidelines and the target population had been clearly defined. There was disagreement about the circumstance where exceptions might be made when applying the guidelines and on patient's choice. The recommendations were clearly presented and different options for management were explicit. The health benefits and potential risks had been described, but the agreement between appraisers was weak. There was no estimate of the likely cost or expenditure.

The guideline document had suggested methods for the dissemination and implementation of the guideline and had proposed criteria for monitoring compliance. There was uncertainty that standards and measures of outcome had been defined. The document had identified key elements to be considered by local groups.

Taken from The management of imminent violence: A clinical practice health guideline to support mental health services (RCP): Appraisal report, Health Care Evaluation Unit, St George's Hospital Medical School (1998), 1. **Full appraisal document available on request**
Appendix 13 CRITICAL APPRAISAL OF BREAKING THE CIRCLES OF FEAR: A REVIEW OF THE RELATIONSHIP BETWEEN MENTAL HEALTH SERVICES AND AFRICAN AND CARIBBEAN COMMUNITIES

AGREE Appraisal Tool (carried out independently by 2 reviewers).


Publisher: Sainsbury Mental Health Centre London. Developed by: Sainsbury Mental Health Centre

<table>
<thead>
<tr>
<th>Scope and Purpose (Domain 1)</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The overall objective(s) of the guideline is (are) specifically described.</td>
<td>4</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><em>Comments:</em> The aims of the project are clearly presented (p8/14).</td>
<td>4</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. The clinical question(s) covered by the guideline is (are) specifically described.</td>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Comments:</em> The aims appear to be the clinical questions being addressed and are given at the beginning of every chapter. These aims have also been determined by the methodological approach of the co-operative enquiry. (P84) This is more of a report than a guideline so this question is not entirely relevant.</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The patients to whom the guideline is meant to apply are specifically described.</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><em>Comments:</em> The target population is specifically described throughout.</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
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<th>Stakeholder Involvement (Domain 2)</th>
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<tr>
<td>4. The guideline development group includes individuals from all the relevant professional groups.</td>
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<tr>
<td><em>Comments:</em> There is steering group that manages the project and an advisory group of relevant professionals. Service user participation seems absent from the groups. There seems to have been a great deal of input from service user organisations, but no input from nursing organisations.</td>
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<td>5. The patients’ views and preferences have been sought.</td>
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<td><em>Comments:</em> This is the whole purpose and thrust of the report. (p84)</td>
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<td><em>This has been achieved through a variety of means including focus groups and interviews.</em></td>
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<td>6. The target users of the guideline are clearly defined.</td>
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<td><em>Comments:</em> The target users of the recommendations are reported. (p8)</td>
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7. The guideline has been piloted among target users.

*Comments:* There is no evidence for this.
This is more of a report than a guideline, so this question is not entirely relevant

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<th>Rigour of Development (Domain 3)</th>
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<td>8. Systematic methods were used to search for the evidence.</td>
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<tr>
<td><em>Comments:</em> This report does not follow a traditional systematic approach, which has probably been deliberate. The overall approach appears to be systematic and thorough. (p8/84) This is not a guideline and so it does not search for evidence - it is more of a research centred report.</td>
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<td>9. The criteria for selecting the evidence are clearly described.</td>
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<td><em>Comments:</em> The inclusion of evidence and its collection is reported. (p84) Quality of evidence and gradings have not been reported This question is not relevant</td>
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<td>10. The methods used for formulating the recommendations are clearly described.</td>
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<td><em>Comments:</em> They appear to be generated from the key findings, There is no description of how the recommendations were generated by the advisory group but are described as a process of argument based on findings. (p74-82) The recommendations are based on the findings of the research. This is apparent.</td>
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<td>11. The health benefits, side effects and risks have been considered in the formulating the recommendations.</td>
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<td><em>Comments:</em> This is not directly relevant. The implications are at the policy level with an implementation strategy. (p74-82) This question is not relevant to this topic</td>
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<td>12. There is an explicit link between the recommendations and the supporting evidence.</td>
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<td><em>Comments:</em> It is clear in reading the report but is not conducted in the direct and rigorous methods expected in a NICE guideline</td>
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<td>13. The guideline has been externally reviewed by experts prior to its publication.</td>
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<td><em>Comments:</em> This report does not mention being reviewed by others external to the process. The steering group may have acted as such to the advisory group but membership overlapped. An advisory group was convened, but it contained members of the steering committee.</td>
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<td>14. A procedure for updating the guideline is provided.</td>
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<tr>
<td><em>Comments:</em> No procedure to update is mentioned, however this may not be appropriate. There is an implementation project. This question is not appropriate to the report, which stresses the need for more awareness and research in this area.</td>
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<td>15. The recommendations are specific and unambiguous.</td>
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<td><em>Comments:</em> They are clear but general</td>
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<td>16. The different options for management of the condition are clearly presented.</td>
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### Comments

1. I am unsure about the relevance of this question to this report. This is not relevant to the topic being considered.

2. Key recommendations are easily identifiable.

3. The key recommendations in the guideline are easily identifiable and include implementation. They are clearly laid out at the beginning of the report.

4. The guideline is supported with tools for application.

5. Implementation of recommendations given 9p10-11, 77-82.

### Applicability (Domain 5)

| 19. The potential organisational barriers in applying the recommendations have been discussed. | 4 |
| Comments: Organisational changes that are required to implement the guideline recommendations are discussed (p68-72). | 4 |

| 20. The potential cost implications of applying the recommendations have been considered. | 1 |
| Comments: There is no discussion or evidence review for the cost implications of the recommendations. | 1 |

| 21. The guidelines presents key review criteria for monitoring and/or audit purposes. | 1 |
| Comments: Not given in report. Additional information suggests the subsequent implementation project will monitor. This is not done, but would have been useful. | 1 |

### Editorial Independence (Domain 6)

| 22. The guideline is editorially independent from the funding body. | 2 |
| Comments: The authors and editor are stated on p. 7 however not where they are from, funder is understood to be the Sainsbury Centre and they are represented on the Steering group and advisory group. | 1 |

| 23. Conflicts of interest of guideline development members have been recorded. | 1 |
| Comments: There is no information concerning how conflicts of interest were either resolved or recorded. | 1 |

### Overall Assessment

<table>
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<th>Recommendation</th>
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<tr>
<td>Would you recommend these guidelines for use in practice?</td>
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<tr>
<td>Comments: This report did not set out to be a guideline and therefore does not adopt the rigorous approach expected. However it is providing guidance targeted at a strategic and national level and intends to implement the strategy via the recommendations proposed. It is highly relevant to the current guideline and therefore the needs to be noted.</td>
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Note: 4 = strongly agree, 1 = strongly disagree.
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<th>Domain 1</th>
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Appendix 14

THE EXPERIENCES OF BLACK SERVICE USERS IN THE UK IN-PATIENT SETTINGS IN RELATION TO THE SHORT-TERM MANAGEMENT OF DISTURBED (VIOLENT) BEHAVIOUR

(DRAFT NOT FOR QUOTATION OR CIRCULATION)

MAY 2004
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² Patient Involvement Unit (of the National Institute for Clinical Excellence), 74? High Holborn, London, WC.?
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CONTENTS

Acknowledgements ........................................................................................................... 373
SUMMARY .......................................................................................................................... 374

CHAPTER ONE: EVIDENCE REVIEW
1.1. Background .................................................................................................................. 376
1.2. Methods ....................................................................................................................... 377
1.3 Objectives....................................................................................................................... 380
1.3. Clinical Evidence ......................................................................................................... 381

CHAPTER TWO: FOCUS GROUP METHODS
2.1.Aim................................................................................................................................. 385
2.2.Objectives....................................................................................................................... 385
2.3.Methods........................................................................................................................ 385
2.4. Design .......................................................................................................................... 385
2.5. Ethical Approval ......................................................................................................... 386
2.6. Sampling, Eligibility and Recruitment .................................................................... 387
2.7.Characteristics of Participants .................................................................................... 387
2.8. Role of Facilitator and Researcher .......................................................................... 387
2.9. Focus Groups ............................................................................................................ 388
2.10. Informed Consent ..................................................................................................... 389
2.11. Confidentiality .......................................................................................................... 389
2.12. Data Analysis ........................................................................................................... 389
2.13. Limitations of the study .......................................................................................... 390

CHAPTER THREE: SERVICE USER FOCUS GROUP FINDINGS
3.0. Background.................................................................................................................. 392
3.1.Powerless/Voicelessness ............................................................................................ 392
3.1.1 Fear .......................................................................................................................... 394
3.1.2.Division/Isolation ................................................................................................... 396
3.1.3. System problems ................................................................................................. 398
3.2. Inhumane Treatment/Control ................................................................................. 399
3.2.1. Uncaring ............................................................................................................... 402
3.2.2. Misunderstanding/stereotypes/alienation/Black experience ......................... 403
3.2.3 Anger ..................................................................................................................... 405
3.3.Dual diagnosis/Drug abuse .................................................................................... 405
3.4. Other Issues ............................................................................................................. 406
3.4.1 Training/Staff Support.............................................................................. 406
3.4.2 Police Involvement.................................................................................. 407
3.4.3 The Difference between Prison and Hospital Care.............................. 407
3.4.4 The In-patient Environment................................................................... 407
3.4.5 Issues Surrounding Admission and A&E............................................... 408
Suggestions for Improvements........................................................................ 409

CHAPTER 4: HEALTHCARE PROFESSIONAL FOCUS GROUP FINDINGS

4.0 Background................................................................................................... 410
4.1 Black Experience.......................................................................................... 410
  4.1.1 Stereotyping............................................................................................ 411
  4.1.2 Disrespect/Control.................................................................................. 412
  4.1.3 Choice/Flexibility.................................................................................... 413
  4.1.4 Fear.......................................................................................................... 414
4.2 Frustration..................................................................................................... 416
  4.2.1 System Problems..................................................................................... 416
  4.2.2 Training/Untrained staff......................................................................... 417
  3.2.3 Monitoring.............................................................................................. 418
  4.2.4 In-patient environment.......................................................................... 419
  4.2.5 Concerns outside the scope of this research........................................... 420
Suggestions for Improvements........................................................................ 421

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions................................................................................................... 422
5.2 Consensus Process....................................................................................... 422
5.3 Recommendations and Good Practice Points............................................ 423
5.4 Suggestions for Future Research................................................................. 425

REFERENCES

APPENDICES
- Appendix 1 Ethnicity Review Evidence Tables - Included Studies
- Appendix 2 Ethnicity Review Evidence Tables - Excluded Studies
- Appendix 3 Ethnicity Review Search Strategy and Search Log
- Appendix 4 Critical Appraisal of Breaking the Circles of Fear (Agree Tool)
- Appendix 5 Service User Participant Information Guide
- Appendix 6 Healthcare Professional Participant Information Guide
- Appendix 7 Service User Focus Group discussion guide
- Appendix 8 Healthcare Professional Focus Group discussion guide
- Appendix 9 Written Consent Form
Acknowledgements

We would like to thank Black Orchid in Bristol and Footprints UK in Walthamstow for organising and facilitating the focus groups. We would also like to thank all the service users who gave their time and shared some very difficult experiences with us.

We would also like to extend our thanks to the healthcare professionals who took part in a focus group in London, the content of which is reported in chapter 4.

In addition, we would like to thank the service users who attended the guideline development group as ‘expert patients’ and whose presentations and discussions echoed much of the material generated by the focus groups.

We would also like to thank the healthcare professionals who acted as expert reviewers for the systematic review on ethnicity.

Thanks must also go to Liz McInnes, Senior Research and Development Fellow at the National Collaborating Centre for Nursing and Supportive care for her assistance with drafts of this report. We would also like to thank Dr Suman Fernando, Dr Joanna Bennett, Dr Aggrey Burke and Dr Joseph Cortis who reviewed the systemic review of the literature for this study (chapter 1).

Finally, thanks must go to Yana Richens, whose report Exploring the Experiences of Women of Pakistani Origin of UK Maternity Service is used as a template for this report (www.yanarichens.com) and who commented on drafts of this work.
Summary

This aim of the study was to explore the in-patient experiences of two different groups of Black service users, one in London and one in Bristol, in relation to the short-term management of disturbed (violent) behaviour. Further information on Black service users treatment within psychiatric in-patient settings in relation to the short-term management of violence was sought from a countrywide group of healthcare professionals and experts with a special interest in this area. The objectives of the study were:

1. To describe Black service users’ experiences of the short-term management of disturbed (violent) behaviour in psychiatric in-patient settings.
2. To describe the experiences and views of healthcare professionals with experience of working with Black service users in relation to the short-term management of disturbed (violent) behaviour in psychiatric in-patient settings.
3. To draw up recommendations to improve psychiatric in-patient services.

A systematic review of the literature was undertaken before the study was conducted. Very little evidence emerged on the experiences of Black Service Users in relation to the short-term management of violence in psychiatric in-patient settings. Two focus groups were therefore set up to provide some primary data to feed into the guidance in relation to the needs of service users from ethnic minority groups. Bristol and London were chosen to capture the views of Black service users from different communities. In Bristol, the Black community is diverse and long established, and many Black service users are constantly in and out of hospital. In London, the focus group considered the experiences of African-Caribbean service users, all of whom were ‘survivors’. Black service users, particularly African-Caribbean service users, were specifically targeted since anecdotal evidence has suggested that their experience of in-patient settings is less positive than that of other service users. A further focus group, made of healthcare professionals with experience of working with Black service users, was also set up. Data was analysed using content analysis. The findings suggest that participants have many negative experiences of the interventions used in psychiatric in-patient settings for the short-term management of violence.

A further focus group was run with healthcare professionals from across the UK who have a special interest in Black service users. This group also considered the short-term management of violence in psychiatric in-patient settings. Data was again analysed using content analysis. The findings suggest that participants also held negative views about Black service user experiences of the interventions used in psychiatric in-patient settings for the short-term management of violence.

In addition to running focus groups, Black service users attended meetings, gave ‘expert patient’ presentations to the guideline development group and joined in the discussion of recommendations alongside the service users on the guideline development group.

All this information was also used to help generate recommendations for improving Black service users’ experiences of the short-term interventions used to manage disturbed (violent)

---

5 A number of recent studies have shown that Black service users have very negative experiences of mental health services in the UK: F Keating et al, Breaking the Circles of Fear: A Review of the Relationship between Mental Health Services and African Caribbean People (London: Sainsbury Centre for Mental Health, 2002); Y. Chrissie, Black Spaces Project (London: Mental Health Foundation, 2003); Footprints UK, Tell it like it is: Giving a Voice to African and Caribbean Mental Health Service Users, (London: Footprints UK, 2003).
behaviour in psychiatric in-patient settings. The key issues that emerged from the focus service user groups were: powerlessness and voicelessness and inhuman treatment and control, while the key issues that emerged from the healthcare professionals focus group were: Black Experience and Frustration.
Chapter One: Systematic Review

1.1 Background

The David Bennett Inquiry highlighted the importance of considering the needs of minority ethnic groups, when managing disturbed (violent) behaviour in the short-term. For the purpose of this guideline, the following definition of minority ethnic groups, taken from the Concise Oxford Dictionary, 2001, has been adopted:

**Minority Ethnic Group**: Of or relating to a group of people having a common national or cultural tradition [...] denoting origin by birth or descent rather than by present nationality. (Concise Oxford Dictionary, 2001).

Although not specifically mentioned in the scope, the importance of this area is widely recognised by healthcare 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, who died whilst being restrained on a secure unit. Therefore, it was decided that a specific review should be conducted on this topic.

The literature, which discusses 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?, 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.

It is recognised 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).

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 stereotype affects the treatment of Afro-Caribbean service users within many mental health settings. (Littlewood and Lipsedge, 1997). 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). (Taken from Oxford English Dictionary Online)

This review seeks to evaluate the evidence for such claims, and those issues relevant to minority ethnic groups and the short-term management of violent (disturbed) behaviour in psychiatric in-patient settings).

As a result of the concerns relating to the treatment of African Caribbean service users, this review has given particular attention to the short-term management of the violent (disturbed) behaviour of African Caribbean service users in psychiatric in-patient settings. It has not done so, however, to the exclusion of other ethnic groups. Although this review has focused particularly on the short-term management of disturbed (violent) behaviour amongst African Caribbean service users in psychiatric in-patient settings., our searches attempted to find material relating to a wide-range of ethnic minorities in relation to the short-term management of violence and the recommendations will not focus on African Caribbean service users to the exclusion of other ethnic minority groups.

This review considers three areas, which are covered by scope of the guideline:

- Diagnosis, Prediction, Interventions
- Relationship between Staff and Service users
- Provision of Services

1.2 Methods

Search Strategies

Search strategies were devised to identify the best available evidence for the interventions and related topics discussed in the guideline (see Appendix 3). 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

Handsearching was not undertaken following NICE advice that exhaustive searching on every guideline review topic is not practical and efficient (Mason, 2002).

Reference lists of relevant order papers were checked for articles of potential relevance.

The evidence review was sent for peer review in an attempt to identify any further relevant papers.
The databases searched, logs of results and all search strategies can be found in Appendix 3.

Evidence of effectiveness, evidence of harm and cost effectiveness information was sought.

**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. Over 50% of all articles in the guideline were then critically appraised by an independent reviewer as a quality check.

**Data Extraction**

Study appraisal and methodological quality were assessed using checklists designed with assistance from the Centre for Statistics in Medicine at Oxford University. (The quality principles used and the checklists are available from the NCC-NSC on request.) Data was abstracted by a single reviewer and evidence tables compiled. Over 50% 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 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% 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 minimised bias (Cullum et al, 2003).

**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.

**Appraisal of Methodological Quality**

Very limited evidence for each of the review questions listed below was found. The resulting evidence reviews must therefore be viewed as mapping exercises, which 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 2). 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.

The guideline development group then considered the evidence statements derived from the evidence reviews and used formal consensus methods (See chapter 5) to derive recommendations and good practice points, particularly for those areas where research evidence was lacking or weak, drawing upon their own and others clinical expertise and experience, as necessary.

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.

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.
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+.

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++.

Evidence level 3 or 4, or Formal consensus.

A good practice point (GPP) is a recommendation for best practice based on the experience of the Guideline Development Group.

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 guideline development group (GDG).

1.3 Objectives

Two review questions were identified and used to inform all searches (see Appendix 3 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 violent (disturbed) 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 violent (disturbed) incident in adult psychiatric in-patient settings?

Selection Criteria

Types of Studies

Systematic reviews to before and after studies. Qualitative studies were also included (Evidence level I-IV).

Types of Setting

All adult in-patient mental health settings, excluding geriatric and learning disability.

Types of Outcome

- Impact of ethnicity on the interventions used for the short-term management of violence 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 violence in psychiatric in-patient settings.
- Bias in treatment or diagnosis, (prevalence/incidence rates).
• Effects of ethnicity/race on service users and/or staff.

1.4 Clinical Evidence

One hundred and sixty eight papers were identified by our searches. After sifting for duplicates and papers outside the scope forty-one were ordered. Only twenty-three of these papers were included. Ten were excluded. The rest were overviews or outside the scope of the review. There were thirteen UK studies and ten US studies. Some of the US studies are based in psychiatric services for veterans (ex-military), a specialised population. Study settings also vary 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 healthcare professionals with expertise in working with Black service users. The results will be detailed in a separate report available for the 2nd stage consultation.

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 violence in psychiatric in-patient settings be linked to ethnicity?


The following studies found that levels of violence towards others were not related to ethnicity: Kho et al (1998) a UK prospective study, Feinstein & Holloway a UK cross sectional study, (2002). In addition, a qualitative UK study by Morley et al, (1991) found that 53% 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 non-white 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
Evidence Level | Evidence Statement
--- | ---
IV | 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 violence than other groups.

1.b Review question: Are the tools used to predict violence in psychiatric in-patient settings ethnically/racially biased?

A large number of tools were identified in the predication evidence review. The majority of these make no mention of testing for racial bias. It must, therefore, 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 patients than occurred amongst white patients 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 culturally sensitive Millon Clinical Multiaxial Inventory personality tool 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, which takes account of racial bias, however some adjustment is needed to the item and scale levels.


Silver (2000) illustrates the effect of confounding according to locality of individual’s residence and how this may effect reporting of results of violent incidents.

Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>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.</td>
</tr>
</tbody>
</table>
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 behaviour than service users from other ethnic backgrounds. (p<0.03).

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 violent (disturbed) 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 & 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 blacks.

A UK descriptive survey (Wilson and Francis, 1997), found African Caribbean service users and African service users felt misunderstood because they are feared, ignored or stereotyped.

The two focus groups which 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. (The full report will be available at the 2nd stage consultation).

No studies were identified which examined staff perspectives race/ethnicity in relation to the use the interventions considered in this guideline for the short-term management of violent (disturbed) behaviours in psychiatric in-patient settings.

