Complete Summary

GUIDELINE TITLE

Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments.

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Nursing and Supportive Care. Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. London (UK): National Institute for Clinical Excellence (NICE); 2005 Feb. 292 p.

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- September 17, 2007, Haloperidol (Haldol): Johnson and Johnson and the U.S. Food and Drug Administration (FDA) informed healthcare professionals that the WARNINGS section of the prescribing information for haloperidol has been revised to include a new Cardiovascular subsection.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Disturbed/violent behaviour

GUIDELINE CATEGORY

Evaluation
Management
Prevention
Risk Assessment
Treatment

CLINICAL SPECIALTY

Emergency Medicine
Internal Medicine
Nursing
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Emergency Medical Technicians/Paramedics
Health Care Providers
Hospitals
Nurses
Occupational Therapists
Patients
Physical Therapists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

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

TARGET POPULATION

Adults (>16 years) who exhibit disturbed/violent behaviour across the range of adult psychiatric in-patient settings and emergency departments

Excluded are adults with learning disabilities, patients with a primary diagnosis of substance abuse, and patients with organic brain disorders or progressive neurological disease.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Requirements for environment of in-patient psychiatric settings
    - Maintenance of safety and security
    - Accommodation of service users' needs (e.g., for daily activities such as exercise, recreation, therapy) and concerns
    - Use of alarms
    - Maintenance of safety of clinical environment
    - Establishment of policies for police intervention
2. Prediction of disturbed/violent behavior
    - Establishment of policies and strategies
    - Risk assessment and recognition of risk factors
    - Recognition of antecedents and warning signs
3. Staff training
    - Establishment of policies for staff training
    - Training in racial, cultural, social, ethnic, gender, and special needs of service users
    - Training in incident recording
    - Use of refresher training courses, as needed
    - Evaluation of training
    - Service user involvement in training
4. Working with service users
    - Creation of a feeling of safety and understanding
    - Creation of special provisions for pregnant women
    - Maintenance of adequate service provision to black and minority ethnic service users and service users with disabilities
    - Management of the risk of human immunodeficiency virus (HIV) or other infectious diseases
    - Maintenance of confidentiality
5. Establishment and carrying out of a policy for searching of service users and visitors
6. Use of de-escalation techniques
7. Observation and engagement interventions
    - Establishment of observation and engagement policies
    - Recognition of antecedents or warning signs that observation is required
    - Carrying out observation
    - Use of nurses and other staff for observation
    - Recognition of service user needs
8. Physical interventions
9. Seclusion
10. Rapid tranquillisation*
    - Policies for rapid tranquillisation

    - Recognition of risks of rapid tranquillisation
    - Use of oral or parenteral medication (antipsychotics [haloperidol, risperidone, olanzapine]; benzodiazepines [lorazepam])
11. Incident reporting and post-incident reviews following rapid tranquillisations, physical interventions, and seclusion
12. Interventions to be used by emergency department staff

*See "Major Recommendations" for medications specifically not recommended or not recommended routinely for rapid tranquillisation.

MAJOR OUTCOMES CONSIDERED

- Incidence of disturbed/violent behaviour
- Appropriateness, effectiveness, and safety of de-escalation techniques and other interventions
- Effectiveness of staff training
- Side effects and adverse reactions of pharmacological interventions
- Staff and service user perspectives on techniques and intervention procedures
- Sensitivity, specificity, and positive and negative predictive values of screening tools
- Economic outcomes

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

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

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

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

The search strategies were structured as follows:

- An overarching strategy for interventions (covered environment, prediction, de-escalation, observation, physical interventions, seclusion, and rapid tranquillisation, along with service user and staff perspectives on these interventions) across a wide range of databases

- A search of additional databases to identify guidance and reports not indexed in databases searched
- A topic specific search strategy on major databases (See Appendix 4 of the original guideline document. for more details.)

Handsearching was not undertaken following National Institute for Health and Clinical Excellence (NICE) advice that exhaustive searching on every guideline review topic is not practical or efficient. Reference lists of relevant order papers were checked for articles of potential relevance.

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

The databases searched, logs of results and all search strategies can be found in Appendix 4 of the original guideline document. Unless otherwise stated all searches were run from 1985-2002/3. Searches began from this date as this guideline updates the RCPsych guideline, *The Management of Imminent Violence*, 1998, which was due for review. GDG members were asked throughout the guideline development process whether any further relevant research had been identified post search that might impact on the recommendations.

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

Sifting and Reviewing the Evidence

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

- 1st sift: Sift for material that potentially meets eligibility criteria on basis of title/abstract by two reviewers
- 2nd Sift: Full papers ordered that appear relevant and eligible or where relevance/eligibility not clear from abstract
- 3rd Sift: Full articles critically appraised and checked by one reviewer

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

Cost Effectiveness Identification of Papers

Searches were undertaken by the School of Health and Related Research at the University of Sheffield (SchARR) alongside the clinical literature reviews to identify relevant cost-effectiveness, cost utility, and cost-benefit analyses. Details of the databases searched and the search strategies can be found in Appendix 9 of the original guideline document. Titles and abstracts were sifted and relevant papers ordered by one reviewer.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

1++ High quality meta-analyses, systematic review of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+ Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1- Meta-analyses, systematic review of RCTs, or RCTs with a high risk of bias*

2++ High quality systematic reviews of case-control or cohort studies. High quality case-control or cohort studies with a very low risk of confounding, bias, or chance and a high probability that the relationship is causal

2+ Well conducted case-control or cohort studies with a low risk of confounding, bias, or chance and a moderate probability that the relationship is causal

2- Case-control or cohort studies with a high risk of confounding, bias, or chance and a significant risk that the relationship is not causal*

3 Non-analytic studies (for example, case reports, case series)

4 Expert opinion, formal consensus

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

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Data Extraction

Study appraisal and methodological quality were assessed using checklists designed with assistance from the Centre for Statistics in Medicine at Oxford University. (Quality principles can be found in Appendix 10 of the original guideline document.) Data was abstracted by a single reviewer and evidence tables compiled. Over 50% of all articles were then subject to a second quality assessment by a second reviewer. Any discrepancies between reviewers were

resolved by discussion. Where needed, a third reviewer assisted with decisions on the inclusion or exclusion of a study.

The following were extracted where possible (the reporting of many studies sometimes lacked essential detail) and relevant:

> Author, setting, number of participants at baseline and follow-up, methods and details of baseline and outcome measures, results including summary statistics and 95% confidence intervals, and comments made on methodological quality

Masked assessment, whereby data extractors are blind to the details of the journal, authors, etc., was not undertaken because there is no evidence to support the claim that this minimises bias.

Data Synthesis

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

Appraisal of Methodological Quality

Very limited evidence for each of the review questions listed below was found. The resulting evidence reviews must therefore be viewed as mapping exercises, which aimed to highlight the range of research undertaken (which was often of mixed quality), in order to facilitate informed discussion by the Guideline Development Group (GDG), to assist with deliberations around recommendation formulation and also to identify research gaps

Where a study was particularly weak it was excluded (see Appendix 6 of the original guideline document). It was considered particularly weak where the number of confounders and flaws were great enough to jeopardise the results. Concerns regarding the quality of individual studies are detailed in the relevant evidence table.

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

- Inappropriately small sample sizes
- Inter-rater reliability not always quantified where applicable
- Conclusions do not always appear to be supported by a study's results.
- Methodologies are not always sound (that is, don't adhere to standard processes).
- Designs do not always appear appropriate - sometimes this is recognised by the authors.
- Methods of analysis are not always clearly outlined.
- Under-reporting
- Lack of detail about follow-up duration, losses to follow-up, and drop-out rates

- Descriptions of interventions are not always adequate; descriptions of how outcomes were measured are not always adequate or are sometimes lacking.
- Poor reporting

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

Authors were not contacted about any of the included studies due to time constraints and the age of many of the studies.

In areas without sufficient evidence, previous guideline material was collated to help facilitate informed discussion by the GDG.

Clinicians and service users were also invited to give presentations on areas without sufficient evidence at guideline development group meetings to facilitate discussion. They acted as experts in these capacities. They sat within the group and entered fully into discussion. However, they were not GDG members and did not have voting rights, nor were they involved in drawing up the final wording of the recommendations.

