• Welcome to the Course!
• Please ensure that you have:
  • Printed & Signed the Course Registration Form
  • Completed the Participant Risk Assessment
  • Turned Off your Mobile Phone
Course House Keeping

Course Instructor Introduction and Participant Introduction
Venue Fire Procedures & Escape Routes
Course Times
Comfort & Hospitality Facilities
Mobile Phones
Safe Training
Infection Control
Signing Register
Confidentiality
Course Aims

To promote an explicit values base that is compatible with the ethos of a caring service, relevant professional ethics & legal guidance.

To ensure that course participants achieve the required competency and capability levels to safely use team physical interventions.

Demonstrate an understanding of restraint-related risks, as outlined in the Independent Inquiry into the death of David Bennett and NICE guidelines with a view to incorporating risk reduction strategies into practice.

To practice decision making and documentation around Team Physical Interventions.

Demonstrate an understanding of the need for and scope of post-incident review procedures and how to identify strategies and interventions for future prevention.
Course Objectives

On Completion of the Course Each Participant will:

- Be able to describe the Trust Values & Legal base in relation to Team Physical Interventions

- Demonstrate an understanding of the positive contributions service users can make to prevention strategies, including awareness of how issues relating to culture, race, disability, sexuality and gender can enhance this process.

- Be able to use techniques to ensure service user and colleague safety both in training and in practice.

- Be able to describe aggression & violence issues in the context of the younger person service user.

- Be able to document relevant risk & manage service user risk factors prior to & every time crisis management interventions are used.

- Utilise problem based learning (case study/scenario/skills development) to attain competency and capability levels.

- Undertake a formative and summative course assessment.

- Have trained safely.

And owned & enjoyed YOUR training experience.
**Key Principles**

- Promote an explicit values base that is compatible with the ethos of a caring service and relevant professional ethics.

- Show a demonstrable focus on issues of diversity compatible with the principles of anti-oppressive practice.

- Commitment to service user involvement in the development, implementation and evaluation of training.

- Integrate Primary, Secondary and Tertiary prevention strategies and not just teach crisis management skills.

- Always use Team Physical Interventions when every non-physical intervention has been explored first & as a last resort for the minimum time necessary.
Counter Fraud Security Management Service (NHS Body) working with the National Institute for Mental Health in England to develop
- Evidenced Base Syllabus for Physical Intervention Training
- Towards Safer Service: National Minimum Standards
- Trainer/Instructor Professional development
- Concordat Agreements with the Health & Safety Executive, the Commission for Social & Healthcare and the Clinical Negligence Scheme for Trusts
- Expert Reference Group
- Integration of N.I.C.E. Standards
- Cross Government Group Liaison
- No Specific National Guidance exists for Child Service Users & physical Interventions currently

The Core Syllabus is expected to be published in 2008. The Trust Instructor Group will then look at implementation.
MVA Level 4 Team Physical Interventions: CAMHS

**Day 1**
- Registration, Risk Assessment, Course Aims & Objectives
- Course & Practice Values Base
- Childrens Perceptions of Restraint
- Communication and the Reactionary Gap
- Two Person Approaches (Primary Escort, Secondary Escort, Standing De-escalation & Sitting)
- Three Person Approach, Head Support & Walking as a Team
- Session Debrief
  - *Knowledge Based Competencies*
    - Non Verbal Influences, Values, No Go Areas of the Body, Secure Arm Holds, Role of the Head Person & Case Study

**Day 2**
- Review of Course Day 1
- Assessing Service User Risk in relation to TPI
- Use of Force & legal Considerations
- Working as a Three Person Team (Engagement, Sitting & Standing)
- Negotiating Doors/Corridors
- Controlled Descent to the Floor (Prone Position)
- Rest positions
- Formative Assessment & Debrief

