Clinical Practice Guidelines for

The Short-term Management of Disturbed/Violent Behaviour in Adult Psychiatric In-patient Settings and Accident and Emergency Settings

July 2004

Draft for 2\textsuperscript{nd} Stage Consultation Period

This guideline was commissioned by the National Institute for Clinical Excellence
This work was undertaken by the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC), School of Health and Related Research, University of Sheffield, (SchARR) and the Guideline Development Group (GDG) formed to develop this guideline on behalf of the National Institute for Clinical Excellence (NICE). Funding was received from the National Institute for Clinical Excellence. The NCC-NSC consists of a partnership between: the Centre for Evidence-Based Nursing (University of York), the Centre for Statistics in Medicine (Institute of Health Sciences, Oxford), the Clinical Effectiveness Forum of Allied Health Professionals, the Healthcare Libraries (University of Oxford) the Health Economics Research Centre (University of Oxford), the Royal College of Nursing and the UK Cochrane Centre. The views expressed in this publication are those of the authors and not necessarily those of either the Royal College of Nursing or the National Institute for Clinical Excellence.

The NCC-NSC would also like to thank the following who contributed to the guideline:

Paul Hewitson, project manager until August 2002; the CHI audit team at the Royal College of Psychiatrists, Maureen McGeorge and Rob Chaplin, who contributed the audit criteria for this guideline; Alison Chisholm and Jacoby Patterson, who assisted with systematic reviewing; Phil Alderson from the UK Cochrane Centre and Maggie Westby from the RCNI for methodological advice and assistance; Paul Yerrell who facilitated the consensus meetings to finalise the guideline recommendations; Pauline Abbot-Butler and Joan Field-Thorn from Footprints UK and Black Orchid, who facilitated the focus groups with Black service users in London and Bristol; Jane Cowl from the Patient Involvement Unit (PIU) for assisting with the focus groups and focus analysis; the service users who took part in the focus groups; the healthcare professionals who participated in an additional focus group; and all the experts and observers who attended GDG meetings; Yana Richens who advised on the methodology for the focus groups; the Resuscitation Council UK for advise about defibrillation, Geoff Rushton for advice about anaesthesia definitions, Antony Harrison for providing a template for the Accident and Emergency algorithm and Dave Brandford for reworking the introduction to rapid tranquillisation.
Disclaimer

As with any clinical guideline, recommendations may not be appropriate for use in all circumstances. A limitation of a guideline is that it simplifies clinical decision-making (Shiffman 1997). Decisions to adopt any particular recommendations must be made by the practitioners in the light of:

- available resources
- local services, policies and protocols
- the patients circumstances and wishes
- available personnel
- clinical experience of the practitioner
- knowledge of more recent research findings.

Terminology

1. Where the term ‘carer’ is used, this refers to unpaid carers as opposed to paid carers (e.g. careworkers).
2. Where the term 'service user' is used, this refers to any users of mental health services.
3. Where the term 'healthcare professional' is used, this refers to any nursing or allied healthcare professions and other medical staff, including healthcare assistants.

Legal Review

These guidelines have been referred to principles of law summarised by NICE solicitors and have undergone a legal review as part of the 1st stage stakeholder consultation.
### Abbreviations and general glossary

#### Abbreviations

#### Technical terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ABS</td>
<td>Agitated Behaviour Scale (Corrigan, 1989)</td>
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<td>AED</td>
<td>Automated External Defibrillators</td>
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<td>ARP</td>
<td>Aggression Risk Profile (Kay et al., 1987)</td>
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<td>BARS</td>
<td>Behavioural Activity Rating Scale (Swift et al, 1998)</td>
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<td>ARP</td>
<td>Barnes Akathisia Rating Scale (Barnes, 1989)</td>
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<tr>
<td>BPRS</td>
<td>Brief Psychiatric Ratings Scale (Overall &amp; Gorham, 1962)</td>
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<td>BVC</td>
<td>Brøset Violence Checklist (Almvik, 1996)</td>
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<td>CGI</td>
<td>Clinical Global Impressions Scale (Guy &amp; Bonato, 1970)</td>
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<tr>
<td>CGI-I</td>
<td>Clinical Global Impression of Improvement - subscale of CGI (Guy &amp; Bonato, 1970)</td>
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<td>CGI-S</td>
<td>Clinical Global Impressions Severity of Illness Scale - subscale of CGI (Guy &amp; Bonato, 1970)</td>
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<td>EAQ</td>
<td>Environment Assessment Questionnaire (Lanza, 1996)</td>
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<td>EPS</td>
<td>Extrapyramidal symptoms</td>
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<td>GCI</td>
<td>Global Clinical Impressions Scale</td>
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<td>GDG</td>
<td>Guideline Development Group</td>
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<tr>
<td>HCR-20</td>
<td>Historical/Clinical/Risk - 20-item scale, version 2 (Webster et al., 1997)</td>
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<tr>
<td>IFP</td>
<td>Information for the Public version</td>
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<tr>
<td>ILS</td>
<td>Intermediate Life Support</td>
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<tr>
<td>MBPRS</td>
<td>Modified Brief Psychiatric Ratings Scale (Tariot et al, 1993)</td>
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<td>MMSE</td>
<td>Mini Mental State Examination (Folstein et al., 1975)</td>
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<td>MOAS</td>
<td>Modified Overt Aggression Scale (Kay et al., 1988)</td>
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<tr>
<td>NOSIE-30</td>
<td>Nurses Observation Scale for In-patient Evaluation (Honigfeld, et al 1966)</td>
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<td>OAS</td>
<td>Overt Agitation Scale (Yudofsky, 1997)</td>
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<td>Abbreviation</td>
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<tr>
<td>PANSS</td>
<td>Positive and Negative Syndrome Scale (Kay et al., 1987)</td>
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<tr>
<td>PANSS-EC</td>
<td>Positive and Negative Syndrome Scale Exited Component - subscale of PANSS (Kay et al., 1987)</td>
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<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
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<td>PCF</td>
<td>Patient Characteristic Form b (Lanza, 1996)</td>
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<tr>
<td>PCL:SV</td>
<td>Psychopathy Checklist: Screening Version (Hart et al., 1995)</td>
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<td>PRN</td>
<td>Pro-re-nata medication</td>
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<td>QNS</td>
<td>Quantified Neurological Scale (Convit et al., 1994)</td>
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<td>RAPP</td>
<td>Routine Assessment of Patient Progress (Ehmann et al., 1995)</td>
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<td>RCT</td>
<td>Randomised Controlled Trial</td>
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<td>RSU</td>
<td>Regional Secure Unit</td>
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<td>SOAS</td>
<td>Staff Observation Aggression Scale (Palmestierna &amp; Wistedt, 1987)</td>
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<td>SOAS-E</td>
<td>Extended Staff Observation Aggression Scale (Hallenstinsen et al., 1998)</td>
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<td>SOAS-R</td>
<td>Staff Observation Aggression Scale Revised (Nijman et al., 1999)</td>
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<td>TSRS</td>
<td>Target Symptom Rating Scale (Barber et al., 2002)</td>
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<td>VAS</td>
<td>Visual Analogue Scale</td>
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<tr>
<td>VRAG</td>
<td>Violence Risk Appraisal Guide (Harris et al., 1993; Webster et al., 1994)</td>
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**Organizations**

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>MHRA</td>
<td>Medicines and Healthcare Products Regulatory Agency (formerly Medical Devices Agency)</td>
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<td>NCC-NSC</td>
<td>National Collaborating Centre for Nursing and Supportive Care</td>
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<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<td>NIMHE</td>
<td>National Institute for Mental Health in England</td>
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<td>NMC</td>
<td>Nursing and Midwifery Council (formerly the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC), formerly the Standing Nursing and Midwifery Advisory Committee (SNMAC).</td>
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<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>NSF</td>
<td>National Service Framework</td>
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<td>RCN</td>
<td>Royal College of Nursing</td>
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<td>RCPysch</td>
<td>Royal College of Psychiatrists</td>
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<td>SMS</td>
<td>NHS Security Management Service</td>
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<tr>
<td>SchARR</td>
<td>School of Health and Related Research, University of Sheffield</td>
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General Glossary

(partially based on Clinical epidemiology glossary by the Evidence Based Medicine Working Group, www.ed.ualberta.ca/ebm; Information for national collaborating centres and guideline development groups, (NICE 2001).

Absolute risk reduction: The difference between the observed event rates (proportions of individuals with the outcome of interest) in the 2 groups.

Accident and Emergency Settings: Any care setting designed to provide emergency treatment and care.

Acute Care Setting: Short-term (approximately 30 days) in-patient care or emergency services or other 24 hour urgent care setting.

Adherence: The behaviour of taking medicine according to treatment dosage and schedule as intended by the prescriber. In this guideline, the term adherence is used in preference to the term compliance, but is not synonymous with concordance, which has a number of different uses/meanings (NICE, 2002).

Admission Unit: Type of unit into which a service user is admitted either directly from A&E or from ambulance services.

Actuarial Tools: Use statistic technics in an attempt to generate reliable risk factors.

Advance Directive: A document which contains the instructions of a person with mental illness setting out their requests in the event of a relapse, an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to received and any treatment preferences that they may have in the event that they become violent. It also contains people that they wish to be contacted and any other personal arrangement that they wish to be made.
African Caribbean: Of or pertaining to both Africa and the Caribbean; used to designate the culture, way of life, etc or the characteristic style of music of those people of Black African descent who are, or whose immediate forebears were, inhabitants of the Caribbean (West Indies). (Taken from Oxford English Dictionary Online).

Aggression: A disposition, a willingness to inflict harm, regardless of whether this is behaviorally or verbally expressed and regardless of whether physical harm is sustained.

Anaesthetised: General anaesthesia is a state of narcosis (unconsciousness), analgesia (lack of awareness of pain) and muscle relaxation. It is one stage beyond deep sedation. It implies loss of airway control and protective reflexes, and requires the constant attention of trained personnel to keep the patient safe. There is normally no verbal contact. There are of course various depths of anaesthesia, and the risk of obstructed or depressed respiration increases as the anaesthesia deepens.

Antecedents: Warning signs which indicate that a service user is escalating towards a violent act.

Bias: A tendency for the results to depart systematically, either lower or higher, for the ‘true’ results. Bias either exaggerates or underestimates the ‘true’ effect of an intervention or exposure. It may arise due to several reasons such as errors in design or the conduct of the study.

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.

Breakaway: A set of physical skills to help separate or breakaway from an aggressor in a safe manner. They do not involve the use of restraint.
Calming: Reduction of anxiety.

Cardiovascular compromise: Failure of the heart and circulatory system to produce adequate blood flow to the vital organs leading to collapse and often to death.

Case-control study: A study in which the effects of a treatment or management approach in a group of patients is compared with the effects of a similar group of people who do not have the clinical condition (the latter is called the control group).

Clinical effectiveness: The extent to which an intervention (for example, a device or treatment) produces health benefits (i.e. more good than harm).

Cochrane Collaboration: An international organisation in which people retrieve, appraise and review available randomised controlled trials. The Cochrane database of systematic reviews contains regularly updated reviews on a variety of issues. The Cochrane library is the database for the collaboration, it is electronic and regularly updated.

Cohort study: Follow-up of exposed and non-exposed groups of patients (the 'exposure' is either a treatment or condition), with a comparison of outcomes during the time followed-up.

Co-interventions: Interventions/treatments etc other than the treatment under study that are applied differently to the treatment and control groups.

Common Law: Is that body of legal doctrines and principles developed by the courts through their decisions. For example the common law doctrine of necessity and the principles of negligence have been developed by the courts over time.

Co-morbidity: Co-existence of a disease or diseases in a study population in addition to the condition that is the subject of study.
Confidence interval (CI): The range of numerical values in which we can be confident that the population value being estimated were found. Confidence intervals indicate the strength of evidence; where confidence intervals are wide they indicate less precise estimates of effects.

Cost effectiveness: The cost per unit of benefit of an intervention. In cost effectiveness analysis, the outcomes of different interventions are converted into health gains for which a cost can be associated, for example, cost per additional pressure ulcer prevented.

Cost impact: The total cost to the person, the NHS or to society.

David Bennett Inquiry: Public Inquiry into the death of David Bennett, a 38 year old Black man, who died while being restrained in a medium secure unit in the early hours of Saturday 31 October 1998.

De-escalation: A complex range of skills designed to abort the assault cycle during the escalation phase, and these include both verbal and non-verbal communication skills (CRAG, 1996).

Deep Sedation: A reduction of consciousness and motor and sensory activity, where verbal contact is progressively lost, and then (dangerously) if excessive airway control and protective reflexes are lost.

Discounting: A process of reflecting the impact of waiting. If something is to take place in the distant future, then its value, assessed at the present, or “present value”, will be smaller than the value of the same thing happening now. This can be because resources now can be invested to yield more resources in the future, and/or because people are impatient or myopic. Discounting is the process of assessing the value at the present of things allotted to different points in time.
Economic evaluation: Comparative analysis of alternative courses of action in terms of both their costs and consequences.

Effectiveness: The extent to which a specific intervention, when used under ordinary circumstances, does what it is intended to do. Clinical trials that assess effectiveness are sometimes called management trials (NICE, 2002).

Efficacy: The extent to which an intervention produces a beneficial result under ideal conditions. Clinical trials that assess efficacy are sometimes called explanatory trials and are restricted to participants who fully co-operate.

Environment: The physical and therapeutic external conditions or surroundings.

Epidemiological study: A study which looks at how a disease or clinical condition is distributed across geographical areas.

Exceptional circumstances: those circumstances which can not reasonably be foreseen and as a consequence cannot be planned for.

Extrinsic: Factors that are external to the individual.

Follow-up: Observation over a period of time of an individual, group or population whose relevant characteristics have been assessed in order to observe changes in health status or health-related variables.

Forensic Services: Mental health services based on authority derived from judicial actions.

Gender: Those characteristics of women and men that are socially determined, as opposed to 'sex' which is biologically determined. (Mainstreaming Gender and Women's Mental Health Implementation Guide, 2003).
**Gold standard:** A method, procedure or measurement that is widely accepted as being the best available.

**Good Practice Point:** A recommendation for good practice based on the experience of the Guideline Development Group.

**Guideline Recommendation:** A systematically developed statement that is derived from the best available research evidence, using predetermined and systematic methods to identify and evaluate evidence relating to the specific condition in question.

**Health technology assessment:** The process by which evidence on the clinical effectiveness and the costs and benefits of using a technology in clinical practice is systematically evaluated.

**Incidence:** The number of new cases of illness commencing, or of persons falling ill during a specified time period in a given population.

**Intrinsic:** Factors present within the individual.

**Light Sedation:** A state of rest and reduction of psychological activity, but verbal contact is maintained.

**Logistic regression model:** A data analysis technique to derive an equation to predict the probability of an event given one or more predictor variables. This model assumes that the natural logarithm of the odds for the event (the logit) is a linear sum of weighted values of the predictor variable. The weights are derived from data using the method of maximum likelihood.

**Low Secure Units:** Low secure units deliver intensive, comprehensive, multidisciplinary treatment and care by qualified staff for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the
provision of security (Department of Health, Mental Health Policy Implementation Guide, 2002).

**Mechanical Restraint:** A method of physical restraint involving the use of authorised equipment applied in a skilled manner by designated healthcare professionals. Its purpose is to safely immobilise or restrict movement of part/s of the body of the individual concerned.

**Meta-analysis:** A statistical method of summarising the results from a group of similar studies.

**Minority Ethnic Group:** a group which is numerically inferior to the rest of the population in a State, and in a non-dominant position, whose members possess ethnic, religious or linguistic characteristics which differ from those of the rest of the population and who, if only implicitly, maintain a sense of solidarity towards preserving their culture, traditions, religion or language. (F. Capotorti, 'Minorities', in R. Bernhardt et al. eds., *Encyclopedia of Public International Law*, Elsevier (Amsterdam, 1985), vol.8, p.385.)

**Negative predicative value:** The probability that an individual is truly disease-free given a negative screening test.

**NHS Security Management Service (SMS) also known as the Counter Fraud and Security Management Service:** is a Special Health Authority which has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud and corruption and the management of security in the National Health Service ([http://www.cfsms.nhs.uk/](http://www.cfsms.nhs.uk/)).

**Number needed to harm:** The number of people (calculated statistically) who need to be treated to cause one bad outcome. The lower the number needed to harm, the higher the likelihood of harm (NICE, Schizophrenia Guideline, 2002).
**Number needed to treat:** The number of patients who need to be treated to prevent one bad outcome (i.e. a good outcome). It is the inverse of the risk difference (NICE, Schizophrenia guideline, 2002).

**Observation:** A two-way relationship, established between a service users and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user (UKCC, 2002).

**Odds Ratio:** (OR) Ratio of the odds of the outcome in the treatment group to the corresponding odds in the control group. Again, for an adverse outcome, an odds ratio below 1 indicates that the treatment reduces the risk (Glasziou, 2001).

**Patient:** The term 'service user' is preferred to refer to people with mental illness in this guideline. The term 'patient' is used under the following conditions:
- Generic and typical usage, such as NICE programme for patients', Patient Bill of Rights'.
- NICE recommendations which are required to be quoted verbatim.
- Frequently used noun compounds, (e.g. patient sample) (NICE, schizophrenia Guideline, 2002).
- In the sections which described Accident and Emergency settings, where the term ‘patient’ is normally used.

**Physical Intervention:** It is a skilled hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

**PICU (Psychiatric Intensive Care Unit):** Psychiatric intensive care is for patients compulsorily detained usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder (Department of Health, Mental Health Policy Implementation Guide, 2002).
Positive/Therapeutic Engagement: may be defined as a skilled nursing intervention that aims to empower the patient to actively participate in their care. Rather than "having things done to them ie. Observations" the patient negotiates the level of engagement that will be most therapeutic.

Positive predicative value: The probability that a person actually has the disease given that he or she tests positive using a given screening test.

Predictive validity: A risk assessment tool would have high predictive validity if the predictions it makes of violence in a sample became true (i.e. it has both high sensitivity and specificity).

Prevalence: The proportion of persons with a particular disease within a given population at a given time.

Principle of Proportionality: requires that one should not go beyond what is necessary to achieve the object pursued.

PRN: (Pro-re-nata) Medication that may be used as the occasion arises; when necessary.

Psychiatric In-patient Settings: any care setting in which psychiatric treatment is given to inpatients.

Psychosocial Interventions: the term is used to refer to a range of social, educational, occupational, behavioral, and cognitive interventions. Within the short-term management of disturbed/violent behaviour, the two main psychosocial interventions are deescalation and observation.

QTc Interval: The period in the cardiac cycle between depolarization (causing contraction) and repolarisation of the heart muscle. Some drugs prolong this interval.
This can lead to the development of arrhythmias (abnormal electrical activity in the heart) which may cause cardiovascular collapse and death.

**Quality adjusted life expectancy**: Life expectancy using quality adjusted life years rather than nominal life years.

**Quality adjusted life years (QALYs)**: A measure of health outcome which assigns to each time period a weight, ranging from 0-1, corresponding to the health related quality of life during that period, where a weight of 1 corresponds to optimal health, and a weight of 0 corresponds to a health state judged equivalent to death: these are then aggregated across time periods.

**Randomised controlled trial (RCT)**: A clinical trial in which the treatments are randomly assigned to subjects. The random allocation eliminates bias in the assignment of treatment to patients and establishes the bias for the statistical analysis.

**Rapid Tranquillisation**: The use of medication to calm/lightly sedate the service user, reduce the risk to self and/or others and achieve an optimal reduction in agitation and aggression thereby allowing a thorough psychiatric evaluation to take place and allowing comprehension and response to spoken messages throughout the intervention. Although not the overt intention, it is recognised that in attempting to calm/lightly sedate the service user, rapid tranquillisation may lead to deep sedation/anaesthetisa.

**Relative risk**: An estimate of the magnitude of an association between exposure and disease which also indicates the likelihood of developing the disease among persons who are exposed relative to those who are not. It is defined as the ratio of incidence of disease in the exposed group divided by the corresponding incidence in the non-exposed group.

**Respiratory Effect**: the changes in thoracic or abdominal circumference that occur as the subject breathes
**Retrospective cohort study:** A study in which a defined group of persons with an exposure and an appropriate comparison group who are not exposed are identified retrospectively and followed from the time of exposure to the present, and in which the incidence (or mortality) rates for the exposed and unexposed are assessed.

**Seclusion:** the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. Seclusion should be used as a last resort; for the shortest possible time. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of shortage of staff; where there is any risk of suicide or self-harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

**Sensitivity:** Percentage of those who developed a condition who were predicted to be at risk.

**Sleep:** a condition of body and mind such as that which normally recurs for several hours every night, in which the nervous system is inactive, the eyes closed, the postural muscles relaxed, and consciousness practically suspended (the Oxford English Dictionary).

**Specificity:** Percentage of those correctly predicted not to be at risk.

**Systematic review:** A way of finding, assessing and using evidence from studies (usually RCTs) to obtain a reliable overview.

**Threat control override symptoms:** a combination of feeling threatened and losing the sense of internal control of our own thoughts and actions. This cluster of symptoms tends to be most related to an increased risk of violent behaviour toward others.
Validity: The extent to which a variable or intervention measures what it is supposed to measure or accomplish.

Internal validity: of a study referring to the integrity of the design.

External validity: of a study referring to the appropriateness by which its results can be applied to non-study patients or populations.

Violence: The use of physical force which is intended to hurt or injure another person (Wright, 2002).

Vulnerability: Specific factors that relate to the likelihood of an individual being victimised, taken advantage of or exploited by others. Vulnerable individuals may be subject to verbal abuse or harassment, physical or sexual abuse or intimidation, coercion into unwanted acts and bullying. Assessment of vulnerability may include consideration of mental state, physical/physiological conditions, psychological or social problems, cultural or gender issues.
Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings Guideline

Contents

1. Executive Summary 20
2. Principles of Practice 21
3. Key priorities for Implementation 22
4. Background to the Guideline 25
5. Aims of the Guideline 28
6. Pathway of Care for the Short-Term Management of Disturbed/Violent Behaviour 30
   6.1 Introduction (includes legal preface)
   6.2 Prevention
      6.2.1 Environment and Alarm Systems
      6.2.2 Prediction: Antecedents, Warning signs and Risk Assessment
   6.3 Training
   6.4 Working with Service Users (from Diverse Backgrounds)
      6.4.1 Service User Perspectives
      6.4.2 Minority Ethnic Groups
      6.4.3 Gender
      6.4.4 Other Special Concerns
   6.5 Psychosocial Techniques
      6.5.1 De-escalation Techniques
      6.5.2 Observation
   6.6 Other Interventions
      6.6.1 Physical Interventions
      6.6.2 Seclusion
      6.6.3 Rapid tranquillisation
   6.7 Accident and Emergency Settings
7. Methods and Findings 50
   7.1 Summary of Process
   7.2 Key Clinical Questions
   7.3 Review Methods
      7.3.1 Search Strategies
      7.3.2 Sifting and Reviewing the Evidence
      7.3.3 Data Abstraction
      7.3.4 Data Synthesis
      7.3.6 Appraisal of Methodological Quality
   7.4 Evidence Grading
   7.5 Deriving and Grading Recommendations
   7.6 Cost Effectiveness Review and Analysis - Overview
      7.6.1 Identification of Papers
7.6.2 Reviewing the Evidence
7.6.3 Estimation of Cost Effectiveness
7.7 Consensus process
7.8 Methods of Individual Evidence Reviews
7.8.1 Introduction
7.8.2 Prevention
7.8.2.1 Environment
7.8.2.2 Alarm Systems
7.8.2.3 Prediction: Antecedents, Warning Signs and Risk Assessment
7.8.3 Training
7.8.4 Staff and Service User Perspectives
7.8.4.1 Staff and Service User Perspectives - General
7.8.4.2 Minority Ethnic Groups
7.8.4.3 Gender
7.8.4.4 Other Special Concerns
7.8.5 Psychosocial Interventions
7.8.5.1 De-escalation Techniques
7.8.5.2 Observation
7.8.6 Other Interventions
7.8.6.1 Physical Interventions and Seclusion
7.8.6.2 Rapid Tranquillisation
7.8.7 Accident & Emergency Settings

8. Recommendations and Good Practice Points

9. Audit criteria

10. Recommendations for Research

11. Dissemination of Guidelines

12. Validation

13. Scheduled Review of the Guideline

14. Guidelines and Reports Consulted

15. References

16. Appendices (separate file)

Appendix 1 Guideline Development Group
Appendix 2 Scope of Guideline
Appendix 3 An Outline of How the Clinical Questions deliver the Remit via the Scope (separate file)
Appendix 4 Search Strategy, Databases Searched and Search Logs
Appendix 5 Evidence tables - Included Studies
Appendix 6 Evidence tables - Excluded Studies
Appendix 7 Prediction - Ineligible Studies
1. Executive Summary

The National Institute for Clinical Excellence (NICE) commissioned the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) to develop guidelines on the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and Accident and Emergency settings. This follows referral of the topic by the Department of Health and Welsh Assembly Government. This document describes the methods for developing the guidelines and presents the resulting recommendations. It is the source document for the NICE (short-form version), the abridged version for health professionals and the Information for the Public (patient) versions of the guidelines which will be published by NICE, and be available on the NICE website (www.nice.org.uk). The guidelines were produced by a multidisciplinary guideline development group (GDG) and the development process was undertaken by the NCC-NSC.

The main areas examined by the guideline were:

- Environment and Alarm Systems
- Prediction: Antecedents, Warning Signs and Risk Assessment
- Training
- Working with Service Users (from Diverse Backgrounds)
- De-escalation Techniques
- Observation
- Physical Interventions
- Seclusion
- Rapid Tranquillisation
- Accident and Emergency Departments

Recommendations and good practice points based on the best available evidence of clinical and cost effectiveness are presented. However, there was a dearth of evidence in all areas covered by this guideline and all recommendations and good practice points were arrived at by the GDG using formal consensus methods.

Evidence published after 2003 was not considered, with the exception of rapid tranquillisation.

Healthcare professionals should use their clinical judgement and consult with service users when applying the recommendations and good practice points described in this guideline, which aim at reducing the negative physical, social and financial impact of managing disturbed/violent behaviour in adult psychiatric in-patient settings and Accident and Emergency settings in the short-term (72hrs).
2. Principles of Practice

The principles outlined below, describe the ideal context in which to implement the recommendations and good practice points contained in this guideline. Many of these principles are reinforced by specific recommendations and good practice points.

Person-centred care

- Service users and their carers should be made aware of the guideline and its recommendations and be referred to the Information for the Public version (IFP).

- Service users and their carers should be involved in shared decision-making about the preferred choice of intervention for the short-term management of violence through advance directives.

A collaborative inter-disciplinary approach to care

- All members of the inter-disciplinary team should be aware of the guidelines and all interventions should be documented in the service users’ healthcare records.

Organisational issues

- An integrated approach should be taken to the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings, with a clear strategy and policy supported by management.

- Care should be delivered in a context of continuous quality improvement where improvements to care following guideline implementation are the subject of regular feedback and audit.

- Commitment to and availability of education and training are needed to ensure that all staff, regardless of profession, are given the opportunity to update their knowledge-base and are able to implement the guideline recommendations.

- Service users should be cared for by personnel who have undergone appropriate training and who know how to initiate and maintain correct and suitable preventative measures. Staffing levels and skill mix should reflect the needs of service users and healthcare professionals.
3. Key priorities for implementation

The reader is referred to the evidence reviews for a summary of the supporting evidence and evidence statements (section 7). The grading systems can be found in 7.4 and 7.5. A full account of all the recommendations in the guideline can be found in section 8. (The key recommendations follow the order in which they appear in section 8.)

The following have been identified as priorities for implementation.

- Measures to reduce violence need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers must ensure that a full risk management strategy is introduced for all their services. (D)

- 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 or as soon as possible thereafter. 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)

- 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)

- All service providers must have a policy for training employees and staff-in-training in relation to the short-term management of violence. It
must specify who will receive what level of training (based on risk assessment), how often they will be trained and also outline the techniques in which they will be trained. (D)

- All those involved in the administration, prescribing and monitoring of a service user receiving parenteral rapid tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) (covers airway, Cardio-Pulmonary Resuscitation (CPR) and use of defibrillators).

The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within 3 minutes in healthcare settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked weekly. (D)

- Service users and/or service user groups should have the opportunity to become actively involved in training and setting the training agenda, e.g. vulnerable groups such as:
  - service users with a sensory impairment
  - Black and minority ethnic service users
  - service users with a physical impairment
  - service users with a cognitive impairment
  - Women service users (D)

- All staff, whose need is determined by risk assessment, must receive on-going mandatory training to recognise anger, potential aggression, antecedents and risk factors of violence and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with violent behaviour. (D)

- Rapid tranquillisation, physical interventions and seclusion should only be considered once de-escalation and other strategies have failed to calm the
service user. They should never be used as punishment. When determining which of these interventions to employ, clinical need, safety of the service user and others and, where possible, advance directives should be taken into account.

The intervention selected must be a reasonable and proportionate response to the risk posed by the service user. (D)

- During physical restraint one team member must be responsible for protecting and supporting the head and neck at all times. The team member who is responsible for supporting the head should take responsibility for leading the team through the restraint process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored. (D)

- A number of physical skills may be used in the management of a violent incident:
  - The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.
  - Certain techniques use the deliberate application of pain. However, every effort must be made to utilise skills and techniques that do not rely upon the deliberated application of pain, which is only permitted in exceptional circumstances and when other techniques have been tried and proved unsuccessful.
  - It should be noted that the application of pain may lead to a worsening of an already highly charged situation and so should be avoided unless absolutely necessary. (D)

- All facilities must have an operational policy on the searching of service users, their belongings, the environment in which they live and also the searching of visitors. Where necessary the policy should refer to related policies such as those for substance misuse and police liaison. (D)
The searching policy should be in place in order to ensure the creation and maintenance of a safe and therapeutic environment for service users, staff and visitors. (D)
4. Background to the Guideline

Background to Commissioning of the Guideline

In March 2002, the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) was commissioned by NICE to develop cost effective and clinically relevant guidelines on the short-term management of violence in adult psychiatric in-patient settings and Accident and Emergency settings. The remit from the DoH and Welsh Assembly Government was as follows:

To prepare clinical guidelines for the NHS in England and Wales for the short-term management of disturbed/violent behaviour in in-patient psychiatric settings, including consideration of pharmacological, physical (including seclusion and restraint), preventative and psychosocial interventions.

Relationship to Other Key Developments such as NSFs, Other Guidelines; Policies

The short-term management of violence is a key government target. This is outlined in the recently developed Mental Health National Service Framework (1999) which stipulates that staff should be competent to assess the risk of violence, manage individuals who may become violent, and that staff should know how to assess and manage risk and ensure safety. The effective short-term management of disturbed or violent behaviour is a means of helping to minimise the risk of injury to the individual service user, other service users and staff involved in these types of incident.

The short-term management of violence is also a key aim in the cross-Government NHS zero tolerance zone campaign, which was launched in 1999. The aim of this initiative is to combat violence against NHS staff, where violence is defined as:

Any incident where staff are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health.

(www.nhs.uk/zerotolerance/definitions.htm)

In the light of the serious nature of disturbed/violent behaviour in adult psychiatric in-patient settings and Accident and Emergency settings, the interventions for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and related topics were selected as the focus for this NICE guideline.

The Royal College of Psychiatrists produced a guideline (RCPsych guideline) on the short term management of violence, *The Management of Imminent Violence* in 1998, which was due to be updated. All the archive material for this guideline was obtained, search strategies and critical appraisal sheets examined, and copies of the original evidence reviews were considered. The original appraisal of the guideline undertaken
by St George’s hospital was also obtained (see Appendix 12). The guideline and all archive material was then appraised using the Agree Tool (see Appendix 11). On this basis, it was decided that the RCPsych guideline should be used as a basis for the current guideline, meaning that this guideline would update and replace the RCPsych guideline, while also extending it into new areas. Searches for this guideline did not therefore go back further than 1985, unless otherwise stated, as this period was covered by the RCPsych searches. All studies included from RCPsych guideline can be found in the evidence tables of included studies for this guideline (Appendix 5). All evidence statements in this guideline take into account both the evidence-base contained in the RCPsych guideline and that generated from any new studies included here.

The NICE guideline on Schizophrenia (2002) also reviewed rapid tranquillisation in relation to the treatment of schizophrenia. This current guideline builds on the work already done in this area by the National Collaborating Centre for Mental Health (NCC-MH) who developed the NICE guideline on Schizophrenia.

The NICE guideline on Bipolar Disorder (forthcoming 2006) will also review the issue of rapid tranquillisation in relation to the treatment of mania.

In addition to this guideline, several further initiatives are also currently underway which seek to improve the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings. These are:

- The collaborative work being undertaken by the National Institute for Mental Health in England (NIMHE) and the NHS Security Management Service (SMS) who are in the process of establishing a core training curriculum for the short-term management of violence, and a national accreditation scheme for trainers. The core training curriculum is expected to be announced in 2005 and the accreditation scheme is expected to come into force in 2005. The NCC-NSC and the GDG has worked closely with these agencies in developing this guideline and where appropriate, recommendations and good practice points clearly state that guidance in these areas should defer to NIMHE and the SMS once their work has been completed.

- A national audit of the short-term management of violence is being carried out by the Royal College of Psychiatrists on behalf of the Healthcare Commission. The first phase of the audit was scheduled to run concurrently with the development of this guideline. The NCC-NSC liaised closely with the Royal of Psychiatrists and are grateful to them for developing the audit criteria listed in this guideline (see section 9).

- The David Bennett Inquiry raised important concerns about the treatment of Black service users within the NHS. While the inquiry examined the whole of Mr Bennett’s care, many of the recommendations produced by the inquiry are relevant to the scope of this guideline. Each of these recommendations has been carefully considered and reflected upon when developing the recommendations and good practice points in this guideline.
Additional consultation work with Black service users was also undertaken by the NCC-NSC in the course of the development of this guideline. We are grateful to Black Orchid in Bristol and Footprints UK in Walthamstow for running focus groups for us. This work was used to inform the recommendations and good practice points, see in particular the section on working with service users (from diverse backgrounds) found in section 8.4. The NCC-NSC also ran a focus group with healthcare professionals experienced in the area of black mental health (see Appendix 14).

Clinical Need for the Guideline

Disturbed or violent behaviour by an individual in an adult in-patient psychiatric setting poses a serious risk to that individual, other service users and to staff. In 1998/99, an NHS Executive survey found that there were approximately 65,000 violent incidents against staff across the NHS. The average number of incidents in mental health/learning disability trusts was over three times the average for all trusts.

The scope of the guideline discusses the short-term management of disturbed/violent behaviour in adult psychiatric settings (72 hours). The guidance applies to all adult persons between the ages of 18-65.
5. Aims of the Guideline

5.1 Aims of the Guideline

- To evaluate and summarize the clinical and cost evidence for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings;
- To highlight gaps in the research evidence;
- To formulate evidence-based and where possible, cost-effective clinical practice recommendations on the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings based on the best evidence available to the GDG (guideline development group); and
- To provide audit criteria to assist with the implementation of the recommendations.

5.2 Who is this Guideline for?

As detailed in the guideline scope (see Appendix 2), the guideline is of relevance to:

- Mental healthcare professionals and other staff who work in adult psychiatric in-patient settings and Accident and Emergency settings
- Service users
- Families and carers
- Managers and those responsible for service delivery.

5.3 Groups covered by the Guideline

The recommendations made in the guideline cover the care of:
- Adults (18-65years)

Groups not covered

- Children and adolescents below the age of 18 years
- Older people (over the age of 65 years)
- Adults with learning disabilities
- Patients with a primary diagnosis of substance abuse
- Patients with organic brain disorders or progressive neurological disease

Healthcare setting

The recommendations apply to healthcare professionals who are involved in the short-term management of disturbed/violent behaviour across the range of in-patient settings in the UK. **Short-term is defined as 72 hours.**
Interventions and related topics covered

- Environment and Alarm Systems
- Prediction: Antecedents, Warning Signs and Risk Assessment
- Training
- Working with Service Users (from Diverse Backgrounds)
- De-escalation Techniques
- Observation
- Physical Interventions
- Seclusion
- Rapid Tranquillisation
- Accident and Emergency Settings

Interventions not covered

- Interventions for the short-term management of disturbed/violent behaviour in community psychiatric settings, non-psychiatric in-patient settings and learning disability settings.
- Interventions for the long term management of disturbed/violent behaviour in psychiatric settings.

Audit Support

The guideline provides audit criteria and advice drawn up in conjunction with the Royal College of Psychiatrists CHI audit team. (See section 9)

5.4 Guideline Development Group

The guideline recommendations were developed by a multidisciplinary and lay Guideline Development Group (GDG) convened by the NICE-funded National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) with membership approved by NICE. Members include representatives from:

- service user groups;
- nursing;
- field of psychiatric medicine and emergency medicine;
- allied health;
- pharmacy;
- law;
- training;
- researchers; and
- staff from the NCC-NSC.

A list of GDG members is attached (Appendix 1).

The GDG met 12 times between May 2002 and June 2004.
All members of the GDG were required to make formal declarations of interest at the outset, which were recorded. GDG members were also asked to declare interests at the beginning of each GDG meeting. This information is recorded in the meeting minutes and kept on file at the NCC-NSC.
6. Pathway of Care for the Short-Term Management of Disturbed/Violent Behaviour
6.1 Introduction

This guideline considers the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings. It considers a number of interventions and related issues. Although separate from one another, each of the interventions and related issues described here form part of an integrated pathway of care. It is hoped that the order in which these topics are discussed will facilitate this pathway of care.

The guideline begins by considering short-term prevention, the most desirable management strategy for the short-term management of disturbed/violent behaviour. Two areas are examined: the environment, organisation and alarms, and prediction, which is sub-divided into three areas, antecedents of violence, warning signs and risk assessment. The guideline then turns to training needs, since none of the interventions discussed in this guideline can be safely practiced without adequate training. This topic is followed by an examination of service user perspectives, and issues raised in relation to Black and minority ethnic groups, gender and other related concerns, all of which staff need to be conversant with before employing the interventions described in this guideline. The guideline then turns to psychosocial intervention: de-escalation techniques and observation, before examining the other interventions, physical interventions and seclusion and rapid tranquillisation. It then considers post-incident reviews. Finally the guideline considers special issues relating to the short-term management of disturbed/violent behaviour in Accident and Emergency settings, and the issue of searching.

The following background information is offered to contextualise the issues addressed in the evidence reviews, the recommendations and good practice points which follow.