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

Evidence Grading

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

The available evidence for each intervention and related topic was compiled into individual evidence reviews, including health economics information. A summary of all recent reports and guidelines on the topic was also compiled. All this information was then presented to the GDG.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Nominal Group Technique)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guideline recommendations were developed by a multidisciplinary and lay Guideline Development Group (GDG) convened by the National Institute for Health and Clinical Excellence (NICE)-funded National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) with membership approved by NICE. The GDG met 15 times between May 2002 and November 2004.

Grading Recommendations

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

In this guideline, D grade recommendations are differentiated from good practice points (GPP), which also have little or no evidence. Both carry a D grade status, but unlike D grade recommendations, GPPs are principles of practice. The recommendations for this guideline were graded A to D, using the current NICE approach.

Good practice points, as well as D recommendations were arrived at using a formal consensus method.

Consensus Process

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

A modified nominal group technique was used to finalise the recommendations and good practice points. An external facilitator was used to chair the meeting. The consensus process was facilitated by computerised voting consoles, which assured anonymity and allowed percentages to be quickly calculated. It also allowed the GDG to view the range of responses in the form of a graph immediately once voting had occurred. Consensus was set at 80% unless a significant group within the GDG all voted against a recommendation (e.g., if all the psychiatrists voted against a recommendation, even though 80% agreement was achieved, consensus was not considered to have been reached).

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

Grading of Recommendations

Grade A: At least one meta-analysis, systematic review, or randomised controlled trial (RCT) rated as 1++, and directly applicable to the target population, **or**

A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results

Evidence drawn from a NICE technology appraisal.

Grade B: A body of evidence including studies rated as 2++, directly applicable to the target population and demonstrating overall consistency of results, **or**

Extrapolated evidence from studies rated as 1++ or 1+

Grade C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, **or**

Extrapolated evidence from studies rated as 2++

Grade D: Evidence level 3 or 4, **or**

Formal consensus

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

COST ANALYSIS

Reviewing the Evidence

Eligible papers were assessed using the Drummond checklist by one reviewer. Evidence tables were produced for each included paper by one reviewer.

Estimation of Cost Effectiveness

The scope of the guideline is broad and includes the assessment of risk, as well as the short-term management of disturbed/violent behaviour across the whole of range of adult in-patient settings. Little, if any, economic evidence was found for most areas of the guideline. Limited primary economic analysis was undertaken in relation to Immediate Life Support (ILS) training. In many areas the evidence-base was, however, too weak to allow even limited primary economic analysis. (See full details in Appendix 9 of the original guideline document).

Details of the results of the cost analyses are provided in the original guideline document. In addition, National Institute for Health and Clinical Excellence (NICE) has published a "National Cost Impact Report" to accompany this guidance (see the "Companion Documents" field).

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

1. The first draft of the guideline (The full guideline, National Institute for Health and Clinical Excellence [NICE] guideline and Quick Reference Guide) were consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG)
2. The final consultation draft of the Full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

   The final draft was submitted to the Guideline Review Panel for review prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence **(I-IV)** and grading of recommendations **(A-D, [GPP])** are defined at the end of the "Major Recommendations" field.

Environment (In-Patient Psychiatric Settings)

The physical and therapeutic environment can have a strong, mitigating effect on the short-term management of disturbed/violent behaviour. The following recommendations are the minimum requirements that should be expected within inpatient psychiatric settings.

Safety and Security

D - When staff are engaged in the short-term management of disturbed/violent behaviour, every effort should be made to manage the service user in an open care setting.

D - All services should provide a designated area or room that staff may consider using, with the service user's agreement, specifically for the purpose of reducing arousal and/or agitation. In services where seclusion is practised, this area should be in addition to a seclusion room (see next recommendation).

D - In services in which seclusion is practiced, there should be a designated seclusion room fit for purpose. This room should allow clear observation, be well insulated and ventilated, have access to toilet/washing facilities, and be able to withstand attack/damage.

D (GPP) - Secure, lockable access to a service user's room, bathroom, and toilet area is required, with external staff override.

D - The internal design of the ward should be arranged to facilitate observation, and sight lines should be unimpeded (for example, not obstructed by the opening of doors). Measures should be taken to address blind spots within the facility, including consideration of the use of closed-circuit television (CCTV) and parabolic mirrors.

D - Facilities should ensure routes of safe entry and exit in the event of an emergency related to disturbed/violent behaviour.

D (GPP) - There should be a separate area to receive service users with police escorts.

Activities and External Areas

D - The environment should take into account the service user's needs.

- Services should be able to accommodate service users' needs for engaging in activities and individual choice-there should be an activity room and a dayroom with a television, as boredom can lead to disturbed/violent behaviour.
- Service users should have single sex toilets, washing facilities, day areas, and sleeping accommodation.
- There should be a space set aside for prayer and quiet reflection.

D (GPP) - There should be daily opportunities for service users to engage in physical exercise, group interaction, therapy, and recreation.

D (GPP) - There should be access to the day room at night for service users who cannot sleep.

D (GPP) - Service users should be able to have easy access to fresh air and natural daylight.

D - Where practicable, access to an external area should be via the unit and where necessary, appropriate standards of fencing should be provided.

Service User Concerns

D - The environment should take into account service user needs for:

- Safety
- Privacy
- Dignity
- Gender- and cultural-sensitivity
- Sufficient physical space
- Social and spiritual expression

D - Where possible, service users should have privacy when making phone calls, receiving guests, and talking to a staff member.

D (GPP) - Facilities should have adequate means of controlling light, temperature, ventilation, and noise.

D (GPP) - Internal smoking areas/rooms should have powerful ventilation and be fitted with a smoke-stop door(s).

D (GPP) - All areas should look and smell clean.

D (GPP) - Suitable access facilities are needed for people who have problems with mobility, orientation, visual or hearing impairment, or other special needs.

Alarms

D - Each service should have a local policy on alarms and determine the need for alarms according to a comprehensive risk assessment of the clinical environment, service users, and staff. The policy should be disseminated, and staff made familiar with its contents.

D (GPP) - Comprehensive risk assessment of the clinical environment should be used to determine whether supplementary personal alarms should be issued to individual staff members and vulnerable service users.

D (GPP) - Collective responses to alarm calls should be agreed before incidents occur. These should be consistently applied and rehearsed.

D (GPP) - Furniture should be arranged so that alarms can be reached and doors are not obstructed.

D (GPP) - Alarms should be accessible in interview rooms, reception areas, and other areas where one service user and one staff member work together.

D (GPP) - All alarms (for example, panic buttons and personal alarms) should be well maintained and checked regularly.

Clinical Environment

D (GPP) - There should be a regular and comprehensive general risk assessment to ensure the safety of the clinical environment.

D (GPP) - Bed occupancy should be decided at a local level and this level should not be exceeded, because overcrowding leads to tension, frustration, and overstretched staff.

D (GPP) - There should be a stable and consistent in-patient team, as high staff turnover and overuse of short-term bank, locum, and agency healthcare staff may create an unsafe environment.

Interagency Working

D (GPP) - Local protocols should be developed to ensure that the police and staff are aware of the procedures and ascribed roles in an emergency, in order to prevent misunderstanding between different agencies. Such policies should set out what constitutes an emergency requiring police intervention.

Prediction

Disturbed/violent behaviour can never be predicted with 100% accuracy. However, this does not mean that risk assessment should not be carried out.

Policy

D - Measures to reduce disturbed/violent behaviour need to be based on comprehensive risk assessment and risk management. Therefore, mental health service providers should ensure that there is a full risk management strategy for all their services.

Risk Assessment

D (GPP) - Risk assessment should include a structured and sensitive interview with the service user and, where appropriate, carers. Efforts should be made to ascertain the service user's own views about their trigger factors, early warning signs of disturbed/violent behaviour and other vulnerabilities, and the management of these. Sensitive and timely feedback should complete this process.

D (GPP) - Risk assessment should be used to establish whether a care plan should include specific interventions for the short-term management of disturbed/violent behaviour.

D (GPP) - When assessing for risk of disturbed/violent behaviour, care needs to be taken not to make negative assumptions based on ethnicity. Staff members should be aware that cultural mores may manifest as unfamiliar behaviour that could be misinterpreted as being aggressive. The assessment of risk should be objective, with consideration being given to the degree to which the perceived risk can be verified.