*Knowledge Based Competencies*
- Service User Risk Assessment, Verbal De-escalation Strategies
- Positional Asphyxia & Medical Risks
- Prone/Trouble Position Vital Sign Monitoring. NICE Guidance & Rapid Tranquilisation & Case Study
MVA Level 4 Team Physical Interventions: CAMHS

Day 3
- Review Second Day of Course
- Documenting the Incident
- Transferring Team Members on Floor and Standing
- De-escalation and Standing Up from Prone Position
- Trouble Holds in the Prone Position
- Holds in the Supine Position
- Use of a Leg Person
- Standing from Supine Position
  • Knowledge Based Competencies
  • Documentation, Trust MVA Policy, Use of Force & Case Study

Day 4
- Review of Third Day of Course
- Knowledge Competency Assessment
- Participant Directed Practice
- Escorting on Stairs and Use of Beds
- Recovery Position, BLS, ILS & Post Intervention Observations
- Summative Assessment
- Course Debrief & Continued Learning Needs/Evaluation

Knowledge Based Competencies
Trust Observation Policy, Observation Practice & Recovery Position, Incident debriefing, Assault Cycles (after Kaplan & Wheeler)
Younger Person Restraint
Issues & Concerns

Younger Persons Perception of Restraint
CSCI

Evidence Base for Care Planning

Deaths & Serious Injury:
Myatt & Rickwood
www.caica.org

Values & Practice
Younger Person Restraint
Issues & Concerns

Don’t Let Things Build - Key points
• Staff need to handle the initial problem well and should only use restraint as a last resort.
• Something quite small – or something seen as unfair – can trigger a build-up that ends in restraint.
• It’s vital to avoid problems building up to danger level and restraint wherever possible.
• Staff who try restraint when they don’t know how to can make things even more dangerous for everyone.

When to Restraining - Key points
• Restraint is sometimes necessary – but only when someone is likely to get hurt or property is likely to get seriously damaged.
• Restraint should not be used when people are ‘just messing’ or shouting and screaming.
• Restraint should not be used as a punishment.
• Calling the police is usually unnecessary.

How Restraint Makes You Feel Key points
• Young people need to know that they can be restrained.
• Staff need to understand that some people do not like an adult touching or holding them because of past abuse.
• Restraint can make you want to get your own back – it’s better to talk about what happened and why.
• Restraint also affects the people watching it happen.

Children's Views on Restraint
The survey of the views of children and young people in residential homes and residential special schools

www.rights4me.org.uk
Younger Person Restraint
Issues & Concerns

How to Do Restraint - Key points
• Restraint should never involve pain.
• Staff need to be trained in how to restrain without hurting and without making you get even more out of control.
• Restraint should calm you down – not make you angrier.

AVOIDING RESTRAINT - Key points
• It’s important to try to calm someone down before restraint becomes necessary – and even when it does.
• Each individual’s Placement Plan should describe how to deal with the person if they lose control.
• It’s important to think of alternative ways to take the heat out of a situation.

www.rights4me.org.uk

Children’s Views on Restraint
The survey of the views of children and young people in residential homes and residential special schools

www.rights4me.org.uk
Younger Person
Causes of Aggression & Violence
Michael is 16 years old. He lives at home with his Mother, Step Father and 2 sisters. He has normal developmental milestones but teachers at school have always described him, from the age of 6 as aggressive and rough with other children in his class. He has missed a lot of his secondary education due to school refusal, truancy and walking out following incidents with teachers. This led to suspension and permanent exclusion following an assault on a teacher 1 year ago. He will not cooperate with alternative education arrangements and has become isolated in his own room over the last 12 months. He allows his younger sister in to deliver his meals.

He is 5’10” and weighs 15 stone. Following conflict at home and assaults on his sisters, Michael reported to a social worker that he was troubled by voices. He has begun refusing food and self harming. Whilst working with the CAMHS outpatient service his behaviour has deteriorated. His latest aggressive outburst hospitalised his Mother and Sister. He then tried to overdose on the contents of the family medicine cabinet. Following this he was assessed and admitted.