The focus group which the NCC-NSC ran with nine healthcare professional who had experience of working with Black and ethnic minority service users found that these healthcare
professionals felt that the short-term management of violence in the UK is racially/ethnically biased. (The full report will be available at 2rd stage consultation).

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>III</td>
<td>The 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.</td>
</tr>
<tr>
<td>IV</td>
<td>There is insufficient evidence to determine whether or not 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.</td>
</tr>
</tbody>
</table>

### III Admission

#### III.a Review question: Are admission procedures ethnically/racial 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 healthcare professional prior to admission and that two third of admissions involved the police.

Involvement of the police was examined in two studies. Morley, (1991) identified the role of police in admissions to hospital by 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.

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>III</td>
<td>Studies suggest that Black service users may be likely to have some level of police involvement during the admission process.</td>
</tr>
</tbody>
</table>

### Economic Evidence

No studies containing relevant economic data were found.
Chapter 2: Methods

2.1 Aim

The aims of the study were two fold:
- to listen to the experiences of Black Service users in relation to the short-term management of violence in two different settings, Bristol and London. In London, the group was made up entirely of African-Caribbean service users.
- To listen to the views and experiences of healthcare professionals with experience of working with Black service users in relation to the short-term management of violence across a variety of settings.

2.2 Objectives

The objectives of the study were
- To describe Black service user’s experiences and views of the short-term management of disturbed (violent) behaviour in psychiatric in-patient settings.
- To describe the experiences and views of healthcare professionals with experience of working with Black service users in relation to the short-term management of disturbed (violent) behaviour in psychiatric in-patient settings.
- To draw up recommendations to improve psychiatric in-patient services.

2.3 Methods

The framework for the design and analysis of this report was taken from Richens (2003). Richens used focus groups to gather sensitive information from Pakistani women who had recent experience of the maternity services in the UK. Focus groups are commonly used to collect information or investigate individual responses to different situations or policy initiatives, particularly those that are of a sensitive nature (Gebich, 1999). They are particularly useful for encouraging participation from people who are reluctant to be interviewed on an individual basis or who feel they have nothing to contribute, as well as for tapping into a given cultural context (Kitzinger, 1995). Richens work further confirms the findings of Hennings et al., 1996; Duff, 1999 and Wilkins and Winslow et al., 2002 whose studies illustrate that focus groups are useful and appropriate when working with ethnic minority groups. As Richens demonstrates, focus groups can be used for ‘obtaining rich information within a particular social context’ (Richen, 2003:19).

2.4 Design

Following Richens (2003) we taped and transcribed each focus group. We then treated the transcribed manuscript as a text for analysis. As in Richen (2003), we used content analysis as outlined in Burnard (1991) to generate a number of high and low order themes from each of the texts. The thematic overlap from the two focus group texts was such that we merged these to create one set of high and low order themes. The text generated from the healthcare professional focus group was treated separately, and unique high and low order themes were derived.
2.5. Ethical Approval

As the service user focus groups were undertaken through service user organisations, who identified volunteers and facilitated the groups, no ethical approval was sought.

No ethical approval was sought for the healthcare professional focus group.

All participants gave written consent (See appendix 9 for consent form template).

2.6. Sampling, Eligibility and Recruitment

Quota sampling was used to select participants for the two service user focus groups. Richens notes that Bowling defines this approach as:

a deliberate non-random method of sampling, which aims to sample a group of people, or setting, with a particular characteristic (Bowling 2002:380 cited in Richens 2003).

All participants came from Black and African Carribean communities and had direct experience of the interventions for the short-term management of disturbed (violent) behaviour in psychiatric in-patient settings being considered in the guideline. In London, all the service users were African Caribbean, in Bristol all belonged to the Black community which is situated in and around St. Paul's.

A snowballing technique was used to select the healthcare professionals for the other focus group. The process started with the guideline development group (GDG) and was continued with the experts who were nominated by the GDG. All participants had some expertise with Black service users in psychiatric in-patient settings.

No participants were deliberately excluded from any focus group. A full description of the characteristics of the participants is given below in section 2.7.

Prior to commencing the focus groups, information leaflets and consent forms were sent to the two service user organisations several months in advance to distribute to potential participants. This material received a positive response.

Participants were paid travelling expenses, provided with lunch and were also given a small payment, as a gesture for attending the focus groups. The money was not used as an incentive since this was given out at the end of focus group interviews.

Recruiting participants to the study was not difficult. With reference to the two service user focus groups, in London potential participants had to be turned away, while in Bristol the situation was more difficult. Many potential participants in Bristol were constantly in and out of hospital (one participant was accompanied from hospital) The ‘revolving door’ situation in Bristol meant that a large number of participants were invited to be involved in the focus group as it was unclear who would be available to attend on the day. In the end this resulted in an overly large focus group, which is described below in section 2.7. Healthcare professionals were keen to participate in the focus group held in London.
2.7 Characteristics of Participants

2.7.1 London Service Users

Number of Participants:
Age range: 20-55
Sex: 6 Females, 3 males
Ethnicity: - African Caribbean
Range of Settings Experienced: Secure and Acute Settings.

2.7.2 Bristol Service Users

Number of Participants:
Age range: 18-60
Sex: 2 females, 12 males
Ethnicity: - African Caribbean and African-Caribbean born in England. (Most participants classified themselves as ‘Black’). (Also included Somalian refugees, but see 2.9.1 below).

(In addition 1 female advocate and 2 male advocates also attended)

2.7.3 Healthcare Professionals (this section needs adding)

Number of Participants:
Age range:
Sex: 3 Females, 6 Males
Medical Specialism, Training, Diversity Lead, Management
Range of Settings Worked in: Forensic, A&E, Acute Care

2.8. Role of the Facilitator and Researcher

Two researchers attended each service user focus group in addition to the facilitator. One researcher was from the Collaborating Centre for Nursing and Supportive Care, the other was from the Patient Involvement Unit. One of the researchers acted as a second facilitator, helping guide the discussion so that the participants only discussed their experiences of the short-term management of violence in psychiatric in-patient settings, rather than other related issues. The other researcher took notes during the focus groups to support the taped analysis and provide any additional relevant information on mood, behaviour and group dynamics. A representative from Black Orchid and Footprints UK acted as the first facilitator for each of the groups respectively.

Two researchers attended the healthcare professional focus group. One researcher was from the Collaborating Centre for Nursing and Supportive Care, the other was from the Patient Involvement Unit. One acted as the facilitator, the other took notes during the focus group and also acted as a second facilitator.

2.9. The Focus Groups

2.9.1 Service User Focus Groups
Twenty-three participants were recruited to the focus group study, and they all met the eligibility criteria. Each focus group lasted approximately one and three quarter hours, with a break for lunch. They were held in local settings that were familiar to the participants. The Bristol focus group was conducted in facilities at Black Orchid, the London focus group was held in a the Black Persons' Community Centre in Walthamstow. The London focus group included three men and six women, as well as two researchers and the facilitator. The Bristol focus group included twelve men and two women, as well as two researcher and the facilitator. In addition, three advocates were present and three Somalian refugees. The refugees did not participated verbally in the discussion, so even though they attended and were counted as part of that focus group, they has not been included in the total number of participants, see table 2.

Table 2

<table>
<thead>
<tr>
<th>Group</th>
<th>Focus Group Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>9</td>
</tr>
<tr>
<td>B</td>
<td>14 (+ 3 participants who did not communicate verbally)</td>
</tr>
<tr>
<td>total</td>
<td>23</td>
</tr>
</tbody>
</table>

Following Richens (2003), in addition to the facilitator two researchers were present at each focus group. This meant that one researcher was able to help facilitate the discussion, while the other researcher was free to take notes to assist with the subsequent transcription and data analysis (Krueger and Casey, 1998 cited in Richens, 2003). This enabled comprehensive transcripts to be produced by ensuring that unclear sections on the tapes did not result in lost data. It also allowed comparison between researchers for the purpose of verification.

Prior to each focus group a brief summary of the aims and objectives of the focus group was distributed to participants. The interview schedule and research protocol (Appendix 7) aimed to obtain service users’ views and experiences of:

- Interventions use for the short-term management of violence in psychiatric settings (rapid tranquillisation, seclusion, restraint, de-escalation, observation, predication)
- The in-patient environment and its impact on disturbed (violent) behaviour
- Staff and service users relationships in psychiatric in-patient settings and its impact on disturbed (violent) behaviour

Prompts were included in the focus group schedule.

2.9.2 Healthcare Professional Focus Group

Nine participants were recruited to the healthcare professional study, and they all met the eligibility criteria. The focus group lasted approximately 2 hours. The focus group was held in the Royal College of Nursing Headquarters in London.

Table 3

<table>
<thead>
<tr>
<th>Group</th>
<th>Focus Group Participants</th>
</tr>
</thead>
</table>

DRAFT FOR SECOND CONSULTATION JULY 2004
Prior to each focus group a brief summary of the aims and objectives of the focus group was distributed to participants. The interview schedule and research protocol (Appendix 8) aimed to obtain healthcare professionals’ views and experiences of:

- Interventions use for the short-term management of violence in psychiatric settings (rapid tranquillisation, seclusion, restraint, de-escalation, observation, predication)
- The in-patient environment and its impact on disturbed (violent) behaviour
- Staff and service users relationships in psychiatric in-patient settings and its impact on disturbed (violent) behaviour

Prompts were included in the focus group schedule.

2.10. Informed Consent

Prior to all focus groups, each participant received a copy of the Information Sheet. This was supported by verbal information from the service user organisations in the case of the two service user focus groups, explaining the study and what it entailed for participants. Participants were given an opportunity to ask questions and withdraw from the study prior to being asked to sign the consent form and were provided with some basic background information (Appendix 9). Participants were informed that all information received would remain confidential and were reassured that any care and future treatment would not be affected as a result of their participation in the study. One participant in the service user focus group was not completely happy about signing a consent form, since he felt suspicious about what would be done with the information and feared that the focus group would achieve very little. After discussion, the participant did however sign the consent form and participate in the focus group.

Following Richens, 2003 the researchers were ware that consent in research is not a ‘one-off event’. The report of the focus groups was therefore sent to the participants to ensure they felt happy that it reflected all the issues raised before being circulated to the guideline development group. In Bristol a feedback group was held with participants.

2.11. Confidentiality

Following methods used by Richens (2003), each participant was allocated a number, and each focus group was given a letter of the alphabet as an identifier. All information collected, including cassette tapes were stored in a locked drawer, which was only accessible to the researchers.

2.12 Data Analysis

Using the methods cited in Richens (2003), the data was independently analysed by all three researchers using the approach to content analysis described by Burnard (1991). This involves generating theme from verbatim transcripts of the focus groups and then groups them und er
reasonably exhaustive categories in order to explore the issues that were expressed. As Burnard states, the aim of this approach is to:

Produce a detailed and systematic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system (Burnard, 1991:462 cited in Richens 2003).

The themes were then categorised into high order themes which reflect a natural clustering of categories and low order (sub) themes. High order themes are the main themes, and these occurred also through a natural clustering of categories, low order themes are sub orders, which relate to the main identified theme (Richens, 2003). These categories are presented with supporting illustrations (that is, direct quotations) from the focus groups in accordance with qualitative data analysis (Kitzinger, 1995).

All three researchers met to finalise the high and lower order themes. The completed report was then circulated to the participants as part of respondent validation. Participants were invited to add any further thoughts or feelings to the findings. This process ensures that the researcher’s interpretation reflects the views of the participants and that the research does not yield misleading or inaccurate conclusions about the study (Murphy et al, 2002).

2.13. Limitations of the Study

'Group think', Carey and Smith (1994 cited in Richens, 2003), where stronger members of a group have major control or influence over group dynamics and may hinder articulation of quieter members’ views is a danger in focus groups. In one service user focus group and in the healthcare professional focus group incidents of ‘group think’ did occur. However, it was to a large extent prevented by both facilitators and researchers being aware of this and intervening to ensure that all members were given the opportunity to give their viewpoints and to nominate areas they would like discussed.

A further limitation of the focus group in Bristol was the size of the study and mix of participants. It was impossible to predict how many of the participants who had been invited to attend would be able to attend on the day. As there is a revolving door situation in Bristol with service users in and out of hospital it is difficult to see how we could have over come this problem. It might, however, have been better to invite fewer participants and have run the risk of a very small focus group. Given that only one focus group was taking place in Bristol, it was felt that it would be better to have slightly too many members than very few.

Most participants who attended the Bristol focus group came from the African-Caribbean community, there were however, three Somalian refugees who spoke very little English. On reflection, it would have been better to have conducted a separate focus group or structured interviews via an interpreter with these individuals. Funding costs and time constraints made running a separate focus group for these participants impractical. Since these three participants did not speak during the focus group were excluded from the final results in Group A.

Another issue was the mix of participants. Most participants had been in-patients with a primary diagnosis of mental illness. One participant however, did not have a mental health diagnosis, but had been admitted to a psychiatric institute on a number of occasions for drug induced
psychosis. To ensure a more homogenous group it might have been better to exclude those with a primary diagnosis or a sole diagnosis of drug abuse.
Chapter 3: Service User Focus Group Findings

3.0. Background

The findings below are derived from data collected from 23 participants. See section 2.9.2.

The findings are categorised into high order and low order themes and are presented below in Table 4.

Table 4: Themes arising from data analysis

<table>
<thead>
<tr>
<th>High Order Themes</th>
<th>Low Order Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powerlessness/voicelessness</td>
<td>Fear</td>
</tr>
<tr>
<td></td>
<td>Division/isolation</td>
</tr>
<tr>
<td></td>
<td>System problems</td>
</tr>
<tr>
<td>Inhumane treatment/control</td>
<td>Custodial/Authority</td>
</tr>
<tr>
<td></td>
<td>Uncaring</td>
</tr>
<tr>
<td></td>
<td>Misunderstanding/Stereotypes/ Alienation/ Black Experience</td>
</tr>
<tr>
<td></td>
<td>Anger</td>
</tr>
</tbody>
</table>

Dual diagnosis/drug abuse

Direct quotations of relevance are included below which support the themes above.

3.1. Powerless/Voicelessness

Powerlessness/Voicelessness was identified as a high order theme. Three low order themes within powerlessness/voicelessness were identified, namely; fear, division/isolation, system problems.

It's about controlling people […] it's keeping them in a zombified state so that their job is made easier and then they feel powerful (Participant 1)

It's like punishment, I'm punishing you and I'm going to show you I have the power to punish you and there's nothing you can do about it (Participant 1)

It's all about power (Participant 1)

My experience is that trained staff were of a violent nature themselves and would always suggest to you, they wouldn't say it in so many words that we're going to bend you over for an injection in two minutes but they'd hint that if you don't do as they say you've had it and you haven't done anything wrong. (Participant 7)

The participants identified their lack of ability to influence their care or to have their needs met as a major concern affecting their experiences of in-patient care. This related not only to mental health needs, but also physical needs, which were often left unmet. They felt not only powerless in relation to their own care, but also that of other service users. Only rarely was
Participants also expressed distress that complaints were not taken seriously and that there was no proper mechanism for dealing with incidents which arose. This lead to a greater sense of powerlessness and voicelessness, and fear that they too might suffer from bad practice. Many of the problems and their inability to challenge them were consider to operate at a system level.

The system is failing us (Participant 5)

Participants also felt powerless because they were unable to get any information about the medication they were receiving and details about the length of their stay.

Where regular medication was too strong, they were powerless to get it changed, despite marked side-effects:

I walked around like a zombie, I couldn't feel any sensation in one of my arms, […] when I went to walk it was like a curved pensioner, couldn't take pigeon steps. (Participant 7)

I couldn't communicate at all, my family had to bath me. (Participant 7)

They give you so much injection, that I was like a jelly fish. (Participant 3)

Dribbling, couldn't speak properly and they kept saying it wasn't my medication doing to me but my illness. But I didn't come in like it. (Participant 3)

One time I was on such strong medication […] it was like […] when you're physically disabled. (Participant 1)

A common perception was that if you asked too many questions you would be branded as a trouble-maker.

I think the things is the more you're able to challenge the nursing staff and know your rights, the more likely you are to be threatened and be locked away. (Participant 2)

One participant compare being an in-patient with being in school, and expressed feeling like a child who had no real voice:
To me it's like school [...] they treat you like you're an idiot coz your like a little school boy, a little pupil and they're the big teacher or whatever and they're the ones in charge and they've got all the authority. (Participant 17)

Other participants also referred to being treated like babies when medication was given out:

It's like baby time [...] everyone queues up for their medication, there's no confidentiality [...]. (Participant 2)

This highlights the need for service users to be able to assume some kind of control over their care and to feel certain that they can protect themselves and their rights whilst in in-patient units.

3.1.1. Fear

For many participants fear was an over-riding emotion that summed up their in-patient care. They reported that even when they themselves were not subject to what they perceived as bad practice, they were afraid that they would be next.

One man who couldn’t speak English was picked up from the ward [...] the door was slightly ajar, you heard the nursing shouting at him and swearing to speak English [...] The nurses was shouting, they were laughing, [...] the injection happened and he did the toilet or whatever [...] which they all laughed about [...]. It was terrible, it was quite frightening actually because what it did was made you think (Participant 2)

You’re going to be next! (Participant 5)

Yeah! (Participant 6)

Debriefing or the lack of it appeared to contribute in a major way to participant fear. One the few occasion were a member of staff had taken the time to explain to a service user why a particular intervention had been implemented there was much more acceptance of the practice.

Yeah, well, I got restrained and I came and I asked them, "Why was it necessary to restrain me?", and they said because I had smashed the television and they thought there was potential that I might get aggressive against someone else. [...]which I understood because I could have got violent with someone, you never know. (Participant 5)

Despite reports of some good nursing practice, there were however far more reports of over use of interventions such as rapid tranquillisation, restraint and seclusion, without any perception of prior de-escalation being used.

I refused to have my bath and I normally do take my bath, I do not have a hygiene problem [...] this Irish woman, I'll never forget what she did, she got these men to grab me, took off my clothes, and put me in the bath and she made all the men come in and have a look at me. (Participant 1)

They don't have any alternative therapy to use, they don't call up a consultant to talk to you if you're distressed or call a nurse, a psychiatrist to talk to you if you're distressed,
the only things they've got to do is restrain you, medicate you or seclusion, something like that. (Participant 5)

The only thing they're really aware of is the medication, they don't have group work skills, they don't have counselling skills, they don't have listening skills [...] I'm not quite sure what the qualification is for a mental health nurse but I think it must be GCSE level! (Participant 2)

These kind of practices and attitudes generated fear, as well as anger and mistrust.

Observation was also seen to be of little therapeutic value:

I think in terms of close obs, it doesn't work [...] they're following you around like a shadow but there's no support with that technique [...] so in a sense it actually makes you even more depressed. (Participant 2)

Another participant reported that the nurses talked to him and some were nice and played cards, but he still saw observation as a very intimidating procedure.

You sit on one chair and you'd have two nurses who sit and watch you [...] You get some friendly nurses [...] and you get some nurses who you can tell just can't stand their job and can't wait til it's time to go home and it's them ones you've got to watch out for. (Participant 17)

Participants also reported that it was possible to get a history of being aggressive without deserving it.

I had to protect myself and it was written on my files that I was 'aggressive'. (Participant 7)

Service users reported that it was not only service users who were afraid. Often staff appeared frightened of service users, avoiding some people altogether.

I think it's about their peace of mind, not the peace of me [...]. It's not about the client, it's about staff safety. (Participant 2)

Staff over-use of interventions such as rapid tranquillisation, restraint and seclusion also appeared to illustrate staff fear.

Now the way I was restrained it lingered on me, I find it very difficult to talk about and it's had a lasting effect on me so far as when I go into hospital for my medication or my check-up to see the doctor, it really affects me and sometimes I come out all nervy and fearful of going in the hospital. You know it's a very serious thing, restraint because it leaves a lasting effect on you. (Participant 8)

This fear was also illustrated in ill-thought out limit setting which provoked service user aggression.