D (GPP) - All staff should be aware of the following factors that may provoke disturbed/violent behaviour:

- Attitudinal
- Situational
- Organisational
- Environmental

D - Actuarial tools and structured clinical judgement should be used in a consistent way to assist in risk assessment, although no "gold standard" tool can be recommended.

D - Since the components of risk are dynamic and may change according to circumstance, risk assessment (of the environment and the service user) should be ongoing and care plans based on an accurate and thorough risk assessment.

D - The approach to risk assessment should be multidisciplinary and reflective of the care setting in which it is undertaken. The findings of the risk assessment should be communicated across relevant agencies and care settings, in accordance with the law relating to patient confidentiality.

Antecedents and Warning Signs

D (GPP) - Certain features can serve as warning signs to indicate that a service user may be escalating towards physically violent behaviour. The following list is not intended to be exhaustive and these warning signs should be considered on an individual basis.

- Facial expressions tense and angry
- Increased or prolonged restlessness, body tension, pacing
- General over-arousal of body systems (increased breathing and heart rate, muscle twitching, dilating pupils)
- Increased volume of speech, erratic movements
- Prolonged eye contact
- Discontentment, refusal to communicate, withdrawal, fear, irritation
- Thought processes unclear, poor concentration
- Delusions or hallucinations with violent content
- Verbal threats or gestures
- Replicating, or behaviour similar to that which preceded earlier disturbed/violent episodes
- Reporting anger or violent feelings
- Blocking escape routes

Risk Factors

Certain factors can indicate an increase risk of physically violent behaviour. The following lists are not intended to be exhaustive and these risk factors should be considered on an individual basis.

D (GPP) - Demographic or personal history should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features.

- History of disturbed/violent behaviour
- History of misuse of substances or alcohol
- Carers reporting service user's previous anger or violent feelings
- Previous expression of intent to harm others
- Evidence of rootlessness or "social restlessness"
- Previous use of weapons
- Previous dangerous impulsive acts
- Denial of previous established dangerous acts
- Severity of previous acts
- Known personal trigger factors
- Verbal threat of violence
- Evidence of recent severe stress, particularly loss event or the threat of loss

- One or more of the above in combination with any of the following:
    - Cruelty to animals
    - Reckless driving
    - History of bed wetting
    - Loss of a parent before the age of 8 years

D (GPP) - Clinical variables should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features

- Misuse of substances and/or alcohol
- Drug effects (disinhibition, akathisia)
- Active symptoms of schizophrenia or mania, in particular
    - Delusions or hallucinations focused on a particular person
    - Command hallucinations
    - Preoccupation with violent fantasy
    - Delusions of control (especially with violent theme)
    - Agitation, excitement, overt hostility, or suspiciousness
- Poor collaboration with suggested treatments
- Antisocial, explosive, or impulsive personality traits or disorder
- Organic dysfunction

D (GPP) - Situational variables should be taken into account when assessing the risk of disturbed/violent behaviour, including the following features.

- Extent of social support
- Immediate availability of a potential weapon
- Relationship to potential victim (for example, difficulties in relationship are known)
- Access to potential victim
- Limit setting (for example, staff members setting parameters for activities, choices, etc.)
- Staff attitudes

Training

Staff need to have the appropriate skills to manage disturbed/violent behaviour in psychiatric inpatient settings. Training in the interventions used for the short-term management of disturbed/violent behaviour safeguards both staff and service users. Training that highlights awareness of racial, cultural, social, and religious/spiritual needs, and gender differences, along with other special concerns, also mitigates against disturbed/violent behaviour. Such training should be properly audited to ensure its effectiveness.

Policy

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

D - All service providers should specify who the training provider is and ensure consistency in terms of training and refresher courses.

D - Training relating to the management of disturbed/violent behaviour should be subject to approved national standards. (Note: The National Health Service [NHS] Security Management Service [SMS] is developing a training curriculum for the management of violence. The National Institute for Mental Health in England [NIMHE] is drawing up an accreditation scheme for trainers. The work is due for completion in 2005.)

D - If participants on training courses demonstrate inappropriate attitudes then trainers should pass this information onto the relevant line manager for appropriate action

Specific Staff Training Needs

D - There should be an ongoing programme of training for all staff in racial, cultural, spiritual, social, and special needs issues to ensure that staff are aware of and know how to work with diverse populations and do not perpetuate stereotypes. Such courses should also cover any special populations, such as migrant populations and asylum seekers that are relevant to the locality.

D - All staff whose need is determined by risk assessment should receive ongoing competency training to recognise anger, potential aggression, antecedents, and risk factors of disturbed/violent behaviour and to monitor their own verbal and non-verbal behaviour. Training should include methods of anticipating, de-escalating, or coping with disturbed/violent behaviour.

D - Staff members responsible for carrying out observation and engagement should receive ongoing competency training in observation so that they are equipped with the skills and confidence to engage with service users.

D - All staff involved in administering or prescribing rapid tranquillisation, or monitoring service users to whom parenteral rapid tranquillisation has been administered, should receive ongoing competency training to a minimum of Immediate Life Support (ILS - Resuscitation Council UK) (covers airway, cardiopulmonary resuscitation [CPR], and use of defibrillators).

D - Staff who employ physical intervention or seclusion should as a minimum be trained to Basic Life Support (BLS - Resuscitation Council UK).

D - All staff whose level of need is determined by risk assessment should receive training to ensure current competency in the use of physical intervention which should adhere to approved national standards. (Note: The NHS Security Management Service (SMS) is developing a training curriculum for the management of violence. The National Institute for Mental Health in England (NIMHE) is drawing up an accreditation scheme for trainers. The work is due for completion in 2005.)

D - Service providers should ensure that staff's capability to undertake physical intervention and physical intervention training courses is assessed.

D - All staff whose level of need is determined by risk assessment should receive ongoing competency training in the use of seclusion. Training should include appropriate monitoring arrangements for service users placed in seclusion.

D - All staff involved in rapid tranquillisation should be trained in the use of pulse oximeters.

D - Prescribers and those who administer medicines should be familiar with and have received training in rapid tranquillisation, including:

- The properties of benzodiazepines; their antagonist, flumazenil; antipsychotics; antimuscarinics; and antihistamines
- The risks associated with rapid tranquillisation, including cardio-respiratory effects of the acute administration of these drugs, particularly when the service user is highly aroused and may have been misusing drugs; is dehydrated or possibly physically ill
- The need to titrate doses to effect

D - All staff involved in undertaking of searches should receive appropriate instruction which is repeated and regularly updated.

Incident Recording

D - Training should be given to all appropriate staff to ensure that they are aware of how to correctly record any incident using the appropriate local templates.

Refresher Courses

D - Services should review their training strategy annually to identify those staff groups that require ongoing professional training in the recognition, prevention, and de-escalation of disturbed/violent behaviour and in physical intervention to manage disturbed/violent behaviour.

Evaluating Training

D - All training should be evaluated, including training in racial, cultural, religious/spiritual, and gender issues, along with training that focuses on other special service user concerns.

D - Independent bodies/service user groups should, if possible, be involved in evaluating the effectiveness of training.

Service User Training/Involvement in Training

D - Service users and/or service user groups should have the opportunity to become actively involved in training and setting the training agenda, for example groups with potential vulnerabilities such as:

- Service users with a sensory impairment
- Black and minority ethnic service users
- Service users with a physical impairment

- Service users with a cognitive impairment
- Female service users
- Service users with communication difficulties

Working with Service Users

There is a growing acceptance that service users in adult psychiatric in-patient settings ought to be involved in their care, as far as possible. This extends to the short-term management of disturbed/violent behaviour where service user input can be made through measures such as advance directives. Listening to service users' views and taking them seriously is now also regarded as an important factor in the short-term management of disturbed/violent behaviour. Service users may also have physical needs that need to be taken into account when using the interventions discussed in this guideline. The recommendations and good practice points that follow also address the needs that arise from diversity (cultural, social, religious/spiritual, and gender-related needs) and physical needs in the context of the short-term management of disturbed/violent behaviour. It is important that service users should not be treated less favourably on the basis of their culture, gender, diagnosis, sexual orientation, disability, ethnicity, or religious/spiritual beliefs.

Creating a Feeling of Safety and Understanding

Preventing disturbed/violent behaviour is a priority. Providing relevant information so that service users feel safe and understand what may happen to them in the event that they become disturbed/violent will help prevent unnecessary aggravation.