He remains angry, aggressive and distrustful of you. He isolates himself and intervention provokes violent reaction. Some staff let him isolate to avoid the conflict.
Case Study - MVA Problem Solving - Group 2

Letitia is 14 years old and lives in foster care. She has lost contact with her birth family. Her Aunt and Uncle who looked after her whilst her Mother was in hospital with mental health problems, were successfully prosecuted for Letitia’s abuse and neglect. Letitia has gone through a number of placements with the foster care breaking down due to her extreme behavioural reaction to boundary setting e.g staying out through the night, clothes, aggression and violence to other family members. She terminated her last foster care through starting a small fire in her bedroom. She has made a number of allegations against various child services staff and is seen as a lead figure by other children in the challenging behaviour residential unit run by the local authority. She is slightly built and carries edge weapons as they make her feel safe.

Following an increase in self harming behaviour, a planned admission for assessment has been arranged by the CAMHS Team. She has been on the ward for 15 minutes and becomes angry about her room and missing personal items. She blames the staff and another child for taking her things.
Each Session will begin with a warm up consisting of:

- A Pulse Raising Activity
- Mobilising of Joints and Limbs
- Gentle Stretching
- Another Light Pulse Raising Activity
EMERGENCY STOP WORD
Values and MVA

“A principle, standard, or quality considered worthwhile or desirable”

“By service user values we mean the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient”

Sackett et al 2000

Values can be Personal and Organisational. Sometimes referred to as

Principles Standards Ethics Morals

VALUES EXERCISE 1
Key Message - How would you rather manage violence?

- With this? Think people.....
  - Empathy
  - Listening
  - Compassion
  - Patience
  - Caring
  - Helping
  - Talking
  - Hearing
  - Sharing
  - Understanding

- Or this? Think problems... Stop/think.
  - Restrain
  - Prosecute
  - Seclude
    - Section
    - Medicate
    - Contain
    - Inject

Pennine Care
NHS Trust
Knowledge Competencies 1

The No – Go! Areas of the body

- Hair
- Eyes
- Nose
- Mouth
- Neck/Throat
- Ears (NEVER Cap or Cover)
- Chest
- Abdomen/Stomach
- Back
- Spine
- Groin and Gender Specific Areas

Touch or Pressure in these areas may cause damage, serious injury, undue discomfort and complaint. THINK VALUES & SAFETY – Maintaining Therapeutic Relationship

- Long Bones
- Joints (Peg don’t Pressure them)
- Hyper-extension of the Knee and Elbow Joints
- Excessive Wrist Flexion – Maintain above 90 Degrees
- Remember a full risk assessment and health & safety screen on admission or after a change in health status may add to this list with respect to a service users individual no go areas
The Reactionary Gap

• 1 to 2 arms length from the service user

• As the name implies the distance is maintained to allow you to react if the person becomes physically hostile

• The Reactionary Gap is maintained at approximately 45 degrees angle (outside of the person’s fighting arc on their dominant side) with a sideways stance and your arms kept in a useful position and free of objects

• The Reactionary Gap can be utilised seated & standing and is increased as the person becomes more aroused or in the presence of a weapon

• Verbal and Non-verbal conflict resolution skills are used from the Reactionary Gap

• Primary (Non Physical Contact) Escort, Psychological Cornering/Command Presence and Two/Three Person Engagement begins from the Reactionary Gap

REACTIONARY GAP EXERCISE
Knowledge Competencies 2
Role & Function of the Head Person

- The Head Support Persons role in the team is critical
- Blofield Inquiry (David Bennett) highlighted the lack of a head person in ground situations may contribute to increase risk of serious injury for the person being held.

