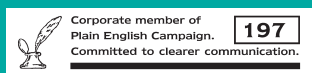


# Violence: managing disturbed/violent behaviour

**Understanding NICE guidance – information for  
service users, their advocates, families and carers,  
and the public**

February 2005



## **Violence: Managing disturbed/violent behaviour**

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**Issue date:** February 2005

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## **National Institute for Clinical Excellence**

MidCity Place  
71 High Holborn  
London  
WC1V 6NA

[www.nice.org.uk](http://www.nice.org.uk)

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# About this information

This information describes the guidance that the National Institute for Clinical Excellence (called NICE for short) has issued to the NHS on how to manage disturbed/violent behaviour in psychiatric units, wards and emergency departments. It is based on 'Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments', which is a clinical guideline produced by NICE for doctors, nurses and others working in the NHS in England and Wales. A brief description of the type of behaviour covered by the term 'disturbed behaviour' in the context of violence is given on page 5.

## Clinical guidelines

Clinical guidelines are recommendations for good practice. The recommendations in NICE guidelines are prepared by groups of healthcare professionals, lay representatives with experience or knowledge of the condition being discussed, and scientists. The groups look at the evidence available on the best way of treating or managing a condition and make recommendations based on this evidence.

There is more about NICE and the way that the NICE guidelines are developed on the NICE website ([www.nice.org.uk](http://www.nice.org.uk)). You can download the booklet 'The guideline development process – an overview for stakeholders, the public and the NHS' from the website, or you can order a copy by phoning the Department of Health Publications Order Line on 0870 1555 455 (quote reference number N0472).

## What the recommendations cover

NICE clinical guidelines can look at different areas of diagnosis, treatment, care, self-help or a combination of these. The areas that a guideline covers depend on the topic. They are laid out in a document called the scope at the start of guideline development.

The recommendations in the NICE guideline on managing disturbed/violent behaviour cover how the people in the NHS should try to prevent violent situations from happening, and what they should do if someone becomes violent.

The information that follows tells you about the NICE guideline. It doesn't attempt to explain the possible methods that could be used in detail. If you have specific questions, talk to one of the healthcare professionals you see regularly.

## How guidelines are used in the NHS

In general, healthcare professionals in the NHS are expected to follow NICE's clinical guidelines. But there will be times when the recommendations won't be suitable for someone because of his or her specific medical condition, general health, wishes or a combination of these. If you think that the treatment or care you receive does not match the treatment or care described on the pages that follow, you should talk to your doctor, nurse, advocate or other healthcare professionals involved in your care.

### **'Disturbed behaviour' resulting in violence**

For some people with mental health problems there are times, particularly when they are emotionally distressed, when they may behave in a way that directly affects other people. There may be a risk that the person will react in a violent way towards other people, or harm themselves or property.

## A note on the way this information has been written

In general, we have tried to make this information more readable for service users by using 'you' rather than 'a service user'. This does not mean that all service users are potentially disturbed/violent.

We have split the information into parts.

- 'What you can expect' covers the general points made in the NICE guideline – describing how you should be treated by staff in an in-patient area or emergency department. Also covered is the information that you should be given about what is going on, and what the unit or ward should be like.
- 'Predicting disturbed/violent behaviour' looks at how staff should judge whether you're going to become disturbed/violent, and what should happen if you need to be searched.

- ‘Preventing disturbed/violent behaviour’ describes what should happen if you start to behave in a way that could become violent. It also covers observation and what should happen if staff need to observe you as a way of helping you to stay calm and to watch for signs of disturbed/violent behaviour.
- ‘Interventions – stopping a violent incident’ covers methods staff may use to stop disturbed/violent behaviour if talking to you doesn’t help you to calm down.
- ‘If you go into an emergency department’ covers specific recommendations NICE are making about providing care for people with mental health problems in this setting.
- The final section outlines the other parts of the NICE guideline that aren’t dealt with in this booklet. These are mainly recommendations covering staffing issues and training, and the policies and procedures that should be in place.

An explanation of technical words used in this booklet appears at the end.

## What you can expect

### **Important principles that apply during your time in the unit, ward or emergency department**

- You should be treated with dignity and respect whatever your cultural background, sex, diagnosis, sexuality, disability, ethnicity or religious or spiritual beliefs. (See also page 61 for the recommendations that have been made to help to ensure this.)
- Staff should take the time to listen to you and to take your views on board, whatever your individual background and circumstances. It is important that you feel supported and understood, particularly if you have had any previous experiences in the mental health system related to your culture or background.

## Finding out what's happening and making your wishes known

### Information you should be given

Every time you're admitted to a unit or ward, you should be given information on:

- the staff member who has been assigned to you and how and when they can be contacted – if possible, you should be able to choose your key worker
- why you have been admitted – if you've been detained ('sectioned'), you should be told why this has happened, what powers have been used to detain you and what they cover, and your rights of appeal
- your rights on agreeing (consenting) to treatments
- your right to complain about the care you receive
- how you can get independent advice and someone to speak on your behalf (an advocate)
- what may happen if you behave in a disturbed/violent way.

This information should be provided in a way that is suitable for you. You should have help if needed to understand the information (for example, if someone's preferred language isn't English, they should be able to have an interpreter). The information should be repeated to ensure that you can understand it.

