Section 1 General Aspects of Management

Section 1: General Advice and Recommendations

This section sets the tone for the rest of this book. The management of the threat of violence is a highly individual matter that cannot be decided unilaterally by any official guidance. But all management requires a framework within which practitioners have to work, only going outside it under exceptional circumstances. In Chapter 1, Eric Baskind makes a bold attempt to bring all together with the suggestion of a common set of guidelines, as violence can show itself, often Medusa-like in its sudden venom, in every possible setting. So, it is wise to have a common policy of management. But we are not there yet, and Chapter 2 tells us exactly where we are at present in terms of legislation, a subject that changes often and which depends on the locality. This is an excellent aide-memoire to those who organise management programmes and need to ensure that they are both legal and justified.

Chapter 3 explores the hinterland of violence, the territory where the effects of violence or its threat can affect others of all ages. Safeguarding is an essential element here; we may not be able to prevent all violence but good safeguarding can nullify its effects.

Chapter 4 describes the advice given by the National Institute for Health and Clinical Excellence (NICE), which requires all services to follow in England and Wales but with some modifications in Scotland and Northern Ireland. It also includes a section on risk and its management, one of the most difficult subjects in the study of violence, as so much of risk is dependent on individual circumstances that cannot be anticipated. Standard assessments of risk are suspect and we need more dynamic assessments that do not just rely on often distant past behaviour.

The last part of this section (Chapter 5) describes what should take place in a service after a significant incident of violence. Post-incident review of a violent episode is an essential part of management, not a luxury to be taken on at some distant point in the future when time permits, as almost invariably such reviews show what might have been done differently to either prevent or minimise the violent episode. Lessons are always learnt from a good post-incident review; it can be a powerful brake on repetition.

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Chapter 1

The Need for a Common Set of Guidelines

Eric Baskind

Violence and aggression never present themselves in a vacuum, yet this is typically the way policymakers approach the subject, its prevention and its management. Although guidelines exist in different sectors, apart from a few common messages, too often little or no consideration is given to many of the wider issues in play, particularly the use of restraint whenever it becomes necessary.

Numerous commentators have described the harm that can result from restraint. It has been described as inherently dangerous [1] and, even if used appropriately, can result in physiological and/or physical harm [2]. Restraint can be '*humiliating, terrifying and even life-threatening*' [3; emphasis added]. Accordingly, with the exception of acting in self-defence, the use of physical interventions should be based on a careful assessment that it will cause less harm than not intervening.

Because the risk of serious harm is greater the longer the restraint is applied, it is generally accepted that the safest way of bringing a violent person under control is rapid initial restraint, carried out by those who have had proper training [4, 5]. Any suggestion that such an approach to gaining control is excessive is misconceived because the use of forceful restraint is only needed in cases of significant violence: minor incidents should not need any forceful restraint and, in most cases, require no physical intervention at all. When considering the question of safety, it is important to consider the safety of all parties: an intervention that reduces risk for patients but places staff and others at risk is undesirable and detrimental to the overall safety and efficient management of the service.

In comparison to other settings, the use of restrictive interventions in healthcare services is highly regulated, and rightly so. For example, in the United Kingdom, the National Institute of Health and Care Excellence (NICE) Guideline NG10, 'Violence and aggression: Short-term management in mental health, health and community settings', aims 'to safeguard both staff and people who use services by helping to prevent violent situations and providing guidance to manage them safely when they occur'. Since April 2021, certification of training services has been a requirement for certain NHS-commissioned services, and the Care Quality Commission (CQC) will expect regulated services to use certified training [6].

The call for the regulating and accrediting of the use of physical interventions is not new and in recent years has become more vocal. At the 2013 Royal College of Nursing (RCN) Annual Congress, the motion 'That this meeting of RCN Congress asks Council to lobby UK governments to review, accredit and then regulate national guidelines of approved models of physical restraint' was passed by 99.8% of delegates.