- Roles are:
  1) To Communicate with the Service User
  2) To Communicate with the Team
  3) To Co-ordinate the Environment
  4) Coordination of Vital Sign Monitoring during Physical interventions
Knowledge Competencies 3
The 3 Principles of a Secure Arm Hold

- A Capped Elbow
- A Fixed Wrist
- Thumb & fore-finger engaged

Whatever position you are in when actively holding the person (other than trouble positions) you will need to work for these principles. When all three are achieved then you have a:

- **Secure Arm Hold**
Knowledge Competencies 4
Basic MVA Risk Assessment – Static & Dynamic Factors

- Obesity (Visual Assessment)
- Alcohol (Observation, Smell, Alcometer results)
- Drugs (Visual Field Tests, Presence on Searching, Arrest Offence)
- Medical Presentation (Stated illness, Acute Respiratory Infections, Chronic Respiratory Conditions, Sickle Cell) - Medication
- Mental Illness
- Excessive Detention Anxiety – Diversity Issues inc effect of language differences, Young people, Crime/forensic specific.
- Pregnancy
- Diabetes, Epilepsy etc
- Disability (Sensory)
- Combined Presentation

- Remember other sources of Risk information
- Risks from Arrest Trauma & Restraint
- Where the person was found
- Behavioural Arousal during escort to Custody Centre/Police Station/136 Assessment Suite/P.I.C.U.
- External Sources of Information.

The presence of any risk factor should not exclude the decision to restrain however they will mitigate risk management actions during restraint.
Physical & Psychological Risks Associated with Restraint Procedures

- Positional & Restraint Asphyxia
  - restriction of action of diaphragm
  - airway blocking/crushing
- Asphyxia secondary to Neck Compression
- Acute Behavioural Disturbance
  - Phases: (Hyperthermia, Delirium, Respiratory Arrest & Death)
  - Cocaine Based Substances (not toxic levels)
  - Alcohol use and Mental Illness
- Head Injury
- Fractures
- Underlying Cardio Pulmonary Problems

- Catecholamine Rush (particularly Juveniles with longstanding behavioural problems)
- Hyperpyrexia (Fatal Heart Temperature)
- Blunt Trauma to the Chest
- Aspiration of Stomach Contents (Supine Position)
- Internal/External Bleeding
- Prolonged Struggle – Exhaustion, Dehydration etc
- PTSD
- State Dependent Memory Evoked Behaviours
- Non Compliance with Pain
Knowledge Competencies 5
Signs & Response to Positional and Restraint Asphyxia

- Positional Asphyxia

1. Verbal Complaints
2. Increased in Agitation
3. Breath Holding
4. Arching of Back
5. Increased Costal (Shallow Breathing)
6. Flaring of Nostrils/Nasal Breathing
7. Decreasing Responsiveness
8. Noisy Laboured Breathing
9. Cyanosis
10. Supra Clavicular “Sucking”

- Observations begin during restraint at:
  - 1 minute into stabilised ground/seated restraint position, if any risk factors are present
  - 3 minutes if no risk factors
- Repeated at 3 minute intervals

- 1) Respiration Rate (Normal between 16 – 20 Adult at rest. Below 12 definite cause for concern)
- 2) Pulse 60 – 90 pm. Note homeostatic adjustments and condition of pulse eg strong, weak and thready etc

- 1 to 4 & 7 – Behavioural. 5 to 10
- Physiological.
Knowledge Competencies 5
Signs & Response to Positional and Restraint Asphyxia

3) Level of Consciousness using A.V.P.U. scale – relates to Glasgow Coma Scale
   - Alert – verbally and physically alert. Interactions mesh and are coherent
   - Verbal – May be responsive to questions but slurred, incoherent or nonsensical
   - Pain Response – avoid ear lobe pressure. Below lower lip, finger pinch
   - Unresponsive – Non Responsive
   - Time is important with consciousness e.g speed of lowering of consciousness.

