NICE National Institute for Health and Care Excellence

NICE guideline

Violence and aggression: short-term management in mental health, health and community settings

NICE guideline

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This guideline replaces CG25.

Introduction

Violence and aggression refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

Violence and aggression are relatively common and serious occurrences in health and social care settings. Between 2013 and 2014 there were 68,683 assaults reported against NHS staff in England: 69% in mental health or learning disability settings, 27% against ambulance staff, 25% involving primary care staff and 26% involving acute hospital staff. Violence and aggression in mental health settings occur most frequently in inpatient psychiatric units and most acute hospital assaults take place in emergency departments.

The manifestation of violence and aggression depends on a combination of intrinsic factors, such as personality characteristics and intense mental distress, and extrinsic factors, such as the attitudes and behaviours of surrounding staff and service users, the physical setting and any restrictions that limit the service user's freedom. The impact of violence and aggression is significant and diverse, adversely affecting the health and safety of the service user, other service users in the vicinity, carers and staff. Violence and aggression can also affect public opinion about services and service users and result in a strong negative impact on the overall experience of care. Although the guideline contains recommendations on intervening before violence and aggression occur, it is not always possible to avoid violence. Therefore a graded set of interventions is needed to prevent minor violence from escalating into severe violence.

Since the publication of the previous guideline in 2005 (NICE guideline CG25) there have been some important advances in our knowledge of the management of violence and aggression, including service users' views on the use of physical intervention and seclusion, and the effectiveness, acceptability and safety of drugs and their dosages for rapid tranquillisation. The previous guideline was restricted to people aged 16 and over in adult psychiatric settings and emergency departments; this update has been expanded to include some of the previously excluded populations and settings. All areas of NICE guideline CG25 have been updated and this guideline replaces it in full.

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This guideline covers the short-term management of violence and physically threatening behaviour in mental health, health and community settings. This includes inpatient psychiatric care, emergency and urgent care, secondary mental health care (such as care provided by assertive community teams, community mental health teams, early intervention teams and crisis resolution and home treatment teams), community healthcare, primary care, social care and care provided in people's homes. The guideline covers anticipating and reducing the risk of violence and aggression, prevention methods (such as searching, de-escalation and pharmacological strategies, including p.r.n. medication), restrictive interventions (for example, restraint, rapid tranquillisation and seclusion), staff training, and post-incident debrief and review.

This guideline includes adults (aged 18 and over), children (aged 12 and under) and young people (aged 13 to 17) with a mental health problem who are currently service users within mental health, health and community settings. It also covers carers of service users with mental health problems in these settings.

This guideline does not cover but may be relevant to practice regarding people who do not have mental health problems, those who are not carers of people with mental health problems, people in whom the primary behaviour is self-harm and people with a primary diagnosis of learning disability.

Safeguarding children

Remember that child maltreatment:

- is common
- can present anywhere, such as emergency departments and primary care or on home visits.

Be aware of or suspect abuse as a contributory factor to or cause of the symptoms or signs of violence or aggression in children. Abuse may also coexist with violence or aggression. See the NICE guideline on child maltreatment for clinical features that may be associated with maltreatment.

This section has been agreed with the Royal College of Paediatrics and Child Health.

Medicines

The guideline assumes that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual service users.

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This guideline recommends some medicines for indications for which they do not have a UK marketing authorisation at the date of consultation, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The service user (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. Where recommendations have been made for the use of medicines outside their licensed indications ('off-label use'), these medicines are marked with a footnote in the recommendations.

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Person-centred care

This guideline offers best practice advice on the care of service users with mental health problems whose behaviour is violent or aggressive.

Service users and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Service users should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the service user is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in patient experience in adult NHS services.

NICE has also produced guidance on the components of good service user experience. All healthcare professionals and social care practitioners working with people using adult NHS mental health services should follow the recommendations in service user experience in adult mental health.

If a young person is moving between paediatric and adult services, care should be planned and managed according to the best practice guidance described in the Department of Health's Transition: getting it right for young people.

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with mental health problems whose behaviour is violent or aggressive. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

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Key priorities for implementation

The following recommendations have been identified as priorities for implementation. The full list of recommendations is in section 1.

See implementation: getting started for information about putting the recommendations on manual restraint, rapid tranquillisation and formal external post-incident reviews into practice.

Anticipating and reducing the risk of violence and aggression

Reducing the use of restrictive interventions

Staff training

- Health and social care provider organisations should train staff who work in services in which restrictive interventions may be used in psychosocial methods to avoid or minimise restrictive interventions. This training should enable staff to develop:
    - a person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship
    - an understanding of the relationship between mental health problems and the risk of violence and aggression
    - skills to assess why behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors
    - skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation)
    - skills, methods and techniques to undertake restrictive interventions safely when these are required
    - skills to undertake an immediate post-incident debrief (see recommendations 1.4.55–1.4.61)
    - skills to undertake a formal external post-incident review in collaboration with experienced service users who are not currently using the service (see recommendations 1.4.62–1.4.63).

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A framework for anticipating and reducing violence and aggression in inpatient psychiatric wards

- Use the following framework to anticipate violence and aggression in inpatient psychiatric wards, exploring each domain to identify ways to reduce violence and aggression and the use of restrictive interventions.
    - Ensure that the staff work as a therapeutic team by using a positive and encouraging approach, maintaining staff emotional regulation and self-management (see recommendation 1.3.19) and encouraging good leadership.
    - Ensure that service users are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties.
    - Recognise possible teasing, bullying, unwanted physical or sexual contact or miscommunication between service users.
    - Recognise how each service user's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression).
    - Anticipate the impact of the regulatory process on each service user (for example, being formally detained, having leave refused, having a failed detention appeal or being in a very restricted environment such as a low-, medium- or high-secure hospital).
    - Improve or optimise the physical environment (for example, use unlocked doors whenever possible, enhance the décor, simplify the ward layout and ensure easy access to outside spaces and privacy).
    - Anticipate that restricting a service user's liberty and freedom of movement (for example, not allowing service users to leave the building) can be a trigger for violence and aggression.
    - Anticipate and manage any personal factors occurring outside the hospital (for example, family disputes or financial difficulties) that may affect a service user's behaviour.

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Preventing violence and aggression

Using p.r.n. medication

- When prescribing p.r.n. medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:
  - do not prescribe p.r.n. medication routinely or automatically on admission
  - tailor p.r.n. medication to individual need and include discussion with the service user if possible
  - ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan
  - ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British national formulary (BNF) when combined with the person's standard dose or their dose for rapid tranquillisation
  - only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented and carried out under the direction of a senior doctor
  - ensure that the interval between p.r.n. doses is specified.

De-escalation

Staff training

- Health and social care provider organisations should give staff training in de-escalation that enables them to:
  - recognise the early signs of agitation, irritation, anger and aggression
  - understand the likely causes of aggression or violence, both generally and for each service user
  - use techniques for distraction and calming, and ways to encourage relaxation
  - recognise the importance of personal space
  - respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation.

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General principles

- Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.

Using restrictive interventions in inpatient psychiatric settings

Using restrictive interventions

- Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

Rapid tranquillisation

- If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.

