mentalwelfare
commission for scotland

GOOD PRACTICE GUIDE

Responding to violence in a mental health or learning disability care setting

Reviewed 2017

This document was reviewed in Spring 2017 in light of changes to the Mental Health Act. The previous title of this publication was 'Zero Tolerance: Responding to violence in mental health or learning disability care settings'.

Contents

Who we are

We put individuals with mental illness, learning disability and related conditions at the heart of all we do: promoting their welfare and safeguarding their rights.

There are times when people will have restrictions placed on them to provide care and treatment. When this happens, we make sure it is legal and ethical.

We draw on our knowledge and experience as health and social care staff, service users and carers.

Our values

Individuals with mental illness, learning disability and related conditions have the same equality and human rights as all other citizens. They have the right to:

- Be treated with dignity and respect;
- Ethical and lawful treatment and to live free from abuse, neglect or discrimination;
- Care and treatment that best suits their needs;
- Lead as fulfilling a life as possible.

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health and learning disability care. Sometimes we investigate where something has gone seriously wrong with a person's care.
- We identify and promote good practice in mental health and learning disability services.
- We provide information, advice and guidance to service users, carers and service providers.
- We have a strong and influential voice in service and policy development.
- We promote best practice in mental health and incapacity law.

Why we wrote the guidance

The Mental Welfare Commission has the duty to provide advice on matters relevant to our functions. We also have the general duty to promote best practice in observing the principles of mental health legislation. As a result, we often give advice on applying best legal and ethical principles to individual people's care and treatment. Sometimes, we receive several requests for advice on the same topic. Where it is not always easy to give 'correct' advice, we try to provide a guide to best practice.

Over recent times, we have heard of several situations where criminal justice agencies have been involved following violence by people receiving care and treatment for mental illness or learning disability. This was described as a 'zero tolerance' policy. We heard concerns that this involvement may not have been appropriate. We also heard from service users who had been assaulted or threatened by other service users and did not feel there was an appropriate response from staff.

We considered that existing guidance did not fully address the problem of responding to workplace violence in mental health or learning disability care. Violence is unacceptable, but when it relates to mental ill-health within a care setting, the issues are complex. We thought that staff needed more guidance than presently exists. When applied to mental health and learning disability settings, we thought that using the term 'zero tolerance' carried a risk of misinterpretation of care providers' responsibilities.

Paterson et al (2005)[1] provided a helpful analysis of the use of the 'zero tolerance' concept in health and social care settings. They remind us that, while violence towards healthcare workers (and social care workers) is unacceptable, the causes are complex. 'Zero tolerance' may not be an appropriate concept to apply to violence towards staff in mental health or learning disability care, but there should be 'zero tolerance' of employers' lack of action to address violence in care settings.

Staff may be caught between:

- Providing appropriate and sensitive care for people whose mental disorder results in violence, and;
- Reporting significant incidents to the police in order to protect the person, other service users and themselves.

Police, Procurators Fiscal and the judiciary may also have difficulty deciding how best to proceed following such incidents.

We have excluded certain categories of violence from this guidance. We have not considered violence fuelled primarily by alcohol or drugs. We have not included violence that takes place outside mental health or learning disability care settings (e.g. public places, A&E departments).

[1] Paterson, B, Leadbetter, D, Miller, G. (2005) Beyond Zero Tolerance, a Varied Approach to Workplace Violence. British Journal of Nursing vol 14 no 14 pp 746-753

Also, we have not included the issue of allegations of assaults by staff on service users. This is a serious, but quite separate, issue. The individual who makes the allegation of assault has the right to make a complaint to the employer and to the police. We expect to see that all such allegations are properly investigated.

This guidance is primarily aimed at the care of people in hospital. However, our analysis of the issues to consider when responding to incidents may be of use to other care providers.

Meaning of 'zero tolerance'

In the context of this guidance, 'zero tolerance' refers to policies of service providers regarding violence towards staff (and also to other service users). This may include action, usually involving criminal justice agencies, taken against a user of mental health or learning disability services following an episode of violence. Much has been written about 'zero tolerance' in general healthcare settings. Much of this refers to problems occurring in accident and emergency departments. The problem is often the person intoxicated with alcohol or drugs. Intoxication, in itself, is not a mental disorder and does not, therefore, come within the scope of this guidance.