### **Making an advance directive**

If you are thought to be at risk of becoming disturbed/violent, you should be offered the chance to make your needs and wishes known. This may mean making what is known as an 'advance directive'. This can include information about what you do and don't want to happen if you become disturbed/violent. You should have the chance to review your advance directive with staff so you can make changes if you want. This review should be repeated at intervals so your advance directive is up to date.

A record of what you've said in your advance directive should be put into your care plan (see page 11) and your medical notes.

## Your care plan

When you're admitted to a unit or ward, the staff will need to find out what sort of care will be best for you, your views and preferences on how you wish to be treated, whether you have any particular physical needs and how likely you are to become disturbed/violent. To do this they will talk to you and ask you some questions, and assess your physical needs. Your care plan will be based on this, and will set out the details of the care you should receive and what staff plan to do if you become disturbed/violent.

You should be given a copy of your care plan. A copy will be given to your carer if you agree to this happening.

## Giving medicines

When staff are giving you your medicines, they should make sure that the type of medicines you have remains confidential.

If you want to have your medicines reviewed, the person who prescribes them should listen to your concerns and see if changes can be made.

## **If abuse happens**

If you suffer any form of harassment or abuse while you're in the unit or on the ward it should be looked into as soon as possible. There should be a procedure in place that staff should follow.

## **Extra information for specific groups**

### **If you're pregnant**

If you're pregnant and there's a chance you might become disturbed/violent, your care plan should contain details of special measures that should be taken to protect your health and that of your baby if staff need to intervene because of your behaviour.

### **If you're Black or from a minority ethnic group**

Each health trust should have a board member who, at a senior level, is responsible for making sure all individual service users are treated equally and that staff don't resort to stereotyping people.

## If you have a disability

If you have a disability, impairment and/or other problems communicating and there's a chance you might become disturbed/violent, your care plan should say what staff need to do when using de-escalation methods, rapid tranquillisation, physical intervention and seclusion if these are needed (these are described in the section that starts on page 33).

## If you have an infectious disease

Although all service users have a right to confidentiality about their medical circumstances, there are certain times when this may have to be overridden to protect others. This may be the case if you have an infectious disease and start behaving in a way that puts other people at risk of infection.

If anyone is hurt during a violent incident where blood is spilt, the skin is broken or there has been direct contact with bodily fluids, steps should be taken to help protect staff and other service users from infection (all bodily fluids should be treated as if they are infected).

## The unit or ward

### General points

Units and wards should be organised so that you:

- feel safe
- have some privacy
- keep your dignity
- have some space
- can be yourself socially and spiritually.

The particular needs of women, men and people from different cultural groups should be met.

If a person first arrives with a police escort, staff should meet them in a separate area.

## Facilities and activities

The building should be designed to let everyone move around and make use of the facilities, regardless of any disabilities or impairments.

Men and women should have separate toilet and washing facilities, day areas and sleeping accommodation. There should be an activity room, a dayroom with a television, and a quiet area set aside for prayer and reflection. The dayroom should be open during the night for people who can't sleep. Where it's possible, there should be a private area where you can make phone calls, and meet and talk to your visitors and to staff.

Every day, you should get the chance to exercise and take part in group activities and therapy if you want to. And while you're in the unit or ward, you should have easy access to fresh air and natural daylight. Where the building design allows it, you should be able to get to an outside area through the unit.

All areas should look and smell clean. Areas and rooms for smoking should be fitted out so that the smell of smoke doesn't filter through to non-smoking areas. And it should be possible to control the lighting, temperature and noise levels throughout the unit or ward to help make sure the environment is comfortable.

## Safety and security

Your room, bathroom and toilet should be secure and should have a lock (staff should be able to unlock the door from the outside if they have to).

The unit or ward should be designed and organised so staff can see all the exits and entrances. Closed-circuit television (CCTV) and special mirrors may be considered necessary for places such as corridors, stairs and reception areas (potential blind spots). If there's an emergency situation because a person has become disturbed/violent, it should be possible for other people to go into and come out of the area safely.

## Alarms

There must be alarms in interview rooms and in reception areas and any places where there are one-to-ones between service users and staff. And it should be easy to get to the alarms – they must not be blocked by furniture, for example. Other alarms must be in places where there's a possible risk of an incident, and this will depend on the individual unit and service user. This also applies to personal alarms, which may be given to some service users and staff if they have a higher risk of being caught in a difficult situation.

# Predicting disturbed/ violent behaviour

It's important that the risk of violence in psychiatric units is as low as possible. To make this happen, staff need to be aware of all of the possible risks and these need to be managed effectively (a full 'risk management strategy' should be in place).

## Assessing the risk of violence (risk assessments)

Staff need to be aware of how likely you are to become disturbed/violent, and the likelihood of this in a given situation. This is done through something called a risk assessment. Staff look at the individual service user and the possible surroundings and situations that they may find themselves in, and work out the likelihood of a violent incident happening.

The risk assessment should not be biased in any way, and should not be affected by staff's own feelings or opinions, for example on race or culture. Although some types of behaviour may seem unfamiliar to some staff members, they shouldn't be mistaken for aggression.

Carrying out risk assessments is an important part of working with people with mental health problems, and the results should help the staff when they're preparing your care plan (see page 11). The risk assessments themselves should involve a team of different types of healthcare professionals.

Since the things that affect the risk of disturbed/violent behaviour change, risk assessments should be carried out on an ongoing basis. The results of the assessment should be passed on to all the places where you receive treatment and care, though patient confidentiality should be respected.

