

Managing aggression and violence¹

Effective risk management is particularly important in prison, as some prisoners have major issues in dealing with anger and aggression. Risk management is a part of the health and safety rights and responsibilities of all staff. The health care manager has additional responsibilities under Health and Safety law to make an environmental risk assessment and take action, as appropriate, to reduce risk.

Aggression and violence are not a mental disorder, though people who are aggressive and violent may have one of a number of disorders. This section aims to give advice to help clinicians reduce the risk of violence and aggression and to deal with it if it occurs. The aim is not to 'cure' the individual of being aggressive, but to reduce aggression so that the clinician can address the individual's other health problems safely.

Preparations to be made in advance

Layout of the healthcare centre

- **Avoid excess stimulation.** Noisy waiting rooms, loud music or bright lights can overload an already tense or disturbed individual. Ensure waiting areas are well ventilated.
- **Consider, if possible, a destimulation area,** eg a lounge area with toilet facilities for use by individuals who pose a particular risk.
- **Consider, in the longer term, developing a de-escalation suite** or snoozelen room for use by patients who have become very agitated.

Layout of the interview room

- **Ensure a safe escape route for the patient** (such as an unobstructed exit). A distressed individual would rather escape than fight; aggression levels rise if the individual feels cornered or has trouble finding an exit.
- **Ensure a safe escape route for yourself** (eg be nearest the door). This is important if violence is premeditated or goal-directed, eg an individual is threatening a doctor to try to obtain particular drugs.
- **Ideally then both individual and clinician will have equal access to a safe exit, preferably separate exits.** If this is not possible, then the clinician should be nearest the exit or the room should have an observation panel that allows a clear view from, say, secretary's desk outside.
- **The door should open outwards or swing both ways to prevent possible barricades.**
- **Discreet buzzer to call for help.**
- **Décor and furniture should be as pleasant and relaxing as possible,** eg easy chairs, pastel colours.
- **Other staff members to be clearly visible** or seen to pass the room at frequent intervals.
- **Interview room to have externally locking doors,** so that help cannot be locked out.
- **Scissors, knives or any other unnecessary objects** that can be picked up and thrown should not be kept in the interview room.

Clothing and jewellery

Remove items of clothing that might cause injury if a potentially violent individual catches hold of them, eg earrings, necklaces, neckties, pens or pencils (from pockets), cigarette lighters. Do not wear clothes or shoes that may make a quick exit difficult.

Standard procedures

- **Fear can lead to violence.** Provide information about the symptoms of the illness, any medical procedures, the names and roles of any clinicians who are also present and the role of the health centre.
- **Behave calmly.** Non-verbal stress and anxiety can be difficult to distinguish from anger. To a patient who is confused, hearing voices or lost in distressing thoughts, a highly anxious clinician may be perceived as threatening.

- **Inform patients about anticipated delays.** Offer appropriate resources (eg magazines, drink, bathroom, etc). Simple consideration can help reduce hostility.
- **If delays are anticipated, have a member of staff search the toilet area for objects that might be used as weapons.** Maintain staffing levels to allow patients to be escorted to and from the toilet area.
- **Have a clear policy**, written or reviewed within the last 3 years and known by all in advance, about the prescription and administration of opiates and benzodiazepines.

Assess the risk of violence

Consider the following questions.² The more often you answer 'yes', the greater the risk of violence.

- Is the person I am dealing with facing high levels of stress? Consider recent bad news, bereavement, a court date and significant anniversary dates.
- Is the person likely to be drunk or on drugs?
- Does the person have a history of violence?

Before interviewing an individual who is unknown to you, review old notes (if available) or talk to wing staff to look for reports of previous violence (the strongest predictor of violence).

- Does the person have a history of psychiatric illness?
- Does the person suffer from a medical condition that may result in loss of self-control?
- Has the person verbally abused me or others in the past?
- Has the person threatened me or others with violence in the past?
- Has the person attacked me or others in the past?
- Does the person perceive me as a threat to his/her children?
- Does the person think of me as a threat to his/her liberty?
- Does the person have unrealistic expectations of what I can do for him/her?
- Does the person perceive me as wilfully unhelpful?
- Have I felt anxious for my safety with this person before?
- Are other people present who will reward the person for violence?

Visits to wings/units

If visiting a patient in their cell do the following.

- Make staff aware of your presence before entering the cell.
- Acknowledge the patient's territorial rights and respect his/her personal space and possessions. Always ask whether you may enter the cell, sit down, etc. By doing so, you will allow the individual to retain a sense of control and thus will reduce a perceived threat.
- Do not allow yourself to be directed to a seat you are uncomfortable with, eg sitting on the bed.

