# Safeguarding Mental Health Patients *in* Emergency Departments

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Part and parcel of a Healthcare Security Officer role is that, with little or no notice, they can be tasked with personal responsibility to safeguard (i.e. keep safe) people who are experiencing a mental health crisis. No amount of training can fully prepare them for it. But, that's not to say that the task could not be made safer - for everyone.

## Contents

# Essential First Steps

The police are the apex of any hospital's arrangements for the management of extreme violence. (The police have TASER!)

It is essential that Hospital Security Managers develop close working relationships with local police and actively engage to produce (and disseminate) clear and agreed protocols covering all aspects of police attendance at the healthcare site including, specifically:

- Where police attend the ED with a person whom they have detained under s136 MHA;
- Whenever Police convey any person to hospital (i.e. to avoid 'dump and run' tactics.)
- Where an ambulance crew have asked police to follow behind for back-up;
- Where police attendance is requested onsite to manage a violent situation.

# Emergency Department Reception

Hospital managers should take all practicable steps to facilitate police attendance onsite, including provision of dedicated parking and RVP.

It would also make sense to ensure, as far as is practicable, ED reception staff always give immediate attention to police who attend the hospital with a patient.

This does not necessarily mean that the patient gets given priority treatment which is not in line with clinical triage, but that may be the most sensible practical step to take to safely 'manage' the risks.

At the very least, delays in the patient being seen need to be avoided.

Mental health triage should be undertaken for all service users on entry to Emergency Departments alongside physical health triage. (See NICE GUIDANCE NG1O "Violence and aggression: short-term management in mental health, health and community settings" at 1.5.7, page 44.)

The national review of NHS clinical standards has declared patients presenting with an emergency mental health need should receive a response from the liaison psychiatry team within one hour of being referred, and within 24 hours for an urgent referral.

ED staffing levels also need to reflect predictable demand for mental health services.

For example, presentations at A&E for all mental health conditions (other than dementia) are highest outside of regular working hours and the peak hours for self-harm admissions via EDs are between 11pm and 5am, when it accounts for 6% of all admissions.



# Before Accepting Responsibility For A Patient

Before accepting formal, legal responsibility for any person who has arrived accompanied or transported to the hospital by police, Emergency Department reception staff must first be satisfied they are aware of the likely risks the person presents and that the ED staff can safely manage these. In making this assessment, it would be essential to consult with security.

Any decision to accept an individual as a patient should be made by the senior clinical staff member on duty on behalf of the Trust. This is usually the senior nurse in charge. This person should only accept legal responsibility for an individual if they are confident that the ED staff, including security staff, are suitably trained and in sufficient numbers to be able to manage the person appropriately should they become violent.

Note: NICE GUIDANCE NG1O "Violence and aggression: short-term management in mental health, health and community settings" at 1.5.6, page 44, 'Staffing' states:

*"Healthcare provider organisations should ensure that, at all times, there are sufficient numbers of staff on duty in emergency departments who have training in the management of violence and aggression in line with this guideline."*

Hospitals should therefore be keeping a readily accessible register of 'restraint trained' staff who are rostered to be available to support the ED staff, as and when required.

The thing is, if ED staff indicate to police that they are either unwilling or unable to accept legal responsibility for the person, the person will continue to remain in the legal custody of the police who brought them to the ED. In such circumstances, the police will not therefore leave the hospital and instead remain and continue to provide the support needed.

# Taking Time To Fully De-Brief Police Officers

ED reception staff should be looking to learn (and record) as much information about the patient, as early as possible from the police before they leave.

ED reception staff should be conscious of the (natural) desire of police officers to hand over the patient to them and leave as quickly as possible. But the process should not be rushed. Information about a person's behaviour immediately prior to attendance at hospital (e.g. attempts to escape or self-harm) can really help to inform the level of restrictiveness that will need to be imposed in order to keep them and others safe.

It is vital that the ED staff get a clear understanding of the risks posed by the individual, so as to ensure that they can give clear and specific directions to security staff about the risks the person presents and what level of vigilance is required. This is especially true where legal responsibility for the patient is being accepted by the ED staff and police are going to leave.