For any common guidelines to be beneficial they need to be universally adopted, and this requires the broad support of those who will be affected by them, including staff and the users of the services. They also need to take account of the best available evidence. There are

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many examples where the evidence has not been followed, leading to confusion and uncertainty. A good example of this confusion concerns the so-called banning of prone restraint and pain-compliance interventions, as well as the curious antipathy towards mechanical restraining devices, even in circumstances where these kinds of intervention might be the safest and least restrictive methods, taking into account all the circumstances of an incident.

The Winterbourne View scandal [7] brought the question of prone restraint into public focus. Despite Winterbourne being principally about the abuse of its vulnerable residents rather than restraint per se, the subsequent serious case review made the following recommendation in relation to restraint positions: 'The Department of Health, Department for Education and the Care Quality Commission should consider banning the t-supine restraint of adults with learning disabilities and autism in hospitals and assessment and treatment units' [7, p. 135]. T-supine restraint is a face-up position and is defined in the report as 'restraint that results in people being placed on the ground with staff using their body weight to subdue them' [7, p. xi].

Just how a recommendation to *consider* banning a kind of supine restraint led to an attempt to ban prone restraint remains debatable, yet provides further evidence of the confusion amongst policymakers. Yet further confusion can be seen in the backtracking of the policy to ban positions of prone restraint in subsequent guidelines, policies and announcements, with the Department of Health stating that what people considered to be a ban was no more than guidance. Widespread (but by no means universal) concern was expressed by practitioners as to this so-called ban, and it was pointed out that in many cases, especially those involving extreme levels of violence, trying to restrain the subject in a position other than prone is often unsafe, unpredictable and, in many cases, impossible.

To some extent, the United Kingdom's NHS Protect (now disbanded) clarified the position on prone restraint positions following a consultation with the Department of Health and the Health and Safety Executive. It concluded that it was 'not acceptable for restrictive interventions, such as face-down restraint, to have become normalised' but there 'may be exceptional circumstances where prone restraint will happen'. It acknowledged that 'on rare occasions, face-down restraint may be the safest option for staff and service users, with few, if any, viable alternatives'. It concluded by pointing out that 'if Boards decide that they need staff to be trained in prone restraints it is vital that they are trained in the risks and appropriate techniques' [8].

These clarifications met with the approval of many practitioners, but those against the use of prone restraints were unmoved in their views that they should be banned, with some forbidding their use in their own services. Regrettably, this has led to the use of prone restraint being unreported in some services.

However, just one month later, NICE Guideline NG10 [9] declared a preference for supine positions over prone positions (para. 6.5.1). NICE NG10 recommended that for manual restraint, staff should avoid taking the service user to the floor, but if this becomes necessary they should use the supine position where possible; if the prone position is deemed necessary, it should be used for as short a time as possible (paras. 6.6.3.8 and 8.4.5.2).

Furthermore, the Welsh Assembly Government clarified their position on the use of prone restraints by advising practitioners that they should 'continue to use their

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professional judgement to determine whether use of a particular restraint technique is an appropriate response to a given situation' [10].

Smallridge and Williamson [11] carried out a comprehensive review of restraint in juvenile secure settings. They concluded that

> Some, but not all, prone restraint positions have a significant effect on breathing. It is clear that recommendations given previously, either to consider all prone restraint as dangerous or to consider prone restraint as presenting no additional risk, are not supported by empirical results . . . We are aware that the secure estate is looking to us for guidance on prone restraint. But there are no simple answers. We are wary of over-simplification over prone restraint and are cautious on the issue. Where a young person is held face down with pressure only on the limbs the evidence is that there is likely to be only a small effect on lung function, and in these cases prone may be quite safe for most young people, for most of the time. However, more 'forced' prone restraint, when body weight is applied to the back or hips may be unsafe for almost everyone. In the light of the competing evidence we feel that we cannot make any recommendation to ban prone restraint, but we consider it prudent that when prone restraint is used there should be a re-assessment of the risks after control has been obtained in the initial restraint. There should be procedures in place to ensure that a senior member of staff responds to the incident, assesses the situation, evaluates the competing risks and implements an alternative to prone if safety demands. (paras. 6.34 and 6.35)

