



COT/ BAOT Briefings

Management of Disturbed/ Violent Behaviour

Publication Date: December 2005
Lead Group: Practice
Review Date: June 2007
Country Relevance: UK wide

Introduction

In 2005, two important documents were published regarding the management of violence and aggression in mental health settings. The National Institute for Mental Health in England (NIMHE (E), 2005) issued a mental health policy implementation guide related to the subject, and the National Institute for Clinical Excellence issued guidelines for the *Short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments* (NICE 2005). The aim was to give specific guidance to staff that deal with and have to manage aggressive or violent behaviour as part of their work environment.

In 2004/05 there were a recorded 43,301 incidents of physical assault perpetrated against staff in mental health and learning disability settings in England. Figures, which were released in August 2005, indicated that there was a fifteen-fold increase in the number of prosecutions against people who have physically assaulted NHS staff. (Figures quoted in NHS Press Release 19th October 2005) Occupational therapy staff are not exempt from these figures and often the use of newly qualified, inexperienced or locum staff can compound this. October 2005, saw the launch of a national training syllabus, developed by the NHS Security Management Service to assist frontline staff in mental health and learning disability services to deal with violent behaviour.

Present situation

In high security hospitals it is mandatory for occupational therapy staff to be trained in the Patient Management of Violence and Aggression (PMVA), previously referred to as Control and Restraint (C&R). In medium, low secure and psychiatric intensive care units (MSU's), the situation varies considerably according to local policy; some staff are trained in PMVA techniques whilst others in what is called Breakaway (the ability to escape from a situation). In acute mental health settings, the situation is also variable.

Implications for occupational therapists

The College of Occupational Therapists recognises that occupational therapists must be cognisant of the facts, figures and emerging policies and guidance which are emerging, not only to assist staff



who deal with violent or disturbed behaviour, but also to assist with the prevention, recognition and de-escalation of such behaviour.

The following are suggested to assist staff to be in a more suitable position to act in accordance with the interests of not only their own safety, but also the patients, clients and service users for whom they provide and deliver a service.

▪ **Education and training**

There should be adequate training at both pre and post-registration for occupational therapy staff. This should cover both the prevention, recognition and de-escalation skills required for violent or disturbed behaviour, gender and cultural awareness, the specific needs of people with learning disability, or communication and cognitive impairments.

Occupational therapists and their managers must make themselves aware of relevant training, information and guidance at both local and national level at the earliest opportunity, if they are to work in environments where violent or disturbed behaviour is likely to occur. Training in both PMVA and Breakaway may be necessary in many circumstances. Dealing with most extreme forms of violent behaviour (for example, riots or hostage taking) will require especially trained individuals. Occupational therapists must ensure that they are aware of their own professional and clinical competence when dealing with violent and disturbed behaviours; and in addition their own physical limitations if physically required to deal with such behaviours. Extreme caution is needed if it is necessary to use physical skills, as this can be damaging and harmful to the individual. Regular checks and monitoring of an individual's physical condition and vital signs must take place to ensure there is no undue physical stress (Rocky Bennett Inquiry 2003). Equal emphasis must be given to the importance of relational aspects of dealing with violent and disturbed behaviour, for example using your knowledge of the individual, their likes, dislikes and distraction methods.

Occupational therapists, both at an individual and organisational level, should ensure that they analyse adverse incidents of a violent or disturbed nature to see what might have caused an incident, could it have been prevented and what needs to be put into place to prevent it occurring again. Feedback (whether positive or complaints) from patients, clients and service users should be used to influence the development of relevant training and service initiatives.

It should also be recognised that dealing with violent or disturbed behaviour, verbal or physical, can be both emotionally and psychologically traumatising for staff and therefore occupational therapists are advised to take advantage of support, guidance, supervision or counselling systems which are in place in the work setting.