4) Basic blood pressure/heart output using Capillary Refill Test
   - Forehead or Nail Bed pressure for 5 second and see if refills in 2 seconds.
5) Temperature (Skin Patch Indicators). Remember basic respiration rate one of the most valuable observations that should be carried during and after physical interventions.
Knowledge Competencies 5
Signs & Response to Positional and Restraint Asphyxia

- Observations MUST be recorded (Use of Force Form)
- Observations can be designated across the restraint team
- Observations training must be practiced during restraint training at training level resistance
- Use of Head Person
- Use of Supervisor/Coordinator.
- Minimum amount of restraint required for least amount of time
- A restrained person should be medically examined
- Consider seclusion as opposed to prolonged restraint
- Use of Recovery Position
- Staff Observing Post intervention
National Institute for Clinical Excellence CG 25 Violence

- Prompt Examination by Medical Examiner/Health professional
- Use of Recovery Position
- Active Observations
  - engage in conversation, observing breathing rate as well as further arousal signs.
  - Training in competency observation are required
  - Custody staff may require formal obs schedule e.g
    - Level 1: General observation
    - Level 2 Intermittent observation
    - Level 3 Within eyesight observation
    - Level 4 Within arms length observation
- N.I.C.E. CG 25 Violence in IP Mental health settings and emergency departments

- Level of Observations should be set by a responsible trained person and only reduced by team decision involving the responsible person.
- Observations must always be documented including reasoning why observations were reduced or increased
- Observation is a complex skill and no one should be carrying them out for more than 2 hours at a time.

• See Also Pennine Care NHS Trust Observation Policy and MVA Policy
National Institute for Clinical Excellence CG 1 Schizophrenia

- Rapid Tranquilisation
Documenting the Incident:
Trust Incident Form & The MVA Use of Force Form

- All MVA Incidents to be documented at 3 levels
  - 1) Clinical Healthcare Record & Clinical Risk Assessment
    - Risk Assessment & future prevention
  - 2) Trust Incident Report Form
    - SUI, Legal & Trend Monitoring
  - 3) Trust MVA Policy Use of Force Form
    - Specific Detail & Ethnicity Monitoring

- All information documented should be reviewed by the care team and added to clinical risk management information for the service user.

Avoidance of Future Incidents

- Documentation Principles
- State what happened and what action you and others took.
- Use the following model to write the report
  - 5 W H Model
  - What happened?, Where did it happen?, When did it happen? Who was involved? And Why did it happen? Also How did it happen?
  - Record the IMPACT FACTORS
  - Record the LEVEL OF FORCE used by the person and used by yourselves
Impact Factors & Level of Force Used to Document and Legally Review Actions

- **Impact factors: Yours and Others**
- Height and Weight: Size
- Age
- Numbers
- Mindset/Mental Health State
- Drug Use
- Capacity
- Presence of a Weapon
- Previous Knowledge (Person/History)
- Gender
- Specialist Training
- Location
- Environment
- Arousal & Aggression

- **Levels of Resistance and Force**

<table>
<thead>
<tr>
<th>Resistance</th>
<th>Force</th>
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<tbody>
<tr>
<td>Compliance</td>
<td>None</td>
</tr>
<tr>
<td>Verbal resistance</td>
<td>Verbal direction</td>
</tr>
<tr>
<td>Passive resistance</td>
<td>Command</td>
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<tr>
<td></td>
<td>presence</td>
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<tr>
<td>Active resistance</td>
<td>Primary control</td>
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<tr>
<td>Active resistance</td>
<td>Secondary Control (Team P.I.)</td>
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<tr>
<td>Active resistance with</td>
<td>Specialist Control</td>
</tr>
<tr>
<td>Serious force</td>
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</tbody>
</table>
MVA – Legal Considerations

- **Mental Health Act Code of Practice**
- **Health and Safety at Work Act (1974)**

  ‘It is the employers responsibility to ensure that employees receive such information, instruction, training and supervision, as is necessary, to ensure the health, safety and welfare of staff by ensuring that staff are competent.’