Another example where the evidence has not been followed concerns the issue commonly referred to as 'prolonged restraint'. The longer a person is held in restraint, especially on the ground, the greater the risk of harm, including the risk of death. A question that is often asked is whether there is a maximum period of time for which it is considered safe to maintain restraint. Since it is known that death can occur extremely quickly this question must be answered in the negative. Despite this, several attempts have been made to prescribe such a time limit, the latest being NICE Guideline NG10 [9] which advises practitioners that manual restraint should not routinely be used for more than ten minutes (para. 6.6.3.13). This guidance was provided despite the earlier Bennett Inquiry recommendation that a person should not be restrained in a prone position for more than three minutes [4] being rejected by the profession as misleading and unworkable.

The confusion around these issues is manifest. It is also damaging, for the reason given at the beginning of this chapter: namely, that violence and aggression never present themselves in a vacuum. The reluctance of some staff to intervene in an incident is understandable when there is so much confusion about how they should intervene, and with the real prospect of sanctions if their response fails to follow policy, yet at the same time suspecting that adhering to policy could place themselves and patients at risk. With that in mind, it might be thought that a policymaker seeking to ban a particular intervention would have alternatives in mind, but policymakers have consistently stated that alternative interventions are not matters for them. This leaves a wholly unacceptable vacuum which is regrettably all too often filled by the police, who work to an entirely different set of standards to those that operate within healthcare settings. Not only are police officers not constrained by the prohibitions referred to earlier, they are also trained in techniques that healthcare staff would not wish to see used on patients. The answer must be to provide those within healthcare settings with appropriate training to increase the organisation's capacity and capability to deal with potentially violent situations without recourse to external agencies.

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Effective training will enable staff to be more self-sufficient so as to minimise requests for police attendance [12]. This was the approach taken in the memorandum of understanding (MoU) made between a number of parties, including the RCN, the Royal College of Psychiatrists and the College of Policing [12]. The aim of the MoU was to provide clarity on the role of the police service in responding to incidents, with the intention of outlining when and how the responsibilities of the police service fit in to the established roles and responsibilities of care providers.

Much of the debate about common standards concentrates on the type of individual interventions used by different organisations, which are often influenced by trainer choice. The choice of intervention ought to be secondary to, and informed by, principles and guidelines. Before considering these principles, it is important to emphasise that in all cases there needs to be a shift in focus from the reactive and limited approaches seen in restraint to more holistic approaches emphasising human rights, the better meeting of specific needs, prevention, non-escalation, de-escalation, reflective practice and, where appropriate, recovery. This shift in focus is crucial if we are to prevent over-reliance or dependence on restraint so as to give proper meaning to last-resort principles, thereby helping prevent the organisation becoming 'dysfunctional and ultimately toxic' to those who work in it and those it seeks to support [13, p. 28]. The practice of providing training in restraint, as an isolated set of skills, is outdated and should not be used. Restraint training should be seen as part of the overall practice of patient and staff safety, wherein a range of skills aimed at minimising its use should be emphasised. Similar principles should apply to all forms of restrictive practice.

So, what would a common set of guidelines look like? The essential ingredients should include the following principles:

- A human rights-based approach which emphasises the need to minimise the use of all restrictive interventions and ensures those that are absolutely necessary are rights respecting. Although the Human Rights Act 1998 applies only to public authorities, its principles ought to be adopted in other settings.
- With regard to children, reference should be made to the United Nations Convention on the Rights of the Child, which ensures that all children have the right to be heard and protected from harm. Reference should be made to Article 3 (the best interests of the child shall be a primary consideration), Article 16 (no arbitrary or unlawful interference with the child's privacy, etc.) and Article 19 (protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation).
- For people with disabilities, reference should be made to the United Nations Convention on the Rights of Persons with Disabilities and, in particular, to Article 10 (right to life), Article 12 (equal recognition before the law), Article 14 (liberty and security of person), Article 15 (freedom from torture or cruel, inhuman or degrading treatment or punishment) and Article 16 (freedom from exploitation, violence and abuse).
- Compliance with the legislative framework governing restrictive interventions. This requires a thorough understanding of both primary and secondary legislation pertaining to the country and specific setting. We will only consider the legislation pertaining to England and Wales, although a significant part also applies elsewhere in the United Kingdom and the legislation in other countries is often drafted in similar terms. The principal pieces of legislation for all settings include the Human Rights Acts 1998, Health & Safety at Work etc. Act 1974, Management of Health and Safety at Work Regulations 1999, Manual Handling Operations Regulations 1992, Equality Act 2010, Criminal Law

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Act 1967 (section 3(1)) and Criminal Justice and Immigration Act 2008 (especially sections 76 and 119–22). In the healthcare settings, the principal legislation includes the Mental Health Units (Use of Force) Act 2018, Mental Health Act 1983 (as amended, most recently by the Mental Health Act 2007), Mental Capacity Act 2005, Mental Capacity (Amendment) Act 2019 (including the Liberty Protection Safeguards (LPS), which replaces the Deprivation of Liberty Safeguards (DoLS)) and the Care Act 2014. The relevant sections from the legislative framework should be incorporated into policy and training.
- A statement about compliance with relevant guidelines, setting out which guidelines are relevant. Where guidelines cannot be complied with, the reasons must be clearly documented.
- A statement setting out the organisation's position in respect of the tension between the rights of the patient and those of staff insofar as the use of restrictive interventions is concerned.
- Where it applies, conformity to the Restraint Reduction Network (RRN) Training Standards: 'These standards will be mandatory for all training with a restrictive intervention component that is delivered to NHS-commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. Implementation will be via commissioning requirements and inspection frameworks from April 2021' [6].

The RRN training standards [6] are divided into four sections. Section 1 deals with the process that needs to be completed before a training curriculum is developed. Section 2 covers what needs to be included in the curriculum. Section 3 covers the post-delivery processes. Section 4 relates to trainer standards. We will refer to the relevant RRN standards as they apply.

Before a Training Curriculum is Developed

Before developing a training curriculum, it is necessary to carry out a suitable and sufficient assessment of the risks. The curriculum must be based on a training needs analysis (RRN 1.1). Training is typically provided either by in-house trainers or by an external training provider. In-house trainers should already have detailed knowledge of the service or services for which the training is being provided, including the population being supported and the needs and characteristics of the staff providing such support. External training providers will need to understand as much about the population and staff as their in-house counterparts before developing any package of training. This helps to ensure that all training is appropriate, proportionate and fit for the specific needs of the population, named individuals and staff, taking account of any specific needs that were identified during the initial fact-finding process. This process should be reviewed on a regular basis and updated where changes are identified with the population, specific individuals or staff, or where specific risks have been acknowledged.

Commissioning organisations should check with prospective training providers that they have appropriate professional indemnity and public liability insurance cover (RRN 4.5) and that this insurance is maintained throughout the period of the contract.

What Needs to be Included in the Curriculum

Physical intervention techniques should be considered as part of the overall process in the prevention and management of violence and aggression (PMVA) rather than being taught in isolation. This helps ensure that these techniques are not seen as the only, or even the

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main, response to PMVA. In practice, physical intervention techniques ought to be a small part of the overall approach to PMVA, albeit an important one.

In terms of the training provided to staff, the emphasis should be on primary prevention skills, consisting largely of skills aimed at predicting and preventing violence and aggression and proactive de-escalation strategies. Where such primary prevention skills are unsuccessful, secondary intervention skills may be deployed. These consist mainly of supportive holds aimed at preventing any escalation in the incident. To achieve this, the secondary intervention skills should include active de-escalation responses. Only where the incident cannot safely be managed at the primary or secondary level should reactive responses be considered. These consist of physical intervention techniques aimed at bringing the incident under control as safely as possible.