### **Talking to you as part of the risk assessment**

To help staff judge how likely you are to become disturbed/violent, one or more members of staff should talk to you, and possibly your carers, in an interview. Staff doing interviews should always talk to you and treat you in a sensitive way. If you've become disturbed/violent before, you should be asked:

- what sets off this type of behaviour (the things that do this are sometimes called trigger factors)
- whether there are any warning signs that you're going to become disturbed/violent
- whether there's anything else that could be linked to this type of behaviour
- what you think would be the best way of managing you if any of the things you mention happen while you're in the unit or on the ward.

From the results of the risk assessment, staff should judge whether your care plan needs to include specific descriptions of how you should be treated if you become disturbed/violent. Staff should give you feedback on your risk assessment.

## Things that can make violence more likely

Staff should know about the things that can start off a violent incident. Generally, these can be grouped into people's attitudes, situations that a service user is in, the organisation of the unit and other things affecting a service user, and their environment.

The NICE guideline lists some of the things that can make a person more likely to become violent (called risk factors). These will vary between service users but may include:

- things about the person's background (such as having been violent before, or having had violent feelings before)
- things about their mental health symptoms or the effects of their treatment
- things about their situation (such as having a weapon to hand).

Some things that can be warning signs for disturbed/violent behaviour are listed in the box on pages 21 and 22. They will vary from person to person. If there's a risk that you could become disturbed/violent, you should be encouraged to recognise your own particular early warning signs – a note of these should be included in your care plan (you should have a copy of this).

## Some potential warning signs for violence

- The person is more restless than usual, or is restless for longer than normal, or their body is tense or they are pacing around
- The person is breathing more quickly, their heart is beating more quickly, their muscles are twitching and/or their pupils are larger than normal
- The person is talking more loudly than normal and/or they are making unexpected and unpredictable movements
- The person's face is tense and angry
- The person holds eye contact for longer than normal
- The person is unhappy, refuses to talk, or is withdrawn, scared and/or irritated
- The person isn't thinking clearly or can't concentrate properly
- The person thinks something is happening that isn't, and what they think is happening has an element of violence attached

- The person says threatening things or makes threatening gestures
- The person is acting in a way that's similar to how they acted before an earlier episode of violence
- The person says they feel angry or violent
- The person is blocking or has blocked the way so another person can't move away

## Searches

Searching service users and visitors is an important part of running a safe unit. But searching has to be carried out sensitively and legally and only when it's really needed.

## Consenting (agreeing) to a search

The sort of search that is carried out should depend on the reason for the search and the person involved. Staff should always ask for your consent (agreement) to be searched, though in some circumstances the search will go ahead even if you don't consent. If you haven't consented but the search has gone ahead, there should be a review of what happened before and during the search. As part of this, you should be seen by an advocate or a hospital manager so your views can be included in the review.

## The search

The type of personal search that's done should depend on the reasons for the search – a 'rub down' search shouldn't be done unless there are reasons for doing it. Staff should pay attention to the dignity and privacy of the person being searched. Women should be searched by female staff and men by male staff. If you're being searched, you should be told what is happening and why.

If a search is needed but the person doesn't let staff near them to carry it out, the health team will decide whether the person needs to be physically held while the search is being done. The policy on searching should describe the options for staff if the decision is made not to go ahead with the search.

### Keeping a record of the search

Every time a search is carried out, a detailed record should be made of what happened and why the search was needed. The results of the search should be added into other records and notes as appropriate (for example, if something is found that shows you may have been planning to harm yourself or others, this will affect your risk assessment).

After a search, help and advice should be available for you and everyone else involved.

## Preventing disturbed/ violent behaviour

If you become angry or show signs of disturbed/violent behaviour, staff must respond in a reasonable way that's right for the individual situation you're in. To help with this, staff should learn to recognise what generally upsets and calms people. And they should also make themselves aware of what specific things upset and calm you. To do this, they should listen to what you say is upsetting, and this should be noted in your care plan. Staff should be aware of what they do and say and the effect that things like making eye contact and standing in certain ways can have on people. They should learn to check these things and make sure that they aren't doing or saying something that could make a situation worse.

If you start to show signs of behaving in a disturbed/violent way, staff should make every effort to try to help you calm down in an open area (that is, you shouldn't be moved unless it's necessary). However, sometimes staff may ask you to move to a safe area or room designed to help people calm down (the seclusion room, in units where seclusion is used, shouldn't be used for this purpose – see page 38 for more information on seclusion).

## At the first signs of agitation, or disturbed/violent behaviour

If possible, staff should first try to get you to calm down using what are known as de-escalation methods. The next sections cover how staff should treat you in these circumstances.

At the start of a situation where you could become disturbed/violent, one member of staff should take control. This person should explain to you and anyone else in your immediate area what they plan to do. They'll organise the people around them – for example, getting other service users to leave the area, getting help from other staff, and letting you know that you have some choices about what happens next. All the time, this person should be talking to you and trying to reach an agreement with you to help calm you down. They shouldn't say anything you could take as a threat.

When trying to calm down the situation the staff member should:

- ask you about what has happened (the facts) and what has made you angry (questions about facts rather than feelings can help to calm things down)
- encourage you to think through what has happened and what you are doing
- give you some realistic choices about what can happen next
- show that they're concerned through their words and actions
- listen carefully to what you say, and be understanding about the things that have upset you (you shouldn't be patronised).