- The employer has a responsibility to ensure, as far as is reasonably practical, the health, safety and welfare of their employees.’

- Employees are also tasked with a responsibility to maintain a safe working environment by complying with measures put in place by the employer.

- Section 3 of the H&S at Work Act - requires you to assist with the safety of others

- **Management of Health and Safety Regulations(1999)**

  Every employer shall make and give effect to such arrangements as are appropriate, having regard for the nature of his activities and the size of his undertaking, for the effective planning, organisation, control, monitoring and review of the preventative and protective measures.’

- **Common Law.**

  Common Law is not defined by an Act of Parliament it is ‘judge made’ in accordance with the facts presented

  Necessity & Proportionality are defined by Common Law

  what is reasonably proportionate to the amount of harm likely to be suffered if no forcible intervention was made.

  Proportionate response will be considered with reference to the degree, duration and nature of force used.
MVA – Legal Considerations

- Assessing reasonableness
  - Crown Prosecution Service-Offences Against the Person-Charging standards (1996) state that offences will be considered in the context in which they are allegedly committed. In all cases, surrounding circumstances will aid the decision with regard to pursuit of criminal proceedings.
  - A number of factors will be considered e.g.
    - The assailant-height, build, gender, level of threat, use of weapon, intent to harm.
    - The victim-height, build, gender, alternative courses of action available.
    - Location.
    - Circumstances e.g. action deemed suitable in response to a threat in a pub may not be considered appropriate in a care home.
  - IMPACT FACTORS

- ANY FORCE MUST BE –
  - ABSOLUTELY NECESSARY.
  - PROPORTIONATE.
  - Honestly Held Belief
    - The questions if necessity and proportionality are answered on the basis of the facts as they were believed to be at the time.
    - ‘The test to be applied for self defence is that a person may use such force as is reasonable in the circumstances as he honestly believed them to be in the defence of himself or another.’

- STATUTE LAW
  - Criminal Law Act 1967
    - Section 3(1) of the 1967 Criminal Law Act provides a statutory defence.
      - ‘a person may use such force as is reasonable in the circumstances in the prevention of a crime, or in affecting or assisting in the lawful arrest of offenders, suspected offenders or of persons unlawfully at large.’
MVA – Legal Considerations

- Human Rights in the Workplace.
  - **Article 2 - Right to life** (limited right)
    Everyone's right to life shall be protected by law. No one shall be deprived of life intentionally save in the execution of a sentence of a court following conviction of a crime for which the penalty is provided by law.'
  - **Article 2(1) The positive obligation to preserve life.**
    This states that authorities must not only refrain from taking life intentionally but also take appropriate action to safeguard life.
  - **Article 2(2)-Exceptions to the right to life.**
    states that deprivation of life will not be a contravention of the Act in certain circumstances.
    This application has been examined in case law and refers to –
    NECESSITY, PROPORTIONALITY and
    HONESTLY HELD BELIEF

- **Article 2 –Vulnerable persons**
  Article 2 refers to the positive obligation to preserve the life of those vulnerable by nature.
- **Article 5 - Right and Liberty and security of person**
  Article 5 states that no one shall be detained if detention is not authorised by law.
  Care staff have a duty of care legally, morally and ethically to protect vulnerable persons.
- **Article 8 – The right to respect for private and family life**
  Within a clinical context consideration must be given to privacy and dignity.
  Access to family must be actively facilitated as part of the care planning process.
- **Article 9 – Freedom of thought, conscience and religion**
  Cultural needs
  e.g. access to space to pray, must be addressed.
MVA – Legal Considerations

- **Article 3 – Prohibition of Torture (absolute right)**
  - This prohibits torture and inhumane or degrading treatment. The provision aims to protect individuals from physical and mental ill treatment.