This guidance deals with contentious situations where there are many factors to weigh up when deciding what action to take. We have considered the issue of violence that results from intoxication with drugs or alcohol where the person is receiving treatment for another mental health problem or learning disability in a care setting. In general, hospital wards are not appropriate places for managing violent behaviour by people intoxicated with, in particular, alcohol. Early involvement of the police is strongly advised in those situations.

Also, this guidance is not intended to deal with other criminal behaviour in care settings, such as drug dealing or theft. These are crimes that should result in police involvement, and local policies should reflect this.

Meaning of 'violence'

In this context, violence has a broader definition than physical assault. The Health and Safety Executive describes workplace violence as "incidents where persons are abused, threatened or assaulted in circumstances related to their work involving an explicit or implicit challenge to their safety, wellbeing or health."

We adopt the same definition in relation to behaviour toward other service users in a health or social care setting. It is particularly important that other service users feel safe. Some of our reports show that many do not[2]. We attach particular importance to the need for action if other service users are assaulted or feel threatened by an individual receiving care and treatment in the same facility.

2 http://reports.mwcscot.org.uk/web/FILES/Left_Behind.pdf

How we went about the task

We wanted to help organisations to respond appropriately to incidents of violence by service users. We thought it would be helpful to use case examples to look at policy and practice in this area. We asked a variety of stakeholder organisations and concerned individuals to send accounts of their experiences of responses (or lack of them) to violence by people receiving care and treatment for mental health problems or learning disability. We received 38 responses.

Where there had been police involvement in incidents of violence, respondents were fairly equally split between those who thought that involvement had been excessive and those who felt not enough had been done. We divided the responses into four categories depending on whether or not action was taken and whether or not the respondent thought the action was appropriate:

1. Action was taken and it seemed appropriate to do so;
2. Action was taken and it seemed inappropriate to do so;
3. Action appeared to have been insufficient;
4. Action was not taken and it was right not to take action.

Following this, we held a national consultation event to examine these cases (anonymised to protect the identity of the individuals whose cases were reported to us). We asked participants to examine the cases and come to a view on the following questions:

- What factors should be taken into account when deciding whether or not to involve the police?
- What are the expectations of police involvement (and are these expectations shared among care workers, police and Procurators Fiscal)?
- What are the benefits of police involvement?
- What are the drawbacks of police involvement?
- How should all agencies respond to aggressive or violent incidents to provide an appropriate balance between providing care and treatment and protecting staff and others from harm?

Because of the serious nature of the issues we wanted to discuss, we widened the discussion by using our roadshows to consult further. The guidance reflects the wide discussions we had with stakeholders at all these events.

The context of ‘zero tolerance’

The phrase ‘zero tolerance’ appears to have emerged in the USA in the early 1970s as a form of policing that allows no crime or anti-social behaviour to be overlooked. It has developed many other uses since then.
In 1999, the UK Government launched a campaign against violence toward healthcare staff. This encouraged staff to report all violent incidents in order that healthcare workers were given the full protection of the law. The (then) Scottish Executive launched a similar but more measured initiative in 2003. Guidance on managing violence is contained in the Managing Health at Work PIN guidance[3] and includes the following statement of values:

- Organisations should develop and promote a culture in which the personal safety of all staff is valued and protected and where violence towards staff is seen as unacceptable.
- Senior managers within organisations should show their commitment to reducing violence, make available the resources for putting policies into practice and make sure that it is clear who is responsible for each function.
- All staff should expect that any risk to them or their colleagues will be reduced as far as possible by using effective risk-management systems.
- Staff and their representatives should be fully involved in developing and putting in place local strategies and policies to reduce the problem of violence at work.
- Effective support systems should be in place to support staff who become victims of violence.

Health and safety at work

Health and safety law applies to risks from workplace violence just as it does to other risks arising from work. Employers must ensure that they are familiar with health and safety legislation. Briefly, the relevant pieces of legislation are:

- Health and Safety at Work etc Act (1974). This places responsibilities on employers to ensure, as far as is reasonably practicable, that employees and others on the premises (e.g. patients, visitors, contractors) are not exposed to risks to their health and safety. This includes work-related violence.
- Management of Health and Safety at Work Regulations (1999). These require employers to carry out workplace risk assessments and put in place control measures to prevent or control the risks.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (2012)[4]. These require employers to notify their enforcing authority of certain incidents at work. This includes any act of non-consensual physical violence done to a person at work.