6.1.1 Legal Preface

The short-term management of disturbed/violent behaviour in psychiatric in-patient settings takes place within a multi-faceted legal framework, compliance with which is a core measure of quality and good practice. For example, the management of disturbed behaviour frequently involves interventions to which an individual does not – or cannot – consent. It is especially important that such interventions are in accordance with best practice.

The law provides the authority to respond to disturbed behaviour in some circumstances, and it sets out considerations that are extremely important when service-providers have to decide what action they may take. The contribution of the law to the management of disturbed behaviour should be recognised as positive and facilitative.

All those involved in the short-term management of disturbed/violent behaviour in psychiatric in-patient settings should:

- Be familiar with, in particular:
The relevant sections of the Mental Health Act 1983 and its Code of Practice;

- The principles underlying the Common Law doctrine of ‘necessity’; and

- The requirements of the relevant articles of the European Convention on Human Rights, including Article 3 (the right to be free from torture or inhuman or degrading treatment or punishment), Article 5 (the right to liberty and security of person save in prescribed cases) and Article 8 (the right to respect for private and family life), and the principle of ‘proportionality’.

- Receive regular training on the legal aspects of the management of disturbed behaviour.

- Ensure that a comprehensive record is made of any intervention necessary to manage an individual’s disturbed behaviour, including full documentation of the reason for any clinical decision;

- Ensure or contribute to ensuring that all aspects of the management of disturbed behaviour are monitored and audited on a regular basis, and that any consequential remedial action is drawn to the attention of those responsible for implementing it.

- Be aware of the obligations owed to a service-user while his/her disturbed behaviour is being managed, and of parallel obligations to other service users affected by the disturbed behaviour, to members of staff, and to any visitors.

- Ensure or contribute to ensuring that any service-user who has exhibited disturbed behaviour should not be the subject of punitive action by those charged with providing him/her with care and treatment, and that where the disturbed behaviour is thought to warrant criminal sanction, it is drawn to the attention of the proper authority.

### 6.2 Prevention

#### 6.2.1 Environment and Alarm Systems

Environmental factors are believed to be important determinants of disturbed or violent behaviour in psychiatric in-patient settings. A therapeutic environment is one that allows individuals to enjoy safety and security, privacy, dignity, choice and independence without compromising the clinical objectives of the service. Comfort, noise control, light, colour and access to space will all have an impact on the well-being of both staff and service users. However, to date there has been very little research conducted to ascertain how the environment affects staff and service users of in-patient psychiatric settings.
The little existing research in this area has suggested that high traffic areas in in-patient units are the location of the largest number of assaults. Several studies have indicated that the highest proportion of assaults occur in either the day room/communal room or in the corridors (Carmel, 1989; Coldwell and Naismith, 1989; Lanza et al, 1993; Rosenthal et al, 1992), suggesting that assault frequency is related to either a chance encounter or that crowding (service user population density) is a significant factor. Studies of temporal variation show that most assaults occur during mealtimes and afternoons and increase in frequency until late evening (Carmel, 1989; Lanza et al, 1993; Manfredini et al, 2001).

Recent national guidance documents have highlighted the need for in-patient psychiatric settings to not only be safe and secure for staff and service users, but further, have recommended that the quality of design and finish should also be a prime consideration. Indeed, recent audit reports have indicated that many UK psychiatric in-patient facilities have failed to meet basic standards for a decent working or residential care environment and these wards are rated by staff, service users and visitors as noisy, hot, smelly and dirty (College Research Unit, 2000; 2001).

Alarm systems are also an essential environmental safety feature in psychiatric in-patient settings. The report Violence and Aggression to Staff in Health Services, outlines three types of alarm system:

**Panic Buttons**

Panic button systems are hardwired systems operated by strategically placed buttons installed throughout the area where a threat exists. When they are activated, an audible or visual alarm is triggered on a monitoring console. [...] panic buttons may be useful in treatment and consulting rooms, where their location is known only to members of staff (Health & Safety Commission, 1997, p21).

**Personal Alarms**

Personal alarms may be of the simple 'shriek' type or may form part of more complex systems. [...] They are most effective in situations where other people may hear them and can respond (Health & Safety Commission, 1997, p21).

**More Complex Personal Alarms**

More complex systems may be suitable in particularly high risk areas. They include personal alarms linked to fixed detection systems by infra-red or radio systems (Health & Safety Commission, 1997 p23).

The RCPsych guideline suggested that personal and institutional alarms and communication devices are a useful means of pre-empting disturbed/violent behaviour and of protecting staff when instances of violent behaviour arise. However, there is a paucity of research in this area.
6.2.2 Prediction: Antecedents, Warning Signs and Risk Assessment

While most service users in psychiatric in-patient settings are not violent, a small minority place healthcare professional and other service users at serious risk of assault. The prediction of short-term violence is not therefore an outcome which is measured for its own sake, but is part of a risk management plan which works towards minimising violence and aggression, allowing both service users and staff to feel safe. As a consequence, risk assessment must be seen as an essential intervention, possibly the single most important intervention, in the therapeutic management of disturbed and violent behaviour. Worryingly, a survey conducted in 1999 by the Standing Nursing and Midwifery Advisory Committee (SNMAC) found that risk management, which should logically follow from risk assessment, is poorly defined and practice is highly variable (SNMAC, 1999). Furthermore they found that risk assessment was not regarded as an essential aspect of clinical practice (SNMAC, 1999). While nothing can ever be predicted with 100% accuracy, prediction of short-term violence and risk assessment are integral to the management of violence in psychiatric in-patient healthcare settings. The recent UKCC report stresses,

While it is absolutely clear that violence is often unpredictable, the use of comprehensive risk assessment materials, followed by a properly developed plan is an absolute pre-requisite for the recognition, prevention, and therapeutic management of violence (UKCC, 2002, p15, p22).

Much of the research pre-1995, the cut-off points for the majority of the searches underlying the original RCPsych guideline, suggested that risk factors of short-term psychiatric in-patient violence can be identified. Key risk factors appear to include a history of violence, young age and number of admissions. However, Stein (1998) argues that the real challenge is not their identification, but in how they should be combined and weighted. As he states,

The prediction of [...] harm to others is a complex and unreliable synthesis of observed past behaviour (both inside and outside of hospital [...]. The key predictors are well understood but there is much less agreement about how they should be weighed [...] 

The issue that therefore faces mental healthcare professionals is how the best predictive validity can be attained. Three main approaches have been adopted:

- the clinical approach ('first generation')
- the actuarial approach ('second generation') which includes actuarial tools or checklists
- structured clinical judgment ('third generation').
Most of the literature prior to 1995 suggests that clinical judgment has poor positive predictive validity of around 33% (Doyle and Dolan, 2002). A 'second generation' of risk assessment studies therefore adopted actuarial measures in an attempt to raise the positive predictive validity of short-term psychiatric in-patient violence. This actuarial approach depends on 'assessors reaching judgments based on statistical information according to fixed and explicit rules' (Doyle and Dolan, 2002). Actuarial checklists have been created to enhance this process. Both the use of checklists and this general approach has been suggested to improve predictive validity (Doyle and Dolan, 2002). However, there are noticeable disadvantages to this approach, in particular the tendency it generates to focus on static factors, such as history of violence, demographic information and diagnosis, without taking individual service users cases needs into consideration.

Most recently, it has been suggested that prediction needs to be carefully slotted into a more holistic approach which places emphasis on the empirical or static factors isolated by the actuarial approach whilst combining it with clinicians' judgments. This 'third generation' approach, described by Doyle and Dolan (2002) as 'structured clinical judgment' has the advantage of placing emphasis on the service user as an individual and allowing risk to be seen as a moving rather than static entity, so that stage of disease, and any fluctuations in personal and environment factors are taken into consideration. Such an approach seems to mirror the objectives of the UKCC report, where it states that,

\[
\text{The assessment of risk is an essential part of the care and treatment of all patients. It is most important to stress that risk levels change. Therefore, [...] the nature and level of risk should be subject to regular review (UKCC, 2002, p15, p22).}
\]

### 6.3 Training

There are currently no formal regulations governing training for the short-term management of violence in the UK. There are over 700 training providers in the UK. The David Bennett Inquiry (2004) recommended that a national approach to training should be set up in the next year. The National Institute for Mental Health in England (NIMHE) are currently mapping the various training packages on offer in the UK and in conjunction with the NHS Security and Management Service (SMS) are drawing up a core training curriculum for the UK and setting up an accreditation scheme for trainers.

At present very few of the training programmes are based on evidence of either the effectiveness of training or the benefits perceived by staff and/or service users. As Leadbetters and Perkin (2002) states,

\[
\text{The assumption that training is the key element in reducing risk and increasing safety is common [...] Such simplistic populist assumptions support quick-fix organisational solutions [...] and are challenged by}
\]
As training is expensive, it is necessary that Trusts are able to measure its benefits. Without such an evidence-base there is a danger that training that is beneficial and possibly life-saving, will be neither sought or offered.

6.4 Working with Service Users (from Diverse Backgrounds)

6.4.1 Service User Perspectives

In recent years a great deal has been written within guidance material on the need to involve service users in their care. One of the guiding principles of the NSF on Mental Health is to involve service users and their carers in planning and delivery of care (Mental Health, National Service Framework, 1999). This principle is echoed by the Department of Health who argue that:

In order to create a genuinely patient-centred service several processes should be created to enable users to contribute to the design and delivery of care. The aim is to promote a non-judgmental, non-patronising, collaborative approach to care (Department of Health, Mental Health Policy Implementation Guide, 2002, p14).

The UKCC laid out a number of principles that they believe need to be met in order to fulfil such aims in relation to adult service users in psychiatric in-patient settings. They argue that:

- The prevention and management of violence should primarily be viewed as an occupational problem, requiring a cohesive, multi-faceted organisational approach. The safety and homeliness of clinical areas, the quality of life in clinical areas and the nature of staff interventions with patients and the assessment of the needs of patients and their clinical management are at least as important in this regard as training in and use of any specific intervention strategies. The importance of these factors needs to be recognised and emphasised in training and practice (UKCC, 2002).

- Service users, their advocates, and their carers should be involved in reviews of policies, and their contribution to the planning and provision of training should be seen as essential. The recent inquest of the death of David Bennett highlighted once more the need to consider race, culture, and ethnicity in all areas of policy, practice and training. The input by service users, advocates and carers noted above must be incorporated into these perspectives (UKCC, 2002).

6.4.2 Ethnicity
The David Bennett Inquiry (2004) highlighted the importance of considering the needs of Black and minority ethnic groups, when managing disturbed/violent behaviour in the short-term. For the purpose of this guideline, the following definition of minority ethnic groups, taken from the Concise Oxford Dictionary 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, an African Caribbean service user who died whilst being restrained on a secure unit.

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? (DOH/Social Service Inspectorate, 1998), has been adopted:

**Black:** refers to those members of the ethnic minority groups who are differentiated by their skin colour or physical appearance, and may therefore feel some solidarity with one another by reason of past or current experience, but who may have many different cultural traditions and values.

For this purpose of this guideline, the following definition of African Caribbean has been adopted:

Of or pertaining to both Africa and the Caribbean; used to designate the culture, way of life, etc or the characteristic style of music of those people of Black African descent who are, or whose immediate forebears were, inhabitants of the Caribbean (West Indies). (Taken from Oxford English Dictionary Online)

It is maintained that Black and particularly African Caribbean service users are over-represented within the mental health services in the UK, particularly in forensic settings. A variety of reasons have been advocated, including:

- Prevalence of schizophrenia amongst African Caribbean service users (Ndegwa, 2000)
- Institutional racism (Sashidharan, 2003).
It is also suggested that recent shifts in government policy have led to a more punitive approach within mental health services, particularly secure settings, and that young Black African Caribbean men have been made to bear the burden of this altered approach (Fernando et al, 1998). Again it has been asserted that this burden reflects racial stereotyping that regards young African Caribbean men as 'big, black and dangerous' (Prins H, *Big, Black and Dangerous? Report of the Committee of Inquiry into the death in Broadmoor Hospital of Orville Blackwood and a Review of the deaths of two other Afro-Caribbean patients*, 1993). It is suggested that this stereotyping affects the treatment of African Caribbean service users within many mental health settings. (Littlewood and Lipsedge, 1997).

As a result of the concerns relating to the treatment of African Caribbean service users, the review in this guideline has given particular attention to the short-term management of the disturbed/violent behaviour of African Caribbean service users in psychiatric in-patient settings. It has not done so, however, to the exclusion of other ethnic groups.

6.4.3 Gender

Gender needs must also be taken into consideration, as far as possible, in the short-term management of violence in psychiatric in-patient settings. For the purpose of this guideline the following definitions of gender has been adopted:

Gender describes those characteristics of women and men that are socially determined, as opposed to 'sex' which is biologically determined. (*Mainstreaming Gender and Women's Mental Health Implementation Guide*, 2003).

While general differences between men and women in terms of mental health have been recognised, (for example, women are more likely to self-harm and suffer from depression, and men more likely to experience earlier onset and more disabling courses of schizophrenia), a recent report by the Department of Health, *The Women and Mental Health Strategy* (2003) stresses that these differences should be used to inform our understanding of an individual rather than obscure their individuality. A further report reinforced the message that women's mental health needs to be conducted in relation to an individual woman's experiences, beliefs and struggles, as well as her ethnic group, age and sexual preferences (*Good Practices in Mental Health*, 1996).

In terms of managing violent (disturbed) behaviour in psychiatric in-patient settings, the main concern raised in *The Women and Mental Health Strategy* has been to identify gender specific needs, such as single-sex facilities, and to ensure that both male and female service users feel safe, listened to and involved in identifying and meeting gender related needs (*Mainstreaming Gender and Women’s Mental Health Implementation Guide*, 2003).

6.4.4 Other Special Concerns
This evidence review focuses specifically on disabilities, other than learning disabilities, in the context of the short-term management (i.e. **72 hours**) of disturbed/violent behaviour within psychiatric in-patient departments and Accident and Emergency settings. It aims to consider the effects of sensory impairment, as it has been noted that service users with such sensory impairments are particularly vulnerable when managed using the interventions discussed in this guideline. One such example is the restraining of a deaf service users hands, thereby preventing them from communicating.

Very little has been written on the needs of disabled service users in relation to the short-term management of violence in psychiatric in-patient settings.

### 6.5 Psychosocial Interventions

#### 6.5.1 De-escalation Techniques

De-escalation (also referred to as 'defusing' or 'talk-down') involves the use of various psychosocial short-term techniques aimed at calming disruptive behaviour and preventing violent incidents from occurring. Every effort is made to avoid confrontation. This can include talking to the service user, often known as verbal de-escalation, moving service users to a less confrontational area, or making use of a specially designated space for de-escalation. Stevenson and Otto (1998) offers the following definition of verbal de-escalation:

> What is verbal de-escalation? A nurse might describe it as "talking the patient down," but it is actually a complex, interactive process in which a patient is redirected towards a calmer personal space.

There are competing theoretical approaches to de-escalation, including verbal de-escalation. Some approaches make use of communication theory (e.g. Paterson and Leadbetter, 1997), others of situational analysis (Rix, 2001). All approaches emphasise the need to observe for signs and symptoms of anger and agitation, approaching the person in a calm controlled manner, giving choices and maintaining the service users dignity. Some approaches suggest mirroring the patients mood. De-escalation techniques also emphasise the therapeutic use of the nurse's own personality and relationship with the person (use of self) as one method to interact therapeutically with the patient.

In all approaches to de-escalation, stress is laid on the need for training and self-awareness. For example, Rix (2001) comments:

> Becoming competent at de-escalation is in itself a sophisticated activity requiring much more than just a theoretical understanding of aggression. It cannot be considered in purely academic terms. The practitioner must undertake a developmental process, resulting in highly evolved self
Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings Guideline

awareness enabling the skills of de-escalation to become instinctive.

A recent report notes, however, that despite the emphasis that is often placed on the importance of de-escalation, little research has been carried out into the effectiveness of any given approach, leaving nurses to contend with conflicting advice and theories:

Unfortunately, there has been little research conducted into the effectiveness of different approaches to de-escalation, or, for that matter, into the effectiveness of training in any given approach. As Paterson and Leadbetter (1999) note, there is no standard approach to de-escalation. At the same time, practitioners may be faced with contradictory advice provided in the context of differing theoretical explanations for the violent event (National Institute for Social Work Research Unit, 2000, p24).

6.5.2 Observation

Although much of the research carried out on observation has been undertaken in relation to the management of suicide and self-harm, the UKCC report (Feb 2002), which focuses on the short-term management of violence in psychiatric in-patient settings, argues that these principles form a good basis for the short-term management of violence in psychiatric in-patient settings. The UKCC report (Feb 2002) recommends that the principles of observation found in Addressing Acute Concerns (1999), a report that focuses on the management of suicide and self-harm, should be adopted nation-wide.

Although the focus of the work on observation in Addressing Acute Concerns was on suicide and self-harm, there are obvious implications for the use of observation in recognising the possibility of violence occurring and for preventing interventions (UKCC, 2002, p24).

[…] observation (carried out as set out in Addressing Acute Concerns) should underpin all other strategies (UKCC, 2002, p24).

Addressing Acute Concerns, defines observation as “regarding the patient attentively” while minimising the extent to which they feel that they are under surveillance’(addressing Acute Concerns, 1999, p2). The UKCC report (Feb 2002), regards observation as a ‘core nursing skill’ and ‘arguably a primary intervention in the recognition, prevention and therapeutic management of violence’(UKCC, 2002, p23). It suggests that observation must be a two-way relationship, established between a service user and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user. This relationship is considered to be the basis on which risk assessment, violence management and a programme of supportive observation can then be undertaken (UKCC, 2002).
Addressing Acute Concerns outlines four levels of observation (General Observation, Intermittent Observation, Within Eyesight, Within Arms Length) which, with slight modification, have been adopted within this current guideline. Other reports and studies detail a variety of other terms and levels of observation. The UKCC report (Feb 2002) argues that there is a need for the terminology to be standardised, quoting the following passage from Addressing Acute Concerns:-

Research on the nursing practice of observing patients who are at risk from self harm, or of causing harm to others, shows that there is no consistency in the definition of terms, principles or processes. In some trusts there is no written policy for observation. Trusts vary greatly in the indications for observation and in the personnel that are thought appropriate to perform it. Where policies and procedures do meet reasonable standards, they may not be implemented properly (Addressing Acute Concerns, 1999, p15).

Whilst the UKCC report (Feb 2002) has stressed the value of observation, Addressing Acute Concerns suggests that both nurses and service users have found this a difficult intervention with many nurses considering it custodial and lacking in therapeutic value (Addressing Acute Concerns, 1999).

6.6 Other Interventions

6.6.1 Physical Interventions

In the UK the physical interventions primarily used in the short-term management of disturbed/violent behaviour are manual holds, not mechanical devices such as belts, body vests or handcuffs. Such physical interventions are predominantly described in the literature as restraint. In this guideline, this terminology is avoided because of its association with particular techniques, like Control and Restraint (C&R). We believe that this association is unhelpful as a wide range of physical interventions are now currently employed, many very different from C&R.

Control and Restraint (C&R) was originally developed in 1981 for prison staff and was taken up by the special hospitals in the mid 1980’s. It is now widely used in the NHS, although modifications have been developed to make these techniques more appropriate to the therapeutic care of service users; for instance, C&R General Services, which introduced uses of pain as a restraint technique (Wright, 1999). The issue of pain compliance is controversial; the recommendations for this guideline comment on its use (see section 8.6.1). For the purpose of this guideline physical interventions are defined as:

A skilled hands-on method of physical restraint involving trained designated healthcare professionals to prevent individuals from harming themselves, endangering others or seriously compromising
the therapeutic environment. Its purpose is to safely immobilise the individual concerned.

The current Code of Practice to the Mental Health Act 1983 states that physical interventions should be a last resort

Physical restraint should be a last resort, only being used in an emergency where there appears to be a real possibility of significant harm if withheld. It must be of the minimum degree necessary to prevent harm and be reasonable in the circumstances. (18.10-18.11)

There appears to be a dearth of knowledge about current practice. The literature review undertaken for the UKCC report in 2002, found ‘no high quality studies that evaluated either the use of restraint or of seclusion in those with mental illness’ (UKCC, 2002). The rate of physical interventions per annum in the UK is currently unknown. At present the National Institute for Mental Health in England (NIMHE) are compiling a register of all the techniques used in the UK.

6.6.2.1 Staff Injury

A significant issue relating to the use of physical interventions is the possibility of injury to staff or service users. A US study in a maximum-security forensic hospital found costs incurred in relation to staff injury from violent incidents accounted for 2% of the hospital budget; forty five per cent of injuries were sustained during physical interventions (Hillbrand et al, 1996).

6.6.2.2 Sudden Death

Sudden death can occur when physical interventions are used. Although sudden death during physical intervention is a rare event, every safeguard must be put in place to ensure that sudden death does not occur. The David Bennett Inquiry drew attention to the fact that there is currently no central agency that record physical intervention-related deaths in the UK. The national reporting and learning system is a non-mandatory system set up by The National Patients Safety Agency (NPSA) which records anonymised data on in-patient settings. It is anticipated that deaths in psychiatric in-patient settings will be reported through this system and it is hoped that this will lead to a clearer picture of the probable causes of death.

6.6.3 Seclusion

Seclusion is the formal placing of a service user in a specially designated room for the short-term management of disturbed/violent behaviour. While it is recognised that this intervention is unpopular with service users, it is sometimes the preferred course of action to prevent prolonged physical intervention where rapid tranquillisation is contra-indicated or when service users have indicated a preference for it in advance directives.
The RCPsych Council Report (41) argues that the definition of seclusion needs to be broad to allow for the seclusion room door being open, closed but unlocked or locked. Therefore, or the purpose of this guideline, the following definition of seclusion has been taken from the Code of Practice.

Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. Seclusion should be used as a last resort; for the shortest possible time. Seclusion should not be used as a punishment or threat; as part of a treatment programme; because of shortage of staff; where there is any risk of suicide or self-harm. Seclusion of an informal patient should be taken as an indicator of the need to consider formal detention.

Seclusion must be differentiated from asking a service user to go to a designated room for the purpose of calming down. The latter is a de-escalation technique and the seclusion room should not routinely be used for this purpose. While seclusion is not normally viewed as therapeutic, letting the service user calm down in specifically designated areas is regarded as a therapeutic procedure which separates the service user from other service users and places them in a positive milieu (Cashin, 1996).

6.6.3 Rapid tranquillisation

6.6.3.1 Definitions

**Rapid Tranquillisation (also called urgent sedation):** The use of medication to calm/lightly sedate the service user and reduce the risk to self and/or others. The aim is to achieve an optimal reduction in agitation and aggression thereby allowing a thorough psychiatric evaluation to take place whilst allowing comprehension and response to spoken messages throughout.

**Calming:** a reduction of anxiety.

**Light Sedation:** a state of rest and reduction of psychological activity, but verbal contact is maintained.

**Deep Sedation:** a reduction of consciousness and motor and sensory activity, where verbal contact is progressively lost.

**Anaesthetised:** a state of narcosis (unconsciousness), analgesia (lack of awareness of pain) and muscle relaxation. It is one stage beyond deep sedation. It implies loss of airway control and protective reflexes, and requires the constant attention of trained personnel to keep the patient safe. There is normally no verbal contact.
Sleep: "a condition of body and mind such as that which normally recurs for several hours every night, in which the nervous system is inactive, the eyes closed, the postural muscles relaxed, and consciousness practically suspended".

Of all these terms, sleep is the one with the greatest terminological inexactitude. For the purposes of this guideline we have adopted this definition from the Oxford English Dictionary. However, because of its inexactitude, we have generally avoided using this term.

6.6.3.2 Rapid tranquilisation

Rapid tranquilisation or urgent sedation (Broadstock, 2001), as it is sometimes called, is used in situations requiring the rapid control of agitation, aggression or excitement. Deep sedation/sleep is not considered a desirable endpoint for rapid tranquilisation.

For the purposes of this guideline rapid tranquilisation describes the use of medication to control severe mental and behavioural disturbance, including aggression associated with the mental illness of schizophrenia, mania and other psychiatric conditions. It is used when other less coercive techniques of calming a service user, such as verbal de-escalation or intensive nursing techniques, have failed. It usually involves the administration of medication over a period of 30-60 minutes in order to produce a state of calm/light sedation.

Rapid tranquilisation differs from rapid neuroleptisation, which is the practice of giving a high dose antipsychotic at the beginning of ongoing treatment with the aim of rapidly stabilising symptoms. Rapid neuroleptisation, has been found to be hazardous and no more effective than standard treatment (Royal College of Psychiatrists, 1997).

The medications used for rapid tranquilisation should ideally have a low level of side effects and rapid onset of action. There is, at present, no world-wide formal agreement on which drugs should be used as first line for rapid tranquilisation. As a consequence, there is a wide variation in the type of medicines used in rapid tranquilisation throughout the world. This has been compounded by changes in the stated aims of rapid tranquilisation over recent years (Cunnane, 1994, Pererira et al, 2003).

There is also little agreement about the doses to be used. Rapid tranquilisation is not a recognised clinical procedure in the British National Formulary (BNF). Although the use of high dose antipsychotics has been criticised by several inquiries (Royal College of Psychiatrists, 1995), expert clinician opinion may from time to time support prescribing outside the dose limits set by the BNF or SPC (RCPsych draft report on antipsychotic drugs). The BNF have been formally consulted in the preparation of these guidelines and will carefully consider the findings to decide whether to incorporate any of the recommendations into BNF guidance.
This lack of standardisation also reflects the fact that very few randomised controlled trials have been conducted which examine the efficacy of medicines that are used for the purpose of rapid tranquillisation. Their use is often based purely on clinical experience. Overall there is a lack of high quality clinical trial evidence surrounding the drugs used for rapid tranquillisation and their safety, a point which has been noted in a number of recently conducted systematic reviews (Cure and Carpenter, 2002; Carpenter, 2002; Carpenter and Berk, 2002). Clinical trials that examine the effectiveness and safety of drugs used for rapid tranquillisation encounter a number of ethical issues. Service users recruited into these clinical trials should ideally represent those with highly agitated states in circumstances similar to those encountered in normal clinical practice. Unfortunately such service users are normally unable to give consent due to their highly agitated states.

6.6.3.3 Route of Administration

It is generally accepted that oral formulations should be offered in the first instance. If they are refused or are inappropriate medication should be administered parenterally. This involves administration by intramuscular (IM) injection or, in exceptional circumstances, intravenously. The latter should only be done with extreme caution and with appropriate supervision and monitoring, as clarified by the recommendations in this guideline.

6.6.3.4 Drugs used for Rapid Tranquillisation

The classes of drugs commonly used in the UK for rapid tranquillisation are benzodiazepines and antipsychotics.

6.6.3.4.1 Benzodiazepines

Benzodiazepines are frequently used as first line treatments for rapid tranquillisation. Some, such as diazepam have erratic and slow absorption intramuscularly and are associated with prolonged sedation following repeated doses. Lorazepam, has a shorter elimination half-life than many other benzodiazepines, which limits the risk of excessive sedation due to the cumulative effects of the drug. For this reason it is often chosen as the first drug of choice in rapid tranquillisation. There is a risk of respiratory depression when benzodiazepines are given in high doses or when used in combination with other hypnosedatives (including alcohol and some illicit drugs)(Broadstock, 2001).

6.6.3.4.2 Antipsychotics

Antipsychotics are commonly used as second line treatments for rapid tranquillisation and in some cases as first line treatments if benzodiazepines are contraindicated or have proven ineffective in the past. Older antipsychotics (commonly called conventional antipsychotics) have a greater propensity to cause extrapyramidal side effects than the newer (commonly called atypical) antipsychotics.
6.6.3.4.3 Combination of drugs

Combinations of a benzodiazepine, an antipsychotic and other drugs may be given either deliberately or inadvertently in rapid tranquillisation. Although it has become common practice to co-administer both benzodiazepine and antipsychotic together there is no evidence that this practice either achieves a better or faster outcome than when using the drugs separately. If combinations of IM injections are used they should not be mixed together in the same syringe.

Users may also inadvertently receive combinations of drugs through poor control of PRN prescribing. The practice of routinely prescribing a wide range of drugs for PRN use without clear guidelines or preference may lead to users inadvertently receiving combinations of drugs.

6.6.3.4.4 High doses.

Sometimes it is necessary to knowingly exceed the BNF upper dose limits and knowingly use drugs outside of their marketing authorisation (off-label). In such circumstances clinicians are referred to the recommendations of the Royal College of Psychiatrists consensus statement of the use of high dose antipsychotic medication.

For the purpose of rapid tranquillisation, care must be taken to ensure that high doses do not accidentally occur through the use of PRN medication given in combination with regular medication. If PRN medication is given, it is important to allow time for the drug to work before giving further doses by either oral or intramuscular means. In addition, clinicians must bear in mind that the plasma concentration of the antipsychotic is not only affected by the total dose but also the route of administration. Clinicians should also be aware that absorption from intramuscular administration (IM) can occur far more rapidly when a service user is agitated, excited or physically overactive (Keck, 1991).

6.6.3.4.5 Dangers associated with Antipsychotics

There are two main areas of concern with the use of antipsychotics for rapid tranquillisation; extrapyramidal effects and cardiac effects.

Extrapyramidal side effects are mostly associated with conventional antipsychotics. Side effects such as dystonia and oculogyric crisis are very unpleasant for the service user and may adversely affect their future preparedness to access either treatments or services. Fortunately the side effects can mostly be rapidly reversed by administration of antimuscarinic drugs such as procyclidine. The availability of atypical antipsychotic drugs provides an opportunity to avoid these side effects.

The second main issue of concern relevant to rapid tranquillisation is the rare occurrence of drug induced arrhythmias and sudden cardiac death. This comes about because of the manner in which some antipsychotic drugs affect cardiac ventricular repolarisation in susceptible individuals. The main measure of ventricular repolarisation is the QT interval - the time from the onset of ventricular depolarisation to complete repolarisation. A number of cardiac, metabolic and other factors such as physical exertion and stress impact on the QT interval. Where the service user has a prolonged QT interval, they may be at increased risk of cardiac arrhythmias,
particularly Torsade de Pointes. The cardiac QT interval usually measured as the QTc interval (QT corrected for heart rate) is a useful if somewhat imprecise indicator of the risk of cardiac events. This prolongation can be congenital or acquired, however, service users who already have prolonged QT repolarisation are at risk of developing arrhythmia when given drugs which further lengthen the QT interval. Service users who have had Torsade de Pointes are at an increased risk, even where this was caused by a different drug. Service users with left ventricular dysfunction or hypertrophy are also at an increased risk as are service users with liver disease (Day, et al 1993). Diuretics, also appear to increase risk. Women who have a longer QT interval on average than man appear to be an increased risk of Torsade de Pointes (Rautaharju et al, 1992; Makkar et al, 1993).

An issue which further complicates the relationship between antipsychotics, ventricular tachycardia and sudden cardiac death is that service users are known to be a high risk group for cardiovascular death (Hensen et al, 1997). However, it is known that QT prolongation and resulting arrhythmias are drug concentration related (Drici et al, 1998; Warner et al, 1996; Reilly, 2000; Ray et al, 2001). It is also important to note that several case reports of sudden death involved agitated service users who were subject only to physical interventions. As discussed above, physical interventions have been linked to increased risk of arrhythmia, as has the use of the illicit drugs ecstasy (Drake and Broadhurst, 1996) and cocaine (Pereira, 1997).

6.6.3.5 Acute manic or mixed episodes in bipolar affective disorder

For service users with bipolar affective disorder the British Association of Psychopharmacology (BAP) Guidelines should be taken into consideration.

6.6.3.6 PRN medication

Although only rapid tranquillisation is mentioned directly in the scope, PRN medication pro re nata (as needed) medication is also sometimes used in a similar way to rapid tranquillisation in psychiatric in-patient settings. A recent editorial suggests that very little has been written on the effectiveness of PRN medication as a short-term measure for managing violence and that those studies that do consider this issue contain serious flaws (Ray and Meador, 2002).

6.6.3.7 Service user views

Service user satisfaction with rapid tranquillisation, was rarely, if ever, measured as a part of the few existing clinical trials.

6.7 Accident and Emergency settings

This guideline also considers the short-term management of violence for adults with psychiatric illness who present in Accident and Emergency settings immediately prior to admission to an adult psychiatric in-patient settings.
All the interventions and related topics are relevant to Accident and Emergency settings. However, Accident and Emergency settings sometimes have special requirements in addition to those addressed in psychiatric in-patient settings. These requirements are considered in the specific recommendations in chapter 8.
7. Methods and Findings
7.1 Summary of development process

The methods used to develop this guideline are based on those outlined by Eccles and Mason (2001) and in the NICE ‘technical manual’ (www.nice.org.uk).

The following sources of the evidence were used to inform the guideline:
- The Royal College of Psychiatrists Clinical Guidelines on the Prevention and Management of Imminent Violence (see Agree Tool in Appendix 11 and Summary of St Georges report in Appendix 12);
- Other recent guidelines and reports (see section 14 below);
- Reviews of assessment processes, tools, tests and instrument’s for identifying those at risk (NCC-NSC);
- Reviews of the interventions currently used in the UK for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings (NCC-NSC);
- Reviews of studies examining patients views and experiences of the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings (NCC-NSC);
- Reviews of the evidence on costs and economic evaluations (SchARR);
- Reviews on other topics and areas related to the short-term management of disturbed/violent) behaviour in adult psychiatric in-patient settings in the UK (NCC-NSC);
- The minority ethnic groups section was further informed by Breaking the Circles of Fear (Sainsbury’s Centre for Mental Health, 2002), (see Appendix 13 for appraisal with Agree Tool) and focus groups run through Black service user organisations and with relevant healthcare professionals (see Appendix 14).

The stages used to develop this guideline were as follows:

- Develop scope of guideline;
- Convene multidisciplinary guideline development group (GDG);
- Develop review questions;
- Identify sources of evidence;
- Retrieve potential evidence;
- Evaluate potential evidence;
- Undertake systematic reviews of the evidence;
- Extract relevant data from studies meeting methodological and clinical criteria;
- Interpret each paper taking into account the results, including where reported, the beneficial and adverse effects of the interventions, costs and acceptability to service users, level of evidence, quality of studies, size, precision of effect and relevance and generalisability of included studies to the scope of the guideline;
- Prepare evidence reviews and tables which summarise and grade the body of evidence;
- Draft evidence statements;
Formulate conclusions about the body of available evidence, based on the evidence reviews by taking account the factors above;

Trawl any recent and relevant guidance literature in areas where evidence is weak or lacking and present this to the GDG for comment;

Send out evidence reviews for peer review;

Agree final recommendations by formal consensus voting and apply recommendation gradings;

Submit first drafts (short version and full versions) of guidelines for feedback from NICE-registered stakeholders;

Consideration by GDG of stakeholders comments following 1st stage consultation;

Submit final drafts of all guideline versions (including Information for the Public version and algorithms) to NICE for second stage of consultation;

Consideration by GDG of stakeholders comments;

Final copy submitted to NICE.

7.2 Key Clinical Questions

The guideline development group identified the key clinical questions which were raised by the scope. Each of these questions related to an intervention or area addressed in the scope.

An algorithm detailing how the scope was translated into clinical questions can be found in Appendix 3.

Each of the clinical questions is outlined in the relevant methods section of this guideline.

7.3 Review Methods

7.3.1 Search Strategies

Search strategies were devised to identify the best available evidence for the interventions and related topics discussed in the guideline (see Appendix 4). It was recognised very early within the process that, in most instances, this evidence would not constitute meta-analyses, systematic reviews or randomised controlled trials (RCTs). Therefore searches were not limited to these study designs.

Where little evidence was available, studies were included in related areas, from which evidence could be extrapolated.

Searches were not limited to English language citations. Relevant European foreign language papers were translated. Unpublished and published papers were included.

The search strategies were structured as follows:

- an overarching strategy for interventions (covered environment, prediction, de-escalation, observation, physical interventions, seclusion and rapid tranquillisation,
along with service user and staff perspectives on these interventions) across a wide range of databases
- a search of additional databases to identify guidance and reports not indexed in databases searched
- a topic specific search strategy on major databases. (See Appendix 4 for more details).

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

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

Each evidence review was sent for peer review prior to the first consultation phase in an attempt to identify any further relevant papers. GDG members were invited to nominate any relevant research that may have been missed.

The databases searched, logs of results and all search strategies can be found in Appendix 4. Unless otherwise stated all searches were run from 1985-2002/3.

For each intervention and related topic evidence of effectiveness, evidence of harm and cost effectiveness information was sought.

### 7.3.2 Sifting and Reviewing the Evidence

Once articles were retrieved, the following sifting process took place:

- 1st sift: Sift for material that potentially meets eligibility criteria on basis of title/abstract by two reviewers;
- 2nd Sift: Full papers ordered that appear relevant and eligible or where relevance/eligibility not clear from abstract;
- 3rd Sift: Full articles critically appraised and checked by one reviewer. Over 50% of all articles in the guideline were then critically appraised by an independent reviewer as a quality check.

### 7.3.3 Data Extraction

Study appraisal and methodological quality were assessed using checklists designed with assistance from the Centre for Statistics in Medicine at Oxford University. (Quality principles can be found in Appendix 10.) Data was abstracted by a single reviewer and evidence tables compiled. 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 the inclusion or exclusion of a study.

The following were extracted where possible (the reporting of many studies sometimes lacked essential detail) and relevant:
Masked assessment, whereby data extractors are blind to the details of the journal, authors etc., was not undertaken because there is no evidence to support the claim that this minimises bias (Cullum et al, 2003).

7.3.5 Data Synthesis

All studies were put into evidence tables and summarised using a qualitative narrative approach. No quantitative analysis was carried out for this review. Summary statistics of significance were reported in the evidence tables.

7.3.6 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 6). It was considered particularly weak where the number of confounders and flaws were great enough to jeopardise the results. Concerns regarding the quality of individual studies are detailed in the relevant evidence table.

A large range of quality related concerns were commonly found across many of the studies included in these review. These included:

- inappropriately small sample sizes;
- inter-rater reliability not always quantified where applicable;
- conclusions do not always appear to be supported by a study's results;
- methodologies are not always sound (that is, don’t adhere to standard processes);
- designs do not always appear appropriate - sometimes this is recognised by the authors;
- methods of analysis are not always clearly outlined;
- under-reporting;
- lack of detail about follow-up duration; losses to follow-up and drop-out rates;
- descriptions of interventions are not always adequate;
- description of how outcomes were measured are not always adequate or are sometimes lacking;
- poor reporting.