Post-incident debrief and review

Formal external post-incident review

- The service user experience monitoring unit or equivalent service user group should undertake a formal external post-incident review as soon as possible and no later than 72 hours after the incident. The unit or group should ensure that the formal external post-incident review:
    - is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame
    - uses the information recorded in the immediate post-incident debrief and the service user's notes relating to the incident
    - includes interviews with staff, the service user involved and any witnesses if further information is needed
    - uses the framework in recommendation 1.2.7 to:
        - evaluate the physical and emotional impact on everyone involved, including witnesses

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- help service users and staff to identify what led to the incident and what could have been done differently
- determine whether alternatives, including less restrictive interventions, were discussed
- determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
- recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate
- avoid a similar incident happening in future, if possible.

Managing violence and aggression in emergency departments

- If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with recommendations 1.4.1–1.4.45 and do not use seclusion. Regard the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.

Managing violence and aggression in community and primary care settings

- Health and social care provider organisations, including ambulance trusts, should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting and the extent to which staff move between settings.

Managing violence and aggression in children and young people

Staff training

- Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of violence and aggression using a training programme designed specifically for staff working with children and young people. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible. Staff who might undertake restrictive interventions should be trained:
  - in the use of these interventions in these age groups

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  - to adapt the manual restraint techniques for adults in recommendations 1.4.23–1.4.33, adjusting them according to the child or young person's height, weight and physical strength
  - in the use of resuscitation equipment (see recommendation 1.4.3) in children and young people.

Managing violence and aggression

- Manage violence and aggression in children and young people in line with the recommendations for adults in sections 1.1–1.6, taking into account:
  - the child or young person's level of physical, intellectual, emotional and psychological maturity
  - the recommendations for children and young people in this section
  - that the Mental Capacity Act 2005 applies to young people aged 16 and over.

Assessment and initial management

Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression.

> The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation). See about this guideline for details.

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1 Recommendations

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

Terms used in this guideline

Advance decision A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.

Advance statement A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

Advocate A person who represents someone's interests independently of any organisation, and helps them to get the care and support they need.

Breakaway techniques A set of physical skills to help separate or break away from an aggressor in a safe manner. They do not involve the use of restraint.

Carer A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled.

Children People aged 12 years or under.

De-escalation The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression. P.r.n. medication can be used as part of a de-escalation strategy but p.r.n. medication used alone is not de-escalation.

Incident Any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

Manual restraint A skilled, hands-on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user.

Mechanical restraint A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts, applied in a skilled manner by designated healthcare

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professionals. Its purpose is to safely immobilise or restrict movement of part(s) of the body of the service user.

Observation A minimally restrictive intervention of varying intensity in which a member of the healthcare staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others. There are different levels of observation, as defined in recommendation 1.4.11.

Positive engagement An intervention that aims to empower service users to actively participate in their care. Rather than 'having things done to' them, service users negotiate the level of engagement that will be most therapeutic.

p.r.n. (pro re nata) When needed. In this guideline, p.r.n. refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to violence or aggression; it does not refer to p.r.n. medication used on its own for rapid tranquillisation during an episode of violence of aggression

Rapid tranquillisation Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Restrictive interventions Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation.

Seclusion Defined in accordance with the Mental Health Act 1983 Code of Practice: 'the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others'.

Violence and aggression A range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

Young people People aged between 13 and 17 years.

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1.1 Principles for managing violence and aggression

Improving service user experience

1.1.1 Use this guideline in conjunction with NICE's guideline on service user experience in adult mental health and:

- work in partnership with service users and their carers
- adopt approaches to care that respect service users' independence, choice and human rights
- increase social inclusion by decreasing exclusionary practices, such as the use of seclusion and the Mental Health Act 1983.

1.1.2 Ensure that the safety and dignity of service users and the safety of staff are priorities when anticipating or managing violence and aggression.

1.1.3 Use of restrictive interventions must be undertaken in a manner that complies with the Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.

1.1.4 Unless a service user is detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation or order under the Mental Capacity Act 2005, health and social care provider organisations must ensure that the use of restrictive interventions does not impose restrictions that amount to a deprivation of liberty.

Staff training

1.1.5 In any setting in which restrictive interventions could be used, health and social care provider organisations should train staff to understand and apply the Human Rights Act 1998, the Mental Capacity Act 2005 and the Mental Health Act 1983.

Involving service users in decision-making

1.1.6 Involve service users in all decisions about their care and treatment, and develop care and risk management plans jointly with them. If a service user is unable or unwilling to participate, offer them the opportunity to review and

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revise the plans as soon as they are able or willing and, if they agree, involve their carer.

1.1.7 Check whether service users have made advance decisions or advance statements about the use of restrictive interventions, and whether a decision-maker has been appointed for them, as soon as possible (for example, during admission to an inpatient psychiatric unit) and take this information into account when making decisions about care.

1.1.8 If a service user has not made any advance decisions or statements about the use of restrictive interventions, encourage them to do so as soon as possible (for example, during admission to an inpatient psychiatric unit). Ensure that service users understand the main side-effect profiles of the medications recommended in this guideline for rapid tranquillisation (see recommendation 1.4.37) so that they can make an informed choice.

1.1.9 Ensure that service users understand that during any restrictive intervention their human rights will be respected and the least restrictive intervention will be used to enable them to exercise their rights (for example, their right to follow religious or cultural practices during restrictive interventions) as much as possible. Identify and reduce any barriers to a service user exercising their rights and, if this is not possible, record the reasons in their notes.

1.1.10 Ensure that carers are involved in decision-making whenever possible, if the service user agrees, and that carers are involved in decision-making for all service users who lack mental capacity, in accordance with the Mental Capacity Act 2005.

Preventing violations of service users' rights

1.1.11 Evaluate, together with the service user, whether adjustments to services are needed to ensure that their rights and those of their carers (including rights related to protected characteristics as defined by the Equality Act 2010) are respected, and make any adjustments that are needed. Adjustments might include providing a particular type of support, modifying the way services are delivered or the approach to interaction with the service user, or making changes to facilities. Record this in the service user's care plan.

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1.1.12 Health and social care provider organisations should train staff in cultural awareness and in the organisation's duties under the Equality Act 2010.

Working with the police

1.1.13 Health and social care provider organisations should work with the police, and local service user groups if possible, to develop policies for joint working and locally agreed operating protocols that cover:

- when and how police enter health or social care settings (including psychiatric and forensic inpatients, emergency departments, general health inpatients, GP surgeries, social care and community settings and 136 place-of-safety suites)
- when and how health and social care professionals enter police cells
- transferring service users between settings.

Review the operating protocols regularly to ensure compliance with the policies and update the policies in light of operational experience.

1.2 Anticipating and reducing the risk of violence and aggression

Reducing the use of restrictive interventions

Staff training

1.2.1 Health and social care provider organisations should train staff who work in services in which restrictive interventions may be used in psychosocial methods to avoid or minimise restrictive interventions. This training should enable staff to develop:

- a person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship
- an understanding of the relationship between mental health problems and the risk of violence and aggression
- skills to assess why behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors

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- skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation)
- skills, methods and techniques to undertake restrictive interventions safely when these are required
- skills to undertake an immediate post-incident debrief (see recommendations 1.4.55–1.4.61)
- skills to undertake a formal external post-incident review in collaboration with experienced service users who are not currently using the service (see recommendations 1.4.62–1.4.63).

Restrictive intervention reduction programme

1.2.2 Health and social care provider organisations should ensure that all services that use restrictive interventions have a restrictive intervention reduction programme (see recommendation 1.2.3) to reduce the incidence of violence and aggression and the use of restrictive interventions.