- *everyone is entitled to the protection of Article 3 regardless of their own conduct.*

- Torture - Deliberate, inhumane treatment causing very serious and cruel suffering.

- Inhumane Treatment - Treatment that causes intense physical and mental suffering.

- Degrading Treatment - Treatment that arouses in a victim a feeling of fear and inferiority capable of humiliating and de basing the victim and possibly breaking his/her physical or moral resistance.

- **Does the use of pain compliance constitute torture?**
- Does this breach article 3?
- If used to positively protect life is pain compliance acceptable?
- ‘the use of pain compliance is justified legally by reference to the concept of reasonable force, and ethically by reference to utilitarianism’  
  *Aggression and Violence - Approaches to effective Management - John Turnbull and Brodie Paterson - 1999.*

- **HOWEVER**

- **Pain Compliance - Legal and Ethical Aspects.**
- *Where a non pain compliance technique can be used a pain compliance technique should not be used.*
MVA – Professional Accountability & Responsibility

- **Use of force in professional practice**
  - Professionally healthcare staff are trusted to always act in the best interests of the service user, to protect the public and do no harm.
  - Such ethical principles are reflected in professional codes of conduct and in service contracts.
  - It is therefore essential to balance rights with responsibilities.
  - A legitimate reason to use force must exist – must be a reason considered legitimate by law.
  - A forceful intervention *may* be justified in the following circumstances –
    - Statutory Authority e.g. Mental Health Act.
    - Compulsory care or treatment orders.
    - Prevention of a crime e.g. assault.
    - Necessity – common law principle applied in best interests.

- **Professional Accountability**
  - Potential consequences of UNREASONABLE use of force –
    - Disciplinary action.
    - Professional misconduct hearing.
    - Dismissal.
    - Personal moral accountability.
    - Legal consequences of UNREASONABLE use of force –
      - Criminal offence – e.g. assault.
      - Breach of Mental Health Act.
      - Breach of Human Rights Act.
      - Civil offence – e.g. assault, wrongful detention, negligence.

  - **The consequences of inaction i.e. failure to intervene can also have consequences.**
    - Failure in moral, ethical and legal duty of care.
    - Civil offence - Negligence.
    - Criminal offence – Omission amounting to negligence.
Violence & Aggression
Overview of Theory & Models

- Violence in services for people with mental health / learning disability is not new
- Reliable data problematic but concerns that problem is getting worse in some areas
- Increasing demands from staff, unions and service users for safe and therapeutic services
- Focus of this initiative is on violence by people with mental disorder directed towards staff
- Service users can also be Victims
- Violence by staff towards staff also a serious problem

- Over reliance on training in crisis management?
- "nurses are trained to expect violence and how to react it but not how to stop it happening" (Nursing and Midwifery Council (NMC) 2004:1).

- a "culture of violence in mental health care in the UK (NMC 2004:1)

- Service users perceptions "restraint of service users was the main goal at all times"
  (Horton 2001:7).
The Public Health Model

Primary Prevention
- Addressing the root causes before it has happened

Secondary Prevention
- Reactive responses; De-escalation techniques

Tertiary Prevention
- Physical interventions, post incident reviews & debriefs

Zero Tolerance Message, THINK Campaign, Personal Safety, Police Agreements
MVA – Definitions & Models

- Physical assault - *The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort*
  
  *Eisener v. Maxwell 1951, Kaye v. Robinson 1991*

- Non-physical assault - *The use of inappropriate words or behaviour causing distress and/or constituting harassment*

- Violent Incident Models: Five possibilities (Paterson and Miller 2005)
  
  1. AFFECTIVE
  2. INSTRUMENTAL
  3. MIXED
  4. AVERSIVE
  5. STIMULUS - RESPONSE - CONSEQUENCE
MVA – Co-ordinated Approach: Low Risk Situation

- Person is responsive to verbal interaction
- Use active listening
- Problem solving
- Verbal prompts
- Be aware of - personal space
- Non verbal communication
- and exits

Conflict Resolution Training Course
MVA Level 2

- Person needs persuasion to cooperate
- Maintain Dialogue
- Offer Explanation
- Offer a guiding hand
- Be aware of - Personal safety
- Exits
- Assistance available should situation escalate
MVA – Co-ordinated Approach: Medium Risk Situation

- Un co operative (Passive)
  - Not responding to verbal direction/
  - Not aggressive to others.