Where the studies in a review raise other, more specific quality concerns, these are mentioned under the evidence summary for each review.

Authors were not contacted about any of the included studies due to time constraints and the age of many of the studies.
In areas without sufficient evidence, previous guideline material was collated to help facilitate informed discussion by the GDG.

Clinicians and service users were also invited to give presentations on areas without sufficient evidence at guideline development group meetings to facilitate discussion.

The guideline development group then considered the evidence statements derived from the evidence reviews and used formal consensus methods (see section 7.7) to derive recommendations and good practice points, particularly for those areas where research evidence was lacking or weak, drawing upon their own and others clinical expertise and experience, as necessary.

7.4 Evidence Grading

Once individual papers had been assessed for methodological quality and relevance in terms of the clinical questions, they were graded according to the levels of evidence currently used by NICE.

Classification of Evidence:

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Type of Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1++</td>
<td>High quality meta-analyses, systematic review of RCTs, or RCTs with a very low risk of bias</td>
</tr>
<tr>
<td>1+</td>
<td>Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias</td>
</tr>
<tr>
<td>1-</td>
<td>Meta-analyses, systematic review of RCTs, or RCTs with a high risk of bias*</td>
</tr>
<tr>
<td>2++</td>
<td>High quality systematic reviews of case-control or cohort studies. High quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal.</td>
</tr>
<tr>
<td>2+</td>
<td>Well conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal.</td>
</tr>
<tr>
<td>2-</td>
<td>Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal.*</td>
</tr>
<tr>
<td>3</td>
<td>Non-analytic studies (for example, case reports, case series).</td>
</tr>
</tbody>
</table>
Expert opinion, formal consensus.

*Studies with a level of evidence ‘-’ should not be used as a basis for making a recommendation

The available evidence for each intervention and related topic was compiled into individual evidence reviews including health economics information. A summary of all recent reports and guidelines on the topic was also compiled. All this information was then presented to the guideline development group (GDG). The methods and findings from each of these reviews are outlined in below in section 7.8.

### 7.5 Deriving and Grading Recommendations

The derivation of recommendations involves a process of assessment in which the available evidence is interpreted in relation to the clinical questions asked. Where evidence is lacking or is not directly related to every area covered by the clinical question, the recommendation will demand some degree of consensus. For example, it is possible to have sound methodological evidence in an area that is not particularly relevant to the target audience of the guideline. When applied to the target audience, this would therefore result in a lower grade of recommendation than the evidence might initially seem to suggest since inferences would have to be made from the available evidence which are beyond the empirical data. This will be the case where the evidence only partially covers the clinical question which the guideline sets out to answer. Where no, or insufficient evidence is available, recommendations have to be arrived at using formal consensus methods alone.

In this guideline, D grade recommendations are differentiated from good practice points (GPP), which also have little or no evidence. Both carry a D grade status, unlike D grade recommendations, GPPs are principles of practice.

The recommendations for this guideline were graded A to D, using the current NICE approach.

**A** At least one meta-analysis, systematic review or RCT rated as 1++, and directly applicable to the target population, or
A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.
Evidence drawn from a NICE technology appraisal.

**B** A body of evidence including studies rated as 2++, directly applicable to the target population and demonstrating overall consistency of results, or
Extrapolated evidence from studies rated as 1++ or 1+. 
C A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or Extrapolated evidence from studies rated as 2++.  

D Evidence level 3 or 4, or Formal consensus.  

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

The Schizophrenia guideline used a older grading system which had only three grades A-C. Some recommendations which carry a C grade in the Schizophrenia guideline carry a D grade in the current guideline. However, there is no difference in evidence level.  

In the current guideline, good practice points, as well as D grade recommendations were arrived at using a formal consensus method.  

7.6 Cost Effectiveness Review and Analysis  

7.6.1 Identification of Papers  

Searches were undertaken by SchARR alongside the clinical literature reviews to identify relevant cost-effectiveness, cost utility and cost-benefit analyses. Details of the databases searched and the search strategies can be found in Appendix 9. Titles and abstracts were sifted and relevant papers ordered by one reviewer.  

7.6.2 Reviewing the Evidence  

Eligible papers were assessed using the Drummond checklist (Drummond et al. 1996) by one reviewer. Evidence tables were produced for each included paper by one reviewer.  

7.6.3 Estimation of Cost Effectiveness  

The scope of the guideline is broad, and includes the assessment of risk, as well as the short-term management of disturbed/violent behaviour across the whole of range of adult in-patient settings. Little, if any, economic evidence was found for most areas of the guideline. Therefore, primary economic analysis was undertaken for key recommendations where possible. In many areas the evidence-base was too weak to allow primary economic analysis. Where this was undertaken it is included under the results for each intervention in section 7.8 below (full details in Appendix 9).  

7.7 Consensus process
Due to a dearth of good quality evidence, many of the recommendations in this guideline were arrived at solely, or in large part, by means of formal consensus methods. Three consensus meetings were held in March 2004.

A modified nominal group technique was used to finalise the recommendations and good practice points. An external facilitator was used to chair the meeting. The consensus process was facilitated by computerised voting consoles, which assured anonymity and allowed percentages to be quickly calculated. It also allowed the GDG to view the range of responses in the form of a graph immediately voting had occurred. Consensus was set at 80% 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.

Prior to voting on each recommendation and good practice point, a discussion took place and modifications were made as necessary. The wording was re-typed if necessary and then displayed on a screen so that GDG members could see the recommendation or good practice point they were voting on. If consensus was achieved the GDG moved on to discuss the next recommendation or good practice point. However, if consensus was not achieved, the recommendation or good practice points was discussed a second time, modifications made to reflect the concerns of the GDG and re-voting took place. After debate on some areas, consensus was achieved for all recommendations submitted for first stage consultation.
7.8. Methods for Individual Evidence Reviews

7.8.1 Introduction

This guideline is divided into a number of interventions and related topics. For most of these areas separate literature searches were undertaken (see appendix 4). The number of papers found, included and excluded and the details of the resulting evidence-base is discussed separately for each area. Section 7.3 above details the reviewing process that was common to all areas of the guideline. Where there were deviations from this process this is highlighted below under the relevant section.

7.8.2 Prevention

7.8.2.1 Environment

7.8.2.1.1 Objectives

The original RCPsych evidence-base on environment was examined. The following hypothesis was used to inform search strategies

RCPsych Hypothesis

- Characteristics of the human and physical environment have powerful effects in mitigating and preventing, or exacerbating and precipitating the manifestation of violence.

After sifting and quality appraisal 17 papers were included by the RCPsych reviewer. However, the evidence-base was too weak to offer support for this hypothesis.

Current Guideline (Update of RCPsych Guideline)

Three review questions were identified by the GDG and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs). Unlike the RCPsych review, this review did not consider staff characteristics associated with an increased rate of disturbed/violent behaviour, which were instead considered in the prediction review.

Review Questions

- What factors in the physical environment of adult psychiatric in-patient settings contribute to either the promotion or reduction of disturbed/violent behaviour?

- What factors in the physical environment of psychiatric in-patient settings reduce the risks in relation to disturbed/violent behaviour?

- What are staff and service user views about the role of the ward environment in promoting or reducing disturbed/violent behaviour in psychiatric in-patient settings?
The studies had to meet the following inclusion criteria:

**7.8.2.1.2 Selection Criteria**

**Types of Studies**
Systematic reviews through to before and after designs. Qualitative studies were also included (Evidence levels 1-2).

**Types of Setting**
All adult in-patient mental health settings, excluding geriatric and learning disability.

**Types of outcome**
- Measurement of environmental factors that may impact on the short-term management of violence
- Service users’ and clinicians’ views

**7.8.2.1.3 Clinical Evidence**

Seventy-five articles were identified after combining the results of the main ‘intervention’ searches and the specific search for the ‘physical environment’. Thirty-two articles were ordered. Nine of the ordered articles were not directly related to the research questions, and were therefore not included for the present review. Seven of the remaining twenty-three articles were included in the evidence review. In addition, seven papers from the RCPsych review were considered relevant and were included in this review. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6)

**Appraisal of Methodological Quality**
In addition to the quality concerns mentioned in section 7.3.6, the studies raised the following methodological concerns:

- All of the studies are largely descriptive in content and none had a controlled comparison group.
- The variation between studies in regard to the methods of data collection, outcome variables and statistical analysis make it impossible to aggregate the results.
- Overall, the methodological quality, execution and reporting of the included studies are poor.

**Included Studies**

Three of the studies are uncontrolled before-and-after designs with one an interrupted time-series design, one was a correlation study and two were qualitative studies.

Three of the studies (Haller *et al*, 1996; Rauter *et al*, 1997; Velasco *et al*, 1996) were concerned with the effects of a cigarette smoking ban in in-patient psychiatric settings. Two of the studies (Haller *et al*, 1996; Velasco *et al*, 1996) concluded that
smoking bans on locked in-patient wards do not have an effect on increased violence by service users. Haller \textit{et al} (1996) indicated that although staff were in favour of the intervention, service users held decidedly negative feelings towards the smoking ban. There was no increase in aggressive behaviour in the outcome measures used in the study. The prospective study by Velasco \textit{et al} (1996) found the number of verbal assaults increased after implementing the ban, as did the consumption of nicotine replacement products by the service users. The authors suggest that dangerous behaviour did not follow the implementation of the smoking ban. The methodological quality of the study by Rauter \textit{et al} (1997) is insufficient to draw any reliable conclusions regarding smoking bans in psychiatric in-patient facilities.

An interrupted time-series design was used to evaluate the effects of removing the Music Television (MTV) channel from the television of a maximum security facility (Waite \textit{et al}, 1992). The analysis indicated that there was a significant reduction in aggressive behaviour following the removal of MTV from the television. Although the study is well-designed and executed, the relevance of these findings to the UK context is uncertain (e.g. the number of psychiatric settings in the UK where a music television station is received is unknown).

Mistral \textit{et al} (2002) conducted a qualitative study in an intensive psychiatric care environment, to evaluate the effect a £70,000 ward refit, training on risk assessment and control and restraint techniques, and clarity on rules and sanctions on staff illness, staff turnover, patient aggression and the rate of seclusion. Although results were not significant, there was a positive trend for all outcomes.

Johnson \textit{et al} (1997) conducted a qualitative study to explore service users and experiences prior to an aggressive incident. A phenomenological approach was used. Five key themes emerged: lack of space, relationships, restrictions on privileges, lack power verses feelings of powerfulness during aggressive incidents and ineffective self-empowerment strategies.

The study by Nijman (1999) is concerned with crowding in psychiatric in-patient units and aggressive behaviour. However, the study is poorly designed and the statistical methodology is flawed. The study is essentially a correlation study. The RCPsych review also included three studies which examined the issue of crowding (Palmstierna \textit{et al}, 1991; Palmstierna and Wistedt, 1995; Lanza \textit{et al}, 1994). These studies suggested that crowding increased the rate of violent incidents.

A further study in the RCPsych review, Hunter and Love, (1996) used an uncontrolled before and after study to evaluate the effectiveness of procedural changes at mealtimes on the number of violent incidents at mealtimes. A number of suggestions were implemented: plastic utensils were substituted for silverware, music selected by the hospital music therapists was played, the dinning room, gym and courtyard were left open after meals for service users with special privileges, and food service workers were trained in therapeutic communication. This study showed a significant (40%) reduction in violent incidents.

Two further studies in the RCPsych review considered staff roles. A participant observer study by Katz and Kirkland (1990) suggested that good leadership,
structured staff roles and predictable routines are associated with less violence on wards. While a retrospective cohort study (James et al, 1990) suggested that high staff turnover and extensive use of agency staff was associated with an increase in violent incidents.

Another descriptive study included in the RCPych review found that video cameras detected more, but milder, episodes of violence than nurses (Crowner et al, 1994).

None of the above studies significantly changed the findings of the RCPsych review.

**Evidence Statement**

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The evidence suggests that environmental factors such as crowding, banning smoking, high staff turnover and careful limit setting do have an effect on the incidence of violent incidents. However, further research is needed to identify additional environmental factors.</td>
</tr>
<tr>
<td>4</td>
<td>The evidence suggests that both staff and service users believe that environmental factors, such as banning smoking, limit setting, medication, seclusion, physical interventions and communication have an effect on the incidence of violent incidents. Further research is needed to identify additional factors.</td>
</tr>
</tbody>
</table>

**7.8.2.1.4 Economic Evidence**

No studies containing relevant economic data were found. (See Appendix 9)

**7.8.2.2 Alarm Systems**

**7.8.2.2.1 Objectives**

No specific searches on alarm systems was undertaken in the RCPsych guideline. Any papers would have been included under the environment review.

In the current guideline, three review questions were identified by the GDG and used to inform all searches (see Appendix 4 for search strategy, databases searched and search log).

**Review Questions**
• Are personal and institutional alarms and communication devices an effective means of alerting staff to occurrences of disturbed/violent behaviour in adult psychiatric in-patient settings?

• What principles of practice are necessary to ensure the effectiveness of personal and institutional alarms and communication devices reducing disturbed/violent behaviour in psychiatric in-patient settings?

• What are staff and service user views about the effectiveness of alarms in reducing disturbed/violent behaviour in psychiatric in-patient settings?

7.8.2.2.2 Selection Criteria

Types of Studies
Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence Levels 1-2).

Types of setting
All adult in-patient mental health settings, excluding geriatric and learning disability

Types of Outcome
• Any measures of change to management of short-term violence or rates of violent episodes as a result of alarms
• Service users’ and clinicians’ views of alarms

7.8.2.2.3 Clinical Evidence

Eighty-one studies were identified in the initial sift by the information scientist. These were then subjected to two further sifting by two reviewers. After sifting for relevance and duplicates seventy full papers were ordered. However, most were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review.

Seven papers were primary research studies. However, after critical appraisal and quality assessment only one of these contained information relevant to the research questions. References were checked for missing articles but no further studies were identified. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6.)

Included Studies

• The only study did not address the question of effectiveness of alarms as measured by changes in incidence rates or impact on management and could have been excluded on this basis.
• A summary of this study has been included to provide information on the existing research in this area.

A postal survey of 122 NHS and 19 private acute admission wards within the M25 area was conducted (Bowers et al, 2002), with the aim of assessing current safety and
security measures. The questionnaire was divided into 4 sections, survey of banned items, searching policy, practice (e.g. locking doors, counting cutlery), items present or absent (e.g. alarms, intercom systems, CCTV). Response rate was 70% (not including 17 discarded responses, because they were not from acute admissions wards). Results were analysed with descriptive statistics and Pearson correlation tests. Fifty-six percent of respondents had panic alarms which sounded in the whole unit. In eighteen percent they sounded in the ward only while thirteen percent of wards didn’t have any. Personal alarms were issued in forty-four percent of trusts whilst forty-five percent didn’t use them. Forty-two percent of Trusts had an emergency telephone extension and forty-five percent did not. Panic alarms were found in all rooms in thirty-six percent of Trusts, some rooms for thirty-two percent and in only one room for twenty percent. Whilst three percent of trusts had panic alarms only in the office, eighty-seven percent did not. The authors note two types of unrelated security systems were identified by the report: type A (Door security, Restrictions, Banned items) and type B (Searches, Guards, Alarms).

In nine wards, who had taken part in a previous study (Bowers et al, 2002), Type A was associated positively with absconding rates and Type B negatively with aggressive/angry behaviour. However, these results should be tested in a larger sample. The survey does not discuss the efficiency of alarms. The survey has been replicated in Northern Ireland. The results will be published later this year. Unfortunately the NCC-NSC was not able to obtain the unpublished paper prior to the second consultation.

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>There is insufficient evidence to determine whether personal and institutional alarms and communication devices are an effective means of alerting staff to occurrences of disturbed/violent behaviour.</td>
</tr>
<tr>
<td>4</td>
<td>There is insufficient evidence to determine which principles of practice are necessary to ensure the effective use of personal and institutional alarms and communication devices.</td>
</tr>
<tr>
<td>4</td>
<td>There is insufficient evidence to ascertain staff and service user views about the effectiveness of alarms in reducing disturbed/violent behaviour in psychiatric in-patient settings.</td>
</tr>
</tbody>
</table>

#### 7.8.2.2.4 Economic Evidence

No studies containing relevant economic data were found. (See Appendix 9)
7.8.2.3 Prediction: Antecedents, Warning Signs and Risk Assessment

7.8.2.3.1 Objectives

The original RCPsych guideline evidence-base on prediction was examined. A list of excluded studies was available in the archived information received from the Royal College of Psychiatrists Research Institute. The following information was taken from the final report in the RCPsych guideline, which states that this hypothesis was used to inform the search strategies:

**RCPsych Hypothesis:**

- It is possible, in acute clinical settings, to predict with reasonable accuracy which patients are more likely to become aggressive or violent in the near future.

After sifting and quality checks, sixteen references to prediction were included in the RCPsych evidence review.

However, the included studies did not offer generalisable criteria in support of this hypothesis so the RCPsych guideline concluded that:

> The studies do not provide a clear consensus on items that would be clinically useful for short-term prediction across a variety of clinical settings. This does not mean that prediction (still less assessment) is impossible; only that no generalisation can be made from these results. (Royal College of Psychiatrists, 1998, p45)

**Current Guideline**

The current guideline aims to assess whether research undertaken since 1995 now offers consensus on items and tools that are clinically useful in the short-term prediction of violent/aggressive behaviour. Four review questions were identified and used to inform the search strategy (see Appendix 4 for search strategy, databases searched and search logs).

**Review Questions:**

- *What are the risk factors and antecedents for disturbed/violent behaviour in psychiatric in-patient settings? Do they have good predictive validity?*

- *Which instruments most reliably predict disturbed/violent behaviour in psychiatric settings in the short-term? Do they have good predictive validity?*
• Are there any identifiable staff characteristics which act as risk factors for disturbed/violent behaviour?

• What factors do service users and staff report as increasing the risk of disturbed/violent behaviour?

The studies had to meet the following inclusion criteria:

7.8.2.3.2 Selection Criteria

Risk factors/Antecedents/Staff Characteristics

Types of Study
Prospective cohort studies (with or without controls) to before and after studies, and qualitative studies (Level III-IV).

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

Types of outcome
• measurement of risk factors/antecedents
• staff characteristics associated with violence

Predictive Instruments

Types of Study
Prospective cohort studies (with or without controls) (Level III)

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

Types of Interventions
Actuarial checklists/tools and structured clinical judgment checklists/tools.

Types of Outcome
• Sensitivity
• Specificity
• Positive and negative predictive values.

Service User & Staff Perspectives

Types of Study
Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence Levels 1-2).

Types of Setting
All adult in-patient mental health settings, excluding geriatric and learning disability.
Types of Outcome
Staff and service user views on risk factors, antecedents, predictive instruments and staff characteristics associated with violence.

7.8.2.3.3 Clinical Evidence

The same search strategy covered all the review questions. One thousand and twenty-five studies were identified in the initial sift. After sifting for relevance and duplicates two hundred and ninety full papers were ordered. However forty further duplicates were later identified.

On scrutiny, one hundred and twenty were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review (see Appendix 7 for all primary research papers which fell outside the inclusion criteria). There were also fourteen letters or editorials. A further nineteen studies were on topics to be considered elsewhere in the guideline and were critically appraised in subsequent evidence reviews. Seventy-three primary research papers were identified, sixty-one met the inclusion criteria. No study offered evidence above level III. References were checked but no further studies were identified. In addition, all papers (16) from the RCPsych prediction review, five papers from the RCPsych environment review and two papers from the RCPsych review of restraint and seclusion were considered relevant and were included in this review. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6.)

Included Studies

I Antecedents or Warning Signs

Eight studies were included that considered the antecedents or warning signs of short-term disturbed/violent behaviour. Four were UK studies, set in a variety of psychiatric in-patient environments. Three were US studies, two were set in veterans medical centres, the other in a general psychiatric unit. The final study was undertaken in Norway, set in a secure unit. A range of study designs were used. One study was a prospective cohort, four were retrospective cohorts, one was a cross-sectional study within a prospective cohort, one was a survey and the other used semi-structured interviews. Although most of the studies associated violence with verbal abuse and aggressive/agitated behaviour, only the prospective cohort study is a sufficient design to allow predictors of violence to be discussed. The one prospective cohort study (Whittington and Patterson 1996) found no significant difference in behaviour between non-violent and violent cohorts in the 24 hours prior to an aggressive incident, although aggressive behaviour was the best predictor of short-term violence. They did, however, note significant differences in behaviour 3 days prior to an aggressive incident. The violent cohort showed increased levels of anger and aggression (p=0.0001), verbal abuse, P<0.05), threatening gestures/stance (p<0.01) and abnormal activity level (p<0.05) compared to the non-violent cohort. This study was set in a rural hospital in the UK. The predictive validity of this study and the generalisability of these findings need to be validated by further prospective cohort
studies that examine antecedents of short-term violence across a variety of settings. Three further studies in the RCPsych review examined antecedents. Only one study (Sheridan et al., 1990) noted anything different, commenting that staff limit setting often preceded violent incidents.

None of the above studies significantly change the findings of the RCPsych review.

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests that the following may act as antecedents/warning signs for violent incidents: verbal abuse, aggressive/agitated behaviour, threatening gestures and abnormal activity levels and staff-limit setting.</td>
</tr>
</tbody>
</table>

### II Clinical Approaches to Prediction ('first generation')

The literature searches yielded seven prospective cohort studies investigating clinical judgment as a means of violence prediction. One study (McNiel and Binder, 1991), included in the RCPsych review did not offer information on predictive validity. Two studies (McNiel and Binder, 1995, included in the RCPsych review; Haim, 2002) suggested low positive predictive values for clinical prediction. The first study was set in a locked facility in the US and the other in a forensic psychiatric hospital in Israel. Three studies (Rabinowitz et al., 1999; Nijman, et al. 2002; McNiel et al., 1998) suggested that clinicians’ judgment had a better predictive validity than the earlier analysis allowed and demonstrated positive predictive values of 41%, 58% and 75% and negative predictive values of 76.9%, 86% and 98% respectively. The three studies were conducted in a range of adult psychiatric in-patient settings, and were undertaken in different countries, the first in Israel, the second in Holland and the third in the US. In a final study (Hoptman et al., 1999) the overall specificity arrived at by clinicians was 79%, with a corresponding sensitivity of 54%. This study was set in the US, in a forensic psychiatric hospital. It is a distinctive study in that 57.4% of the participants were African-American and only 35% Caucasian. In most of the other studies the majority of participants were of Caucasian origin.

Whilst four of the seven of the included studies suggest that clinicians are able to predict violence with a greater degree of accuracy than has previously been suggested, there are no identifiable features to explain the greater degree of clinician predictive accuracy found in these four studies. One study relates accuracy to confidence, but does not state if this is also related to experience. Another study admits that the inability of the study to provide an underlying reason for the high predictive value is a key weakness of the design. In order for clinicians’ judgments alone to be recommended over and above other approaches to prediction, further studies, that are tested across a variety of settings, are required to validate these findings. Whilst the general trend of the studies stresses that clinicians may be able to predict violence with some degree of accuracy, there is a lack of consensus amongst the studies.
None of the studies significantly change the findings of the RCPsych review in which five further studies (Apperson et al, 1983; Janofsky et al, 1988; Kirk, 1989; McNiel et al, 1988; Yesavage, 1983) also indicated the low predictive validity of clinician judgment.

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The evidence suggests that clinician judgment has a relatively low predictive validity, only slightly better than chance.</td>
</tr>
</tbody>
</table>

### III Actuarial Approaches (‘second generation’)

#### III. i Risk Factors

Whilst antecedents or warning signs are risk factors, in this review they are distinguished from more static variables which could be used to predict violence, such as diagnosis, demographic variables etc, which are referred to as risk factors. It is such risk factors that this next group of studies examines.

The literature search identified the following relevant studies: eight prospective cohort studies, six retrospective cohort studies, one cross-sectional study, two prospective case-controlled studies and one retrospective case-controlled study.

Seven prospective cohort studies identified the following significant risk factors:

- community violence, male gender, young age, younger age at first hospitalisation, more frequent visitors - at least monthly, not having own clothing, low level of self-care functioning, number of admissions, duration of admission, coercive behaviour and lack of satisfaction of care, a diagnosis of organic psychotic condition, personality disorder, schizophrenia, and bi-polar affective disorder.

Five further studies in the RCPsych reviews also examined risk factors. The studies noted the following risk factors:

- history of violence, hostile suspiciousness, agitation-excitement, thinking disturbances, use of intoxicants, command hallucinations, impostor delusions and delusions about personal targets.

Only prior community violence/history of violence were mentioned in more than one study as a risk factor, and was then only regarded as a risk factor within the first 1-2 days of admission and not afterwards.

The other prospective cohort study (Owen et al, 1998a) examined the risk factors amongst adult recidivists in psychiatric acute care settings, including geriatrics. It
identified the following significant risk factors: being older, widowed, having personality disorder, or organic brain disorder, being detained under the mental health act, and being highly sedated prior to the incident.

Within the studies there are no risk factors which consistently emerge except for prior community violence. There is also no consensus within the studies as to how these various risk factors ought to be weighted. These studies only serve to illustrate that a huge range of variables are possible risk factors. Most of the studies did however, suggest that demographic variables were largely irrelevant in risk prediction.

Most of the studies did not discuss the predictive validity of this approach. One study which discusses community violence as a risk factor (Beck and Bonner, 1988) notes a positive predictive validity for the first day of admission of 31%, slightly worse than that averaged by clinicians’ judgment in the studies discussed above in section II. One study (McNiel et al, 1998), notes that the actuarial approach was significantly better than clinician prediction. In this study however, clinician prediction was particularly low (true positives=26.7%, false positives=73.3%). Only 1 study (Rabinowitz and Garelik-Wyler, 1999) shows a higher positive predictive value of 61.6% and a negative predictive value of 69.3% in predicting the violent group of service users. On the basis of these results it is not been possible to establish risk factors for the prediction of violence.

None of the studies significantly change the findings of the RCPsych review.

**Evidence Statement**

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2+ to 2-</td>
<td>The evidence suggests that the following may be risk factors for disturbed/violent behaviour: community violence, male gender, young age, younger age at first hospitalisation, not having own clothing, low level of self-care functioning, number of admissions, duration of admission, coercive behaviour + lack of satisfaction of care, a diagnosis of organic psychotic condition, personality disorder, schizophrenia, and bi-polar affective disorder. However, further research is needed to reliably determine additional factors that may need to be considered across different populations.</td>
</tr>
<tr>
<td>4</td>
<td>There is insufficient evidence to determine how various risk factors associated with disturbed/violent behaviour in psychiatric in-patient settings ought to be weighted.</td>
</tr>
<tr>
<td>4</td>
<td>The available evidence suggests that demographic variables (gender, ethnicity)</td>
</tr>
</tbody>
</table>
III.ii Predictive Actuarial Tools

Eleven prospective cohort studies were identified through the literature searches. These studies assessed the predictive validity of a range of actuarial tools or checklists in adult in-patient psychiatric settings as a means of predicting violence (see table I below). A wide range of risk factors were considered. Echoing the findings from the review of the actuarial approaches to determining risk factors considered in section III.i above, there is no agreement amongst the tools examined here, as to which risk factors are most important or how the various risk factors ought to be weighted.

None of the studies took place in the UK, five took place in the US, one in Australia, one in Sweden, one in Norway, one in Spain, one in Italy and one in Taiwan. There is a need to test these actuarial tools in a European and in a UK context. Research into prediction of violence in psychiatric in-patient settings involving the use of these tools is still at a preliminary stage. None of the studies considered whether prediction with a particular tool led to a decrease in disturbed/violent behaviour/incidents.

On the basis of the clinical evidence, no one tool emerged as the 'gold standard'. Six studies (Yesavage, 1984; Chou et al, 2002; Ehmann et al, 2001; Arango et al, 1999; Krakowski et al, 1999; Almvik et al, 1998) reported on the positive and negative predictive values established using this approach. With the exception of the Brøset Violence Checklist, which is still in a preliminary stage of development, the various actuarial tools showed consistently higher positive and negative predictive values than those established by clinical judgment alone in the aforementioned analysis (see table below). These results suggest that important developments have been made since the RCPsych guideline. Whilst more research is needed to validate the findings of these studies, and to test the instruments across a range of settings, the clinical evidence suggests that there is a trend towards greater predictive accuracy with actuarial tools than with clinical judgment alone.

Only three studies in the RCPsych review considered the use of actuarial tools. Since the completion of the RCPsych review more studies as outlined above have examined the predictive accuracy of actuarial tools. These studies suggest that actuarial tools offer greater predictive accuracy than clinical judgment alone.

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>There is insufficient evidence on which to determine a ‘gold standard’ predictive actuarial tool.</td>
</tr>
<tr>
<td>4</td>
<td>The current evidence suggests a trend towards greater predictive accuracy with</td>
</tr>
</tbody>
</table>
actuarial tools than with clinical judgment alone. However, further comparative research is needed.
### TABLE 1

<table>
<thead>
<tr>
<th>Tool</th>
<th>Number of studies</th>
<th>Purpose of tool</th>
<th>Significant Results/Predictive Validity</th>
<th>Known advantages</th>
<th>Known Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOAS (Palmstierna, Wistedt, 1989)</td>
<td>3 (Palmstier na, 1989, Chou et al, 2002, Grassi et al, 2001)</td>
<td>Records individual incidents. Includes verbal and physical aggression and property damage. These are not rated separately. (Bowers, 1999)</td>
<td>study 1 highlighted history of violence against property and substance abuse study 2 highlighted history of violence, psychotic diagnosis and history of smoking study 3 highlighted, younger age, single, living with nuclear family and acute psychosis</td>
<td>Tries to separate means, aims and results of aggressive incidents. Good inter-rater reliability (0.96) Some evidence for predictive validity. The most widely used scale, therefore allowing comparison between studies (Bowers, 1991)</td>
<td>Conflates severity with outcome. Means and aims of aggression incompletely conceptualised. (Bowers, 1991)</td>
</tr>
<tr>
<td>SOAS-E (Hallenstinsen et al, 1998)</td>
<td>Same as SOAS</td>
<td>Authors argue that the new categories are exhaustive.</td>
<td>Same as SOAS</td>
<td>Adds 11 additional warning signs</td>
<td></td>
</tr>
<tr>
<td>SOAS-R (Nijman, 1999)</td>
<td>1 (Grassi et al, 2001)</td>
<td>Same as SOAS</td>
<td>highlighted acute psychosis</td>
<td>Same as SOAS</td>
<td>Has a new scoring system to objectify the severity of a violent episode</td>
</tr>
<tr>
<td>RAPP (Ehmann et al, 1995)</td>
<td>1 (Ehmann et al, 2001)</td>
<td>21-item scale that assesses symptoms and functional domains</td>
<td>RAPP total negative predictive value=95%, positive predictive values of 78% and 62% in 2 random subsets. RAPP safety score (sensitivity=81%, specificity=96%, positive predictive value=87% improvement over change=62%).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MOAS (Kay et al, 2001)</td>
<td>1 (Ehmann et al, 2001)</td>
<td>Retrospective record of most aggressive behaviour.</td>
<td>Rating 3 or 4 was used to determine aggressive behaviour.</td>
<td>Easy to collect, and does not need a heavy</td>
<td>Loss of information on individual incidents, their</td>
</tr>
</tbody>
</table>
### Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings

**Guideline**

<table>
<thead>
<tr>
<th>1988, Bowers, 1999</th>
<th>Serious incidents in pat week. Includes 4 dimensions: verbal and physical aggression, property damage and self harm.</th>
<th>The following were noted as risk factors: female, alcohol abuse and non-paranoid schizophrenia.</th>
<th>Commitment from ward nurses. Good inter-rater reliability (0.85-0.94). Moderate longitudinal correlations for the same patient. (Bowers, 1999)</th>
<th>Antecedents and consequents. Conflates severity with outcome. Diverse behaviours grouped together.</th>
</tr>
</thead>
</table>
| NOSIE (Honigfield 1966) | Measures three positive factors: social competence, social interest and neatness, and three negative factors: irritability, psychosis and motor retardation. | **Study 1** - irritability scale significant predictor (positive predictive value=78%, negative predictive value-79%).  
**Study 2** - irritability, difficulty following ward instructions. | Study 2 - Total BPRS score was not significantly related to assault.  
**Study 3** - Severe psychotic symptoms | **Study 1** - schizophrenia rating was significant in combination with low neuroleptic serum levels and violence prior to admission.  
**Study 2** - Total BPRS score was not significantly related to assault.  
**Study 3** - Severe psychotic symptoms |
| BPRS(Overall, Gorham, 1962) | 24-items. Ratings range from 1-7 with higher rating indicating more severe symptoms. | **Study 1** - schizophrenia rating was significant in combination with low neuroleptic serum levels and violence prior to admission.  
**Study 2** - Total BPRS score was not significantly related to assault.  
**Study 3** - Severe psychotic symptoms | | |

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SECOND DRAFT FOR CONSULTATION JULY 2004 Page 77 of 279
<table>
<thead>
<tr>
<th>Test</th>
<th>Authors</th>
<th>Questions/Assessment</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE (Folstein et al, 1975)</td>
<td>1(Swett &amp; Mills, 1977)</td>
<td>11 yes-no questions asked by psychiatrist to service user</td>
<td>Total MSME score was not significantly related to assault.</td>
<td></td>
</tr>
<tr>
<td>QNS (Convit 1994)</td>
<td>1 (Krakowski et al 1999)</td>
<td>assesses neurological symptoms</td>
<td>Severe neurological symptoms were significantly related to assault.</td>
<td></td>
</tr>
<tr>
<td>PANSS(Kay et al, 1992)</td>
<td>2 Ehmann et al. 2001, Arango et al 1999)</td>
<td>Assesses psychopathology.</td>
<td>Study 1 - sensitivity=67%, specificity=91%, positive predictive value=71%, base rate=24%, improvement over chance=47%. Study 2 - total PANSS score - sensitivity=31.3%, specificity=91.5%,</td>
<td></td>
</tr>
</tbody>
</table>
positive predictive value=55.5% negative predictive value=79.6%.
Insight into psychotic symptoms, general psychopathy score and violence in previous week correctly classified 84.1% of service users (sensitivity=50%, specificity=95.7%, positive predictive value=80% negative predictive value=79.6).

<table>
<thead>
<tr>
<th>Study</th>
<th>Tool (Year)</th>
<th>Description</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCF (Lanza et al, 1996)</td>
<td>1 (Chou et al, 2002)</td>
<td>Scale includes sociodemographic data, medical diagnosis, time since admission, history of assaults and history of drug &amp; alcohol abuse.</td>
<td>Significant service user characteristics: history of violence (OR=4.14) psychotic diagnosis (OR=2.07), history of smoking (OR=1.45) and duration of admission (OR=0.99).</td>
</tr>
<tr>
<td>EAQ (Lanza et al, 1996)</td>
<td>1 (Chou et al, 2002)</td>
<td>Scale includes, location time, date, number of patients on ward and their acuity level, space density, &amp; number of staff on ward.</td>
<td>Severity of assault was related to space density and staff/patient ratio.</td>
</tr>
<tr>
<td>ARP (Kay)</td>
<td>1 (Kay et al, 39 item tool)</td>
<td></td>
<td>Physical aggression was predicted by</td>
</tr>
<tr>
<td>et al 1987</td>
<td>1988</td>
<td>covering 4 main areas: demographics, current psychiatric diagnosis, history of aggression and clinical profile</td>
<td>anger, hostility, history of attacks on others, history of greater total aggression (p&lt;0.01) Verbal aggression was predicted by motor excitement, difficulty with gratification, depressed feelings (p&lt;0.025) Total aggression was predicted by younger age, more acutely ill, more threatening of violence by history, previously rated more agitated and labile in affect (p&lt;0.05).</td>
</tr>
</tbody>
</table>
IV Structured Clinical Judgment Instruments ('third generation')

Three studies examined the usefulness of instruments that measure structured clinical judgment. Two were European studies one set in Sweden and the other in the UK, the third was a US study. Two of these were prospective cohort studies and are described below:

The first prospective cohort study was undertaken in Sweden, (Belfage et al, 2000). It considered both the HCR-20 and the PCL:SV within a maximum security correctional setting. The study found that history of violence was not a good predictor of future violence. The authors suggest that this is unsurprising in a setting where all patients will score highly on the H-10, the historical part of the tool. The R-5 showed the best predictive validity (p=0.004). Thirty out of forty-one participants were psychopaths for whom the R-5 was the only tool with any predictive validity (p=0.002). The PCL:SV showed a higher score for violent recidivists and was significant when considered in conjunction to older age (p<0.1).

The second prospective cohort study (Hill et al, 1996) was conducted in the US in a state hospital to assess whether the PCL:SV was a good predictor of aggression amongst 55 male forensic psychiatric service users. The authors found that the PCL:SV total was a significant predictor of aggression. The PCL:SV was then reduced to presence or absence of psychopathy, where it again predicted aggression (multiple r = 0.69; R²=0.48; Beta = 0.69).

Three other studies which examine the effect size of the PCL and the PCL:SV are mentioned by Doyle and Dolan (2000). They also note a good predictive validity for the tool in a forensic setting. However, as of yet, insufficient research has been carried out to test the predictive validity of these instruments in UK adult psychiatric in-patient settings. More studies also need to be undertaken to validate the results of these studies. All studies are detailed in table 2 below.

All these studies have taken place since the RCPsych review. They suggest that structured clinical judgment gives a greater predictive accuracy that clinicians judgment alone, similar to that achieved by the use of actuarial tools.