There was a guy in there [...] it was a friendly environment, he had managed to get the TV and video out of the cupboard. [...] staff [...] came to take the telly back [...] the
way they actually approached it was coming in with literally all the staff on the wing and saying ‘We’re going to take the telly back’ which upset everyone. This guy, it set him off, he’s picked up a chair and he just threw it through the window [...] because of the way they actually approached him [...] they’ve come in heavy-handed [...] which I found a bit of a cowardly way of doing it. (Participant 6)

3.1.2 Division/isolation

One of the major concerns of many participants was that there was a divide between staff and service users - a clear ‘them and us’ mentality, which left many service users feeling isolated and bored. It was also perceived as a catalyst for violence. Staff tended to spend most of their time with other staff members and often shut themselves in the office. They did not respond to service user requests for help or listen to concerns and complaints:

I found that when I was actually in there that the staff tended to do their own thing, like they’d come in and they’d play table-tennis together by themselves while in the next room one patient would be violent to another patient [...] They’d all be cooking their own food, they would not really be interacting with the patients and to me it needs to be more friendly, more communication so that you don’t get that kind of divide. (Participant 6)

Another participant described the time when she asked staff to turn down the television because the noise was keeping her awake:

I was there voluntarily and my room was right next to the lounge where the television was [...] the remote busted and the volume was too loud when it busted so they couldn’t turn the volume down. [...] So they kept leaving the door open so I came out of room [...] and said ‘Could you please keep the door shut? [...] It was my first night in hospital and I’d come in because I was feeling depressed, you know and I need my sleep [...] she wouldn’t make sure the door was kept shut, people were going in and out and it kept waking me up. So I got up and there was a pool table inside the lounge and I picked up a pool ball and I threw it at the television and it busted and then I went back to my room. Anyway they called the police because it was criminal damage. [...] they [police] took me to the seclusion room and told me to strip. (Participant 5)

When asked to clarify whether Black staff were different, some participants stated that it made no difference and that Black staff just become part of the culture of the in-patient department:

The Black staff are just as bad if not worse, the Black nurses, Black so-called professionals. (Participant 1)

Because from my experience they’re not on your side just because they’re Black and they work there they have adopted the same attitude, the same mentality, the same ignorance, lack of feeling, lack of empathy, they’re just the same, I think they’re actually worse (Participant 1)

In fact, in a difficult situation it was a White nurse who came to this participants aid:
When I was restrained it was made up of Black people who restrained me and it was a White nurse that came to me and helped me and got me out of the situation that I was in. (Participant 8)

Another participant suggested that Black staff were embarrassed by Black service users because they were culturally too close. Some participants, however, suggested that it was easier to talk to Black staff:

It's different if you've got your own people there. (Participant 18)

The problem of assuming that all Black people share the same culture was also raised. Participants stressed that there are important cultural differences between Black Africans and African Caribbeans:

Now it has been acknowledged that the African communities and the Caribbean communities have very different cultural experiences and there's an assumption that because you have Black nurses, their culture and their understanding of racism or what they've been through, this culture here, would reflect us and I think that this needs to be taken on board that with the Black communities there's a host of different experiences. (Participant 2)

One of the main concerns of all participants was that staff should listen to service users. There was a perception that some of the lack of listening and lack of contact time was related to fear of a service users because of their ethnicity.

One participant suggested that:

I'm quite a big guy and I was going through a very tough time [...] the staff tended to keep away from me [...] they wouldn't come and talk to me because like they had that kind of stereotypical he's a big, Black, violent guy [...] It was very few what actually came and spoke to me and found out what I was about. (Participant 6)

For all the participants in the focus groups their over-riding concern was not the ethnicity of the staff or staff mix, but that staff should spend time with service users, get to know them as individuals and gain their trust. There were however concerns that where this trust had been gained it should not be abused. One participant recounted how a nurse who had talked to them was able to persuade them to take medication for agitation, but how the side-effects were not considered or addressed for several days. The service user felt as though they had been conned:

She said she was going to give me something to calm down and it made me actually didn't want to be inside my body, I could have jumped off the roof, that's how I felt and they didn't tell me that it was an antidote to my side effect until the next day and I was walking round literally trying to rip my skin off [...] and I wouldn't have taken it if I hadn't felt comfortable with the person [...]. (Participant 6)

She conned you in a way? (Participant 7)
Yeah, she conned me. (Participant 6)

### 3.1.3. System problems

Many of the problems which led participants to feel powerless and voiceless related to problems that they believed were part of the mental health in-patient system. Participants noted that often the ward atmosphere would be governed by one or two nurses who had particularly authoritarian attitudes and whose behaviour appeared cruel.

> One bad apple can spoil a barrel, so you know what I mean and if you get a few of them on the wing at the same time, working the same shift, you can have absolute hell on the wing. (Participant 6)

One particular problem was an inability to have complaints about overly authoritative nurses heard and dealt with in an equitable manner. If any misconduct occurred there was a perception that staff would stick together:

> The problem I've found is because you're actually in there [...] you tend not to be taken seriously about the way you feel about things. [...] Like you could be sitting there absolutely telling the truth about something but they will not take what you're saying as the truth [...] they take the staff's side more. If one of nursing staff says that's what happened, that's what happened and that person could be an absolute bastard. (Participant 6)

Participants expressed their mistrust in the complaints procedures, which they regarded as next to useless:

> Well I've got to say that they don't take any notice, even if they do have a patients council, you can go to them and talk to them until you're blue in the face because at the end of the day it's a professional and it's like they all work together [...] okay they might get two weeks off, they might get a slap on the wrist but they go back and do a lot worse. (Participant 1)

The only time that any real action occurred was when one participant phoned the police. The police believed the service user and the nurse was suspended. However, the suspension only lasted for the duration of this participant's in-patient stay. The participant felt disgusted that more had not been done to address this situation and ensure that similar situations did not arise in the future.

> He assaulted me got suspended for three months but they took him back, I rang the police because he assaulted me. [...] But they took him back, when I was discharged the day after he was back at work [...] It got so far but it didn't go far enough because that particular nurse was the key instigator for most of the abuse that was going on in the ward. (Participant 7)

Staff attitudes toward Black service users were also seen as part of a system problem that required addressing on a system level.
One of the reasons why I think this is really important is that we're dying, Black people are dying in the police cells and the psychiatric hospitals and it's an issue about Black people dying, really and truly it is Black people dying in the hospitals and the prison cells. So it's something to do with not just their experience, it's to do with a level of racism, so racism on the ward must be quite acute within the institutions themselves (Participant 2)

3.2. Inhumane treatment/control

Inhumane treatment/control was also identified as a high order theme. This theme has three low order themes, which are uncaring, misunderstanding/stereotypes/alienation/Black experience, and anger.

A consistent theme arising from the focus groups was the inappropriate utilisation of the interventions used for the short-term management of violence:

They don’t try to calm any situation and they not that polite (Participant 1)

I agreed to go on the ward just for an overnight stay while they sorted me out […] when I got there I was told I was to be injected and I refused […] I wanted to talk to whoever was in charge and I went to the office but by that time I was already in a temper, I know I wouldn’t hurt anyone […] they got a doctor and he just went ‘inject her’ and they kicked me to the ground and I had bruises on both my legs when I came round. (Participant 7)

When rapid tranquillisation was used, oral medication was not offered first, it was always given by injection. One participant recalled his anger at being called into the office and finding the syringe laid out on the table ready for use. Nurses response to his action of grabbing the syringe confirmed to him that the dose was dangerously high and for control rather than assisting his agitation:

They called me in for my injection and I seen it on the table, they locked the door behind me and I seen it right in front of me, so I went for 'em and I picked it up and I said, 'I'm going to give you this', and they were like 'Oh, I don't want to die, I don't want to die'. So I was like, 'Beg your pardon, what did you say?' and it was like 'Oh, I don't want to die, it will kill me', 'Then what you giving it me then?', It was like 'Oh, it helps you, it helps you.' (Participant 23)

One participants recalled being restrained by a large number of nursing staff:

At least six of them are holding you. (Participant 2)

Yeah yeah (general agreement)

Depending on how big you are, because it sometimes depends on how big you are, there are at least six people holding you down to inject you, its not necessary, and they pin you down.(Participant 2)
Participants suggested that this treatment was dehumanising. Another participant also recalled being injured during restraint:

I just think that there should be something where they constantly train people in restraint, [...] people tend to get hurt, the patient tends to get hurt. (Participant 6)

One participant argued that nurses like to get a bit rough with service users during restraint:

There's too much nurses, once they get you on the floor, they could do anything with you [...] a lot of them are out just to get you annoyed so they can get a bit rough with the patients, beat up some of them, kick them. (Participant 23)

Another major concern was the removal of clothes during seclusion. Although the Royal College of Psychiatrists Guidance issued in 1998 is clear that clothing should not be removed during seclusion, many participants recorded this as a common practice. This was true of the one service user who was still an in-patient:

When I've been in seclusion they seem to like to strip off as much clothes as possible, they get a kick out of doing that. (Participant 1)

One participant noted how police involvement had lead to his clothes being removed during seclusion, raising issues about the liaison between police and medical staff in psychiatric in-patient settings:

They took me to the seclusion room and told me to strip, take my clothes off, I was stripped and then halfway through taking my clothes off because the policeman told me to strip my clothes off, he told me to stop as I reached my pants and I was like talking sarcastic ‘Are you sure you don’t want to take them off?’ [...] Policeman said grab him, restrain him [...] they grabbed me, threw me to the floor, injected me and like they all backed off and left the room and I passed out for ten seconds. (Participant 5)

Other issues of control related to the length of seclusion, not being brought food while in seclusion, not knowing what medication they were being given even when they asked about it and lack of confidentiality about medication.

Seclusion I’ve experienced in a rough way is being forgotten at meal times. (Participant 7)

But in terms of medication [...] there’s no confidentiality, everyone queues up and so if you see someone on Methadone, its a breach, to me its a breach of patient’s human rights because we’re not supposed to know what the other person’s taking. (Participant 2)

Some participants stated that staff often wanted to provoke violence in order to have an excuse to use interventions and to have a chance to abuse their authority:

You’re eating your meal and they’re sort of like over your shoulder trying to make something out of nothing. (Participant 7)
Some of them was kind of aggressive, one of them told me not to fuck with them and I thought who are you talking to and it made me a bit, it made me a bit more angrier, do you know what I mean? (Participant 17)

There was a general feeling that these interventions were used too much. In focus group B there were no participants who had not been subject to restraint during their in-patient care.

One participant stated that he had seen someone killed in an in-patient department. He did not specify their ethnicity.

I've seen a man killed, I've seen a man killed. (Participant 19)

Several participants saw these problems as part of the system and stressed the role of a few bad nurses. Some participants did stress that they had positive experiences of good nurses, yet on the whole participants suggested that good nurses were few and far between.

Some of the nurses are alright, but they're a minority (Participant 17)

The nurses, them that are there, they are very friendly [...] they will bend over backwards to try and help you, but some of them just stay in the office and do office work. (Participant 19)

Participants stressed that the methods of restraint employed did not differ from those used by the police. One participant recounted being placed in a hog-tied position:

That's the same treatment you get in hospital as well. (Participant 1)

Other participants recalled the use of pain compliance and its unnecessary use:

When I was in prison [...] I was actually restrained and their techniques tended to be even more kind of violent [...] you'd tend to come out and you can't move your thumb and your wrists feel like their broken, you shoulders feel like they're out of joint and your arms are hanging down like that by the time they've finished with you. (Participant 6)

They [nurses] pounced on this girl and just bent her leg one way, one leg bent that way, bend one arm that way, bend one arm the other way and inject. (Participant 5)

I've been bent up into a figure four with my actual foot behind my knee and they're actually bending my foot so they're actually pulling my knee joint out of place and plus their actually sitting with my head in between their legs and they're actually sitting on my head so you can't breathe properly. (Participant 6)

Unless you scream they are not going to stop bending until you actually start screaming your head off and if you're screaming your head off like that, you are not going to stop wriggling. (Participant 5)

For one participant the effects of pain compliance were quite pronounced and caused her further emotional distress when, as a result, she was unable to plait her daughter's hair.
I was restrained by a particular nurse had a technique where he put my armed behind my back and crunched my fingers together until the knuckles swapped over and wrench it in a different direction so it would swell up like when you do boxing and I couldn’t use my fingers at all […] I plait my little girl’s hair, so I wasn’t able to plait her hair her and it was making me more upset. (Participant 7)

3.2.1. Uncaring

Many of the attitudes of nurses was perceived of as uncaring. There was a perception that nurses shut themselves away in the office and did not attend to service user needs. This lack of input endangered service users:

We had a lady who was having real problems, she’d wake up at 7 o’clock in the morning and walk around the ward and she would scream out all her woes […] until someone’s decided to hit her […] but they didn’t care, they’d come in the morning, they’d sit down, have coffee, load out their medicine, a bit of breakfast and that was them for the morning and this lady was getting hit consistently or pushed over or abused on the ward […] and they did nothing. (Participant 6)

Service users reported how this lack of care led them to take on therapeutic roles. Their involvement in these roles was not seen as an entirely negative experience. However, it was generated by a lack of staff input, and participants felt unqualified and afraid that they would do more harm than good:

We’re going in there for care and support but what’s happens is we’re going in to nurse other people. (Participant 2)

I found that the users were taking more care of other users in there than the staff were […] It was like we had our own kind of therapy group going out without staff and who are we to say that we can do that and if we break someone down we can actually put them back together again? (Participant 2)

Service users also recall having to get help for other service users who were in distress:

We were doing more observation than the staff were, we had a girl in there, a young girl, she was about 17 I think and […] she was taking her clothes off and lifting her skirt up, taking her knickers off […] and it was us, the users saying ‘Don’t do that’ […] some of us were a bit better than others, had to go in the meeting and actually stress it to the head doctors […] and that was what changed it for her. (Participant 6)

As noted above, a participant recounted how service users were left in a great deal of distress and that staff did not intervene. Nurses were not the only staff who were identified as uncaring, doctors were also noted to ignore participants and not give them time:

I think she was a junior doctor and I got on quite well with her, she kinda admitted me […] a couple of days later I was feeling quite stressed and I kinda saw her in the corridor and said to her ‘Have you got time to speak to me? I need to speak to someone’ and she just turned round and said to me ‘I’m not your doctor, go and find your doctor’ […] I ended up smashing a few things up that day. (Participant 6)
3.2.2 Misunderstanding/stereotypes/ Alienation/Black experience,

Several participants mentioned that they felt misunderstood and that stereotypes affected the way in which staff relate to Black people. Connected to this participants mentioned feeling alienated because of their ethnicity and suggested that their ‘Black’ experience wasn't recognised:

I think the level of stereotypes, of negative, the Black experience on the ward creates a level of violence and tension. (Participant 2)

Participants noted that large Black men (and women) are often avoided. As noted earlier, they related this to the stereotype that young Black men are dangerous. One participant commented on the cruel treatment of a large Black woman:

On one occasion she was refusing to comply to sitting where they said she had to sit, she said they had no right to tell her where to sit, she just got up and walked out and this nurse grabbed hold of her from behind and was trying to direct her to the chair, now of course she’s going to lash out at him which she did and he just set upon her and I set upon him. (Participant 7)

They suggested that some Black people are restrained more often than other service users:

There was a woman that was constantly being picked on with regards to restraint and she was a Jamaican. (Participant 7)

They also suggested that Black service users are more likely to have pain compliance applied on the way to the seclusion room:

Most of the time, if you’re Black, you’re going to get bent and twisted up and carried into seclusion. (Participant 23)

Participants suggested that some of the humiliating treatment that they received was related to race:

They got about six doctors or nurses, quite a few were men and they got them all to look at me and gave me an injection in the bum and they were all looking. […] it’s like their fighting a real mad person who’s really, really strong. That’s just like abuse, they really like to get a look in on somebody’s fat Black arse so to speak and it’s so degrading, just because I couldn’t sleep, I wasn’t doing anything to harm anybody. (Participant 1)

In addition, they suggested that drugs were the only therapy offered to Black people.

What I’m trying to say now is the Black community, as soon as we go into hospital we get injections and tablets. (Participant 8)

This was further reinforced in relation to A&E (see below)
They suggested that Black culture was misunderstood as aggressive, confirming stereotypes already held by staff:

A lot of Black people are actually quite boisterous and quite loud [...] we're quite loud when we get together [...] it's like a misunderstanding of culture and the environment and thinks like that, the way we are this is picked up, as like, they're ready to go off, kind of thing. So you get all the staff coming down and they could be just having a laugh about something. (Participant 6)

On the ward, African Caribbean people, we're seen as a lot more aggressive rather than this is how we culturally are, so we're treated this way. (Participant 1)

There was also issues of stereotyping concerning Black people using marijuana:

They claim so many times I have marijuana induced psychosis, never touched the stuff, [...] they write on the files, [...] oh she has a history now and she's Black. (Participant 7)

One participant recounted how she was made to give a urine sample for marijuana because she was Black, even though she was asthmatic and didn't smoke:

On one occasion I was asked to give a urine sample, they were saying that I was smoking weed and I don't smoke, I'm asthmatic [...] they gave me a pot to pee in and they said ‘You're doing it here right now' [...] there were male nurses there are well [...] they were empowered to stand there and witness me giving a urine sample and they know I don't smoke, I was the only patient that didn't smoke on the ward and I was the only one with asthma problem and when my asthma puffers had run out they just gave me a replacement. (Participant 7)

Another participant recalled how when relatives or friends visited him the staff ask him afterwards if they were drug dealers:

They see your family and they see like a group of guys come up to visit you [...] and they're like 'Oh, he's doing very well, and he should be out of this place soon', and the next minute when the visitors gone they're like 'Who was that that come up to visit you? And they're ' Oh, I bet he's a drug pusher, your pimp or whatever', shit like that. (Participant 23)

However, during the feedback on the report, on participant stated that she did think that drug abuse in hospital was an issue which needed addressing.

Another issue pertinent to this theme, but also to others above, was that some participants stated that they were avoided, which left them with a sense of alienation. There was also the suggestion that these stereotypes are ingrained in the institutions.

What you find is that their reaction to you as a Black person is based on their racism and the stereotypes that they have, so for some of them it's an institutional thing' (Participant 1)
The participants also commented that refugees and those who couldn’t speak English suffered from racist abuse.

I’ve seen the violence towards refugees or people who don’t have English as a first language. (Participant 1)

There was also disbelief that this kind of treatment of Black people could be taking place in England:

The guy wasn’t being violent [...] he was screaming [...] when you saw them all rush to him, pick him up, throw him and the abuse he got in that room was quite terrifying to be honest [...] the nurses picked a foot up to kick him but none of us could see if she actually kicked him and this is a Black man. [...] I don’t know what his experience was but then to come in there and you think this is happening in England. I know it sounds ridiculous but on the ward you’re thinking, hold on a minute, where am I, but it’s happening in England. (Participant 2)

As discussed under another theme, participants were concerned that there is a misconception that all Black cultures are the same, particularly the confusion between African and African-Caribbean cultures. They were also concerned about institutional racism and the number of Black people who die in hospital and in police custody.

3.2.3 Anger

The result of the participants experience of psychiatric in-patient departments in the UK was often anger. Participants became angry when staff wouldn’t listen to them, when staff mistreated them or fellow service users and at the lack of information that they received:

He (nurse) said ‘keep out of it’ and he pushed me and I went flying like that and I thought no, I’m not taking none of this and I got to my feet and I said ‘Look you’ve got to stop, leave her alone’ [...] I ended up getting my boots and clomping him on the head [...] he [...] got suspended for three months. (Participant 7)

Several participants felt permanently scarred by their experience of treatment in an in-patient environment. Several participants stressed that being in hospital made them more unwell:

What I’m trying to say now is the Black community, as soon as we go into hospital we get injections and tablets, I want other ways to be looked at [...] alternative therapy, because speaking from experience myself, I haven’t been in hospital for ten years and that’s because I ended up having counselling, I talked my problems through whereas I could have kept on going in and out, in and out. (Participant 1)

The way I was restrained it linger on me [...] it leaves a lasting effect on you (Participant 8)

3.3 Dual diagnosis/Drug abuse

A number of participants raised concerns about the treatment of those who have a dual diagnosis or whose psychosis is solely drug induced. Concern was expressed by one of the facilitators that one participant had not been offered therapy for their drug problem.
Black people are less likely to be given the option of going to a drying-out clinic to address your intake, whether it's marijuana, crack cocaine, or whatever, because your symptom is of a psychotic nature then you're given the treatment of psychiatric care. (Facilitator A)

There were also issues relating to participants being sectioned for drug problems. As drug-induced psychosis falls outside the scope of the guideline, these issues were not pursued in the focus group.

3.4 Other Issues

A number of other issues arose in the focus groups which included training and staff support, police involvement, the difference between prison and hospital care, the in-patient environment and issues surrounding admission and A&E.

3.4.1. Training/Staff Support

A consistent theme identified by the participants was the need for staff training and support. Participants questioned how staff, who were themselves dis-empowered by the system, would be able to empower service users. They noted that dealing with people who are mentally unwell can be frightening for staff, as well as emotionally taxing. They also noted that healthcare professionals lack training and suggested that this ought to be provided.

