

# Safety for psychiatrists

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### Terms of reference

To revise and update the College's report on the Safety for Trainees in Psychiatry (CR78), broadening the scope to encompass all psychiatrists working in situations where their safety may be endangered. The recommendations will take into account health and safety measures developed by related working groups which have focused on safety of all mental health staff.

# Executive summary and recommendations

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## Summary

In 1999, the Royal College of Psychiatrists produced a report, *Safety for Trainees in Psychiatry* (CR78), prepared by a Collegiate Trainees' Committee (CTC) working party, which was an update of a previous CTC report in 1991 putting forward safety recommendations. In 2004, when this report was due for a review, the Public Policy Committee suggested that the scope of a report on safety should be broadened to include all practising psychiatrists. A working party was formed with representation from the CTC and the Faculties of General Psychiatry, Liaison Psychiatry and Substance Misuse, who consulted with other Faculties within the College, receiving comments from Child and Adolescent, Learning Disability, Old Age and Psychotherapy. This working party reviewed the safety literature published since the last report, including recommendations made for all mental health professionals and Government initiatives to improve safety in the workplace. In arriving at its recommendations, the working party has consulted widely with other organisations that have produced similar reports, aimed at improving the safety for all mental health practitioners working in a variety of settings, as well as user and carer organisations. We have also been helped by a survey produced by the Health Policy and Economic Research Unit at the request of the working party and the British Medical Association Junior Doctor's Committee, aimed at assessing current safety arrangements for psychiatrists in training (British Medical Association, 2005).

In its conclusions, the working party has focused on those measures that psychiatrists should be aware of which can reduce the chances of assaults taking place, or of serious injury being sustained should they occur. Trusts and other employing organisations already have statutory obligations to ensure that the environment in which mental health professionals work is safe and secure, and this report will not dwell on this, but will point out where psychiatrists still notice deficiencies.

## Recommendations

1. Although junior psychiatrists are now more likely receive training in the recognition and prevention of violence, and in using de-escalation strategies and breakaway techniques, there is less evidence to suggest that this is happening with senior psychiatrists. This should take place early on in the post, with regular refreshers.
2. Senior clinicians have a central role in preventing seriously aggressive behaviour in their patients. They not only have experience of assessing the risks posed by patients, but they can also advise their colleagues on how to

manage such risks. Early detection of possible eruption of violence in an in-patient setting can be enhanced by close working relationships with nurses, ability to read and take action when difficult atmospheres exist, and more active participation of psychiatrists in therapeutic activities.

3. Psychiatrists need to be aware of the potential for aggressive behaviour which might emanate as a direct result of their intervention, particularly where there exists an atmosphere of perceived confrontation, such as assessments under the Mental Health Act 1983, meetings with advocates, tribunal hearings, or when they are unrealistically expected to resolve problems outside their brief, skills or capacity.
4. Recognition of issues that require sensitive handling, in particular regarding racial or gender issues, and the careful use of language in heated interchange, can help prevent violent outbursts. The judicious use of interpreters can also calm distressed patients who are unable to communicate in English.
5. In out-patient settings, accident and emergency departments and prisons robust safety measures need to be in place, such as adequate and well functioning alarm systems, clear exit facilities, and arrangements for support by other staff in cases of emergency. This procedure should be checked regularly. Recognition of the anxiety experienced by patients when coming to see a psychiatrist, or waiting to be seen, can do much to reduce tension and enhance the quality of the interview.
6. For psychiatrists working in the community it is important to gather as much information as possible before the visit about the patient, the family, and the environment where the visit will take place in order to take adequate preventative measures. In particular psychiatrists should carry a means of communication and ensure that the base is aware of the time of the appointment, and what to do if the psychiatrist fails to return to base within an agreed time. It is recommended that psychiatrists should not visit private dwellings alone if they are not sure about the circumstances, and never at night.
7. As far as Mental Health Act assessments in the community are concerned, a pre-visit conference with all parties concerned, including the family, police and social workers, is strongly recommended in order to plan the intervention and take appropriate measures.
8. For those working with families and carers, in particular in old age and child and adolescent psychiatry, it is important to bear in mind that members of the family can also become highly agitated, aggressive and violent on behalf of their ill relative.
9. Psychiatrists should receive specific training on the assessment, management and risk assessments of patients with dual diagnoses.
10. The working party has endorsed the recommendations of the earlier College report *Safety for Trainees in Psychiatry* (CR78), many of which apply to all psychiatrists. In particular it wishes to highlight the importance of induction

courses which take into account local safety considerations, matters of personal privacy, behaviour and appearance, and clear guidelines on what must be done following a violent incident.