## Not Free To Leave

Where a person is sectioned under the Mental Health Act, it means they are not free to leave, meaning reasonable force can be used to prevent them leaving.

In addition, the Mental Capacity Act also authorises deprivation of liberty, if it is in the best interests of a person who lacks capacity.

In other emergency situations, the Common Law Doctrine of Necessity will apply.
ED staff should, as early as possible in proceedings, inform Security Officers of the legal basis supporting the person's continued detention and it should be the first thing that Security Officers ask for when they are called to assist.

What is important is that all relevant information about the patient is conveyed to the security staff deputed to safeguard the patient; and that they, in turn, always accurately pass it on to other staff who may support or relieve them.

## Risk Assessment

An individual suffering mental ill health presents a range of risks. One is the risk of them absconding. Another is risk of imminent intentional serious self-harm (suicide). Another is the risk of them unintentionally causing serious harm to themselves, through misperceiving their situation, for example, by running in front of a vehicle. Another is the threat of them immediately causing harm to others or property.

Every individual is different and will have a unique threat potential.

Some may be athletic and highly mobile while others may not; some may be physically very powerful and others may be very persuasive liars and very cunning, etc.

So, they are broadly categorised as High, Medium or Low risk in terms of being an immediate danger to themselves or others.

## Assessing Staff Capability

The security team will be best placed to assess staff capability to safeguard a particular patient.

But they won't be able to do this kind of assessment remotely. You need to see an individual to get a proper sense of their potential.



## Numbers of Restraint Trained Staff Needed

Will it ever be safe for one security officer on their own to safeguard a patient?
No, not if the patient may need to be physically restrained to prevent them leaving.

This is simply because to attempt to restrain a person on your own is known to be unsafe practice (and for this reason it is quite rightly prohibited by many 'risk conscious' NHS Trusts.)

Most restraint training provider organisations recommend that a minimum of three restraint trained staff are needed to safely manage physical restraint. The Prison Service advocate a team of four.

So, if there is a risk of the patient absconding, there will need to be more than one security officer present in order for physical restraint to be an option.

## How Restrictive Should Safeguarding Measures Be?

When patients with mental illness and agitated behaviour arrive at an Emergency Department it can be difficult to strike the right balance between restricting their freedom of movement, (which may increase distress and provoke violence) and supervising them in a less restrictive manner whilst using verbal and body language techniques to de-escalate potential crisis.

The emphasis should be on de-escalation as much as possible, as the length of time patients are required to remain in the ED is often unpredictable and physical restraint can only be used for a short period of time to protect patients and staff.

It is widely accepted that 'within arm's length' observation is very intrusive and can be distressing to patients and stressful for staff, which is why this level of observation is generally only used when a patient is assessed as being an immediate danger to himself/herself or others.

The thing is, Emergency Departments are insecure environments. Unlike a police station or secure mental facility, the doors can't be secured. This means that Security Officers dealing with at risk patients likely to abscond have to be especially alert and vigilant.

But it is not enough for security officers to just keep a patient under vigilant observation. The Judgement of Mr Justice Bean in his in the case of Mark Webley v (1) St George's Hospital NHS Trust and (2) The Metropolitan Police (2010) at 31 states:

*"The strategy of managing psychiatric patients at risk of absconding by observing them and only intervening once an attempt to abscond is underway appears to have an intrinsic risk of failure, even with a high level of vigilance."*

In order to be able to prevent an attempt to abscond, Security Officers will need to be constantly physically close to the patient (i.e. within arms' length), avoid distractions and not sit down.

## Sitting Prevents Rapid Response

Mr Justice Bean in his Judgement in the case of Mark Webley v (1) St George's Hospital NHS Trust and (2) The Metropolitan Police (2010) at 53 (14) stated:

*"It would seem common sense that a guard would be less able to respond rapidly to an unexpected event (which could have been any of a range of dangerous behaviours, not just absconding) if sitting."*

## On The Principle of Minimal Restraint

Mr Justice Bean was not persuaded that the risk of 'greater agitation resulting from oppressively close supervision' had the potential for more immediate harm than that presented by the obvious risks of Mr Webley absconding and coming to harm. (see 53 (12)).