All physical intervention techniques need to be risk assessed by a competent person before being considered for inclusion in any training package (RRN 1.3). This assessment should consider the risks associated with each technique with respect to its biomechanical properties, its physical and psychological risks, and its suitability both for the general population and for any specific individuals that the service supports, as well as for the staff who might need to use the skills. A legal review of the proposed training package should also be carried out to ensure compliance with all relevant legislation and guidance. Trainers should be provided with copies of all pertinent risk assessments prior to the training taking place. Because physical intervention is a manual handling activity, this review should ensure compliance with the relevant manual handling regulations.

A process for the periodic review of each physical intervention technique should be included, the timing of which should be determined during the initial review. Such periodic review ought to be undertaken at least every two years (RRN 1.3.3), or immediately in the case that any variation to a specific technique is to be considered or where a reassessment or incident reasonably calls into question its safety or efficacy.

The choice of techniques to be included in the curriculum will, to a large extent, be dependent on a number of variables, including the population and any specific individuals that the service supports as well as the staff who might need to utilise the skills. This will require regular monitoring to ensure that the techniques selected remain appropriate. Pain-compliance techniques (i.e. techniques that deliberately use a painful stimulus to control or direct a person's actions, typically used to break the cycle of harmful, violent or resistant behaviour and achieve compliance) remain the subject of huge controversy and debate. The RRN training standards 'do not support the use of pain to gain compliance. Training providers must not include the teaching of any restrictive intervention that uses pain to force an individual to comply' (RRN 1.3.7, Appendix 21A). Notwithstanding that Appendix 21A confirms that 'the cross sector RRN steering group does not endorse the use of pain-based techniques', Appendix 21B acknowledges the argument that pain-compliance techniques may be needed 'for escape or rescue purposes' and that 'where there is an immediate risk to life, the NICE guidelines (NG10) refer to the use of techniques which may cause pain-based stimulus to mitigate the risk to life'. Although the expression 'immediate risk to life' is open to wide interpretation, the proper use of pain-compliance techniques should only be considered as an exceptional intervention.

A recent review [14] of international evidence and practice on non-pain-inducing techniques which was commissioned principally to identify, review and assess alternatives to pain-compliance techniques across the secure juvenile estate concluded that 'it was . . .

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not possible, based on the evidence available, to identify a safe, more effective system of restraint readily available to specifically manage volatile and serious situations within the youth secure estate in England and Wales'.

Whichever techniques are chosen for inclusion, it is important that training is provided within the context of an explicit commitment to the reduction of all restrictive practices (RRN 1.4) and that the views of appropriate people who have experienced restrictive practices should help inform the content of training (RRN 1.5). The content of the training should be person centred and rights based (RRN 2.1), both in respect of the people being trained and those upon whom the techniques may be used.

Once the initial training has been delivered, staff should undergo refresher training at least annually (RRN 1.6), with the full programme attended every fourth year (RRN 1.6.1). This means that the full training programme, as agreed with the commissioning organisation, will be delivered in full in year one, with refresher training in years two and three and the full programme repeated in year four. This is a curious requirement and does not reflect how training is, or should be, delivered. Accordingly, it is hoped that this requirement will be removed from the RRN standards. In any event, the frequency of refresher training may need to be increased if indicated by risk assessment, staff or organisational circumstances.

Neither the RRN standards nor the associated British Institute of Learning Disabilities (BILD) Association of Certified Training (ACT) certification scheme lay down a syllabus or specify which techniques should be included. Instead, the standards describe the principles which need to be followed when compiling the training syllabus. Questions as to which physical techniques or systems ought to be taught are complex and are often used by training providers seeking to demonstrate the superiority of their own methods. It is hoped that future editions of the standards, or alternative standards, will look more closely at the specific techniques as it is often the use of inappropriate techniques, or appropriate techniques applied inappropriately, that cause the most harm. The Safety Without Compromise (SWC) Experts Group has developed a guidance and approval-rating system for physical techniques which can be used alongside the RRN standards or as a standalone system [15].