D - All service users, regardless of culture, gender, diagnosis, sexual orientation, disability, ethnicity, or religious/spiritual beliefs should be treated with dignity and respect.

D - Service users should have access to information about the following in a suitable format:

- Which staff member has been assigned to them and how and when they can be contacted
- Why they have been admitted (and if detained, the reason for detention, the powers used and their extent, and rights of appeal)
- What their rights are with regard to consent to treatments, complaints procedures, and access to independent help and advocacy
- What may happen if they become disturbed/violent
- This information needs to be provided at each admission, repeated as necessary, and recorded in the notes.

D (GPP) - An effective and fair complaints procedure should be put in place.

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

D - Service users identified to be at risk of disturbed/violent behaviour should be given the opportunity to have their needs and wishes recorded in the form of an advance directive. This should fit within the context of their overall care and should clearly state what intervention(s) they would and would not wish to receive. This document should be subject to periodic review.

D (GPP) - During the staff/service user risk assessment interview, where a risk of disturbed/violent behaviour is discussed or identified as a possibility, intervention and management strategies (and the service user's preferences regarding these) should be recorded in the service user's care plan and healthcare record. Efforts should be made to ascertain the service user's own views about their trigger factors, early warning signs of disturbed/violent behaviour, and other vulnerabilities, and the management of these. The service user should be given a copy of the care plan and, subject to their agreement, a copy should be given to their carer.

D (GPP) - The physical needs of the service user should be assessed on admission or as soon as possible thereafter and then regularly reassessed. The care plan should reflect the service user's physical needs.

D - Following any intervention for the short-term management of disturbed/violent behaviour, every opportunity should be taken to establish whether the service user understands why this has happened. Where possible, this should be carried out by a staff member not directly involved in the intervention. This should be documented in the service user's notes.

D (GPP) - Staff should take time to listen to service users, including those from diverse backgrounds (taking into account that this may take longer when using interpreters), so that therapeutic relationships can be established.

D - All services should have a policy for preventing and dealing with all forms of harassment and abuse. Notification of this policy should be disseminated to all staff and displayed prominently in all clinical and public areas.

D (GPP) - In the event of any form of alleged abuse, the matter should be dealt with by staff as soon as is practicable in accordance with relevant policies of the service.

D (GPP) - During the administration or supply of medicines to service users, confidentiality should be ensured.

D (GPP) - Prescribers should be available for and responsive to requests from the service user for medication review.

D - Staff should be encouraged to talk to service users from diverse backgrounds, including those with special needs, about their experiences and to offer them support and understanding, especially if their experience has been negative.

Pregnant Women

D (GPP) - Special provision should be made for pregnant women in the event that interventions for the short-term management of disturbed/violent behaviour are needed. These should be recorded in the service user's care plan.

Black and Minority Ethnic Service Users

See also recommendation under "Risk Assessment."

D - Services must identify a board member to take specific responsibility for all matters relating to equality and diversity. Responsibilities must include the nature and adequacy of service provision in relation to the short-term management of disturbed/violent behaviour, training on all matters relating to equality and diversity, monitoring service usage by ethnicity, and consultation with local Black and minority ethnic groups.

Service Users with Disabilities

D (GPP) - Each service should have a policy that outlines the procedures for dealing with service users who have disabilities, including those with physical or sensory impairment and/or other communication difficulties.

D (GPP) - Individual care plans should detail staff responsibilities for de-escalation, rapid tranquillisation, physical intervention, and seclusion of service users who have disabilities, including those with physical or sensory impairment and/or other communication difficulties.

Managing the Risk of Human Immunodeficiency Virus (HIV) or Other Infectious Diseases

Policy

D (GPP) - Services should have policies in place, developed in conjunction with the Trust infection control officer or relevant officer in the service, that outline the reasonable steps that can be taken to safeguard staff and other service users if a service user who has HIV, hepatitis, or other infectious or contagious diseases is acting in a manner that may endanger others.

D (GPP) - If staff are aware that a service user has HIV, hepatitis, or other infectious or contagious diseases, the advice of the Trust infection control officer or relevant officer in the service should be sought.

Confidentiality Issues

D (GPP) - Service users are owed important obligations of confidentiality but these are not absolute. In certain circumstances they may be breached to safeguard others. This is particularly relevant where a service user has HIV, hepatitis, or other infectious or contagious diseases, and is acting in a manner that puts others at risk. Legal and ethical advice should be sought in these circumstances.

D (GPP) - If any service user or staff member has sustained any injury during the management of disturbed/violent behaviour where blood has been spilt or the skin has been broken, or there has been direct contact with bodily fluids (all bodily fluids should be treated as potentially infectious), the local infection control policy should be followed.

Searching

The undertaking of necessary and lawful searches of both service users and visitors can make an important contribution to the effective management of disturbed/violent behaviour in psychiatric in-patient settings. Unlawful, insensitive and unnecessary searches can also exacerbate disturbed/violent behaviour. Searches should be undertaken by appropriately trained staff. See also recommendations under "Training."

Policy

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

D - The searching policy should address all aspects of personal through to environmental searching, from the decision to initiate a search through to the storage, return, or other disposal (including the lawful disposal of any items such as firearms and illicit drugs) of items found.

D - Post-search support for all those involved should be provided.

D - The searching policy should set out, in terms that can easily be understood by all those with responsibilities under the policy, the legal grounds for undertaking searches in the absence of consent.

D - The searching policy should specifically address the searching of service users detained under the Mental Health Act; informal service users without capacity to consent at the time of the search; informal service users with capacity to do so; and staff and visitors.

D - The searching policy should also extend to the routine and random searching of detained service users, where it is proposed to do so because there is a pressing social need to do so (for example, there is a chronic substance abuse problem on the ward) and undertaking such searches is a proportionate response to that need.

Carrying Out Searches

D - The level of intrusiveness of any personal search undertaken must be a reasonable and proportionate response to the reason for the search. Ordinarily,

rub down or personal searching should be provided for in the policy together with procedures for their authorisation in the absence of consent.

D - All searches should be undertaken with due regard to the service user's dignity and privacy and by a member(s) of staff of the same sex.

D - The searching policy should provide for the circumstances in which a service user physically resists being searched. In this event a multidisciplinary decision should be made as to the need to carry out a search using physical intervention. If a decision is made not to proceed, then the searching policy should set out the options available to deal with the situation.

D - The searching policy should make provision for the following:

- Service users, staff, and visitors should be informed that there is a policy on searching.
- The consent of the person it is proposed to search should always be sought.
- The person being searched should be kept informed of what is happening and why.
- A comprehensive record of every search should be made, including its justification.
- Any consequent risk assessment and risk management should be placed in the appropriate records.

D - Following every search undertaken where consent has been withheld there should be a post-incident review that includes an advocacy service or hospital managers visiting the service user who has been searched.

D - The exercise of powers of search should be audited regularly and the outcomes reported regularly to the Trust Board or appropriate body.

De-escalation Techniques

De-escalation involves the use of techniques that calm down an escalating situation or service user; therefore, action plans should stress that de-escalation should be employed early on in any escalating situation. Action plans should be developed at a local level that detail how to call for help in an emergency.

See also recommendations under "Environment" and "Training."

General

D (GPP) - A service user's anger needs to be treated with an appropriate, measured, and reasonable response. De-escalation techniques should be employed prior to other interventions being used.

D (GPP) - Staff should accept that in a crisis situation they are responsible for avoiding provocation. It is not realistic to expect the person exhibiting disturbed/violent behaviour to simply calm down.

D (GPP) - Staff should learn to recognise what generally and specifically upsets and calms people. This will involve listening to individual service users' and carers' reports of what upsets the service user, and this should be reflected in the service user's care plan.

D (GPP) - Staff should be aware of, and learn to monitor and control, their own verbal and nonverbal behaviour, such as body posture and eye contact.

D (GPP) - Where possible and appropriate, service users should be encouraged to recognise their own trigger factors, early warning signs of disturbed/violent behaviour, and other vulnerabilities. This information should be included in care plans and a copy given to the service user. Service users should also be encouraged to discuss and negotiate their wishes should they become agitated.

D (GPP) - Where de-escalation techniques fail to sufficiently calm a situation or service user, staff should remember that verbal de-escalation is an ongoing element of the management of an escalating individual. Verbal de-escalation is supported but not replaced by appropriate physical intervention.