11. A jointly agreed and understood protocol for the reporting of untoward incidents should be in place in each workplace. This will only work if the culture allows staff to feel comfortable about reporting incidents without prejudice. Reporting incidents should be linked to a structure that allows learning to take place, and adaptation of practices as a result of incidents. Clinical governance principles should be followed, with regular audits of violent incidents, and effective measures introduced resulting from their recommendations.
12. In cases of serious assault, the matter should be reported to the police, who jointly with the trust should consider pressing charges against the perpetrator. In less serious incidents, a judgement needs to be made on clinical grounds as to whether this is the best form of action to prevent recurrences. This may need to be discussed with the legal advisor of the trust, as well as the medical defence society.

## Introduction

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Despite many investigations and inquiries into violent incidents in mental health settings, resulting in reports and guidelines, safety considerations for mental health staff continue to be an issue of serious concern. Violence reflects societal mores and problems, so it is not surprising that it also extends to the clinical context and psychiatry in particular, where the management of disturbed behaviour is an essential element of care. These concerns were substantiated by the results of the survey on trainee psychiatrists commissioned jointly by the working party. Despite the low response rate, it is of concern that more than two-thirds of doctors could recall situations where they were put at risk, and that many had actually experienced verbal and, to a lesser extent, physical assaults, in hospital, out-patient and domiciliary settings. Accident and emergency departments were particularly singled out as unsafe environments, and the lack of suitable interview rooms, personal alarms or chaperones was repeatedly mentioned. Some prison environments were deemed inappropriate or unsafe for assessments, and many reported the shortage of experienced nursing staff when risks were identified. The plight of pregnant trainees was also highlighted. Finally, the need for adequate and regular induction schemes and training was emphasised, as well as protocols, guidelines and effective reporting systems. As noted in a recent guideline from the National Institute for Mental Health in England (NIMHE, 2004), despite previous recommendations there are still serious gaps in training and safety standards.

Unfortunately there have been very few reports addressing the safety needs of psychiatrists as a whole, and this report attempts to address that shortfall. Psychiatrists from different disciplines are likely to be exposed to different degrees of threat to their safety, but no particular branch of psychiatry is immune. In the same vein, the context in which psychiatric practice is delivered will also have a bearing on the likelihood of violence, be it on in-patient units, in out-patient settings, in accident and emergency departments, in prisons and other custodial institutions, or in patients' homes.

Aggression and violence are often preventable. Their prevention relies heavily on the awareness and skills of mental health clinicians working in organisations that are supportive and that help professionals develop practical skills in a safe physical environment. Having said that, the latest national audit of violence (Royal College of Psychiatrists' Research Unit, 2005) indicates that there are still serious gaps, and points out flaws in the design of in-patient units, inadequate staffing and over-reliance on agency staff, poor leadership, and changes in client mix, with overcrowding and a higher proportion of patients with dual diagnosis, a higher prevalence of substance misuse, high levels of boredom and dissatisfaction among staff with the appropriateness of training in the management of violence.

The audit also reported high proportions of staff stating that they have been assaulted, threatened or made to feel unsafe, ranging from 29% in forensic units to 43% in acute units and 72% in psychiatric intensive care units.

There will always be some patients who experience psychiatric care as threatening, intrusive or even violent. In their professional roles, psychiatrists are often seen as the perpetrators of this perceived violence and may become targets for aggression. A user perspective is therefore a crucial aspect of prevention.

# Safety in the in-patient setting

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## Vignette – The right choice of words

Peter, a 50-year-old gentleman, was admitted following concerns about his bizarre hoarding behaviour which the neighbours complained constituted a public health risk. The local council and housing association had repeatedly made attempts to try and help him, and eventually had to intervene when they discovered that not only had he been storing his own urine and faeces in bottles and containers, but he had also collected so many items that these now constituted a fire safety hazard, especially as he had no space to move in his home. An early care programme approach (CPA) meeting was arranged, which was unexpectedly attended by a large group of officials who challenged Peter and threatened to evict him unless he changed his ways and accepted that cleaners could be sent in to clear the house. He reluctantly agreed, but later regretted it, stating that he was concerned that many of his valuables would be thrown away. In a pre-discharge CPA, the consultant, trying to mediate, inadvertently used the word 'unnecessary items' to describe his accumulation of miscellaneous objects, which with benefit of hindsight predictably sent Peter into a rage. He lunged at the consultant accusing him of failing to understand his predicament. 'How would you feel if you returned home one day to find out that your family was no longer there? How would you react if somebody came into your house and wiped off the memory of your computer?'

With the benefit of hindsight, could something have been done to prevent Peter's outrage? It seems obvious that Peter must have felt threatened by the unexpected attendance of council officials at the early CPA meeting, and the psychiatrist's unfortunate use of language at a later meeting must have confirmed to him that everyone misunderstood his need to hoard. More sensitive handling of the ward review might have prevented what turned out to have been a risky confrontation.