Before considering which physical techniques to include, it is important to consider how they will fit in with an organisation's overall violence and restraint reduction plans. A good example of this can be seen in Figure 1.1, which illustrates the 'hierarchy of responses' approach used by the West London NHS Trust and incorporated into the training manual used by the United Kingdom's four high-security hospitals (and which, at the time of writing, is the only such training manual to be endorsed by NICE), as well as by a number of other organisations. (The author was the Independent Expert Advisor to the High Secure Services Violence Reduction Manual Steering Group and wrote significant parts of the manual.) The 'hierarchy of responses' approach illustrates how the risks associated with a strategy increase as staff move up the hierarchy from primary through secondary and then to tertiary/escape and rescue interventions. Staff should aim, as far as possible, to keep strategies in the primary proactive prevention section and only move to secondary interventions when necessary.

Primary responses are non-physical and include, as part of a proactive de-escalation process, a range of prediction and prevention strategies aimed at managing the incident without recourse to any hands-on intervention. Secondary interventions include supportive holds as part of the active de-escalation process. By contrast, tertiary/escape and rescue responses should be considered as medical/psychiatric or environmental/situational

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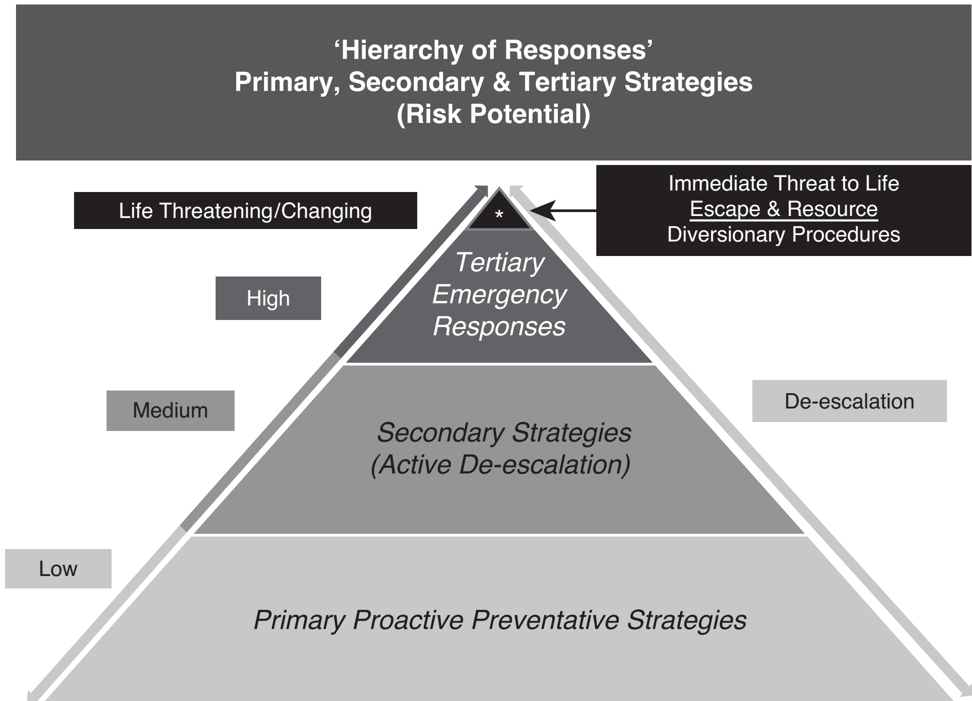