De-escalation Techniques

D (GPP) - One staff member should assume control of a potentially disturbed/violent situation.

D (GPP) - The staff member who has taken control should:

- Consider which de-escalation techniques are appropriate for the situation
- Manage others in the environment, for example removing other service users from the area, enlisting the help of colleagues, and creating space
- Explain to the service user and others in the immediate vicinity what they intend to do
- Give clear, brief, assertive instructions
- Move towards a safe place and avoid being trapped in a corner

D (GPP) - The staff member who has taken control should ask for facts about the problem and encourage reasoning. This will involve:

- Attempting to establish a rapport and emphasising cooperation
- Offering and negotiating realistic options and avoiding threats
- Asking open questions and inquiring about the reason for the service user's anger, for example "What has caused you to feel upset/angry?"
- Showing concern and attentiveness through non-verbal and verbal responses
- Listening carefully and showing empathy, acknowledging any grievances, concerns, or frustrations, and not being patronising or minimising service user concerns

D (GPP) - The staff member who has taken control should ensure that their own nonverbal communication is non-threatening and not provocative. This will involve:

- Paying attention to nonverbal cues, such as eye contact and allowing greater body space than normal
- Adopting a non-threatening but safe posture
- Appearing calm, self-controlled, and confident without being dismissive or over-bearing

D (GPP) - Where there are potential weapons the disturbed/violent person should be relocated to a safer environment, where at all possible.

D (GPP) - Where weapons are involved a staff member should ask for the weapon to be placed in a neutral location rather than handed over.

D (GPP) - Staff should consider asking the service user to make use of the designated area or room specifically for the purpose of reducing arousal and/or agitation to help them calm down. In services where seclusion is practised, the seclusion room should not routinely be used for this purpose. See also recommendations under "Safety and Security."

Observation and Engagement

The primary aim of observation should be to engage positively with the service user. This involves a two-way relationship, established between a service user and a staff member, which is meaningful, grounded in trust, and therapeutic for the service user. Observation is an intervention that is used both for the short-term management of disturbed/violent behaviour and to prevent self-harm. The recommendations and good practice points below are specifically directed towards the use of observation as an intervention for the short-term management of disturbed/violent behaviour. However, many are also applicable where observation is used to prevent self-harm. The terminology covers both uses of observation.

See also recommendations under "Training."

Policy

D - Each service should have a policy on observation and engagement that adheres to contemporary NICE terminology and definitions. This policy should include:

- Who can instigate observation above a general level
- Who can increase or decrease the level of observation
- Who should review the level of observation
- When reviews should take place (at least every shift)
- How service users' perspectives will be taken into account
- A process through which a review by a full clinical team will take place if observation above a general level continues for more than 1 week

Definitions of Levels of Observation

D - The observation terminology used in this guideline should be adopted across England and Wales to ensure consistency of use.

D - *General observation* is the minimum acceptable level of observation for all in-patients. The location of all service users should be known to staff, but not all service users need to be kept within sight. At least once a shift a nurse should set aside dedicated time to assess the mental state of the service user and engage positively with the service user. The aim of this should be to develop a positive, caring, and therapeutic relationship with the service user. This assessment should always include an evaluation of the service user's moods and behaviours associated with risks of disturbed/violent behaviour, and these should be recorded in the notes.

D - *Intermittent observation* means that the service user's location should be checked every 15 to 30 minutes (exact times to be specified in the notes). Checks need to be carried out sensitively in order to cause as little intrusion as possible. However, this check should also be seen in terms of positive engagement with the service user. This level is appropriate when service users are potentially, but not immediately, at risk of disturbed/violent behaviour. Service users who have previously been at risk of harming themselves or others, but who are in a process of recovery, require intermittent observation.

D - *Within eyesight* means the service user should be kept within eyesight and accessible at all times, by day and by night and, if deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed. It is required when the service user could, at any time, make an attempt to harm themselves or others. It may be necessary to search the service user and their belongings, while having due regard for the service user's legal rights and conducting the search in a sensitive way. Positive engagement with the service user is an essential aspect of this level of observation.

D - *Within arms length* is needed for service users at the highest levels of risk of harming themselves or others, who may need to be supervised in close proximity. On specified occasions more than one member of staff may be necessary. Issues of privacy, dignity, and the consideration of gender in allocating staff, and the environmental dangers need to be discussed and incorporated into the care plan. Positive engagement with the service user is an essential aspect of this level of observation.

Possible Antecedents or Warning Signs that Observation is Required

D (GPP) - In addition to the antecedents that indicate disturbed/violent behaviour (See recommendations under "Antecedents and Warning Signs" in the "Prediction" section), observation above a general level should be considered if any of the following are present:

- History of previous suicide attempts, self-harm or attacks on others
- Hallucinations, particularly voices suggesting harm to self or others
- Paranoid ideas where the service user believes that other people pose a threat
- Thoughts or ideas that the service user has about harming themselves or others
- Threat control override symptoms
- Past or current problems with drugs or alcohol
- Recent loss

- Poor adherence to medication programmes or non-compliance with medication programmes
- Marked changes in behaviour or medication
- Known risk indicators

Carrying Out Observation

D (GPP) - Designated levels of observation should only be implemented after positive engagement with the service user has failed to dissipate the potential for disturbed/violent behaviour.

D (GPP) - The least intrusive level of observation that is appropriate to the situation should always be adopted so that due sensitivity is given to a service user's dignity and privacy whilst maintaining the safety of those around them.

D (GPP) - Decisions about observation levels should be recorded by both medical and nursing entries in the service user's notes. The reasons for using observation should be clearly specified.

D (GPP) - All decisions about the specific level of observation should take into account:

- The service user's current mental state
- Any prescribed medications and their effects
- The current assessment of risk
- The views of the service user as far as possible

D (GPP) - When making decisions about observation levels, clear directions should be recorded that specify:

- The name/title of the persons who will be responsible for carrying out the review
- The timing of the review

D - Observation skills should be used to recognise, prevent, and therapeutically manage disturbed/violent behaviour. Specific observation tasks should be undertaken by registered nurses, who may delegate to competent persons.

D (GPP) - Nurses and other staff undertaking observation:

- Should take an active role in engaging positively with the service user
- Should be appropriately briefed about the service user's history, background, specific risk factors, and particular needs
- Should be familiar with the ward, the ward policy for emergency procedures, and potential risks in the environment
- Should be able to increase or decrease the level of engagement with the service user as the level of observation changes
- Should be approachable, listen to the service user, know when self-disclosure and the therapeutic use of silence are appropriate, and be able to convey to the service user that they are valued

D - An individual staff member should not undertake a continuous period of observation above the general level for longer than 2 hours.

D (GPP) - The service user's psychiatrist/on-call doctor should be informed of any decisions concerning observation above the general level as soon as possible.

D (GPP) - A nominated hospital manager should be made aware when observation above the general level is implemented so that adequate numbers and grades of staff can be made available for future shifts.

D (GPP) - Staff members should be aware that service users sometimes find observation provocative, and that it can lead to feelings of isolation and even dehumanisation.

Service User Needs

D (GPP) - The service user should be provided with information about why they are under observation, the aims of observation, and how long it is likely to be maintained.

D (GPP) - The aims and level of observation should, where appropriate, be communicated with the service user's approval to the nearest relative, friend, or carer.

D (GPP) - Although difficult, where possible, the handover from one nurse or staff member to another should involve the service user so that they are aware of what is being said about them.

Other Interventions

Where de-escalation techniques have failed to calm a service user, it may be necessary to make use of additional interventions, such as physical intervention, rapid tranquillisation, and seclusion to manage the incident. All such interventions should only be considered once de-escalation techniques have been tried and have not succeeded in calming the service user. The choice of intervention(s) will depend on a number of factors, but should be guided primarily by:

- Service user preference (if known)
- The clinical needs of, and risks to, the service user
- Obligations to other service users affected by the disturbed/violent behaviour
- The protection of staff, service users, and visitors
- The facilities available within the particular setting

The intervention selected must amount to a proportionate and reasonable response to the risk posed. This section should be read alongside the Mental Health Act Code of Practice (www.dh.gov.uk/assetRoot/04/07/49/61/04074961.pdf).

Overarching Recommendations

See also recommendations under "Training" and "Incident Reporting."