## Weapons

If there are potential weapons around, you should be moved to a safer place if possible. If you have a weapon, you should be asked to put the weapon down somewhere (rather than being asked to hand it over).

## Observation

Observation is a way that staff can help someone who's showing signs of becoming disturbed/violent. Its main aim is to help the service user and staff member connect ('engage') in a positive and trusting way, to help reduce the risk of disturbed/violent behaviour. It's also used to help prevent a person from harming themselves.

There are four levels of observation that can be used, depending on the likelihood of violence – these are described below. It's normally a qualified nurse who carries out observation, though they may ask other staff to do specific tasks connected with the observation. If this happens, it's still the responsibility of the nurse to make sure that the observation is done properly. All staff involved should be aware that service users sometimes find observation difficult to cope with – staff should be sensitive to your feelings at all times so they don't provoke a situation that might not otherwise happen.

**General observation:** staff should know where you are, but they don't have to be able to see you all the time. At least once during their shift, a nurse should check on how you are, and whether your mood or behaviour shows any signs that you are becoming disturbed/violent – a record should be kept of this in your notes. Most service users are observed in this way.

**Intermittent observation:** staff should check on where you are every 15 to 30 minutes (the exact times should be specified in your notes). As far as possible, this should be done without disturbing you or making you feel you're being checked on. This type of observation should be used if you might possibly become disturbed/violent as long as there's no sign that this is going to happen immediately. It should also be used if, for a time, there was a risk that you could harm yourself or other people, but this is getting less likely.

**Within eyesight:** staff should keep you within eyesight at all times of the day and night. They should be able to easily reach you at all times, too, just in case something happens. If necessary, anything that you could use to harm yourself or others should be removed. Staff may need to search you and your belongings, though they should do this in a sensitive way and should keep your legal rights in mind. This type of observation should be used if there's a risk you could try to hurt yourself or another person at any time.

**Within arms length:** when you're having this level of observation, one or more members of staff should stay close to you. Your privacy and dignity should be respected as far as possible, though. You should be asked your opinions on different aspects of being under this level of observation (for example, would you prefer to be observed by staff of the same sex as yourself). Details of how the observation should be done and any special considerations should be written in your care plan. This type of observation should be used if you're likely to hurt yourself or another person if you get the chance.

## How staff should behave

Nurses and other staff involved in your observation should have been briefed on your previous medical history, and should know about any particular needs you have or areas where particular care should be taken. They should try to engage positively with you, listen to what you're saying, and value you as a person. The same member of staff shouldn't observe you for more than 2 hours if you are being observed at higher than the general level.

## Deciding which level is needed

You should be observed using the lowest level of observation possible, given the circumstances (and you should only go to a higher level if staff haven't been able to engage with you and help you feel more calm). A balance should be struck between your dignity and privacy and the safety of yourself and those around you.

Decisions about your level of observation should take into account your current behaviour, the medicines you're on, and the current risk that you'll become disturbed/violent. The same applies to decisions about how often a check should be made on how you're getting on, and who should be responsible for doing this check.

Your views should also be taken into account as far as possible. Your psychiatrist or the doctor on call should be told of any decisions about increasing your level of observation as soon as possible, and decisions should be written in your notes, together with the reasons for using observation. Your level of observation should be reviewed by staff at least every shift.

Some of the signs that a person may need a higher level of observation are described in the NICE guideline.

### Keeping you informed

If your observation level is increased above the general level, you should be given information about why this has happened, the aim of the change, and when you are calmer how long the observation is likely to last. Where it's possible, you should be involved in the handover between staff at the end of observation shifts so you know what is being said about you.

Your nearest family, friend or carer should be told about the observation that you're going to be under, if you agree to them knowing.

## Interventions – stopping a violent incident

If de-escalation methods haven't helped to calm you, staff may need to do something else to stop the situation getting out of control. Depending on the situation, you may be physically held for a short time (physical intervention) so that you can't hurt yourself or anyone around you, or you may be moved to the safety of a seclusion room. Sometimes medicines may be given to help calm you (this is called rapid tranquillisation).

### Important note

Physical intervention, seclusion and medicines are ways of managing and calming a person down if they have become violent so that a situation does not get out of control. They should only be used once all the other ways of trying to calm the person have been tried. Whilst using these methods staff should continue to use calming (de-escalation) techniques.

When deciding what to do, staff should think about the service user's needs and safety. If the service user has made an advance directive that covers the situation, this should be taken into account wherever possible. Staff should follow the guidance set out in the Mental Health Act Code of Practice (chapter 19) – if they take a different approach, they should record what they are doing, and give good reasons for doing it.

When deciding what to do, staff should bear in mind the effects of the situation on other service users, staff and visitors. They must avoid using excessive force to manage the situation and help you to calm down.

The box below has some general points on what should happen if physical intervention, seclusion or rapid tranquillisation is used.

**If a physical intervention, seclusion or rapid tranquillisation is used**

- Staff should take steps to make sure you don't feel humiliated during the process of calming you down
- Staff should make notes of what is happening as soon as possible
- As soon as it's possible, staff should explain to you why the action was taken
- You should be given the chance to write up your account of what happened in your notes

## Access to a doctor and emergency equipment

If staff are using physical intervention, seclusion or rapid tranquillisation and need medical advice or help, they should be able to alert a doctor. He or she should be on hand to help as quickly as possible.