1.2.3 Restrictive intervention reduction programmes should:

- ensure effective service leadership
- address environmental factors likely to increase or decrease the need for restrictive interventions (see recommendation 1.2.7)
- involve and empower service users and their carers
- include leisure activities that are personally meaningful and physical exercise for service users
- use clear and simple care pathways
- use de-escalation
- use crisis and risk management plans and strategies to reduce the need for restrictive interventions
- include post-incident debrief and review (see recommendations 1.4.55–1.4.61)

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- explore the current and potential use of technology in reporting, monitoring and improving the use of restrictive interventions
- have routine outcome monitoring, including quality of life and service user experience
- be based on outcome measures (safety, effectiveness and service user experience) to support quality improvement programmes
- include regular staff training in line with recommendation 1.2.1.

1.2.4 Health and social care provider organisations should collate, analyse and synthesise all data about violent events and the use of restrictive interventions, and involve service users in the process. The information should:

- be shared with the teams and services involved
- be shared with the trust board or equivalent organisational governing body
- be linked to the standards set in safeguarding procedures.

1.2.5 Health and social care provider organisations should develop a service user experience monitoring unit, or equivalent service user group, led by service users and including staff, to report and analyse data on violence and aggression and the use of restrictive interventions.

1.2.6 Health and social care provider organisations should publish board reports on their public websites that include data about incidents of violence and aggression and use of restrictive interventions within each team, ward and service, and include reasons for the similarities and differences between services.

A framework for anticipating and reducing violence and aggression in inpatient psychiatric wards

1.2.7 Use the following framework to anticipate violence and aggression in inpatient psychiatric wards, exploring each domain to identify ways to reduce violence and aggression and the use of restrictive interventions.

- Ensure that the staff work as a therapeutic team by using a positive and encouraging approach, maintaining staff emotional regulation and self-management (see recommendation 1.3.19) and encouraging good leadership.

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- Ensure that service users are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties.
- Recognise possible teasing, bullying, unwanted physical or sexual contact, or miscommunication between service users.
- Recognise how each service user's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression).
- Anticipate the impact of the regulatory process on each service user, for example, being formally detained, having leave refused, having a failed detention appeal or being in a very restricted environment such as a low-, medium- or high-secure hospital.
- Improve or optimise the physical environment (for example, use unlocked doors whenever possible, enhance the décor, simplify the ward layout and ensure easy access to outside spaces and privacy).
- Anticipate that restricting a service user's liberty and freedom of movement (for example, not allowing service users to leave the building) can be a trigger for violence and aggression.
- Anticipate and manage any personal factors occurring outside the hospital (for example, family disputes or financial difficulties) that may affect a service user's behaviour.

Assessing and managing the risk of violence and aggression

1.2.8 When assessing and managing the risk of violence and aggression use a multidisciplinary approach that reflects the care setting.

1.2.9 Before assessing the risk of violence or aggression:

- Take into account previous violent or aggressive episodes because these are associated with an increased risk of future violence and aggression.
- Do not make negative assumptions based on culture, religion or ethnicity.
- Recognise that unfamiliar cultural practices and customs could be misinterpreted as being aggressive.

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- Ensure that the risk assessment will be objective and take into account the degree to which the perceived risk can be verified.

1.2.10 Carry out the risk assessment with the service user and, if they agree, their carer. If this finds that the service user could become violent or aggressive, set out approaches that address:

- service user-related domains in the framework (see recommendation 1.2.7)
- contexts in which violence and aggression tend to occur
- usual manifestations and factors likely to be associated with the development of violence and aggression
- primary prevention strategies that focus on improving quality of life and meeting the service user's needs
- symptoms or feelings that may lead to violence and aggression, such as anxiety, agitation, disappointment, jealousy and anger, and secondary prevention strategies focusing on these symptoms or feelings
- de-escalation techniques that have worked effectively in the past
- restrictive interventions that have worked effectively in the past, when they are most likely to be necessary and how potential harm or discomfort can be minimised.

1.2.11 Consider using an actuarial prediction instrument such as the BVC (Brøset Violence Checklist) or the DASA-IV (Dynamic Appraisal of Situational Aggression – Inpatient Version), rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan in inpatient psychiatric settings.

1.2.12 Consider offering service users with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

1.2.13 Regularly review risk assessments and risk management plans, addressing the service user and environmental domains listed in recommendation 1.2.7 and following recommendations 1.2.9 and 1.2.10. The regularity of the review should depend on the assessment of the level of risk. Base the care plan on accurate and thorough risk assessments.

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1.2.14 If service users are transferring to another agency or care setting, or being discharged, share the content of the risk assessment with staff in the relevant agencies or care settings, and with carers.

An individualised pharmacological strategy to reduce the risk of violence and aggression

1.2.15 A multidisciplinary team that includes a psychiatrist and a specialist pharmacist should develop and document an individualised pharmacological strategy for using routine and p.r.n. medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an inpatient psychiatric unit.

1.2.16 The multidisciplinary team should review the pharmacological strategy and the use of medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used. The review should be recorded and include:

- clarification of target symptoms
- the likely timescale for response to medication
- the total daily dose of medication, prescribed and administered, including p.r.n. medication
- the number of and reason for any missed doses
- therapeutic response
- the emergence of unwanted effects.

If rapid tranquillisation is being used, a senior doctor should review all medication at least once a day.

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1.3 Preventing violence and aggression

Searching

Developing a policy on searching

1.3.1 Health and social care provider organisations should have an operational policy on the searching of service users, their belongings and the environment in which they are accommodated, and the searching of carers and visitors. The policy should address:

- the reasons for carrying out a search, ensuring that the decision to search is proportionate to the risks
- the searching of service users detained under the Mental Health Act 1983 who lack mental capacity
- the rationale for repeated searching of service users, carers or visitors, for example those who misuse drugs or alcohol
- the legal grounds for, and the methods used when, undertaking a search without consent, including when the person physically resists searching
- which staff members are allowed to undertake searching and in which contexts
- who and what can be searched, including persons, clothing, possessions and environments
- the storage, return and disposal of drugs or alcohol
- how to manage any firearms or other weapons carried by service users, including when to call the police
- links to other related policies such as those on drugs and alcohol, and on police liaison.

1.3.2 Develop and share a clear and easily understandable summary of the policy on searching, for use across the organisation for all service users, carers or visitors who may be searched.

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Carrying out searches

1.3.3 Health and social care provider organisations should ensure that searches are undertaken by 2 members of staff, at least 1 of whom should be the same sex as the person being searched.

1.3.4 When a decision has been made to undertake a search:

- provide the person who is to be searched with the summary of the organisation's policy on searching
- seek consent to undertake the search
- explain what is being done and why throughout the search
- ensure the person's dignity and privacy are respected during the search
- record what was searched, why and how it was searched, and the disposal of any items found.

1.3.5 If a service user refuses to be searched, carry out a multidisciplinary review of the need to perform a search using physical force and explore any consequences in advance. Use physical force only as a last resort.

1.3.6 If consent for a search has not been given, a multidisciplinary review has been conducted and physical force has been used, conduct an immediate post-incident debrief (see recommendations 1.4.55–1.4.61) and a formal external post-incident review (see recommendations 1.4.62–1.4.63) with the service user that includes a visit from an advocacy service or hospital manager.

1.3.7 If a service user is carrying a weapon, ask them to place it in a neutral location rather than handing it over.

1.3.8 If a service user who is at risk of becoming violent or aggressive is in a room or area where there are objects that could be used as weapons, remove the objects or relocate the service user.