[3] http://www.scotland.gov.uk/Publications/2003/02/16388/18311

[4] http://www.hse.gov.uk/riddor/index.htm

The Health and Safety Executive (HSE) has produced guidance for employers to help them to identify, assess and control the risks arising from the workplace: Five steps to risk assessment[5].

- STEP 1 of the guidance requires the identification of hazards that workers may be exposed to and the potential for such exposure to cause harm. Violence is widely recognised as a significant hazard in many healthcare workplaces and some areas of healthcare have been described as violence-prone.
- STEP 2 requires the identification of who may be exposed to the hazard and how such exposure might be harmful. It is clear that violence in healthcare is a significant hazard at work to healthcare workers in Scotland. Serious physical assault is infrequent but does occur and can cause serious injury. Verbal abuse and threatening behaviour can, however, represent significant sources of distress.
- STEP 3 requires the risks to be evaluated and for reasonably practicable precautions to be developed to control the risks. Such control measures include policy development, security measures (including building design and alarm provision) as well as training.
- STEP 4 requires the findings of the risk assessment to be recorded and to be implemented.
- STEP 5 requires the assessment to be reviewed regularly and updated.

Offences

It is beyond the scope of this guidance to give an exhaustive list of possible offences for which a person may be charged. However, acts which could result in charges being brought include threatening behaviour, damage to property and actual assaults.

Assault is defined as “every attack directed to effect physically on the person of another whether or not actual injury is inflicted. There must be criminal intent: an accidental injury, even although caused by a mischievous act, does not amount to assault.”

Role of police

Tackling crime and the causes of crime are key priorities for the police. Ethical recording of crime is integral to modern policing and it is vitally important that crime recording and disposal practices are capable of withstanding rigorous scrutiny. Policing is much more than arrest and possible prosecution. Community safety is important and this extends to care settings. The police will assess the situation. If they consider that a crime has been committed, they are required by law to report the matter to the Procurator Fiscal.

5 http://www.hse.gov.uk/pubns/indg163.pdf

Role of the Procurator Fiscal

If the police report an incident to the Procurator Fiscal (PF), this may result in a decision to prosecute. The PF has considerable discretion and will consider whether prosecution is in the public interest[6]. If there is sufficient evidence to prosecute, other factors are taken into account, including:

- Seriousness of the offence;
- Length of time since the offence took place;
- Interests of the victim and other witnesses;
- Age of the offender, any previous convictions and other relevant factors;
- Local community interests or general public concern;
- Any other factors at his/her discretion, according to the facts and circumstances of the case.

The majority of cases reported to the PF do not result in prosecution. The victim can request an explanation if there is a decision not to prosecute.

Role of the Health and Safety Executive (HSE)

HSE is the regulator for health and safety in the workplace in Great Britain. HSE inspectors enforce health and safety law in healthcare establishments, such as hospitals, clinics, etc. They visit premises to investigate accidents, ill health or complaints. They may also carry out inspections and may offer advice or guidance. If there is a serious risk to health and safety, the inspector may take enforcement action, such as serving an Improvement Notice, which allows time for the recipient to comply, or a Prohibition Notice, which prohibits an activity until remedial action has been taken. In the most serious cases, HSE inspectors can report offences to the Crown Office and Procurator Fiscal Service, who will decide whether or not to prosecute. The HSE has guidance on workplace violence[7].

6 http://www.copfs.gov.uk/about/how-does-prosecution-system-work

7 http://www.hse.gov.uk/healthservices/violence/index.htm

Prevention of violent incidents

The risk of a particular violent incident happening at a particular time and place depends on the combination of the characteristics and current state of the perpetrator, the set of circumstances at the time, victim availability and the characteristics of that victim. In England and Wales, the National Institute for Clinical Excellence (NICE) produced guidance on this topic[8]. While the full guidance is not directly relevant in Scotland, some aspects may be helpful in seeking to prevent violence. There is a helpful review article by Davison[9]. The Royal College of Psychiatrists[10] has also issued guidance on this topic.

Staff should not come to work expecting to be assaulted. One of the problems of 'zero tolerance' is that it can create unrealistic expectations. The law requires employers only to do that which is reasonably practicable in providing safe systems of work and safe systems of working. What is reasonably practicable depends on context setting and 'industry standard' at the time. Policies on unacceptability of certain behaviours will help staff and patients understand what is not tolerated and the possible actions that staff might take.