Many of the general principles required to address safety issues are clearly outlined in the NIMHE guidance (2004) and we will not reproduce the details here. It is perhaps fair to say that nurses and junior psychiatrists are now more likely to be receiving training in the recognition and prevention of violence, and in using de-escalation strategies. However, this is less likely with senior psychiatrists. The UK Central Council for Nursing, Midwifery and Health Visiting (1999, 2001) has also provided further recommendations for topics to be included in trust policy documents. In addition, it is advisable for all psychiatrists to receive training in cultural sensitivity in order to improve communication with patients from Black and minority ethnic groups.

The in-patient ward is one of the areas where violent incidents are more likely to take place. Increasing levels of substance misuse have been cited as the main triggers of violent incidents observed on in-patient units, followed by inadequate numbers and training of staff, entrenched negative attitudes, lack of privacy, overcrowding, and problems with medication and boredom (Royal College of Psychiatrists' Research Unit, 2005). More often than not, the assaults are directed against nurses, who because of their front-line status, direct-care responsibilities

and frequent need to enforce treatments against patients' wills are on the receiving end of resistance and assaultive behaviour. Other potential targets include fellow patients, when behaviour in close environments becomes intolerable and acting out emerges as a result. Junior psychiatrists are also vulnerable because they are more accessible and represent the authority which some patients may feel they need to challenge.

In the in-patient setting, senior psychiatrists are less likely to be the victims of serious incidents, because their contact with patients is more sporadic and usually takes place in the presence of other staff, such as during ward reviews or meetings with the families or carers. However, sometimes these meetings can become heated, and unpredictable attacks may be directed at the consultant, who is seen to be in charge and sometimes has to make decisions which are unwelcome. It is worthwhile, therefore, to be aware of the potential for aggressive behaviour which might emanate as a direct result of consultant intervention.

Consultants will often be seen as responsible for decisions involving admission to hospital, especially those relating to a Section of the Mental Health Act 1983. A confrontational atmosphere clearly affects the doctor-patient relationship in these circumstances, and more so if an appeal is made and the matter is presented at a hearing of the mental health tribunal or of hospital managers. Issues concerning periods of leave, contact with relatives, return to employment and even resolution of practical housing or benefits difficulties may also be laid at the consultant's door, irrespective of whether they have the power or influence to resolve them. The consultant may also be blamed for prescribing and sometimes imposing treatments, and for any adverse effects experienced. Finally, and not least, senior clinicians will be seen as responsible for the diagnosis of a mental disorder, which can have a major effect on patients' lives.

Although not an exhaustive list of issues that divide psychiatrists and their patients, all of them can be exacerbated by the use of alcohol or other illicit substances.

As illustrated in the vignette, one way of interpreting an attack on a clinician is by understanding it as a patient's attempt to get through to the person they see as able to offer a solution to their difficulties. One of the issues frequently reported by patients who have assaulted senior psychiatrists is that they have experienced them as being unavailable or distant, or having little time to listen to their complaints. It is reasonable to assume that when clinicians spend more time with in-patients, participating in therapeutic groups for instance, assaultive behaviour is less likely to occur.

Insensitive handling, particularly of racial or gender issues, can also sometimes provoke an attack.

Senior clinicians have a central role in preventing seriously aggressive behaviour in their patients. They not only have the experience for assessing the risks posed by patients, but they can also advise their colleagues on how to manage such risks. A role that often receives little discussion or acknowledgement is to contain the anxiety experienced by the team of mental health professionals who have to

work closely with patients. Fulfilment of this role can have a positive impact on patients who then feel contained and more secure. It is less likely that assaultative behaviour will take place in a safe environment.

# Safety in the accident and emergency department

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There are a number of factors that increase the risk of violence by patients in the accident and emergency department. Firstly, staff do not have specific training in mental health and often feel less confident in managing patients with psychiatric problems. Patients regularly present in crisis, including acute psychotic episodes and heightened emotional states. Such episodes may be directly a result of, or compounded by, alcohol and drugs, which are associated with an increased risk of violence. In addition, it may be difficult to obtain background information to inform a risk assessment. Generally, a psychiatrist assessing a patient in the accident and emergency department should carefully consider what precautions need to be taken.

## Vignette – A drip stand an offensive weapon?

One evening, Margaret, who is 43 years old, presents to her local accident and emergency department complaining of feeling unwell. She reports that she has a diagnosis of bipolar affective disorder and feels that her illness may be relapsing. She has been prescribed lithium and admits to having taken extra doses to try and control her mood. The triage nurse notes that the patient appears agitated and somewhat confused. He takes a blood sample for investigations, including a lithium level, and hangs up a saline drip. The patient is asked to wait in a cubicle to see a doctor. The patient becomes increasingly impatient and angry. She begins to pace around the department brandishing a drip stand and shouting that she wants to see a doctor immediately. The staff contact the on-call psychiatry senior house officer for assistance.