Figure 1.1 Hierarchy of responses

emergencies and are therefore exceptional interventions. Their use must be necessary, reasonable and proportionate to the risks presented by the patient or incident, and they must only be used by staff who have been adequately trained in their use. A tertiary/escape and rescue response is the most restrictive of interventions and is designed to manage significant increases in risk in a patient's violence and aggression to themselves or others. Tertiary responses may include, where appropriate, placing or holding the subject on the ground, in the most appropriate and safe position, and/or using one of the approved emergency distraction techniques. Such techniques may be justified when the patient cannot safely or reasonably be managed with less restrictive techniques, or to prevent the dangers associated with prolonged restraint in any position, and then only for the shortest possible time and with appropriate monitoring to help ensure the patient's safety.

The diagram also provides staff and patients with a visual tool to work collaboratively and design person-centred individualised support plans to manage differing levels of risk (RRN 2.6.1). Plans can be agreed at each stage of the triangle to provide advanced directions and expressed wishes to better predict and prevent behavioural disturbances that can often lead to acts of serious self-harm and interpersonal violence.

The black triangle at the tip of the diagram covers a range of emergency interventions, such as wrist flexion and so-called 'distraction' techniques. These techniques are intended to cause pain and should be considered as truly exceptional interventions. They are referred to in the RRN standards under Appendix 21B: 'The use of pain for escape or rescue purposes'. The double-headed arrow on the right of the triangle emphasises the importance of de-escalation

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throughout the entire process, with the aim of bringing the restraint to an end at the earliest possible time.

The duty of candour is of particular importance to healthcare professionals and it is unsurprising that RRN 2.2 requires training content to cover this in all settings. The duty of candour is also a CQC requirement; Regulation 20 explains that its aim is

> to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment . . . Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body.

This duty also includes a duty of 'openness', enabling concerns and complaints to be raised freely and without fear, with any questions asked to be answered, and including specific reference to the commissioning organisation's whistle-blowing policy and procedures. This is to be welcomed not least because of the serious problem of under-reporting uses of restrictive interventions at both the individual and organisational levels.

For any training in physical intervention skills to be worthwhile and beneficial to staff it should, subject to the confines of safety, expose staff to a degree of aggression and chaos that they are likely to encounter operationally. This requires a degree of resistance from those playing the part of the aggressive patient. RRN 2.8.11 states that where simulated resistance is used during training (which it must), the person playing the role of the aggressive patient must be taken by the trainer. This is impracticable for a number of reasons. First, it is beneficial for staff to have the technique applied on them so they can appreciate the same from the patient's perspective. Second, staff need to practise the techniques on people of different sizes, weights, etc. Third, staff need to practise the techniques a number of times before they are familiar with them and are able to perform them under stress. Restricting this training so that staff only practise the techniques on the trainers would tie up the trainers, preventing them from carrying out their other duties, including teaching other skills and supervision/assessment. Fourth, with certain types of intervention, practising them only on the trainers would give rise to foreseeable risk of injury to the trainers by having the same technique repeated on them by every member of the class. The normal method of practising these techniques, whereby the trainers demonstrate the skills and then supervise the trainees whilst they practise them, works perfectly well and should not be abandoned. It may be appropriate for trainers to play the role of the aggressive patient in scenarios that incorporate higher levels of aggression.

Any use of mechanical restraint needs to be approved at board level (RRN 2.8.A.1) and only considered for use 'in exceptional circumstances in specific settings and under specific circumstances' (RRN 2.8.A.2). Moreover, the use of mechanical restraint should represent the least restrictive option for the individual upon whom it is to be used, and it needs to be shown why alternatives would not be appropriate [15]. In no circumstances should mechanical restraint be used for the convenience of staff.

The training should make it clear that there is no such thing as a safe physical intervention as they all carry risks of physical, psychological or emotional harm (RRN 2.9.1). Accordingly, the training should include all known risk factors associated with each technique, with instructions on how to perform each manoeuvre as safely as possible, setting out the factors that might contribute to or elevate the risk. Furthermore, the training should

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