1.3.9 Audit the exercise of powers of search and report the outcomes to the trust board or equivalent governing body at least twice a year.

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Using p.r.n. medication

1.3.10 When prescribing p.r.n. medication as part of a strategy to de-escalate or prevent situations that may lead to violence and aggression:

- do not prescribe p.r.n. medication routinely or automatically on admission
- tailor p.r.n. medication to individual need and include discussion with the service user if possible
- ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan
- ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British national formulary (BNF) when combined with the person's standard dose or their dose for rapid tranquillisation
- only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor
- ensure that the interval between p.r.n. doses is specified.

1.3.11 The multidisciplinary team should review p.r.n. medication at least once a week and, if p.r.n. medication is to be continued, the rationale for its continuation should be included in the review. If p.r.n. medication has not been used since the last review, consider stopping it.

De-escalation

Staff training

1.3.12 Health and social care provider organisations should give staff training in de-escalation that enables them to:

- recognise the early signs of agitation, irritation, anger and aggression
- understand the likely causes of aggression or violence, both generally and for each service user
- use techniques for distraction and calming, and ways to encourage relaxation

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- recognise the importance of personal space
- respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation.

General principles

1.3.13 Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.

1.3.14 Separate agitated service users from others (using quiet areas of the ward, bedrooms, comfort rooms, gardens or other available spaces) to aid de-escalation, ensuring that staff do not become isolated.

1.3.15 Use a wide range of verbal and non-verbal skills and interactional techniques to avoid or manage known 'flashpoint' situations (such as refusing a service user's request, asking them to stop doing something they wish to do or asking that they do something they don't wish to do) without provoking aggression.

1.3.16 Encourage service users to recognise their own triggers and early warning signs of violence and aggression and other vulnerabilities, and to discuss and negotiate their wishes should they become agitated. Include this information in care plans and advance statements and give a copy to the service user.

1.3.17 Communicate respect for and empathy with the service user at all stages of de-escalation.

De-escalation techniques

1.3.18 If a service user becomes agitated or angry, 1 staff member should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the service user and negotiate to resolve the situation in a non-confrontational manner.

1.3.19 Use emotional regulation and self-management techniques to control verbal and non-verbal expressions of anxiety or frustration (for example, body posture and eye contact) when carrying out de-escalation.

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1.3.20 Use a designated area or room to reduce emotional arousal or agitation and support the service user to become calm. In services where seclusion is practised, do not routinely use the seclusion room for this purpose because the service user may perceive this as threatening.

1.4 Using restrictive interventions in inpatient psychiatric settings

Restrictive interventions are most likely to be used in inpatient psychiatric settings, but may be used in emergency departments, outpatient services and child and adolescent mental health services (CAMHS).

See implementation: getting started for information about putting the recommendations on manual restraint, rapid tranquillisation and formal external post-incident reviews into practice.

Staff training

1.4.1 Health and social care provider organisations should train staff working in inpatient psychiatric settings to undertake restrictive interventions and understand the risks involved in their use, including the side-effect profiles of the medication recommended for rapid tranquillisation in this guideline, and to communicate these risks to service users.

Staffing and equipment

1.4.2 Health and social care provider organisations should:

- define staff:patient ratios for each inpatient psychiatric ward and the numbers of staff required to undertake restrictive interventions
- ensure that restrictive interventions are used only if there are sufficient numbers of trained staff available
- ensure the safety of staff during the use of restrictive interventions, including techniques to avoid injuries from needles during rapid tranquillisation.

1.4.3 Health and social care provider organisations should ensure that resuscitation equipment is immediately available if restrictive interventions might be used and:

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- include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, suction and first-line resuscitation medications
- maintain equipment and check it every week.

1.4.4 Staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used.

Using restrictive interventions

1.4.5 Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention.

1.4.6 Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.

1.4.7 Ensure that the techniques and methods used to restrict a service user:

- are proportionate to the risk and potential seriousness of harm
- are the least restrictive option to meet the need
- are used for no longer than necessary
- take account of the service user's preferences, if known and it is possible to do so
- take account of the service user's physical health, degree of frailty and developmental age.

Observation

General principles

1.4.8 Staff should be aware of the location of all service users for whom they are responsible, but not all service users need to be kept within sight.

1.4.9 At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the service user. As part of the

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assessment, the nurse should evaluate the impact of the service user's mental state on the risk of violence and aggression, and record any risk in the notes.

Developing a policy on observation

1.4.10 Health and social care provider organisations should have a policy on observation and positive engagement that includes:

- definitions of levels of observation in line with recommendation 1.4.11
- who can instigate, increase, decrease and review observation
- when an observer should be male or female
- how often reviews should take place
- how service users' experience of observation will be taken into account
- how to ensure that observation is underpinned by continuous attempts to engage therapeutically
- the levels of observation necessary during the use of other restrictive interventions (for example, seclusion)
- the need for multidisciplinary review when observation continues for 1 week or more.

Levels of observation

1.4.11 Staff in inpatient psychiatric wards (including general adult wards, older adult wards, psychiatric intensive care units and forensic wards) should use the following definitions for levels of observation, unless a locally agreed policy states otherwise.

- Low-level intermittent observation: the baseline level of observation in a specified psychiatric setting. The frequency of observation is once every 30–60 minutes.
- High-level intermittent observation: usually used if a service user is at risk of becoming violent or aggressive but does not represent an immediate risk. The frequency of observation is once every 15–30 minutes.

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- Continuous observation: usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated one-to-one nurse, with immediate access to other members of staff if needed.
- Multiprofessional continuous observation: usually used when a service user is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.

Using observation

1.4.12 Use observation only after positive engagement with the service user has failed to dissipate the risk of violence and aggression.

1.4.13 Recognise that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation.

1.4.14 Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.

1.4.15 Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the service user agrees, tell their carer about the aims and level of observation.

1.4.16 Record decisions about observation levels in the service user's notes and clearly specify the reasons for the observation.

1.4.17 When deciding on levels of observation take into account:

- the service user's current mental state
- any prescribed and non-prescribed medications and their effects
- the current assessment of risk
- the views of the service user, as far as possible.

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1.4.18 Record clearly the names and titles of the staff responsible for carrying out a review of observation levels (see recommendation 1.4.11) and when the review should take place.

1.4.19 Staff undertaking observation should:

- take an active role in engaging positively with the service user
- be appropriately briefed about the service user's history, background, specific risk factors and particular needs
- be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment
- be approachable, listen to the service user and be able to convey to the service user that they are valued.

1.4.20 Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours. If observation is needed for longer than 2 hours, ensure the staff member has regular breaks.

1.4.21 When handing over to another staff member during a period of observation, include the service user in any discussions during the handover if possible.

1.4.22 Tell the service user's psychiatrist or on-call doctor as soon as possible if observation above the general level is carried out (see recommendation 1.4.11).

Manual restraint

1.4.23 Health and social care provider organisations should ensure that manual restraint is undertaken by staff who work closely together as a team, understand each other's roles and have a clearly defined lead.

1.4.24 When using manual restraint, avoid taking the service user to the floor, but if this becomes necessary:

- use the supine (face up) position if possible **or**
- if the prone (face down) position is necessary, use it for as short a time as possible.

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1.4.25 Do not use manual restraint in a way that interferes with the service user's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose.

1.4.26 Do not use manual restraint in a way that interferes with the service user's ability to communicate, for example by obstructing the eyes, ears or mouth.