What you have is you have nurses, well helpers who come in to assist the nurses and it's nurses that hand out drugs and the assistants, they're not trained in anything, so that needs to be looked at. (Participant 8)

One participant also commented on the need to train agency staff

I think the training should be given to the nurses to handle violent patients and a lot of them haven't got no training, they don't know how to handle it because they're from agencies and what I've noticed is agency workers are mainly people who are not trained. (Participant 8)

There was a suggestion that staff should be forced to have some form of formal counselling to allow them to off-load their own problems and emotions, and so be in a position to help service users:

Make the consultant and the nurse have a day when they come to work but before they start work they come in like an hour or two early and then get some professional counsellors to apply some form of therapy. (Participant 16)

An advocate in Group A echoed these needs and said that she had given up working as a mental health nurse due to the lack of support.

You're expected to empower these clients when you're being dis-empowered yourself. (Participant 22)
Concerns were raised by the facilitator of one of the groups that any training should be monitored to demonstrate its value, as she perceived that a great deal of training in cultural awareness took place to very little effect:

"We've been training staff in cultural awareness now for the last twenty odd years and millions of pounds have been invested in this training but no one actually go and evaluates whether the staff have learnt any skills and changed the way they practice or interact on the ward. (Facilitator A)"

### 3.4.2. Police Involvement

Issues surrounding police involvement and liaison between hospital staff and police officers were discussed. As noted above, it appeared that police officers often took control in the in-patient environment even in seclusion practices and in instigating rapid tranquillisation. Police were also involved in admitting many of the participants (see 3.2.4). Participants stressed that the methods of restraint employed in hospital did not differ from those used by the police. (see above 3.1)

### 3.4.3. The Difference between Prison and Hospital Care

A number of participants had been in both prison and hospital settings. One participant in particular described the differences between the two environments in relation to restrain and seclusion. The participant stressed that restraint was rougher in prison and that you were more likely to get hurt:

"In prison was restraining in a different way, the same way there they twist your hands up and push your hands back and if you ain't crying out in pain they just push you even further. (Participant 23)"

As noted above, other participants argued that the same techniques were used in prison and hospital.

In prison, in one participant’s experience the seclusion room was a cell with a mattress if you’re lucky, while in hospital he had a bed to sleep on:

"If you're lucky at night they might throw in a mattress but most of the time you're just there and nobody even know that you're in. I was somewhere like that for about three days in jail, so when I went into seclusion in hospital I just said it's better than in jail because the bed's there and you've got time to wind down, but still it ain't a nice place to be, isolated from everyone else. (Participant 23)"

### 3.4.4. The In-patient Environment

Several participants expressed concerns about the in-patient environment and stressed that it needed to be more homely:

"It needs to be more like a comfortable environment […] like flowers, pictures, you know, carpet on the wards. (Participant 9)."
They also suggested that better ventilation was needed and that the places needed to be cleaner and smell better.

There’s not enough air a lot of the time because you can’t open the window, because people would jump through them, and then you don’t get much hot water and its smells very badly sometimes. [...] they took the carpet up but it still stank. (Participant 1)

Participants also stressed the need for more activities and related boredom to outbreaks of disturbed behaviour.

The nurses and doctors, they leave you on your own after a couple of days and then you don’t see them morning or night until it’s tablet time [...] because [...] they’re not doing their job properly, patients get into fights. (Participant 19)

They also commented on the need for alarms which pinpointed were an incident was taking place

Sometimes the alarm goes off and they are running around because they don’t know where the incident is taking place [...] they’re so het up [...] It’s terrible actually. [...] you’re got staff running around shouting ‘Where is it? Where is it?’ and everyone else is getting up and distressed but by the time they reach the person to jump on them, and that’s what they do, they jump on them, the staff have wound themselves up to a frenzy. (Participant 2)

3.4.5. Issues Surrounding Admission and A&E

Many participants stated that their route of admission had been via A&E. They recalled that they had only been offered rapid tranquillisation and that refusal had often resulted in police involvement. Many participants stated that they were taken from A&E to a police cell before being admitted to a psychiatric in-patient department:

All I know is that they offered me an injection and I wouldn’t take it so I was taken to the police station instead. [...] All I wanted to know was what they were going to inject me with in the first place and they wouldn’t tell me. (Participant 17)

There were concerns that staff in A&E were not caring and took an extremely authoritative approach to the management of disturbed (violent) behaviour:

Some people are just very heavy-handed, animalistic, they are just power hungry. (Participant 6)

There were also concerns that Black people are immediately given medication, and one participant recounted the tragic consequences of this for a relative:

The whole Black community, when you go to A&E, as soon as you go to A&E they put you on injections, they put you on tablets, yeah. Now I have a recent family member who was in hospital, and he just had an ordinary problem, well he’s obviously Black, when he was admitted to hospital he was automatically given medication, this confused him, affected him and if, the case is being looked into at the moment, it
confused him and so what happened to him is he committed suicide. [...] He was only 18, it didn't have to happen had he had counselling and attention, the attention that he needed. (Participant 8)

Suggestions for improvement

At the end of each focus group, the participants were asked if they had any suggestions for adding to or improving current service provision. While their suggestions could have been coded into one of three themes, they are listed below.

The suggestions made by the participants included:

- Staff who listen
- A cleaner environment
- Changes to the system
- Training and support for staff
- Staff who have knowledge of drugs and how the interventions feel
- The need to recognise that everyone gets angry sometimes

All the issues and themes raised in these focus groups have been fed into the conclusions and inform the recommendations and good practice points outlined below in chapter 5.
Chapter 4: Healthcare Professional Focus Group Findings

4.0. Background

The findings below are derived from data collected from 9 participants. See section 2.9.2.

The findings are categorised into high order and low order themes and are presented below in Table 5.

Table 5: Themes arising from data analysis

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<thead>
<tr>
<th>High Order Themes</th>
<th>Low Order Themes</th>
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<tr>
<td>Black Experience</td>
<td>Stereotyping</td>
</tr>
<tr>
<td></td>
<td>Disrespect/control</td>
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<tr>
<td></td>
<td>Choice/flexibility</td>
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<td></td>
<td>Fear</td>
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<tr>
<td>Frustration</td>
<td>System Problems</td>
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<tr>
<td></td>
<td>Training/Untrained staff</td>
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<td></td>
<td>Monitoring</td>
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<td></td>
<td>In-patient environment</td>
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<td>Concerns outside the scope of this research</td>
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Direct quotations of relevance are included below which support the themes above.

4.1. Black Experience

Black Experience was identified as a high order theme. Four low order themes within Black experience were identified, stereotyping, disrespect/control, choice/flexibility, fear.

Participants were very concerned with how Black adult service users experienced psychiatric in-patient settings. Whilst they acknowledged that some had good experiences, they expressed the belief that most have negative experiences.

While there are a certain percentage of Black patients who will probably say they've got good experiences and positive experiences of the mental health [services ...] what we find is that too large a population or percentage equally say we've had a bad experience. (Participant 31)

They saw this as the product of a number of key elements, namely stereotyping, disrespect and over-controlling attitudes by staff, and lack of choice or flexibility, all of which, in turn, produced fear on the wards, both for service user and for staff.

4.1.1 Stereotyping

The term 'Black' was almost exclusively used to refer to the experience of African Caribbean service users.
Participants stressed that Black service users were often stereotyped as dangerous.

The stereotype is that you’re Black […] particularly a Black, young man […] you are dangerous (Participant 27).

They argued that such stereotyping is self-fulfilling since staff were often primed for violence when they see a Black service user, with the outcome that staff respond defensively/in a hostile manner, which in turn often result in Black service users becoming angry..

It’s a self-fulfilling prophecy isn’t it, where you expect certain behaviour and sometimes you know if you like, enabling that behaviour to rear itself. (Participant 31)

They also stressed than many Black service users expect the wards to be violent.

The experience of many Black people is that you go onto the ward where there is an expectation that there is going to be violence on that ward. (Participant 32).

They felt that some of the misconceptions arose from cultural misunderstanding of a loud and boisterous culture.

The perception that goes along with being Black is that they're violent and they are aggressive and the misconception that necessarily because we might gesticulate quite a lot or we might talk loudly, we might laugh loudly, yeah, the perception that’s linked with that is of a violent and aggressive nature. (Participant 29).

Participants argued that race/cultural awareness training was not the answer.

Race awareness and all that kind of like's a waste of money, and somebody's making a good living out of it. (Participant 32)

Instead they stressed that what was needed was a more individual approach, which treated people as individuals, rather than making over generalisations, which were disrespectful, offered no choice or flexibility and were therefore inherently racist.

Racism, institutional racism, aggressive racism is about making over-generalisations […] Let's do the individual thing and […] take a bit of rigidity out of the system. (Participant 25).

It’s about the individual understanding where the individual’s coming from. (Participant 25).

In relation to this, participants stressed the difference between Black African and African Caribbean communities. On this basis, they challenged the concept of all Black teams for Black service users, which they saw as possibly leading to low status Black workers caring for Black service users

I don't agree with the Black set up teams with Blacks only for Blacks, I actually believe that those teams are flawed. (Participant 27).
Participants saw all these as element underling these racist attitudes in operation within UK psychiatric in-patient departments.

What we’re talking about basically is the dynamics of racist attitudes and beliefs and the interplay that takes place anywhere. (Participant 31).

4.1.2 Disrespect/Control

Participants defined disrespect as being put down and being made to lose face. This was closely connected to staff control over the wards.

Participants saw disrespect as a major contributor to in-patient violence, over and above other concerns, such as environmental factors.

If that person is going to be disrespected or that patient is being disrespected regardless of the food, the decor or whatever it is, they will still lash out because they feel disrespected, they feel oppressed. (Participant 26).

One participant stressed that being treated with disrespect is taken very seriously within the Black community, especially within Black youth culture.

One of the worst things that you can do in that environment is to insult somebody; it is to disrespect somebody. (Participant 27).

Participants stressed that disrespecting Black service users reinforces treatment that they receive everyday. They argued that when this is received from those who are meant to be caring for you, it is especially insulting, and unsurprising if it leads to violence on the part of the service user.

When you’re experiencing disrespect every day of your life and you’re in an environment with nurses who are supposed to care for you and they’re still disrespecting you in your face, it’s not surprising you then become violent. (Participant 31)

Participants argued that this behaviour was linked to racism and to a self-fulfilling prophecy that those you predict to be violent will be violent because of the way that you will treat them subsequent to the prediction.

They will be violent if you predict; they will be violent. (Participant 31)

Participants argued that one of the worse things that you can do to someone is to make them lose face.

What Nelson Mandela has said is the worse thing you can do to somebody is to make them lose face. […] People never forget that […] people never forget instances if they’re made to lose face. (Participant 26)
Participants argued that what was needed was for staff to establish relationships with service users, showing them respect and then putting in place proper care plans,

[It’s] about getting a relationship, showing them some sort of common decency, getting proper care plans (Participant 32)

Participants saw staff disrespect of Black service users as a factor within staff power and control. They stressed that staff need to negotiate rather than impose.

You need to be more negotiating, respectful (Participant 26)

They also argued that staff power needed to be reduced.

Reduce some of that power (Participant 31)

At the same time participants argued that there was a racist imbalance of control, even on wards were the majority of staff were Black. They argued that although many of the lower level staff were Black, those with the real power tended to be White.

Although you have a large majority of Black staff, at the helm, somebody who is actually in charge, you know tends to be (Participant 30).

They’re White. (Participant 31)

Absolutely. (Participant 30)

4.1.3 Choice/Flexibility

Integrated with the theme of disrespect/control was that of choice. Participants argued that nursing staff were not always prepared to relinquish power and give a service user choice as they get better.

You’re not thinking about this person as human who has just been through a terrible experience, who is probably very flat due to having lots of medication, probably far too much and is now coming back and wanting to behave normally, wanting to have choices. (Participant 31)

Participants argue that lack of choice leads to violence, and that there is a need for a change in culture, so that healthcare professionals do not have all the power, and make all the choices.

[It’s] about allowing people to make choices and having autonomy about things if they’re not in secure settings or whatever, and allowing people to have autonomy [...] as much as we can [...]. There is a tendency to be prescriptive about everything. (Participant 29)

Participants also stressed the need for flexibility within the system. One particular issue was staying up at night.

We know that many sort of young Blacks stay up most of the night and sleep in during the day but in hospital they want to stay up during the night but you’re not
allowed to because the ward staff say you have to go to bed and they say you have to get up at this sort of time. (Participant 28).

While participants recognised that while service users must be given choice, at the same time, they acknowledged that staff must be protected. They suggest that the key to this was being able to take stock of the risk and know when to set limits and impose restrictions.

The risk has to come from predictors that aren’t just about physical appearance. (Participant 28)

The new buzzword is responsible risk-taking; you should take risks but make sure you are doing it responsibly. (Participant 26)

If you can’t deal with it on your own, then make sure you get other people in, but really not waiting until that end point, where it is imminent. (Participant 28)

4.1.4 Fear

One participant stressed that fear of young Black men is a real problem to which there are no easy solutions.

One of the things that I’m grappling with is this issue of fear and where that comes from and how people acknowledge that they feel this fear when they come into contact or have some interaction with Black, young men in particular. (Participant 31).

Other participants agreed that this is a real problem within the interaction between Black service users and White staff.

We’re talking about fear that exists in that interaction between Black and White people and how do staff then understand the genesis of that fear, how that fear is then perpetuated and how that fear is used in the interaction between themselves and patients. (Participant 31)

As well as White people being afraid of Black people by White people, participants argued that many Africans are afraid of African Caribbean people.

Some Nigerians are scared of Jamaicans, you know. (Participant 31)

Participants noted that there were further problems with wards being staffed by Africans but populated by African Caribbean people. They also noted that there are differences between Black people born overseas and those born in this country.

I’ve worked in environments before where there was actually a lot of conflict between Blacks. (Participant 26)

Yes I have. (Participant 27.

Between Blacks from Africa and Blacks from the Caribbean and Blacks who are born in this country and it’s to do with different aspirations. (Participant 26)
Participants argue that these differences need to be acknowledged and that the solution did not lie in simply populating wards containing predominantly Black service users with Black staff. Rather each service user needed to be treated like an individual.

This parachuting of Blacks, it’s part of all this wrongness and we need to be de-emphasising these things and saying, in terms of looking after me, it doesn’t matter what colour they are, it doesn’t matter what colour you are, it’s about the individual understanding where the individual is coming from. (Participant 25)

At the same time they stressed that colour was an issue that needed to be treated seriously.

If you don’t see my colour then you don’t see me. (Participant 30)

A further element of fear was that experienced by the service user and the need for staff to communicate in a way which takes such fear into consideration.

What is important is the patient who is scared and you communicated with the patient and you try and strike a balance. (Participant 24)

Apart from racist fear, participants also argued that staff have a general fear of service users.

One interesting dynamic is that one of; staff fear the patients more than the patients fear each other. (Participant 26)

Another type of fear that participants identified was staff fear, often of being too authoritarian, which led to situations getting out of control and more authoritarian interventions being implemented.

I’m sometimes concerned that we put […] so much, kind of, awareness training, that, in fact, people who supposedly can predict violence are so right on, they don’t want to take any kind of remedial action […] in danger of them being see as […] being draconian. (Participant 32)

Participants suggested that this fear also extended into a need to control service users, so that when service users start to get better, staff think that they are relapsing.

I know a lot of cases […] where for instance you will have a situation where a Black patient is becoming much better and he’s beginning to smile, he’s beginning to express himself and probably talk a bit more […] a lot of professionals will see this as the person becoming unwell again. (Participant 30)

Participants also stressed the need for a culture of openness amongst staff, so that if a staff member finds a service user particularly frightening they can pass them over to another staff member, rather than opting for, perhaps unnecessary, authoritarian measures.

If you were to say to your colleagues that I’m really, really frightened of this person, you know, I’m not necessarily the best person to be engaged with that person just now, you know, that could diffuse situations quite a bit. (Participant 28)
An outcomes of fear which participants noted in relation to Black service users was the use of force and authoritarian interventions

I think generally nurses are far too eager to jump on Black patients in numbers and use excessive force on them and it goes back to a lot of what we're already said about fear and so on. (Participant 31)

4.2 Frustration

Frustration was also identified as a high order theme. Five low order themes within Frustration were identified, system problems, untrained staff, monitoring, in-patient environment and then a number of concerns which fell outside the scope of this research.

Participants expressed a great deal of frustration with current adult psychiatric in-patient services in the UK. They felt that the system often works against Black service users, that the existence of many untrained staff exacerbate problems and lead to dangerous practice, that monitoring of practice is desperately needed, and that the in-patient environment needs to be made friendly for Black service users.

4.2.1 System Problems

The participants suggested that many of the problems encountered by service users in relation to the short-term management of violence were inherent within the system.

It was argued that you were far more likely to be restrained if you are Black

We know from whatever little data is available that Black patients are more likely to be restrained, secluded, medicated and so on, so that the whole process of heavy-handed management is an issue for Black patients. (Participant 31)

Participants noted that sometimes staff react to violence when the situation has passed. Often, if a service user throws some furniture when no one is around, endangering no one.

It's five minutes later. (Participant 26)

[Staff] wait for the team to come along and then they all go in when this person they want is sitting there. (Participant 28)

Participants argued that once an authoritarian approach has been taken the cycle of restraint, medication, seclusion automatically follows.

Then you have the cycle, you know restraint, medication, and quite often seclusion, even now it follows that. [...] You've got the person down on the floor restrained. What are you going to do with them next? Oh yes, well let's give them some medication, but they can't stay there all the time. Oh yes, put them in seclusion. (Participant 28)

Participants argued that the cycle is unnecessary. One intervention would often do. What is more, they suggest that service users are given an unnecessary amount of drugs, both an anti-
psychotic and benzodiazepine, when one would do, or it would be possible to wait before giving the second drug.

   Everybody goes for restraint, medication, seclusion; any of those interventions could work on themselves, on their own. (Participant 26)

   People not only give an antipsychotic, they give a benzodiazepine rather than the benzodiazepine and wait and then give the other thing. (Participant 26)

The participants note that there is a pressure to act in this more authoritarian way.

   If you didn’t give the two things, I mean people think you are weak or something. (Participant 26)

   Soft, sounds soft, right? (Participant 29)

Participants argued, however, that if interventions, such as Seclusion, were not a possibility, alternatives would be found.

   If you say you’re not going to have seclusion, people will look for alternative ways of managing violence. (Participant 28)

This was reinforced by references to units which did not have seclusion rooms, and in particular, in reference to a unit in which the seclusion room had to be closed for a time.

   The seclusion room was closed for something like twelve weeks….during that time they found the alternatives….by the time it reopened seclusion was hardly used because people have found other things to do. (Participant 26)

4.2.2 Training/Untrained staff

The participants raised concerns that there was no clear guidance as to the number of staff needed for restraint and participants were themselves unclear whether the norm was five-person or three-person restraint teams.

   From my understanding the training is that it’s generally a three-man team. (Participant 31)

However, one participant stressed that having five person teams was not heavy-handed if it was a safety measure.

   I used to think that it is heavy-handed when I’d seen five people launching onto one patient and pinning them to the ground until I actually understood what the restraint was about and the way that one of those people is controlling the head, one person is on either arm and [...] the numbers were actually there from the safety point-a-view. (Participant 29)

Participants argued that it was essential that staff should be trained not only in physical skills, but also in theoretical skills and in how to de-escalate a violent situation.
You should never be training people just in the physical skills required to restrain people. (Participant 28)

Absolutely. (Participant 31)

[...] equal weight must be given to the issues, the theoretical aspects of managing someone and the issues of how to de-escalate someone, how to recognise what is happening in front of you and to take action before it reaches the point where you have to restrain and I don't think that enough is being done on that. (Participant 28)

Participants also stressed that nurses need to be trained in the use of resuscitation equipment and for that equipment to be available and a doctor to also be available.

One of the issues in terms of training I would like to add is, the resuscitation, dealing with emergency situations, because every single death that has occurred its always a factor that nurses do not seem to be able to resuscitate appropriately, they don't know how to use the equipment, the equipment is not available, there's no doctor on site. (Participant 31)

Of particular concern to participants, was the use of untrained staff for the short-term management of disturbed behaviour within psychiatric in-patient settings.

The reality, as I understand it, is that untrained staff are being placed [...] in places like Broadmoor with dangerous patients. (Participant 27)

Around the issues of best practice, participants wanted to see mandatory requirements in law relating to the various interventions used to for the short-term management of disturbed behaviour.

The Mental Health Commission needs to write in their Code of Practice; kind of, something about when you can use various interventions, for what. (Participant 26)

4.2.3 Monitoring

Participants stressed the need for monitoring. They argued that a monitoring committee should be set up, with a number of Black participants to agree on minimum standards of care and practice.