Evidence Statements

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The evidence suggests that there is trend towards greater predictive accuracy with structured clinical judgment tools than with clinical judgment alone, similar to that achieved by the use of actuarial tools.</td>
</tr>
<tr>
<td>4</td>
<td>There is insufficient evidence on which to determine a ‘gold standard’ structured clinical judgment instrument.</td>
</tr>
</tbody>
</table>
### TABLE 2

<table>
<thead>
<tr>
<th>TOOL</th>
<th>Number of Studies</th>
<th>Purpose of Tool</th>
<th>Results/Predictive Validity</th>
<th>Known Advantages</th>
<th>Known Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCL:SV (Hart et al, 1995)</td>
<td>3 (Doyle et al, 2002, Belfrage, 2000, Hill, 1996)</td>
<td>12-item instrument to assess psychopathy Scored 0 (not present) 1 (maybe) 2 (present)</td>
<td><strong>Study 1</strong> PCL:SV total score and interpersonal subscale = best predictors of any violence (Sensitivity=0.76, Sensitivity=0.50) Interpersonal subscale = best predictor of violence against persons resulting in injury (Sensitivity=0.76, Sensitivity=0.50) (compared with VRAG and H-10) <strong>Study 2</strong> High scores on part 2 suggested recidivism <strong>Study 3</strong> The PCL:SV total was a significant predictor of aggression. The PCL:SV when reduced to presence or absence of psychopathy again predicted aggression (multiple r = 0.69; R²=0.48; Beta = 0.69).</td>
<td>Quicker, shorter and easier to administer than the Psychopathology checklist revised (PCL-R). Psychometrically sound Not so concerned with overt criminal acts as the PCL and the PCL-R</td>
<td></td>
</tr>
<tr>
<td>VRAG (Harris et al, 1993, Webster et al, 1994)</td>
<td>1 (Doyle, 2002)</td>
<td>Includes 12 variables including PCL-R score, elementary school maladjustment, age (negative associated with violence) personality disorder, separation from parents before 16, failure on previous conditional release, history of non-violent</td>
<td>Did not show good predictive validity (but this was a retrospective study)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study 1 Risk management sub-score had best predictive validity in correction maximum security institutions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study 2 H-10 did not show better predictive validity that the PSL:SV (see above)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3 further studies examine the predictive validity of the PCL and PCL: SV and note the effect size for this instrument amongst forensic psychiatric patients. The effect sizes are given as follows: d=0.63, d=1.92, AUC of ROC at 3 month=0.75. (Dolan, Doyle, 2000)
V Staff Characteristics associated with the likelihood of Aggressive Incidents

Nine studies were identified which examined the relationship between staff characteristics and assault (Flannery et al, 1995; Flannery et al, 2001; Chou et al, 2001; Chou et al, 2002; Lanza et al, 1997; Owen et al, 1998b; Soares et al, 2000; Augestad and Vatten, 1994; Ray, 1988; Morrisson, 1998). In addition a further 5 studies were identified in the RCPsych review (Binder and McNeil, 1994; Carmel & Hunter, 1991; Whittington, 1994; Whittington and Wykes, 1994; Whittington and Wykes, 1996;). All the studies, except one (Lanza, 1997) surveyed staff in a range of psychiatric settings. Lanza (1997) was set in a neuropsychiatric department in a Veterans hospital in the US. This study found no relationship between staff characteristics and assault. The other twelve studies identified the following characteristics as significant correlates of staff characteristics and the occurrence of aggressive incidents:

- younger age, between youngest and oldest age, work experience,
- training in the management of violence, and grade, lack of training
- and limit setting/confrontation, authoritarianism, social
- restrictiveness, young age, limited supervision and gender. (It was
- also suggested that gender was non-significant (Binder and
- McNeil, 1994). The study (Augestad and Vatten, 1994) which
- emphasises gender as significant notes that whilst overall risk for
- men was significantly higher, the relative risk according to ward
- type was similar for men and women). Several other correlates
- were identified, but were not significant

There was no consistency across the studies.

None of the studies significantly change the findings of the RCPsych review.

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests that the following staff characteristics may be associated with greater incidents of violent/aggressive behaviour: younger age, level of experience, training and grade, gender, and involvement in limit-setting activities. However, further research is needed.</td>
</tr>
</tbody>
</table>

VI Service User Perspectives on Reasons for Assault

Seven studies were identified which examined service user perspectives on the causes of violent (disturbed) behaviour.

One Canadian study surveyed a heterogeneous group of 12 thought-ordered individuals across two hospitals. Service users reported that factors which caused violence tended
to be external rather than internal (i.e. caused by factors on the ward rather than by illness). The results of this study would need to be validated on a larger scale and replicated across other settings before any evidence-based conclusions could be drawn about service user perspectives on the causes of aggressive incidents.

Another study (Whittington and Wykes, 1996) conducted semi-structured interviews with staff in the UK to ascertain whether aversive stimulation (such as limit setting) had occurred prior to an assault. The results were verified by interviews with some service users and witnesses, indicating that some form of aversive stimulation often precedes an assault. However, the study is unclear about the number of service users who were interviewed or the extent to which they agreed with staff. The study reports that many staff believed that aversive stimulation trigger the majority of the aggressive incidents (see staff perspectives below).

One survey (Gillig et al, 1998) found that service users saw less of a causal connection between their own verbal abuse of staff and the physical abuse of staff than staff (p<0.05). However, they saw more of a causal connection between verbal abuse of service users by staff and physical violence against staff, than staff (p<0.05). This pattern and significance was echoed with regards to hostility and threats. Service users identified staff use of drugs and alcohol (p<0.05), the use of forced medication (p<0.05), restraints (p<0.05) and seclusion (p<0.05) as causes underlying violent incidents. They also stressed cross-cultural racism as a cause of violence.

Another study which used incident forms, a survey and interviews for data collection (Duxbury, 2002) noted that service users believed that external and situational factors (such as interactions with staff and restrictive regimes) were largely to blame for violent incidents (p<0.001).

A further study using semi-structured interviews (Bensley et al, 1995), noted that service users, like staff, considered restrictions on service users smoking, access to outdoors, defective staff clinical skills, service users not being treated with respect, as well as the use of seclusion and restraint, to contribute to violent incidents. Service users were also concerned that rules were not adequately explained.

Using video footage and interviews (Crowner et al, 1995) it was found that 12% of service users argued that they had been playing with the victim, 12% claimed that they had been subjected to verbal abuse, and 8% claimed that they had been subjected to objectionable behaviour; the other 41% gave a range of responses from no response to anger at ward rules, and anger at unwanted sexual attention.

Ilkiwa-lavelle and Grenyer, (2003) found that service users believe improved handling of inter-personal conflicts would prevent violent incidents.

The RCPsych review did not specifically consider this issue.

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests that service</td>
</tr>
</tbody>
</table>

Second Draft for Consultation July 2004 Page 86 of 279
users see external factors (such as limit setting, verbal abuse by staff and other service users, lack of respect by staff and harassment) as more likely reasons for assault then internal factors (i.e. caused by illness).

VII Staff Perspectives on Reasons for Assault

Nine studies were identified which examine staff perspectives on reasons for assault.

Four studies (O’Sullivan & Meagher, 1998; Gim et al, 1999; Duxbury, 1999; Gillig et al, 1998;) carried out questionnaire surveys to assess healthcare professionals views on the risk factors associated with psychiatric in-patient violence. The first study is set in Ireland, the second in Singapore, the third in the UK and the fourth in the US. The following were proposed as risk factors by staff but not validated:

- personality disorder
- schizophrenia
- substance abuse
- intoxication
- violent lifestyles
- active hallucinations
- paranoid ideas against others
- non-compliance with treatment
- internal factors
- provocation.

Only personality disorder was mentioned in two of the studies although all studies mention internal factors, including diagnosis. These suggest that staff emphasise diagnosis over other variables. However, more studies are needed before the generalisability of these findings can be assessed.

Two studies (Whittington 1996; Bensley, 1995) conducted semi-structured interviews with staff. One study (Whittington 1996) attempted to assess whether they had caused aversive stimulation prior to an assault. After validating the results of the interviews by interviewing service users and witnesses, it was noted that 86% of all assaults were preceded by some form of aversive stimulation (such as limit setting), although the authors suggest an interplay with diagnosis. These results require validation and replication across a variety of settings.

Using semi-structured interviews (Bensley, 1995) found that staff believed that inadequate staffing levels was the single factor that most contributed to assaults on staff. Like service users, staff were also concerned about service user restrictions on smoking, access to outdoors, staff clinical skills, service users being treated with respect, as well as the use of seclusion and restraint on the wards. Staff also mentioned a need for training in the management of violence, as well as concerns about the general physical environment. However, the study was of low quality.

Using incident forms, questionnaires and interviews (Duxbury, 2002) noted that staff most commonly reported problematic interaction and restrictive environments as the causes of violence/aggression. However, staff did not consider their own personal interactions with service users to be problematic. Staff were unable to identify a cause
for 26% of all incidents. Staff attributed much more weight to internal factors (i.e. illness) as underlying causes of violence/aggression than service users.

Using focus groups and surveys (Delaney et al, 2001), the following were noted as impacting on the possible risk of violence: service user history, service user status and mode of arrival, ongoing informal nurse assessment, individualised care, peer support and administrative responsiveness, nursing stress and current policies/manuals. However, the study was of low quality.

Ilkiwa-lavelle, (2003) found that staff believed the service user's illness to be a key causal factor whereas service users believed inter-personal conflicts were relevant. Staff believed improved medical management would prevent violent incidents.

The RCPsych review did not specifically consider this issue.

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests that staff users see internal factors (i.e caused by illness) and the interplay between internal and external factors (such as staff limit setting) as contributing to disturbed/violent behaviour.</td>
</tr>
</tbody>
</table>

7.8.2.3.4 Economic Evidence

No studies containing relevant economic data were found. (See Appendix 9)

7.8.3 Training

7.8.3.1 Objectives

No specific searches on training systems was undertaken in the RCPsych guideline.

Current Guideline

Two review questions were identified by the GDG and used to inform all searches:

- What are the most effective and safe training programmes for the prevention of and the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings?

- What are the views of staff and service users about the various training programmes in adult psychiatric in-patient settings and their content?

Included studies were subdivided into more specific review questions which related to each of the interventions and related topics covered in this guideline.
7.8.3.2 Selection Criteria

Types of studies
Systematic reviews to controlled before and after studies. Qualitative studies were also included. (Evidence levels 1-2)

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

Types of Outcomes
- Effectiveness of training packages in managing or reducing aggressive/violent behaviour
- Safety of training packages managing or reducing aggressive/violent behaviour
- View of staff and service users on the various training programmes for managing or reducing aggressive/violent behaviour
- Increased staff knowledge resulting from training
- Staff attitude change resulting from training
- Reduction in the number of violent/aggressive incidents
- Reduction in the number of staff days lost through illness

7.8.3.3 Clinical Evidence

Two hundred and thirty nine papers were identified in the initial sift. Eighty four studies were ordered. After quality checking, twenty-two papers were included in the review. Eight studies were excluded. The remaining studies were overviews. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6.)

Appraisal of Methodological Quality

In addition to those mentioned in section 7.3.6, the following methodological concerns were raised by these studies:

- All the studies included in this review have relatively small sample sizes.
- For most of the studies the training package was not specified.
- Where the training package was specified insufficient details were provided to allow meaningful comparisons to be made with other training packages.
- Long-term outcomes, such as improvement in service user care, were not measured.

Included Studies

Fourteen before and after studies were included in this review (one of these before and after studies (Perkins and Leadbetter, 2002) is conducted in an area outside of the scope of the guideline. This study is included here, however, because the CALM technique which it evaluates is one of many training packages used in the UK for the
Short-term management of violence. Two pilot studies are also included. The first study (Frey and Weller, 2000) is included, despite only being a pilot study, since it is the only study, which considers the effectiveness of training service users rather than staff as a means of reducing in-patient violence in adult psychiatric settings. The second study (Bournemouth University, unpublished) is included since it is one of only 2 studies to evaluate the effectiveness of training in a clinical environment. Of the other studies included, one study is a retrospective cohort study, and seven are cross-sectional surveys.

As the studies often address multiple issues, the findings of the studies have been grouped together under topics. This means that some studies are referred to a number of times.

I.a Review question: What are the most effective and safe training programmes for the prevention of and the short-term management of violent (disturbed) behaviour in adult psychiatric in-patient settings?

The effectiveness of training staff in interventions for the short-term management of violence: general outcomes

Increased knowledge
In a before and after study (Calabro et al, 2002), significant increases were noted immediately after training in Non-violent Crisis Intervention (CPI) in post-test knowledge scores (p<0.001), positive change of attitude towards the techniques taught (p<0.001), self-efficacy (p<0.01) and positive change in behavioural intention (p<0.05). A further before and after study (Ilkiw-Lavalle et al, 2002), found that staff knowledge improved significantly immediately after training, with ancillary staff improving by the largest effect size (2.25). Staff with no prior training had the greatest improvements immediately after training (p <0.01) A before and after study (Paterson et al, 1992) noted a significant increase in knowledge immediately after training in post-test knowledge scores (p=<1%). Stress, as assessed by a general health questionnaire was also significantly reduced (p=<1%). In a controlled before and after study (Rice, 1985), significant improvements were found in all areas of knowledge (self-defense and patient restraint written test p<0.0001 for lesser security staff only) immediately after training.

None of these studies assess the effectiveness of training in a clinical environment

Attitude Changes
A before and after study (Collins, 1994), found that staff were less likely to hold service users entirely responsible for their behaviour, and acknowledge facts such as service user fear as causative immediately after training and at 6 months post-training. In a before and after study using the CALM techniques in a school for children with learning difficulties (Perkins, 2002) no significant changes in staff attitude toward pupil aggression were noted.

In a before and after study (Collins, 1994), staff confidence was found to increase immediately after training. Staff remained more confident 6 months post-training. In a before and after study using the CALM techniques in a school for children with
learning difficulties (Perkins and Leadbetter, 2002) it was noted that 82% of staff interviewed expressed increased confidence in their ability to deal with an aggressive incident 6 months post-training.

**None of these studies assess the effectiveness of training in a clinical environment**

**Number of Violent Incidents**

In a retrospective cohort study (Carmel & Hunter, 1990), training in managing aggressive behaviour and CPR was not found to be significantly linked to the number of violent incidents on the wards. In a before and after study (Sjöström et al, 2001), no significant reduction in the number of aggressive incidents using the Social Dysfunction Aggression Scale (SDAS-9) were noted 6 weeks after training.

In a controlled before and after study (Rice, 1985), there was a significant reduction in violent incidents (p<0.05) for the 18 months after training. Taxis, (2002) shows a dramatic decrease in the use of seclusion and restraint after a forty-two month period of training.

In a before and after study (Whittington and Wykes, 1996), it was noted that wards who sent the majority of their staff to a one day training course that did not involve restraint training noticed a significant reduction in assaults (p<0.05) for the 28 days after training. Staff who took part in training had a 31% lower rate of assault after training than those who did not take part. The decrease was unusual but did not reach significance.

**Staff injuries and missed work days**

In a retrospective cohort study (Carmel & Hunter, 1990), when wards highly compliant with training were compared to wards with low training compliance, a significant positive relationship was noted between those trained in managing aggressive behaviour and the number of staff injuries (p<0.005).

In a retrospective cohort study (Carmel & Hunter, 1990), a significant relationship was noted between individual staff who were trained in either managing aggressive behaviour or CPR and a reduction in staff injuries based on monthly reports over the course of a year (p<0.001).

In a before and after study (Martin, 1995), it was noted that 2 years after a training programme was initiated, although the number of aggressive incidents increased along with the level of aggression, the number of staff injuries fell and the number of missed work days fell resulting in a saving (in relation to missed work days) of $173,960 (year 1); $2,478 (year 2); $2,414 (year 3). (NB: Not enough information reported to assess quality).

In a controlled before and after study (Rice, 1985), there was a significant reduction in lost work days on wards that took part in the training relative to those that did not (p<0.001) for the 18 months post-training.

In a before and after study (Sjöström et al, 2001), noted that 6 weeks after training, no significant reduction in the number of staff on sick leave were noted.
**Prediction and Risk Assessment**

In a cross-sectional survey of 193 UK Trusts providing mental health services (Davis, 2001), just over 50 of the 84% replying provided training on risk assessment for harm to others.

A before and after study (Ilkiw-Lavalle et al, 2002), found that staff knowledge of prediction was significantly increased immediately after training (p<0.01).

**None of these studies assess the effectiveness of training in a clinical environment**

**De-escalation Techniques**

In a before and after study (Paterson et al, 1992), 'blinded' raters judged that there was a significant increase in staff competence in de-escalation immediately after training.

In a before and after study (Philips and Rudestam, 1995), judges rated that immediately after training the experimental group of staff who received training placed significantly more value on non-aggressive responses to service user violence/aggression (p=0.05) than a control group who were not trained or a control group who received only didactic training.

A controlled before and after study (Wondrak and Dolan, 1992), trained student nurses to deal with verbal abuse. Using role play, blind raters noted that there was significant improvement for those trained immediately after training compared to those not trained in all areas except empathy, eye contact and anger levels. Post-test, the attendees appeared more relaxed to blind raters (p=0.031), less upset (p=0.001) and had a more effective use of posture (p=0.005). On self-reported questionnaires three areas achieved significance in those trained: feeling less angry (p=0.002), feeling less out of control (p=0.005), and feeling less threatened (p=0.035) in a similar situation.

In a before and after study using the CALM techniques in a school for children with learning difficulties (Perkins and Leadbetter, 2002), semi-structured interview suggested that verbal de-escalation appeared to have increased 6 months after training.

**None of these studies assess the effectiveness of training in a clinical environment**

**Restraint**

In a before and after study (Paterson et al, 1992) 'blinded' raters judged that there was a significant increase in staff competence in control and restraint and disengagement immediately after training.

In a before and after study (Philips and Rudestam, 1995), immediately after training, judges rated the experimental group of staff who received training as significantly more competent in physical skills as well as displaying less fear and aggression (p=0.05) than a control group who were not trained or a control group who received only didactic training.

In a controlled before and after study (Rice, 1985), there were significant improvements in areas of skill (sensitive situations skill test p<0.001) and audio-taped simulations test (p<0.01) immediately after training. There was also a significant
increase in the On-Ward job reactions scale 6 weeks after training for maximum security workers compared to controls (p<0.01). This scale measures how comfortable participants are with their interactions with service users.

In an unpublished pilot study conducted by Bournemouth university, the effectiveness of restraint and breakaway techniques were considered in a PICU. The study used a prospective cross-sectional approach over 32 months. Over this period 346 adverse incident forms were collected. They did not record the use of breakaway techniques, however, when 19/22 staff were interviewed retrospectively, 3 recalled using recognised breakaway techniques, 1 a restraint technique and 1 an unrecognised technique. Staff did not recall any techniques used being inappropriate or ineffective. They recalled problems with taking the client to the floor. All were satisfied with the training they had received but wanted more frequent refresher courses and a greater emphasis on de-escalation.

Parkes (1996) conducted a before and after study in a 44-bed medium secure unit to assess the effectiveness of a 4 day C&R training course. Interviews were conducted with all staff involved in a restraint incident for the 18 months prior to training and the 12 months after all staff had been trained. Data was collected on all 340 incidents involving physical restraint. One hundred and forty-nine incidents involving restraint occurred after training, for statistical purposes these were compared with 149 incidents immediately prior to training. Staff injuries during the restraint phase increased after training (p<0.05). Injuries to service users during restraint phase did not significantly alter post-training. No other significant changes in injury rates were noted. Overall change in injury rates were not significant. There were no significant changes in difficulty rating or risk rating after training. The modal number of staff restraining a person increased to 3 after training. Highest number of staff involved in a single restraint decreased from 10 to 6 after training.

Only two studies, Bournemouth University, (unpublished) and Parkes (1996), assessed the effectiveness of training in a clinical environment. However, the first was a pilot study.

**Evidence Statements**

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests that short-term improvements in knowledge, skills and reduction in stress occur after staff training in the management of violence.</td>
</tr>
<tr>
<td>III</td>
<td>The lack of evaluations mean that a 'gold standard’ training package for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings cannot be determined.</td>
</tr>
</tbody>
</table>
Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings Guideline

I.b Review question: The effectiveness of training service users in the management of their aggressive and violent behaviour

One before and after pilot study (Frey and Weller, 2000) examined the effect on incidences of aggressive and violent behaviour, of training service users to respect themselves, peers and staff. Service users demonstrated a significant increase in knowledge based on a questionnaire immediately after the training ($p<0.05$). A nurses survey indicated a reduction in aggressive behaviour in the week after training ($p<0.05$). Authors claim that the training inadvertently led staff to alter their behaviour. It caused staff to become more aware of causes of service user aggression through examining the feedback. It is therefore unclear whether changes of staff behaviour or training service users had the most impact on reducing violence.

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
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<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests training service users to respect themselves, peers and staff may reduce violent incidents.</td>
</tr>
</tbody>
</table>

I.c Review question: What are the views of staff about the various training programmes in adult psychiatric in-patient settings and their content?

General Perspectives

Staff assessment of training needs

In a Canadian cross-sectional survey (Chaimowitz & Moscovitch, 1991) of medical students to assess the adequacy of training to deal with violent incidents, 34.3% thought that staff psychiatrists were adequately trained, 24.4% thought that psychiatric residents were adequately trained, 50.4% thought that nurses were adequately trained and 79.5% wanted improvements in education and training for staff. In a cross-sectional survey of medical trainees in New Zealand (Coverdale et al, 2001), only 30% had training in the management of violence and only 36% of these viewed it as adequate. Only 62% of those who were psychiatry trainees had received training in the management of violence.

PICU ward managers at a PICU conference took part in a UK cross-sectional survey (Clinton et al, 2001). Eighty-one percent of respondents stated that they would attend a course on violence management, however only 17% were aware of relevant courses in their locality.

In a before and after study (Ilkiw-Lavalle et al, 2002), it was noted that staff with previous training would have preferred to focus on special skills rather than repeat basic training.

In a cross-sectional study using semi-structured interviews (Southcott et al, 2000), it was noted that staff wanted more frequent refresher courses (3-6 monthly). In an unpublished pilot study by Bournemouth University it was noted that staff interviewed, 19/22, wanted more frequent refresher courses and a greater emphasis on de-escalation.
**Staff satisfaction with training**

In a before and after study (Goodykoontz and Herrick, 1990), it was found that staff felt more confident in their ability to handle violent situations after training and stated four months after training that they were more likely to intervene than they had been, rather than waiting for hospital security. After training they felt that they had a plan of how to proceed when faced with a violent incident.

In a controlled before and after study (Rice, 1985), the training course was well received (mean=5.5 on a 6-point scale where 6 is the best possible score). The results were little altered at 6 weeks and 15 months.

In a cross-sectional study using semi-structured interviews (Southcott et al, 2000), it was noted that staff were generally satisfied with the training that they had received and felt that the techniques that they had learnt were both effective and appropriate immediately after training. (All staff received training in control and restraint and breakaway techniques).

In an unpublished cross-sectional pilot study with retrospective interviews (Bournemouth University) it was noted that all staff interviewed, 19/22, were satisfied with the training they had received.

In a before and after study using interviews with a standard form (Parkes, 1996), staff felt safer and more in control when relocating the service user after having received training. They felt that C&R techniques appeared more professional to observers than unauthorised holds. Staff felt that training made it easier to hold the service user for a protracted length of time.

**Staff Perspectives relating to specific interventions**

**Prediction and Risk Assessment**

In a before and after study (Collins, 1994), nurses believed that some prediction of violence was possible immediately after the training course and 6 months post-training.

**De-escalation Techniques**

In a before and after study (Beech, 1999), students nurses were confident that they could manage verbal aggression immediately after training (p=0.0000).

In a cross-sectional study using semi-structured interviews four months after training (Southcott et al, 2002), it was noted that staff felt that de-escalation training should be provided before breakaway training.

**Restraint**

In a cross-sectional study using semi-structured interviews four months after training (Southcott, 2002), it was noted that staff felt that the process of restraint was often messy and uncoordinated and could be improved with better planning. (All staff received training in control and restraint and breakaway techniques).
Self-Defense
In a before and after study (Beech, 1999), immediately after training, student nurses believed that they would be able to protect themselves using reasonable force (p<0.0000).

Evidence Statements

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
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<tbody>
<tr>
<td>4</td>
<td>Staff perceive that training in the short-term management of disturbed/violent behaviour is beneficial and increases confidence in dealing with disturbed/violent behaviour.</td>
</tr>
<tr>
<td>4</td>
<td>The evidence suggests that staff often feel that their need for training is not met.</td>
</tr>
</tbody>
</table>

I.d Review question: What are the views of service users about the various training programmes in adult psychiatric in-patient settings and their content?

In a controlled before and after study (Rice, 1985), it was noted that after staff training, service users showed positive changes on a modified Coppersmith Self-Esteem Inventory, a scale measuring depression and anxiety from an adjective checklist and on a modified Feelings Scale. The results were significant on maximum secure wards (p<0.05). The questions were given to each service user weekly from 6 weeks before training until 6 weeks after training. The researcher had wanted to assess service user responses to staff training through a Ward Atmosphere scale but staff objected.

Evidence Statements

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<thead>
<tr>
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<th>Evidence Statement</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>There is insufficient evidence to determine service user perspectives on service user training to help service users manage their aggressive and/or disturbed/violent behaviour.</td>
</tr>
</tbody>
</table>

III Current Practices in Training in the UK

Four cross-sectional studies were found that examined current training arrangements in the UK.

Wright et al (2000) examined the policies for the management of violence in PICUs and RSUs. One hundred and twelve wards were surveyed, thirty three policies were returned (representing a good geographical spread). Nine percent of policies were current and not awaiting update, and 9% were out of date, 27% were undated. Less than two thirds of the policies had a stated aim or a definition of violence. Three
quarters of the policies stressed the need to report incidents, have post-incident team support, review the incident, outlined expectations and responsibilities of staff, emphasised prevention and de-escalation and had a commitment to train all appropriate staff. Just over half also mentioned the need for refresher courses. However, where a commitment to training was mentioned, less than half stated who was responsible for ensuring training was provided. Ninety four percent of policies listed physical restraint as an acceptable method for managing violence, less than half the policies however listed unacceptable methods of restraint.

Lee et al (2001) investigated the training which is undertaken in PICUs and RSUs. One hundred and twelve units were contacted (760 staff) - there was a 47% response rate. It was noted that it was possible to identify a core curriculum of twelve techniques across a range of courses: taking the patient to the floor, three-person restraint team, sitting & standing the patient, negotiating stairways and doors, restraining hold, roles within team, turning the patient over, breakaways, entry into & exit from seclusion, blocking punches, blocking kicks, separating fighting patients. Eighty-two percent of staff were able to identify the organisation who provided their training. Most initial courses lasted for 5 days. Respondents in RSUs were significantly more likely to be taught breakaway techniques (p=0.03), entry and exit from vehicles (p=0.00017) and defense against weapons (p=0.02) than respondents in PICUs. The three techniques most commonly used in practice were verbal de-escalation, restraining holds and use of 3-person team. Thirty one percent of respondents did not state that their courses contained ethical and safety issues or verbal de-escalation. While 39% received training within three months of taking up post, 21% did not receive training for a year or more and 8% had received no training at the time of the survey. Ninety-eight percent stated that they expected to attend a refresher course. Confidence in the skills learnt was high (mean=4.63 on a 6-point scale).

Davis et al, (2001) approached clinical directors in 193 NHS trusts which provide mental health services to assess how much risk assessment training takes place. The survey had an 82% response rate. Just over 50% provided training on risk assessment for harm of others. Most trusts provided training on mental health legislation. Most trusts provided annual training courses, but these were not compulsory. Clinical directors noted that staff attendance was low, but that many staff received additional training as part of routine clinical work or courses such as MRCPsych. Around 50% provided follow-up courses. The existence of written policies varied, most trusts had policies on observation.

Bleetman and Boatman (2001) conducted a cross-sectional questionnaire survey across 305 acute and community trusts, 30 ambulance trusts, 40 personal training organisations, and 63 corporate organisations. Mental health trusts were excluded. The aim was to provide an overview of control and restraint issues in the health services. The response rate was low. Acute and community trusts - 29%, Ambulance trusts - 30%, Training organisations - 45%, Corporate organisations - 13%. The following results were noted: No significant difference in levels of confidence in the reporting process were found between those Trusts using a specific aggressive/violent incident form and those using a general form. No significant results were found on the use of
PPE or personal alarms. Training organisations reported the following results: 72% stated staff were certificated to deliver training - but no standardisation, 56% reported trainers were qualified first aiders, 78% offered non-physical conflict management and 67% offered training in physical skills (types of skills outlined). Fifty percent knew skills taught were operationally effective. The evaluation of content of training packages appears subjective. This demonstrates the lack of standardisation in the UK. Authors note that it was not possible to reach any firm conclusions about the effectiveness of training techniques employed in the UK on the basis of this study.

Taken together, these four studies suggest that the following constitute the core curriculum of training courses in the UK:

- Taking the patient to the floor
- Three-person restraint team
- Sitting & standing the patient
- Negotiating stairways and doors
- Restraining hold
- Roles within team
- Turning the patient over
- Breakaways
- Entry into & exit from seclusion
- Blocking punches
- Blocking kicks
- Separating fighting patients

However, the limited scope of these studies limit the generalisability of their findings.

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
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<tbody>
<tr>
<td>4</td>
<td>The evidence on current training practices in the UK suggests that there is a lack of standardisation in the way staff are targeted for courses, and in the range of interventions covered. In addition, the effectiveness of training has not been adequately evaluated.</td>
</tr>
</tbody>
</table>

#### 7.8.3.4 Economic Evidence

No studies containing relevant economic data were found. The following additional exploratory cost analysis was carried out (for full details see Appendix 9).

- The cost effectiveness of life support training was considered. It was concluded that the cost per QALY of intermediated life support (ILS) training with automated external defibrillators AED under scenario 1 is around £47,000. For
this to be cost effective (ie. 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 advanced life support (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 are basic life support (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.

- The cost benefits of Automated External Defibrillators and Advanced Life Support training were also considered. The cost benefits of these two measures are not demonstrated. However, the evidence base is lacking.

7.8.4 Staff and Service User Perspectives

7.8.4.1 Staff and Service User Perspectives - General

7.8.4.1.1 Objectives

No specific searches on staff and service user perspectives was undertaken in the RCPsych guideline.

Current Guideline

Three review questions were identified by the GDG to be addressed in this review:

Review Questions

- Do staff and service users perceive themselves to be safe in psychiatric in-patient settings?

- What impact does disturbed/violent behaviour in psychiatric in-patient settings have on staff and/or service users?

- What are staff and service users attitudes towards the short-term management of disturbed/violent behaviour?

7.8.4.1.2 Selection Criteria

Types of studies
Systematic reviews to before and after studies. Qualitative studies were also included (level 1-2).

Types of setting
All adult in-patient mental health settings, excluding geriatric and learning disability.
Types of outcome
General staff and service perspectives on the short-term management of disturbed/violent behaviour.

7.8.4.1.3 Search Strategy

No specific searches were undertaken to identify papers that discussed staff and/or service user perspectives on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings since all searches were broad enough to retrieve papers which examined staff and/or service user perspectives. The articles which form the basis of this review were identified by the various searches for each of the interventions covered in this guideline but rather than looking at a single intervention or area, we considered this topic in relation to the short-term management of disturbed/violent behaviour as a whole.

7.8.4.1.4 Clinical Evidence

Eleven papers which examine general staff and service users’ perspectives on the short-term management of disturbed/violent behaviour were identified by our searches. After critical appraisal nine papers were included in this review. One was excluded. The other papers were overviews of a general nature, and were therefore ineligible. (Evidence tables of studies included only in this review can be found in Appendix 5. Evidence tables of studies excluded only from this review can be found in Appendix 6.)

General: Staff and Service User Attitudes towards Disturbed/Violent Behaviour in Psychiatric In-patient Settings

Nine studies were identified which considered staff attitudes towards disturbed/violent behaviour. A range of study designs and perspectives were examined making the results difficult to synthesise.

1.a Review question: Do staff and service users perceive themselves to be safe in psychiatric in-patient settings?

In a survey (Baxter et al, 1992), it was noted that staff felt uncomfortable with the belief that they should be able to predict violent incidents and were concerned about the frequency with which violence occurred. They felt that there was a lack of support/protection from the hospital.

One cross-sectional study (Thomas et al, 1995) examined staff attitudes toward service user safety. Seventy five percent of nurses rated both themselves and service users as safe. However a smaller (unspecified) number of nurses stated that they believed that service users actually felt safe.

An overt researcher-as-participant study (Quirk et al, 2003) considered strategies used by service users to keep safe in adult psychiatric in-patient settings. The study was
supplemented by interviews with staff, service users and advocacy work, as well as by results from a national audit. The following strategies for managing risk of violence were identified: avoiding risky situations, avoiding service users who explicitly warned others to keep away, finding a safe haven (like a bedroom), getting ‘specialled’ or not resisting it, using de-escalation techniques, allying oneself with someone high on the ‘pecking order’, making risk assessments of other service users (including proactive information gathering), warning staff about another service user, and getting discharged. The authors note that avoidance tactics were harder to employ in certain circumstances, like the canteen where service users had to rely more heavily on staff. The authors concluded that service users take an active role in making a safe environment for themselves and are not passive recipients of safety interventions by staff. They suggest that, in part, this results from feeling unable to rely on staff to ensure their safety.

1b Review question: What impact does violence in psychiatric in-patient settings have on staff and or service users?

Using mostly interviews and/or questionnaires (one study, Wykes & Whittington, 1998, used a case-control design, one study, Cheung et al, 1997, used a cross-sectional approach eight studies were identified which sought to examined the impact of violence on staff. None were found that looked at the general impact of violence on service users.

Two studies looked specifically at the impact of physical assault. Poster and Ryan (1989) tracked staff responses to physical assault over the course of a year. Although the authors noted that 82% of nurses had resolved the crisis by week 6, they also noted that 21% of staff met responder criteria six months after the event, and 16% met responder criteria 1 year after the event. The authors argue that there is a need to support staff to help them cope with their responses to physical assault. Omérov (2002) used interviews to assess the impact of physical attack and found that 43% of staff felt insulted by the attack and one third of staff felt angry. Men were more likely to be frightened (p<0.05) and women were more likely to feel surprised (p<0.01) regardless of the outcome of the assault. Most staff felt very uncomfortable after the assault, brought the incident home, found it hard to relax, had frequent nightmares and found returning to work difficult. All but one staff member would have welcomed self-defense training and refresher courses. The majority of staff requested some kind of post incident debriefing. Interviews were performed three days after an incident. There was no long term follow.

Wykes & Whittington (1998) noted a significant difference between non-assaulted and assaulted nurses in terms of psychological distress in relation to the General Health Questionnaire anxiety scale. Participants were assessed twice, once within ten days of the incident and once approximately four weeks later. Comparisons were made with baseline scores in a control group. There was a decrease in distress levels between time 1 and time 2. However, two new victims met the diagnosis criteria for post traumatic stress disorder (PTSD) at time 2 according to the post traumatic stress scale (PTSS).

In debriefing procedures it was noted (Flannery et al, 1995) that staff who had been verbally assaulted had similar PTSD-like symptoms and disruption in mastery and
meaning to those who had suffered physical or sexual assault. Time between debriefing and incident is not specified. There was no long term follow up.

Using SOAS, Cheung et al (1997) noted that one third of staff were emotionally shaken by the incidents they had been involved in, even though the rate of injuries requiring treatment was low.

Gillig et al (1998) noted that 18% of the staff they interviewed were considering changing their careers because of the emotional impact of violence/aggression.

In a questionnaire survey of Swedish and UK nurses (Nolan et al, 2001) it was found that less support was available for UK nurses following an incident (p<0.01), although they were significantly more likely to experience violence (p<0.01), sustain minor injuries and experience violence involving a weapon (p<0.05) than Swedish nurses. UK nurses reported lower self-esteem (p<0.05), and if they had experienced violence in the preceding twelve months were more likely than their Swedish counterparts to always find their jobs psychologically taxing (p<0.05). In the study overall, a significant positive correlation was found between self-esteem and feedback from line managers (p<0.05).

In a further questionnaire survey of Swedish nurses (Soares et al, 2000), it was noted that victims of violence were more likely to be less satisfied with their salary (p<0.05), complain of insufficient lighting and poor ventilation (p<0.001) complain about noise (p<0.001), find their psychological environment taxing (p<0.005), report that their work site was unpleasant (p<0.005), feel restless (p<0.05), feel less proud of their organisation (p<0.005), and state that they lacked resources (p<0.005).

**Review question: What are staff and service users attitudes towards the short-term management of violence?**

Eight studies attempted to elicit nurses’ attitudes toward the management of violent incidents.

Support/control emerged as a major theme in one survey (Lowe et al, 2002). Junior nurses were more likely to place an emphasis on limit setting and controlling strategies than senior nurses. Roper and Anderson, (1991) conducted an ethnographic study on an in-patient emergency psychiatric unit to explore the variables underlying service user/staff interactions which might lead to violent incidents. Staff control emerged as a key theme, along with staff tension, helplessness/hopelessness, and counter-transference.

In a hermeneutical study, Cutcliffe (1999) noted a relationship between a nurse's ability to deal with an incident in a manner which promoted a therapeutic outcome and the nurse feeling supported in their work. Whilst there may not be a causal relationship between these two outcomes, this finding suggests the importance to nurses of being able to maintain a therapeutic relationship with service users.
Using semi-structured interviews, Spokes et al (2002) found that nurses identified three key areas related to violence management: their clinical skills, personal characteristics (such as an ability to remain calm) and interpersonal skills.

Employing causal modelling, Morrison (1993) noted that psychiatric nurses disagree amongst themselves over how to define the seriousness of an incident.

Cutcliffe (1998) also noted that the decision to report an incident as violent depended on the therapeutic relationship between nurse and service user. Using unstructured interviews, Critchon, (1997) noted that nurses management strategies were dependent on the diagnosis and gender of the service users as well as the seriousness of the aggressive action. For example, seclusion was felt more appropriate for male service users.

Again using unstructured interviews, this time with video vignettes, Critchon et al (1998) noted that Canadian nurses tended to advocate more controlling measures, like PRN medication and seclusion, whilst UK nurses tended to opt for less controlling techniques, like de-escalation. UK nurses were also more likely to talk to the service user about what had happened.

Using a phenomenological approach, Carlsson et al (2000) identified seven themes underlying nurses management strategies: respecting one's fear, respecting the client, touch, dialogue, situated knowledge, stability, mutual regard, and pliability.

Five studies examined service user perspectives of violence in psychiatric in-patient settings. Three studies used questionnaires, one study (Kumar and Ng, 2001) conducted a focus group and one study (Lancee, 1995) used role play scenarios.