Mr. Justice Bean clarified that, whilst both the law and their training require security staff to adopt a least restrictive measures approach when dealing with a disturbed patient, the requirement to prevent the patient from leaving is the more important. (see 53 (2)).

Mr Justice Bean said:
*"I do not find, that it was necessary for either or both of the security guards to take hold of the Claimant….I accept….the desirability of allowing psychiatric patients not to feel crowded and of a policy of minimal restraint…but the desirability of minimal restraint had to be balanced against the risk of an escape. Mr Webley should have been guarded, and not simply observed, by two security guards".*

## The 'Duty Of Care' To Keep The Patient (And Others) Safe Will Always Be Paramount

But what if the patient has a phobia about being held in a confined space, or wants to have a cigarette?

Efforts to manage a person in the least restrictive way practicable will always need to be considered secondary and conditional to the 'duty of care' to keep the patient (and others) safe.

# Strategic Positioning

In addition to maintaining a high level of vigilance, avoiding distractions and remaining physically near the patient at all times (i.e. within arms' reach), security officers engaged in safeguarding need to actively monitor the patient and position and re-position themselves, so as to minimise opportunity for an escape.

Note: Mr Justice Bean in his Judgement in the case of Mark Webley v (1) St George's Hospital NHS Trust and (2) The Metropolitan Police (2010) at 53 (8) states:
*"Positioned as they were, (Security Officers) Mr Murcott and Mr Cole were at more than arm's length from the Claimant and did not react quickly enough to catch him when he escaped."*

The environment will be a critical factor in determining how many security staff will be required to prevent an escape and identify where they should be positioned.

Health and Safety Risk Assessments (and associated Procedures and Instructions) for detained patients will therefore need to consider the environment where they are to be detained i.e. in order to determine how many security staff are going to be needed. Obviously, the safer the 'environment', the better.

# Provision of a Safe, Calming Environment

The busy, brightly lit, noisy, open-door nature of Emergency Departments means managing individuals who need to be detained presents a real challenge. The solution is provision of a protected, calming environment that is fit for purpose. Every ED should have at least one.

NICE GUIDANCE NG1O "Violence and aggression: short-term management in mental health, health and community settings" at 1.5.8, Preventing violence and aggression), at page 44, states:

Healthcare provider organisations should ensure that emergency departments have at least one designated interview room for mental health assessment that:

- is close to or part of the main emergency department receiving area
- is made available for mental health assessments as a priority
- can comfortably seat 6 people
- is fitted with an emergency call system, an outward opening door and a window for observation
- contains soft furnishings and is well ventilated
- contains no potential weapons.



The DoH publication 'Health Building Note 03-01 – Adult acute mental health units' at 8.147, page 35, offers the following 'Best Practice' guidance on the design of interview/assessment rooms:

8.147 The interview/assessment room should accommodate up to six people, with space for assessment and restraining where necessary. A door may be required at opposite ends of the room for safety reasons. Adequate sound attenuation is required so that conversations are not overheard outside the room.

8.148 The room may also need to accommodate the following:

- a phone line with outside dialling;
- a choice of fixed upright and easy chairs;
- good lighting;
- good observation into the room from a vision panel in the door or wall;
- CCTV.

The Psychiatric Liaison Accreditation Network (PLAN) is an initiative of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) in partnership with the Royal College of Physicians, the Royal College of Nursing, the College of Emergency Medicine and the mental health charity Mind.

PLAN provides the following recommendations for psychiatry interview rooms for conducting high-risk assessments:

They should:

- be located within the main emergency department;
- have two doors (to provide additional security); all new assessment rooms must be designed with two doors);
- have at least one door which opens outwards and is not lockable from the inside;
- have an observation panel or window;
- have a panic button or alarm system (unless staff carry alarms at all times);
- only include furniture, fittings and equipment which are unlikely to be used to cause harm (e.g. sinks, sharp-edged furniture, lightweight chairs, tables, cables, televisions or anything else that could be used to cause harm or used as a missile are not permitted);
- not have any ligature points.