1.4.27 Undertake manual restraint with extra care if the service user is physically unwell, disabled, pregnant or obese.

1.4.28 Aim to preserve the service user's dignity and safety as far as possible during manual restraint.

1.4.29 Do not routinely use manual restraint for more than 10 minutes.

1.4.30 Consider rapid tranquillisation or seclusion as alternatives to prolonged manual restraint (longer than 10 minutes).

1.4.31 Ensure that the level of force applied during manual restraint is justifiable, appropriate, reasonable, proportionate to the situation and applied for the shortest time possible.

1.4.32 One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are:

- able to protect and support the service user's head and neck, if needed
- able to check that the service user's airway and breathing are not compromised
- able to monitor vital signs
- supported throughout the process.

1.4.33 Monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint.

Mechanical restraint

1.4.34 Health and social care provider organisations should ensure that mechanical restraint in adults is used only in high-secure settings (except when transferring

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service users between medium- and high-secure settings as in recommendation 1.4.36) and its use is reported to the trust board.

1.4.35 Use mechanical restraint only as a last resort and for the purpose of:

- managing extreme violence directed at other people **or**
- limiting self-injurious behaviour of extremely high frequency or intensity.

1.4.36 Consider mechanical restraint, such as handcuffs, when transferring service users who are at high risk of violence and aggression between medium- and high-secure settings. In this context, restraint should be clearly planned as part of overall risk management.

Rapid tranquillisation

Rapid tranquillisation in this guideline refers to the use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

1.4.37 Use either intramuscular lorazepam on its own or intramuscular haloperidol combined with intramuscular promethazine for rapid tranquillisation in adults. When deciding which medication to use, take into account:

- the service user's preferences or advance statements and decisions
- pre-existing physical health problems or pregnancy
- possible intoxication
- previous response to these medications, including adverse effects
- potential for interactions with other medications
- the total daily dose of medications prescribed and administered.

1.4.38 If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, use intramuscular lorazepam.

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1.4.39 If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.

1.4.40 If there is a partial response to intramuscular lorazepam, consider a further dose.

1.4.41 If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine.

1.4.42 If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, consider a further dose.

1.4.43 If there is no response to intramuscular haloperidol combined with intramuscular promethazine, consider intramuscular lorazepam if this hasn't been used already during this episode. If intramuscular lorazepam has already been used, arrange an urgent team meeting to carry out a review and seek a second opinion if needed.

1.4.44 When prescribing medication for use in rapid tranquillisation, write the initial prescription as a single dose, and do not repeat it until the effect of the initial dose has been reviewed.

1.4.45 After rapid tranquillisation, monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user:

- appears to be asleep or sedated
- has taken illicit drugs or alcohol
- has a pre-existing physical health problem
- has experienced any harm as a result of any restrictive intervention.

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Seclusion

1.4.46 Use seclusion in adults only if the service user is detained in accordance with the Mental Health Act 1983. If a service user not detained under the Mental Health Act 1983 is secluded in an emergency, arrange a mental health assessment under the Mental Health Act 1983 immediately.

1.4.47 Services that use seclusion should have a designated seclusion room that:

- allows staff to clearly observe and communicate with the service user
- is well insulated and ventilated, with temperature controls outside the room
- has access to toilet and washing facilities
- has furniture, windows and doors that can withstand damage.

Carrying out seclusion

1.4.48 Record the use of seclusion in accordance with the Mental Health Act 1983 Code of Practice.

1.4.49 Ensure that seclusion lasts for the shortest time possible. Review the need for seclusion at least every 2 hours and tell the service user that these reviews will take place.

1.4.50 Set out an observation schedule for service users in seclusion. Allocate a suitably trained member of staff to carry out the observation, which should be within eyesight as a minimum.

1.4.51 Ensure that a service user in seclusion keeps their clothing and, if they wish, any personal items, including those of personal, religious or cultural significance, unless doing so compromises their safety or the safety of others.

Rapid tranquillisation during seclusion

1.4.52 If rapid tranquillisation is needed while a service user is secluded, undertake with caution following recommendations 1.4.37–1.4.45 and:

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- be aware of and prepared to address any complications associated with rapid tranquillisation
- ensure the service user is observed within eyesight by a trained staff member
- undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect.

Post-incident debrief and formal review

In this guideline an incident is defined as any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation) – to manage violence or aggression.

1.4.53 Health and social care provider organisations should ensure that wards have sufficient staff with a mix of skills and seniority levels that enable them to:

- conduct an immediate post-incident debrief (see recommendations 1.4.55–1.4.61)
- monitor and respond to ongoing risks, and contribute to formal external post-incident reviews (see recommendations 1.4.62–1.4.63).

1.4.54 The trust board or equivalent governing body should ensure that it receives regular reports from each ward about violent incidents, the use of restrictive interventions, service users' experience of those interventions and the learning gained.

Immediate post-incident debrief

1.4.55 After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post-incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.

1.4.56 Use the framework outlined in recommendation 1.2.7 to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.

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1.4.57 Advise the service user experience monitoring unit, or equivalent service user group, to start a formal external post-incident review.

1.4.58 Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer. Offer the service user the opportunity to write their perspective of the event in the notes.

1.4.59 Ensure that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened.

1.4.60 Ensure that all staff involved in the incident have the opportunity to discuss their experience with staff who were not involved.

1.4.61 Discuss the incident with service users, witnesses and staff involved only after they have recovered their composure and aim to:

- acknowledge the emotional responses to the incident and assess whether there is a need for emotional support for any trauma experienced
- promote relaxation and feelings of safety
- support a return to normal patterns of activity
- ensure that everyone involved in the service user's care, including their carers, has been informed of the event, if the service user agrees.

Ensure that the necessary documentation has been completed.

Formal external post-incident review

1.4.62 The service user experience monitoring unit or equivalent service user group should undertake a formal external post-incident review as soon as possible and no later than 72 hours after the incident. The unit or group should ensure that the formal external post-incident review:

- is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame

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- uses the information recorded in the immediate post-incident debrief and the service user's notes relating to the incident
- includes interviews with staff, the service user involved and any witnesses if further information is needed
- uses the framework in recommendation 1.2.7 to:
  - evaluate the physical and emotional impact on everyone involved, including witnesses
  - help service users and staff to identify what led to the incident and what could have been done differently
  - determine whether alternatives, including less restrictive interventions, were discussed
  - determine whether service barriers or constraints make it difficult to avoid the same course of actions in future
  - recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate
- avoid a similar incident happening in future, if possible.

1.4.63 The service user experience monitoring unit or equivalent service user group should give a report to the ward that is based on the formal external post-incident review.

1.5 Managing violence and aggression in emergency departments

For guidance on manual restraint and rapid tranquillisation, which may be used in emergency departments, see recommendations 1.4.23–1.4.33 and recommendations 1.4.37–1.4.45 respectively. Emergency department staff may also be involved in immediate post-incident debriefs (see recommendations 1.4.55–1.4.61).

Liaison mental health

1.5.1 Healthcare provider organisations and commissioners should ensure that every emergency department has routine and urgent access to a multidisciplinary liaison team that includes consultant psychiatrists and registered psychiatric

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nurses who are able to work with children, young people, adults and older adults.

1.5.2 Healthcare provider organisations should ensure that a full mental health assessment is available within 1 hour of alert from the emergency department at all times.