One survey (Svensson and Hansson, 1994) assessed the effect of personality traits, diagnosis and perceived coercion on service users’ satisfaction with psychiatric in-patient settings. It was noted that service users with a higher level of 'trait aggressive nonconformity' were significantly less satisfied with the ward’s physical and psychosocial environment (p<0.05), the treatment design (p<0.05) and the treatment programme (p<0.05). Service users with a higher level of trait sociability were more satisfied with the treatment programme (p<0.05). Service users with affective disorders had significantly better satisfaction than service users with schizophrenia concerning information and influence (p=0.004), ward environment (p=0.005) and general satisfaction (p=0.003). Service users who were involuntarily admitted were less satisfied with care in the areas of staff-patient relationship, ward environment, treatment programme and general satisfaction (p<0.001). A significant two-way interaction was detected between perceived coercion and the personality trait, aggressive nonconformity (p=0.05). Service users who perceived improvement in their condition had higher satisfaction with ward environment (p<0.01), treatment design (p<0.01), treatment programme (p<0.001) and general satisfaction (p<0.01). The phenomenon of acquiescence was not related to reported levels of satisfaction. The authors comment that careful consideration needs to be given to how to collect satisfaction scores from service users with schizophrenia or who perceived coercion in connection with their treatment.
Another survey (Gillig et al, 1998) noted that service users reported more depression and worry (p<0.05) and a change in appetite (p<0.05) than staff as a result of violence in psychiatric in-patient settings.

A further survey (Thomas et al, 1995) investigated service user reactions to being assaulted. They noted that female service users were more likely than their male counterparts to feel happy with staff responses to an incident (39% vs. 23%). However, they noted that women were less likely than men to feel safe on the wards (57% vs. 81%).

Six service users took part in a focus group (Kumar, 2001) to discuss the experiences of being either perpetrators, victims or witnesses of violence. Several members fell into several or all of these categories. Six over-arching themes were identified: firstly, that an imbalance of power exists in the mental health system; secondly, that violence has psychological sequelae; thirdly, that the mental health service is not geared to help victims of ‘institutional violence’; fourthly, that the present mental health system fosters violence; fifthly, that a radical change is needed in the infrastructure of the mental health system and sixthly, that reinforcement and reform may come from parallel efforts by staff and service users. Although acknowledging that the results may not be generalisable to a wider population, the authors argue that information saturation was achieved.

Role play was used (Lancee, 1995) to assess service user responses to different limit setting styles. Ninety-six service users participated, with limit setting styles ranging from belittlement to affective involvement with options. Service user anger at a particular limit setting style was the primary outcome variable. Three independent variables were considered: limit setting style, impulsivity and diagnosis. All proved significant (limit setting p<0.001, impulsivity p<0.001, diagnosis, p<0.05). The interaction between diagnosis and style had a greater significant (p<0.01). For all diagnostic groups, belittlement was most likely to cause anger. Impulsive service users were more likely to respond with anger to all limit setting styles than non-impulsive service users; non impulsive users had low anger for three limit setting styles - solution with options, affective involvement without options and affective involvement with options. Service users with high impulsivity only responded with low anger to affective involvement with options. The same was also true of service users with Schizophrenia. The sample size was too small to make other diagnosis specific observations. The authors argue that the study confirms that interpersonal factors play an important role in the management of anger in adult psychiatric in-patient settings.

Lanza et al, (1994) used interviews to compare staff and service user recollection of a violent incident. She found that with regard to 'objective' measures, such as limit setting and service users actions during assault there was general agreement between staff and service users. However, with regard to 'subjective' measures such as the relationship between staff and service users, content of service users speech, loudness of speech, number of staff and service users involved, and the cause of the incident there was much less agreement.
**Evidence Statements**

<table>
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<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
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<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests that staff and service users believe that building therapeutic relationships, in which service users feel respected, leads to less violent incidents. Key areas to be addressed in building such relationships include limit setting, and imbalance of power.</td>
</tr>
<tr>
<td>IV</td>
<td>The limited evidence suggests that service users are adversely affected by in-patient violence.</td>
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</table>

**7.8.4.1.5 Economic Evidence**

No studies containing relevant economic data were found. (See Appendix 9)

**7.8.4.2 Minority Ethnic Groups**

**7.8.4.2.1 Objectives**

No specific searches on minority ethnic groups were undertaken in the RCPsych guideline.

**Current Guideline**

Two review questions were identified and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs).

- *Does race/ethnicity of a service user or staff member make a difference to how they are treated when they are involved in an disturbed/violent incident in adult in-patient settings?*
- *Do staff and/or service users perceive that the race/ethnicity of a service user or staff member makes a difference to how they are treated when they are involved in a disturbed/violent incident in adult psychiatric in-patient settings?*

**7.8.4.2.2 Selection Criteria**

**Types of Studies**

Systematic reviews to before and after studies. Qualitative studies were also included (Evidence level 1-2).

**Types of 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 disturbed/violent behaviour in psychiatric in-patient settings.
- Staff and service user perspectives on the impact of ethnicity on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
- Bias in treatment or diagnosis, (prevalence/incidence rates).
- Effects of ethnicity/race on service users and/or staff.

7.8.4.2.3 Clinical Evidence

One hundred and sixty eight papers were identified by our searches. After sifting for duplicates and papers outside the scope, 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 varied from general acute psychiatric to specialist services-forensic or psychiatric intensive care. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6)

To supplement the evidence base for this review we also conducted three focus groups, two with Black service users and one with healthcare professionals with expertise in working with Black service users (See Appendix 14).

Included papers covered three broad areas that fall within the scope of the guideline: Prediction, Interventions and Admission. Special review questions were devised to focus the review in each of these areas.

I Prediction

Seventeen studies were identified which addressed these questions. A range of study designs and perspectives were examined making the results difficult to synthesis.

1. 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 and 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 Black and minority ethnic service users: Kho et al (1998) showed Asian patients to be more aggressive. Lawson et al (1984) showed whites to be more violent, to make more threats and to commit more self-destructive acts.

### Evidence Statement

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<tr>
<th>Evidence Level</th>
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<tr>
<td>4</td>
<td>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.</td>
</tr>
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</table>

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 service users than occurred amongst white service users and could lead to an erroneous interpretation as race was the only variable to emerge as a determinant of over hostility.

Choca et al (1990) tested the culturally sensitive of the Millon Clinical Multiaxial Inventory to assess whether it was culturally fair. This personality instrument has weighted scores to provide different norms for Black, White and Hispanic individuals to address potential bias. This study concluded that this test was a useful tool for prediction which takes account of racial bias, however some adjustment is needed to the item and scale levels.

racial stereotyping did not occur at first interview. 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. Reubin et al (1997) suggested that elevated levels of the enzyme creatine kinase can be used as a biological marker to predict aggression amongst African Americans. This finding could not verified from any other study.

### Evidence Statement

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<tr>
<td>4</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>
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</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/violent behaviour than service users from other ethnic backgrounds. (p<0.03).

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</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 Black service users.

A UK descriptive survey (Wilson and Francis, 1997), found that African Caribbean service users and African service users felt misunderstood as a consequence of being feared, ignored or stereotyped.

The two focus groups 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 (see Appendix 14).

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 minority ethnic service users found that these healthcare professionals felt that the short-term management of disturbed/violent behaviour in the UK is racially/ethnically biased (see Appendix 14).

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The limited evidence base suggests that Black/ethnic service users perceive that there is racial/ethnic bias in staff choice of intervention for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings. Staff-service user relationships, and feelings of being stereotyped, ignored and afraid are key areas of concerns for this group.</td>
</tr>
<tr>
<td>4</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, both from the US. Morley (1991) identified the role of police in admissions to hospital for African Caribbean service users experiencing psychotic symptoms. Commander et al (1997a) noted that two-thirds of African Caribbean service user admissions involved the police and that the admission of Asian service users also had a higher level of police involvement than the admission of white service users.

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</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>

#### 7.8.4.2.4 Economic Evidence

No studies containing relevant economic data were found (See Appendix 9).

#### 7.8.4.3 Gender

#### 7.8.4.3.1 Objectives

No specific searches on gender were undertaken in the RCPsych guideline.

**Current Guideline**

Two review questions were identified and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs).

- What impact does gender have on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?

- What are staff and service users perspectives on whether gender has an impact on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?

#### 7.8.4.3.2 Selection Criteria

**Types of studies**

Systematic reviews to before and after studies. Qualitative studies were also included. (Evidence levels 1-2).
Types of Settings
All adult in-patient mental health settings, excluding geriatric and learning disability.

Types of Outcomes
- Impact of gender 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 gender on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

7.8.4.3.3 Search Strategy

Searches were run from 1998-2003/6, to capture current legislation, attitudes and organisation of care.

7.8.4.3.4 Clinical Evidence

Three hundred and seventeen studies were identified in the initial sift. After sifting for relevance and duplicates, twenty full papers were ordered. Three met the inclusion criteria, fourteen were excluded. All the other papers were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review. References were checked but no further studies were identified. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6.)

Included Studies

1 Review question: What impact does gender have on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?

One study was included that considered the gender differences among perpetrators of violent assaults resulting in injury to staff: a case-control study in the USA (Lam et al 2000). This study showed no difference in the proportion of male and female psychiatric in-patients perpetrating such violence (20% of male patients vs. 18% of female patients).

No studies were found that answered the question of whether male and female perpetrators of violence in the in-patient psychiatric setting were treated differently.

One small cross-sectional survey of 59 psychiatric inpatients (31 males, 28 females, representing only 39% of eligible patients) was included that considered the different experiences of male and female patients who were potential or actual victims of other patients (Thomas et al, 1995). A similar proportion of the men and women reported harassment (physical or verbal or sexual) by other patients (68% of males and 75% of females) or having been hit (42% of males and 36% of females). More women were molested sexually (32% of females and 7% of males, p=0.01) and fewer females felt safe on the wards (57% vs. 81% of males, p=0.05). While many incidents were not reported to staff, more females were satisfied with the staff response when they did
report an incident (25% vs. 7% of males, p=0.05). However, the small and possibly unrepresentative sample precludes generalisation from this data.

One case-control study from the USA, involving over 200 staff over a period of 2.5 years, examined whether the gender of staff was a factor in the risk of being assaulted by a psychiatric in-patient (Binder & McNiel, 1994). In this study, staff gender was not associated with the risk of being assaulted for doctors, nurses or both disciplines together, but nurses were more likely to be assaulted than doctors.

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests that the gender of staff or service users does not impact on the incidence of disturbed/violent behaviour in psychiatric in-patient settings.</td>
</tr>
</tbody>
</table>

**II.i Review question: What are staff and service users perspectives on whether gender has an impact on the short-term management of disturbed/violent in-patient psychiatric settings?**

No studies addressed this review question.

### Evidence Statement

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>There is no evidence to determine staff and service user perspectives on the impact or influence of gender on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.</td>
</tr>
</tbody>
</table>

**7.8.4.3.5 Economic Evidence**

No studies containing relevant economic data were found. (See Appendix 9)

**7.8.4.4 Other Special Concerns**

**7.8.4.4.1 Objectives**

No specific searches on other special concerns were undertaken in the RCPsych guideline.

**Current Guideline**
Two review questions were identified and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs).

- What special considerations are needed in the short-term management of disturbed/violent behaviour where the service user has physical disabilities?

- What are the staff and service users perspectives of the considerations needed for the short-term management of disturbed/violent behaviour where the service user has physical disabilities?

7.8.4.4.2 Selection Criteria

Types of studies
Systematic reviews to before and after studies. Qualitative studies were also included. (Evidence levels 1-2).

Types of setting
All adult in-patient mental health settings, excluding geriatric and learning disabilities.

Types of outcome
- Impact of special concerns 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 special concerns on the interventions used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

7.8.4.4.3 Search Strategies

Searches were run from 1998-2003/6, to capture current legislation, attitudes and organisation of care.

7.8.4.4.4 Clinical Evidence

Nine papers were found in our searches. However all were excluded as none of them addressed the review questions.

Evidence Statements

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>There is no evidence which identifies the special considerations that are needed in relation to the short-term management of disturbed/violent behaviour where the service user has physical disabilities.</td>
</tr>
<tr>
<td>4</td>
<td>There is no evidence to determine staff and service users perspectives on what special considerations are required in</td>
</tr>
</tbody>
</table>
7.8.4.4.5 Economic Evidence

No studies containing relevant economic data were found. (See Appendix 9)

7.8.5 Psychosocial Interventions

Original RCPsych Guideline

The original RCPsych evidence review, covering all psychological interventions including both de-escalation techniques and observation, was examined. Their searches were undertaken based on the following review questions and hypotheses:

RCPsych Review Questions
- Can psychological interventions have the effects of reducing aggressive behaviour?
- Are particular psychological interventions more effective in reducing aggressive behaviour?

RCPsych Hypotheses
- That psychological interventions can have the effect of reducing levels of violence.

RCPsych Sub-hypotheses
- That psychological interventions have no effect in reducing levels of aggressive behaviour.
- That particular psychological interventions are more effective in reducing levels of aggressive behaviour.
- That psychological interventions are similar in terms of reducing aggressive behaviour.

After sifting and quality checks, only 8 papers relating to psychological interventions were included by the RCPsych reviewer.

The reviewer indicated that no evidence had been found on which evidence-based recommendations could be made.

In conclusion, I found it impossible to answer our original hypotheses. We had no good evidence to support any of our original hypotheses. [...] We are unable to comment on whether any intervention is more effective that any other in reducing levels of aggression. (RCPsych unpublished evidence review).

7.8.5.1 De-escalation Techniques
7.8.5.1.1 Objectives

Current Guideline
The current guideline focuses more specifically on particular psychological interventions, i.e. de-escalation and observation. Two review questions were identified and used to inform the search strategy (see Appendix 4 for search strategy, databases searched and search logs).

Review Questions:
- Are psychosocial techniques, such as de-escalation effective in pre-empting, dissipating or preventing disturbed/violent behaviour?
- What are staff and service users views about the effectiveness and appropriateness of de-escalation techniques as a means of diffusing disturbed/violent and potentially violent situations?

7.8.5.1.2 Selection Criteria

Types of Studies
Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence levels 1-2).

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

Types of Outcome
- The effectiveness of de-escalation techniques at decreasing the number of violent/potentially incidents without the use of other interventions.
- Staff and service user perspectives on de-escalation techniques.

7.8.5.1.3 Clinical Evidence

One hundred and ten studies were identified in the initial sift. After sifting for relevance and duplicates ten full papers were ordered. Seven were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review. References were checked and four further studies were identified and ordered. However, only four studies were primary research papers, three of which proved relevant to the research question. No study offered evidence above level III. No additional studies from the RCPsych review were included. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6.)

Included Studies

A prospective observation study (Jambunathan and Bellaire, 1996) attempted to evaluate the effectiveness of Crisis Prevention (CPI) techniques in preventing the need for mechanical restraint and seclusion. Techniques were assigned levels and these were linked with a stage of escalation (see table below). Ten registered nurses
prospectively collected data in 4hr shifts. All were trained in CPI on 12hr initial training and 4hr refresher course. The study evaluated aggressive incidents including a wide cross-section of psychiatric patients in a state-run in-patient psychiatric facility. The study suggests that CPI techniques allow most conflict situations (84.2%) to be resolved without the need for mechanical restraint or seclusion. Most service users’ behaviour cues (76.6%) and most staff interventions (69.4%) occurred at level 2 (However, there appeared to be a lack of intervention at level 1.) It was also noted that more than 50% of the incidents occurred on admissions units. More medication was administered where staff did not have an in-depth knowledge of the service users.

Outline of CPI techniques

<table>
<thead>
<tr>
<th>Escalation Level and associated behaviour</th>
<th>LEVEL 1: Anxiety (change or increase in behaviours such as crying, pacing, rocking, wringing hands, raising voice.)</th>
<th>LEVEL 2: Defensive (begins to lose rationality, becomes verbal, yelling, belligerent, sarcastic, intimidates, uses verbal threats, shakes fists.)</th>
<th>LEVEL 3: Acting Out (looses control, physical episode)</th>
<th>LEVEL 4: Tension Reduction (regains control)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPI techniques used</td>
<td>supportive, emphatic, active listening, asking questions, discussing thoughts/feelings, reducing stimuli, refocusing tasks, offering medication as needed.</td>
<td>limit setting, allow verbal release, isolate situation, assemble a team, planning for de-escalation or physical control.</td>
<td>physically holding patient, escorting patient to safe area, mechanical restraints or seclusion if CPI unsuccessful.</td>
<td>attempt to regain therapeutic rapport, coping mechanisms, contracting.</td>
</tr>
</tbody>
</table>

(N.B. Most CPI techniques were verbal de-escalation techniques, however physical restraint is included in the third stage as a CPI technique.)

While the study is reasonably designed, it is a non-experimental pilot study, observers were not blinded to either staff or service users, and staff were informed that observations would be carried out prior to the study. The results also do not allow the different service user groups to be analysed independently. No supporting evidence is offered for selection of antecedents of violence, not for their division into 4 levels of escalation. Supporting evidence is also lacking with regard to the relationship between levels of escalation and CPI techniques.

A before and after study at a veterans medical centre, (Richmond et al, 1996) also measured whether the implementation of de-escalation techniques reduced the use of restraint and seclusion, (unlike Jambunathan and Bellaire (1996), they did not treat physical restraint as a de-escalation technique.) They suggested that training in verbal de-escalation, ‘time out’, relaxation techniques, medication, diversional activities and decreased stimulation led to a 47% decrease in restraint use and a 31% decrease in the use of seclusion. Whilst these results seem promising, the study design is non-experimental and confounders are not explored.

Staff perspectives

A qualitative study (Johnson and Hauser, 2001) used unstructured interviews was to elicit nurses views on how to de-escalate the escalating service user. The author
reported that expert nurses were able to develop an awareness of where service users are on the continuum of escalation, noticing early behavioural and verbal signs, which allowed them to successfully implement de-escalation techniques. However, the sample size was very small, and the method non-experimental.

Service user perspectives

A triangulation study using incident forms, questionnaires and interviews, (Duxbury, 2002), noted that service users were not aware of staff using de-escalation techniques (p<0.000).

The RCPsych review did not include any studies which evaluated de-escalation techniques. The findings of this review therefore alter the findings of the RCPsych psychosocial interventions review, although the evidence presented above is limited.

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>The limited evidence suggests that de-escalation techniques decrease rates of violence.</td>
</tr>
</tbody>
</table>

7.8.5.1.4 Economic Evidence

No studies containing relevant economic data were found (See Appendix 9).

7.8.5.2 Observation

7.8.5.2.1 Objectives

Current Guideline
Two review questions were identified and used to inform all searches (see Appendix 4 for search strategy, databases searched and search logs).

Review Questions:

- Are psychosocial techniques, such as observation effective in pre-empting and preventing disturbed/violent behaviour?

- What are staff and service views about the effectiveness and appropriateness of observation as a means of pre-empting and preventing disturbed/violent and potentially violent situations?

7.8.5.2.2 Selection Criteria

Types of Studies
Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence Levels 1-2).

**Types of Setting**
All adult in-patient mental health settings, excluding geriatric and learning disability.

**Types of Outcome**
- The effectiveness of observation techniques at decreasing the number of violent/potentially incidents without the use of other interventions.
- Staff and service user perspectives on observation techniques.

**Types of outcome excluded**
- Observation which pertained to suicide or self-harm.
- Observation in non-psychiatric in-patient care settings.

### 7.8.5.2.3 Clinical Evidence

Seventy five studies were identified in the initial sift. After sifting for relevance and duplicates twenty-two full papers were ordered. However, twelve were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review.

Fourteen studies were primary research, however, only nine studies proved relevant to the research question. No study offers evidence above level III. References were checked for missing articles but no further relevant primary studies were identified. No additional studies from the RCPsych review were included. (Evidence tables of included studies are found in Appendix 5. Evidence tables of excluded tables are found in Appendix 6.)

**Appraisal of Methodological Quality**

In addition to the quality concerns mentioned above, these studies raised the following methodological concerns:

- Most of the studies (with the exception of Shugar and Rehaluk, 1990 and Bowles and Dodds, 2001) did not address the question of effectiveness

These studies were included to provide a systematic review of the research that has been conducted on observation in psychiatric in-patient settings. Gaps in the research can be readily identified and low graded evidence statements were presented to assist the GDG in their deliberations.

**Included Studies**

Several state-wide surveys to establish the reason why constant observation (CO) was used, have been conducted in the States. Torkelson and Dobal (1999), carried out a six-month state-wide survey focusing primarily on surgical and medical units and their use of CO. Stratified randomisation was used to select hospitals. Authors found that the decision to initiate and discontinue CO could be made by a wide spectrum of
people (clinician, nurse, family member) The most common reason for CO was either danger to self or others. Although 84/89 hospitals agreed to participate, very little information on cost was provided. The results are difficult to analyse from the perspective of violence to others since this is not differentiated from violence to self. The analysis is also flawed. No firm conclusions of the effectiveness of CO are offered.

Moore et al (1995) also undertook a State-wide survey. Hospitals were selected by stratified randomisation; 19/26 agreed to participate. However only fifteen made use of constant observation (CO). Of these only six were psychiatric hospitals. Again a wide spectrum of people made the decision to initiate CO. Those observing requested more training and information. There was a lack of information on costs. No attempt was made to differentiate between different interpretations of CO. The hospitals which used CO to combat violence are not specified.

Bowers et al (2000) carried out a random stratified sample survey of constant observation (CO) policies in England and Wales. There was no consistency amongst trusts (see evidence table for full details). Out of twenty six policies supplied, only two used the same terminology (constant observation had different meanings in different locations, level 1 meant either high or low levels of observation). Differences also existed between official policy and questionnaire responses. It was noted that this is particularly worrying as agency staff are often used to carry out CO. The report does not discuss the effectiveness of CO.

Shugar and Rehluk (1990) conducted a retrospective controlled cohort study to consider the effectiveness of close observation (CO). Carried out in a psychiatric teaching unit, this study examined the use of CO in both civil and forensic patients. Various predictors signalling the need for CO were identified. However, most patients had CO supplemented by medication, so that it is difficult to assess the efficacy of CO. The authors acknowledges this and therefore only offer tentative conclusions. Authors suggests that CO should only be used as a short-term measure but offer no evidence. While an interesting study, the design is weak and the conclusions may therefore be limited.

Philips et al (1977b) used a retrospective two year cross-sectional survey to assess whether a correlation existed between involvement in constant observation (CO) and absenteeism. A statistically positive correlation (p<0.05) was noted. Discrepancies were explained in terms of reduced staffing levels forcing a reduction in CO, and high demand for CO obligating nurses not to take sick leave. There is a lack of essential information in this study. The conclusions drawn should be interpreted with caution.

Philips et al (1977a) identified the type of service users who usually receive continuous observation (CO). Using a retrospective ten year cohort study, they found that service users receiving CO were most likely to be female and suffering from either schizophrenia or depression. (CO was used for suicide risk for both types of service users, and for behavioural reasons with service users suffering from schizophrenia). The age range for service users with depression was between 30-50, while for schizophrenia, it was between 15-29yrs and 35-40yrs. Staff concerns about
CO related to length of time an individual nurse was engaged in CO (entire shift) and the effect of CO on other service users and staff within the ward. Seventy-five percent were in favour of a special unit for CO, with 45% suggesting they would be prepared to work there full time, 34% sometimes and 21% never. The author stresses that more research is necessary to elicit the therapeutic value of CO - a procedure, which is identified as cost effective but time consuming.

Bowles and Dodds (2001) report the effect of dismantling the formal observation policy in a 21-bedded acute ward in Bradford. They argue that formal observation became redundant, and after 18 months one-to-one observation was not used at all, and 5-10 minute checks were used only rarely. The number of suicides did not increase, but the levels of absconding were almost halved, with self-harm falling by two thirds and violence and aggression by a third. Staff sickness was also reduced by two thirds. Removal of the policy has also meant a saving of £45,000 over 12 months. They state that service users are now more involved in their care and in ward decisions. The authors argue that the removal of this policy which they describe as an 'outmoded ritual of mental health nursing' has freed up nurses time, allowing activities to be set up and time to be 'gifted' to service users as required. Ninety-five percent of service users now receive daily one-to-one time with a nurse, which the authors argue is the most valuable intervention. The author acknowledges that the study is too small for the results to be generalised, but insists that it should bring the practice of formal observation into question. This study does not provide enough information about their previous formal observation policy and so is open to a number of interpretations. The one-to-one interventions implemented once formal observation was dismantled could be viewed as a more therapeutic and appropriate form of formal observation.

A 3.5 month prospective audit was conducted in a psychiatric intensive care unit (Lehane and Rees, 1996). It examined responses to incidents that would have formerly led to seclusion. The author notes that one-to-one nursing was used in 86% of cases, but does not offer any information on its effectiveness. The sample size is relatively small.

Service User Perspectives

One study examined service user perspectives on observation. Jones et al (2000) conducted a 3 month survey in one mental health trust to assess service users' feelings about and preferences within constant and close observation (the highest level out of 4 levels employed within the trust). The study revealed that mental health service users, including those who exhibited aggressive behaviour, but particularly those with suicidal tendencies, preferred to be observed and felt safest when observed by either nurses they knew or nurses who talked to them.

Staff Perspectives

One study considered staff perspectives on observation. Neilson and Brennan (2001) carried out a retrospective audit to determine staff knowledge of and attitudes toward a new hospital special observation (SO) policy and differences between wards with respect to these two variables (assessed by a knowledge questionnaire, semi-structured
Yonge and Stewin (1992) conductive qualitative research using ‘Ethnography’ a programme for textual analysis. Findings suggested that close Observation (CO) is a procedure that nurses find stressful. Nurses felt that they were also on CO and had to find ways of dealing with emotions caused by this encounter. Meal times and bathroom visits were flagged up as particularly stressful for nurses. None of the nurses interviewed accompanied the patient into the bathroom (even where this was in breach of hospital policy). Nurses also supported one another in handover, attempting to limit the repetitive questions for the patient. At the same time, some saw CO as an opportunity to develop a quality relationship with the patient. Different preferences were expressed by nurses for certain types of CO patients (psychotic, depressed).

The RCPsych review did not include any studies which evaluated observation. The findings of this review therefore alter the findings of the RCPsych psychosocial interventions review, although the evidence presented above is limited.

### Evidence Statements

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>It is not possible to ascertain the effectiveness of observation on the basis of the available evidence.</td>
</tr>
<tr>
<td>4</td>
<td>The limited evidence suggests that service users prefer to be observed by a nurse that they know and that most staff find observation a stressful procedure.</td>
</tr>
</tbody>
</table>

### 7.8.5.2.4 Economic Evidence

No studies containing relevant economic data were found. (See Appendix 9)

### 7.8.6 Other Interventions

#### 7.8.6.1 Physical Interventions and Seclusion
7.8.6.1.1 Objectives

The original RCPsych guideline evidence-base on restraint and seclusion was examined. A list of excluded studies was available in the archived information received from the Royal College of Psychiatrists Research Institute. The following information was taken from the final report in the RCPsych guideline, which states that these hypotheses were used to inform the search strategies:

**RCPsych Hypothesis:**

- Restraint when skillfully applied by trained and supervised staff according to monitored protocols and the context of other methods, is an effective and safe means of coping with overtly violent behaviour.

- When properly used and explained, restraint can be acceptable both to users of services and to staff.

- Seclusion is unnecessary if restraint is properly applied in association with other methods of good practice.

After sifting and quality checks, sixteen references on restraint and seclusion were included in the RCPsych evidence review.

However, the included studies did not offer generalisable criteria in support of these hypothesis so the RCPsych review concluded that:

> No strongly evidence-based conclusions can be drawn from the quantitative evidence.

**Current Guideline**

Three review questions were identified and used to inform all searches (see Appendix 4 for search strategies, databases searched and search logs). Physical interventions include the use of pain compliance.

**Review questions**

- *Are physical interventions safe and effective for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?*

- *Is seclusion safe and effective for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?*

- *What are service users perspectives on the use of seclusion physical intervention and seclusion for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings?*

7.8.6.1.2 Selection Criteria
Types of Study
Systematic reviews through to before and after designs. Qualitative studies were also included. (Evidence Levels 1-2).

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

Types of Outcome
- Effectiveness and safety of various physical interventions and seclusion when used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
- Staff and service user perspectives on physical interventions and seclusion when used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

7.8.6.1.3 Clinical Evidence

One hundred and thirty three studies were identified in the initial sift. After sifting for relevance and duplicates eighty-four full papers were ordered. After quality appraisal twenty-one papers were included, four papers were excluded and sixty were opinion pieces, anecdotal reports, or fell outside the inclusion criteria for this review. References were checked and fourteen further studies were identified and ordered. None met the inclusion criteria. In addition, ten studies from the RCPsych review were included. (Evidence tables of all included studies can be found in Appendix 5. Evidence tables of all excluded tables can be found in Appendix 6).

One systematic review, one retrospective cohort study, two cross-sectional studies and three before and after studies were included in this review. Two of the primary research studies were set in the UK and the rest were from the US or Canada.

A Cochrane review undertaken by Salias & Fenton, (2001) focused on the effectiveness of restraint or seclusion or strategies designed to reduce the need for restraint or seclusion in the treatment of mental illness and found no trials which met the minimum criteria. It concluded,

No controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness. There are reports of serious adverse effects for these techniques in qualitative reviews. Alternative ways of dealing with unwanted or harmful behaviours need to be developed. Continuing use of seclusion or restraint must therefore be questioned from within well-designed and reported randomised trials that are generalisable to routine practice.

This Cochrane systematic review is currently being updated. Contact with the author suggests that the conclusions are unlikely to change.
Four studies in the RCPsych review considered the role of the seclusion room in a psychiatric in-patient setting (Haftner et al., 1989; Craig et al., 1989; Kingdon & Bakewell, 1988; Brooks et al., 1994). Two of these studies suggest that use of seclusion rooms reduce violent incidents. However, one study (Kingdon & Bakewell, 1998) suggests that violent incidents are better reduced by improved staffing patterns, education and management participation. The fourth study (Brooks et al., 1994) suggested that both levels of restraint and seclusion are increased by overcrowding.

None of these studies significantly change the findings of the RCPsych review.

**Evidence Statement**

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>There is insufficient evidence to determine the effectiveness and safety of either physical interventions or seclusion for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.</td>
</tr>
<tr>
<td>4</td>
<td>There is insufficient evidence to determine the effectiveness or acceptability of pain compliance as a technique for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.</td>
</tr>
</tbody>
</table>

**Sudden Death**

Evidence from published case series which link physical interventions to adverse reactions was collated. (See Evidence tables of included studies, Appendix 5). It was not possible to determine whether there was a relationship between physical interventions and an increased likelihood of sudden death.

Three studies were conducted in attempt to show the relationship between restraint and positional asphyxia. Parkes (2000), Schmidt & Snowden (1999) and Chan et al. (1997) conducted experimental studies on healthy subjects. All suggest that restraint in the prone position does not result in effects likely to cause death and that other factors need to be in situ.

This issue was not specifically addressed in the RCPsych review.

**Evidence Statement**

<table>
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<th>Evidence Level</th>
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<tr>
<td>4</td>
<td>The available evidence suggests that there may be severe adverse effects associated with the use of physical interventions.</td>
</tr>
</tbody>
</table>

**Staff and Service user perspectives**
Six studies examined staff perspectives on physical intervention and seclusion:

One study, focused on staff decision-making processes. A sample of 64 nurses (response rate of 77%) were asked about knowledge and experience gained, as well as values and concerns with regard to the practice of seclusion. Key themes emerged around safety and the abuse of seclusion. However, in a further study nurses stated that seclusion had a place in real world practice (Alty, 1997).

Muir-Cochrane, (1996) found that, in a sample of seven nurses, the core underlying themes relating to the use of seclusion were control and that staff saw themselves as gatekeepers who maintain control.

Mason, (1997) took a random sample of twenty-five nurses in a forensic hospital and found decision-making around the use of physical interventions and seclusion to be based on the need to stick to an original decision. They found that a feeling of being under the gaze of others in authority led to the need to balance the responsibility of an untoward incident against care of the individual. Furthermore they found that nurses felt a need to justify their actions to those in authority and therefore tended to adopt positions of safety.

Marangos-Frost and Wells, (2000) in an ethnographic study interviewed six nurses on an unlocked psychiatric ward. They found themes consistent with other studies presented here, in particular, concerning the decision-making dilemma of choosing between risking harm to the patient and others, or restraining; both equally unwelcome options. However, the findings were based on those that self-harmed as well as those that harmed others and the nurses were very experienced and, therefore, not representative of the usual ward staff-team.

Holzworth & Wills, (1999) found a sample of nine nurses in a short-term psychiatric hospital had a preference for seclusion over restraint. However, they noted that overall, there was inconsistency between nursing staff in selecting seclusion, restraint or observation. Lemonidou, (2002) conducted a descriptive survey of nurses attitudes and choice of restrictive intervention. The study involved 190 nurses in adult psychiatric inpatients in five hospitals in Greece. The findings suggest that nurses prefer seclusion to restraint. It was also noted that nearly half of the service users continue to be aggressive after restraints were removed. However, this study focused on the use of mechanical restraints.

The RCPsych review also contained two further studies (Soliday, 1985; Tooke & Brown, 1992), which compared staff and service user perceptions of seclusion. Service users who had been secluded had less favourable attitudes towards seclusion than either staff or service users who had not been secluded. Some service users saw seclusion as punitive. However, other service users saw a need for seclusion. In one of the studies staff stated that they could not see how they could cope without access to a seclusion room.

Four studies examined service user perspectives on physical intervention and seclusion:
A relatively recent UK based study carried out by Sequeria and Halstead, (2002) with a sample of fourteen inpatients who had been interviewed twelve hours after being restrained, found emergent themes of anger with a sense of injustice and that service users felt that the intervention was unwarranted. The researchers also noted that anxiety continued long after the incident, along with mental upset. Contrary to this, the study also found that female patients restrained by female staff welcomed the safe feeling of containment, which even led to them seeking restraint.

A study by Gallop et al (1999) highlighting concerns raised about the effects of restraint on those who may have previously suffered sexual abuse. They found that service users reported negative experiences of being rendered powerless and being degraded. In this study, six out of the ten participants were restrained for self harm. Therefore, care is required whilst extrapolating to this review. The study nevertheless highlights the need to be aware of previous history when considering this intervention.

Bonner et al, (2002) conducted a pilot study in the UK where he interviewed two members of staff and a service user involved for each incidents which resulted in physical restraint. Initial findings suggested that failed communication is an antecedent of restraint. The study further suggested that restraint was used as a last resort to contain and support the patient. The study also suggests that both patient and staff can suffer trauma and distress after the incident and that support, post incident, is important to both groups.

Using a questionnaire survey (Mann et al, 1993), suggested a range of attitudes towards the seclusion room with only a minority of service user suggesting that there should be no such room. The authors noted that many service users reported that the room was helpful. They noted that these tended to be service users who had no history of substance abuse (p<0.05). Conversely service users with no history of substance abuse more often reported that the room was like a padded cell (p<0.05). Service users who used the room for the first time were more likely to report that it was stuffy (p<0.05) and to describe it as torture (p<0.05). Non-compliers were less likely to label the room safe and secure (p<0.05). Service users with disorders other than depressive disorders were more likely to report that once in the seclusion room it is difficult to get out (p<0.05).

Three further studies in the RCPsych review (Binder & McCoy, 1983; Hammill et al, 1986; Wise et al, 1988) surveyed service users who had experienced seclusion. Another study (Eriksson & Westrin, 1995) surveyed service users about seclusion, rapid tranquilisation and restraint. These studies found a mixed response to these measures. Whilst service users sometimes saw a need for them, on many occasions they felt that they had been used unnecessarily.

None of these studies significantly change the findings of the RCPsych review.

**Evidence Statement**

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<th>Evidence Level</th>
<th>Evidence Statement</th>
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<tbody>
<tr>
<td>4</td>
<td>The available evidence suggests that staff</td>
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may find using seclusion and physical interventions traumatic, but also consider that these interventions serve a necessary function.

4 The limited evidence suggests that service users may find seclusion and restraint degrading, although some service users believe that measures, such as seclusion and physical intervention are sometimes justified.

7.8.6.1.4 Economic Evidence

No studies containing relevant economic data were found. (See Appendix 9)

7.8.6.2 Rapid tranquillisation

7.8.6.2.1 Objectives
The aim of this review is to examine the existing evidence on the efficacy and safety of the medications currently used for rapid tranquillisation (IV, IM, oral (any form) in psychiatric in-patient settings. It builds on the original RCPsych guideline, the NICE schizophrenia guideline (2002) and a recent New Zealand Health Technology appraisal (2001) all of which also examined this intervention.

1 Original RCPsych Guideline
The original RCPsych evidence review on rapid tranquillisation was examined. Their searches were undertaken based on the following review questions and hypotheses:

RCPsych Review Aim
- To produce a systematic review of the use of medication in managing violent incidents in clinical settings in which mental health care is provided.

RCPsych Hypotheses and sub-hypotheses
- Is medication effective and safe in preventing and managing violent incidents?
- What are the contra-indications to using medication to manage violence?
- Is the effectiveness of medication related to general sedation or to specific therapeutic effect on an underlying disorder?
- Is medication effective in the management of violence irrespective of the aetiology of violence?

The RCPsych review inclusion criteria:
Any controlled or non-controlled (including qualitative) research studies

The RCPsych outcome measures:
- The reduction of violence
- An increase of safety to patients and staff
Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient and Accident and Emergency Settings Guideline

- Measure of therapeutic effectiveness
- Measure of harmful effects of medication
- Measure of the threshold of the use of medication

Searches were made from 1986-1996 on Medline, Cinahl, Embase and Psychlit

After sifting and quality checks, fifteen references relating to rapid tranquillisation were included by the RCPsych reviewer. Of these only six were controlled studies which were judged to be fair to good.

The reviewer indicated that no evidence had been found on which evidence-based recommendations could be made.

The review of the literature has shown that using strictly evidence based criteria, no individual or combined psycho-pharmacological agent(s) is the definitive intervention during or just prior to an act of violence [...]. It is clear that more research needs to be carried out if the questions posed in our hypotheses are to be satisfactorily answered.

II Schizophrenia Guideline

The systematic review for the NICE schizophrenia guideline (2002) drew on Broastock (2001) and the Cochrane Review of Zuclopenthixol Acetate (Fenton M et al, 2001). They identified six phase III randomised controlled trials which addressed the issue of rapid tranquillisation in relation to schizophrenia. These have been added to the evidence review for this guideline.

III New Zealand Health Technology Appraisal (HTA) (M. Broadstock, 2001)

The systematic review identified twelve phase III randomised controlled trials which addressed the issue of rapid tranquillisation. These have been added to the evidence review for this guideline. One of these studies (Thomas et al, 1992) was excluded from the current review as most of the participants had a primary diagnosis of intoxication and therefore fall outside the population considered in the guideline. Another study (Salzman et al, 1991) was excluded as it did not appear to be an randomised controlled trial. Three of these studies were also identified by the searches employed for the current guideline.