Recognising potential aggression at an early stage

Signs include the following.

- Any change in behaviour that varies from what is normal for that individual.
- Pale or flushed face.
- Rising voice.
- Focusing/narrowing of gaze.
- Tensing of muscles.
- Increased agitation and disturbance in behaviour, eg pacing.
- Unusual calmness.
- Disturbed communication.

Defuse aggression before it becomes violence (verbal de-escalation)

Adoption of a non-threatening body posture

- Use a calm, open posture (sitting or standing). Place yourself to the patient's side or take up a side-on stance. Reduce eye contact by use of peripheral vision — as direct eye contact can be confronting.
- Allow the individual adequate personal space. The amount varies between individuals, so be aware of signs that the patient feels you are too close or too far away.
- Keep both hands visible with open palms as a calming gesture.
- Do not stand if the individual is sitting or you will appear threatening.
- Do not whisper or talk over the patient. Keep him/her involved in all relevant discussions wherever possible.
- Avoid sudden movements that may startle or be perceived as an attack. Movement towards the individual may be perceived as a threat. Move backwards or sideways if you move at all. Do not turn your back on the individual.
- Avoid audiences — an audience may escalate the situation.

Display an understanding

- Remain calm and patient.
- Speak firmly, slowly and clearly, but with normal tone and intensity — do not raise your voice. Avoid sounding accusatory or punitive.
- Offer support: do not make retaliatory remarks. Reassure the individual that you accept that he/she is angry. If the individual makes a conciliatory gesture, respond accordingly.
- Ask questions: ask how the patient is feeling. Do not say: 'I know how you feel.' Ask what is causing his/her anger. Ask how he/she thinks the situation can be resolved.
- Give time for the individual to think about the situation, to hear the full story. Do not rush the individual.
- Avoid interrupting the individual. If an interruption is necessary, do it quietly and calmly.
- Show that you are willing to help where possible.
- Make an apology if appropriate.
- Do not take the individual's comments personally. Abusive statements may be the only way the individual can express his/her feelings at the time.
- Try to be honest with the individual and do not make promises that you cannot keep.
- If physical contact is made (eg holding your hand or patting you on the back), try and remain calm. Do not pull away or overreact, as this may trigger suspicion.

Provide supportive feedback

Note the individual's non-verbal cues and feed your impression back to him/her. For example:

You seem a bit agitated. Perhaps you can tell me why you're feeling agitated, then I may be able to help you in some way.

I can see that you're very upset about something. Tell me what's upsetting you? Tell me what you would like me to do to help you.

This technique is often useful, but occasionally it infuriates the individual further. If this occurs, move on to another technique.

Provide the individual with choice

A choice of alternatives, even if none are what the individual would ideally like, may help him/her feel in control of their situation, and so may alleviate some of their distress. For example, you could say:

I can see that you're extremely distressed and agitated by the voices you're hearing. I can help you to feel better by giving you your usual tablets. You always tell me that the pills make the voices quieter. You can then go back to the unit. If you don't want me to help you in that way then you can go into a room on the ward. The choice is yours. Tell me what you'd like me to do.

Set limits

Many individuals struggle to avoid becoming aggressive and by setting limits you show that you will not tolerate aggression and that you will help the individual to remain calm. Thus, limits can act to decrease the individual's anxiety

about losing control. Limit-setting may be especially effective if you acknowledge the individual's present emotions, so explaining why limits are being set. For example:

I can see that you're very angry and it's not surprising given your circumstances today. I'd like to help you but I cannot do so if you lose your temper. First of all I'd like you to sit down, then you can tell me how I can help.

You're obviously very annoyed about something. I can see that you feel like hitting something and I'm a bit scared that you may hit me. I'm going to ask the prison officer to stand in the room with us. I'd like you to take a seat and then you can tell me what you're annoyed about.

I'd like to help you but I can't do so if you yell at me. Either you stop yelling and talk to me calmly or I'll have to leave you alone until you've calmed down.

Time out

Time out may involve leaving the individual alone in an unlocked room for a few minutes or asking the person to take a break. It should be clear to the individual that the strategy is not a form of punishment. For example, you could say:

Look — this is getting intense (or emotional). Let's take a break for a few minutes. It will help us (or me) to think.

If the situation escalates despite these efforts

Do not try to handle a violent individual on your own. **If he/she claims to have a weapon, GET OUT of the room or building.** If you cannot escape, then do the following.