What points should the assessing psychiatrist consider?

- **Risk assessment:** Who is at risk? Those to be considered include the patient (both a risk of inadvertent self-injury and the risks associated with an untreated lithium toxicity), other patients, staff and the psychiatrist.
- **De-escalation:** Depending on the risk assessment, the psychiatrist may try basic de-escalation techniques, including a calm and reassuring approach, offering to help the patient.
- **Control and restraint:** If the patient does not respond to de-escalation, and continues to pose a risk to herself or others, control and restraint may be required. This should only be carried out by trained staff, to avoid unnecessary injury to the patient and staff involved. This will usually require hospital security staff or, where this is not possible, the police.
- **Interview room:** A quiet environment may be important in helping to settle the patient. The psychiatrist should consider what precautions are necessary before assessing the patient. A chaperone (nursing or security staff) may be required. The charge nurse in the accident and emergency department should be made aware of the plan.

- **Background information:** Ideally, there should be access to the mental health electronic information system in the accident and emergency department. This might include the patient's care plan and a risk management plan that will inform the assessment.

The points below are safety issues in the accident and emergency department that are relevant to an individual psychiatrist. They are adapted from Council Report CR118 *Psychiatric Services to Accident and Emergency Departments* (Royal College of Psychiatrists & British Association for Accident and Emergency Medicine, 2004), which also contains a broader discussion of safety in the accident and emergency department.

### **Facilities**

The Council Report CR118 contains recommendations for interview facilities for psychiatric consultations in the accident and emergency department. These include the need for a properly equipped interview room. This room should be close to the main receiving area. It should have two outward opening doors with observation windows, and an alarm system alerting staff nearby or a suitable security system. A closed-circuit television (CCTV) security system is an additional safeguard. Although technology (such as CCTV) can be of assistance in improving safety, it should only be employed in association with the implementation of good practice.

Where there is no specific psychiatric interview room, staff should take particular care to consider what precautions may be necessary to safeguard themselves when interviewing patients.

### **Background information**

It is a sensible precaution for staff to have prior warning about patients known to pose a risk of violence, in order to ensure that the patient is assessed in conditions that keep the risk to staff at a minimum.

Where possible, background information should be obtained prior to interview. Swift access to case records is therefore an important safety issue. Warnings about propensity for violence should be written in a prominent place in the mental health case notes and, where possible, be recorded on the computer information system in the accident and emergency department.

### **Interviewing**

Although patients have a right to privacy, confidentiality and respect for their cultural sensitivities, this must be balanced against the staff's right not to be assaulted, and to take appropriate precautions to minimise this risk.

Staff interviewing a patient should always inform a senior member of the accident and emergency nursing staff before commencing the interview. There

should be agreed procedures regarding chaperones: the presence of a chaperone should be regarded as the norm, and interviews without chaperones should only proceed after discussion with relevant staff. It should be a conscious and a consensus decision.

Departmental procedures should include guidance on regular checks via the observation window while the interview is taking place (e.g. every 5 min).

### **Learning from incidents**

A jointly agreed and understood protocol for the reporting of untoward incidents should be in place. This will only work if the culture allows staff to feel comfortable about reporting incidents without prejudice. Reporting incidents should be linked to a structure that allows learning to take place, and adaptation of practices as a result of incidents.

## Safety in out-patient settings

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The waiting room of a mental health setting can frequently be the scene of frustration and associated violent behaviour, which may be provoked by waiting for the consultation as well as pent-up feelings about what is going to be talked about. Levels of anxiety are sometimes palpable before the assessment takes place, and often a perceptive receptionist will be the one to alert the psychiatrist that somebody is 'distressed' or 'on the warpath'. Some patients are likely to attend under the influence of alcohol or drugs, which again can be detected by the receptionist or as soon as the patient enters the consulting room. Psychiatrists will need to be clear about how to handle a patient who is likely to be more disinhibited or with a low threshold to frustration. Patients from Black and minority ethnic groups may also have specific needs which must be respected. These may include the presence of relatives and suitable interpreters at consultations, and appointments with female doctors where possible.

Recognition that the out-patient interview can be very stressful for the patient can do much to alleviate anxiety and reduce the chance of an uncomfortable encounter. If the patient has been waiting for some time beyond the agreed time for the interview, it is appropriate to offer an apology before the meeting formally starts. Before seeing a patient who appears to be highly aroused it is crucial to decide whether the interview should take place or should be postponed. In the case that a decision to see the patient has been made, it is prudent to ensure that the consulting room has a number of readily available safety features which increase confidence that a difficult situation can be adequately handled. It is preferable that the psychiatrist in these circumstances is joined by a colleague. In cases where this is not possible, it is important to ensure that the room chosen has a functioning and inconspicuous panic alarm system which is regularly monitored and tested, is close to other previously alerted staff from whom help can be obtained urgently if required, that the door has an easy exit arrangement and cannot be easily blocked, and that the psychiatrist places themselves between the door and the patient.