D - Rapid tranquillisation, physical intervention, and seclusion should only be considered once de-escalation and other strategies have failed to calm the service user. These interventions are management strategies and are not regarded as primary treatment techniques. When determining which interventions to employ, clinical need, safety of service users and others, and, where possible, advance directives should be taken into account. The intervention selected must be a reasonable and proportionate response to the risk posed by the service user.

Equipment

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

Personnel

D - At all times, a doctor should be quickly available to attend an alert by staff members when rapid tranquillisation, physical intervention, and/or seclusion are implemented. (Note: The Bennett report recommended that a doctor should be available within 20 minutes. The Guideline Development Group considers quick attendance to mean within 30 minutes of an alert.)

Legal Concerns

D (GPP) - All staff need to be aware of the legal framework that authorises the use of rapid tranquillisation, physical intervention, and seclusion. The guidance of the Mental Health Act Code of Practice (chapter 19) should be followed, with any departures from that guidance clearly recorded and justified as being in the service user's best interest.

Service User Concerns

D (GPP) - When using interventions such as rapid tranquillisation, physical intervention, or seclusion, steps should be taken to try to ensure that the service user does not feel humiliated (such as respecting a service user's need for dignity and privacy commensurate with the needs of administering the intervention).

D (GPP) - The reasons for using rapid tranquillisation, physical intervention, or seclusion should be explained to the service user at the earliest opportunity.

D (GPP) - After the use of rapid tranquillisation, physical intervention, or seclusion, the service user's care plan should be reassessed and the service user should be helped to reintegrate into the ward milieu at the earliest safe opportunity.

D (GPP) - Service users should be given the opportunity to document their account of the intervention in their notes.

Physical Intervention

See also recommendations under "Training."

Carrying Out Physical Intervention

D - During physical intervention, staff should continue to employ de-escalation techniques.

D - There are real dangers with continuous physical intervention in any position. Physical intervention should be avoided if at all possible, should not be used for prolonged periods, and should be brought to an end at the earliest opportunity. To avoid prolonged physical intervention an alternative strategy, such as rapid tranquillisation or seclusion (where available), should be considered.

D - During physical intervention, one team member should be responsible for protecting and supporting the head and neck, where required. The team member who is responsible for supporting the head and neck should take responsibility for leading the team through the physical intervention process, and for ensuring that the airway and breathing are not compromised and that vital signs are monitored.

D - During physical intervention, under no circumstances should direct pressure be applied to the neck, thorax, abdomen, back, or pelvic area. The overall physical and psychological well being of the service user should be continuously monitored throughout the process.

D - A number of physical skills may be used in the management of a disturbed/violent incident.

- The level of force applied must be justifiable, appropriate, reasonable, and proportionate to a specific situation and should be applied for the minimum possible amount of time.
- Every effort should be made to utilise skills and techniques that do not use the deliberate application of pain.
- The deliberate application of pain has no therapeutic value and could only be justified for the immediate rescue of staff, service users and/or others.

D - Mechanical restraints are not a first-line response or standard means of managing disturbed/violent behaviour in acute mental health care settings. In the event that they are used, it must be a justifiable, reasonable, and proportionate response to the risk posed by the service user, and only after a multidisciplinary review has taken place. Legal, independent expert medical and ethical advice should be sought and documented.

Seclusion

See also recommendations under "Environment" and "Training."

Carrying Out Seclusion

D - The use of seclusion should be recorded in accordance with the guidance in the Mental Health Act Code of Practice.

D - Seclusion should be for the shortest time possible and should be reviewed at least every 2 hours and in accordance with the guidance in the Mental Health Act Code of Practice. The service user should be made aware that reviews will take place at least every 2 hours.

D (GPP) - If seclusion is used, an observation schedule should be specified.

D (GPP) - A service user in seclusion should retain their clothing, as long as it does not compromise their safety and the safety of others.

D (GPP) - Service users in seclusion should be allowed to keep personal items including those of religious or cultural significance (such as some items of jewellery) as long as they do not compromise their safety or the safety of others.

Rapid Tranquillisation and Seclusion

D (GPP) - The use of seclusion with rapid tranquillisation is not absolutely contraindicated. However, the following advice should be carefully considered and followed.

- If the service user is secluded, the potential complications of rapid tranquillisation should be taken particularly seriously.
- The service user should be monitored by "within eyesight" observation by an appropriately trained individual.
- Once rapid tranquillisation has taken effect, seclusion should be terminated.

Rapid Tranquillisation

See also recommendations under "Training."

D - Medication for rapid tranquillisation, particularly in the context of physical intervention, should be used with caution owing to the following risks:

- Loss of consciousness instead of tranquillisation
- Sedation with loss of alertness
- Loss of airway
- Cardiovascular and respiratory collapse
- Interaction with medicines already prescribed or illicit substances taken (can cause side effects such as akathisia, disinhibition)
- Possible damage to patient-staff relationship
- Underlying coincidental physical disorders

Policy

D - Local protocols should be produced that cover all aspects of rapid tranquillisation. Such protocols should be in accordance with legal requirements (especially in respect of detained patients, the consent to treatment, and the emergency treatment powers and duties under the Mental Health Act), and relevant National Institute of Health and Clinical Excellence (NICE) guidance, and should be subject to review.

Risks Associated with Rapid Tranquillisation

D (GPP) - There are specific risks associated with the different classes of medications that are used in rapid tranquillisation. The specific properties of the individual drugs should be taken into consideration. When combinations are used, risks may be compounded. Staff need to be aware of the following.

For Benzodiazepines

- Loss of consciousness
- Respiratory depression or arrest
- Cardiovascular collapse (in service users receiving both clozapine and benzodiazepines)

For Antipsychotics

- Loss of consciousness
- Cardiovascular and respiratory complications and collapse
- Seizures
- Subjective experience of restlessness (akathisia)
- Acute muscular rigidity (dystonia)
- Involuntary movements (dyskinesia)
- Neuroleptic malignant syndrome
- Excessive sedation

For Antihistamines

- Excessive sedation
- Painful injection
- Additional antimuscarinic effects

Circumstances for Special Care

D - Extra care should to be taken when implementing rapid tranquillisation in the following circumstances:

- The presence of congenital prolonged QTc syndromes
- The concurrent prescription or use of other medication that lengthens QTc intervals both directly and indirectly
- The presence of certain disorders affecting metabolism, such as hypo- and hyperthermia, stress and extreme emotions, and extreme physical exertion

Carrying Out Rapid Tranquillisation

D - The service user should be able to respond to communication throughout the period of rapid tranquillisation. The aim of rapid tranquillisation is to achieve a state of calm sufficient to minimise the risk posed to the service user or to others.

D (GPP) - When a service user is transferred between units, a full medication history, including the service user's response to medications, any adverse effects, and an advance directive should accompany them. Where possible, the service

user's account of their experience of rapid tranquillisation should also be included. On discharge, all such information should be filed in their healthcare record and be subject to regular review.

Oral Therapy for Rapid Tranquillisation

D - Oral medication should be offered before parenteral medication as far as possible.

D - All medication given in the short-term management of disturbed/violent behaviour should be considered as part of rapid tranquillisation (including pro re nata [PRN] medication taken from an agreed rapid tranquillisation protocol or as part of an advance directive).

D - Oral and intramuscular medications should be prescribed separately and the abbreviation of o/i/m should not be used.

B - When the behavioural disturbance occurs in a non-psychotic context, it is preferable to initially use oral lorazepam alone, or intramuscularly if necessary.

D - When the behavioural disturbance occurs in the context of psychosis, to achieve early onset of calming/sedation or to achieve a lower dose of antipsychotic, an oral antipsychotic in combination with oral lorazepam should be considered in the first instance. (See chart for rapid tranquillisation in the original guideline document.)

B - The Medicines and Healthcare products Regulatory Agency (MHRA) has warned against the use of risperidone or olanzapine in the treatment of behavioural symptoms of dementia, due to increased risk of stroke and death.

B - Sufficient time should be allowed for clinical response between oral doses of medication for rapid tranquillisation. (See chart for rapid tranquillisation in the original guideline document.)

Parenteral Therapy for Rapid Tranquillisation

D - If parenteral treatment proves necessary, the intramuscular route (i/m) is preferred over intravenous (i/v) from a safety point of view. The service user should be transferred to oral routes of administration at the earliest opportunity.