Worryingly, a survey of psychiatric assessment rooms in UK emergency departments, published April 2016, indicated that only about one in four Hospital Emergency Departments had a psychiatric assessment room that met all the safety criteria. Respondents to the survey also suggested that barriers to the establishment of an appropriate facility including it being regarded a low priority by hospital management; and the assessment room being sometimes used for other purposes, including the storage of equipment (which, besides detracting from the ambience, can also compromise arrangements to eliminate ligature points.)

The CQC publication 'Right here, right now – help, care and support during a mental health crisis' dated June 2015, included a Case Study (at page 83) which highlighted that *"While the acute hospital had made the best use of the resources they had, it was not an appropriate location as it was not a designated place of safety and was not suitable for vulnerable patients due to the area containing free standing equipment, cords and a number of ligature points."*

One can only hope that the situation has improved.

# Preventing Ligature Asphyxiation

Any person experiencing mental ill health is at risk of attempting a ligature asphyxiation. It's a very popular form of suicide with a 70% success rate.

People are resourceful and ingenious and if left alone for even a short time may utilise, adapt and improvise all kinds of innocuous items to create a ligature.

For example, ligatures can be made from bras, shoelaces, belts, scarfs, towels, bedding, electrical cables, rope and even by carefully tearing a paper pillowcase into strips and then platting them together to make a noose.

And, all kinds of fixtures and fittings can present a risk of being used as a ligature point, such as radiators, door frames, windows, basin taps and bed frames. People have even been known to pick out soft silicone type filler in wall fittings to provide a ligature point!

The secure custody sector work on the principle if something stands proud 2mm or more, it can be used as a ligature point.

Contrary to popular belief, you don't need a significant 'drop distance' for a ligature death. The Care Quality Commission (CQC) has advised that a typical ligature point is between 0.7 and 4 meters from the floor.

The risk of a ligature death is a significant safeguarding issue that cannot be ignored.

Healthcare providers have legal responsibilities under the Health & Safety at Work legislation and Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to assess all known risks and make sure that the premises and any equipment used is safe.

A Risk Assessment should not only identify risks but also specify the measures (systems, procedures, instructions, staffing and training) needed to minimise the risks.

Failure to conduct a full and sufficient risk assessment and take appropriate risk reduction measures can leave NHS Trusts wide open to full liability and prosecution in the event of adverse outcomes occurring that should have been prevented.



In the case of Mark Webley v (1) St George's Hospital NHS Trust and (2) The Metropolitan Police (2010), it was found that:

> *a) "Policy and training as to the use of Cubicle 9*; (there was neither any policy, written or otherwise, nor any training or guidance for the Security Guards, written or otherwise, for the management of disturbed patients in cubicle 9.*
>
> *b) Risk assessment as to the use of Cubicle 9*: No risk assessment had been made as to the management of disturbed patients in cubicle 9, either by D1 generally or by the clinical staff on duty in relation to C as an individual.*

* Cubicle 9 was a room designated by the Trust for accommodating potentially disturbed or dangerous patients within A&E.

NHS Trusts should be aware that CQC are now assessing ligature risk management policy and procedures and inspectors are asking for documentary evidence such as, ligature risk reduction policy, risk assessments and audits.

Unfortunately, knowing what could be used to create a ligature is not just a matter of common sense and being able to spot potential ligature points in a setting is a real skill. Without specialist training, (such as provided by Expert Witness, Joanne Caffrey), conducting a Risk Assessment for Ligature Points may be likely to be outside the competency scope of staff who have only been trained in the slip, trips, and falls style of risk assessing.

It's worth keeping in mind that three factors need to combine together for a death to result from ligature asphyxiation (i.e. the ligature risk triangle.) These are:

1. The means to create a ligature
2. The availability of a ligature point
3. The opportunity to complete the act without interruption

Healthcare providers only need to prevent one of the three factors being 'readily available' in order to successfully prevent the death.