Safe therapeutic environments

The above reports identified factors that affect the levels of violence in care environments. These are:

- A pleasant environment in which there is no overcrowding;
- Respectful attitudes of staff towards service users;
- A predictable routine;
- A good range of meaningful activities;
- Well-defined staffing roles;
- Good staffing levels;
- Privacy and dignity (without compromising observation on the ward).

Staff training and support were also a major factor identified in the literature. Staff must have training and experience in risk assessment and management, management of de-escalation, personal safety and breakaway techniques, and appropriate use of restraint. These are important matters to discuss in individual supervision and personal development planning. Whilst employers will have ultimate responsibility, managers will have day-to-day responsibility for ensuring the safety of temporary or visiting staff and others (e.g. visitors, contractors).

8 http://www.nice.org.uk/nicemedia/live/10964/29716/29716.pdf

9 Davison, S. The management of violence in general psychiatry. Advances in Psychiatric Treatment (2005), vol. 11.

10 http://www.rcpsych.ac.uk/files/pdfversion/op57.pdf

When there is a higher potential for violent incidents, extra staffing may be required. It may be relatively easy to call on extra staff where the unit is on a large site with several other units/wards nearby. There are some isolated units where this is not possible. Managers should bear in mind the availability of back-up from additional staff when conducting risk assessments of isolated sites.

We cannot place enough emphasis on prevention. While this document is primarily about response to violence, employers must ensure that good risk management procedures are in place. As well as individual risk management (see below), they must assess overall risk and ensure that staff have the skills that prevent violence.

Individual risk assessment and management

Most people who receive care and treatment in mental health or learning disability facilities pose a very low risk of violence. For the minority who may present a risk, individual risk assessment and risk management are essential to ensure the safety of that individual and others. Risk assessment, in relation to the risk of violence, should include:

- A thorough history, especially a personal history, any substance misuse and a record of risk factors for violence;
- Any previous history of violence, including the circumstances in which it occurred, early warning signs and previous effective interventions;
- Good quality information from a variety of sources, including information from carers;
- Availability of information on risk at all relevant times.

Responding to violent incidents

We looked into the factors that staff took into account when deciding what action to take following a violent incident. In particular, we wanted to know how staff made decisions on whether or not to involve the police. These were:

a) The severity of the incident. An incident resulting in serious injury to the victim or major damage to property would be reported to the police. In particular, police may have an important role if the incident is ongoing. When the incident is less serious, other factors influence the decisions of staff.

b) The views of the victim. The person who has been the victim of an assault has the absolute right to report the matter to the police. All policies on this matter must make this clear. The decision of the victim, especially a member of staff, may be influenced by other factors listed below. If the victim declines to involve the police, it may still be appropriate for staff or managers to do so.

c) The events leading up to the incident. Staff may be less likely to report incidents if the person appeared to have been provoked. This may have been provocation by another service user, actions of staff (e.g. restraint or restrictions on liberty) or receiving bad news (e.g. information about being detained or failing in attempt to have the detention revoked). Also, the action by staff may differ depending on whether the behaviour is regarded as spontaneous or premeditated.

d) The perception of the person's mental state and motivation for the incident. Staff would be less likely to report incidents where the behaviour is thought to be a result of symptoms of mental illness, physical pain or discomfort or adverse effects of treatment. They would be more likely to report an incident if they thought the person was capable of deciding to behave aggressively and therefore 'responsible' for his/her actions. They would also be more likely to report an incident if the behaviour was seen as 'goal-directed', e.g. a way of getting treatment with a particular medication. This relies on judgements and assumptions that may or may not be correct. We have seen inappropriate judgements made in this situation. There is a particular risk in adolescents where behaviour resulting from mental illness is misinterpreted as 'just bad behaviour'.

e) The person's views and capacity to learn from the incident. Staff consider involving police if they think it is likely that the person will learn that the behaviour was unacceptable. They would also take account of the views of the person who has behaved dangerously, including any advance statement the person had made

f) The views of others who know the person well. This is important in determining whether aggressive behaviour is a feature of the way the person generally behaves or whether it is likely to be a sign of illness. While this is always important, it is especially important for children and adolescents.

g) The person's legal status. People who are detained in hospital are less likely to be judged to have capacity. In this situation, it is more likely that the response would be a review of the level of security needed to manage the person safely in a hospital environment, e.g. referral to an intensive psychiatric care unit (IPCU). This would not rule out appropriate police involvement in serious incidents.

h) The risk of recurrence. If there appears to be a likelihood that the person will continue to pose a risk to others, staff may be more likely to involve police. In any event, this would trigger a review of the management of individual risk.

i) The impact on service users. Reports following Commission visits show that many people do not feel safe in hospital. Visible action taken following episodes of violence, especially the involvement of police, may help people feel safer, especially where another service user is the victim. It may also help everyone in the unit by sending clear messages that the behaviour is unacceptable.