It might also be helpful to introduce emergency codes or phrases that alert other staff to a problem, but do not raise the alarm unduly to other patients who may be on the premises or warn the aggressor that help has been requested. All staff will require regular updates and should follow agreed procedures when these codes are used.

An advocate can be a valuable support in helping a patient to articulate difficult feelings, but on occasions they may exacerbate the propensity to violence through fuelling the patient's resentment and hostility. It can therefore be important to have considered how to handle the presence of an advocate who is unannounced in a way that defuses the situation.

## Safety in the community

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The following are some recommendations for psychiatrists working in the community.

- Psychiatrists should check on their own health regularly if they are involved frequently in community work. This should include immunisation for tetanus, tuberculosis, hepatitis B and influenza. A clinician who is pregnant or who has a disability should carefully consider their potential vulnerability when visiting patients at home.
- Psychiatrists should consider their own limitations and experience.
- As much information as possible should be obtained beforehand about the patient, their carers, and even pets. This could be obtained from the referrer, general practitioner or other member of the community mental health team if the patient is known. If unfamiliar with the area that they will be visiting, the psychiatrist should enquire about risky environments, such as dark alleys, waste grounds, subways or isolated pathways. In situations where violence is anticipated, the police may be of help in providing information, and where certain prescribed offences have been committed within statutory limits, multi-agency public protection panels will need to be involved.
- As far as practicable, psychiatrists should avoid displaying 'on call stickers' or anything that identifies the vehicle with a healthcare professional. Bags and any other equipment left within the vehicle should be concealed and the car should be parked as near as possible to the patient's home, out of a cul de sac, but not necessarily in front of the house. The car make, colour and registration number should be known at the community base and by the employing organisation.
- Psychiatrists should take means of identification.
- Depending on the possible clinical state of the patient, the time of the day or night, and the environment where the visit will take place, the psychiatrist should decide whether to visit alone or with another mental health colleague. We recommend that night visits should never be made alone. In general, it is preferable to arrange joint visits, not only for safety purposes, but also because the assessment is likely to benefit from consultation between professionals.
- When clinically feasible and desirable, a member of the family should be present during the interview. A clinical decision should be made on the basis of the details of the referral as to whether the patient should be informed of the visit, but in general families should always be informed of the intention to visit and the approximate time of arrival.
- Cultural expectations should be respected.

- Psychiatrists should ensure that they have a mobile phone with charged batteries and credit and the phone should be programmed to access base with one press of a button.
- Staff at base should know who psychiatrists will be visiting and when they are expected to return. If the interview goes on longer than expected the psychiatrist should phone base. Staff at base will need to be clear which procedures to follow if there is a failure to communicate after a reasonable time, making sure that attempts are made to contact the psychiatrist on their mobile phone, or the patient's home, and finally the police if unsuccessful. Previous discussion of these issues with the local police force is very helpful.
- Psychiatrists should stand back from the door after ringing the bell, and stand sideways to present a narrower target.
- They should be prepared to abort the visit until adequate safeguards can be put in place if, for example, the patient refuses to be seen or threatens violence, is drunk, or alone. If the visit proceeds, the occupants should be followed into the residence, and the psychiatrist should make a mental note of the environment and possible routes of escape. If feasible they should place themselves between the patient and the exit door.
- The psychiatrist should be aware that their behaviour may trigger or prevent aggression. They should respect privacy and personal space, particularly when patients have a paranoid predisposition, and communicate clearly about their task and speak courteously, with sensitivity to issues of personal dignity, particularly if there are onlookers or strangers around.
- Psychiatrists should not wear expensive items of jewellery or watches, in particular earrings, bracelets or necklaces, or ties which can be used to strangle or injure. Apparently innocuous items, such as fountain pens with steel nibs, may also be used as weapons.
- A first-aid kit should be kept in their vehicle.
- Taxis should be used when visiting known problem dwellings where personal property may be at risk.
- Control and restraint techniques should not be used by psychiatrists working alone, although breakaway techniques are valuable to avoid serious injury, and these skills need to be regularly updated.

## **Assessment under The Mental Health Act 1983**

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An assessment under the Mental Health Act 1983, particularly if it is going to take place in the community, requires forethought and planning. By definition the visit is taking place under conditions of duress, at least as far as the patient is concerned, and is likely to provoke some level of resistance or active opposition.