Current Guideline

The current guideline focuses on the efficacy of rapid tranquillisation as an intervention for the short-term management of violence. Unlike the RCPsych review, however, dual diagnosis is not included in the scope. This has meant that some papers included by the RCPsych and the New Zealand HTA are excluded from this review. The inclusion criteria are also more stringent, as only systematic reviews to phase III randomised controlled trials are included, as noted below, which has led to further exclusions from the RCPsych review.
The following questions were identified and used to inform the search strategy of the current review (see Appendix 4 for search strategy, databases searched and search logs).

**Review Questions:**

- What is the effectiveness of brief or fast acting pharmacological interventions for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings?
- How safe are the pharmacological agents which are used for rapid tranquillisation and what are the side effects?
- What are staff and service users views/perceptions about the effectiveness and appropriateness of pharmacological interventions as a means of intervening in a disturbed/violent and imminently violent situation?
- How safe and effective is PRN medication for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings?

**7.8.6.2.2 Selection Criteria**

**Types of study**

Systematic reviews through to phase III randomised controlled trials. (Evidence Levels 1) Qualitative studies and surveys were also included to obtain information on staff and service user views.

**Interventions**

Rapid Tranquillisation IV, IM, and oral (any form)

**Types of Setting**

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

**Types of Outcome**

- Decrease in hostility/aggression
- Tranquillisation
- Sedation/somnolence
- Side effects and adverse reactions
- Satisfaction with care
- Economic outcomes (considered in separate economic review - see Appendix 9)

**7.8.6.2.3 Search Strategy**

In addition to the searches covering 1985-2003, searches were also conducted covering 1969-1985 on all databases to ensure that no research papers were missed in the RCPsych review.

**7.8.6.2.4 Clinical Evidence**
Eighty-three studies were identified in the initial sift. After sifting for relevance and duplicates seventy one full papers were ordered.

**Medication**

Twenty three papers were opinion pieces, anecdotal reports, letters, or fell outside the inclusion criteria for this review. References were checked and one further study was identified.

Eight papers were systematic reviews, seven of which proved relevant to the research question. However, one systematic review was a duplicate, so only six systematic reviews were included in the review. Eleven randomised controlled trials were retrieved, one was excluded because it was already included in an included systematic review, ten further randomised controlled trials, which were not mentioned in any of these systematic reviews, were located, all of which proved relevant to the research question. All trials were phase III. All evidence is level I-II.

The rapid tranquillisation search strategy was broad enough to have found any articles on PRN which related to short-term management of violent (disturbed) behaviour. One systematic review (Whicher et al, 2002) was found and five further studies were identified.

**Service User and Staff Perceptions**

Six surveys and qualitative studies examined staff and service user perceptions of rapid tranquillisation and PRN medication. These studies were included as they address the acceptability of this intervention to staff and service users and therefore supplement the evidence base from randomised controlled trials. All evidence is level IV.

**Sudden Death**

Although sudden death was not searched for specifically one case study on sudden death was retrieved by the searches. Three further studies were located in references to studies ordered for this review. No study presented evidence above level IV.

(In addition to the search from 1985-2003 a further search was conducted from 1969-1985 to ensure that no research papers were missed by the RCPsych review. Seventy papers were identified in this search. After sifting for relevance and duplicates thirty full papers were ordered. A further seven papers were included, nineteen papers were excluded and thirteen papers were opinion pieces, anecdotal reports, letters, or fell outside the inclusion criteria for this review. References were checked, but no further studies were identified)

Of the seven included papers three were randomised controlled studies which examined drugs used for rapid tranquillisation, three were cross-sectional surveys which examined the use of PRN medication in various relevant settings, and one was a cross-sectional study of service user's attitudes to an incidence of forcible medication.
Appraisal of Methodological Quality

Additional methodological concerns were:

- inappropriately small sample sizes (Number needed to treat (NNT) not always stated or sufficient)
- participants not always sufficiently agitated to require rapid tranquillisation
- outcome measures not always sufficiently defined
- Intention to treat analysis not always clearly described
- Statistical measures (OR, RR, CI) not clearly reported.

Included Studies

I Systematic Reviews

Six systematic reviews were used to inform this review. Four of these reviews looked at the efficacy of a particular medication. Three reviews were all of very high quality (Carpenter and Berk, 2000; Cure and Carpenter, 2001; Fenton et al, 2001), a further review was of a lesser quality, but the quality was not overly compromised (Aleman and Kahn, 2001). These reviews were used as part of the evidence base for assessing the efficacy of the medications, droperidol, zuclopethixol acetate, clotiapine and risperidone. Three of these reviews examined the efficacy of these medications specifically with reference to rapid tranquillisation (Cure and Carpenter, 2001; Carpenter and Berk, 2002 Fenton et al, 2002). These three reviews looked at the efficacy of droperidol, clotiapine and zuclopethixol acetate respectively. All three reviews concluded that the use of these medications in emergency psychiatry was currently only justified in terms of clinical (i.e. expert opinion), rather than research, evidence. Clotiapine is off-patent and currently unavailable in the UK since the manufacturers, Novartis, found the production costs prohibitive off-patent. Droperidol was voluntarily withdrawn by the manufacturer, Janssen-Cilag Ltd, from the end of March 2001, amid concerns over the medication's safety as a oral treatment for chronic conditions. Cost effectiveness of production resulted in other forms of the medication also being withdrawn. The reviewers suggest that further research is needed into the efficacy of droperidol for the purposes of rapid tranquillisation, for which it seemed to be safe, although the evidence underlying the medication’s safety is also clinical rather than research-based. Likewise authors of the review on clotiapine also stressed that whilst they did not want to discourage the use of this medication for rapid tranquillisation, more research is needed to establish its efficacy and safety in relation to other medications used for this intervention. Similar conclusions were reached about zuclopethixol acetate, with the reviewers stressing that there was no evidence to suggest that this medication was either safer or more effective than other medications currently used for rapid tranquillisation. Furthermore zuclopethixol acetate is slow acting and therefore is normally no longer recommended for rapid tranquillisation. This evidence is graded at level I.
The evidence from these reviews indicates that none of these medications emerges as a gold standard medication for use in rapid tranquillisation. Zuclopenthixol acetate is slow acting and not normally used for rapid tranquillisation and both droperidol and clotiapine are unavailable in the UK for rapid tranquillisation. The evidence tables and meta-analyses relating to these medications are given in an Appendix 8.

The other systematic review which was included as part of the evidence base for this guideline examined risperidone (Aleman and Kahn, 2001), an atypical antipsychotic. This study did not focus on the issue of rapid tranquillisation. However, it was included because it informed the review about the action of this agent and its various side effects. (All meta-analyses from this systematic review are included in Appendix 8).

The review of risperidone (Aleman and Kahn, 2001) considered this medication's function for the management of aggression, but excluded a study because it looked specifically at violence, although there were additional quality issues underlying this exclusion. Some attempt was made to counter the heterogeneity of the studies by carrying out analyses of only double-blinded randomised studies and those with similar doses in order to assess the significance of various methodological differences between the studies. The reviewers argue that there was a clear superiority of risperidone over conventional antipsychotics (mostly haloperidol). However, the authors acknowledge that the service users in the included studies did not have chronic aggressive behaviour, which limits the generalisability of the result in relation to rapid tranquillisation. The reviewers also note that risperidone is not available as an intramuscular preparation, which further limits its suitability for an emergency situation. The authors’ conclusions on the efficacy and appropriateness of risperidone appear to be overly optimistic in relation to the evidence base and should, therefore, be interpreted with caution.

All the papers included in the above reviews are not included separately in the evidence tables. The literature was trawled for further studies which would add to the evidence base of these reviews but no additional studies were located.

Two further systematic reviews were included in this evidence review, but were considered principally in terms of background information. Both reviews had a similar aim to the current review, that is to assess the efficacy and safety of rapid tranquillisation as an intervention for the short-term management of violence (NICE, Schizophrenia Guideline, 2002; Broadstock, 2001). Both of these reviews stressed the dearth of the evidence base. Neither suggested that one medication emerged as the gold standard medication for use in rapid tranquillisation. The Schizophrenia guideline undertook limited meta-analysis, Broadstock did not. Both studies identified medications that they believed were safe and efficacious for rapid tranquillisation, on the basis of very limited evidence. The NICE Schizophrenia guideline closely followed the Broadstock, which is being used as a base for this current review. In addition, many of the recommendations from the Schizophrenia guideline were drawn verbatim from the RCPsych review. In addition to recommending the use of intramuscular haloperidol (a conventional antipsychotic) and intramuscular lorazepam (a benzodiazepine), they also suggested that intramuscular olanzapine (an atypical
antipsychotic) should be considered for use in rapid tranquillisation. They suggested that a combination of haloperidol and lorazepam should be used only in exceptional circumstances and also that the BNF limits should not be exceeded except within exceptional circumstances. They recommended the use of intravenous medications as the original RCPsych guideline had done for exceptional circumstances. They also recommended that diazepam IM and chlorpromazine IM should not be used for rapid tranquillisation.

The New Zealand Health Technology Appraisal, undertaken by Marita Broadstock, suggested that benzodiazepines and anti-psychotics seemed to be reasonably safe and effective for rapid tranquillisation and that no significant differences in terms of effectiveness were noted between them or between single and combination regimes. The review argued that there was some evidence to suggest that droperidol may be faster acting than other antipsychotics but equally safe and effective. They found no studies which appraised the effectiveness of valproate or atypicals and therefore did not comment on their efficacy or safety for use in rapid tranquillisation. They also noted that there was some evidence to suggest that there was less Extrapyramidal symptoms (EPS) associated with benzodiazepines (lorazepam) or benzodiazepines and antipsychotics (lorazepam and haloperidol) in combination than when antipsychotics were used alone (haloperidol, clotiapine). The reviewer notes that the conclusions arrived at are broadly consistent with those found in the RCPsych guideline.

Conclusion

The studies included in these reviews were included or excluded from this review on the basis of the inclusion criteria outlined above. One study (Thomas et al., 1992), included in both Broadstock, 2001 and the RCPsych guideline was excluded in this review because the study population did not necessarily or primarily have a psychiatric illness. This trial was excluded from the systematic review (Cure and Carpenter, 2001) on these grounds and because most of the participants were intoxicated. The current guideline is not considering studies where the primary diagnosis is alcoholism or substance abuse. All other randomised controlled trials included in these reviews were also included in the current review and are assessed below in conjunction with several additional randomised controlled trials identified in the searches.

II Randomised controlled trials

Nineteen randomised controlled trials, not included in the systematic reviews by Carpenter and Berk, 2000; Cure and Carpenter, 2001; Fenton M et al., 2001, are included in this review. One of these studies reported on two different trials (Garza-Trevino et al., 1989). Eleven of these studies were conducted in the USA. One took place in Israel, one took place in Brazil, one took place in India, one took place in Denmark and the other three were multi-country studies. Unless otherwise stated, all studies compared intramuscular loading (IM). Some studies switch to oral loading after the first 24hrs, where this occurs this is indicated in the evidence tables.

_Haloperidol vs. Lorazepam (vs. Haloperidol & Lorazepam)_
Four studies compared the benzodiazepine lorazepam (IM) and the conventional antipsychotic haloperidol (IM). (Foster et al, 1999; Battaglia et al, 1997; Bienien et al, 1998; Garza-Trevino et al - study I, 1989). Three of the studies evaluated the efficacy and safety of these two medications against each other. Two of the studies also considered the efficacy and safety of these two medications against a combination of haloperidol and lorazepam. One study only considered the efficacy and safety of haloperidol against that of a combination of haloperidol and lorazepam. All the studies had relatively small sample sizes. Whilst two of the studies compared the same single doses, and two of the studies compared the same combined doses, there were many methodological problems with these studies. These problems included: short follow up periods, side effects not being recorded, many comparisons performed with no adjustment for p-value, baseline information not recorded. The studies were also noticably heterogeneous. One study (Garza-Trevino et al, 1989) was not double-blind, one study (Battaglia et al, 1997) considered sleep as a desirable endpoint, but the other studies did not, and combination doses were not equivalent to single medication doses. With such heterogeneity meta-analysis is not appropriate. In terms of efficacy, no study found the antipsychotic to differ from the benzodiazepine. However, given the side effects caused by haloperidol (e.g. dystonia), all authors suggested that lorazepam may be the preferred course of treatment. All three studies (Foster et al, 1999; Bienien et al, 1997; Garza-Trevino et al - study I, 1989) which compared combination against a single medication or medications suggested the superiority of the combination in terms of efficacy, but two studies note that since the single dose was not equivalent to the combined dose it remains unclear whether the combined doses were more effective simply because of the strength of dose. The study (Battaglia et al, 1997) which did not comment on this regarded sleep as a desirable endpoint and therefore viewed effectiveness in terms of a different outcome. One study (Foster et al, 1999) noted that there is need for more dose-response studies.

**Conclusion**

The studies appear to indicate that the medications haloperidol (IM) and lorazepam (IM) are equally effective. However, on the basis of these studies no firm conclusions can be arrived at regarding the efficacy and safety of haloperidol or lorazepam vs. a combination of these two drugs. No firm conclusions about the safety of lorazepam vs. haloperidol can be arrived at on the basis of these studies. Whilst more Extra pyramidal side effects (EPS) are recorded with haloperidol individual service user histories should dictate which is the medication of choice. There are many methodological problems with the studies.

**Olanzapine vs. Haloperidol vs. Placebo**

Two trials (Wright et al, 2001; Brier et al, 2002) evaluated olanzapine (IM) against haloperidol (IM) and against placebo (IM). Both studies were large multi-site, multi-country studies which only included participants with schizophrenia (571 participants in total). Both authors were involved in both studies and both work for Eli Lilly who sponsored both studies. It is unclear whether the participants actually required rapid tranquillisation since all gave consent before being included in the study. Objective measures of behaviour were used in both studies at baseline (PANSS). There was no
long term follow up with either study. Both olanzapine and haloperidol were significantly more effective than placebo in reducing agitation at 2 and 24 hours in both studies. At 30 minutes a dose of 5.0mg, 7.5mg or 10mg were significantly more effective that placebo. Olanzapine was significantly more effective than haloperidol in reducing agitation at 15, 30 and 45 minutes (Wright et al., 2001). In Brier et al. (2002), group sizes did not allow comparison with placebo. Acute dystonia was not associated with olanzapine, but was found in 7% of the haloperidol group. (Wright et al., 2001) Brier et al., (2002) also found that olanzapine was not associated with dystonia. There were no differences between olanzapine, haloperidol and placebo in terms of hypotension and clinically relevant changes in the QTc interval (Brier et al., 2002). On this basis Brier, 2002 suggests that olanzapine has a safer profile than haloperidol. The Schizophrenia guideline examined both of these studies and undertook a meta-analysis which slightly favoured olanzapine. (See Appendix 8)

**Conclusion**

Olanzapine (IM) would appear to be both effective and safe for use in rapid tranquillisation for service users with schizophrenia. It would also appear to have less side effects than haloperidol (IM) and more rapid onset of action. The two RCT studies had populations where rapid tranquillisation was not necessarily required. Case studies from the US appear to confirm these findings. However, further RCTs with appropriate populations are needed to verify the findings from these trials. (Level I & Level IV.)

**Ziprasidone (vs. Haloperidol)**

Three studies considered the efficacy and safety of Ziprasidone (IM) (Lesem et al., 2001, Daniel et al., 2001, Brook et al., 2000). Two considered this medication only (Lesem, 2001, Daniel et al., 2001), measuring the effectiveness and safety of different doses (2mg vs. 10mg and 2mg vs. 20mg). The other study compared ziprasidone (IM) with haloperidol (IM). The same methodology was used in the studies by Daniel et al., (2001) and Lesem et al., (2001); both were sponsored by Pfizer. It was not clear whether either of the studies dealt with truly agitated participants since all gave consent. Both 10mg and 20mg were noted to be significantly more effective than 2mgs. Lesem et al., (2001) argues that 10mg is a therapeutic dose but probably at the lower end of the spectrum, especially given the agitation levels of the participants in the study. There was no significant difference in side effects with any of the doses. Most side-effects were moderate, suggesting the reasonable safety of this atypical antipsychotic. The study comparing haloperidol with ziprasidone did not consider rapid tranquillisation, but the management of acute psychosis. In this context, compared to haloperidol, ziprasidone was significantly more effective in managing aggression by day seven. However, no firm conclusions about the relative effectiveness of ziprasidone compared to haloperidol as an agent for rapid tranquillisation can be arrived at on the basis of this study.

**Conclusion**

It would seem that ziprasidone 20mg IM is relative safe for use in rapid tranquillisation. Its effectiveness needs further testing with more highly agitated participants. Whilst meta-analysis of these two studies would have been possible the
value of doing so appears limited given that the participants did not necessarily require rapid tranquillisation, no comparison with other medications was made (Level I). The relative effectiveness and safety of ziprasidone (IM) compared to haloperidol (IM) as an agent for rapid tranquillisation cannot be established on the basis of this evidence (Level II). Ziprasidone received a black box warning in 2002 in relation to its QTc prolonging potential, which may be increased in situations of high arousal.

**Loxapine (IM) vs. Haloperidol (IM), (vs. Thiothixene (IM))**

Four studies examined the use of loxapine (IM). Three compared it to haloperidol (IM) (Tuason, 1986; Fruensgaard *et al.*, 1977; Paprocki and Versiani, 1977) and the other to thiothixene (IM) (Dubin and Weiss, 1986). Neither Tuason, 1986 nor Dubin and Weiss, 1986 were double-blinded and in one of these studies (Dubin and Weiss, 1986) it is unclear whether participants required rapid tranquillisation. The other two studies (Fruensgaard *et al.*, 1977; Paprocki and Versiani, 1977) were, however, double-blinded. All medications achieved significant improvement from baseline and there were no significant difference in numbers of adverse reactions between groups, except in one study (Fruensgaard *et al.*, 1977) where loxapine 50mgs IM produced more pronounced sedation (p<0.025). However, whilst haloperidol 5mg did not differ in median time to rapid tranquillisation from loxapine 25mg (Tuason, 1986) or loxapine 50mgs (Fruensgaard *et al.*, 1977; Paprocki and Versiani, 1977), thiothixene 10mgs (Dubin and Weiss, 1986) was significantly less tranquillising in the initial phase of treatment than loxapine 25mgs (60min vs. 95min).

**Conclusion**

The studies had various limitations which make it difficult to formulate firm conclusions about the relative effectiveness and safety of loxapine (IM) compared to either haloperidol (IM) or thiothixene (IM). However, at the doses prescribed loxapine would appear to provide a more rapid tranquillising effect than thiothixene (Level I).

**Thiothixene & Lorazepam (IM) vs. Haloperidol & Phenobarbital (IM)**

A further study also considered the use of thiothixene in combination with lorazepam (IM) against haloperidol in combination with phenobarbital (IM) (Garza-Trevino *et al.*, 1989 - study II). This study was not double-blinded, there was a very short follow up period (24hr) and the side effects were not described although the authors claim that there were few indications of over-sedation or dystonic reactions. There appeared to be no difference in effectiveness between the two groups. The authors argue therefore that a combination of antipsychotic and a hypnosedative is a useful intervention for the management of agitated behaviour.

**Conclusions**

It is difficult to generalise concerning the effectiveness and safety of these medication combinations on the basis of only one study given the various limitations noted above (Level II).

**Haloperidol (vs. flunitrazepam, vs. molidone, vs. midazolam & sodium amytal vs. midazolam, vs. chlorpromazine)**
Four trials (Dorevitch et al, 1999; Binder & McNiel, 1999; Wyant et al, 1990; Reschke, 1974) evaluated the efficacy and safety of five further medications against haloperidol; flunitrazepam, molindone, and midazolam, sodium amytal, and chlorpromazine. Neither of the first two studies showed a significant difference between haloperidol and the other medication in terms of effectiveness. Flunitrazepam showed a slightly quicker reduction in aggression at 30 minutes, molindone showed slightly less reduction in symptoms at 3 hours. Erythema at injection site was slightly more common for molindone than haloperidol. This side-effect is not discussed in relation to Flunitrazepam. Both studies had small sample sizes and neither used objective measures to evaluate behaviour at baseline. In the study of molindone there was no adjustment to p value to account for the many comparisons and outcomes (outcomes were not restricted to rapid tranquillisation). It was also difficult to assess whether side effects resulted from the oral phase of the intervention.

The study of haloperidol vs. midazolam or sodium amytal (Wyant et al, 1990) randomly assigned participants to either 10mg haloperidol, 5mg midazolam or 250mg sodium amytal. Over 2 hours sodium amytal and midazolam proved significantly more effective than haloperidol in terms of mean global ratings for motor agitation (p< or =0.05), but there was no significant difference in hostility rating (p=0.10). It was not possible to test the relative effectiveness of these medications in controlling flight of idea or auditory hallucinations because of differences in participants across groups. This study has several limitations, not least being a very small sample size. It is also only single blinded. Side effects are not mentioned. On both these counts it could have been excluded but is reported here to illustrate the available research on these medication combinations. The authors recognise the need for a large scale future study comparing midazolam with lorazepam.

In the study of haloperidol vs. chlorpromazine aggression was significantly more effectively controlled with haloperidol 5mgs IM and 2mgs IM (p<0.05) compared to haloperidol 1mg IM, chlorpromazine 25mgs IM or placebo. More adverse reactions were noted with haloperidol (transient hypertension, drowsiness (awake), dry mouth and mild EPS) than chlorpromazine, although there was greater somnolence with chlorpromazine. The study had a very small sample size. Most participants in this study were women.

Conclusions
Given the limitations of the studies no firm conclusion can be reached about the relative superiority of these medications compared to haloperidol, although both flunitrazepam, molindone appear to be reasonably safe and effective within these trials. The study of midazolam and sodium amytal did not mention side effects. The limitations of these trials means that no firm conclusions about these medications can be arrived at (Level II). The study of midazolam used sleep as a desirable endpoint, making comparisons difficult. Chlorpromazine was slower acting than haloperidol, although it had less side effects. Chlorpromazine is no longer considered a suitable medication for rapid tranquillisation since it is a local irritant if given intramuscularly, carries a risk of cardiovascular complications,causes hypotension due to α-adrenergic receptor blocking effects, especially in the doses required for rapid tranquillisation, is
erratically absorbed and its effect on QTc intervals also suggests that it is unsuitable for use in rapid tranquillisation.

**Haloperidol plus Promethazine (vs. Lorzepam, vs. Midazolam)**

One study (Trec, 2003) compared haloperidol-promethazine with midazolam. Clinicians decided doses within a range of 7.5-15mgs IM of midazolam and 5mgs IM of haloperidol plus 25-50mgs IM promethazine. More somnolence was noted in the midazolam group. One man suffered respiratory depression with midazolam 15mgs IM and recovered after being given flumazenil 0.25mgs IV. One woman with epilepsy suffered a Grande mal seizure with haloperidol 5mgs and promethazine 50mgs. She recovered after receiving benzodiazepines.

The other study (Alexander, Unpublished), compared haloperidol-promethazine with lorazepam. Doses were haloperidol 10mgs IM plus promethazine 25-50mgs IM or lorazepam 4mgs IM. Haloperidol plus promethazine was significantly more likely to induce sleep for all time periods (p=0.00). Haloperidol plus promethazine also resulted in quicker onset of tranquillisation (p=0.0001)/sleep (p=0.0000). Four people in lorazepam group were never tranquil, one person in haloperidol plus promethazine group was never tranquil. No adverse reactions were noted with haloperidol plus promethazine. One person in the lorazepam group with history of bronchial asthma complained of moderate worsening of respiratory difficulty, one person reported nausea and dizziness. There was no dystonia. Sleep was considered the desirable endpoint.

**Conclusions**

Unlike most of the other studies in this review both these were large studies of a high methodological quality. Despite this, after consultation with two independent methodological advisers it was decided that meta-analysis would not be appropriate for the following reasons: It is not clear that the two benzodiazepines are sufficiently similar clinically as to be treated as a single class nor is it clear that the two benzodiazepine doses are equivalent, which could make the effect size vary or even change the direction, the primary outcome was 4 hours in TREC (2003) but 15minutes in Alexander (Unpublished). These were rated by blinded raters. While TREC (2003) did take measurements at 20 mins these were not made by blinded raters. There is also a danger of masking differences in effect when combining different time points.

One of these trials (Alexander, Unpublished) considered sleep the primary desirable outcome. The study did, however, detail numbers asleep and numbers tranquil at each endpoint (as did Huf, 2003). Alexander (unpublished) argues that sleep is a safer option for staff, however, no significant difference in injury rates were noted with lorazepam, which was less sleep inducing. Neither study mentioned whether monitoring procedures, e.g. observation, ECG, etc. were put in place once participants were classified as asleep. There is disagreement between the studies as to whether haloperidol plus promethazine is actually more likely to induce sleep than a benzodiazepine. As sleep is not normally considered a desirable endpoint for rapid tranquillisation the studies suggests that haloperidol plus promethazine may be an
effective and safe alternative to haloperidol alone or in combination with a benzodiazepine, or a benzodiazepine alone. However, further research is needed.

Few patients treated with Haloperidol plus promethazine suffered dystonic reactions, since promethazine has anti-cholingeric properties.

Heterogeneity

The included studies had many heterogeneous aspects, such as differing settings, insufficient samples sizes to measure NNT, NNT not stated, different comparator medications, doses and outcomes (e.g. sleep as endpoint and sleep as adverse effect). As noted in section 6.6.3 the term sleep is often loosely defined, and makes comparison difficult. Follow-up periods also differed across studies. After consultation with our methodological advisors, it was considered that in the face of such heterogeneity, meta-analysis would be inappropriate and would not reveal a gold standard medication for rapid tranquillisation.

Appraisal of Methodological Quality

A further concern with many of the studies were quality related. For instance, most studies did not report their method of randomisation nor how they ensured blinding/lack of bias. It was felt that meta-analysing studies of such poor quality might hide real differences between the studies and be misleading.

Evidence Statements

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<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
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<tbody>
<tr>
<td>1+ to 1-</td>
<td>It has not been possible to establish a gold standard medication for rapid tranquillisation.</td>
</tr>
<tr>
<td>1+ to 1-</td>
<td>There appear to be no conclusive benefits in terms of effectiveness of one antipsychotic over another, of antipsychotics over benzodiazepines or of combination medications over single medication regimes.</td>
</tr>
<tr>
<td>1+ to 1-</td>
<td>Rapid tranquillisation as an intervention for the short-term management of violence appears both reasonably effective and reasonably safe. Both benzodiazepines and antipsychotics appear to be effective and reasonably safe for use in this intervention.</td>
</tr>
<tr>
<td>4</td>
<td>It is not possible to determine the safety or effectiveness of medications other than antipsychotics and benzodiazepines.</td>
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</table>

III Studies other than Randomised Controlled Trials
Most of the non-randomised studies which examined rapid tranquillisation that were identified by our searches investigated medications which were considered in the randomised controlled trials or systematic reviews discussed above. One study discussed a medication not considered elsewhere. This study (Lee et al., 1992) was a prospective cohort study (n. participants =10) which considered the use of Lithium Citrate. There were considerable limitations to this study noted by the authors, such as a lack of a wash out period and the lack of a double-blind control. They suggest that this medication may be an alternative treatment to neuroleptics or benzodiazepines, particularly for service users who demonstrate persistently agitated behaviour despite treatment with neuroleptics, benzodiazepines, barbiturates and/or antihistamines. However, they recognised the need for a randomised controlled trial.

### Evidence Statements

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<tr>
<td>4</td>
<td>It has not been possible to determine the safety or effectiveness of Lithium Citrate for use in rapid tranquillisation.</td>
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</table>

### V Sudden Death and Rapid Tranquillisation

No randomised controlled trials had death as an adverse event. However, four case studies were identified in which death was linked to medication. One case study reported in a letter, noted that a young adult who was give IV diazepam 20mg and IV haloperidol 20mgs by a GP and psychiatrist at home suffered a fatal cardiac arrest (Quesnstedt et al 1992). Only one other case of sudden death (Dolan et al, 1995) occurred after rapid tranquillisation. In this case, post-mortem examination revealed some congestion of the pulmonary parenchyma and the author expressed concern that the autopsy had partially attributed the cause of death to medication when sudden death in similar circumstances without the presence of medication is known to occur. In another study, (Lynch and Kotsos, 2001) a white female was found at home with a fatal dose of benzatropine. It is unclear whether a suicide attempt was made. In the final study (Kumar, 1997) an aggressive service user was restrained and stopped breathing before rapid tranquillisation took place, but a toxic level of chlorpromazine was found in his blood after treatment with chlorpromazine, zuclopenthixol acetate and zuclopenthixol decanoate in the weeks preceding his death. One study did not specify the ethnicity of the deceased, the other three studies all noted that the deceased was Caucasian, three service users were male, the other was female.

### Evidence Statements

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<tr>
<td>4</td>
<td>It is not possible to determine whether there is either a positive or negative association between sudden death and pharmacological interventions used for the short-term management of disturbed/violent behaviour.</td>
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</tbody>
</table>
IV Qualitative Studies and Surveys

Our searches identified six qualitative studies which were deemed to be of reasonable quality to merit inclusion in this review. Two were conducted in the UK, one in the USA, one in Israel and one in Sweden. The two studies set in the UK did not specifically ask staff and service users about their feelings and beliefs about rapid tranquillisation. The first study (Hyde et al, 1998) compared user dissatisfaction scores with incidents of rapid tranquillisation and found that there was no correlation between a service user satisfaction score and their experience of this intervention. However, as the questionnaire did not ask service users to score their satisfaction/dissatisfaction with this intervention, there are many other confounders which could obscure this correlation. It is unclear how general the questionnaire was or what its aims were. The other UK study (Duxbury, 2002) asked staff, service users and medical staff for their views on the approaches used to manage violence. Again there was no specific reference to rapid tranquillisation, but a disparity was noted between actual violence reported in incident forms and the use of rapid tranquillisation. The authors suggest that this is a worrying trend. They note that both staff and service users agreed that there was a need for greater alternatives to restraint, seclusion and rapid tranquillisation.

The other four studies surveyed service users, with the aim of discovering their views about forcible medication. One study (Haglund et al, 2003), also interviewed staff. In the study, service user and nurse perceptions of forced medication differed. Nurses focused more on positive effects of medications, service users stressed the negatives. Nurses often felt the service user had no response, when there was psychological discomfort. Less service users retrospectively approved of forced medication than nurses thought. Nurses mentioned no alternatives to rapid tranquillisation, all service users mentioned at least one alternative (dialogue, more explanation of ill-health, coaxing, waiting, no medication, no injection). Nurses perceived these measures necessary to improve health. Authors note that service users were more likely to accept forced medication from a nurse they knew.

Another study (Schmeid and Ernst, 1983) asked service users to rate the retrospective acceptability of both seclusion and rapid tranquillisation. Service users were asked immediately after the intervention and also once psychosis passed. Service users found rapid tranquillisation more unacceptable than seclusion or restraint (p=0.01; for men only p=0.001). However, many service users were unclear on their feelings about these interventions and did not know which staff member had instigated the intervention. The authors note that this was particularly true for male service users, many of whom had alcohol related problems. This is now an old study and although rapid tranquillisation was the least acceptable of these interventions, it is not possible to generalise whether that service users in the UK also prefer seclusion over rapid tranquillisation. The author suggests that it is beneficial for service user discuss their feelings after the use of one of these interventions.

Greenberg et al (1996) conducted structured telephone interviews with service users two weeks after discharge. This approach led to a more than 50% loss to follow up,
which the authors acknowledge. They noted that 60% of service users interviewed, retrospectively agreed that rapid tranquillisation had been beneficial, and 43% felt that they should be coerced in similar situations in the future. The authors acknowledge, however, that the responses of those lost to follow up might have been more negative. In another study, where semi-structured interviews were conducted on the ward, a far more negative response to rapid tranquillisation was noted. Only 4/11 service users retrospectively approved of rapid tranquillisation and one of these did so only in the vaguest of terms. The rest all disapproved. Staff, however, believed that 7/11 service users had retrospectively approved of the use of this intervention. Despite the fact that the sample size is small this more negative response may more closely reflect service user views, although it is not possible to generalise on the basis of such small studies.

Schwartz et al (1988) assessed service users' mental state both before and after forcible medication (service users with organic brain disorder were excluded). They argued the those who retrospectively disagreed with the treatment did not recognise that they had an illness that had required hospitalisation, did not agree that the hospitalisation was necessary, nor that it had been helpful (p<0.01). They also noted significant differences between those who did and those who did not retrospectively agree with forcible medication on the BPRS scales for thought disturbances and hostile-suspiciousness. At discharge the following 8 items were significant for those who did not retrospectively agree with the forcible medication: conceptual disorganisation (p<0.05), mannerisms and posturing (p<0.01), grandiosity, hostility, suspiciousness, unco-operativeness, unusual thought content (p<0.001). In the light of these findings the authors argue that judicial review of forcible medication is seldom required. However, this was a small study in one hospital setting. The results are not therefore generalisable.

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<tr>
<td>4</td>
<td>The limited evidence suggests that some service users retrospectively believe that rapid tranquillisation was beneficial, but that other service users do not retrospectively believe that rapid tranquillisation was beneficial.</td>
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### VI PRN medication

Although only rapid tranquillisation is mentioned directly in the scope, PRN medication pro re nata (as needed) medication is also sometimes used in a similar way to rapid tranquillisation in psychiatric in-patient settings.

### Effectiveness

One systematic review (Whicher et al, 2002) was found which examined the efficacy of PRN for the short-term management of aggressive behaviour. No randomised trials were found which met the inclusion criteria for this review.
The reviewers conclude that,

This common current practice has no support from randomised trials. Current practice is based on clinical experience and habit rather than high quality evidence. Current practice, therefore, outside of a well designed, conducted and reported randomised trial, is therefore difficult to justify.

No further studies were identified which examined the effectiveness of PRN medication as a pharmacological intervention for the short-term management of disturbed/violent behaviour.

**Staff Perspectives**

A study by Geffin *et al*, (2002a) examined the beliefs of doctors and nurses in in-patient psychiatric units about pro re nata (PRN) (as needed) medication for psychiatric disorders. They concluded that nurses and doctors have different views about the effectiveness of antipsychotics and benzodiazepines. They noted that some of these views are at odds with the known properties of these medications. They argue therefore that doctors should always specify the usage when writing PRN prescriptions. They argue that further education is needed to achieve best practice in PRN medication. They note, however, that the results of the study are not generalisable.

A second survey by Geffin *et al*, (2002b) examined the uses of PRN medication in two large psychiatric units. The authors noted that while a maximum daily dose was normally specified (87%) indications for use were only specified in 6% of cases. Staff noted medication-related morbidity in 37% of service users taking PRN medication, compared to 3% on only regular scheduled medication. Forty-nine percent of PRN medication was given for agitation. However, administration records frequently failed to specify a reason for use in 48% of cases. Nearly two-thirds of administrations (64%) had no recorded outcome. Of the remaining 26%, 76% were reported as being partially or completely effective, with the remainder recorded as ineffective. Higher daily doses of PRN medication were given to manic patients, males, younger patients and those with substance abuse disorders. Co-prescription of typical antipsychotics PRN with atypical antipsychotics was common (64%).

Three further studies were found which also examined the use of PRN medication, one was set in Canada (Craven *et al*, 1987), two were set in the USA (Walker, 1991; Craig and Bracken, 1995). A particularly worrying finding of two of these studies (Craven *et al*, 1987; Walker, 1991) was that indications were not always included in the prescriptions, where an indication was given only one was specified, although the prescriptions was often used for a number of indications, minimum intervals between doses was not always stated and maximum daily doses was also not always specified. In addition very few of the prescriptions specified an end-date. The other study (Craig and Bracken, 1995), noted a difference between the use of PRN medication with service users who had a discrete period of disruptive behaviour and those who had intermittent periods throughout their stay. The following results were significant: Half...
of the intermittent vs. over 90% of those with discrete episodes had an increase in their medication or had their medication changed during the study month (p=0.03). Authors noted that 12/27 service users who had antipsychotic serum levels drawn either before or after the study were found to be in a sub-therapeutic range, with two thirds below detection. They suggest the importance of checking serum levels to ensure that these are adequate, to reduce the need for PRN medication.

### Evidence Statement

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<td>4</td>
<td>The limited evidence suggests that there is inconsistency surrounding the use of PRN medication for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and that clinicians have educational needs in this area.</td>
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</table>

#### 7.8.6.2.5 Economic Evidence

There are two papers that are economic analyses of rapid tranquillisation. One is a UK based cost minimisation study (Hyde et al, 1998) and the other is a cost consequence analysis based in Canada (Laurier et al, 1997); both compare Zuclopenthixol acetate with haloperidol. The two papers are in disagreement regarding which of the two medications is more cost effective, and thus the literature is inconclusive. Zuclopenthixol acetate is no longer recommended for RT due to long onset of action. See discussion above. (For details of the health economics review, see Appendix 9).

#### 7.8.7 Accident and Emergency settings

##### 7.8.7.1 Objectives

No specific searches into the short-term management of disturbed/violent behaviour in Accident and Emergency settings were undertaken in the RCPsych Guideline.

Two review questions were identified and used to inform all searches (See Appendix 4 for search strategies, databases searched and search logs)

**Review Questions**

- How is disturbed/violent behaviour by psychiatric patients best managed in the short-term in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?

- What are the views of staff and service users about the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?
These question were addressed in relation to the various interventions and related topics covered in this guideline and specific review questions were devised (see below).

### 7.8.7.2 Selection Criteria

**Types of studies**
Systematic reviews to before and after studies (levels 1-2). Qualitative studies were also included.

**Types of setting**
All adult in-patient mental health settings, excluding geriatric and learning disability.

**Types of outcome**
- Appropriateness, effectiveness and safety of interventions and related concerns for the short-term management of disturbed/violent behaviour of psychiatric patients presenting to A&E.
- Staff and service user perspectives on the appropriateness, effectiveness and safety of interventions and related concerns for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.

### 7.8.7.3 Clinical Evidence

Eighty one papers were identified in the initial sift. After sifting for relevance and duplicates, fifty full papers were ordered. Eighteen met the inclusion criteria, twelve were excluded. All the other papers were opinion pieces, anecdotal reports or fell outside the inclusion criteria for this review. References were checked but no further studies were identified. (Evidence tables of included studies can be found in Appendix 5. Evidence tables of excluded studies can be found in Appendix 6.)

**Appraisal of Methodological Quality**

In addition to the quality concerns raised above, these studies had the following methodological problems:
- confounders not considered or taken into account
- inappropriate sample size
- much anecdotal ‘evidence’ based on author’s experience and reflection rather than on primary research

### I Prevention

Seventeen studies addressed issues around prevention of violence in A&E.