Regardless of whether the police are involved, it is essential to record all violent incidents. This is important for future risk management, including justification of grounds for compulsory treatment. There may also be a need to report any injury to the health and safety enforcing authority under RIDDOR.

What are the expectations of police involvement?

We wanted to know what was expected of the police and the criminal justice system in general following a report of a dangerous incident. We were particularly interested to find out if expectations were shared among care workers, police and Procurators Fiscal. Options for police involvement included:

- Immediate action to control or de-escalate an ongoing incident;
- Remove the person to a safe environment;
- Charge the person with an offence;
- Support care staff and advise or assist with ongoing risk management;
- Help to convey the unacceptability of the behaviour to the person.

If police are called, they must legally investigate regardless of the views of the complainant. This does not necessarily mean that the perpetrator will face criminal charges. The effect of involving the police could have many benefits, but it could have its drawbacks.

Benefits of police involvement

- Most importantly, it may be immediately necessary to manage an ongoing incident and de-escalate the situation. The presence of a police officer may be enough to reduce an imminent threat of violence.
- The person takes seriously what he/she has done. This can help the person to understand that some behaviour is unacceptable.
- The victim is assured that the incident has been taken seriously and is offered support. This is especially important where the victim is another service user. It may also be important where the victim feels unsupported, e.g. because he/she is not a member of the core staff group or lacks the support of colleagues who helped to manage the situation.
- In general, it encourages ‘normalisation’. Violence would not be tolerated in any other setting. Victims are entitled to equal access to justice. The process of police involvement can also give support to the victim.
- The independence of the police may be helpful when investigating the incident.
- It can be a valuable aid to risk assessment and management. This can help the management of the individual(s) involved and the management of the risk of violence in the unit as a whole. Ongoing involvement of community police will also help.
- It may or may not be appropriate for the person to be detained by the police. This decision will be based on the individual circumstances at the time of the incident. In the event that they are removed from the hospital, even for a short period of time, there must be arrangements for necessary treatment to continue.
- It may be necessary to interview the person with a view to possible criminal charges. The police may request a medical opinion on the fitness of the person to be interviewed. National guidance states that the police officer must arrange for an appropriate adult to be present if it is known or suspected that the person has a mental

disorder[11]. This guidance also applies to interviewing victims or witnesses.

- It could result in a record within the criminal justice system of the risk of future violence. This may trigger procedures for multi-agency assessment of the risk of violence. Such procedures could aid safe care and treatment of the person and protection of the public.
- Sensitive and appropriate involvement of police can validate the experience of staff. Knowing what to report and when to report, with assurance from police and managers that the action was appropriate, helps staff to know their areas of competence and when there is a need for extra support.

Drawbacks of police involvement

- There is a risk that, for some people, the presence of the police increases anxiety. As a result, the environment may appear less therapeutic. It may also damage the morale of staff who may feel they should have been able to contain the situation.
- Too hasty a decision to involve the police may detract from staff responsibility to address risk and devise a management plan.
- It may stigmatise the individual. This is a particular risk if the decision to involve the police is based on the staff's views about the capacity and motivation of the person rather than the severity of the incident(s).
- It may cause stress to vulnerable victims and witnesses.
- It may damage the therapeutic relationship and trust between the person (and other patients) and the staff. This may escalate the level of conflict and heighten the risk of further incidents.
- It may raise unrealistic expectations that there will be action taken under criminal procedures.
- If the action is taken purely as a measure to 'punish' the person or to try to emphasise the inappropriateness of the behaviour, there is a risk of failing to properly address the causes.
- The argument that police involvement could deter the person from behaving in a similar way in future may be flawed if the person lacks the capacity to understand or learn.
- Charges and a possible criminal record could have serious consequences for the person. A record of offences occurring when a person had a particular illness under a particular set of circumstances could result in unfair discrimination at a later date.
- It may interrupt the provision of necessary care and treatment. It may also inhibit the person's access to care and treatment at a later date. This may be a particular problem if the person is taken from the care setting into police custody.
- It may give 'mixed messages' about the attitude of staff. The person who is regarded as unwell enough to receive inpatient care, especially under compulsory measures, may have difficulty understanding the involvement of the police for violence directly related to mental illness.