Staff training

1.5.3 Healthcare provider organisations should train staff in emergency departments in methods and techniques to reduce the risk of violence and aggression, including anticipation, prevention and de-escalation.

1.5.4 Healthcare provider organisations should train staff in emergency departments in mental health triage.

1.5.5 Healthcare provider organisations should train staff in emergency departments to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses).

Staffing

1.5.6 Healthcare provider organisations should ensure that, at all times, there are sufficient numbers of staff on duty in emergency departments who have training in the management of violence and aggression in line with this guideline.

Preventing violence and aggression

1.5.7 Undertake mental health triage for all service users on entry to emergency departments, alongside physical health triage.

1.5.8 Healthcare provider organisations should ensure that emergency departments have at least 1 designated interview room for mental health assessment that:

- is close to or part of the main emergency department receiving area
- is made available for mental health assessments as a priority
- can comfortably seat 6 people

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- is fitted with an emergency call system, an outward opening door and a window for observation
- contains soft furnishings and is well ventilated
- contains no potential weapons.

1.5.9 Staff interviewing a person in the designated interview room should:

- inform a senior member of the emergency nursing staff before starting the interview
- make sure another staff member is present.

Managing violence and aggression

1.5.10 If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with recommendations 1.4.1–1.4.45 and do not use seclusion. Regard the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.

1.6 Managing violence and aggression in community and primary care settings

For guidance on manual restraint, which may be used by ambulance staff, see recommendations 1.4.23–1.4.33. Ambulance staff may also be involved in immediate post-incident debriefs (see recommendations 1.4.55–1.4.61).

Developing policies

1.6.1 Health and social care provider organisations, including ambulance trusts, should ensure that they have up-to-date policies on the management of violence and aggression in people with mental health problems, and on lone working, in community and primary care settings, in line with this guideline.

Staff training

1.6.2 Health and social care provider organisations, including ambulance trusts, should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-

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escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting and the extent to which staff move between settings.

1.6.3 Health and social care provider organisations, including ambulance trusts, should ensure that staff working in community and primary care settings are able to undertake a risk assessment for violence and aggression in collaboration with service users known to be at risk and their carers if possible. The risk assessment should be available for case supervision and in community teams it should be subject to multidisciplinary review.

Managing violence and aggression

1.6.4 After a risk assessment has been carried out, staff working in community and primary care settings should:

- share the risk assessment with other health and social care services and partner agencies (including the police and probation service) who may be involved in the person's care and treatment, and with carers if there are risks to them
- be aware of professional responsibilities in relation to limits of confidentiality and the need to share information about risks.

1.6.5 In community settings, carry out Mental Health Act 1983 assessments with a minimum of 2 people, for example a doctor and a social worker.

1.6.6 Community mental health teams should not use manual restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police.

1.7 Managing violence and aggression in children and young people

Staff training

1.7.1 Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of violence and aggression using a training programme designed specifically for staff working with children and young

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people. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible. Staff who might undertake restrictive interventions should be trained:

- in the use of these interventions in these age groups
- to adapt the manual restraint techniques for adults in recommendations 1.4.23–1.4.33, adjusting them according to the child or young person's height, weight and physical strength
- in the use of resuscitation equipment (see recommendation 1.4.3) in children and young people.

1.7.2 CAMHS should have a clear and consistently enforced policy about managing antisocial behaviour and ensure that staff are trained in psychosocial and behavioural techniques for managing the behaviour.

1.7.3 CAMHS staff should be familiar with the Children Act 1989 and 2004 and the Mental Health Act 1983, as well as the Mental Capacity Act 2005 and the Human Rights Act 1998. They should also be aware of the United Nations Convention on the Rights of the Child.

Managing violence and aggression

1.7.4 Manage violence and aggression in children and young people in line with the recommendations for adults in sections 1.1–1.6, taking into account:

- the child or young person's level of physical, intellectual, emotional and psychological maturity
- the recommendations for children and young people in this section
- that the Mental Capacity Act 2005 applies to young people aged 16 and over.

1.7.5 Collaborate with those who have parental responsibility when managing violence and aggression in children and young people.

1.7.6 Use safeguarding procedures to ensure the child or young person's safety.

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1.7.7 Involve the child or young person in making decisions about their care whenever possible.

Assessment and initial management

1.7.8 Assess and treat any underlying mental health problems in line with relevant NICE guidelines, including those on antisocial behaviour and conduct disorders in children and young people, attention deficit hyperactivity disorder, psychosis and schizophrenia in children and young people, autism diagnosis in children and young people and autism.

1.7.9 Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression.

1.7.10 Identify cognitive, language, communication and cultural factors that may increase the risk of violence or aggression in a child or young person.

1.7.11 Consider offering children and young people with a history of violence or aggression psychological help to develop greater self-control and techniques for self-soothing.

1.7.12 Offer support and age-appropriate interventions (including parent training programmes) in line with the NICE guideline on antisocial behaviour and conduct disorders in children and young people to parents of children and young people whose behaviour is violent or aggressive.

De-escalation

1.7.13 Use de-escalation in line with recommendations 1.3.12–1.3.20 for adults, modified for children and young people, and:

- use calming techniques and distraction
- offer the child or young person the opportunity to move away from the situation in which the violence or aggression is occurring, for example to a quiet room or area
- aim to build emotional bridges and maintain a therapeutic relationship.

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Restrictive interventions

1.7.14 Use restrictive interventions only if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent.

1.7.15 When restrictive interventions are used, monitor the child or young person's wellbeing closely and continuously, and ensure their physical and emotional comfort.

1.7.16 Do not use punishments, such as removing contact with parents or carers or access to social interaction, withholding nutrition or fluids, or corporal punishment, to force compliance.

Manual restraint

1.7.17 If possible, allocate a staff member who is the same sex as the child or young person to carry out manual restraint.

Mechanical restraint

1.7.18 Do not use mechanical restraint in children.

1.7.19 Healthcare provider organisations should ensure that, except when transferring young people between medium- and high-secure settings (as in recommendation 1.7.20), mechanical restraint in young people is used only in high-secure settings (on those occasions when young people are being treated in adult high-secure settings), in accordance with the Mental Health Act 1983 and with support and agreement from a multidisciplinary team that includes a consultant psychiatrist in CAMHS.

1.7.20 Consider using mechanical restraint, such as handcuffs, when transferring young people who are at high risk of violence or aggression between medium- and high-secure settings, and remove the restraint at the earliest opportunity.

Rapid tranquillisation

1.7.21 Use intramuscular lorazepam for rapid tranquillisation in a child or young person and adjust the dose according to their age and weight[1].

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1.7.22 If there is only a partial response to intramuscular lorazepam, check the dose again according to the child or young person's age and weight and consider a further dose.

1.7.23 Monitor physical health and emotional impact continuously when undertaking rapid tranquillisation in a child or young person.

Seclusion

1.7.24 Decisions about whether to seclude a child or young person should be approved by a senior doctor and reviewed by a multidisciplinary team at the earliest opportunity.

1.7.25 Report all uses of seclusion to the trust board or equivalent governing body.

1.7.26 Do not seclude a child in a locked room, including their own bedroom.

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[1] At the time of publication (May 2015), lorazepam did not have a UK marketing authorisation for use in children and young people for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.

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2 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline.

2.1 Medication for promoting de-escalation

Which medication is effective in promoting de-escalation in people who are identified as likely to demonstrate significant violence?