Staff involved in using these methods should be trained in emergency resuscitation procedures. Staff should be able to get emergency equipment to an incident within 3 minutes in units, wards and departments where physical intervention, seclusion or rapid tranquillisation might be used.

## Physical intervention

A physical intervention is a way of holding someone so that they can't move easily. Staff shouldn't use this unless it's absolutely necessary. If it is used, it should be done for the shortest time possible either to allow the immediate danger to pass or to organise an alternative such as rapid tranquillisation (whichever is sooner in the particular situation).

Staff should never directly press on your neck, chest, abdomen, back or pelvic area during physical intervention. One person should be responsible for protecting and supporting your head and neck the whole time. This person should also watch what the other members of staff are doing to make sure that the physical intervention is being done safely (for example, they should make sure you can breathe properly), using recommended techniques. Staff should be keeping a check on how you are (physically and mentally) the whole time.

Whatever technique is used, the force used must be just enough to control you and it should be used for the shortest possible time.

Staff should make every effort not to use techniques that cause pain, but very occasionally they may be needed if staff, service users or others need to be rescued immediately.

Staff shouldn't normally use equipment to restrain you. If equipment is used, there should be a valid reason for it and the decision should be made by a group of healthcare professionals with different areas of expertise before it is used.

## Seclusion

Seclusion is a way of putting someone in a safe environment to calm down. If seclusion is used for you, it should be done for the shortest time possible, and staff should make scheduled regular checks on you. Every 2 hours (or more often), staff should review whether you've calmed down enough that you can come out of the seclusion room. Staff should tell you that these reviews will happen. You will be observed by a member of staff at all times from outside the room (see also Observation, pages 28–30).

Your clothes shouldn't be removed when you're in seclusion (the possible exception is if you're wearing something that could be used to harm yourself or another person). You should also be allowed to keep things that are important to you because of your religion or culture (for example, some items of jewellery), again as long as they couldn't be used to cause harm.

## The seclusion room

If the unit or ward uses seclusion, it should have a seclusion room that's designed so a person in it can be seen clearly. The room should be well insulated and ventilated, and safe, and there should be access to toilet/washing facilities.

## Rapid tranquillisation

In some circumstances, one or more medicines may be used to calm you down. This is called rapid tranquillisation. Any medicine given to help you calm down in the short term should be thought of as being part of rapid tranquillisation.

### Giving the medicines

Some of the medicines used for rapid tranquillisation are taken by mouth (orally), but others are injected. Usually, you should be offered the medicine orally. If injections are needed, they should be given into a muscle rather than directly into the blood (via a vein), if possible, because it's generally safer to inject into a muscle. If injections are used, you should be switched to oral medicines as soon as possible. Staff should allow the medicine time to work before deciding to try another dose.

The team of healthcare professionals involved in rapid tranquillisation should include a pharmacist who has specialist knowledge and experience in preparing medicines for people with mental health problems. The pharmacist has a responsibility to monitor how the medicines are used and to make sure that they're being given safely and correctly.

## The medicines that should be used

The best type of medicine to use for rapid tranquillisation depends on your particular circumstances. Staff shouldn't use two of the same type of medicine at the same time (for example, two antipsychotics). In all situations, the person who prescribes the medicine and the person who gives it to you should try to get your consent (agreement) to have the medicine.

There are some circumstances where staff should take extreme care if they use rapid tranquillisation, and these are shown in the box on page 41.

After you've had the medicines, you should be able to understand and respond to what is being said to you. This is important because there are some risks with the medicines used – if they aren't used properly, you may become unconscious or drowsy, or stop breathing properly. Some of the possible problems are shown in the box on pages 42 and 43. If you can't respond to what's being said to you, you should get the same kind of general care that a person would have if they were under a general anaesthetic.

**Rapid tranquillisation should be used with extra care in these people, if it's used at all**

- The person was born with a specific heart condition that affects their heartbeat (they have what's known as a prolonged QTc syndrome)
- The person is taking another medicine that affects their heartbeat in a specific way
- There's something that might change the way the person's body copes with the medicine – for example, they may be very cold (have hypothermia), have a high temperature (hyperthermia), be stressed or very emotional, or have just done something that will have made their heart beat very quickly (such as hard exercising)

## Possible problems with the different medicines used for rapid tranquillisation

### Benzodiazepines (for example, lorazepam)

- Passing out (losing consciousness)
- Slowing or stopping breathing
- Heart problems (the heart may stop working properly if the person is also taking the medicine clozapine)

### Antipsychotics (for example, haloperidol)

- Passing out (losing consciousness)
- Heart and breathing problems
- Seizures (fits)
- Restlessness (the medical name is akathisia)
- Rigid muscles (dystonia)
- Unwanted uncontrolled movements (dyskinesia)

- Neuroleptic malignant syndrome: this is rare but serious – the person becomes very ill, with symptoms that include a very high temperature, losing consciousness, sweating, and a fast heart rate
- Becoming too drowsy

#### Antihistamines (for example, promethazine)

- Becoming too drowsy
- Painful injection
- Side effects such as dry mouth or blurred vision

## If you have psychosis

Psychosis is the medical word used to describe mental health problems that stop the person from thinking clearly, understanding what's real and what's not, and acting in a normal way. If you have psychosis, the first medicines that should be considered for you are an oral antipsychotic medicine and oral lorazepam. Lorazepam is a type of medicine known as a benzodiazepine, which makes people feel calmer. It is used to bring about an early calming response giving time for a lower dose of the antipsychotic to take effect.