### I.i Environment
I.i.a Review question: How does the environment and organisation impact on disturbed/violent behaviour by psychiatric patients in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?

No studies addressed this review question.

I.i.b Review question: What are the views of staff and service users about how the environment and organisation impacts on the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?

Lillywhite et al (1995) audited the interview rooms and surveyed the staff of a mental health service to assess the safety of interview rooms in general hospital outpatients, general hospital A&E, and a psychiatric hospital, according to 10 safety criteria, and to assess medical staff’s ratings of the relative importance of these ten criteria. A&E rooms scored least well in terms of suitability for interviewing potentially aggressive patients, scoring poorly on every criteria other than ‘alarm bell.’ This was due to a) isolated position from other staff, especially at night when most psychiatric assessments take place; b) cubicles used are cramped, have inadequate seating and lack of privacy; c) A&E is where junior doctors are most likely to assess disturbed and potentially violent patients, and unlikely to have support of psychiatric trained nurses or access to their notes prior to assessment. Features felt to be most important with agitated/potentially violent patients were space, access, layout, weapons, alarm and ease of exit. The study indicated a large disparity between the features of the ideal interviewing situation and those actually available. The authors recommend safety features should be incorporated, and that violent incidents should be monitored and logged, reviewed and acted upon. The numbers of staff surveyed was low (22), and of those only 3 were A&E staff which, divided between three sites, provides a weak basis for generalisation.

Burns and Harm (1993) conducted a questionnaire and interview study of 682 emergency nurses. Interviewees reported feeling that there was a lack of concern for their personal safety. Emergency nurses found debriefings helpful. It was suggested that Critical Incident Stress Debriefing teams should formulate strategies for involving nurses in the debriefing process and that nurse peers should play a significant role in the debriefings.

Cembrowicz & Shepherd (1992) conducted survey of staff in a UK A&E department which concluded that fitted furniture and padded seating should be installed, and that potential weapons should be stored out of sight. They suggest that CCTV may deter casual hooliganism, but will be ignored by the highly intoxicated. In their view, security officers tend to be under-trained. They suggest that the use of uniforms may aggravate a violent situation.

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<tr>
<td>4</td>
<td>It is not possible to determine how the</td>
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I.ii Prediction: Antecedents, Warning Signs and Risk Factors

I.ii.a Review question: How is disturbed/violent behaviour by psychiatric patients best predicted in A&E settings immediately prior to admission to an adult psychiatric in-patient setting and what are the key risk factors?

In a survey of staff and records in the Violent Incident Book of the A&E department of a UK general hospital, Cembrowicz & Shepherd (1992) reported that in four of the last twenty incidents recorded, the violent patient was known to have a psychiatric illness. They found nursing staff and male doctors were most frequently assaulted, receptionists least frequently. The recording of information by staff was haphazard, sometimes due to time pressures, because they hadn’t been injured themselves or because they wanted to avoid blamed if they made frequent reports. Assailants mostly used implements ready to hand as weapons. The study concluded that staff need to be aware of body language which signals an angry outburst (flared nostrils, staring eyes, aggressive stance, pointing and pacing) and of the risks of violent behaviour associated with intoxication.

Beck et al (1991) conducted a case-control study, using record review of 99 patients identified over six months as violent (evidence of assault or battery) or potentially violent (verbal threat or staff impression of poor control and anger or agitation), and 95 control patients, judged not to be violent or potentially violent and staff interviews. They found that women were more often violent, and men were more often potentially violent, made threats or were a source of concern to staff (p<0.03). Study patients were, on average, four years younger than control patients (p<0.005), more often brought in by police, and subsequently hospitalised (62% versus 29%).

Cooper (1988) undertook a retrospective survey of patients referred by a general emergency department to a psychiatric unit. He analysed the antecedents and mapped the course of violent behaviour. Thirty percent had physically attacked another person immediately prior to presentation in ER. Most of this violence had been perpetrated by non-psychotic individuals in the throws of an interpersonal crisis. Twenty-five percent were found to be acutely intoxicated with alcohol, but intoxication may have gone undetected in many more. The majority of patients referred from ER to a psychiatric ward were judged to be non-psychotic, presenting with situational crises and personality disorders rather than a major mental illness.
In a cross-sectional survey of all 130 qualified staff in the A&E departments of two hospitals, Lee *et al* (2001) found that greater self-efficacy (judgments of what one can accomplish, rather than skills one possesses was observed in higher grade staff who had experienced higher levels of aggression. The author notes that the nature of the association between self-efficacy and levels of violent behaviour encountered is not illuminated by this study. This study did not differentiate between violence committed by people with psychiatric illness and people without psychiatric illness.

**Evidence Statement**

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<tr>
<td>4</td>
<td>The limited evidence suggests that heightened arousal, depressive symptoms and alcohol intoxication are antecedents of disturbed/violent behaviour</td>
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</table>

I.ii.b *Review question: What are the views of staff and service users about prediction of disturbed/violent behaviour by psychiatric patients in an A&E setting?*

No studies addressed this review question.

**Evidence Statement**

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<tr>
<td>4</td>
<td>There is no evidence on risk factors for violence in A&amp;E settings, from the perspective of staff and service users.</td>
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</table>

II Training

II.a *Review question: How effective is training in the short-term management of disturbed/violent behaviour by psychiatric patients in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?*

No studies addressed this review question

II.b *Review question: What are the views of staff and service users about training in the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?*

No studies addressed this review question

**Evidence Statement**

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<tr>
<td>4</td>
<td>There is no evidence to determine the effectiveness of training in the short-term</td>
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management of disturbed/violent behaviour in A&E, nor staff views on such training.

III Minority Ethnic Groups, Gender and Other Special Concerns

III.i.a Review question: How do ethnicity, gender or other special concerns impact on the short-term management of disturbed/violent behaviour by psychiatric patients in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?

No studies addressed this review question.

III.i.b Review question: What are the views of staff and service users about the impact of ethnicity, gender or other special concerns on the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?

No studies addressed this review question.

**Evidence Statement**

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<tr>
<td>4</td>
<td>There is no evidence to ascertain whether: ethnicity, gender or special concerns impact on or influences the approach to short-term management of disturbed/violent behaviour by psychiatric patients in A&amp;E settings.</td>
</tr>
<tr>
<td>4</td>
<td>There is no evidence to determine staff or service user perspectives on whether ethnicity, gender or other special concerns influences or has an impact on the short-term management of disturbed/violent behaviour in A&amp;E settings.</td>
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IV Psychosocial Techniques

IV.i De-escalation Techniques

IV.i.a Review question: Are de-escalation techniques an effective tool for the short-term management of (violent) behaviour by psychiatric patients in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?

Lee et al (2001) found that nurses’ aggression management training did not appear to equip them with the skills required to manage violent behaviour in A&E
departments. He recommends that aggression management training should encourage nurses to examine their beliefs about violence and should focus on diffusion and de-escalation of violence, rather than control and restraint techniques.

Lane (1986) reports case studies of three patients admitted to the Emergency Department. He describes how techniques employing empathy (a combination of the suspension of judgment and sympathetic and creative imagination) were used to manage violence where more severe measures (restraint and medical management) might otherwise have been used. Generalisability is very limited.

**IV.i.b Review question: What are the views of staff and service users about the use of de-escalation techniques for the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?**

No studies addressed this review question.

**Evidence Statement**

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<tr>
<td>4</td>
<td>There is no evidence suggesting if de-escalation techniques are an effective tool for the short-term management of (violent) behaviour by psychiatric patients in A&amp;E settings.</td>
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**IV.i.a Review question: Is observation an effective tool for the short-term management of disturbed/violent behaviour by psychiatric patients in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?**

No studies addressed this review question.

**IV.i.b Review question: What are the views of staff and service users about the use of observation for the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?**

No studies addressed this review question.

**Evidence Statement**

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>There is no evidence on whether observation is an effective tool for the short-term management of (violent) behaviour by psychiatric patients in A&amp;E settings.</td>
</tr>
</tbody>
</table>
V Other Interventions

V.i Pharmacological Interventions: Rapid Tranquillisation and PRN Medication

V.i.a Review question: Are pharmacological interventions effective and safe for the short-term management of disturbed/violent behaviour by psychiatric patients in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?

Roberts & Geeting (2001) describe the use of ketamine to tranquillise a dangerous and violent patient on admission to the A&E department. Within 2-3 minutes of intramuscular administration of 480mg ketamine (5mg/kg), violent activity had completely ceased. Mild sinus tachycardia and transient hypertension were observed ten minutes after initial sedation, but all vital signs were normal 50 minutes after ketamine administration. Ketamine effect dissipated within 2 hours, however additional aliquots of lorazepam were required to control agitation over the next 12 hours. No immediate complications from ketamine or emergence phenomena were observed.

The author’s argue that given ketamine’s wide safety profile, potent anaesthetic effects, rapid onset, ease of intramuscular administration, absence of respiratory depression and short duration of action, it is considered useful for immediate tranquillisation of selected undifferentiated uncontrollable adults who are in a life-threatening situation that requires immediate medical intervention. Concomitant use of benzodiazepines, and selected use of atropine, are suggested to ameliorate emergence phenomena, and to dry excessive oral secretions. Author’s stress that after use, close monitoring of cardiovascular parameters is essential. This is a case study of a single patient, so it is not possible to generalise.

V.i.b Review question: What are the views of staff and service users about the use of pharmacological interventions for the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?

Binder & McNiel (1999) conducted a cross-sectional survey of twenty medical directors of psychiatric emergency departments. The aim was to assess how acutely violent patients were managed in psychiatric emergency rooms, to examine medical director’s practices and to investigate ER characteristics. Fourteen reported that acutely violent patients are usually put in restraints and medicated intramuscularly or intravenously and given a medical work-up only after they were less agitated. Thirteen used the same acute medication regimen for all violent patients, regardless of eventual diagnosis. Eleven used haloperidol plus lorazepam, with or without benzatropine. Five used droperidol, in one case alongside lorazepam and diphenhydramine. Fifteen stated that the intramuscular route was most the common, two preferred intravenous route whenever possible. All twenty felt that their preferred medication regimen was effective for calming the violent patient, usually after one dose and always after one to two repeated doses. Only three stated that agitated patients will usually take medications orally and that
mechanical restraints are rarely used. Factors cited as allowing them to use less coercive techniques included a system where most contacts were with people who were known to the system or who had case management protocols; a computerised system where information on patients is available within 30 to 60 seconds; a less violent patient population; and the availability of nurse clinicians who know the population. Results suggest that the strategies most frequently advocated in recent review articles for the assessment and management of violent patients are not generally applied by those responsible for the emergency management of acutely violent patients. Clinicians appeared to place the highest priority on prevention of patient and staff injuries by rapidly reducing violent behaviour through restraints and intramuscular medications, typically a combination of neuroleptics and benzodiazepines, irrespective of diagnosis. The authors suggest that one could argue that these practices involve risks of excessive coercion, overmedicating patients, and exacerbating underlying medical conditions. On the other hand, the clinical experience of practitioners suggests that these strategies rapidly ameliorate acute violence and thereby reduce the risk of injury.

No studies were found on the use of PRN in Accident and Emergency settings

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Evidence Statement</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>There is no evidence to suggest that different medication regimes are either more effective or safe for rapid tranquilisation in A&amp;E department than medication regimes commonly used for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.</td>
</tr>
<tr>
<td>4</td>
<td>The limited evidence suggest that staff in A&amp;E departments may use unrecognised strategies for dealing with the short-term management of disturbed/violent behaviour in service users.</td>
</tr>
</tbody>
</table>

V.ii Physical Interventions

V.ii.a Review question: Are physical interventions effective and safe for the short-term management of (violent) behaviour by psychiatric patients in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?

In Beck et al, (1991) study in a psychiatric emergency service, psychotic patients who were restrained were 6.36 times more likely to be hospitalised than were psychotic patients who were not restrained (p<0.05). Non-psychotic patients who were restrained were 5.36 times more likely to be hospitalised than non-psychotic patients who were not restrained (p<0.03). Patients brought in by police were more
likely to be put into restraints than patients brought in by others, and more likely than patients who came in unaccompanied.

V.ii.b Review question: What are the views of staff and service users about the use of physical interventions for the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?

Foust & Rhee (1993) conducted a prospective descriptive questionnaire study of all staff in an emergency department over nine months, to determine the incidence of battery (willful and unlawful use of force or violence on the person of another) against emergency department medical staff by patients or visitors. Over the course of the study period, nineteen instances of battery occurred. In eight cases, battery occurred when the patient was restrained, and four when the patient was restrained but restraint was being modified.

The department’s unusual restraint policies were described, whereby all patients placed on psychiatric or substance abuse ‘holds’ (requiring that they are a danger to themselves, to others or gravely disabled) be restrained with a loosely applied cloth belt that encircles the abdomen. Four of the incidents occurred when the patient was in abdominal restraint only, and eight other incidents when in abdominal and extremity restraint. The restraint procedures were not described. It was noted that 79% of battery was carried out by patients with psychiatric problems or who were intoxicated. Consistent with other studies, incidents were significantly under-reported. In only four cases were hospital incident forms filled out. Authors recommend that strategies to prevent or control violence should be concentrated on evening and nightshifts.

**Evidence Statement**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>There is insufficient evidence to assess whether physical interventions are either effective or safe for the short-term management of disturbed/violent behaviour by psychiatric patients in A&amp;E settings on the basis of the available literature.</td>
</tr>
</tbody>
</table>

V.iii Seclusion

V.ii.a Review question: Is seclusion effective and safe for the short-term management of disturbed/violent behaviour by psychiatric patients in A&E settings immediately prior to admission to an adult psychiatric in-patient setting?

No studies addressed this review question.
V.ii.b Review question: What are the views of staff and service users about the use of Seclusion for the short-term management of disturbed/violent behaviour by psychiatric patients in an A&E setting?

No studies addressed this review question.

### Evidence Statement

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Due to the absence of evidence it is not possible to determine whether seclusion is either effective or safe for the short-term management of disturbed/violent behaviour by psychiatric patients in A&amp;E settings.</td>
</tr>
<tr>
<td>4</td>
<td>Due to the absence of evidence it is not possible to determine staff or service user views on the use of seclusion for the short-term management of disturbed/violent behaviour by psychiatric patients in A&amp;E settings.</td>
</tr>
</tbody>
</table>

### 7.8.7.4 Economic Evidence

No studies containing relevant economic data were found. (See Appendix 9)
8. Recommendations and good practice points

(These paragraph numbers reflect those in the short form version. All recommendations derive from the available evidence, guideline development group input and formal consensus processes, all of which are detailed in previous sections).

Environment

The physical and therapeutic environment can have a strong, mitigating effect on the short-term management of disturbed/violent behaviour. The following recommendations include the minimum requirements that should be expected within psychiatric facilities:

Safety and Security

1.1.1
When staff are engaged in the short-term management of violence, every effort should be made to manage the service user in an open care setting. (D)

1.1.2
Services in which seclusion is practiced must have a designated room fit for purpose. This room must allow clear observation, be well insulated, have access to toilet/washing facilities and be able to withstand attack/damage. (D)

1.1.3
A safe designated area or room specifically for the purpose of reducing arousal and/or agitation should be provided in addition to a seclusion room. (D)
1.1.4 Secure lockable access to a service user's room, bathroom and toilet area is required with external staff override. (D)GPP

1.1.5 The internal design of the ward must be arranged to facilitate observation and sight lines must be unimpeded (for example, not obstructed by opening of doors). Measures must be taken to address ‘blind spots’ within the facility. (D)

1.1.6 Facilities must ensure routes of safe entry and exit in the event of a violence-related emergency. (D)GPP

1.1.7 All exits and entrances should be within the sight of staff. (D)GPP

1.1.8 Consideration should be given to the use of CCTV and parabolic mirrors (in such areas as corridors, staircases, reception) (D)GPP

1.1.9 There should be a separate area to receive service users with police escorts. (D)GPP

**Activities and External Areas**

1.1.10

- Services should be able accommodate service users’ needs for engaging in activities and individual choice - there should be an activity room and a dayroom with a television, as boredom can lead to violent behaviour.
- Service users must have single sex toilets, sleeping accommodation, day areas and washing facilities.
- There should also be a space set aside for prayer and quiet reflection. (D)

1.1.11 There must be regular opportunities for service users to engage in physical exercise, group interaction, therapy and recreation. (D)GPP
1.1.12 Service users must be able to have easy access to fresh air and natural daylight. (D)

1.1.13 Where practicable, access to an external area should be via the unit and appropriate standards of fencing should be provided. (D)GPP

**Service User Concerns**

1.1.14 The environment should take into account service user needs for
- safety
- privacy
- dignity
- gender- and cultural-sensitivity
- sufficient physical space
- social and spiritual expression. (D)

1.1.15 Where possible, service users should have privacy when making phone calls, receiving guests, and talking to a staff member. (D)GPP

1.1.16 Facilities must have adequate means of controlling light, temperature, ventilation and noise. (D)GPP

1.1.17 Internal smoking areas/rooms must have powerful ventilation and be fitted with a smoke-stop door(s). (D)GPP

1.1.18 All areas should look and smell clean. (D)GPP

1.1.19 Bed occupancy should be decided at a local level and this level should not be exceeded, since over-crowding leads to tension, frustration and over-stretched staff. (D)GPP
1.1.20 Suitable access facilities are needed for people who have problems with mobility, orientation, visual or hearing impairment or other special needs. (D)GPP

1.1.21 There should be access to the day room at night for those who cannot sleep. (D)GPP

**Alarms**

1.1.22 Each service must have a local policy on alarms and determine the need for alarms according to a comprehensive risk assessment of the clinical environment, service users and staff. The policy must be disseminated and staff made familiar with its contents. (D)

1.1.23 Collective responses to alarm calls should be agreed before incidents occur, consistently applied and rehearsed. (D)GPP

1.1.24 Furniture must be arranged so that alarms can be reached and doors are not obstructed. (D)GPP

1.1.25 Alarms must be accessible in interview rooms, and in reception areas and any other areas where one service user and one clinician work together. (D)GPP

1.1.26 All alarms (panic buttons, personal alarms etc.) must be well maintained and checked regularly. (D)GPP

1.1.27 Comprehensive risk assessment of the clinical environment must be used to determine whether supplementary personal alarms should be issued to individual staff members and vulnerable service users. (D)GPP

**Staffing Requirements**
1.1.28 Adequate staff and service user ratios are essential to ensure a safe clinical environment. (D)GPP

1.1.29 There should be a stable and consistent inpatient team, as high staff turnover and over-use of short-term bank, locum and agency healthcare staff may create an unsafe environment. (D)GPP

Interagency working

1.1.30 Local protocols should be developed to ensure that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between different agencies. (D)GPP
**Prediction**

Violence can never be predicted with 100% accuracy. However, this does not mean that risk assessment should not be carried out.

**Policy**

1.2.1 Measures to reduce violence need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers must ensure that a full risk management strategy is introduced for all their services. (D)

**Risk Assessment**

1.2.2 Risk assessment should include a structured and sensitive interview with the service user and where appropriate carers. Efforts should be made to ascertain the service user’s own views about their antecedents to violence, warning signs and management of these feelings. (D)GPP

1.2.3 Risk assessment should be used to establish whether a care plan needs to include specific interventions for the short-term management of violence. (D)GPP

1.2.4 When assessing for risk of violence care needs to be taken not to make negative assumptions based on ethnicity. There should be awareness that cultural mores may manifest as unfamiliar behaviour that could be misinterpreted as being aggressive. The assessment of risk should be objective with consideration being given to the degree to which the perceived risk can be verified. (D)GPP
1.2.5 All staff must be aware of any of the following factors that may provoke violent behaviour:
- attitudinal
- situational
- organisational
- environmental. (D)GPP

1.2.6 Actuarial tools and structured clinical judgement should be used in a consistent way to assist in risk assessment, although no ‘gold standard’ tool can be recommended. (C)

1.2.7 Since the components of risk are dynamic and may change according to circumstance, risk assessment (environment and service user) must be on-going and care plans must be based on an accurate and thorough risk assessment. (D)

1.2.8
- The approach to risk assessment must be multidisciplinary and reflective of the care setting in which it is undertaken.
- The findings of the risk assessment must be communicated across relevant agencies and care settings. (D)

**Antecedents/Warning Signs**
Certain features can serve as warning signs to indicate that a service user may be escalating towards physically violent behaviour. The following list is not intended to be exhaustive and these warning signs must be weighed on an individual basis.

1.2.9
- Facial expressions tense and angry
- Increased or prolonged restlessness, body tension, pacing
• General over-arousal of body systems (increased breathing and heart rate, muscle
twitching, dilating pupils)
• Increased volume of speech, erratic movements
• Prolonged eye contact
• Discontented, refusal to communicate, withdrawn, fear, irritation.
• Thought processes unclear, poor concentration
• Delusions or hallucinations with violent content
• Verbal threats or gestures
• Replicating, or behaviour similar to that which preceded earlier violent episodes
• Reporting anger or violent feelings
• Blocking escape routes
• Carers reporting service users previous anger or violent feelings (D)GPP

Risk Factors
Certain factors can indicate an increase risk of physically violent behaviour. The
following list is not intended to be exhaustive and these risk factors must be weighed
on an individual basis.

1.2.10 Demographic or personal history
• History of violence
• Previous expression of intent to harm others
• Evidence of rootlessness or ‘social restlessness’
• Previous use of weapons
• Previous dangerous impulsive acts
• Denial of previous dangerous acts
• Severity of previous acts
• Known personal trigger factors
• Verbal threat of violence
• Evidence of recent severe stress, particularly loss event or the threat of loss
• History of bed wetting, cruelty to animals, reckless driving, loss of a parent before
the age of 8 years. (D)GPP
1.2.11 Clinical variables

- Misuse of substances and/or alcohol
- Active symptoms of schizophrenia or mania, in particular if:
  - delusions or hallucinations are focused on a particular person
  - preoccupation with violent fantasy
  - delusions of control (especially with violent theme)
  - agitation, excitement, overt hostility or suspiciousness
- Poor collaboration with suggested treatments
- Anti-social, explosive or impulsive personality traits or disorder
- Organic dysfunction (D)GPP

1.2.12 Situational variables

- Extent of social support
- Immediate availability of a potential weapon
- Relationship to potential victim
- Access to potential victim
- Limit setting
- Staff attitudes (D)GPP
Training

Staff need to have the appropriate skills to manage disturbed/violent behaviour in psychiatric inpatient settings. Training in the interventions used for the short-term management of violence safeguards both staff and service users. Training that highlights awareness of racial, cultural, social, religious/spiritual, and gender, along with other special concerns, also mitigates against violent behaviour. Such training must be properly audited to ensure its effectiveness.

Policy

1.3.1

All service providers must have a policy for training employees and staff-in-training in relation to the short-term management of violence. It must specify who will receive what level of training (based on risk assessment), how often they will be trained and also outline the techniques in which they will be trained. (D)

1.3.2

- All service providers must specify who the training provider is and ensure consistency in terms of training and refresher courses. (D)

- In 2005, training relating to the management of violence should be subject to the national accreditation and regulation scheme being set up by the National Institute for Mental Health in England (NIMHE) and the Security Management Service (SMS) when this comes into force. (D)

1.3.3

Both training and auditing should be in accordance with the current principles being developed by the National Institute for Mental Health in England (NIMHE) and the Security Management Service (SMS). (D)

1.3.4
If participants of training courses demonstrate inappropriate attitudes then trainers must pass this information onto the relevant line manager for appropriate action. (D)

Specific Staff Training Needs

1.3.5

- There should be an on-going programme of training for all staff in racial, cultural, spiritual and social issues to ensure that staff are aware of and know how to work with diverse populations and do not perpetuate stereotypes.
- Such courses should also cover any special populations, such as migrant populations and asylum seekers that are relevant to the locality. (D)

1.3.6

All staff, whose need is determined by risk assessment, must receive on-going mandatory training to recognise anger, potential aggression, antecedents and risk factors of violence and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with violent behaviour. (D)

1.3.7

Healthcare staff responsible for carrying out observation must receive on-going mandatory training in observation so that they are equipped with the skills and confidence to engage with service users. (D)

1.3.8

- All those involved in the administration, prescribing, and monitoring of a service user receiving parenteral rapid tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) (covers airway, Cardio-Pulmonary Resuscitation (CPR) and use of defibrillators).
- The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available
within 3 minutes in healthcare settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked weekly. (D)

1.3.9
All staff, whose level of need is determined by risk assessment, must receive mandatory training in the use of physical interventions. A core module of physical interventions is being developed by NIMHE and SMS. This module should be followed once it comes into effect in 2005. (D)

1.3.10
All staff, whose level of need is determined by risk assessment, must receive mandatory training in the use of seclusion. Training must include appropriate monitoring arrangements for service users placed in seclusion. (D)

1.3.11
All staff involved in rapid tranquillisation must be trained in the use of pulse oximeters. (D)

1.3.12
Prescribers of medicines must be familiar with and must have received training in all aspects of rapid tranquillisation, including:
- the properties of benzodiazepines and their antagonists (flumazenil), anti-psychotics, antimuscarinics and antihistamines.
- the risks associated with rapid tranquillisation, particularly when the service user is highly aroused and may have been misusing drugs, be dehydrated or possibly physically ill.
- cardio-respiratory effects of the acute administration of these drugs.
- the need to titrate doses to effect. (D)
1.3.13 Service providers should ensure that staff’s capability to undertake physical interventions and physical interventions training courses is assessed. (D)GPP

Incident Recording
1.3.14
- Templates for incident recording were issued by SMS in November 2003. Mandatory training must be given to all appropriate staff to ensure that they are aware of how to correctly record an incident using the appropriate nationally recognised templates. (D)

Refresher Courses
1.3.15
- Services must review their training strategy annually through audit to identify those staff groups that required on-going professional training in the recognition, prevention and de-escalation of disturbed/violent behaviour and in physical interventions training to manage disturbed/violent behaviour. (D)

Auditing Training
1.3.16
- All such training must be audited, including training in racial, cultural, religious/spiritual and gender issues, along with training that focuses on other special service user concerns.
- Independent bodies/service user groups should, if possible, be involved in auditing the effectiveness of training.(D)

Service user training/involvement in training
1.3.17
Service users and/or service user groups should have the opportunity to become actively involved in training and setting the training agenda, e.g. vulnerable groups such as:
- service users with a sensory impairment
- Black and minority ethnic service users
- service users with a physical impairment
- service users with a cognitive impairment
- Women service users (D)
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 that 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.

1.4.1

Service users must have access to suitable 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 An effective and fair complaints procedure must be put in place. (D)GPP

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

1.4.4 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 or as soon as possible thereafter. 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)

1.4.5 The physical needs of the service user should be assessed on admission or as soon as possible thereafter and then regularly re-assessed. The care plan should reflect physical needs. (D)GPP

1.4.6 Following any intervention for the short-term management of disturbed/violent behaviour, every effort should 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)

1.4.7 Staff should take time to listen to service users, including those from diverse backgrounds, (taking into account that this may take longer when using interpreters), so that therapeutic relationships can be established. (D)GPP
1.4.8  
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)

1.4.9  In the event of any form of alleged abuse, the matter should be dealt with by staff as soon as is practicable in accordance with relevant Trust policies.(D)GPP

1.4.0  
All service users, regardless of culture, gender, diagnosis, sexual orientation or religious/spiritual beliefs should be treated with dignity and respect. (D)

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

1.4.12 Prescribers should be available and responsive to requests for medication review. (D)GPP

1.4.13 Special provision should 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 users care plan. (D)GPP

**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.
1.4.14

Trusts must identify a board member to take specific 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

1.4.15 Each service must have a policy that outlines the procedures for dealing with service users who have disabilities, including those with physical or sensory impairment. (D)GPP

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. (D)GPP

Service users with HIV or other sexually transmitted diseases

Policy

1.4.17 Services must have policies in place, developed in conjunction with the Trust infection control officer that outline the reasonable steps that can be taken to safeguard staff and other service users if a service user who has HIV, hepatitis or other infectious or contagious diseases is acting in a manner that may endanger others (D)GPP

1.4.18 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. (D)GPP
Confidentiality Issues

1.4.19

- Patients are owed important obligations of confidentiality but these are not absolute. In certain circumstances they may be breached to safeguard others:
  - This is particularly relevant where a service user has HIV, hepatitis or other infectious or contagious diseases, and is acting in manner that puts others at risk.
- Legal and ethical advice should be sought in these circumstances. (D)GPP

1.4.20 If any person 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 local infection control policy should be followed. (D)GPP
**De-escalation Techniques**

Action plans should be developed at a local level, which detail how to call for help in an emergency. De-escalation involves the use of techniques that calm down an escalating situation or service user, therefore, action plans should stress that de-escalation should be employed early on in any escalating process.

**Environment**

1.5.1

A safe designated area or room specifically for the purpose of reducing arousal and/or agitation should be provided in addition to a seclusion room. (D)

**Training**

1.5.2

All staff, whose need is determined by risk assessment, must receive on-going mandatory training to recognise anger, potential aggression, antecedents and risk factors of violence and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating or coping with violent behaviour. (D)

**General**

1.5.3 Service user anger needs to be treated with an appropriate, measured and reasonable response. Where at all possible, de-escalation skills need to be employed prior to other interventions being used. (D)GPP

1.5.4 Staff should accept that in a crisis situation they are responsible for avoiding provocation. It is not realistic to expect the disturbed/violent person to simply calm down. (D)GPP
1.5.5 Staff should learn to recognise what generally upsets and calms people and they should also make themselves aware of what specific things upset and calm those in the Service. This will involve listening to individual service user's reports of what upsets them and this must be reflected in service users care plans. (D)GPP

1.5.6 Staff should be aware of, and learn to monitor and control their own verbal and non-verbal behaviour, such as body posture, eye contact etc. (D)GPP

1.5.7 Where possible, service users should be encouraged to recognise the early warning signs of violence within themselves. This should be included in care plans and a copy given to the service user. They should also be encouraged to discuss and negotiate their wishes should they become agitated. (D)GPP

1.5.8 Where de-escalation techniques fail to sufficiently calm a situation/service user, staff should remember that verbal de-escalation is an ongoing element of the management of an escalating individual. It is supported but not replaced by appropriate physical interventions. (D)GPP

De-escalation Techniques

1.5.9 One staff member should assume control of the situation. (D)GPP

1.5.10 The staff member who assumes control should explain to the service user and others in the immediate vicinity what they intend to do. This will involve:

- managing others in the environment, for example removing other service users from the area, enlisting the help of colleagues, suggesting to the aggressor that he/she moves to another area, creating space and making sure that the service user feels that they have options;
- giving clear, brief, assertive instructions, negotiating options and avoiding threats;
- moving towards a safe place and avoiding being trapped in a corner. (D)GPP
1.5.11 The staff member who assumes control should ask for facts about the problem and encourage reasoning. This will involve:

- offering realistic options;
- encouraging reasoning by use of open questions and inquiring about the reason for the service user's anger;
- asking questions about the facts rather than the feelings to assist in de-escalation, e.g. ‘What has caused you to feel upset/angry?’;
- showing concern and attentiveness through non-verbal and verbal responses;
- listening carefully and showing empathy, acknowledging any grievances, concerns or frustrations. Not being patronising or minimising service user concerns. (D)GPP

1.5.12 The staff member who assumes control should ensure that their own non-verbal communication is non-threatening. This will involve:

- considering which de-escalation techniques are appropriate for the situation;
- paying attention to non-verbal cues, such as eye contact. Allowing greater body space than normal;
- adopting a non-threatening but safe posture;
- avoiding provocative non-verbal behaviours;
- attempting to establish rapport and emphasising co-operation;
- appearing calm, self controlled and confident without being dismissive or over-bearing. (D)GPP

1.5.13 Where weapons are involved the staff member who assumes control should ask for the weapon to be placed in a neutral location rather than handed over. (D)GPP

1.5.14 Where there are potential weapons the aggressor should be relocated to a safer environment, where at all possible. (D)GPP

1.5.15 Staff should consider asking the service user to make use of a safe area or room specifically designed for the purpose of reducing arousal and/or
agitation to help them calm down. The seclusion room should not routinely be used for this purpose. (D)GPP
Observation and Engagement

The primary aim of observation should be to engage positively with the service user. This involves a two-way relationship, established between a service user and a nurse, which is meaningful, grounded in trust, and therapeutic for the service user (UKCC, 2002). Observation is an intervention that is used for both the short-term management of violence and to prevent self-harm. The recommendations and good practice points below are specifically directed towards the use of observation as an intervention for the short-term management of disturbed/violent behaviour. However, many are also applicable where observation is used to prevent self-harm. Terminology covers both uses of observation.

Policy

1.6.1 Each service must have a policy on observation and engagement (reflecting the needs of specialist facilities), that adheres to contemporary NICE terminology and definitions. The risk levels that a service user poses must be reviewed every shift. This policy must include:
- who can instigate observation
- who can increase or decrease observation level.
- who must review level of observation
- when reviews must take place
- how service user perspectives will be taken into account
- a process through which a review by a full clinical team will take place if observation above a general level continues for more than 1 week. (D)

Training

1.6.2 Healthcare staff responsible for carrying out observation must receive on-going mandatory training in observation so that they are equipped with the skills and confidence to engage with service users. (D)
Definitions of levels of observation

1.6.3

The terminology outlined in the current guideline must be adopted across England and Wales so that there is consistent observation terminology. (D)

1.6.4

*General observation* is the minimum acceptable level of observation for all in-patients. The location of all service users should be known to staff, but not all service users need to be kept within sight. At least once a shift a nurse should set aside dedicated time to assess the mental state of the service user and engage positively with the service user. The aim of this should be to develop a positive, caring and therapeutic relationship with the service user. This interview should always include an evaluation of the service user's moods and behaviours associated with risks of disturbed/violent behaviour and these should be recorded in the notes. (D)GPP

1.6.5

*Intermittent observation* means that the service user's location must be checked every 15 to 30 minutes (exact times to be specified in the notes). Checks need to be carried out sensitively in order to cause as little intrusion as possible. However, this check should also be seen in terms of positive engagement with the service user. This level is appropriate when service users are potentially, but not immediately, at risk of disturbed/violent behaviour. Service users who have previously been at risk of harming themselves or others, but who are in a process of recovery, require intermittent observation. (D)GPP

1.6.6

*Within eyesight* is required when the service user could, at any time, make an attempt to harm themselves or others. The service user should be kept within eyesight and accessible at all times, by day and by night and, if deemed necessary, any tools or instruments that could be used to harm self or others should be removed. It may be necessary to search the service user and their belongings while having due regard for
the service user's legal rights and conducting the search in a sensitive way. Positive engagement with the service user is an essential aspect of this level of observation. (D)GPP

1.6.7

Within arms length Service users at the highest levels of risk of harming themselves or others, may need to be supervised in close proximity. On specified occasions more than one member of staff may be necessary. Issues of privacy, dignity and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the service user is an essential aspect of this level of observation. (D)GPP

1.6.8 Possible antecedents or warning signs that observation is required

In addition to the antecedents that indicate disturbed/violent behaviour the following indicate that observation above a general level may be required:

- History of previous suicide attempts, self-harming or attacks on others
- Hallucinations, particularly voices suggesting harm to self or others
- Paranoid ideas where the service user believes that other people pose a threat
- Thoughts or ideas that the service user has about harming themselves or others
- Threat control over-ride symptoms
- Past or current problems with drugs or alcohol
- Recent loss
- Poor adherence to medication programmes or non-compliance with medication programmes
- Marked changes in behaviour or medication
- Known risk indicators (D)GPP

Carrying out Observation

1.6.9 Designated levels of observation should only be implemented after positive engagement with the service user has failed to dissipate the potential for disturbed/violent behaviour. (D)GPP
1.6.10 The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to a service user's dignity and privacy whilst maintaining the safety of those around them. (D)GPP

1.6.11 Decisions about observation levels should be recorded by both medical and nursing entries in the service user's notes. The reasons for using observation should be clearly specified. (D)GPP

1.6.12 Decisions regarding the specific level of observation implemented, clear directions regarding therapeutic approach, timing of next review, and name/title of person who will be responsible for carrying out review should take into account current mental state, prescribed medications and their effects, and current assessment of risk. The views of the service user should be taken into account as far as possible. (D)GPP

1.6.13 Observation skills may be used to recognise, prevent and therapeutically manage violence. Specific observation tasks are primarily undertaken by registered nurses, who may delegate to competent persons while retaining overall responsibility and accountability. (D).

1.6.14 Each staff member responsible for observation should take an active role in engaging positively with the service user by knowing their history, risk factors, early warning signs and likes and dislikes.

1.6.15 An individual staff member must not undertake a continuous period of observation for longer than 2 hours. (D)
1.6.16 The service user's psychiatrist/on-call doctor should be informed of any decisions concerning observation as soon as possible. GPP(D)

1.6.17 A nominated hospital manager should be made aware when observation is implemented so that adequate numbers and grades of staff can be made available for future shifts. (D)GPP

**Observation Skills**

1.6.18 Nurses and other staff responsible for carrying out observation:
- must be appropriately briefed about the service user, including their history, background, specific risk factors and particular needs. (D)GPP
- should be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment. (D)GPP
- must be able to increase or decrease the level of engagement with the service user as the level of observation increases. (D)GPP
- should be approachable, listen to the service user, know when self-disclosure and the therapeutic use of silence are appropriate and be able convey to the service user that they are valued. (D)GPP

1.6.19 Healthcare professionals should be aware that service users sometimes find observation provocative, and that it can lead to feelings of isolation and even dehumanisation. (D)GPP

**Service User Needs and Responses**

1.6.20 The service user is entitled to information about why they are under observation, the aims of observation and how long it is likely to be maintained. For some service users a written contract stating the roles and expectations of staff and service user might have some therapeutic potential. (D)GPP

1.6.21 The aims and level of observation should where appropriate be communicated, with the service user's approval, to the nearest relative, friend or carer. (D)GPP
1.6.22 Though difficult, where possible, the handover from one nurse or healthcare professional to another should involve the service user so that they are aware of what is being said about them. (D)GPP
1.7 Other Interventions

Where de-escalation techniques have failed to calm a service user, it may be necessary to make use of additional interventions, such as physical interventions, rapid tranquillisation and seclusion. All such interventions should only be used once de-escalation techniques have been tried and have not succeeded in calming the service user. The choice of intervention must be guided by clinical need and the obligations owed to the service-user, other service users affected by the disturbed/violent behaviour and to members of staff and any visitors. The intervention selected must amount to a proportionate and reasonable response to the risk posed.