Why this is important

Although there are studies that demonstrate the value of medication in the management of violence and aggression, there is little information on management before violence becomes overt. Often p.r.n. medication is given at this point but there is little evidence of efficacy. It is clearly preferable to avoid violence whenever possible.

This question should be addressed by a randomised controlled trial in which people at risk of becoming violent are randomised, with their consent, to 1 or more of the medications commonly used to effect rapid tranquillisation or other medication not normally used for this purpose. Outcomes should include measures of violence, degree of sedation, acceptability of the medication and adverse effects, all recorded over a suitable timescale to match the pharmacokinetic properties of the drugs.

2.2 Violence related to drug or alcohol misuse

What is the best environment in which to contain violence in people who have misused drugs or alcohol?

Why this is important

There are major problems in managing drug- and alcohol-related violence. The risk of severe violence can last for many hours in people who have misused drugs and alcohol and most settings in which violence takes place (such as emergency departments) do not have the facilities needed to contain people for several hours with an adequate level of supervision. As a consequence many people are taken, often inappropriately, to police cells. It is likely that there are less expensive and more effective environments available for this purpose.

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Data about the size of this problem and an epidemiological survey of its frequency and duration, as well as current methods of managing drug- and alcohol-related violence, are needed to start answering this question.

2.3 Advance statements and decisions

What forms of management of violence and aggression do service users prefer and do advance statements and decisions have an important role in management and prevention?

Why this is important

There are widely differing opinions among service users about the best way of managing violence and decisions are often made according to personal preference. Advance statements and decisions are not widely used, although they might have an important role in management and prevention.

The question could be answered by randomising people who are at risk of becoming violent or who have demonstrated repeated violence into 2 groups: a control group with no advance statements and decisions, and a group who make advance statements and decisions indicating the forms of management they prefer and those they do not want. The subsequent frequency of violent episodes and their outcomes could then be compared.

2.4 Content and nature of effective de-escalation

What is the content and nature of effective de-escalatory actions, interactions and activities used by mental health nurses, including the most effective and efficient means of training nurses to use them in a timely and appropriate way?

Why this is important

Although it is regularly recommended, there has been little research on the nature and efficacy of verbal and non-verbal de-escalation for adults with mental health problems who become agitated. Research is needed to systematically describe current techniques for de-escalation and develop and test these techniques with adults who have cognitive impairment or psychosis. In addition, research should be carried out to develop methods of training staff and test the outcomes of these methods.

There is a similar lack of research on the nature and efficacy of verbal and non-verbal de-escalation of seriously agitated children and young people with mental health problems. These techniques

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need to take account of and be adapted to the specific background, developmental/cognitive and psychiatric characteristics of this age group. Additional research should therefore be commissioned on the lines recommended for adults. The research should systematically describe expert practice in adults, develop and test those techniques in aroused children and young people with mental health problems, and develop and test different methods of training staff working with children and young people with mental health problems.

2.5 Long duration or very frequent manual restraint

In what circumstances and how often are long-duration or repeated manual restraint used, and what alternatives are there that are safer and more effective?

Why this is important

Adults who are agitated and violent sometimes continue to struggle and fight during manual restraint and rapid tranquillisation may fail. This results in long periods of restraint and further doses of medication. These occurrences are used as justifications for seclusion and, very rarely, for the use of mechanical restraint if repeat episodes occur. Yet there is no information about the frequency of such events or the demography and symptomatology of the adults who are subject to such measures. Exploratory survey work should be commissioned as a matter of urgency to assess the scope of this problem and potential measures for prevention or alternative management that minimise excessive, severe and risky containment methods.

The reasons why children and young people with mental health problems need long-duration or very frequent manual restraint may be expected to vary from those in adults but have similarly been little investigated. Exploratory survey work should therefore specifically address the scope of this problem as it affects children and young people and assess potential measures for prevention or alternative management that minimise any existing excessive, severe or risky containment methods.

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3 Other information

3.1 Scope and how this guideline was developed

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guideline. The Centre established a Guideline Development Group (see section 4), which reviewed the evidence and developed the recommendations.

The methods and processes for developing NICE clinical guidelines are described in the guidelines manual.

3.2 Related NICE guidance

Further information is available on the NICE website.

General

- Smoking cessation in secondary care (2013) NICE guideline PH48
- Patient experience in adult NHS services (2012) NICE guideline CG138
- Service user experience in adult mental health (2011) NICE guideline CG136
- Medicines adherence (2009) NICE guideline CG76

Condition-specific

- Challenging behaviour and learning disabilities (2015) NICE guideline NG11.
- Psychosis and schizophrenia in adults (2014) NICE guideline CG178
- Antisocial behaviour and conduct disorders in children and young people (2013) NICE guideline CG158
- Psychosis and schizophrenia in children and young people (2013) NICE guideline CG155
- Attention deficit hyperactivity disorder (2008) NICE guideline CG72

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- Drug misuse - opioid detoxification (2007) NICE guideline CG52
- Drug misuse - psychosocial interventions (2007) NICE guideline CG51
- Dementia (2006) NICE guideline CG42
- Self-harm (2004) NICE guideline CG16

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4 The Guideline Development Group, National Collaborating Centre and NICE project team, and declarations of interests

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4.4 Declarations of interests

The following members of the Guideline Development Group made declarations of interests. All other members of the Group stated that they had no interests to declare. The conflicts of interest policy (2007) was followed until September 2014, when an updated policy was published.

Member	Interest declared	Type of interest	Decision taken
Peter Tyrer	Wife has a pecuniary interest in Anxiety and Worry Service Ltd.	Personal family interest	Declare and participate
Peter Tyrer	Director (unpaid) of Anxiety and Worry Service Ltd. Chair of NIDUS-UK (charity for mental health reform).	Personal non-pecuniary interest	Declare and participate
Len Bowers	Accepted paid speaking engagement for a conference run by CPI (Crisis Prevention International).	Personal pecuniary interest	Declare and participate
Len Bowers	Author of many systematic reviews in this area, creator of the Safewards model and interventions, and the Principal Investigator of the Safewards trial.	Personal non-pecuniary interest	Declare and participate

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Mike Hunter	[Non-specific]: Local principal investigator for a randomised controlled trial of an investigational medicinal product for schizophrenia sponsored by Amgen Ltd. This study has been adopted in the NHS through the Mental Health Research Network.	Non-personal pecuniary interest	Declare and participate
Catherine King	Occasional paid reviews for booklets for Mind.	Personal pecuniary interest	Declare and participate
Catherine King	Member of Mind.	Personal non-pecuniary interest	Declare and participate
Peter Pratt	Chaired College of Mental Health Pharmacy session (morning only, on 8 November 2014). Last minute stand-in for presenter who was unable to present. Received a small honorarium payment plus travel expenses.	Personal pecuniary interest	Declare and participate
Faisil Sethi	Sponsored by Janssen to attend the American Psychiatric Association Annual Meeting, May 2013. The sponsorship covered reasonable costs for travel, accommodation and registration at the conference; did not conduct any work for Janssen nor receive any speaker fees. Speaker fee and sponsorship by the University Psychiatric Centre of Hvidore in Copenhagen to give Psychiatric Intensive Care lecture at their conference, November 2013. The sponsorship covered reasonable costs for travel, accommodation and registration at the conference.	Personal pecuniary interest	Declare and participate
Faisil Sethi	Vice Chair and member of the Executive Committee of the National Association of Psychiatric Intensive Care Units (NAPICU). Elected member of the Executive Committee of the General Adult Faculty of the Royal College of Psychiatrists.	Personal non-pecuniary interest	Declare and participate

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Implementation: getting started

While developing this guideline, the Guideline Development Group identified 13 recommendations in 6 areas as key priorities for implementation. With input from stakeholders, experts and health professionals, 3 areas were identified as having a big impact on practice and being challenging to implement. This section highlights some important changes to practice that may result from implementing the guideline. However, other changes to practice may be needed to fully implement the guideline.