- INTERVENTION Non harmful methods aimed at assisting compliance

- Personal risk assessment –
  - Action if situation escalates e.g. access to assistance, route of escape.

- Un co operative (active, threatening) Resisting in a defensive manner, may use verbal and psychological intimidation and threats.
  - To regain safety via appropriate methods of control.

- INTERVENTION – ensure assistance – use physical interventions as necessary with regard to proportionate response.

- PERSONAL RISK ASSESSMENT – Safety of self/others/assailant – consider withdrawing until safe to intervene.
MVA – Co-ordinated Approach: High Risk Situation (Unarmed)

Causing actual harm to self or others or serious damage to property.

- AIM - To cease harm to self / others or serious damage to property.
- INTERVENTION – Continue dialogue as before. Utilise necessary and proportionate physical interventions.
- Contain assailant / remove others if safer.
- Police assistance if required.

Assess risk-
Consider containment
Physical restraint
Necessary and proportionate response
Consider police response.
MVA – Co-ordinated Approach: VERY High Risk Situation (Armed)

- Causing risk to life and limb.
- Leave and defend self and others.
- Contain and call police.

AIM – To survive encounter.

- INTERVENTION – Continue dialogue if safe to do so – if so maximise space between self and assailant.
- Contain assailant if possible.
- Warn others and withdraw to safer area.
- Contact police.

PERSONAL RISK ASSESSMENT – Serious risk of injury – only staff with proper training and protective equipment should approach armed assailant.
MVA – Debrief & Closing the Loop

**Antecedent** - what happened prior to the incident?

- Has de-briefing been offered:
  - Staff
  - Service Users
  - Witnesses
- Has appropriate support been arranged?

**Behaviour**
- Describe events occurring factually.
  - E.g. Violence, self harm, medical emergency

**Consequence 1**
- Staff response - what action was taken to manage the crisis?

**Consequence 2**
- Service User response - what were the reasons for the events occurring?

**Follow up**
- Who needs to be informed?
- Has the incident been appropriately recorded?
- Has the risk assessment been updated?
- Has the care plan been updated?

**OUTCOME**
- What lessons can be learned from the incident?
- What actions are required to minimise the risk of recurrence?

Paterson & Millar 2005
MVA – Debrief & Closing the Loop

Staff Perspectives

- Staff members who have been the victim of aggression or violence need to be listened to.
- They need to feel that their safety and well-being matters.
- They need to know action will be taken to reduce the risk of recurrence.
- They need to know how and where to access ongoing support if it is required.

- Organisations must ensure support structures are available and accessible for staff involved in incidents.
- This may include team support, external counselling and, in some cases access to the criminal justice system.
MVA – Debrief & Closing the Loop
Service User Perspectives

- Service users are at risk of being the victims of violent assault whilst in care.
- Service users who experience (or witness) physical restraint can experience trauma.
- Service user safety must be a priority both legally and ethically.
- Service users must be provided with post incident de briefing.
- If a service user is the victim of assault it must be addressed and action to ensure safe future management agreed.
- If a service user is restrained this must be discussed and the reasons why this was deemed necessary shared.
- Collaborative planning to prevent recurrence is essential.

- This may include support from the care team, advocacy, external counselling and, in some cases access to the criminal justice system.
- Organisations must ensure support structures are available and accessible for service users involved in incidents.
- A robust reporting and complaints procedure for service users is essential to ensure incidents are reported and action is taken.