- Summon assistance. If possible, give the helpers information about the situation to prevent overreactions. (Staff running into a room where a patient is armed may trigger off an assault).
- Stay calm.
- Do not wrestle or argue with the aggressor.
- Adopt a non-threatening stance. Keep your palms open as a gesture of calm. Minimise eye contact with the use of peripheral vision.
- A side-on stance creates a smaller target with the vital organs protected and with better stability.
- Obey the individual's instructions and try not to upset him/her.
- Speak only as much as is needed to keep the individual speaking — rather than acting.
- If the individual calms down a bit, it may be possible to suggest that he/she puts the weapon on the table or in another safe place. Do not attempt to grab the weapon, but play for time until help arrives. Talk empathetically with the individual to continue to defuse the situation. However, do not agree with ludicrous delusions. It may help to say something like: 'I can see you're upset by this belief. Maybe it's true; maybe it's not'.
- Use surrounding objects and furniture as shields if violence occurs.

Use of control and restraint

Physical restraint should only be used when there is no other more appropriate course of action and there are sufficient people for it to be done safely. This is supported by the relevant Prison Service Order (currently PSO 1600, 'Use of Force'). Staff should be trained in the use of restraint and in CPR. Use only the degree of force appropriate to the actual danger or resistance shown by the violent individual. Healthcare staff must attend situations where the use of restraint is planned in any part of the prison. Although their role is to ensure that restraint is applied only when essential and in such a way that the prisoner's health is protected and not to use it themselves, nurses may find it useful to be trained in control and restraint in order to understand better what is happening. Monitor vital signs throughout the time that restraint is applied.

Dos and don'ts of the use of restraint

Do	Don't
Always call for assistance Ask a patient to summon help when appropriate	Do not try to manage on your own
Be aware of the environment and of the whereabouts of your colleagues	Do not put yourself in a position knowingly where you have no immediate exit or that your colleagues are not in a position to respond should you summon assistance

Be aware of the patient's disabilities, old injuries or medical conditions	Do not apply pressure to parts of the body that could restrict breathing, eg stomach and neck
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Be aware of medication that the patient is taking and of the possibility that he/she is using illicit drugs

Protect the patient's airway

Continue to hold onto the patient once he/she is immobilised	Do not relax the hold the moment struggling stops
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Continue to talk to the patient	Do not stop talking to the patient because he/she does not reply
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Remember that a patient struggling during restraint may just be trying to get into a position where he/she can breathe	Do not restrain a patient face down for long periods as natural body weight and anxiety can put severe stress on the heart and lungs
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Consider the accessories you wear or pens and other items you carry in your pockets as these can cause injury during a struggle	Do not wear jewellery, cufflinks, brooches, watches, rings, etc. of a design that might cause injury during a struggle
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For further guidelines on the use of physical restraint, see PSOs 1600, 'Use of force', and 1700; Department of Health and Welsh Office Code of Practice (1990); Mental Health Act 1983; and UKCC 'Managing Aggression' (June 2001).

Where treatment without consent under common law is considered (eg rapid tranquillisation), see **Emergency treatment under common law** (page 168).

Other forms of management of violent patients

Occasionally it may be necessary to use other means to prevent a patient from being violent. Where the patient has a mental illness and either gives permission for treatment to be administered or is not competent to give or withhold consent, then medication is an option. For advice on the use of rapid tranquillisation under common law, see **Emergency treatment under common law** (page 168).

Currently, in prisons in England and Wales, Prison Service guidance allows that where a patient has a medical condition leading to the violent behaviour, a doctor may order the use of 'medical restraint', ie the use of a 'special cell' or of a loose canvas restraint jacket. In addition, for all forms of violent behaviour, as a very last resort, a prison governor may order the use of 'mechanical restraint', ie the use of a body belt with metal cuffs or the use of special accommodation. Where a governor has ordered the use of either mechanical restraint or special accommodation, the role of the doctor is to assess whether there is any medical reason for not using these and, if there is, to order their use to be ended immediately.

In the use of any such form of physical restraint, the following are essential points of principle.