Staff working in inpatient mental health and emergency care settings may be particularly affected by these changes.

Manual restraint

See recommendations 1.4.4–1.4.6, 1.4.24 and 1.4.29.

Potential impact of implementation

This guideline recommends that taking service users to the floor during manual restraint should be avoided, but that if it is necessary, the supine (face up) position should be used in preference to the prone (face down) position. The Winterbourne View Hospital: Department of Health review and response reported that restraint was being used to abuse service users. Mind's Mental health crisis care: physical restraint in crisis found that restrictive interventions were being used for too long, often not as a last resort, and sometimes purposely to inflict pain, humiliate or punish. Mind also reported that in 2011/12 the prone position was being used, in some trusts as many as 2 to 3 times a day. This position can, and has, caused death after as little as 10 minutes, by causing a cardiac event. Consistent implementation of these recommendations will save lives, improve safety and minimise distress for all involved.

Challenges for implementation

- Higher staffing levels will be needed in some settings to successfully implement these recommendations, particularly ensuring that a doctor trained to use emergency equipment is immediately available if manual restraint might be used.
- Training will be needed in psychosocial interventions to avoid or minimise the use of restrictive interventions, and about why manual restraint, when used, should last no longer than 10 minutes.

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Support for implementation

- Section 1.2 of this guideline outlines how to reduce the use of restrictive interventions, including manual restraint, and other methods that can be used to reduce the risk of violence and aggression. It includes a framework for anticipating and reducing violence and aggression in inpatient psychiatric wards.
- The Department of Health's Positive and safe programme promotes a reduction in the use of restrictive interventions. Positive and proactive care: reducing the need for restrictive interventions (Department of Health) and A positive and proactive workforce (Department of Health, Skills for Care and Skills for Health) provide a framework to help staff working in health and social care settings to change their culture, leadership and professional practice to deliver care and support that keeps people safe and promotes recovery.
- The Mental Health Act 1983 Code of Practice provides guidance for professionals as well as guidance about for service users, their families and carers about their rights.

Rapid tranquillisation

See recommendations 1.4.37–1.4.45.

Potential impact of implementation

Rapid tranquillisation is defined in this guideline as the administration of sedative medication by injection, and although a number of effective agents are available for sedation, there is no evidence showing clear superiority for any one agent. Therefore individualised treatment needs to be emphasised, taking into account the service user's view, pre-existing physical health problems, previous response to medications including adverse effects, the potential for interactions with other medications, and the total daily dose of medications prescribed and administered. Intramuscular lorazepam is recommended for service users who have not taken antipsychotic medication before because it is an effective intervention that is likely to be acceptable to the majority of service users. Prescribing the initial dose of rapid tranquillisation as a single dose will ensure that any subsequent treatment options can be individualised, taking account of both response and any emergent adverse effects of the initial treatment choice.

Challenges for implementation

- During development of the guideline it became known that the manufacturer of intramuscular olanzapine had decided to withdraw the product from the UK market, and so the Guideline Development Group would not be able to make recommendations for its use. However, it

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remains a licensed product in the European Union (EU) and some organisations import the product from elsewhere in the EU.

- Local rapid tranquillisation policies and protocols will need revision and healthcare professionals will need educating in how these differ from previous versions. It may also be necessary to emphasise the need to tailor the choice of medication for rapid tranquillisation to the individual. Where rapid tranquillisation is used, adequate numbers of skilled staff should be available to monitor the outcome of the intervention in order to make an individualised decision about subsequent choice of medication and dose frequency.

Support for implementation

- The rationale for the recommendations is described in section 6.5.1 of the full guideline.
- The cost difference between medication options is not large and the most cost-effective strategy is likely to be one that tailors treatment to the individual, taking into account their preferences, current medication and medication history.
- The use of intramuscular lorazepam for service users who have not taken antipsychotic medication before is supported because of its favourable benefit:harm profile.
- Although it is possible to import intramuscular olanzapine into the UK as an EU-licensed product, the Guideline Development Group was unable to comment on the use of this preparation because the manufacturer had withdrawn it from the UK market.
- These recommendations do not preclude the use of alternative treatment options. However, their use should be tailored to the individual in line with the recommendations for rapid tranquillisation.
- The summary of product characteristics for haloperidol recommends a baseline electrocardiogram (ECG). If an ECG is not available the prescriber should consider the risks and benefits of using this treatment and be able to justify their prescribing decision, because it may be considered an off-label use.

Formal external post-incident reviews

See recommendations 1.4.53–1.4.63.

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Potential impact of implementation

Formal external post-incident reviews are an important aid in identifying the causes and effects of violence if restraint is needed to contain a situation, and the impact of this on all involved. Full recording of incidents of violence and aggression is currently variable and therefore it is difficult to get a clear picture nationally. In Mental health crisis care: physical restraint in crisis Mind reported responses from freedom of information requests made to all 54 mental health trusts in England in 2013 about the use of prone restraint. Of these, 27 trusts did not record this information.

The information gathered during a review can inform future service delivery and, on an individual level, any further work with the service user involved to make it less likely that a similar event will happen again. Use of formal external post-incident reviews could lead to safety improvements for staff and service users, and save costs to the service long-term if, as a result of the review, positive changes are made to avoid such situations in the future.

Challenges for implementation

- In organisations where formal external post-incident reviews are not carried out routinely, new policies and processes will need to be developed; staff will need to be trained to carry out the reviews and service users will need to be supported to take part in this process.
- Additional training and guidance will be needed about when and how to approach service users to include them in the process in ways that meet their needs.
- Getting all of the necessary staff, including a doctor, in addition to volunteers and service users to participate in the review process may have an impact on current workload and service capacity.
- In some settings there can be many incidents in a short time. In such circumstances implementing the 72-hour follow-up may be more challenging.

Support for implementation

- The framework outlined in recommendation 1.2.7 can be used to determine the factors that contributed to an incident that involved using a restrictive intervention.
- No economic evidence was found on post-incident management strategies. Clear costs are incurred when considering the staff time needed to deliver comprehensive post-incident reviews. These costs may be recouped by the potential for improved relationships and better understanding of events, allowing safer and more adaptive practice in the future.

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Further resources

Further resources are available from NICE that may help to support implementation.

Practice examples from organisations that have implemented these recommendations are available from the NICE local practice collection.

The NICE Into practice guide provides practical advice on how to use NICE guidance and related quality standards, for commissioners and practitioners working in health and social care.

Uptake data about guideline recommendations and quality standard measures are available on the NICE website.

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About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions.

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

This guideline was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists. The Collaborating Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), service users and carers, and technical staff, which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in the guidelines manual.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Update information

This guideline updates and replaces NICE guideline CG25 (published February 2005).

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

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For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also person-centred care).

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer…') when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Other versions of this guideline

The full guideline, 'Violence and aggression: short-term management in mental health, health and community settings' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health.

The recommendations from this guideline have been incorporated into a NICE pathway.

We have produced information for the public about this guideline.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when

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exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summaries of product characteristics of any drugs.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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