It doesn't need to be Blacks only, but it certainly needs to have probably four or five people who can, three minimum, going to places and actually agreeing somewhere what are the minimum requirements. [...] I think that monitoring things is absolutely critical. (Participant 27)

In relation to this it was also argued that there was a need for a central register to record all deaths in psychiatric in-patient departments.

We still don't know five years down the road from [David Bennett's] death, how many more people have died in that situation. So there's no monitoring going on. (Participant 31)
4.2.4 In-patient environment

Participants stressed the need for the right environment. They argued that there should be some acknowledgement of Black culture on psychiatric in-patient wards.

You have a ward with a group of Black patients, they want rice and peas and they cannot get rice and peas, so we might see it as very mundane and very basic, but that is actually quite significant to the individual. (Participant 28)

They stressed, however, that this must be done in a relevant way, not to the exclusion of any cultural and ethnic group.

You know, for example, Martin Luther King, I don’t associate what he stood for with the Black population within psychiatric hospitals. (Participant 30)

What I’m actually getting here is striking a balance, not one extreme or the other. (Participant 30)

In relation to food, they stressed that it must be cooked by people who knew how to make it!

On the general ward we were having a lot of Asian patients on the ward and a way of making them feel more at home was to have an Asian menu but the Asian menu was cooked by an English [cook]... and we found on the wards that the patients would not, the Asian patients would not order the Asian meal because it was not cooked the way they would cook at home. (Participant 29)

Participants also stressed that often buildings were badly designed and healthcare professionals were waiting for resources to change the environment.

Most of the buildings are adapted […] hospitals have not enough money to invest in those facilities. (Participant 24)

They argued that the architecture often prevented de-escalation, and didn’t allow service users to be removed to a place other than a seclusion room for the purpose of de-escalation.

There’s not enough space. (Participant 24)

People will not use de-escalation; they would not use some of these non-intrusive interventions until you change the architecture of these places (Participant 26)

Above all else, participants stated the need for patient-centred cared. As noted earlier, it was discussed in relation to bed times and wake up times.

If you’ve got a patient centred care approach and if people have got care plans […] the person centred approach shouldn’t allow that it’s 7 O’clock so everybody get up.’ (Participant 32)

As mentioned above, this was also discussed in more general terms,
Let’s do the individual thing and just changing the culture and take a bit of rigidity out of the system and having a much more flexible system [...] a more holistic approach.’ (participant 25)

Participants also felt concerned the patient mix was not always appropriate. They expressed concern that patients with different diagnosis, particularly those with personality disorder, were mixed together on psychiatric wards.

There is a fundamental error in judgment and psychiatric management and allocation of resources, having all these patients mixed up and I don’t mean all these patients by race, I mean by category. (Participant 27)

We do have personality disordered individuals alongside those who so called need asylum and that these factors interacting do cause violence. (Participant 24)

All the issues and themes raised in this focus groups have been fed into the conclusions and inform the recommendations and good practice points outlined below in chapter 5.

4.2.5 Concerns outside the scope of this research

Many of the participants expressed dissatisfaction that the guideline did not cover preventative measures beyond the short-term management of violence. They argued that many of the problems that arise amongst the Black community within psychiatric in-patient settings are the products of social factors, such as poverty, dysfunctional families, being in care and poor schooling which result in conduct disorders, leading people into pathways of violence. They insisted that if violence in psychiatric in-patient departments is to be reduced, then real efforts must be made to tackle these issues.

We need to probably be looking at prevention, or what comes before those things [i.e. the interventions for the short-term management of violence]. (Participant 30)

There is no emphasis on prevention and cause. (Participant 27)

We’re saying that we need to be looking at prevention rather than, you know, how to manage, you know, disturbance. (Participant 30)

We feel this is a drop in the ocean. (Participant 28)

One participant, in particular, felt that diagnoses were biased against Black service users. The participant stressed that the majority of service users who are classified as dangerous are Black and that there is an over-representation of Black service users within all psychiatric in-patient settings. He also argued that there is a worrying relationship between being sectioned and being Black. Other participants signalled their agreement non-verbally.

In general terms from what we’ve been saying today we all agree that the over-representation of Black patients within psychiatric wards, psychiatric locked wards, medium secure units, the whole range of psychiatric in-patient services is something that we are concerned about. (Participant 27)

Even to get on a ward with a section of the Mental Health Act is a Black phenomenon now within our society. (Participant 27)
Participants expressed fundamental concerns about the use of diagnoses in the UK today.

It goes back to the diagnosis [...] that's about diagnosis because it's easier to diagnose schizophrenia as opposed to PD and offer proper PD services (Participant 32)

Since these issues fall outside the scope of this report and require work which cannot be done within the resources of this study none of the issues discussed in the section above are addressed in the conclusions and recommendations for this report. In order to tackle these issues properly further systemic reviewing and research would be required. This is no way is meant to detract from the validity of these statements.

- **Suggestions for improvement**

As many of the issues above focus directly on issues for improvement, participants were not asked for further suggestions for improvement.
Chapter 5: Conclusions and Recommendations

5.1. Conclusions

There is no doubt that the current government is concerned with and committed to reducing violence throughout the NHS. The following recommendations and good practice points have been generated to assist this process. They draw on five different sources: the focus groups described in this report, the input of ‘expert patients’ in the guideline development group meetings, the expertise of the guideline development group, evidence generated by the systematic review and recommendations found in recent reports and guidelines. All the main themes identified in the focus groups have been used to generate recommendations and good practice points.

In generating these recommendations and good practice points it became apparent that many of the issues raised in the focus groups (such as the need to be listened to or for debriefing) were applicable to all service users. A decision was therefore taken to stress the needs of Black and Minority Ethnic (BME) service users, while also attempting to safeguard the rights of all service users.

It is also important to note that the recommendations and good practice points below form part of a larger whole. The full recommendations and good practice points for this guideline can be found in the full guideline and also in the NICE version. Many of the other recommendations relate to the specific interventions that as used for the short-term management of disturbed (violent) behaviour and how these should be carried out in the event that they are needed. The recommendations and good practice points below should be considered in relation to the overall guidance given on the short-term management of disturbed (violent) behaviour in psychiatric in-patient settings.

5.2 Consensus process

Due to a dearth of good quality evidence, many of the recommendations in this guideline were arrived at solely 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% unless a significant group within the GDG all voted against a recommendation - e.g. if all the psychiatrists voted against a recommendation, if this occurred, even though 80% agreement was achieved, consensus was not considered to have been reached.

For each recommendation and good practice point, prior to voting a discussion took place and modifications were made as necessary. The rewording 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 re-voting took place. After debate on some areas, consensus was achieved for all recommendations submitted for first stage consultation.

5.3 Recommendations and Good Practice Points

1.4 Working with Service Users (from Diverse Backgrounds)

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 violence 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 which need to be taken into account when using the interventions discussed in this guideline.

The following recommendations and good practice points focus specifically on the needs that arise from diversity (cultural, social, spiritual and gender-related needs) and physical needs in the context of the short-term management of disturbed (violent) behaviour since it is important that service users should not be treated less favourably on the basis of their gender, race, diagnosis, religious/spiritual practices, or disability. However, many of these recommendations and good practice points apply to all service users.

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 is and may happen to them in the event that they are violent will help prevent unnecessary aggravation.

Recommendations

1.4.1 Service users must have access to audio-visual information about the following in their preferred language:
- which staff member has been assigned to them and how and when they can be contacted.
- why they have been admitted (and if on a section, why they have been sectioned, type of section, maximum length of detention, right to 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 aggressive/violent.

(this information needs to be provided at each admission) (D)

1.4.2 Where possible (in the form of an advance directive) intervention strategies for the management of disturbed/violent behaviour should be negotiated with all service users at the point of admission to in-patient facilities. These strategies must be documented in the service users care plan and healthcare records. Subject to agreement from the service user, a copy should also be given to their carer. (D)
1.4.3 Following any intervention for the short-term management of disturbed (violent) behaviour, every effort must be made to establish whether the service user understands why this has happened. These efforts must be documented in the service user’s notes. (D)

1.4.4 All Trusts must have a policy for preventing and dealing with all forms of harassment and abuse. Notification to the effect should be disseminated to all staff and displayed prominently in all clinical and public areas. (D)

1.4.5 All service users, regardless of culture, gender, diagnosis, sexuality or religious/spiritual beliefs must be treated with dignity and respect. (D)

**Good Practice Points**

1.4.6 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. GPP(D)

1.4.7 An effective and fair complaints procedure must be put in place. GPP(D)

1.4.8 In the event of any form of abuse, the matter should be dealt with by nursing staff as soon as is practicable. GPP(D)

1.4.9 Where at all possible, service users should have a choice of key worker. GPP(D)

1.4.10 During the administration or supply of medicines to service users confidentiality must be ensured. GPP(D)

1.4.11 Prescribers need to be available and responsive to requests for medication review. GPP(D)

1.4.12 The physical needs of the service user must be assessed on admission and then regularly re-assessed. The care plan should reflect physical needs. GPP(D)

1.4.13 Special provision must be made for pregnant women in the event that interventions of the short-term management of violence are needed. These should be recorded in the service user’s care plan. GPP(D)

**Black and Minority Ethnic Service Users**

There is growing concern that black service users, particularly those from African Caribbean communities are sometimes adversely affected by negative stereotyping in which they are perceived as more dangerous than other service users, which causes staff to use interventions such as rapid tranquillisation, restraint or seclusion before less coercive measures have been tried.

**Recommendation**

1.4.14 Trusts must identify a board member to take responsibility for diversity and ethnic issues. Responsibilities must include the nature and adequacy of service provision in relation to the short-term management of disturbed (violent) behaviour, training on cultural difference, monitoring service usage by ethnicity, consultation with local Black and minority ethnic groups and achieving targets set in advance on a year to year basis. (D)
Service users with Physical Disabilities

Good Practice Points

1.4.15 Each Trust should have a policy which outlines the procedures for dealing with service user who have disabilities, including those with physical or sensory impairment. GPP(D)

1.4.16 Individual care plans should detail staff responsibilities for de-escalating, use of rapid tranquillisation, restraining and seclusion of service users who have disabilities, including those with physical or sensory impairment. GPP(D)

Service users with HIV or other sexually transmitted diseases

Good Practice Points

Policy

1.4.17 Trusts must have policies in place, developed in conjunction with the trust infection control officer which 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 my endanger others GPP(D)

1.4.18 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 should be sought. GPP(D)

Confidentiality Issues

1.4.19

• Whilst patient confidentiality is a right, there are certain circumstances in which this confidentiality 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 manner which puts others at risk. GPP(D)
  - Legal and ethical advice must be sought in these circumstances.

1.4.20 If a staff member has sustained any injury during restraint where blood has been spilt or the skin has been broken or there has been direct contact with bodily fluids, the staff member must act in accordance with local infection control policy. GPP(D)

5.4 Suggestions for Future Research

The following research recommendations are part of a number of recommendation found in the full guideline and NICE version of the guideline. They should be viewed in relation to the other research recommendations found in these documents, which also related to issues concerned with the short-term management of disturbed (violent) behaviour in psychiatric in-patient settings.

• Qualitative and survey research is needed to examine service users’ (including Black and minority ethnic groups) views on the precursors of aggression, aggravating factors. This should also include service users' views on observation, de-escalation techniques
and techniques used to manage short-term violence such as rapid tranquillisation, restraint and seclusion.

- Clinical trials and innovative longitudinal naturalist research should be conducted in settings that reflect current clinical practice in the UK, among large representative samples of adult psychiatric inpatients (including Black and minority ethnic groups) that investigate the utility, acceptability and safety of available medicines and their dosages for rapid tranquillisation and PRN regimes (including atypical and antipsychotics), employing larger samples.

- 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.
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Guidelines and Reports consulted and Studies Appraised

Guidelines and Reports Consulted


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Studies Appraised

*Included*


**Excluded**


### Appendix 1: Ethnicity Review Evidence Tables - Included Studies

<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chen et al (1991)</td>
<td>Case Control/ Case Control/ Settings Nottingham Population: Consecutive series of N=40 Afro-Caribbean and N=40 Non-Caribbean service users matched for age sex and diagnosis schizophrenia</td>
<td>To investigate whether there are any differences between Afro-Caribbean and Non-Caribbean service users with regard to: prescribed dosages of neuroleptic medication during the acute phase of the illness the proportion commenced on depot maintenance therapy after a first episode of psychosis The proportion admitted to hospital, the duration of admission and the use of compulsory procedures The degree of behavioural disturbance in the acute stage of illness.</td>
<td>Information obtained from medical records: Differences in receiving Neuroleptic medication Relationship of medication to behavioural disturbance Episodes of disturbance (violence and bizarre behaviour) Compulsory Detention</td>
<td>More Afro Caribbeans than non-Caribbeans were treated with dosages above 2000mg of chlorpromazine equivalent ($\chi^2=4.98 \ p&lt;0.03$) (not adjusted for confounding e.g. diagnosis) 33% (N=24) disturbed Afro-Caribbean service users received a maximum dosage of above 2000mg whereas none of the 12 disturbed non-Caribbean service users received this dosage. ($p&lt;0.03$, Fishers’s exact probability test) 24 Afro-Caribbeans and 12 non-Caribbeans had one or more disturbed episodes ($\chi^2=6.1 \ p&lt;0.01$) 15 Afro-Caribbeans and 5 Non-Caribbeans had two or more episodes ($\chi^2=5.4 \ p=0.02$). Time period for episodes not stated. 20 Afro-Caribbean service users were detained under the Mental Health Act during admission compared with 9 non-Caribbean ($\chi^2=5.4, \ p&lt;0.02$)</td>
</tr>
<tr>
<td>Country: UK</td>
<td>Evidence Level: IV</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reviewers Comments**
- This appeared to be a matched case control study though was not described as such.
- Data was obtained from chart records.
- Prescribing practice is not directly affected by simple ethnic stereotypes. However, some findings provide limited evidence to support concern about over prescribing of some Afro-Caribbean service users.
<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
</table>
| Choca et al, 1990 | Retrospective Chart review    | To examine how successful the Millon Clinical Multiaxial Inventory (MCMI) test was in producing a culturally fair test. | Clinical fairness of diagnostic tool MCMI to predict psychopathology. (This personality instrument has weighted scores to provide different norms for black, white and Hispanic individuals to address potential racial bias). Items on MCMI were compared before and after grouping into matched pairs (N=209) of diagnostic categories according to DSM-111 (The Diagnostic and Statistical Manual of Mental Disorders (3rd ed.) of the American Psychiatric Association) on discharge (7 groupings substance abuse, anxiety, affective, character, psychotic, organic and ‘other’ disorders) | • Operating characteristics of white and black subjects for the different diagnostic categories (See table below)  
• Results of matched pairs, 45 items on the MCMI showed significant difference as opposed to an expected 9 items if the difference between the two groups was due to chance.  
• Multivariate analysis of the 20 scales including antisocial (<.01) and passive-aggressive/explosive (ns) showed blacks scoring significantly differently from whites on 9 scales (<.05).  
• To evaluate the structure of the test factor analysis was conducted-3 factor structure measuring a) Maladjustment, b) Extroverted acting out, c) Psychosis  
• The factor congruence was .98, .98, .97 respectively indicating high similarity. The factor analysis indicates that the test is measuring similar factors in both groups. Therefore support is maintained for continued use of the test for blacks with some adjustment at item and scale level. Confounding and potential limitations are discussed thoroughly. |

**Reviewers Comments**
- Forms completed over 7 year period and may vary greatly in completion of data.
- Veterans are a specific group of individuals with military experience and therefore are a unique population.

Operating characteristics of white and black subjects for the different diagnostic categories:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Personality disorder</th>
<th>Anxiety Disorder</th>
<th>Affective Disorders</th>
<th>Substance Abuse</th>
<th>Psychotic Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whites</td>
<td>56%</td>
<td>7%</td>
<td>35%</td>
<td>47%</td>
<td>32%</td>
</tr>
<tr>
<td>Blacks</td>
<td>52%</td>
<td>3%</td>
<td>20%</td>
<td>55%</td>
<td>56%</td>
</tr>
<tr>
<td>Overall predictive power</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whites</td>
<td>.55</td>
<td>.21</td>
<td>.43</td>
<td>.67</td>
<td>54</td>
</tr>
<tr>
<td>Blacks</td>
<td>.52</td>
<td>.15</td>
<td>.36</td>
<td>.65</td>
<td>.57</td>
</tr>
<tr>
<td>Chi-square</td>
<td>.99</td>
<td>10.83</td>
<td>18.93</td>
<td>17.52</td>
<td>57.45</td>
</tr>
<tr>
<td>Significance</td>
<td>Ns</td>
<td>.01</td>
<td>&lt;.01</td>
<td>&lt;.01</td>
<td>&lt;.01</td>
</tr>
</tbody>
</table>

Note: Prevalence refers to the percentage of members of that race who were diagnosed as having the disorder. Sensitivity refers to the probability that the MCMI scale is elevated, given the presence of the disorder. Specificity refers to the probability that the MCMI scale is not elevated, given the absence of the disorder. Positive predictive power shows true positives; it indicates the probability that the presence of an MCMI scale elevation accurately predicts the presence of a disorder. Negative predictive power shows true negatives; it indicates the probability that the absence of an MCMI scale elevation accurately predicts the absence of a disorder. Overall diagnostic power shows proportion of cases correctly classified.
<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chu et al (1986)</td>
<td>Prospective Single sample</td>
<td>To compare the differences in psychopathology between black and white schizophrenics</td>
<td>Psychopathology measured by BPRS scale (Brief Psychiatric Rating Scale) and the Ill- Keskiner Psychopathology Rating Scale. Differences measured between items on scales via Melvin Thorner structured interviews with 4 white and 1 black researchers.</td>
<td>Black and white differences adjusted for sex due to potential confounding as ratio of male and female varied between black and white. Black male schizophrenics exhibited asocial behaviour more frequently than white male schizophrenics. [Black 58% White 36% p&lt; .02.] All other results for black males vs. white males were non-significant including items for angry and outbursts. Results for females were more likely to be different black vs. white.</td>
</tr>
</tbody>
</table>

**Reviewers Comments**

Authors note sex ratio in black service users different from white and adjusted for in analysis.

Study does not address the issue of possible observer bias in the test by researchers as blinding of outcome assessors is not stated.
**Source**: Coid et al (2000)

**Country**: UK (England and Wales)

**Funding**: Dept. of Health

**Evidence Level**: III

**Study Design**
- Survey Settings & Population: N=3155 All ethnic first admissions from 1988-1994 to all maximum and medium secure forensic services in 7 of 14 Regional Health authorities. Included urban and rural areas, excluded those no fixed abode or if address inaccurate.

**Aims of Study**
- To estimate population-based prevalence rates of treated mental disorders in different ethnic groups compared to white service users using logistic regression to adjust for independent variables, age, gender, marital status, social deprivation, primary diagnosis of personality disorder, and then stratified by ethnicity according to criminal behaviour and behavioural disorder leading to admission, previous criminal history, previous institutional history, the source of referral for admission, and lifetime diagnoses.
- A sub group of 569 (21%) admitted for violent or difficult behaviour were compared by ethnic group on specific violent behaviour e.g. fire setting, sexual aggression. No differences found. Results not reported.

**Outcome Measures**
- case information taken from notes obtained on visits to the hospitals.
- black and Asian ethnic groups were compared to white service users using logistic regression to adjust for independent variables, age, gender, marital status, social deprivation, primary diagnosis of personality disorder, and then stratified by ethnicity according to criminal behaviour and behavioural disorder leading to admission, previous criminal history, previous institutional history, the source of referral for admission, and lifetime diagnoses.

**Results**
- Losses=18 no data, 164 (5%) no fixed abode, 3 ethnicity not coded.
- Jarman Under Privileged Area Scores were used using postal code to score individual cases into UPA Deciles. The prevalence rate denominator for the population was adjusted for under enumeration of young males in the census from which the population statistic was obtained as they are of most interest to this study.
- Demographic ethnic:
  - Black=21%, White=74%, Asian=3%, Other=2%.
  - There were 5.6 times as many black males admitted than white males, and nearly 3 times as many black females as white females. 12 times as many black males and 9 times more black females were admitted than Asians.
  - See table below for most relevant results.

**Reviewers Comments**
Author's note that these analyses under estimate the prevalence of treated mentally disordered offenders and represents the most serious cases only. Areas vary in the ability to provide locked wards i.e. low security. Selected population though ethnic differences have been previously reported in this population.