So, ED staff can effectively eliminate the opportunity for a ligature death to occur uninterrupted, through maintaining continuous close contact with the patient, i.e. not leaving the patient alone at any time and increasing engagement levels. If there is any doubt about the efficacy of the 'ligature risk reduction measures', this should be what happens, supported by VERY CLEAR INSTRUCTIONS TO STAFF.

## Time Restriction On Security Officers 'Guarding' Patient

For years, it has been common practice in the NHS for Security Officers to be assigned to safeguard patients who may present a threat of violence or serious self-harming and absconding.

However, in recent times, complaints have been made that patients whose behaviour is not criminal are effectively being stigmatised as criminal by being 'guarded' by persons dressed as 'law enforcement agents' (i.e. as opposed to clinical staff) and that this is a breach of their Human Rights. (i.e. Article 3 - the prohibition of torture, inhumane or degrading treatment.)

In short, the argument cuts to this. Security is an emergency response service and so, will be a legitimate response to any emergency crisis. However, the legitimacy for their presence will be time limited to a reasonable time frame i.e. the time it would (reasonably) take to assemble a multi-disciplinary team to develop and implement an appropriate care plan for the patient. The figures I've heard reported for a 'reasonable time frame' was about 2 hours.

So, where uniformed Security Officers are employed to 'guard' a patient for more than two hours, it could be construed as unjustifiable and unlawful – putting NHS Trusts at risk of litigation and compensation claims.

One NHS Trust's temporary solution to the problem has been to, where necessary, post the Security Officers in plain clothes. However, this does mean the Security Officers aren't able to wear their Stab Vests. So, not a perfect solution.

## Recognising Behaviour as a Form of Communication

Security Officers engaged in safeguarding duty need to be able to recognise signs of restlessness and agitation as a signal for a need to:

- Report observations/concerns to clinical staff
- Increase alertness to the prospect of an attempt to abscond
- Take positive action to (subtly) adjust their positioning, so as to block available pathways
- Engage with the patient verbally to calm and reassure them



## Keeping Things Calm and Slow

A person experiencing a mental health crisis may be expected to be feeling scared and anxious.

Overcoming their anxiety is not something that can be accomplished quickly.

It takes time and effort.

Security Officers need to be mindful of the potential negative effects of their appearance (i.e. uniform, stab vest; radio; BWV) on the patient (e.g. nervous, anxious, alarmed, terrified, hostile).

Creating the best 'first impression' relies on Security Officers being armed with a positive care attitude and interest to help.

Just as you can sense hostility, you can also sense when someone is interested to help.

When approaching a patient who is in distress, Security Officers will need to implement the inter-personal communication strategies learned on their NHS Conflict Resolution Training course - modelling open body language; paying particular attention to the person's body language; and adopting a measured approach to proximity and personal space intrusion.

## Introductions Are Important

Security Officers should always, as soon as practicable, introduce themselves, give their name and in simple terms, state their role (e.g. 'I am responsible for everyone's safety here – including yours.')

By giving their name, they will be helping to personalise themselves to the patient. Besides setting a firm foundation for the development of rapport and trust, it can also make it harder for the other person to see them as an object and this can help to prevent attacks.

Asking the person how they would prefer to be addressed (e.g. Mr Subuni or Joseph?) empowers the patient with a choice to make, where typically all decision making is wrested from them. This 'gift' can help to build trust and rapport.

It's obviously important that Security Officers remember to use the person's preferred term of address!

## Give The Person Longer Than Normal Time To Respond

It's best to adopt a slower than normal pace of conversation.

One of the consequences of the anxiety a person may be likely to be experiencing (including apprehension about the presence of security officers) will be that their ability to process information will plummet (the Flight/Flight/Freeze response).

This can mean they may need to be told the same thing multiple times before it registers with them. (It's not that they are not listening.)

Any questions put to the person should be simple and direct and Security Officers should keep give the person longer than normal time to respond.

## Concentrate On Listening

It is essential that Security Officers demonstrate interest to help the person.

One of the best ways to do that is by listening carefully to what the person says, as far as possible without interrupting.