[11] http://www.scotland.gov.uk/Resource/Doc/1099/0053903.pdf

After the incident

It is very important that services keep records of violent incidents. Managers should review serious incidents. They should also look for patterns of reports of less serious incidents. These actions are part of good governance of clinical risk.

We wanted to determine the steps that should be taken after a major incident to review what happened and learn from it. These actions are also appropriate after a series of less severe incidents or 'near miss' events where the risk of recurrence or a future serious incident is significant. Important actions include:

- A session for staff to discuss what led up to the incident and how it was managed. This should be done in a way that does not attach 'blame' to any person involved. Staff and other service users can be badly affected by a serious incident and may need group or individual support.
- An examination of the precipitants for the incident to see if similar situations could be handled differently in future. Incidents that resulted in serious injury to any person will need a more detailed adverse incident review.
- An urgent review of the person's care plan. This will entail an updated risk assessment aimed at preventing further similar events, including a review of the most appropriate care setting and level of staff observation. In many cases, this may involve a review of medication, including an urgent review of any medication that may have provoked or worsened aggressive behaviour. Specialist managerial and clinical input may help the clinical team, especially if there is an ongoing significant risk to others. This review must also ensure that the person remains safe and continues to receive effective care and treatment. It is also important to determine if the person's present care environment is contributing to the problem and to consider how this can be addressed. It is inappropriate and may be dangerous to discharge a person from a healthcare facility if continued safe and effective treatment cannot be guaranteed.
- A review of the incident with the person. Independent advocacy is of particular importance in this situation. It may be appropriate to seek the views of carers and other family members. It is important to explain to the person why staff took certain actions, especially if this involved the police. It is also important as a result of this review to plan how any future incidents would be managed. This will also help the individual understand that some behaviour is not tolerated. Where the person has the capacity to do so, this may be a point at which he/she might make an advance statement about how any future events might be managed. It may also assist the person in developing coping techniques to avoid getting into similar difficulties in future.
- Social work involvement may be helpful. Under the Adult Support and Protection (Scotland) Act 2007, there may be a need for the local authority to make enquiries. This is especially the case where the victim is an 'adult at risk' in terms of the Act. Robust local policies are needed to make sure that there is good communication and understanding between hospital care providers and local authorities.

- In some cases, staff may differ in their views of the person and the reasons for violent incidents. Strong leadership and support are essential to ensure an appropriate and consistent approach. Adult protection case conferences may have a role here.
- If the risk of future violence is significant, there may be a need to make sure that the risk is communicated to persons who may be at risk. For health and social care staff, this can include warnings on case records and emergency/crisis plans. These must be reviewed on a regular basis to ensure that the person is not regarded unfairly as a 'risk' because of past events that do not have a bearing on present care and treatment.
- Disclosure of risk to others, apart from care professionals, should normally be undertaken with the person's consent. Where the person does not, or cannot, consent, information may still be disclosed if necessary to protect others from harm.
- If any service user has come to harm as a result of the incident, staff may need to report this to the Mental Welfare Commission. We have guidance on the sort of incident that should be reported to us.
- If an employee has been injured as a result of work place violence, there may be a need to report the injury to the health and safety enforcing authority under RIDDOR. The HSE has guidance on this[12].
- Involving the police in reviews may be necessary. It would be particularly important to involve the police if there is dissatisfaction or uncertainty over a decision on whether or not to proceed with criminal charges. The police may have reported the matter to the Procurator Fiscal (PF). It will most likely be a decision by the PF whether or not to proceed with criminal charges. It may be helpful to involve the PF in discussions.
- If the police are called to a particular unit on several occasions, it would be important to have discussions about the reasons for frequent calls and the outcomes of police involvement.
- Above all, decisions must be made with the involvement of the person and, where appropriate, the person's carers. This is especially important if there is a decision that future events will be reported to the police. Staff must be open and honest in order to preserve a trusting therapeutic relationship.