B - Where rapid tranquillisation through oral therapy is refused, is not indicated by previous clinical response, is not a proportionate response, or is ineffective, a combination of an intramuscular antipsychotic and an intramuscular benzodiazepine (i/m haloperidol and i/m lorazepam) is recommended.

B - In the event of moderate disturbance in service users with psychosis, i/m olanzapine may also be considered. Intramuscular lorazepam should not be given within 1 hour of i/m olanzapine. Oral lorazepam should be used with caution. (Note: The manufacturer of olanzapine has issued a warning that use outside of the details contained within the Summary of Product Characteristics may increase the risk of fatality.)

B - There is not sufficient evidence that the safety of either combination of i/m haloperidol with i/m promethazine or i/m midazolam alone has been sufficiently demonstrated in the UK. However, it has been shown to be effective and relatively safe elsewhere. The Guideline Development Group is therefore not able to recommend either for routine psychiatric practice in the UK.

B - Sufficient time should be allowed for clinical response between intramuscular (i/m) doses of medications for rapid tranquillisation. (See chart for rapid tranquillisation in the original guideline document.)

D - The use of two drugs of the same class for the purpose of rapid tranquillisation should not occur.

D (GPP) - Medications should never be mixed in the same syringe.

D - When using i/m haloperidol as a means of managing disturbed/violent behaviour, an antimuscarinic agent such as procyclidine or benzatropine should be immediately available to reduce the risk of dystonia and other extrapyramidal side effects, and should be given intramuscularly or intravenously as per manufacturer's recommendations.

D - Intravenous administration of benzodiazepines or haloperidol should not normally be used except in very exceptional circumstances, which should be specified and recorded. This decision should not be made by junior medical staff in isolation.

D - If immediate tranquillisation is essential then intravenous administration may be necessary. If it is used, staff should be appropriately trained to recognize symptoms of respiratory depression, dystonia, or cardiovascular compromise (such as palpitations, significant changes in blood pressure, or collapse).

D - If intravenous medication is used, the service user should never be left unattended. Intravenous administration should never occur without full access to the full support and resuscitation as outlined in recommendations under "Specific Staff Training Needs" and "Equipment".

D - In very exceptional circumstances, which should be specified and recorded, i/m haloperidol in combination with i/m promethazine, or i/m midazolam alone may be considered as an alternative to intravenous administration of benzodiazepines or haloperidol. This decision should not be made by junior staff without discussion with the senior on-call psychiatrist.

<u>Medications Not Normally Used for Rapid Tranquillisation</u>

B - Zuclopenthixol acetate injection (commonly known as "acuphase" by staff and service users) is not recommended for rapid tranquillisation due to long onset and duration of action. However, zuclopenthixol acetate injection may be considered as an option for rapid tranquillisation when:

- It is clearly expected that the service user will be disturbed/violent over an extended period of time

- A service user has a past history of good and timely response to zuclopenthixol acetate injection
- A service user has a past history of repeated parenteral administration
- An advance directive has been made indicating that this is a treatment of choice

B - It should never be administered to those without any previous exposure to antipsychotic medication. The *British National Formulary* and manufacturer's Summary of Product Characteristics (SPC) should be consulted regarding its use.

Medications Not Recommended for Rapid Tranquillisation

The following medications are not recommended for rapid tranquillisation.

C - Intramuscular or oral chlorpromazine (a local irritant if given intramuscularly; risk of cardiovascular complications; causes hypotension due to alpha-adrenergic receptor blocking effects, especially in the doses required for rapid tranquillisation; is erratically absorbed; its effect on QTc intervals suggests that it is unsuitable for use in rapid tranquillisation)

C - Intramuscular diazepam

C - Thioridazine

D - Intramuscular depot antipsychotics

C - Olanzapine or risperidone should not be used for the management of disturbed/violent behaviour in service users with dementia.

Doses for Rapid Tranquillisation

It is recognised that clinicians may decide that the use of medication outside of the SPC is occasionally justified, bearing in mind the overall risks. However, where the regulatory authorities or manufacturer issues a specific warning that this may result in an increased risk of fatality, the medication should only be used strictly in accordance with the current marketing authorisation.

D - When using rapid tranquillisation there may be certain circumstances in which the current British National Formulary (BNF) uses and limits and SPC may be knowingly exceeded (for example, for lorazepam). This decision should not be taken lightly and the risk should not be underestimated. A risk-benefit analysis should be recorded in the case notes and a rationale should be recorded in the care plan. Where the risk-benefit is unclear, advice may be sought from clinicians not directly involved in the service user's care.

D - If current *BNF* or SPC doses are exceeded, it is particularly important that frequent and intensive monitoring of a calmed service user is undertaken, with particular attention to regular checks of airway, level of consciousness, pulse, blood pressure, respiratory effort, temperature, and hydration.

D - In all circumstances of rapid tranquillisation, the prescriber and medication administrator should pay attention to:

- The total dose of medication prescribed
- Arrangements for review
- Issues of consent, *BNF* and SPC requirements, and physical and mental status of the service user

D (GPP) - The dose of antipsychotic medication should be individualised for each service user. This will be dependent on several factors including the service user's age (older service users generally require lower doses); concomitant physical disorders (such as renal, hepatic, cardiovascular, or neurological); and concurrent medication.

D - A specialist mental health pharmacist should be a member of the multidisciplinary team in all circumstances where rapid tranquillisation is used. These pharmacists have a responsibility to monitor and ensure safe and appropriate usage of medication.

Care After Rapid Tranquillisation

D - After rapid tranquillisation is administered, vital signs should be monitored and pulse oximeters should be available. Blood pressure, pulse, temperature, respiratory rate, and hydration should be recorded regularly, at intervals agreed by a multidisciplinary team, until the service user becomes active again.

D - In the following circumstances, more frequent and intensive monitoring by appropriately trained staff is required and should be recorded in the care plan. Particular attention should be paid to the service user's respiratory effort, airway, and level of consciousness:

- If the service user appears to be or is asleep/sedated
- If intravenous administration has taken place
- If the *BNF* limit or SPC is exceeded
- In high-risk situations
- Where the service user has been using illicit substances or alcohol
- Where the service user has a relevant medical disorder or concurrently prescribed medication

D - If verbal responsiveness is lost as a consequence of administration of medication, a level of care identical to that needed for general anaesthesia should be given.

See original guideline document for Chart for Rapid Tranquillisation, which includes time to maximum plasma concentration, approximate plasma half-life, and licensed indications for each medication.

Incident Reporting and Post-incident Reviews Following Rapid Tranquillisation, Physical Intervention and Seclusion

See also recommendations under "Training."

Incident Reporting

D - Any incident requiring rapid tranquillisation, physical intervention, or seclusion should be recorded contemporaneously, using a local template.

D - Incidents of physical assault should be reported to the NHS Security Management Service (SMS) as per Secretary of State directives November 2003 (www.cfsms.nhs.uk/files/FOI%20-publication%20scheme.pdf).

Post-Incident Reviews

D (GPP) - A post-incident review should take place as soon after the incident as possible, but in any event within 72 hours of the incident ending.

D (GPP) - Mental health service providers should have systems in place with appropriately skilled staff to ensure that a range of options of post-incident support and review mechanisms are available and take place within a culture of learning lessons. The following groups should be considered:

- Staff involved in the incidents
- Service users
- Carers and family where appropriate
- Other service users who witnessed the incident
- Visitors who witnessed the incident
- Independent advocates
- Local Security Management Specialist (SMS)

D (GPP) - The aim of a post-incident review should be to seek to learn lessons, support staff and service users, and encourage the therapeutic relationship between staff, service users and their carers.

D (GPP) - The post-incident review should address what happened during the incident, any trigger factors, each person's role in the incident, how they felt during the incident, how they feel at the time of the review, how they may feel in the near future, and what can be done to address their concerns. If possible, a person not directly involved in the incident should lead the review.

D (GPP) - Appropriate support, including ongoing individual post-incident review sessions, should be available as required.

B - One-off post-incident review sessions have been shown to be unhelpful and should not be undertaken.

D (GPP) - Consequential sick leave and the return to work should be monitored and positively and carefully managed to ensure that staff are supported.

D (GPP) - Consequential sick leave should be audited to identify trends within the organisation to inform future strategy and training in relation to the management of disturbed/violent behaviour.