Antipsychotic medicines should be given at the dose that's right for you – this will depend on things like your age and whether you are taking other medicines or have other medical conditions.

**If injections are needed:** if you refuse to take a medicine by mouth or the staff have good reason to judge that oral medicines won't calm you down quickly (for example, if they haven't worked in the past for you, or you're extremely disturbed), you should normally be given injections of haloperidol (an antipsychotic) and lorazepam.

If you're less severely disturbed, staff may give you an injection of a medicine called olanzapine (staff should be aware that there is a particular risk if this drug is used outside of the maker's instructions). If you're given an injection of olanzapine, you shouldn't have an injection of lorazepam until at least an hour later if you have it at all. Oral lorazepam should be used only with caution if you have had an olanzapine injection.

**If you're given a haloperidol injection:** staff should give you another medicine called an antimuscarinic to prevent any side effects such as spasms. This will be given by injection.

**Injections into the blood:** benzodiazepines and haloperidol should not normally be injected straight into the blood for rapid tranquillisation. But if there's an occasion when the situation means you need to be calmed down very quickly, and senior staff think it's the right thing, these medicines can be injected in this way (injecting them into the blood means that they work more quickly, but it also increases the risk of problems). A person who has had an injection into the blood should not be left on their own at all. And these injections should only be given where the staff have had the right training and the right emergency equipment is available (staff should be trained to recognise the signs that the person is having problems breathing or with their heart).

If medicines are injected into the blood, a record should be kept of why and when this was done (records should also be kept for any medications given). The decision to give this type of injection should be made by a senior staff member, not a junior one on their own. In very exceptional circumstances, haloperidol plus a drug called promethazine, or one called midazolam (given on its own) could be injected into a muscle rather than injecting medicines into the blood. Junior staff should discuss this with a senior on-call psychiatrist.

### If there's no psychosis

If there's no psychosis, lorazepam should normally be used (normally it's taken by mouth, but sometimes it's injected into a muscle).

### Zuclopenthixol acetate

Zuclopenthixol acetate (also known as 'acuphase') is an antipsychotic medicine, but it should not usually be used for rapid tranquillisation because it takes a long time to work and then it takes a long time for its effects to wear off. But it may be an option if:

- it's clear that you're going to be disturbed/violent for a long time
- you've had it before and it has calmed you down well and without too much delay
- you've had repeated injections of it in the past
- you've made an advance directive that says you'd prefer to have zuclopenthixol acetate.

Zuclopenthixol acetate should never be given to someone who hasn't had an antipsychotic medicine before.

## Medicines that shouldn't be used for rapid tranquillisation

The following medicines shouldn't be used for rapid tranquillisation:

- chlorpromazine by mouth or by injection into a muscle
- diazepam by injection into a muscle
- thioridazine
- long-acting antipsychotics that are injected deep into a muscle.

If someone has dementia (where the person's mental abilities are worsening and this affects their normal activities), staff shouldn't use olanzapine or risperidone to calm them down if they become disturbed/violent.

## After rapid tranquillisation has been given

Staff should keep a close check on you if you've had medicines for rapid tranquillisation. They should check your 'vital signs' regularly – these are the things that show if a person is all right (for example, the breathing rate and pulse rate). They should also keep a record of your blood pressure, pulse, temperature and breathing rate, and how hydrated you are – this should carry on until you become active again (a team of healthcare professionals should decide how often these things should be checked). A piece of equipment called a pulse oximeter may be used. This clips over a finger or toe and measures the amount of oxygen in a person's blood and their heart rate.

Sometimes, you may need to be checked more often and more closely than normal, and a record of what happens needs to be kept in your care plan. Staff should pay special attention to your breathing and how drowsy you are if:

- you appear to be or are asleep or have been made very sleepy by the medicine
- the medicine was injected into the blood
- more medicine was used than is generally recommended (there may be special reasons for doing this)

- it's more likely than usual that you could experience problems
- you have been using illegal drugs or other substances, or have been drinking alcohol
- you have a medical problem or are taking a medicine that may mean special care is needed.

**If you're moved to another unit:** if you go to another unit or ward, staff should let the new place know all the details of the medicines you've had, with information on how well they worked and whether there were any side effects. The new unit or ward should get your advance directive if you have made one and, if possible, any notes you've written about your experience of having rapid tranquillisation. When you leave the unit or ward, this information should be filed with your medical records and your doctor should review it regularly.

## **Using rapid tranquillisation and seclusion together**

If it's absolutely necessary to use rapid tranquillisation and seclusion together, you should be watched all the time while you're in the seclusion room. The person who watches you should have been trained to look out for any signs of possible side effects of the medicines used.

Once the rapid tranquillisation has worked, you should be taken out of the seclusion room.

## **What should happen after physical intervention, seclusion or rapid tranquillisation has been used**

If rapid tranquillisation, physical intervention or seclusion has been used, your care plan should be checked and changed if necessary. After the incident, you should be helped to get back into normal life in the unit or ward.