1.7.1

- Rapid tranquillisation, physical interventions and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. They should never be used as punishment. When determining which of these interventions to employ, clinical need, safety of service users and others, and, where possible, advance directives should be taken into account.

- The intervention selected must be a reasonable and proportionate response to the risk posed by the service user. (D)

Personel

1.7.2 A medical officer should be available to attend at all times within half an hour of an alert by healthcare staff when rapid tranquillisation, physical interventions and/or seclusion are implemented, throughout the 24 hours, 7 days a week. (D)

Incident reporting

1.7.3 Any incident requiring parenteral rapid tranquillisation, physical restraint or seclusion should be recorded contemporaneously, using a national template that is available from the SMS. (D)
Legal Concerns

1.7.4 All staff need to be aware of the legal framework that authorises the use of rapid tranquillisation, physical interventions and seclusion. If seclusion is considered as an alternative strategy to physical interventions, when managing actual violence, then the guidance on seclusion in the current Mental Health Act Code of Practice must be followed. (D)GPP

1.7.5 The service should provide easy access to competent legal advice in relation to the management of any contentious aspect of disturbed/violent behaviour. (D)GPP

Service User Concerns

1.7.6 When using interventions such as restraint, rapid tranquillisation or seclusion, steps must be taken to try to ensure that the service user does not feel humiliated. (D)GPP

1.7.7 The reasons for using rapid tranquillisation, physical interventions or seclusion should be explained to the service user at the earliest opportunity. (D)GPP

1.7.8 After the use of rapid tranquillisation, physical interventions or seclusion, the service user's care plan should be re-assessed and the service user should be helped to re-integrate into the ward milieu at the earliest safe opportunity. (D)GPP

1.7.9 Service users should be given the opportunity to write up their account of the intervention in their notes. (D)GPP

Physical Interventions

Training
1.8.1
- All those involved in the administration, prescribing, and monitoring of service users receiving parenteral rapid tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation (CPR) and use of defibrillators).
- The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within 3 minutes in healthcare settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked weekly. (D)

1.8.2
All staff, whose level of need is determined by risk assessment, must receive mandatory training in the use of physical interventions. A core module of physical interventions is being developed by NIMHE and SMS. This module should be followed once it comes into effect in 2005. (D)

Carrying out Physical Interventions
1.8.3 During physical interventions, de-escalation techniques should continue to be employed. (D)

1.8.4 There are real dangers with continuous physical interventions in any position. Physical interventions should be avoided if at all possible, not used for prolonged periods, and should be brought to an end at the earliest opportunity. To avoid prolonged physical intervention an alternative strategy, such as rapid tranquillisation or seclusion, should be considered. (D)

1.8.5 During physical restraint one team member must be responsible for protecting and supporting the head and neck at all times. The team member who is responsible for supporting the head and neck should take responsibility for
leading the team through the restraint process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored. (D)

1.8.6 During physical interventions, under no circumstances should pressure be applied to the neck, thorax, abdomen, back or pelvic area. The overall physical and psychological well-being of the service user should be continuously monitored throughout the process. (D)

1.8.7 A number of physical skills may be used in the management of a violent incident:
- The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible amount of time.
- Certain techniques use the deliberate application of pain. However, every effort must be made to utilise skills and techniques that do not rely upon the deliberate application of pain, which is only permitted in exceptional circumstances and when other techniques have been tried and proved unsuccessful.
- It should be noted that the application of pain may lead to a worsening of an already highly charged situation and so should be avoided unless absolutely necessary. (D)

1.8.8 If the need to ‘breakaway’, or to rescue another staff member/service user arises, the deliberate application of pain may be required. This should be for a minimal period to bring them to a point of manageable control. The use of pain in this circumstance is only permitted for protection of staff and service users and has no therapeutic value. Staff must make every effort to de-escalate the situation. (D)

1.8.9
• Mechanical restraints are not a standard means of managing violence in acute mental health care settings.
• In the event that they are used (for example very exceptionally in high security hospitals) it must be a justifiable, reasonable and proportionate response to the risk posed by the service user and once all other interventions have been exhausted and only after a multi-disciplinary review has taken place.

• Legal, independent expert medical and ethical advice must be sought and documented. (D)
Seclusion

Environment
1.9.1

Services in which seclusion is practised must have a designated room fit for purpose. This room must allow clear observation, be well insulated, have access to toilet/washing facilities and be able to withstand attack/damage. (D)

Training
1.9.2

- All those involved in the administration, prescribing, and monitoring of a service user receiving parenteral rapid tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation (CPR) and use of defibrillators).

- The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line drugs) must be available within 3 minutes in healthcare settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked regularly. (D)

1.9.3

All staff, whose need is determined by risk assessment, must receive mandatory training in the use of seclusion. Training must include appropriate monitoring arrangements for service users placed in seclusion. (D)

Carrying out Seclusion
1.9.4

Seclusion should be for the shortest time possible and should be
reviewed at least every 2 hours. The service user should be made aware that reviews will take place at least every 2 hours. (D)

1.9.5 If seclusion is used, an observation schedule must be specified. (D)GPP

1.9.6 A service user's clothes should never be removed when they are secluded (as long as it does not compromise their safety and the safety of others). (D)GPP

1.9.7 Service users in seclusion should be allowed to keep personal items of religious or cultural significance (such as some items of jewellery) as long as they do not compromise their safety or the safety of others. (D)GPP

Rapid Tranquillisation and Seclusion

1.9.8 The use of seclusion with rapid tranquillisation is not absolutely contraindicated for rapid tranquillisation. However the following advice must be carefully considered and followed:

- If the service user is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously.
- The service user should be monitored by constant eye sight observation by an appropriately trained individual.
- Once rapid tranquillisation has taken effect, seclusion should be terminated. (D)GPP
Rapid Tranquillisation

Medication, skilfully given (in the context of good clinical care and milieu), can safely and effectively be used to manage disturbed/violent behaviour. Medication for rapid tranquillisation, particularly in the context of physical interventions, must be used with caution owing to the following risks:

- loss of consciousness instead of tranquillisation
- sedation with loss of alertness
- loss of airway.
- cardio vascular and respiratory collapse.
- interaction with medicines already prescribed or illicit substances taken (such as akathisia, disinhibition).
- possible damage to patient-clinician relationship
- underlying coincidental physical disorders

Policy
1.10.1

- Local protocols must be produced that cover all aspects of rapid tranquillisation. Such protocols must be in accordance with relevant NICE guidance and guidelines and subject to review. (D)

Training
1.10.2

- All those involved in the administration, prescribing or monitoring of service users receiving parenteral rapid tranquillisation or who employ physical interventions or seclusion must receive mandatory training to a minimum of Intermediate Life Support (ILS-Resuscitation Council UK) (covers airway, cardio-pulmonary resuscitation (CPR) and use of defibrillators).
The crash bag (including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, fluids, suction and first-line medications) must be available within 3 minutes in healthcare settings where rapid tranquillisation, physical interventions and seclusion might be used. This equipment should be maintained and checked weekly.

1.10.3
All staff involved in rapid tranquillisation must be trained in the use of pulse oximeters. (D)

1.10.4
Prescribers of medicines must be familiar with and have received training in all aspects of rapid tranquillisation, including:
- the properties of benzodiazepines and their antagonists (flumazenil), anti-psychotics, antimuscarinics and antihistamines.
- the risks associated with rapid tranquillisation, particularly when the service user is highly aroused and may have been misusing drugs, be dehydrated or possibly physically ill.
- cardio-respiratory effects of the acute administration of these drugs.
- the need to titrate doses to effect. (D)

Risks associated with Rapid Tranquillisation
1.10.5 There are specific risks associated with the different classes of medications that are used in rapid tranquillisation. When combinations are used, risks may be compounded. These include:

For Benzodiazepines
- Loss of consciousness
- Respiratory depression or arrest
- Cardiovascular collapse (in service users receiving both clozapine and benzodiazepines).
For Antipsychotics
- Loss of consciousness
- Cardiovascular and respiratory complications and collapse.
- Seizures.
- Subjective experience of restlessness (akathisia),
- Acute muscular rigidity (dystonia)
- Involuntary movements (dyskinesia)
- Neuroleptic malignant syndrome.
- Excessive sedation

For Antihistamines
- Excessive sedation
- Painful injection
- Additional antimuscarinic effects

(D)GPP

Circumstances for Special Care
1.10.6
- Extreme care needs to be taken when implementing rapid tranquillisation in the following circumstances:
  - the presence of congenital prolonged QTc syndromes
  - the concurrent prescription or use of other medication that lengthens QTc intervals both directly and indirectly
  - the presence of certain disorders affecting metabolism, such as hypo- and hyperthermia, stress and extreme emotions, and extreme physical exertion. (D)

1.10.7 Risk benefit analysis must be undertaken in cases where service users are pregnant, as there is insufficient evidence on the safety of rapid tranquillisation in pregnancy. (D)GPP

Carrying out Rapid Tranquillisation
1.10.8 The service user should be able to respond to spoken messages throughout the period of rapid tranquillisation. The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user themselves or to others. (D)

1.10.9 When a service user is transferred between units a full medication history, response, adverse effects, advance directive and, where possible, the service user's account of their experience of rapid tranquillisation should accompany them. On discharge, all such information should be filed in their healthcare record. GPP(D)

i) Oral Therapy for Rapid Tranquillisation

1.10.10
- Oral medication should be offered before parenteral medication as far as possible.(D)

1.10.11
- All medication given in the short-term management of disturbed/violent behaviour should be considered as part of rapid tranquillisation (including PRN taken from an agreed rapid tranquillisation protocol or as part of an advance directive).(D)

1.10.12
- Oral and intramuscular medications should be prescribed separately and the abbreviation of O/IM should not be used.(D)

1.10.13
- Where the behavioural disturbance occurs in a non-psychotic context then it is preferable to initially use oral lorazepam alone, or intramuscularly if necessary.(B)
1.10.14
• When there is behaviour disturbance in the context of psychosis, to achieve early onset of calming/sedation, or to lower dose of antipsychotic, an oral antipsychotic (haloperidol/olanzapine/risperidone) in combination with oral lorazepam, should be considered in the first instance. The MHRA have warned against the use of risperidone or olanzapine in the treatment of behavioural symptoms of dementia, due to increased risk of stroke and death. (B)

1.10.15
• Sufficient time should be allowed for clinical response between oral doses. (See chart for rapid tranquillisation at end of section.) (B)

ii) Parenteral Therapy for Rapid Tranquillisation
1.10.16
If parenteral treatment proves necessary, the intramuscular route is preferred over intravenous from a safety point of view. (D)

1.10.17
• Where rapid tranquillisation through oral therapy has repeatedly failed, is refused, is not indicated by previous clinical response or is not a proportionate response, a combination of an intramuscular antipsychotic and an intramuscular benzodiazepine (IM haloperidol and IM lorazepam) is recommended. (B)

1.10.18
• In the event of moderate disturbance in service users with psychosis, IM olanzapine may also be considered. IM lorazepam must not be given within one hour of IM olanzapine. Oral lorazepam should be used with caution. (B)

1.10.19
• There is not sufficient evidence that the safety of the combination of haloperidol IM with promethazine IM or of midazolam IM has been sufficiently demonstrated
to be able to recommend either for routine psychiatric practice in the UK population. (B)

1.10.20
- Sufficient time should be allowed for clinical response between IM doses. (See chart for rapid tranquillisation at end of section.) (B)

1.10.21
- Using two drugs of the same class for the purpose of rapid tranquillisation is unacceptable. (D)

1.10.22
  Medications should never be mixed in the same syringe. (D)GPP

1.10.23
  When using IM haloperidol as a means of managing disturbed behaviour, an antimuscarinic agent, such as procyclidine or benzatropine, should be immediately available to reduce the risk of dystonia and other extrapyramidal side effects, and should be given IM or IV as per manufacturer’s recommendations. (D)

1.10.24
- Intravenous administration of benzodiazepines or haloperidol should not normally be used, except in very exceptional circumstances, which must be specified and recorded. This decision must not be made by junior medical staff in isolation.
- However, if immediate tranquillisation is essential then intravenous administration may be necessary. If it is used staff must be appropriately trained to recognise symptoms of respiratory depression, dystonia or cardiovascular compromise (such as palpitations, significant changes in blood pressure, collapse).
- If intravenous medication is used the service user must never be left unattended. Intravenous administration must never occur without full access to the full support and resuscitation as outlined in Recommendations 1.10.2 (D)
1.10.25

In very exceptional circumstances, which must be specified and recorded, haloperidol (IM) with promethazine (IM) or midazolam (IM) may be considered as an alternative to intravenous administration of benzodiazepines or haloperidol. This decision must not be made by junior staff in isolation. (D)

Medications Not Normally Used for Rapid Tranquillisation

1.10.26

- Zuclopenthixol acetate (clopixol, acuphase), is not recommended for rapid tranquillisation due to long onset and duration of action.
- However, zuclopenthixol acetate (clopixol, acuphase) may be considered as an option:
  - when it is clearly expected that the service user will be disturbed over an extended period of time
  - when a service user has a past history of good and timely response to zuclopenthixol acetate (clopixol, acuphase).
  - when a service user has a past history of repeated parenteral administration.
  - when an advance directive has been made indicating that this is a treatment of choice.
- It should never be administered to those without any previous exposure to antipsychotic medication.
- The BNF and manufacturer’s SPC must be consulted regarding its use. (B)

Drugs Not Recommended for Rapid Tranquillisation

1.10.27

- The following drugs are not recommended for rapid tranquillisation:
  - Chlorpromazine IM or oral a local irritant if given
  Intramuscularly; risk of cardiovascular complications; causes hypotension due to α-
adrenergic receptor blocking effects, especially in the doses required for rapid tranquillisation. is erratically absorbed; its effect on QTc intervals suggests that it is unsuitable for use in rapid tranquillisation. (C)

- Diazepam IM (C)
- Thioridazine (C)
- IM depot anti-psychotics (D)
- Olanzapine and risperidone should not be used for the management of disturbed behaviour in service users with dementia. (C)

Doses for Rapid Tranquillisation

1.10.28

• When using rapid tranquillisation there may be certain circumstances in which the current BNF uses and limits and manufacturers licence may be knowingly exceeded (for example lorazepam). The rationale must be recorded in the care plan.
• If current BNF doses are exceeded it is particularly important that frequent and intensive monitoring of a calmed service user is undertaken, with particular attention to regular checks of airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature and hydration. (D)

1.10.29

• The total dose of medication prescribed for an acutely disturbed service user must be reviewed:
  - regularly by the responsible consultant or nominated deputy in conjunction with the multi-disciplinary team;
  - at least every 24 hours (or more often in a rapidly changing situation);
  - paying particular attention to issues of consent, BNF requirements and
physical and mental status.

- In all circumstances of rapid tranquillisation, the prescriber and medication administrator must pay attention to issues of consent, BNF requirements and physical and mental status of the service user. (D)

1.10.30

- The dose of antipsychotic medication should be individualised for each service user. (D)GPP
- This will be dependant on several factors including their age; older service users generally require lower doses, those with concomitant physical disorders. (such as renal, hepatic, cardiovascular, or neurological) and concurrent medication. (D)GPP

1.10.31

- A specialist mental health pharmacist must be a member of the multidisciplinary team in all circumstances where rapid tranquillisation occurs.
- These pharmacists have a responsibility to monitor and ensure safe and appropriate usage of medication. (D)

**Care After Rapid Tranquillisation**

1.10.32

- After parenteral treatment is administered, vital signs must be monitored and pulse oximeters must be available. Blood pressure, pulse, temperature, respiratory rate and hydration must be recorded regularly, at intervals agreed by a multidisciplinary team, until the service user becomes active again. (D)
- In the following circumstances more frequent and intensive monitoring by appropriately trained staff is required and must be recorded in the care plan. Particular attention must be paid to the service user’s respiratory effort, airway, and level of consciousness:
  - if the service user appears to be or is asleep/sedated.
  - if intravenous administration has taken place.
  - if BNF limit is exceeded.
- in high risk situations.
- where the service user has been using illicit substances or alcohol.
- where the service user has a relevant medical disorder or concurrently prescribed medication. (D)

1.10.33

If verbal responsiveness is lost as a consequence of medication administration the patient requires a level of care identical to that needed for general anaesthesia. (D)

**Chart for Rapid Tranquillisation**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Time to maximum plasma concentration</th>
<th>Approximate plasma half life</th>
<th>Licenced indications</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olanzapine tablets (spc)</td>
<td>5-8hrs</td>
<td>32-50hrs</td>
<td>- treatment of schizophrenia.</td>
<td>not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response.</td>
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<td></td>
<td>- treatment of moderate to severe manic episode.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder</td>
<td></td>
</tr>
<tr>
<td>Olanzapine dispersable tablets (spc)</td>
<td>5-8hrs</td>
<td>32-50hrs</td>
<td>- treatment of schizophrenia.</td>
<td>not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.</td>
</tr>
<tr>
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<td></td>
<td></td>
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<td></td>
<td>- In patients whose manic episode has responded to olanzapine treatment, olanzapine is indicated for the prevention of recurrence in patients with bipolar disorder</td>
<td></td>
</tr>
<tr>
<td>Olanzapine injection (spc)</td>
<td>15-45mins</td>
<td>32-50hrs</td>
<td>- Indicated for the rapid control of agitation and disturbed behaviours in patients with schizophrenia or manic episode, when oral therapy is not appropriate. Treatment with Zyprexa Powder for Solution for Injection should be discontinued, and the use of oral olanzapine should be initiated, as soon as clinically appropriate.</td>
<td>IM olanzapine may produce a 5 fold increase in plasma concentration vs the same dose given by the oral route. not approved for the treatment of dementia-related psychosis and/or behavioural disturbances.</td>
</tr>
<tr>
<td>Medicine</td>
<td>Indications</td>
<td>Side Effects</td>
<td></td>
<td></td>
</tr>
<tr>
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<tr>
<td>Risperidone tablets</td>
<td>• the treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. • treatment of mania in bipolar disorder.</td>
<td>• not licensed for the treatment of behavioural symptoms of dementia.</td>
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</tr>
<tr>
<td>Risperidone dispersable tablets</td>
<td>1-2hrs 24hrs • the treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. • treatment of mania in bipolar disorder.</td>
<td>• not licensed for the treatment of behavioural symptoms of dementia.</td>
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</tr>
<tr>
<td>Risperidone liquid</td>
<td>1-2hrs 24hrs • the treatment of acute and chronic schizophrenic psychoses, and other psychotic conditions, in which positive or negative symptoms are prominent maintaining the clinical improvement during continuation therapy in patients who have shown an initial treatment response. • treatment of mania in bipolar disorder.</td>
<td>• not licensed for the treatment of behavioural symptoms of dementia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol tablets</td>
<td>3-6hrs 1-36hrs • Schizophrenia and other psychoses. short-term adjunctive management of psychomotor agitation, excitement, olent or dangerously impulsive behaviour, mental or behavioural, disorders especially when associated with hyperactivity and aggression, short-term adjunctive management of severe anxiety, restlessness and agitation in the elderly, intractable hiccup, nause and vomiting, Gilles de la Tourette syndrome and severe tics.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol oral solution</td>
<td>3-6hrs 10-36hrs • Schizophrenia and other psychoses. short-term adjunctive management of psychomotor agitation, excitement, olent or dangerously impulsive behaviour, mental or behavioural, disorders especially when associated with hyperactivity and aggression, short-term adjunctive management of severe anxiety, restlessness and agitation in the elderly, intractable hiccup, nause and vomiting, Gilles de la Tourette syndrome and severe tics.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haloperidol</td>
<td>15-60mins 10-36hrs • Schizophrenia: treatment of symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECOND DRAFT FOR CONSULTATION JULY 2004  Page 201 of 279
- and prevention of relapse.
  - Other psychoses; especially paranoid.
  - Mania and hypomania.
  - Mental or behavioural problems such as aggression, hyperactivity and self-mutilation in the mentally retarded and in patients with organic brain damage.
  - As an adjunct to short term management of moderate to severe psychomotor agitation, excitement, violent or dangerously impulsive behaviour.
  - Nausea and vomiting

### Lorazepam tablets (spc)

<table>
<thead>
<tr>
<th>Duration</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 hrs</td>
<td>short term treatment of moderate and severe anxiety.</td>
</tr>
<tr>
<td>12hrs</td>
<td>short term treatment of anxiety in psychosomatic, organic and psychotic illness.</td>
</tr>
<tr>
<td></td>
<td>short term treatment of insomnia associated with anxiety.</td>
</tr>
<tr>
<td></td>
<td>premedication before operative dentistry and general surgery.</td>
</tr>
</tbody>
</table>

### Lorazepam injection (spc)

<table>
<thead>
<tr>
<th>Duration</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-90mins</td>
<td>Preoperative medication or premedication for uncomfortable or prolonged investigations.</td>
</tr>
<tr>
<td>12-16hrs</td>
<td>The treatment of acute anxiety states, acute excitement or acute mania.</td>
</tr>
<tr>
<td></td>
<td>The control of status epilepticus.</td>
</tr>
</tbody>
</table>
Incident Reporting and Post-Incident Reviews following Rapid Tranquillisation, Physical Interventions and Seclusion

Incident Reporting

1.11.1
Any incident requiring rapid tranquillisation, physical restraint or seclusion should be recorded contemporaneously, using a national template that is available from SMS. (D)

1.11.2
Templates for incident recording were issued by SMS in November 2003. Mandatory training must be given to all appropriate staff to ensure that they are aware of how to correctly record an incident using these appropriate nationally recognised templates. (D)

Post-Incident Reviews

1.11.3 A post-incident review should take place as soon after the incident as possible, but in any event within 72 hours of the incident ending. (D)GPP

1.11.4 Mental health service providers should have systems in place with appropriately skilled staff to ensure that a range of options of post-incident support and review mechanisms are available and take place within a culture of learning lessons. The following groups should be considered:

- Staff involved in the incidents
- Service users
- Carers and family where appropriate
- Other service users who witnessed the incident
- Visitors who witnessed the incident
- Independent advocates
- Local Security Management Specialist (LMS). (D)GPP
1.11.5 The aim of the review must be to seek to learn lessons and support staff, and encourage the therapeutic relationship between staff, service users and their carers. (D)GPP

1.11.6 The post-incident review should address what happened, any trigger factors, each person's role in the incident, how they felt during the incident, how they feel now, how they may feel in a few days, what can be done about it. (D)GPP

1.11.7 Appropriate support, including on-going individual post-incident debriefing sessions, should be available as required. (D)GPP

1.11.8 One-off post-incident debriefing sessions have been shown to be unhelpful and should not be undertaken. (B)

1.11.9 Consequential sick leave and the return to work must be monitored and positively and carefully managed to ensure that staff are supported. (D)GPP

1.11.10 Consequential sick leave must be audited to identify trends within the organisation to inform future strategy and training in relation to the management of disturbed/violent behaviour. (D)GPP
**Accident and Emergency**

In addition to the recommendations and good practice points that are contained within this guideline, the following good practice points relate specifically to Accident and Emergency Settings.

**Training**

1.12.1 In addition to mandatory training in the management of violence, appropriate staff groups in accident and emergency departments must receive training in the recognition of acute mental illness and awareness of organic differential diagnoses. Service user involvement should be encouraged. (D)

**Risk**

1.12.2

- Accident and emergency units should have a system in place to alert staff to patients known by the unit to pose a risk of violence, so that steps can be taken to minimise risks to staff and other patients.
- The system should be reviewed at reasonable intervals to avoid stigmatisation. (D)GPP

**Environment**

1.12.3 Every accident and emergency department must have at least one designated interview room for mental health assessments. Larger accident and emergency departments (more than 75,000 attendances a year) may require additional rooms. The room(s) should be close to or part of the main accident and emergency receiving area. (D)GPP

1.12.4 These rooms must be made available on a priority basis for mental health assessments, be of a sufficient size to comfortably accommodate six seated
persons, be fitted with an emergency call system, with an outward opening
door, a window for observation, reasonable ventilation, have soft furnishings
and be clear of weapons or potential weapons. (D)GPP

1.12.5 Staff interviewing a patient in this room should always inform a senior
member of the accident and emergency nursing staff before commencing the
interview. (D)GPP

1.12.6 Ordinarily a chaperone should be present, and interviews without chaperones
should only proceed after discussion with relevant staff. Where a staff member
is alone, 5-minute checks via the interview room window should occur whilst
the interview is taking place. (D)GPP

Personnel

1.12.7 Every accident and emergency department must have access to an identified
consultant psychiatrist for liaison with providers of local mental health
services. (D)GPP

1.12.8

The attendance of a suitably experienced psychiatrist is needed within
1 hour of alert from the accident and emergency department, at all
times. (D)

1.12.9 There should be at least one registered mental nurse working with
every accident and emergency department. Larger accident and
emergency departments (more than 75,000 attendances a year) may require
more. (D)GPP

1.12.10 Accident and emergency departments should be encouraged to
employ registered mental nurses. (D)GPP

Rapid Tranquillisation
1.12.11 The decision to use rapid tranquillisation should be taken by a senior medical member of staff, where at all possible. (D)GPP

1.12.13 Mental health staff should be contacted at the first available opportunity. (D)GPP

1.12.14 Prior to formal diagnosis, lorazepam is the preferred choice where there is any uncertainty about previous medical history, including history of cardiovascular disease, uncertainty regarding current medication, or possibility of current illicit drug / alcohol intoxication. (D)GPP

1.12.15 Where there is a confirmed history of previous significant antipsychotic exposure, and response, haloperidol alone or in combination with lorazepam are frequently used alternatives. (D)GPP

Where English is not the first language

1.12.16 For patients whose preferred language is not English, interpreting services should be provided. Provision should also be made for patients who are deaf who will need an interpreter who can sign. (D)GPP

Intoxication and Substance Misuse

For detailed information on the care of patients who present with alcohol related problems and substance misuse please refer to CR118: Psychiatric Services in Accident and Emergency Departments, Royal College of Psychiatrics (London, 2004).
Searching

The undertaking of necessary and lawful searches of both service users and visitors can make an important contribution to the effective management of disturbed/violent behaviour in psychiatric in-patient settings. Unlawful, insensitive and unnecessary searches can also exacerbate disturbed/violent behaviour. Searches are the responsibility of nursing staff save in exceptional circumstances where the assistance of others, including the police, may be sought.

1.13.1
- All facilities must have an operational policy on the searching of service users, their belongings, the environment in which they are accommodated and also the searching of visitors. Where necessary the policy should refer to related policies such as those for substance misuse and police liaison.
- The searching policy should be in place in order to ensure the creation and maintenance of a safe and therapeutic environment for service users, staff and visitors. (D)

1.13.2
- The policy should address all aspects of personal through to environmental searching from the decision to initiate a search through to the storage, return or other disposal (including the lawful disposal of any items such as firearms and illicit drugs) of items found.
- Post-search support for all those involved should be provided. (D)

1.13.3
- The policy must set out, in terms that can easily be understood by all those with responsibilities under the policy, the legal grounds for undertaking searches in the absence of consent.
- In doing so, it must specifically address the searching of service users detained under the Mental Health Act; informal service users without capacity to consent at
the time of the search; informal service users with capacity to do so; staff and visitors. (D)

- The policy should also extend to the routine and random searching of detained service users without cause, where it is proposed to do so because there is a pressing social need (for example there is a chronic substance abuse problem on the ward) to do so and undertaking such searches is a proportionate response to that need. (D)

1.13.4

The level of intrusiveness of any personal search undertaken must be a reasonable and proportionate response to the reason for the search. Ordinarily rub down or personal searching should be provided for in the policy together with procedures for their authorisation in the absence of consent. (D)

1.13.5

All searches must be undertaken with due regard to the service user's dignity and privacy and by a member/s of staff of the same sex. (D)

1.13.6

The policy must provide for the circumstance in which a service user physically resists being searched. In this event a multi-disciplinary decision must be made as to the need to carry out a search using physical intervention. If a decision is made not to proceed then the policy must set out the options available to deal with the situation. (D)

1.13.7

- Service users, staff and visitors must be informed that there is a policy on searching.
- The consent of the person it is proposed to search must always be sought.
- The person being searched must be kept informed of what is happening and why.
• A comprehensive record of every search must be made, including its justification.
• Any consequent risk assessment and risk management must be placed in the appropriate records. (D)

1.13.8
Following every search undertaken where consent has been withheld there must be a post incident review that includes advocacy service or hospital managers visiting the service user who has been searched. (D)

1.13.9
The exercise of powers of search should be audited regularly and the outcomes reported from time to time to the Trust Board. (D)

1.13.10
All staff involved in the undertaking of searches must receive appropriate training and refresher courses. (D)
9. Audit Criteria

Technical detail on the criteria for audit

The Royal College of Psychiatrists, on behalf of Healthcare Commission, have developed audit material, most of which could be used at a local level. The audit criteria here are based on those criteria.

There are a wide variety of areas which need to be incorporated in audit relating to the short-term management of disturbed/violent behaviour in psychiatric in-patient settings. The following objective provides an example of one area, environment, and is taken from the Healthcare commission audit tool on the environment. This structure could also be applied to the other areas as listed in the audit criteria table below.

Possible objectives for an audit

- To ensure that the environment is safe and helps prevent disturbed/violent behaviour.

People that could be included in an audit and time period for selection

- Staff who work or have close associations with the ward/unit being audited.

- People who do not have direct links with the ward/unit eg. service user representatives; community health centre members in Wales and patient forms in England; staff from other areas involved in the care pathway.

Measures that could be used as a basis for an audit

These audit criteria were devised by the Healthcare commission audit team at the Royal College of Psychiatrists, who are currently undertaking a national audit on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings.
settings. They represent the key audit criteria that correspond to the areas covered by these guidelines. NICE and the Healthcare commission have worked closely to ensure consistency.
### Criterion Exception Definition of terms

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Exception</th>
<th>Definition of terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All areas look friendly.</td>
<td>Nil exceptions</td>
<td>Refer to recommendations 1.1.1-1.1.6</td>
</tr>
<tr>
<td>2. There is a perception of space and overcrowding is avoided.</td>
<td>Nil exceptions</td>
<td></td>
</tr>
<tr>
<td>3. Sight-lines are unimpeded so that people can see what is happening on different parts of the ward/unit.</td>
<td></td>
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<tr>
<td>4. The day rooms are open at night for people who cannot sleep.</td>
<td>Nil exceptions</td>
<td></td>
</tr>
<tr>
<td>5. There is access to external space.</td>
<td>Nil exceptions</td>
<td></td>
</tr>
<tr>
<td>6. Adequate private spaces are provided for interactions i.e. conversations; phone calls; meeting visitors; interviews with staff.</td>
<td>Nil exceptions</td>
<td></td>
</tr>
<tr>
<td>7. Single bedrooms are provided.</td>
<td>Nil exceptions</td>
<td></td>
</tr>
<tr>
<td>8. Women only spaces have been provided.</td>
<td>Nil exceptions</td>
<td></td>
</tr>
<tr>
<td>1. There is an effective plan to manage</td>
<td>Nil exceptions</td>
<td>Refer to recommendations 1.2.1-1.2.4</td>
</tr>
</tbody>
</table>
risk of violence for each patient at high risk.

1. Staff are able to summon help easily where de-escalation techniques have failed to calm the service user.
   2. All staff are aware of other interventions to be used as detailed in the service user’s risk assessment/advance directives.

   | Nil exceptions | Refer to recommendations 1.5.1-1.5.2 |

   1. Nurses carrying out observation have received training in observation and have been well-briefed about the service user and are familiar with the ward.

   | Nil exceptions | Refer to recommendations 1.6.1-1.6.3 |

   1. All staff responsible for applying physical interventions have received training in those interventions.

   | Nil exceptions | Refer to recommendations 1.7.1-1.7.13 |

   1. During seclusion the following appropriate measures have been
implemented:
- a doctor is present within the first few minutes of seclusion
- a nurse is in sight or sound throughout (and present if the service user is sedated)
- the service user is able to call for assistance
- the service user has kept her/his clothing.
- seclusion is used for the shortest period possible.

1. The appropriate precautions were taken prior to the administration of medication:
   - A history/mental state examination
   - A physical examination (if possible)
   - Establishment of a provisional diagnosis and legal status

| Nil exceptions | Refer to recommendations 1.9.1-1.9.24 |
- A multi-disciplinary discussion as to whether rapid tranquillisation is safe and appropriate.

1. Dignity is maintained.
2. Service user is asked if they are satisfied with the choice of therapies and activities available.
3. The service user is able to speak to staff when needed, for example, if concerned or upset.
4. The service user is asked if they are satisfied with involvement in decisions about care and support.
5. Service user is made to feel safe during their stay.
6. Service user has been advised on what to do if they see or hear about a violent incident and know how to summon help.

| Nil exceptions | Refer to recommendations 1.4.1-1.4.5 and 1.4.14 |
### Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient Settings and Accident and Emergency Settings Guideline

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Nil exceptions</th>
<th>Refer to recommendations 1.3.1-1.3.15</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Service users are asked if staff dealt well with threatening or violent behaviour between service users.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The numbers, skill, experience, and qualifications of the staff on each unit is appropriate to the resident population.</td>
<td>Nil exceptions</td>
<td></td>
</tr>
<tr>
<td>2. Training was received in relation to the prevention or management of violence prior to working on wards/units.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Staff satisfaction is measured regarding support received from other staff on the ward/unit.</td>
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<td></td>
</tr>
<tr>
<td>4. Staff have the opportunity to report when personally attacked, threatened, or made to feel unsafe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Staff are asked if other staff dealt well with threatening and violent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>behaviour towards staff from service users.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Calculation of compliance

Compliance (%) with each measure described in the table above is calculated as follows.

\[
\text{Compliance} \times 100
\]
\[
\frac{\text{Number of patients whose care is consistent with the criterion plus number of patients who meet any exception listed}}{\text{Number of patients to whom the measure applies}} \times 100
\]

Clinicians should review the findings of measurement, identify whether practice can be improved, agree on a plan to achieve any desired improvement and repeat the measurement of actual practice to confirm that the desired improvement is being achieved.
10. Recommendations for Research

The following research recommendations have been identified for this NICE guideline, not as the most important research recommendations, but as those that are most representative of the full range of recommendations. All of the recommendations for research should consider the importance of including study-level variables relating to gender, ethnicity and those with special concerns. These research recommendations have been drawn up by GDG consensus and then further clarification has been added by the NICE technical advisor.

Prospective cohort studies are required to identify antecedents of disturbed/violent behaviour in adult psychiatric inpatient settings.

Before and after studies, surveys, cross-sectional studies and cohort studies should be undertaken to establish the following in relation to the deliberate application of pain in physical interventions used for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and in accident and emergency settings:

- effectiveness
- ethical and legal and safety aspects
- role within range of physical interventions taught to staff
- staff and service user perceptions

Before and after studies, surveys, cross-sectional studies and cohort studies should be undertaken to investigate the following aspects of mechanical restraints for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and in accident and emergency settings:

- effectiveness
- ethical and legal and safety aspects
Qualitative and survey research is needed to examine service users' (including Black and minority ethnic groups) views on the antecedents and risk factors of disturbed/violent behaviour, and the use of observation, de-escalation techniques, physical interventions and seclusion for the short-term management of disturbed/violent behaviour in adult psychiatric in-patient settings and in accident and emergency settings.

Clinical trials and longitudinal cohort studies should be conducted in large, well-designed randomised controlled studies with adult psychiatric inpatients (including Black and minority ethnic groups) that compare the utility, acceptability, safety and desirable endpoints of available medicines and their dosages for rapid tranquillisation and PRN regimes (including atypical and antipsychotics), and assess the long-term side effects.

Controlled before and after studies are needed to evaluate the major training programmes identified by the National Institute for Mental Health in England (NIMHE) and the Counter Fraud and Security Management Service (SMS). These studies must assess the short-term and long-term effectiveness of the training programme in psychiatric in-patient settings and assess the safety of the techniques used in these training packages for both staff and service users.

Prospective cohort studies are needed to develop valid and reliable prediction tools for use in psychiatric inpatient settings appropriate for use in the UK which:

- may predict the imminent onset of disturbed/violent behaviour,
- confirm the predictive validity of key risk factors and assist clinical judgment in risk prediction.
Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient Settings and Accident and Emergency Settings Guideline

Controlled before and after studies that examines whether observation and/or de-escalation techniques minimise the need for seclusion, restraint or rapid tranquillisation are needed.

National audit data collections are required on the incidence of sudden death among psychiatric service users (including ethnicity, age, and gender) receiving rapid tranquillisation and on death/morbidity associated with restraint and seclusion.

Prospective cohort studies, before and after studies and qualitative research is needed to develop restraint techniques, which allow communication between deaf service user and deaf and visually impaired service users and staff, as well as other physically impaired service users while also ensuring staff and service user safety.
11. Dissemination of the Guidelines

- The guideline will be produced in a full and summary format and a version for the public (Information for the Public).
- Full copies of the Guideline will be available through the NICE website (http://www.nice.org.uk) in PDF format and summary through the National Electronic Library for Health (NeLH (http://www.nelh.nhs.uk/) and national Guideline Clearinghouse (http://www.guidelines.gov).

12. Validation

The guideline is validated through two stakeholder consultation processes. The first draft was submitted to NICE in April 2004 and second draft will be submitted to NICE 30th June.

13. Scheduled Review of the Guideline

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

14. Guidelines and Reports Consulted


Practice Guidance: Safe and Supportive Observation of Patients at Risk: Mental Health Nursing: Addressing Acute Concerns, Standing Nursing and Midwifery Advisory Committee (London, 1999).
Short-Term Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient Settings and Accident and Emergency Settings Guideline


Recommendations on the Use of Restraints and Isolation-Clinical Practice Guidelines, Collège des Médecins du Québec (Québec, 1999).


Safety, Privacy and Dignity in Mental Health Units: Guidance on mixed sex accommodation for mental health services. Department of Health (London, 2000).

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Seclusion and Restraint Practice Standards: A Review and Analysis. Steel E, National Mental Health Association (Alexandria, USA, 1999)
Seclusion, control and restraint. Royal College of Nursing (London, 1992)


The Recognition, Prevention and Therapeutic Management of Violence in Mental Health care. United Kingdom Central Council for Nursing, Midwifery and Mental Health Visiting, (London, 2002).


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


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Department of Health (1998) *They Look After Their Own Don’t They?* In: Section of Community Care for Black and Minority Ethnic Older People. London.


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


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


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