Conclusion: policy guidance

When developing local policies on action to be taken following episodes of violence, managers should address the points raised in this guidance. The two essential outcomes from all incidents of violence in mental health and learning disability care settings are:

- Ensuring the safety of all persons. This includes immediate action to ensure safety, short-term action to reduce the risk of recurrence and longer term action to make sure that warning signs are known and communicated to relevant people.

[12] http://www.hse.gov.uk/pubns/hsis1.pdf

- Ensuring that the needs of the person for care and treatment (and the needs of any others affected by the incident, including staff) continue to be met in a safe and appropriate care setting. Any decision to withdraw treatment must be made with great caution and only after a full case review.

Employers should have arrangements in place to control, as far as is reasonably practicable, the risks of injury to employees, service users and others from work-related violence. Organisations should have clear and consistent policies on dealing with violence. These should give general guidance to staff on situations where police involvement is indicated. Each incident needs to be treated on its merits. Managers should avoid rigid policies, especially if this creates a culture that is seen by service users and carers as 'punishment'. Policies must be clear, easily understood and readily available so that everyone understands the reasons for any action taken following a violent incident.

Having taken the views of stakeholders into account, our advice on the development of policies in response to violent incidents is:

- The first and overriding concern is immediate action to make sure that the incident is brought to a close and everyone involved is safe and supported.
- There must be an urgent reassessment of risk and implementation of a management plan to address and control, as far as is reasonably practicable, the risks identified. This must ensure that the person and any other service user involved continue to receive safe and effective care and treatment.
- The victim of any assault has the absolute right to report the matter to the police.
- If the victim does not report the matter, the benefits and potential risks of involving the police need to be considered on an individual basis. Involvement of the police must be based mainly on the severity of the incident (or likely severity had there not been effective intervention) and the risk of recurrence.
- Staff should take care when making judgements about involving the police following relatively minor incidents on the basis of their view of the person's capacity and motivation. In particular, we advise against involvement of police solely as a means of punishment of behaviour that staff deem unacceptable.
- While taking note of the above point, staff should give police their views on the person's capacity in relation to the incident. This will help the police form a view on the likelihood of criminal intent.
- In any case where an individual is removed to police custody following an episode of violence, there must be procedures in place to ensure the provision of any necessary continuing mental health care and treatment, including necessary medication.
- Police involvement may lead to criminal charges. An appropriate adult should be present when any person who is known or suspected to have a mental disorder is interviewed by the police.

- Even if charges are not contemplated, the police can be helpful in contributing to the overall risk management of the individual and the environment.
- There must be a blame-free culture of learning from incidents and supporting staff and others involved. Involvement of specialists in behaviour management and/or forensic mental health should be considered if the risk of recurrence is high, regardless of whether or not the person has been charged or convicted of an offence.
- Communication, communication, communication. Staff must explain their actions to the person, the victim and witnesses. Where appropriate, they should also give an explanation to the person's carers and listen to their views. Appropriate information or alerts on ongoing risk should be available but must be reviewed to ensure they are still relevant.
- The local authority has responsibility for protection of adults at risk in terms of the Adult Support and Protection (Scotland) Act 2007. Policies should be agreed with the local Adult Protection Committee (APC). It is particularly important to establish clear division of responsibility between the APC and any internal review procedures, and to ensure good communication between the two.
- There should be liaison between staff and police (especially community or adult protection coordinators) over specific incidents and general risk management. Relevant information should be shared between services providing organisations to safeguard individuals involved or the wider public. Consent from a patient is always preferable but where this is unrealistic, information may be shared without consent where it is justifiable on the grounds of public protection, crime prevention or the protection of other vulnerable groups.
- There may be a need to report the injury to the health and safety enforcing authority, if appropriate, under RIDDOR. HSE may be involved in investigating incidents if there has been a breach of health and safety law.
- Prevention is better than cure. Managers should pay attention to published evidence on good care environments and practices that reduce the risk of violent incidents. We recommend the use of the Scottish Recovery Indicator (version 2)[13] to assist with practice development. Good individual risk assessment and management will assist in reducing the number and severity of violent incidents.

Appendix – acknowledgements

We gratefully acknowledge the input of the many individuals and organisations that helped us write this guidance. We are especially grateful to the individual service users and carers who shared their own personal experiences.

[13] http://www.sri2.net/

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