▪ ***Use of therapeutic occupations***

It has been documented that engagement in structured and meaningful occupations which are of value and interest to individuals can assist in the prevention of violent or disturbed behaviour (Walsh and Ayres 2003, Torpy and Hall 1993, Flood and Hooton 2001). Occupational therapists are in prime and skilful positions not only to engage clients in therapeutic occupations, but to influence their provision in the working environment. Occupational therapy staff have the skills and knowledge to adapt and grade therapy; and in addition they also have the skills to adapt the environment to best suit the needs of individuals to minimise risk and reduce overt stimulation. They should be aware of 'risk hot spots' such as meal times, periods of inactivity, and clients returning to hospital from periods of leave.

▪ ***Risk assessment and risk management***

One of the most important features which have been highlighted in many of the reports related to violent or disturbed behaviour is the lack of clear communication amongst disciplines and agencies. This is one of the strongest foundations for good risk assessment and management. Occupational therapists must be aware of the local policies and guidance in relation to risk assessment and management in their own area of work; in addition they must make themselves aware of relevant research and risk assessment procedures.

Risk assessment is a complex and important process. It involves the identification and acknowledgement of possible antecedents or triggers for violent and disturbed behaviour; the role of substance abuse; what can perpetuate or minimise risk related behaviours; how a person may be present if violent or disturbed; to what extent their aggressive behaviour will manifest; and finally how mental illness or personality disorder can compound violent or disturbed behaviour.

Recent publications have suggested the use of 'advance directives' in helping individuals identify and establish what should happen in the event that they become disturbed or violent. It should be acknowledged that they are the 'experts' in their own behaviours. The role and knowledge of family, carers or significant others should not be forgotten when considering risk and how this may have been successfully managed in the past.

The searching of patients for weapons and harmful substances or items is another aspect of risk assessment and management. Staff should be aware that the search process itself can be traumatising for those individuals who may have experienced some form of abuse in the past.

In the event of a member of staff being assaulted, occupational therapy staff should follow local policy and inform the Police and/or proper authority as required.



References and suggested reading:

Flood B, Hooton S (2001) Therapeutic activities within psychiatric intensive care units. In Beer D, Periera S, Paton C eds *Psychiatric Intensive Care*. London: Greenwich Medical Media.

NHS (2005) *Protecting your NHS. New measures to tackle violence against staff in mental health and learning disability services*. (Press release). London: NHS Counter Fraud and Security Management Service.

National Institute for Clinical Excellence (2005) *Violence: Short term management of violent/disturbed behaviour in psychiatric inpatients settings and emergency departments*. London: NICE.
<http://www.nice.org.uk/pdf/cg025fullguideline.pdf> accessed 6 Dec 2005.

National Institute for Mental Health in England (2004) *Mental health policy implementation guide: Developing positive practice to support the safe and therapeutic management of violence and aggression in inpatients settings*. London: NIMHE(E). Available at:
<http://www.nimhe-em.org.uk/upload/publication/c5f8f40c4baf7041fcaa.pdf>
accessed 6 Dec 2005.

Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003) *Independent enquiry into the death of David Bennett: an independent inquiry set up under HSG(94)27*. Available at:
<http://image.guardian.co.uk/sys-files/Society/documents/2004/02/12/Bennett.pdf> accessed 6 Dec 2005.

Walsh M, Ayres J (2003) Occupational therapy in a high security hospital - the Broadmoor perspective. In: Couldrick L, Aldred D eds *Forensic occupational therapy*. London: Whurr.

Royal College of Psychiatrists (1998) *Guidelines for the management of imminent violence*. London: RCP. Available at:
www.rcpsych.ac.uk/publications/guidelines/violence_full_h.htm accessed 6 Dec 2005.

Torpy D, Hall M (1993) Violent incidents in a secure unit. *Journal Forensic Psychiatry*, (3): 517-544.



The College of Occupational Therapists would like to recognise and thank the following people for the development of this COT/ BAOT Briefing:

- Jane Cronin-Davis - Senior Lecturer Occupational Science and Occupational Therapy Group, Leeds Metropolitan University
- Joe Ayres - Head Occupational Therapist, Broadmoor Hospital.