Security Officers should employ appropriate body language (active listening skills - nodding and reflecting back) to demonstrate they are listening.

Being able to accurately paraphrase what the person has said is proof you have been listening. Asking them to confirm that your summary of what they've said is correct, invites them to verbally acknowledge that you have been listening. That can really help to build their trust and confidence in you.

## What to Say

A person experiencing a mental health crisis may be totally consumed by disordered thoughts. The sound of a calm, firm voice can help them feel grounded and safe.

Security Officers should aim to build rapport, trust and confidence by:

- Offering reassurance (e.g. 'You are not in any trouble, I'm here to help you – to keep you safe.')
- Reminding the person that they are unwell and in the right place to get help.
- Asking the person directly if they are having thoughts of suicide or self-harm. Don't worry, it will not 'put ideas in their head'. Keep asking that where appropriate. If you can encourage an individual to tell you the thoughts they are having before they act on it, the situation may be de-escalated at an earlier point.
- Keep reminding the person you are there to help, that you care about them and will protect them against coming to any harm.
- Reassuring them they are not a bad person, that they're not worthless and that they are not wasting your time. (Many mental health patients feel guilty that they are a burden or seen as attention-seeking or time-wasting. Repeatedly reassuring them you are there to help them can help them to accept you are going to do what is best for them.)



- Explaining you are not clinically qualified to discuss the patient's medical condition but can talk about other 'normal' things. (This could be anything e.g. sports, hobbies, interests, backgrounds etc., but nothing deep e.g. politics, religion, etc.)
- If appropriate, providing the person with something to hold onto and focus on, such as, a small, soft ball, fidget cube, etc. Maybe even offer your hand for them to hold and squeeze. Many people find it therapeutic and it helps them to be calmer.
- Whilst, appreciating that the person may be so consumed by their illness that they are unable to make a decision, try, where appropriate, to empower the person with options and alternatives (i.e. choices) and where necessary guide them towards making the 'best' choice.
- Being honest and transparent about what is happening and what is going to happen. (This helps the person to trust you far more than if you don't tell them.)
- If you say you will do something, do it - otherwise trust is undermined.
- If the person reports hearing voices or visions, it is okay to say you are not seeing the same things as them but, also reassure them you are interested to learn more about what they are hearing/seeing. Remind the person that they are not well, which is what could explain why you are not seeing/hearing the same things.
- Take physical control when it is necessary.

## If The Person Is Very Disturbed/Distressed

If a person is panicking or terrified, Security Officers can help to relieve their distress by repeating short, brief, direct statements in in a calm, reassuring tone.

- Take a moment
- Chill
- Relax
- I'm here with you
- Focus on my voice
- I'm going to keep you safe
- Try and control your breathing
- Breathe out, then take a deep breath, hold it, then exhale
- You're doing well.
- Well done!

## Things To Avoid Saying

- Calm down
- You're being silly
- Stop messing us around
- Don't start all that
- Anything that includes the words 'kick off'

These common phrases are all unhelpfully patronising to the recipient and can provoke a hostile response.

# Don’t Leave Without Saying Goodbye

It is not uncommon for Security Officers who have spent hours with a person in a crisis situation, talking to them, physically restraining them and keeping them safe, to then hand over to relieving Officers and leave without saying goodbye to the patient.

However, this can unhelpfully leave the patient feeling of little value or significance to you.

It’s something to be avoided.

Always remember the difference you could make

By helping a person to stay safe while mentally disordered and vulnerable, Security Officers will be making a massive difference for the patient right there and then.

But the impact they will have will not stop there, it can stay with the person forever.

As an example, here (below) is what mental health service user, Liv Pontin said:

*“The words you use stay with me. And the impact you have is massive. Not just the night you meet me, when you may directly have saved my life or prevented me from harming myself, but on future nights when I am struggling alone, and can hold onto the words you used with me. You may not see me those future nights. But the words you use the times you do see me can stay with me, and sometimes those words can help me to keep myself safe alone when I may otherwise have turned to self-harm”.*

More information

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