**Comparison of black ethnic group with white ethnic group**

<table>
<thead>
<tr>
<th>Variable</th>
<th>White</th>
<th>Black</th>
<th>OR* (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>17%</td>
<td>9%</td>
<td>0.48 (0.36, 0.65)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>UPA Deciles 9+10</td>
<td>54%</td>
<td>88%</td>
<td>6.31 (4.88, 8.19)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Non crime admission</td>
<td>21%</td>
<td>16%</td>
<td>0.73 (0.58, 0.92)</td>
<td>0.008</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>20%</td>
<td>5%</td>
<td>0.22 (0.15, 0.31)</td>
<td></td>
</tr>
<tr>
<td>Index Offence-Murder grievous bodily harm</td>
<td>1.12 (0.89, 1.43)</td>
<td>(Adjusted)</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Actual bodily harm, threats</td>
<td>1.38 (1.10, 1.73)</td>
<td>(Adjusted)</td>
<td>0.005</td>
<td></td>
</tr>
<tr>
<td>Previous convictions Violence</td>
<td>1.73 (1.44, 2.08)</td>
<td>(Adjusted)</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>Effects of lifetime diagnosis</td>
<td>Schizophrenia</td>
<td>1.83 (1.48, 2.26)</td>
<td>(Adjusted)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Unspecified diagnosis</td>
<td>2.41 (1.34, 4.34)</td>
<td>(Adjusted)</td>
<td>0.003</td>
<td></td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>0.23 (0.13, 0.43)</td>
<td>(Adjusted)</td>
<td>&lt;0.001</td>
<td></td>
</tr>
</tbody>
</table>
Commander et al (1997a)

**Country:** UK

**Evidence Level:** II

<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results (1st Sample)</th>
</tr>
</thead>
</table>
| Commander et al (1997a) | Two single sample prospective cohort 9 month-13 months recruitment Settings Four inpatient facilities in North Birmingham Population: Consecutive Psychiatric admissions and discharged inpatients drawn from Asian, White and Black (N=40 per group) communities Severe mental disorder aged between 16-60 no previous hospital in last month, present admission 7 days | To provide an understanding of the pathway into in-patient psychiatric care, the treatment received during the time spent in hospital and needs for care three months after discharge by people from black and ethnic minorities and their level of satisfaction | • demographic information including history of violence, criminal activity and imprisonment  
• pathways to care-to identify contacts, including police involvement  
• insight  
• information on admission procedures  
• satisfaction  
• social behaviour-Social behaviour scale (SBS) & mental state Krawiecka and Goldberg scale (K&G) From interview and medical records (interviews conducted by four female interviewers, one Asian, two black and one white.) | • Demographics: Mainly uniform across ethnic groups. More males in Asian group. More black service users lived on their own. Majority of blacks and whites were single whereas half of the Asians were married  
• Blacks were less likely to be receiving care from a health care professional prior to admission. Blacks had a more averse pathway nearly two thirds had some police involvement. Asians also had a high level of involvement with the police.  
• No differences between groups on self reported history of violence.  
• Satisfaction with inpatient treatment Asians (75%), Whites (60%) and blacks (39%) were satisfied ($\chi^2=13.3$ df=4 $p<0.01$).  
• Risk behaviour: blacks scored significantly higher on incidence of violence to staff (p=0.02), and general public (p=0.01). Asians and blacks were more a risk to others (35%, 27%) than whites (15%).  
• Blacks(68%) and Asians (58%) more likely than whites (29%) to be detained ($\chi^2$ 12.4 df=2 $p<0.002$).  
• SBS-Blacks scored significantly higher on measures of violence or threats or hostility and inappropriate sexual behaviour ($\chi^2=8.1$ p=0.05) and more likely to be rated with incoherent speech ($\chi^2=7.8$ p=0.02). Whites more significantly depressed with panic attacks ($\chi^2=14.5$ p=0.0007). Asians were more likely to be rated as having socially unacceptable habits or manners ($\chi^2=8.0$ p=0.02).  
• Krawiecka &Goldberg Scale- whites were more depressed($\chi^2=8.8$ p=0.01) and blacks were more likely to have elevated mood ($\chi^2$ 6.6 p=0.04). This suggests either difference in presentation of psychopathology or possibly assessment of psychopathology. |

**Reviewers Comments**

Pilot study had been conducted with adjustments made to schedules.
### Commander et al (1997b)

**Country:** UK  
**Evidence Level:** II

<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results (2nd Sample)</th>
</tr>
</thead>
</table>
| Commander et al (1997b) | Two single sample prospective cohort 9 month-13months recruitment Settings Four inpatient facilities in North Birmingham Population: Consecutive Psychiatric admissions and discharged inpatients drawn from Asian, White and Black (N=40 per group) communities Severe mental disorder aged between 16-60 admission had lasted less than 6 months | To provide a comprehensive understanding of the pathway into in-patient psychiatric care, the treatment received during the time spent in hospital and needs for care three months after discharge by people from black and ethnic minorities and their level of satisfaction | • inpatient experiences (inpatient service questionnaire-reliability and validity of scale required)  
• satisfaction  
• (conducted by four female interviewers, one Asian, two black and one white.  
• social behaviour-Social behaviour scale (SBS) & mental state Krawiecka and Goldberg scale (K&G) | • Demographics similar except Whites were more likely to be younger and female.  
• Similar to 1st sample.  
• Violence in past year-Violence to family more likely to be Asians ($\chi^2=7.3 \ p=0.03$). Violence to staff more likely to be black ($\chi^2=8.6 \ p=0.01$). Blacks were also reported to be more violent towards other people whilst inpatients 35% compared with 13% Asians and 10% Whites. ($\chi^2=9.8 \ df=2 \ p=0.007$).  
• Blacks were also significantly more likely than either Asians or whites to be detained under the mental health Act and be confined to the ward.  
• Medication was non-significant.  
• Researchers had numerous difficulties throughout the study in getting staff to complete schedules. Described as chaotic and incomplete. Scales were not repeated. |

**Reviewers Comments**

Some service users continued into second sample others were new to the study.
<table>
<thead>
<tr>
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<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
</table>
| Davies et al (1996) | Cross-sectional annual prevalence study (1991)    | To compare the risk of detention under the mental Health Act 1983 in a representative group of people with psychotic disorders from different ethnic groups | • for psychosis ICD 10 classification.  
• compulsory admissions collected from Mental Health Act Offices.  
• ethnic group collected from case notes based on classification of the Office of Population Censuses and Surveys.  
• half of all cases were random selected to self-identify ethnic group to validate the case record category. | • Annual period prevalence 1991  
• Demographic details for both black and white participants did not differ except black were younger: mean age 47.4=white, 35.3=black Caribbean, 31.2=black African.  
• Detention under the mental health Act. Reference group white  
  • Black Caribbean OR 3.67 [2.07, 6.50]  
  • Black African     OR 2.88 [ 1.04, 7.95]  
  • (OR adjusted for age)  
• Black Caribbean participants were over three times more likely, and black African participants were nearly three times more likely to be detained under the Mental Health Act than white participants. They also were detained more often under sections 2,3, and 136 of the Act. They were also more likely to be admitted to psychiatric intensive care facility or prison. |

**Country: UK**  

**Evidence Level: III**  

<table>
<thead>
<tr>
<th>Country: UK</th>
<th>Evidence Level: III</th>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
</table>
| UK          | III                 | Davies et al (1996) | Cross-sectional annual prevalence study (1991)    | To compare the risk of detention under the mental Health Act 1983 in a representative group of people with psychotic disorders from different ethnic groups | • for psychosis ICD 10 classification.  
• compulsory admissions collected from Mental Health Act Offices.  
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• Detention under the mental health Act. Reference group white  
  • Black Caribbean OR 3.67 [2.07, 6.50]  
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• Black Caribbean participants were over three times more likely, and black African participants were nearly three times more likely to be detained under the Mental Health Act than white participants. They also were detained more often under sections 2,3, and 136 of the Act. They were also more likely to be admitted to psychiatric intensive care facility or prison. |

**Reviewers Comments**  

Quality of study was good.
### Source

### Study Design
Retrospective chart review

### Country: UK

### Evidence Level: III

### Settings
Inner city mental health trust

### Population
All compulsory admissions under section 2 of the Mental Health Act 1983 within a 12 month period. N=163 detentions, equivalent to 155 service users, M=49%, mean age 38yrs

### Aims of Study
To explore the nature of the reasons for detention; the extent to which these were associated with service user characteristics; and the extent to which the two medical practitioners involved in each case agreed on their reasons (analysed by thematic content analysis)

### Outcome Measures
- reasons for detention
- selected legal criteria for detention
- demographic variables: Gender, age, ethnic group and diagnosis
- agreement of practitioners on reasons for detention

### Results
- Black=18%, Asian=14%, white=61%, other ethnic=7%
- More men than women were described as a danger to others - 60% men 38% women, $\chi^2=7.95$, p = 0.01
- Ethnic collapsed into dichotomous variable white N=100 and ‘other ethnic’ N=63
- Significantly more ‘other ethnic’ people were described as a danger to others - 42% white and 60% ‘other ethnic’, $\chi^2=4.79$, p<0.05
- A significant association was found between ethnicity and diagnosis, $\chi^2=12.62$, p<0.05. Suggesting that reasons for detention were based on ethnic (other ethnic) group and
- A significant association was found between diagnosis, those with schizophrenia and non-compliance with medication as a reason for detention, $\chi^2=10.28$, p<0.05
- In 22% of detentions there appeared to some disagreement between professionals about the extent to which the service user was being detained for the protection of others.
- The extent to which these results reflect inter-relationships between demographic and clinical variables or practitioners stereotypical assumptions remains unclear

### Reviewers Comments
- This study did not set out to determine racial bias. The ethnic group was collapsed and may under estimate effect of bias in detention in particular Afro-Caribbeans.
<table>
<thead>
<tr>
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<th>Results</th>
</tr>
</thead>
</table>
| Feinstein & Holloway (2002) | Cross-sectional Settings Psychiatric Intensive Care Unit (PICU) | To examine the differences in reasons for admission and other characteristics amongst White, Afro-Caribbean and Black service users | Demographic characteristics  
Psychiatric Assessment-DSM-IV  
Global Assessment of Function Scale (GAFS) via interviews on admission and discharge  
Ethnic Comparisons-Asians excluded from analysis and the ethnic groupings were White, Afro-Caribbean and Black African. | Demographic details: Male =63%, White=48%, Afro-Caribbean=42%, Black African=10%, Asian=3%  
80% were compulsorily detained  
40% were schizophrenic-There were no significant differences in demographics of age marital status or living setting between ethnic groups.  
White and Black African service users were more likely to have had a first admission than Afro-Caribbean service users $[\chi^2=8.8 \text{ df}=1 \text{ p}=0.003]$ and to be re-admitted, $[\chi^2=3.5 \text{ df}=1 \text{ p}=0.06]$.  
GAFS: Afro Caribbeans showed greater impairment on admission compared with white service users (p=0.05) and tended to have a longer stay.  
Afro-Caribbeans were significantly more likely to be diagnosed with schizophrenia than white service users but not Black Africans. $[\chi^2=7.8 \text{ df}=1 \text{ p}=0.005]$ Whites were significantly more likely to be diagnosed with personality disorders. $[\chi^2=9.3 \text{ df}=1 \text{ p}=0.002]$.  
Authors state there were no differences in the occurrences of violent behaviour on the ward.  
Afro-Caribbeans were significantly more likely to abuse cannabis that either white or black African service users. $[\chi^2=27.9 \text{ df}=1 \text{ p}=0.00001]$ $[\chi^2=9.1 \text{ df}=1 \text{ p}=0.002]$  
More Afro-Caribbeans were detained under long-term treatment disorders (Section 3) than white service users $[\chi^2=3.6 \text{ df}=1 \text{ p}=0.08]$.  
The unit had a high proportion of Afro Caribbean service users who had a poor level of functioning on admission. The authors argue that the results o not support the view of systematic misuse of PICU and propose a number of possible explanations for the effect, for example difficulties with engagement services, effects of cannabis use or alienation and conflict on open wards. |

**Reviewers Comments**
This study was conducted in 1993.
Study design was not clear.
<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoptman et al (1999)</td>
<td>Single Sample prospective (3 month follow up)</td>
<td>To investigate service user characteristics associated with the</td>
<td>• variables (Patient characteristics: including race), influencing clinician prediction and compared with those influencing actual assaultive behaviour. Violent incidents were measured by a modified Scale for Aggressive and Agitated Behaviours.</td>
<td>• Clinicians rate of correct prediction of assaultive behaviour = 71%, diagnostic sensitivity of 54% and specificity 79%. • Race as a factor associated with clinical prediction was not associated with actual assaultive behaviour. African Americans were over represented in the predicted group whereas Caucasians were under represented. • $\chi^2 = 7.8$ df=3 p&lt;.05.</td>
</tr>
<tr>
<td>Evidence Level: I1</td>
<td>Population: 183 male admissions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reviewers Comments**

Author states study sample different from other forensic populations due to the proportion of ethnicity being higher. Consecutive sampling with 54% participation rate. Authors state no significant difference between participants and non-participants. There was a loss of 16 participants in the final sample, authors state participants and non-participants did not differ.
### Source Study Design Aims of Study Outcome Measures Results

<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
</table>
| Hutton et al (1992) | Retrospective Chart review | To investigate the applicability of the Over-Hostility Scale to black service users and its validity in a forensic setting where psychological assessment is used to identify treatment needs of criminal offenders. | • instant offence  
• psychiatric diagnosis  
• education  
• employment history  
• incidents of physical assault  
• race-comparing black vs white outcome is the difference | • Race was the only variable to emerge as a determinant of Over Hostility (O-H) score.  
• Black service users had higher O-H scores than white service users  
• F(1,410) = 23.726, p<.001.  
• A higher proportion of black service users exceeded the higher level T score 69 cut off point in the scales interpretation of hostility than white service users χ²(1, N=412) = 14.55, p<.001.  
• Comparison of mean O-H scores by race and personality type (N=34 sub-sample)  
F(1,97) = 4.23, p<.05.  
• ANOVA comparisons of O-H scores of black and white service users by criminal history and by clinical problem type were non-significant as were race x criminal history and personality x race interaction.  
• Potential confounders of education and socio-economic status were shown not to significantly predict O-H scores.  
• The findings indicate that using the O-H scale with black service users could lead to an erroneous interpretation of a propensity for aggressive or violent acts. |

**Country:** US  
**Evidence Level:** III

Reviewers Comments  
No details given on randomisation procedure.  
No information provided on race categories given as black and white, in the US Hispanics are another important minority.
# Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings Guideline

<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kho et al (1998)</td>
<td>Prospective with 5 month follow up</td>
<td>To identify factors associated with aggressive incidents in psychiatric acute admission wards</td>
<td>• Weekly reports on levels of aggression were ascertained by two nurses independently using MOAS (The Modified Overt Aggression Scale) of which the mean score = the overall aggression score (actual records = 1147) • Factors potentially affecting aggression • Patient factors e.g. gender, ethnicity, ward factors, effect of stage of admission</td>
<td>• MOAS records N=1147. • Demographic variables were mean age 39, 55% male, ethnic-Caucasian=55%, Asian=15%, Afro-Caribbean=14%, 47% had Schizophrenia and 13% an affective disorder. • No significant results were found for ethnicity and the authors conclude that the results provide little support for the stereotypical view of aggression being associated predominately with young Afro-Caribbean men diagnosed with Schizophrenia. • This study found Asian service users displaying more aggression than others, which is not consistent with other studies. Both Asian and Afro-Caribbeans were of similar proportions on the wards.</td>
</tr>
</tbody>
</table>

**Country:** UK  
**Evidence Level:** II  

**Reviewers Comments**  
This has been reported in Prediction review and therefore only relevant results to this review are included.  
Authors report that reliability of MOAS instrument would have been increased if specific training to staff had been given.
<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawson et al (1984)</td>
<td>Prospective</td>
<td>To test the hypothesis that racial bias in treatment decisions can be documented</td>
<td>• measures of violent behaviour undertaken by nurses with the Modified Lion Scale* • Interrater reliability .84 by rank-order correlation • psychopathology was measured by the Brief Psychiatric rating scale • neuroleptic dosages and serum levels and clinical response</td>
<td>• Lion Scale: Black vs White other p&lt;.0001 • Examination of assault data showed no blacks committed more than one act of violence whereas 7% whites committed 2 or more acts • There was no significant difference between race and psychopathology • Mean neuroleptic serum levels between black and whites was non-significant • Substantial and significant differences were noted in the behavioural measure of inpatient violence. Analysis dichotomised results into Violence against others and violence against self. • This study concludes that whites appear to be more violent, and make far more threats and to commit more self-destructive acts, whilst control for factors such as neuroleptic dosage and serum levels and psychopathology</td>
</tr>
</tbody>
</table>

**Country: US**

**Evidence Level: II**

Population: consecutive admissions of inpatients 24 blacks and 93 whites Sub-population consented to study of neuroleptic dosage, and serum levels 10 black and 34 white

Lion Scale measures service user behaviour e.g. assault, and staff behaviour e.g. decision to seclude or restraint

Reviewers Comments
- US veterans are a unique group due to military experience.
- Small sample size, therefore findings lack statistical power and generalisability.
- Selection of participants not clear.
- Study design and Analysis for control of confounding factors not clear.
<table>
<thead>
<tr>
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<th>Results</th>
</tr>
</thead>
</table>
| Lloyd & Moodley (1992) | Cross sectional Survey Settings Psychiatric Hospital, South London Hospital | To survey psychotropic prescribing in the psychiatric inpatient population in order to discover factors associated with the decision to medicate and whether ethnicity was an independent variable associated with the dose and type of medication | - medication data: Type and dose collected from drug charts.  
- disturbed behaviour- by staff assessment service users notes  
- diagnosis-patients notes and ICD-9  
- compulsory detention                                                                 | - There was only sufficient data on 138 service users, 101 non black and 37 black.  
- Black service users (62%) more likely to have clinical diagnosis of psychosis (ICD 291-299) than non blacks (36%) Yates $\chi^2 = 7.781$, df = 1, p=0.007.  
- Black service users 86.5% were more likely than non-black service users (60.4%) to be receiving anti-psychotic medication Yates $\chi^2 = 7.243$, df=1, p=0.007.  
- Becomes non-significant when adjusted for diagnosis and compulsory detention  
- (62% of black service users are diagnosed with psychosis whereas only 36% have psychosis therefore this result is not unexpected.  
- Black service users with psychosis (56.8%) were significantly more likely to be receiving a depot preparation than non blacks with psychosis (24.8%) $\chi^2 = 12.482$, df=1, p<0.001.  
- Adjusted for ethnicity age sex and diagnosis OR 1.18-2.72 p=0.006  
- Significantly more black service users (67.6%) were detained under the Mental Health Act than non blacks (29.7%) $\chi^2 = 16.197$, df=1, p<0.0001.  
- Adjusted for age sex diagnosis and violence history OR 1.97 p=0.002,  
- Black service users were more likely to have been involved a violent incidence during the index admission $\chi^2 = 12.285$, df=1, P<0.0001.  
- Adjusted for age sex, diagnosis OR 1.81 p=0.006.  
- There is a possible relationship for psychiatric inpatients between compulsory detention, disturbed behaviour, depot medication and being black which is not satisfactorily explained by diagnosis alone. |

**Evidence Level: III**

**Country: UK**

**Population: all psychiatric inpatients on census day N=145**

**Reviewers Comments**

- Authors highlight the relationship of the influence on diagnosis and treatment. Reporting bias discussed as socio demographic data was obtained from case notes.
<table>
<thead>
<tr>
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<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>McNiel &amp; Binder, 1995</td>
<td>Retrospective chart review</td>
<td>To evaluate characteristics of service users whom</td>
<td>• accuracy of clinicians estimates of the service users potential for violence</td>
<td>• This study has been reported in the prediction review and therefore only relevant data is reproduced here.</td>
</tr>
<tr>
<td></td>
<td>Settings Locked, university based,</td>
<td>clinicians accurately assessed as being high or low</td>
<td>• medical Charts reviewed by 8 staff and inter-rata reliability of kappa=0.75</td>
<td>• A multinominal logit analysis was used to identify service user characteristics associated with accurate and inaccurate clinical assessment for potential violence.</td>
</tr>
<tr>
<td></td>
<td>short term inpatient psychiatric</td>
<td>risk for violence and service users for whom</td>
<td>• ratings on N=226 made by 60 physicians averaging 4 each. Scale of 0% (definitely will not attack someone to 100% (definitely will attack someone)</td>
<td>• The risk of violence was over estimated among persons who were non-white: non white service users were more likely to be false positives compared to true negatives. Also service users whose risk of violence was under estimated (false negatives) were more likely to be white in contrast to those whose violence was over estimated (false positives).</td>
</tr>
<tr>
<td></td>
<td>unit</td>
<td>clinicians over estimated or under estimated the risk</td>
<td>• violent behaviour measured on the Overt Aggression Scale. Inpatient violence</td>
<td>• See extracted table below.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>restricted to acts of physical aggression against other people.</td>
<td>• Those who are non white (all those not of white race) are seven times more likely to be falsely predicted for violence and 57% less likely to be given the correct prediction classified as ‘definitely will not attack anyone’.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• False negative: white service users identified as low risk who were then violent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• False positives: non-white service users identified as high risk who were not violent.</td>
</tr>
</tbody>
</table>

**Reviewers Comments**
- Sampling strategy unclear.

<table>
<thead>
<tr>
<th>Variable</th>
<th>True negatives vs. true positives</th>
<th>True negatives vs. false positives</th>
<th>True negatives vs. false negatives</th>
<th>False positives vs. true positives</th>
<th>False Positives vs. false negatives</th>
<th>True positives vs. false negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>White race</td>
<td>OR 0.69 CI [0.27-1.78] ns</td>
<td>OR 0.43 CI [0.27-0.83] ns</td>
<td>OR 3.04 CI [0.66-13.91] ns</td>
<td>OR 1.63 CI [0.65-4.08] ns</td>
<td>OR 7.15 CI [1.50-34.11] ns</td>
<td>OR 4.38 CI [0.83-23.07] ns</td>
</tr>
<tr>
<td>Source</td>
<td>Study Design</td>
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<td>Outcome Measures</td>
<td>Results</td>
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</tr>
</tbody>
</table>
| Minnis et al (2001) | Survey-postal questionnaire | To establish whether racial stereotyping occurred amongst British psychiatrists in rating black service users as more violent than white service users when shown either a picture of a black man or a white man. | • a selection of questions asked:  
• risk of violence to others  
• likely diagnosis e.g. schizophrenia  
• likely to be a management problem  
• rapport likely to be difficult to establish | 823 were contactable. Response rate was 59% N=485 available for analysis. (10% of British Psychiatrists) The power of the study to detect an expected mean (SD) risk of violence of 2.41 (1.76) v 2.87 (1.53) is given as 85% at the 5% level.  
Black N=232  
White N=253  
Risk of violence to others  
20.4 19.9 p=0.005  
Likely diagnosis e.g. schizophrenia  
17.3 13.5 p=0.0001  
Management problem  
16.1 16.6 p=0.001  
Rapport difficult to establish  
18.3 16.2 p=0.01  
Likely to ask:  
Had a criminal record  
16 15 ns  
Had recently used illegal drugs  
96 96 ns  
Authors conclude psychiatrists did not rate black service users as more violent than white, though they were more likely to ask other questions of black service users such as need for learning support and social work. They conclude racial stereotyping at first interview does not account for the inequalities seen in secondary care. |

Country: UK  
Evidence Level: III  
Population: Random sample of 1000 British psychiatrists obtained from the Royal College of Psychiatrists’ database.