Many of the suggestions which have been outlined for community visits apply to assessment under The Mental Health Act carried out in the patient's home, but even more attention must be paid to obtaining detailed information about the antecedents, previous history of violence and current mental state, as well as cultural observances and expectations. Information provided to the psychiatrist and approved social worker must be shared and assessed prior to the visit to ensure that all safety requirements are observed. If the family is aware of and likely to be present at the visit it is imperative that they are involved in a full discussion. This should take into account their advice and experience, and details about the location, rooms, and exit doors where the assessment will take place.

A decision must be made on the basis of that information as to the need to involve the police, and in what capacity. When a warrant under Section 135 is arranged, the police will be able to gain entry to the premises, but it might be important to clarify whether it is necessary for the police to be in attendance during the assessment, depending on the level of arousal observed in the patient, which can be gauged quite quickly.

When carrying out an assessment under Sections 2 or 3, and when there is some doubt about what the assessors may find, it might be prudent to briefly plan and discuss a joint risk assessment with the police and social worker in attendance beforehand, focusing on exit routes, and determining the scale of intervention if behaviour gets out of control. For example, a request can be made for the police to remain close by, but out of sight of the house in order not to provoke a reaction. If two or three assessors come into the house, it might also be prudent to decide beforehand who will call the police to attend if that is required. That person should remain close to the exit.

Prior discussion with the family may also be advisable in order to explain the procedures and likely outcomes, and the necessity or otherwise of the family, and especially children, being present during the interview.

It is also good practice for the assessors to decide beforehand who is going to take the lead during the interview, and how and where a conference can take place in order to arrive at a conclusion.

The way in which the decision is conveyed to the patient can make all the difference. If the patient is receptive, it might be helpful to explain in clear language exactly what has been decided. The assistance of an experienced interpreter when required can be invaluable. If the patient has not been known to the psychiatric

services, it might also be helpful to explain succinctly what to expect from an admission to hospital, where it will take place, how long the assessment and possible treatment will take, and visiting arrangements for the family.

Comments such as the following may be helpful:

- 'We do understand that we may not be in agreement about this, but we have decided that you need a period in hospital for your own health.'
- 'We do think that on the basis of our discussions that is important to assess whether you do have mental health problems, and the safest place to carry this out is in hospital.'
- 'We can assure you that we will not keep you in hospital any longer than necessary, in order to make sure that everything is alright.'

Transportation to hospital can also involve considerable risk. Prompt attendance by the ambulance service can be of great help, especially if a decision has been made that the patient requires hospitalisation, as waiting can increase frustration and the likelihood of violent behaviour. Alerting the ambulance service beforehand as to the likely time of the end of the assessment can save a great deal of trouble. If the patient is resistive, it might be necessary to ask for help from the police in attendance. The presence of a policeman in uniform is often enough to communicate that there is little point in actively opposing the admission, and the police usually are experienced in handling these situations effectively. At other times, it is helpful to communicate to the patient that if the arrangement can be made discreetly it will not attract the attention of neighbours. Once the patient is in the ambulance it is important to decide who will be accompanying the patient in the vehicle in order to minimise risk en route to hospital. The approved social worker is responsible for organising transport, but may well seek the advice of the assessing psychiatrist in this matter.

# Use of interpreters

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## Vignette – Getting through

Sebri, a young immigrant from Slovenia, had only recently arrived in the UK after witnessing the murder of two of his brothers. Fearful for his life he had escaped from Slovenia after threats of further persecution and torture and had made the long and arduous journey to this country requesting asylum status. He was brought by a friend and compatriot to the local accident and emergency department. He knew little English, but his appearance indicated that he was experiencing terrifying hallucinations, and he seemed to be very guarded and suspicious. The casualty officer attempted to interview him on his own, but Sebri's inability to communicate only exacerbated his frustration and he started to lash out uncontrollably. When the psychiatrist on duty was called in to give an opinion, he interviewed the friend initially, was told about Sebri's background and an interpreter was sought. Sebri was able to explain the nature of his distress and calmed down visibly after the interview was conducted.

Trying to communicate distressing feelings is difficult at the best of times, but the importance of using interpreters cannot be overstated, as the example above indicates. Patients not only feel relieved when they are able to communicate and be understood, but having an interpreter from the same part of the world establishes a line of contact and understanding which can have an immediate calming effect and reduce overwhelming feelings and difficult behaviour.

# Safety for trainees

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The 1999 Council Report CR78 (Royal College of Psychiatrists, 1999) presents practical advice for trainees that is sensible and still very applicable. We have only made minor modifications to the content of that report, which we include here. Many of the recommendations are obviously relevant to all psychiatrists.

## Induction courses

At each new placement trainees should attend an appropriate induction course which should include:

- a tour of the site and relevant buildings, including the on-call residence
- written information about relevant local safety policies
- guidance about maintaining personal safety and privacy
- instruction on the recognition, de-escalation and management of violent incidents
- written information on safety, management of imminent violence and risk assessments
- provision and use of alarm systems and mobile telephones when having to travel between different sites.