A review of what happened should be carried out as soon as possible afterwards (in any event, within 72 hours of the incident ending). This review is not about finding fault – it is to see how things went and what can be learnt to prevent it happening again or how to manage it better. It is also an opportunity to strengthen possibly damaged relationships between you (and your family or carers) and staff. Normally, the review should be led by someone who wasn't involved in the incident, and the following people should be considered for involvement in the review:

- you
- the staff involved in the incident
- your family or carers, if this is appropriate
- other service users who saw what happened
- visitors who saw what happened
- an independent advocate (a person who can speak for you), if you want them to
- someone with specialist knowledge of how violent incidents can be managed safely.

The review should look at:

- what happened during the incident
- whether anything triggered it
- what each person did during the incident
- how each person felt during the incident, how they feel now, how they may feel, and what can be done about any concerns they may have (you should get the support you need to deal with any problems).

Staff should make every effort to check you understand why the incident was handled in the way it was. These efforts should be described in your notes.

## If you go into an emergency department

A lot of the information on the previous pages applies to emergency departments as well as psychiatric units (emergency departments are also known as 'accident and emergency' or 'casualty' departments). This is because staff in hospital emergency departments often see people with mental health problems. As well as the information that applies generally, NICE has also made some recommendations specifically for emergency departments, and these are described below.

You should be able to understand what people are saying to you in the emergency department. For example, interpreters should be available if your preferred language isn't English. All people should be given the help they need to understand what's going on; for example, if you are deaf you may need an interpreter who can sign.

## Finding out what's wrong

If you've gone into an emergency department of a hospital and you're showing signs of mental health problems, staff should talk to you in a special interview room to try to find out what's wrong. Usually there should be at least two members of staff in the room. The room itself should be close to or part of the main emergency reception area. It should be big enough for six people to sit comfortably, and it should have safety features so that staff can call for help if they need to. There shouldn't be anything that could be used as a weapon in the room.

## If rapid tranquillisation is needed

Staff in an emergency department may decide to use rapid tranquillisation if you're showing disturbed/violent behaviour. Normally, the decision to use it should be made by someone senior. As soon as they are able, staff should make contact with mental healthcare professionals.

Lorazepam should usually be used if the staff are not sure about your medical history (for example, whether you have heart problems, or what medicines you're taking) or if it's possible that you have used illegal drugs or substances, or are drunk. If staff are sure that you have had an antipsychotic before and it has worked, lorazepam with haloperidol could be used.

## Other points covered by the NICE guideline

All the information covered so far is taken from the NICE guideline called 'Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments'. The guideline also contains other recommendations including training for staff, how the unit or ward should be staffed and organised, and the policies that should be in place. The next sections list the areas covered in the guideline, but don't usually give any detail of what the guideline says (though more information is included where the information directly affects service users). If you want to find out more about any of these areas, please see the NICE guideline on the NICE website ([www.nice.org.uk](http://www.nice.org.uk)).

## Training for staff

Not all staff in units or wards need all the training listed below. Sometimes certain staff members will have training in a particular area – more information is given in the NICE guideline. In most instances, staff who get initial training should continue to receive training in these areas so their knowledge stays up to date. The training that staff receive should be monitored and, every year, there should be a review of the training strategy so that staff get the training they need. The NICE guideline has recommendations on training in the following areas.

- Understanding groups and individuals in society – staff should be trained to understand the needs of particular groups to avoid stereotyping service users and to help them understand better the individuals they may be caring for. If there are groups such as migrant workers or asylum seekers living in the area, staff should also have training to help them care for people from these groups who have mental health problems. Service users and service user groups should be given opportunities to be actively involved in training and setting the training agenda for staff so that staff become aware of the specific needs of different groups (for

example, women, service users with impaired sight or hearing, Black and minority ethnic service users, physically disabled or impaired service users, those with cognitive impairment, and those with communication difficulties).

- Recognising the signs that a person is becoming disturbed/violent and what things may worsen a situation.
- Observation skills.
- Interventions (carrying out seclusion, the safe use of physical intervention, how the medicines used for rapid tranquillisation work, what can affect the way they work, and the problems that could happen during rapid tranquillisation.
- What to do in medical emergencies – training in life support.
- Using a pulse oximeter (for staff involved in rapid tranquillisation – see page 49).
- Carrying out a search.
- How to write up what's happened during an incident.

## Policies and procedures

There should be a procedure for assessing the risk of disturbed/violent behaviour and policies on the following in place.

- Complaining about the care you receive.
- Searching (among other things, the policy should describe the legal position for someone if they don't or aren't able to consent to the search, or if they're in the unit because the Mental Health Act has been used to detain them).
- Observation.
- Training.
- Preventing and dealing with all forms of harassment and abuse.
- Managing the risk of HIV, hepatitis or another infectious disease.
- Alarms in the unit or ward and personal alarms.
- Action plans on what to do in emergency situations (these should be developed locally and aren't covered by the NICE guideline).

There are also national directives to report physical assaults.

## Responsibility for ensuring equality in care

Health trusts should have a board member who is responsible for making sure that all service users receive equal treatment and care during an incident of disturbed/violent behaviour, regardless of the person's ethnic origin or background. This board member's responsibilities should include:

- training staff on equality and cultural and other differences between groups
- monitoring how many people from different ethnic groups use the service
- asking local Black and minority ethnic groups for their views and involving them in developing services.

There should be procedures for service users with disabilities, including those with physical or sensory impairment and/or other communication difficulties.