Reviewers Comments  
- Authors suggest a possible bias of over compensation by those that had the picture of a black man because of awareness of racial bias towards black service users. Also suggested that the study hypothesis had been guessed. This needs to be considered in the present climate of increased awareness of racial discrimination. This was a self-report exercise and may skew the results more favourably towards non-stereotyping because of the self awareness of race issues amongst doctors.
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Morley et al (1991)</td>
<td>Qualitative</td>
<td>To gain descriptive information about the problems faced by Afro-Caribbean</td>
<td>• present State Examination (PSE)</td>
<td>40 service users met inclusion criteria. PSE not obtained on five service users. Eight</td>
</tr>
<tr>
<td>Country: UK</td>
<td>Settings</td>
<td>families with a psychotic member in the early stages of illness, and to test</td>
<td>• disturbed behaviour rating scale, added questions on dangerosity of service</td>
<td>refused permission to interview relative. Two relatives declined to be interviewed. Total</td>
</tr>
<tr>
<td></td>
<td>Three inner</td>
<td>hypotheses about their influence on the process of admission.</td>
<td>user prior to admission.</td>
<td>sample for analysis was of 25 (10 informal and 15 compulsorily detained service users).</td>
</tr>
<tr>
<td></td>
<td>London Health</td>
<td></td>
<td>• difficulties and beliefs-open ended questions</td>
<td>Demographic=60% male, informal mean age 27 and mean age of compulsory group 33. 76% born</td>
</tr>
<tr>
<td></td>
<td>Districts</td>
<td></td>
<td>• attitudes to psychiatric hospitals questionnaires compiled for study</td>
<td>in West Indies but all had been living in the UK for at least 20 years.</td>
</tr>
<tr>
<td></td>
<td>Population:</td>
<td></td>
<td>• help and satisfaction with help.</td>
<td>60% of relatives were mothers and 40% were either wives, husbands, children or siblings.</td>
</tr>
<tr>
<td></td>
<td>Consecutive</td>
<td></td>
<td></td>
<td>Comparisons between dangerous and non-dangerous-56% of ‘dangerous group’ relatives</td>
</tr>
<tr>
<td></td>
<td>admissions (over</td>
<td></td>
<td>wanted help quicker. 67% wanted their relative to be persuaded to take</td>
<td>wanted help quicker. 67% wanted their relative to be persuaded to take medication. 53%</td>
</tr>
<tr>
<td></td>
<td>9 month period)</td>
<td></td>
<td>medication. 53% of compulsory detained service users were not considered to be</td>
<td>of compulsory detained service users were not considered to be dangerous by their relative.</td>
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<tr>
<td></td>
<td>of Afro-Caribbean</td>
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<td>dangerous by their relative. 2x more relatives attributed the difficulties to stress.</td>
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<td></td>
<td>service users</td>
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<td>Relatives explanations for service users’ behaviour-no differences between informal and</td>
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<td></td>
<td>experiencing</td>
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<td>compulsory detained.</td>
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<tr>
<td></td>
<td>psychotic</td>
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<td>Attitudes to services-Over 50% of sample of relatives thought being Psychiatric</td>
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<tr>
<td></td>
<td>symptoms</td>
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<td>hospital was like prison, however 64% thought hospital was a good place to get away</td>
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<td></td>
<td>in regular</td>
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<td>from it all.</td>
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<td></td>
<td>contact with</td>
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<td>Path of Admission-60% of admissions occurred within a month of the onset of</td>
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<tr>
<td></td>
<td>relative or</td>
<td></td>
<td>Conclusion: The study revealed police involvement was associated not with</td>
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<td></td>
<td>partner.</td>
<td></td>
<td>symptoms</td>
<td>relative need but with initial response of health or social care professional and their</td>
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<tr>
<td></td>
<td>(This included 10</td>
<td></td>
<td>Although the hypothesis did not set out to test this.</td>
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<td></td>
<td>informally</td>
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<td></td>
<td>admitted patients</td>
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<td></td>
<td>and 15</td>
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<td></td>
<td>compulsorily</td>
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<td></td>
<td>admitted patients)</td>
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<td>Excluded: organic</td>
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<td>base for</td>
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<td>diagnosis and</td>
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<td></td>
<td>relative with</td>
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<td></td>
<td>psychosis.</td>
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</tbody>
</table>

**Reviewers Comments**

- Well conducted study.
- No respondent validation.
<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
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</tr>
</thead>
</table>
| Reubin et al (1997) | Retrospective Chart Review | To examine the relationship of serum creatine kinase (CK) levels with aggressive behaviour as a function of psychosis and ethnicity in a sample of violent forensic service users. | • CK levels taken routinely on admission  
• Continuous monitoring of violence using the Overt Aggression Scale undertaken by nurses, provides a mean severity score. Frequency of aggression and type of aggression recorded. MANOVA analysis  
• Other variables: age, weight, height, blood pressure. Use of restraints, Intramuscular injections (IM), history of drug or alcohol abuse and diagnosis of schizophrenia on admission. Chi square and t-test analysis.  
CK is an indication of muscle tissue abnormalities | • Demographic variables: mean age 28.7yrs, 53% Caucasian, 36% African American and 11% Hispanic.  
• 164 provided CK samples a further 22 were excluded from this sample as ethnicity did not fall into two categories of Caucasian and Black African.  
• Further exclusions were made due to CK level outliers 3 Caucasian and 6 Black African American. Results based on N=133.  
• African Americans and Caucasian service users differed in CK levels after adjusted for type and frequency of aggression.  
• CK levels for African American service users diagnosed on admission as Schizophrenic (n=33; CK=160.1 ± 107.2 t (53) =2.3 p<.05) differed significantly from those without this diagnosis (n=22; CK 106 ± 33.1). Caucasian service users with schizophrenia (n=41; CK 90.6 ± 71.5; t (75) =-.122, p=.90.  
• Did not differ from Caucasian service users without such a diagnosis (n=36; CK=87.8±55.2).  
• The authors propose that serum CK differences between African Americans and Caucasian represents a unique physiological reaction to chronic psychological stress. It maybe a biological marker of aggression with different manifestations in various ethnic studies. |

**Reviewers Comments**

- A detailed discussion sets out the consistency for these results in the context of other studies and other hypotheses that have been explored. No other subsequent studies have been identified.
- There is an attempt to establish a temporal relationship between CK and aggression-aggression raising CK levels or CK provoking aggression. For example, raised levels of CK are part of neuro-biological response and results in more physically aggressive behaviour. The causal pathway is not clear.
- It is noted in the study that similar results have been found in non-psychiatric service users of black African origin.
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Secker &amp; Harding (2002)</td>
<td>Qualitative Settings Mental Health Resource Centre in one London Borough</td>
<td>To explore the inpatient experiences of African and Afro-Caribbean clients</td>
<td>patient stories of involvement with services, what was helpful, unhelpful, what would have helped more. Data analysis- interviews transcribed tapes-a staged content analysis using WINMAX</td>
<td>26 in-depth interviews (no drop outs). Demographic-16 male, two thirds 25-44 years, 16 African Caribbean and 6 African. Average length of contact 5 years. 16 diagnosis of schizophrenia. Analysis represents subjects most recent experience with themes that included loss of control, experiences of racism, and relationships with staff. Lack of access to talking treatments coupled with reliance on medication to control and contain inappropriate behaviour. Sense of powerlessness and no adequate redress for unsatisfactory treatment Overt and covert racism e.g. not being understood Reference to Black male stereotypes. Positive accounts of relationships with staff are rare. Participants bewildered and sad at lack of therapeutic relationships.</td>
</tr>
</tbody>
</table>

Country: UK

Evidence Level: IV

Population: A purposive selection of the sample was taken to ensure a cross section in terms of gender, age and diagnosis of clients. N=26

Reviewers Comments
- No respondent validation or piloting of developed interview schedule.
- Methodology clearly set out and data analysis thorough.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Sheehan et al (1995)</td>
<td>Retrospective chart review comparison of two geographical areas</td>
<td>To examine the association of ethnicity on the rate of violent incidents in a socially deprived catchment area</td>
<td>• No. of incidents • Serious of incidents-Grade - Involving no damage - Involving only minor damage or injury not requiring treatment - Representing serious damage to property or injury requiring treatment Ethnicity of perpetrators</td>
<td>• Total incidents 50 at inner city hospital and 41 at semi rural. Inner Semi-rural 43 11 29 11</td>
</tr>
<tr>
<td>Country: UK</td>
<td>Settings All Acute general psychiatric wards in an inner city hospital (n=4=48 beds) and all the psychiatric wards at semi-rural hospital district general hospital (n=1 =35 beds) Population: All violent incident forms for a 12 month period</td>
<td></td>
<td></td>
<td>• Caribbean people are over represented in the violent group at the inner city psychiatric wards. • 9/16 Caribbean people were detained as service users compared to 3/14 white European people. • At the inner city hospital, 46% of violent incidents were Caribbean who represented 11% of admissions. Whites represented 66% of admissions but 40% of violent incidents, black Africans constituted 9% of admissions 6% of incidents • Difference in proportions significant p&lt;0.05. • Conclusions cannot be drawn regarding over representation of African Caribbean people</td>
</tr>
</tbody>
</table>
### Source

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Silver (2000)</td>
<td>Prospective cohort-20 week follow up</td>
<td>To examine the effects of race and neighbourhood (locality of residence) disadvantage on violence among persons with mental disorders</td>
<td>• Violence measured on the Conflict Tactics Scale measured 20 weeks post discharge and would include re-hospitalisation data. • Ethnic self report • Neighbourhood disadvantage-Taken from 1990 Census summary Tape files-boundaries are drawn to encapsulate relatively homogeneous populations-details of which is outlined in the paper. Factor analysis was used to reduce possible components to a manageable number.</td>
<td>• 270 service users constituted 145 neighbourhoods. Neighbourhoods divided into 3 categories low n=42, average n=184 and high disadvantage n=44. • 33.3% of sample =African American, 90.9% were in the high group and none were in the low group. • African Americans were 2.7 (OR) times more likely to be violent than whites, however when adjusted for by neighbourhood disadvantage this was reduced to 1.28 (OR) this was significant p&lt;0.05. Thus African American and White service users residing in comparably disadvantaged neighbourhoods showed no differences in their rates of violence.</td>
</tr>
</tbody>
</table>

### Country: US

### Evidence Level: IV

- Population: N=270 discharged psychiatric service users incl. civil admissions, 18-40 yrs, English speaking, African American or white with range of psychiatric diagnoses

### Reviewers Comments

- This study deals with inpatients discharged from the hospital and are community based for the follow up period of the study, however the contextual neighbourhood measurement seems relevant whether in or out of hospital.
- ‘Neighbourhoods’ is relevant in UK context. This study is reported as it attempts to show confounding according to locality of the individual’s residence and how this may affect reporting of results of violent incidents.
<table>
<thead>
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</tr>
</thead>
</table>
| Strakowski et al (1993) | Retrospective Chart Review | To investigate whether clinical over-diagnosis of schizophrenia in non-white service users exists in the public sector and whether co-morbid diagnoses contributed to primary diagnoses | • diagnosis & co-morbidity (drug, alcohol, and other psychiatric diagnoses) measured by DSM-III-R  
• discharge dose of anti-psychotic medication given in haloperidol equivalents | • Black service users were diagnosed with schizophrenia more than white service users by clinicians OR 5.1 (adjusted for sex, drug abuse, alcohol abuse) CI [2.4-10.] p<.0001.  
• Type and frequency of co-morbid diagnoses did not differ significantly between races.  
• Anti-psychotic medication was prescribed in higher doses to black service users than white. t=3.3, df= 171, p=.001.  
• Authors state there may be possible racial bias as diagnosing service users can be a learnt behaviour, or black service users present with different symptom intensity or type than white service users. |
| Country: US | Settings Large public hospital in Tennessee (excl. forensic) | 173 service users with primary diagnoses of psychotic disorders |                                                                                   |                                                                                                      |
| Evidence Level: III | Population:  |                                                                                   |                                                                                   |                                                                                                      |

**Reviewers Comments**
- Note that ethnicity of clinicians diagnosing- 2 Black, 2 Indians, one Filipino
- Clinicians use of DSM-III-R not determined or validated
- Selection of racial grouping not clear
### Source

<table>
<thead>
<tr>
<th>Source</th>
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</tr>
</thead>
</table>
| Strakowski et al (1995)| Retrospective Chart Review          | To observe whether there are racial differences in diagnosis and disposition | • Diagnosis measured by DSM-III-R  
• Disposition (referral for treatment) e.g. public or private, inpatient, outpatient, other agencies.  
• Other information obtained included: substance abuse, use of physical restraints and restraint medication, homicidal ideation. | Staff racial mix White Black  
Nurses: 60 40  
Social workers: 81 15  
Clinicians: 83 17  
• Black race was significantly associated with schizophrenia compared to whites: OR = 1.6 CI [1.0, 2.5] p<.03 adjusted for age, sex and insurance status (SES)  
Socio-economic status. Male sex was significantly associated with schizophrenia OR =2.3 CI[1.5, 6.0] p=.0003.  
• Age was significantly associated with schizophrenia: OR =2.3 CI[1.5, 3.6] p<.0003.  
• Black race was significantly associated with state hospitalisation OR =2.7 CI[1.3, 5.5] p<.006 adjusted for diagnosis, age, sex, insurance status, suicidal and homicidal ideation scores. Suggesting that blacks were more likely to receive hospital treatment rather than whites. |

**Country: US**

**Evidence Level: III**

**Population:** 490 randomly selected  
Patients: N=273 white (56%)  
N=215 black (44%) mean age 35.2

**Reviewers Comments**

- Follow up to previous 1993 study.
- Authors propose limits on generalisability of these findings due to limits of diagnostic procedure and insurance status is not a sensitive measure for SES.
<table>
<thead>
<tr>
<th>Source</th>
<th>Study Design</th>
<th>Aims of Study</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
</table>
| Wilson & Francis (1997)| Descriptive Survey (No follow up)     | To offer a snapshot of African-Caribbean and African people experiences of mental health services | Postal questionnaire with a mix of closed and open questionnaires on diagnosis, nature of services received, experiences of social exclusion and discrimination and views on mental health services. | • 1000 sent out 100 returned =10% response rate.  
• 43% diagnosed with schizophrenia  
• 53% referred by GP  
• 18% under the MHA  
• 17% referred by police  
• 15% self referral  
• Most common form of treatment was psychiatric hospital (85%), 19% had special hospital or medium secure unit experience.  
• 95% had been treated with drugs  
• 66% found their key worker helpful  
• 36% felt that no mental health professionals actually were aware of their cultural and ethnic origin.  
• 36% expressed dissatisfaction with treatment  
• 36% stated being sectioned because of their ethnic origin (36% of 18%)                                                                                           |

**Country:** UK  
**Evidence Level:** III

**Reviewers Comments**  
Not a representative response authors express the view that the low response rate reflects that the questionnaires did not reach the recipients, rather than a refusal to respond.  
Authors conclude African Caribbeans/Africans surveyed feel misunderstood because they are feared, stereotyped or ignored. The stereotypes operate in complex ways as people are seen as black, mad, dangerous and inadequate.
## Appendix 2: Ethnicity Review - Excluded Studies

<table>
<thead>
<tr>
<th>Source</th>
<th>Reason Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bond et al, 1988</td>
<td>• Average age of participants was 15</td>
</tr>
<tr>
<td></td>
<td>• Sample size of Black patients n=9 and therefore too small</td>
</tr>
<tr>
<td>Carpenter et al, 1988</td>
<td>• Does not test for bias in treatment but by location</td>
</tr>
<tr>
<td>Fabrega et al, 1988</td>
<td>• Study design unclear</td>
</tr>
<tr>
<td>Greenblatt &amp; Davis, 1988</td>
<td>• Study design unclear</td>
</tr>
<tr>
<td>Gudjonsson et al, 1999</td>
<td>• Does not examine bias</td>
</tr>
<tr>
<td>Marx &amp; Levinson, 1988</td>
<td>• Deals with US law and therefore does not extrapolate to the UK</td>
</tr>
<tr>
<td>Singh et al, 1997</td>
<td>• Study design unclear</td>
</tr>
<tr>
<td>Toch et al, 1987</td>
<td>• Prison inmates therefore outside scope</td>
</tr>
<tr>
<td>Volvaka et al, 1995</td>
<td>• Deals with violent incidents committed outside hospital therefore outside scope</td>
</tr>
<tr>
<td>Wang &amp; Diamond, 1999</td>
<td>• Ethnicity considered but does not examine bias</td>
</tr>
</tbody>
</table>
Appendix 3: Ethnicity Review Search Report

Major Databases:

The major databases MEDLINE, EMBASE, PSYCINFO, Biological Abstracts and CINAHL were searched first. These are large literature databases, and allow entry and refinement of complex, saveable search strategies. The search strategies followed the same pattern as the intervention searches at this stage in the process: a search strategy developed for mental disorders and for violence (etc.) was used first:

1. explode "Mental-Disorders"/all subheadings
2. mental* or psychiatri* or psycholog* or forensic or paranoid* or psychos?s or psychotic or schizo* or anxiety or hyster* or mania* or manic or hypo?man* or depress* or mood* or affective or b?polar
dual near4 diagnos?s
3. impuls* near4 control*
4. personalit* near disorder*
delud* or delusive or delusion*
5. 1 or 2 or 3 or 4 or 5 or 6
violen* or agonistic or disturb* or hostil* or agitat* or anger or angry or un?toward or rage* or bizarre or harass* or intimidat* or aggress* or danger* or attack* or threat* or abus* or combative or assault* or disrupt*
6. 7 and 8

For the ethnicity search, the following search strategy was added to the above:

7. (race or races or racial* or ethnic*)
8. (asian* or african* or black or indian* or pakistani* or bangladesh* or latin* or non?white* or multi?cultur* or afro-caribbean)
9. 7 or 11
10. 10 or 11
11. 9 and 12

NOTES:

1. The database platform used was Silver Platter (in its Windows version, WinSpirs). Other platforms, such as Ovid, require different conventions and symbols, but the strategies will translate directly. Database terminology varies between databases and different versions of databases.