## Personal privacy

Patients having access to the psychiatrist's home address and telephone number can result in unpleasant incidents and place them or their families at risk. It is advisable to avoid revealing personal information to patients. Hospital switchboards should not reveal personal information to anyone requesting it without the doctor's prior permission. As personal telephone numbers can be traced following a telephone call, unless they are previously blocked by dialling 141, it is advisable not to ring patients from home or personal mobile telephones. Psychiatrists may wish to have an ex-directory number in order to increase safeguards, and may wish to investigate the possibility of restricting some personal information that is normally available from electoral registers. Nuisance calls should be reported to the police. Consideration should be given to only providing work addresses and telephone numbers to the medical directory, as this is available in public libraries.

Patients will very occasionally become fixated on mental health professionals, either with erotic or violent fantasies, and evidence suggests that these abnormal attachments are frequently present in patients who persistently phone, stalk or assault professionals. Any concerns of this nature should be communicated to the police, who can use anti-harassment laws to arrest people even if they have a history of mental illness.

## **Personal appearance**

Professional appearance engenders confidence and trust in the doctor. Expensive, flamboyant or sexually provocative clothing may be misinterpreted by a patient and provoke an assault. Clothing should not be tight in case the psychiatrist has to move quickly. Remember that scarves, ties, long hair and loose items of clothing or jewellery can be used to strangulate or injure. It is best to avoid taking personal belongings, such as an address book, into patient areas.

## **Personal behaviour**

Patients often provoke negative or unpleasant feelings in psychiatrists and they must therefore be very aware of their own reactions. It is essential to be polite and considerate at all times. It is advisable to introduce oneself, to ask how the patient wishes to be addressed and to speak clearly. Interpreters will need to be arranged when necessary. Plenty of space should be allowed between the psychiatrist and the patient, especially when patients are highly aroused or suspicious. Prolonged eye contact can sometimes be perceived as threatening, although a balance must be reached in order to avoid the impression of being scared or uninterested. Note-taking in the patient's presence must be avoided if the patient is suspicious, and it is helpful to ask the patient if they mind before the interview is commenced. Acknowledging the patient's concerns and anxieties, showing empathy to their difficulties, and adopting a gentle and not excessively probing stance is helpful in reducing extreme reactions. The patient should be given the opportunity of terminating the interview if at any time they feel intolerably uncomfortable, and the psychiatrist should also be prepared to foreclose it if they feel threatened.

## **Isolation when on call**

Trainees seeing patients, particularly when asked to interview a recently admitted patient when on call and at night, should ask for as much information to be provided to them beforehand, and to be accompanied by another member of staff. When conducting a physical examination it is advisable to have a chaperone present in order to avoid risks of assault and of being subjected to allegations of inappropriate behaviour.

Trainees should avoid walking alone in poorly lit areas, either inside or outside buildings, and in all circumstances should have the means to raise the alarm in an emergency, or be able to request a security guard or porter to accompany them. Some trainees may prefer to drive the short distance between the on-call accommodation and the hospital as a safety measure. Trainees should not hesitate to inform hospital management if their accommodation does not meet satisfactory safety standards. Trainees should not be expected to make assessments alone in the community in an emergency or at night, and should seek the support of a senior colleague if requested to do so.

## **Alarms**

It is the trainee's responsibility to wear a personal alarm at all times if this is provided. Battery-operated personal attack alarms are not recommended because they may not be heard. Trainees should be aware of where there are alarms in each interviewing room, and be prepared to use them when necessary, making sure that they sit close to them when they enter the room and that they have a free space to exit the room if necessary.

## **Breakaway techniques**

Training in breakaway techniques should be available every 6 months, in order to benefit trainees new to psychiatry, and as a refresher for those who have already been trained, at least once a year. This training should include practical and theoretical aspects of safety. Breakaway techniques are important, but they cannot be relied upon solely for personal protection. Some nursing staff are trained in control and restraint techniques, and trainees should avoid interfering if these techniques are being used. If staff cannot control a disturbance the police should be called without delay.

## **Guidance on what to do in the event of an assault**

Trainees should be given guidance about what to do in the event of an assault. They should contact their educational supervisor, College tutor or the consultant on call to discuss the violent incident as soon as possible. A decision must be made on whether the trainee is in a fit state to continue duties, and if not and on call, arrangements put in place to find an immediate replacement. If necessary, appropriate medical support should be offered as soon as possible.

Debriefing is recommended as near as possible to the time of the incident. A 'root cause analysis' should be carried out to ascertain the antecedents of the incident, not to apportion blame but to offer support and to learn from the experience. Educational supervisors and College tutors should be prepared to arrange psychological support when necessary, preferably outside the local area, and leave of absence or phased return should be available where appropriate.