## Where you can find more information

If you need further information about any aspects of mental health or the care that you or someone you care for is receiving, please ask your doctor, nurse or other health professional. You can discuss this information with them if you wish, especially if you aren't sure about anything. They will be able to explain things to you. NHS Direct may also be helpful – phone 0845 46 47 or visit the NHS Direct website ([www.nhsdirect.nhs.uk](http://www.nhsdirect.nhs.uk) or [www.nhsdirectwales.nhs.uk](http://www.nhsdirectwales.nhs.uk))

## If you want to read the other versions of this guideline

There are four versions of this guideline:

- this one
- the full guideline, which contains all the details of the guideline recommendations and how they were developed, and information about the evidence on which they were based

- a version called the NICE guideline, which lists all the recommendations
- the quick reference guide, which is a summary of the main recommendations for in-patient healthcare professionals and emergency department staff.

All versions of the guideline are available from the NICE website ([www.nice.org.uk](http://www.nice.org.uk)). This version and the quick reference guide are also available from the Department of Health Publications Order Line – phone 0870 1555 455 and give the reference number(s) of the booklets you want (N0829 for this version, N0830 for this version in English and Welsh, and N0828 for the quick reference guide).

## If you want to know more about NICE

For further information about the National Institute for Clinical Excellence (NICE) you can visit the NICE website at [www.nice.org.uk](http://www.nice.org.uk). At the NICE website you can also find information for the public about NICE guidance on schizophrenia. This can also be ordered from the Department of Health Publications Order Line (phone 0870 1555 455) and quote reference N0177 for a version in English, and N0178 for a version in English and Welsh.

## Explanation of technical words used

**Advance directive:** a document that contains the instructions of a person with mental health problems setting out their requests in the event of a relapse, or an incident of disturbed/violent behaviour etc. It sets out the treatment that they do not want to receive and any treatment preferences that they may have in the event that they become violent. It also contains people who they wish to be contacted and any other personal arrangement that they wish to be made.

**Advocate:** an independent person whose job it is to support service users and to help them address their needs. They are often available to attend meetings with healthcare professionals to ensure that the service user's views are put forward and that the service user understands the discussion.

**Antipsychotic:** medicines that block the effects of the excess dopamine (a chemical in the brain) that cause psychosis.

**Benzodiazepine:** a type of medication used to make people sleep and also to make people feel calmer.

**Care plan:** this document is a key part of your care and treatment. You will usually have a general care plan drawn up when first coming into contact with services and also a specific care plan for your time as an in-patient. It sets out in detail areas such as: your current living and family situations, occupation, diagnosis, records of assessments, treatment options, who your care-coordinator is (this is the person who oversees your care and with whom you can discuss your treatment etc), the name of a specific keyworker for your stay as an in-patient, other staff members or services who are involved in your care (for example, social services), and details of regular reviews. Your care plan should be where details of your advance directive are kept.

**CCTV:** video surveillance equipment that is used to help staff ensure that all areas of the environment are safe.

**De-escalation:** a way of trying to help someone who is distressed or disturbed to calm down. This involves talking through what the problems or difficulties may be, and may involve going to a quiet area with a staff member. The staff member should also talk to the person about possible ways of helping these problems or difficulties.

**Intervention:** activities used to prevent violence from happening and/or to manage violent situations when they occur. The interventions used include: calming techniques (de-escalation); being observed (observation and engagement); using medication (rapid tranquillisation); being taken to a room (seclusion); or being physically held (physical intervention).

**Key worker:** the member of the mental health team who has a specific responsibility for the service user and is usually the first person to contact in an emergency.

**Observation:** an intervention that is used when there is a risk that disturbed/violent behaviour might occur. There are different types of observation/engagement, depending on the situation. During this intervention a healthcare professional will closely watch the service user, and will talk to the service user about the risk of disturbed/violent behaviour. The level of risk will be used to decide whether the healthcare professional should check on the service user at regular intervals, or whether they should be constantly present.

**Post-incident review:** A review carried out within 72 hours of an incident to see what happened, what can be learnt to prevent it happening again or how to manage it better. It is not about blaming anyone.

**Psychosis:** the medical word used to describe mental health problems that stop the person from thinking clearly, understanding what's real and what's not, and acting in a normal way. It happens when cells in the brain release too much of a chemical called dopamine. The excessive amounts of dopamine overstimulate the brain, which gives rise to the symptoms of psychosis.

**'Rub down' search:** a search that can include searching pockets, head, hair, around and inside ears, nose and mouth, and under the tongue. The search is done around the collar and tops of the shoulder, and using flat open hands a nurse will check the arms, the front of the body from the neck to the waist, the sides from the armpits to the waist and the front of the waistband. It also includes the back of the collar to the waist, the back of the waistband and the seat of the trousers, the back and sides of each leg from the crotch to the ankle, and the front of the abdomen and the sides of each leg.

**Seclusion room:** a room for the specific purpose of separating a service user from other people if he or she is acting in a violent way. It must meet the requirements laid down in the Mental Health Act Code of Practice.

**Special needs:** needs that relate to service users with communication difficulties, or who may be deaf or blind, or who have particular vulnerabilities.

**Violence:** the use of physical force that is intended to hurt or injure another person.





*National Institute for  
Clinical Excellence*

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MidCity Place  
71 High Holborn  
London  
WC1V 6NA

[www.nice.org.uk](http://www.nice.org.uk)