2. Search statement 1 above represents a Thesaurus (Silver Platter) or Subject (Ovid) search – in this example a MESH search from MEDLINE – i.e. a search on indexer headings or ‘descriptors.’ On different databases, Thesaurus terms vary: so 1. above would become, on EMBASE for example: 1. explode "mental disease"/all subheadings.

3. The other search statements represent Text-word or Free Text or ‘natural language’ searches (again, terminology varies), searching author terms in titles or abstracts of database records. In general, Free Text search terms have been preferred – once a check has been made that any corresponding descriptors and any nested terms would be included – since these are transferable between major databases (some other sources do not support descriptor searching) and indexing may be inconsistent or unreliable or very high-sensitivity searches of the kind required here. The descriptors can be searched with the free text terms (see Note 4), and processing may be quicker for a complex strategy.

4. The Free Text search strings were suffixed with field search qualifiers so that the terms are searched only in the major fields of each record (title, abstract and descriptors), and not, for example, in journal title or address fields. Again, this differs between databases – e.g:
Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings Guideline

Violence in ti,ab,mesh (MEDLINE)
Violence in ti,ab,dem,der (EMBASE) etc.

5. The operator 'near' searches terms (or sets of alternative terms) within the same sentence of a record title or abstract – 'and' searches simultaneous occurrences anywhere in the records. (The number qualifier – e.g. near4 – searches the terms within that number of words in the sentence).

6. The ? symbol is a 'wildcard' standing for 1 or 0 characters (including a hyphen) within a word, on Silver Platter databases.

7. The * (asterisk) symbol is a 'truncation' or 'stemming' symbol, which captures variant word-endings by including any number of characters (including 0) at the end of a word, on Silver Platter databases.

Other Sources:
A large number of databases and Web sources that do not support searching using complex search strategies were searched for all or any interventions for violent behaviour (etc.) involving mental disorders. This includes the Cochrane Library databases, which are not large, and best searched broadly, AMED singularly, SIGLE for 'grey' literature, HMIC or health care grey literature, ASSIA for social science literature, large research journals databases such as ZETOC and the Web of Science which only support simple one- or two-term search strategies, and similarly, specialist Web search engines such as BIOME. Many of the Web-based sources can only be 'trawled' or even 'sampled' rather than 'searched' thoroughly. These other sources are listed in the Literature Search Log for the mental health specific concerns searches.

Jo Hunter
Information Specialist
LITERATURE SEARCH LOG

Guideline: (Project co-ordinator) VIOLENCE – SPECIFIC CONCERNS - ETHNICITY

Date searches required by: (Project co-ordinator) 30 June 2003

Review question: (Project co-ordinator to complete) Does the race/ethnicity of a patient or staff member make a difference to how they are treated when they are involved in a violent incident in inpatient psychiatric settings?

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<thead>
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<th>Study design</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
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</tr>
<tr>
<td>Settings</td>
<td>Inpatient psychiatric settings</td>
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<tr>
<td>Interventions</td>
<td>All interventions: Short-term etc. – management of violence</td>
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<tr>
<td>Outcomes</td>
<td>Racial intolerance, discrimination, harassment</td>
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</tbody>
</table>

Databases and when searched

<table>
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<tr>
<th>Core Databases</th>
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### Additional databases

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<td></td>
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</table>

Template updated: 20 May 2003
Appendix 4: CRITICAL APPRAISAL OF BREAKING THE CIRCLES OF FEAR: A REVIEW OF THE RELATIONSHIP BETWEEN MENTAL HEALTH SERVICES AND AFRICAN AND CARIBBEAN COMMUNITIES

AGREE Appraisal Tool (carried out independently by 2 reviewers).


Publisher: Sainsbury Mental Health Centre London. Developed by: Sainsbury Mental Health Centre

### Scope and Purpose (Domain 1)

| 1. The overall objective(s) of the guideline is (are) specifically described. | 4 |
| Comments: The aims of the project are clearly presented (p8/14). | 4 |

| 2. The clinical question(s) covered by the guideline is (are) specifically described. | 2 |
| Comments: The aims appear to be the clinical questions being addressed and are given at the beginning of every chapter. These aims have also been determined by the methodological approach of the co-operative enquiry. (P84) This is more of a report than a guideline so this question is not entirely relevant. | 2 |

| 3. The patients to whom the guideline is meant to apply are specifically described. | 4 |
| Comments: The target population is specifically described throughout. | 4 |

### Stakeholder Involvement (Domain 2)

| 4. The guideline development group includes individuals from all the relevant professional groups. | 3 |
| Comments: There is steering group that manages the project and an advisory group of relevant professionals. Service user participation seems absent from the groups. There seems to have been a great deal of input from service user organisations, but no input from nursing organisations. | 3 |

| 5. The patients’ views and preferences have been sought. | 4 |
| Comments: This is the whole purpose and thrust of the report. (p84) This has been achieved through a variety of means including focus groups and interviews. | 4 |

| 6. The target users of the guideline are clearly defined. | 4 |
| Comments: The target users of the recommendations are reported. (p8) | 4 |

| 7. The guideline has been piloted among target users. | 1 |
| Comments: There is no evidence for this. This is more of a report than a guideline, so this question is not entirely relevant. | 1 |
### Rigour of Development (Domain 3)

<table>
<thead>
<tr>
<th></th>
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<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Systematic methods were used to search for the evidence.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comments</strong>: This report does not follow a traditional systematic approach, which has probably been deliberate. The overall approach appears to be systematic and thorough. (p8/84) This is not a guideline and so it does not search for evidence - it is more of a research centred report.</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>9. The criteria for selecting the evidence are clearly described.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comments</strong>: The inclusion of evidence and its collection is reported. (p84) Quality of evidence and gradings have not been reported This question is not relevant</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>10. The methods used for formulating the recommendations are clearly described.</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comments</strong>: They appear to be generated from the key findings. There is no description of how the recommendations were generated by the advisory group but are described as a process of argument based on findings. (p74-82) The recommendations are based on the findings of the research. This is apparent.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11. The health benefits, side effects and risks have been considered in the formulating the recommendations.</td>
<td>3</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Comments</strong>: This is not directly relevant. The implications are at the policy level with an implementation strategy. (p74-82) This question is not relevant to this topic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. There is an explicit link between the recommendations and the supporting evidence.</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td><strong>Comments</strong>: It is clear in reading the report but is not conducted in the direct and rigorous methods expected in a NICE guideline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. The guideline has been externally reviewed by experts prior to its publication.</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Comments</strong>: This report does not mention being reviewed by others external to the process. The steering group may have acted as such to the advisory group but membership overlapped. An advisory group was convened, but it contained members of the steering committee.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. A procedure for updating the guideline is provided.</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Comments</strong>: No procedure to up date is mentioned, however this may not be appropriate. There is an implementation project. This question is not appropriate to the report, which stresses the need for more awareness and research in this area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clarity and Presentation (Domain 4)

<table>
<thead>
<tr>
<th></th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>15. The recommendations are specific and unambiguous.</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comments</strong>: They are clear but general</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. The different options for management of the condition are clearly presented.</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Comments</strong>: I am unsure about the relevance of this question to this report. This is not relevant to the topic being considered</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>17. Key recommendations are easily identifiable.</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Comments</strong>: The key recommendations in the guideline are easily identifiable and include implementation. They are clearly laid out at the beginning of the report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. The guideline is supported with tools for application.</td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>
19. The potential organisational barriers in applying the recommendations have been discussed.

Comments: Organisational changes that are required to implement the guideline recommendations are discussed (p68-72).

20. The potential cost implications of applying the recommendations have been considered.

Comments: There is no discussion or evidence review for the cost implications of the recommendations.

21. The guidelines present key review criteria for monitoring and/or audit purposes.

Comments: Not given in report. Additional information suggests the subsequent implementation project will monitor. This is not done, but would have been useful.

22. The guideline is editorially independent from the funding body.

Comments: The authors and editor are stated on p. 7 however not where they are from, funder is understood to be the Sainsbury Centre and they are represented on the Steering group and advisory group.

23. Conflicts of interest of guideline development members have been recorded.

Comments: There is no information concerning how conflicts of interest were either resolved or recorded.

Overall Assessment

Would you recommend these guidelines for use in practice?

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly recommend</td>
</tr>
<tr>
<td>recommend</td>
</tr>
</tbody>
</table>

Comments: This report did not set out to be a guideline and therefore does not adopt the rigorous approach expected. However it is providing guidance targeted at a strategic and national level and intends to implement the strategy via the recommendations proposed. It is highly relevant to the current guideline and therefore the needs to be noted.

Note: 4 = strongly agree, 1 = strongly disagree.

<table>
<thead>
<tr>
<th>Reviewer 1</th>
<th>Domain 1</th>
<th>Domain 2</th>
<th>Domain 3</th>
<th>Domain 4</th>
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<td>Reviewer 2</td>
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APPENDIX 5: SERVICE USER PARTICIPANT INFORMATION GUIDE

Focus Groups on the Management of Violence (Disturbed Behaviour) in Psychiatric In-patient Settings

BACKGROUND

The National Institute of Clinical Excellence (NICE) has commissioned the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) to develop a national guideline which will advise everyone involved in psychiatric inpatient settings about how violence and disturbed behaviour ought to be managed. We are currently in the process of doing this. In order to ensure that all the relevant views are included, amongst other things we are holding a series of focus groups to make sure that the voices from the African Caribbean community are heard. You are being invited to participate in one of these groups. The group will have between 8 and 12 members.

AIM OF THE FOCUS GROUPS

The focus group will discuss the following issues which are being covered by the guideline:

The ward environment - What are your views on the environment within psychiatric inpatient departments? What relationship do you think there is between violence and the ward environment?

Predicting Violence - What are your experiences of healthcare professionals predicting that you or others you know are likely to be violent?

Interventions that are used to manage violent or potentially violent behaviour:

- De-escalation techniques
- Observation techniques
- Restraint
- Seclusion
- Rapid Tranquillisation

- What do you think about these interventions, and have you any experience of them? Why do you think this happened to you?

Accident and Emergency Departments - Do you have any experience of any of the interventions in an emergency department?

Training - Do you have any views about training in the interventions used to manage violence in psychiatric in-patient departments?

The Staff-Service User Relationship - What are your views and experiences of service users relationship with staff?

We would like to know about your experiences, or about experiences of others that you know. Although there may be other issues which are important to psychiatric care, we will only be able to use information which is related to the topics above.

HOW WILL THE FOCUS GROUP BE RUN

Joan Field Thorne will be facilitating the group. She will be responsible for leading you through all the topics and asking you to give more information about a particular point and also asking if other people have had similar experiences.
Two other people will also be attending the meeting. Jane Cowl from the patient involvement unit, who is responsible for making sure that service users views are included in NICE guidelines and Louise Nelstrop, who is the project manager, responsible for co-ordinating the guideline and making sure all the relevant evidence is considered.

WHAT WILL HAPPEN TO THE INFORMATION THAT YOU GIVE?

As long as everyone in the group is gives their permission, the discussion will be taped. The discussion will then be analysed and written up into a report. You will receive a copy of this report, and will be suggest changes if you feel that certain points have been missed or over-emphasised. Once everyone is happy, this information will be passed to the group of people who are responsible for making the recommendation. This group is made up of service users and healthcare professionals, both of whom have an equal say in the recommendations that the guideline will make.

WILL ANYONE BE ABLE TO IDENTIFY YOU PERSONALLY?

No. All the information that you give will be confidential. You will be asked to sign a form stating that you are willing to participate in the group, but no one will be able to identify what you said and you will not be named anywhere in the guideline. You can decide that you want to withdraw the information that you gave at any time.

WILL YOU BE PAID?

You will be paid £35 for taking part in this focus group. You will also be reimbursed for your travel costs and provided with lunch and refreshments.

THANK-YOU FOR TAKING THE TIME TO READ THIS LEAFLET. IF YOU REQUIRE ANY FURTHER INFORMATION ABOUT THE FOCUS GROUP PLEASE CONTACT:

Joan Field Thorn
Black Orchid
189c Newfoundland Rd
St Agnes
Bristol, BS2 9NY
Tel: 0117 9079982

IF YOU WANT TO KNOW MORE ABOUT THE GUIDELINE OR ABOUT NICE OR THE NCC-NSC PLEASE CONTACT:

Louise Nelstrop
RCNI
Radcliffe Infirmary
Woodstock Rd Oxford, OX2 6HE
Tel 01865 224590
E-mail louise.nelstrop@rcn.org.uk
Focus Groups on the Management of Violence (Disturbed Behaviour) in Psychiatric In-patient Settings: Healthcare Professional Views?

BACKGROUND
The National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) is developing a national guideline for the National Institute of Clinical Excellence (NICE) to advise healthcare professionals about the management of violence and disturbed behaviour in psychiatric inpatient settings. In order to ensure that all the relevant views are included, amongst other things we are holding a series of focus group discussions to make sure that the voices from the African-Caribbean community are heard. Two groups are being set up with service users and one with healthcare professionals. You are being invited to participate in the healthcare professional group. The group will have between 8 and 12 members.

AIM OF THE FOCUS GROUP DISCUSSION
The focus group will discuss the following issues which are being covered by the guideline:

The ward environment - What are your views on the environment within psychiatric inpatient departments? What relationship do you think there is between violence and the ward environment?

Predicting Violence - What are your experiences of predicting violence and of other healthcare professionals predicting violence, especially with regard to the Afro-Caribbean service users?

Interventions that are used to manage violent or potentially violent behaviour:

- De-escalation techniques
- Observation techniques
- Restraint
- Seclusion
- Rapid Tranquillisation

- What do you think about these interventions, and do you have any experience of using them? Do you feel that they are used disproportionately with Afro-Caribbean service users?

Accident and Emergency Departments - Do you have any experience of any of these interventions in an emergency department?

Training - Do you have any views about training in the interventions used to manage violence in psychiatric inpatient departments?

The Staff-Service User Relationship - What are your views and experiences of staff relationships with service users, particularly Afro-Caribbean service users?
We would like to know about your experiences, or about the experiences of others that you know. Although there may be other issues which are important to psychiatric care, we will only be able to use information which is related to the topics above.

HOW WILL THE FOCUS GROUP BE RUN

Jane Cowl, from the Patient Involvement Unit (PIU) will be facilitating the group. Jane will be responsible for leading you through all the topics and asking you to give more information about a particular point and also asking if other people have had similar experiences.

One other people will also be attending the meeting, Jackie Chandler Oatts, who assists the project manager, Louise Nelstrop in co-ordinating the guideline and making sure all the relevant evidence is considered.

WHAT WILL HAPPEN TO THE INFORMATION THAT YOU GIVE?

As long as everyone in the group gives their permission, the discussion will be taped. This will help the researchers analyse the discussion afterwards and write a report. You will receive a copy of this report, and will be able to suggest changes if you feel that certain points have been missed or over-emphasised. Once everyone is happy, this information will be passed to the guideline development group, who are responsible for making recommendations. This group is made up of service users and healthcare professionals, both of whom have an equal say in the recommendations that the national guideline will make.

WILL ANYONE BE ABLE TO IDENTIFY YOU PERSONALLY?

No. All the information that you give will be confidential. You will be asked to sign a form stating that you are willing to participate in the group, but no one will be able to identify what you said and you will not be named anywhere in the guideline. You can decide that you want to withdraw the information that you gave at any time.

THANK-YOU FOR TAKING THE TIME TO READ THIS LEAFLET.

IF YOU REQUIRE ANY FURTHER INFORMATION ABOUT THE FOCUS GROUP OR IF YOU WANT TO KNOW MORE ABOUT THE GUIDELINE OR ABOUT THE ORGANISATIONS INVOLVED PLEASE CONTACT:

Jackie Chandler Oatts
NCC-NSC
Royal College of Nursing Institute
Radcliffe Infirmary
Woodstock Rd Oxford, OX2 6HE
Tel 01865 224590
E-mail louise.nelstrop@rcn.org.uk
Appendix 7: Service User Focus Group Discussion Guide

**Topic Guide**

**The Ward Environment** -
- What relationship do you think there is between violence and the ward environment? (Things that are good about the ward environment, things that need to be changed).
- Types of setting are things different in different settings?)

**Predicting Violence** -
- What are your experiences of healthcare professionals predicting that you or others you know are likely to be violent?
- Have you been involved in talking about your history of illness?, etc.

(20 mins)

**Interventions** that are used to manage violent or potentially violent behaviour:

**De-escalation techniques** (Techniques used to calm potentially aggressive situations: talking to someone, mirroring their mood etc.)
- Do you think that de-escalation techniques are a good thing?
- Have you noticed nursing staff using them?
- Are they used enough, too much?
- What are your feelings about these techniques

**Observation techniques** (To be closely watched by nursing staff to prevent aggressive behaviour to others. The watching is either constantly or at very regular intervals)
- Do you have personal experience of being observed?
- Do you think that observation techniques are a good thing?
- Is it used enough, too much?
- What are your feelings about this practice

**Restraint** (To be physically held to prevent harm to self or others)
- Do you have any experience of being restrained?
- Do you know of others who have been restrained?
- Is it used enough, too much?
- What are your feelings about his practice?

**Seclusion** (To be put in isolation and segregated from others)
- Do you have any experience of being secluded?
- Do you know of others who have been secluded?
- Is it used enough, too much?
- What are your feelings about his practice?
Rapid Tranquillisation (To receive medication usually by injection for immediate calming effect)

- Do you have any experience of rapid tranquillisation?
- Do you know of others who have received rapid tranquillisation?
- Is it used enough, too much?
- What are your feelings about his practice?

(40 mins)

The Staff-Service User Relationship

- What are your views on the relationship between staff and service users in the inpatient settings where you have been?
- Have you been involved in making advance directives - planning how you would like to be treated in the event that you become violent during your stay?

Training

- Do you have any views about training in the interventions used to manage violence in psychiatric in-patient departments?

Accident and Emergency Departments

- Do you have any experience of any of the interventions in an emergency department?
- Do you think that there should be a different approach in A&E compared to inpatient settings?

(30 mins)

Time for Debriefing

Evaluation forms

(15 mins)
Appendix 8: Healthcare Professional Focus Group Discussion Guide

Focus Groups on the Management of Violence (Disturbed behaviour) in Psychiatric In-patient Settings: Healthcare Professional Views

**Topic Guide and Timetable**

(Approximate timings for guidance)

1.0 Coffee and Welcome
2.0 Introduction
2.0 Focus Group

**Ward Environment**

The relationship of ward environment to violent behaviour
The effect of different settings e.g. secure facilities

1 Predicting Violence
   How successful is prediction of violence
   Is ethnicity an issue in prediction?

1 Intervention techniques
   De-escalation
   Observation
   Restraint
   Seclusion
   Rapid tranquillisation
   What is your experience of these techniques, their use and effectiveness especially when involving African Caribbean patients.

1.0 The Staff-Service user relationship
   What are your views and experiences of staff relationships with service users, particularly African Caribbean service users

**Training**

Do you have any views on training for staff to manage violence, also on dealing with the needs of an ethnically mixed ward community, and particularly African Caribbean service users.

1 Accident and Emergency departments
   Do you have any A/E Experience with psychiatric patients and what are your views on how they are dealt with in A/E

1 What are the key messages for the Guideline and any other comments.
2.0 Close and Buffet Lunch

The session will be taped and notes will be taken.
There will be a five minute break at suitable point for toilet etc.

Thank You.
Appendix 9: Written Consent Form

CONSENT FORM

Title of Project:

Name of Researcher:

Please initial box

1. I confirm that I have read and understand the information sheet dated ........ (version...) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.

______________________   __________ ___________ _______ _________
Name      Signature   Date

_____________________   __________ ___________ _______ _________
Researcher   Signature   Date

1 copy for participant  1 copy for researcher
Appendix 15

Peer Reviewers

Comments on the Guideline were received from the following Expert Reviewers:

Dr Ann Alty       Morecombe Bay Primary Care Trust
Dr Joanna Bennett  The Sanisbury Centre for Mental Health
Prof. Len Bowers   St Bartholomew School of Nursing and Midwifrey, City University
Dr Aggrey Burke    South West London and St. Georges Mental Health Trust
Gill Chalder       South Staffordshire Healthcare NHS Trust
Dr Joseph Cortis   School of Health Studies, Leeds.
Dr Suman Fernando  Liaison Psychiatry, University of West England
Cathereine Fewster Lancashire NHS Trust
Anthony Harrison   Liaison Psychiatry, University of West England
Dr Patrick O’Brien University of Birmingham
Brodie Paterson   University of Stirling
Carol Paton        Oxleas NHS Trust
Mark Ridge         Derbyshire Mental Health (NHS) Trust
Dr David Taylor    Maudsley Hospital
Mark West          Birmingham and Solihull Mental Health NHS Trust