Emergency Departments

Service users will often attend and be admitted to psychiatric in-patient services through emergency departments. The following section applies specifically to emergency department staff when caring for service users requiring mental health assessments. See recommendations under "Prediction," "Training," "Working with Service Users," "Searching," "De-escalation Techniques," "Other Interventions," and "Incident Reporting and Post Incident Reviews Following Rapid Tranquillisation, Physical Intervention and Seclusion".

Training

D - In addition to ongoing competency training in the management of disturbed/violent behaviour, appropriate staff groups in emergency departments should receive training in the recognition of acute mental illness and awareness of organic differential diagnoses. Service user involvement should be encouraged.

Risk

D (GPP) - Emergency units should have a system in place to alert staff to patient known by the unit to pose a risk of disturbed/violent behaviour, so that steps can be taken to minimise risks to staff and other patients. The system should be reviewed at reasonable intervals to avoid stigmatisation.

Mental Health Assessments

D - On making an initial assessment, if staff working in emergency departments decide a mental health assessment is required, they should seek specialist advice from the relevant mental health professional.

Environment

D - Every emergency department should have at least one designated interview room for mental health assessments. Larger emergency departments (more than 75,000 attendances a year) may require additional rooms. The room(s) should be close to or part of the main emergency department receiving area.

D - The designated interview room(s) should be made available on a priority basis for mental health assessments. It should be of a sufficient size to comfortably accommodate six seated persons, be fitted with an emergency call system, an outward opening door, and a window for observation, have reasonable ventilation, contain soft furnishings, and be clear of potential weapons.

D (GPP) - Staff interviewing a patient in the designated interview room should always inform a senior member of the emergency nursing staff before commencing the interview.

D (GPP) - Ordinarily a chaperone should be present, and interviews without chaperones should only proceed after discussion with relevant staff. When a staff member is alone, 5-minute checks via the interview room window should occur whilst the interview is taking place.

Personnel

D (GPP) - Every emergency department should have access to an identified consultant psychiatrist for liaison with providers of local mental health services.

D - Appropriate psychiatric assessment should be available within 1 hour of alert from the emergency department, at all times.

D (GPP) - In addition to a mental health liaison team, there should be at least one registered mental nurse working with every emergency department. Larger emergency departments (more than 75,000 attendances a year) may require more.

D (GPP) - Emergency departments should be encouraged to employ registered mental nurses.

Rapid Tranquillisation

D (GPP) - The decision to use rapid tranquillisation in an emergency setting should be taken by a senior medical member of staff, where at all possible.

D (GPP) - Mental health staff should be contacted at the first available opportunity after the administration of rapid tranquillisation.

D (GPP) - If rapid tranquillisation is considered necessary, prior to formal diagnosis and where there is any uncertainty about previous medical history (including history of cardiovascular disease, uncertainty regarding current medication, or possibility of current illicit drug/alcohol intoxication), lorazepam should be considered as the first-line drug of choice. Where there is a confirmed history of previous significant antipsychotic exposure, and response, haloperidol in combination with lorazepam is sometimes used.

Communication Provision

D (GPP) - For patients whose preferred language is not English, interpreting service should be provided. Provision should also be made for patients who have communication difficulties who may need additional support, for example, visual aids, simplified language, or an interpreter who can sign.

Definitions:

Levels of Evidence

1++ High quality meta-analyses, systematic review of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+ Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1- Meta-analyses, systematic review of RCTs, or RCTs with a high risk of bias*

2++ High quality systematic reviews of case-control or cohort studies. High quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal.

2+ Well conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal.

2- Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal.*

3 Non-analytic studies (for example, case reports, case series).

4 Expert opinion, formal consensus.

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

Recommendation Grades

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

Evidence drawn from a NICE technology appraisal

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

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

Grade D: Evidence level 3 or 4, **or**
Formal consensus

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

CLINICAL ALGORITHM(S)

A clinical algorithm is provided in the original guideline document for the short-term management of disturbed/violent behaviour.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Consistent high quality of care for patients who exhibit disturbed/violent behaviour

POTENTIAL HARMS

- Seclusion and physical interventions may be traumatic to the service user.
- Possible side effects of medications including:
    - Benzodiazepines
        - Loss of consciousness
        - Respiratory depression or arrest
        - Cardiovascular collapse (in service users receiving both clozapine and benzodiazepines)
    - Antipsychotics
        - Loss of consciousness
        - Cardiovascular and respiratory complications and collapse
        - Seizures
        - Subjective experience of restlessness (akathisia)
        - Acute muscular rigidity (dystonia)
        - Involuntary movements (dyskinesia)
        - Neuroleptic malignant syndrome
        - Excessive sedation
    - Antihistamines
        - Excessive sedation
        - Painful injection
        - Additional antimuscarinic effects

CONTRAINDICATIONS

CONTRAINDICATIONS

- Rapid tranquillisation is contraindicated when the service user has taken previous medication.
- Seclusion is contraindicated when rapid tranquillisation, if given, has taken effect.
- Olanzapine or risperidone should not be used for the management of disturbed/violent behaviour in service users with dementia.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- As with any clinical guideline, recommendations may not be appropriate for use in all circumstances. A limitation of a guideline is that it simplifies clinical

decision-making. Decisions to adopt any particular recommendations must be made by the practitioners in the light of:

- Available resources
- Local services, policies, and protocols
- The patient's circumstances and wishes
- Available personnel
- Clinical experience of the practitioner
- Knowledge of more recent research findings

- This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation in the National Health Service (NHS)

Resource Implications

Local health communities should review their existing practice for the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments against this guideline. The review should consider the resources required to implement the recommendations set out in the original guideline document (and in the "Major Recommendations" section of this summary), the people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of service users that the implementation is as rapid as possible. Relevant local clinical guidelines, care pathways, and protocols should be reviewed in the light of this guidance and revised accordingly.

General

This guideline should be used in conjunction with the NICE guideline on schizophrenia (see Section 6 of the NICE version of the original guideline document) and the Commission for Health Improvement audit material created by the Royal College of Psychiatrists (2004).

Audit

Suggested audit criteria are listed in Section 9 of the original guideline document. These can be used as the basis for local clinical audit, at the discretion of those in practice.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Clinical Algorithm
Foreign Language Translations
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Nursing and Supportive Care. Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. London (UK): National Institute for Clinical Excellence (NICE); 2005 Feb. 292 p.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Feb

GUIDELINE DEVELOPER(S)

National Collaborating Centre for Nursing and Supportive Care - National Government Agency [Non-U.S.]

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National Institute for Health and Clinical Excellence (NICE)

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Guideline Development Group

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Guideline Development Group (GDG) were required to make formal declarations of interest at the outset, and at the beginning of each GDG meeting. This information was recorded in the meeting minutes and kept on file at the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC).

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format [PDF] format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- National Collaborating Centre for Nursing and Supportive Care. Violence. The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. London (UK): National Institute for Health and Clinical Excellence (NICE); 2005 Feb. 83 p. (Clinical guideline; no. 25). Electronic copies: Available in Portable Document Format

(PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

- Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. Quick reference guide. National Collaborating Centre for Nursing and Supportive Care, 2005 Feb. 23 p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Overview algorithm for the short-term management of disturbed/violent behaviour. Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. Algorithm. National Collaborating Centre for Nursing and Supportive Care, 2005 Feb. 2 p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site.
- National Institute for Health and Clinical Excellence. Violence. The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. National cost-impact report. London (UK): National Institute for Health and Clinical Excellence (NICE); 2005 May. 50 p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site.
- National Institute for Health and Clinical Excellence. NICE the management of violent/disturbed behaviour. Costing template (England or Wales). London (UK): National Institute for Health and Clinical Excellence (NICE); 2005. Various p. Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455, ref: N0828. 11 Strand, London, WC2N 5HR.

Additionally, Audit Criteria are available in Section 9 of the original guideline document.

PATIENT RESOURCES

The following is available:

- Violence: managing disturbed/violent behaviour. Understanding NICE guidance - information for service users, their advocates, families and carers, and the public. National Institute for Health and Clinical Excellence (NICE), 2005 Feb. 68 p.

Electronic copies: Available in English and Welsh from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS), 11 Strand, London, WC2N 5HR. Response Line 0870 1555 455, ref N0829.

authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

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