In cases of serious assault, the matter should be reported to the police, who jointly with the trust should consider pressing charges against the perpetrator. In less serious incidents, a judgement needs to be arrived at on clinical grounds as to whether this is the best form of action to prevent recurrences of this behaviour. This may need to be discussed with a senior colleague, the legal advisor of the trust, as well as the medical defence society.

Violent incidents should be recorded and presented at every postgraduate medical education and training approval visit. Incident forms should be reviewed regularly in audit following clinical governance principles, and relevant measures introduced from any recommendations arising from the exercise. In situations of

repeated violence, College tutors must gain the support of management to reduce further risk to trainees.

# Working with patients who misuse drugs and alcohol

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## Vignette – The Devil’s work

Jake is a 26-year-old man of no fixed abode with a documented history of paranoid schizophrenia. He is currently an informal in-patient on a busy general psychiatric ward and is awaiting discharge planning. He was admitted 2 months ago with an acute psychotic relapse and after treatment with anti-psychotic medication his illness is now in remission. Jake has a known history of polysubstance misuse and non-adherence to treatment.

Last night, Jake returned early from home leave and presented in an agitated manner to ward staff. He appeared to be extremely restless and was suspicious of fellow patients. He stated that he could hear ‘the Devil’s voice’ and that people in the street were talking about him. When approached by ward staff, he became quite hostile and stated that they were ‘doing the Devil’s work too’. On one occasion he lashed out and hit a female member of staff on the head. Staff were concerned and placed him on an increased level of observation and gave him a benzodiazepine. His behaviour returned to normal over the next 2 days, however a fellow room-mate informed staff that he had seen Jake ‘taking something’ while on the ward.

Could this situation have been avoided, or at least the risks reduced to the member of staff that was assaulted?

There is a recognised increased risk of violence from some mental health service users who also misuse substances including alcohol. The association appears to be strongest for those with a severe mental illness such as schizophrenia or affective disorder. There is also an increased risk of violence in people with personality disorders who misuse substances.

Psychiatrists should especially consider the following recommendations in order to minimise risk with this group of patients:

- They should take care to document any history of substance misuse and ensure that this is included in any risk assessment of the patient.
- It is important to be aware of unusual presentations, changes in activity levels or even disinhibition that may alert staff to the fact that the patient may have been using alcohol or illicit substances. Psychiatrists must take suitable precautions when interviewing patients who have misused substances (as documented elsewhere in this guidance).
- The patient’s behaviour may become more unpredictable during intoxication with a substance (such as a stimulant) or as a result of withdrawal from other substances (sedatives or alcohol). Psychiatrists must be able to recognise the basic signs and symptoms that are characteristic of each of these circumstances.
- If there are suspicions that a patient has been misusing substances, psychiatrists should request suitable investigations. This will include a careful history and mental state examination. A sceptical attitude to what the patient is prepared to admit to in these situations is perfectly reasonable and a careful physical examination and a urinary drug screening is also

recommended. If the patient refuses these investigations one must assume that they might have used substances.

- Psychiatrists must be satisfied that there are detailed policies in place to ensure that patients/visitors do not bring illicit substances onto National Health Service (NHS) premises, and that notices are visibly displayed indicating that the trust will take reasonable measures to ensure that this does not happen, including reserving the right to search for and confiscate any drugs which might be imported into the unit and referring the matter to the police in appropriate circumstances.
- Visitors or patients entering NHS premises should be checked for illicit substances if there is a high index of suspicion that they may be in possession of these. If necessary the police should be involved in disputed cases.
- Staff should ensure that they have been fully immunised against the major blood-borne infections and that they are aware of how to deal with needle-stick injuries and those which may facilitate viral transmission – for example during restraint procedures. The incidence of blood-borne infections is higher in patients with dual diagnosis.
- Psychiatrists should receive specific training on the management and risk assessments of patients with dual diagnoses.

## Working with children and adolescents

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- Children and young people with mental disorders can display significant violence and disinhibition, which could be directed towards the professionals who are trying to assess and provide treatment for them.
- As with adults, drugs and alcohol may be highly relevant aetiological factors in violent behaviour.
- In child and adolescent psychiatry one has to consider both the violence that the child may present but also that presented by parents. Parents can become highly agitated, aggressive and violent on behalf of their children. This can in itself be exacerbated where there is parental disagreement, violence, separation and major conflict.
- Family violence is an important backdrop to some violent behaviour by children and young people. Therefore, when dealing with violent behaviour in the children one is often also dealing with a broader context of significant intrafamilial violence.
- Similarly, mental disorder in children may be associated with significant mental disorder among adult parents.
- Weapon carrying (knives and guns) is on the increase among young people.

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