- It should be used as a last resort and for the shortest time possible.
- Steps should be taken to ensure the minimum possible invasion of the individual's dignity, eg audiences should be moved away.
- The individual should be treated in a way likely to calm rather than aggravate their aggression, eg speaking to them calmly and with respect.
- The individual's mental state should be regularly assessed and an opinion urgently sought from a psychiatrist if there is any history or current indication of mental illness, self-destructive behaviour or substance misuse.
- Where the patient has a mental disorder, care and treatment should be planned if necessary and appropriate under common law (see **Emergency treatment under common law**, page 168). Where indicated, steps should be taken to remove them urgently to a hospital where treatment can be given (see **Interface with the NHS and other agencies**, page 149).
- Where the patient has a history of very difficult behaviour, a full, multidisciplinary assessment and care plan should be arranged (see **Management of prisoners with complex presentations and very difficult behaviours**, page 202).

Action to take after a violent outburst

Staff

- Staff members involved will require support and appropriate attention, if required, to meet psychological or physical needs following an incident.
- It is usually helpful for participants to discuss their experiences of the incident. Staff should together talk about what happened, how they felt, what went wrong, what went right and how to handle such situations more effectively in the future. The new information should be shared with staff who were not directly involved in the incident. This kind of review is equally helpful in situations where a violent outburst seemed very likely but which was prevented.
- Some staff may suffer injury (eg orthopaedic strain) during restraint. Encourage staff members to check any potential injuries with the occupational health service.

Patient

A record should be made in the individual's file. In a prominent position inside the file (**NOT** on the front cover) record: 'See (**date**)' and give the date of documentation of violent episode. Then, in the notes on that date, give a detailed record of the violence. Include the grade or severity of the violence, the circumstances in which the violence occurred (eg whether the individual was psychotic or drunk) and whether the violence was provoked.

Offer to discuss the incident with the individual when he/she has recovered. He/she is likely to feel shaken after such an event, especially if restraint or medication were used. If the violent incident was out of character for the individual, he/she may have trouble understanding why it occurred. If the violence was part of a pattern of aggressive behaviour, the individual may be more willing at this point to accept help for his/her violence.

Assess the individual to exclude possible physical and neurological causes for the violence. Arrange a multidisciplinary psychiatric assessment to determine a management plan. Violence is associated with the following.

- Any cause of confusion, either acute (delirium) or chronic (dementia). A thorough medical check-up is advised (see **Delirium** and **Dementia**, pages 41 and 43).
- Acute psychosis.
- Paranoid states.
- Acute organic brain syndromes.
- Head injuries.
- Substance abuse or withdrawal.
- Personality disorders, eg antisocial characteristics or borderline disorder.

Where the violent outburst is part of a pattern of aggressive behaviour that is relatively mild, assertiveness training and anger management training may be helpful.³ Where problems in controlling anger or aggression have led to the crime the individual has committed, the individual may be eligible for one of the relevant offending behaviour courses (for more details, see **Offending behaviour programmes**, page x).

Medication

The Royal College of Psychiatrists guidelines⁴ allow psychotropic medication to be used in patients with **chronic** aggressive behaviours where there is:

- a high level of arousal/anxiety that cannot be reduced by environmental, behavioural or other therapeutic methods or
- a low threshold of stress tolerance that cannot be reduced by environmental, behavioural or other therapeutic methods.

The lowest dose possible should be used. Medication should be part of a comprehensive plan including environmental factors and other therapies. Consult a specialist about prescribing for this indication. For advice on rapid tranquillisation, see **Emergency treatment under common law** (page 168).

If it is suspected that a patient may be violent to others

Potentially violent individuals raise legal, ethical and clinical problems for clinicians. It is generally accepted internationally that a health professional has a duty to protect a person whom a patient threatens to harm by warning that person or contacting the police. UK case law supports this providing the decision about the serious risk is taken on adequate information and the information is disclosed to the appropriate authorities. This includes all potential victims of violence, including domestic violence and including groups of individuals (eg female staff). Where a clinician believes there is a reasonable chance that a patient will seriously harm someone else (eg a family member or prison officer), you should do the following.

Assess the risk of violence

Factors associated with potential violence.

- History of violence (the single strongest predictor).
- Intention to commit violence (most important clinical variable (see below)).
- Male gender.
- Being unemployed.
- Living or growing up in a violent subculture.
- Coming from a violent family.
- Abuse of drugs or alcohol.
- Having weapons available.
- Having victims available.
- History of poor impulse control.
- Factors that weaken self-control (eg psychotic illness, paranoid thinking).

Assess the **strength of motive and intention**. This is the most important predictive clinical variable. If you suspect violence, ask the following questions.

- 'Are you angry with anyone?'
- 'Are you thinking of hurting anyone?'

If 'yes', then ask the following.

- 'Who are you angry with, or thinking of hurting?'
- 'When do you think you might hurt [the person mentioned]?'
- 'Where will you do this?'
- 'How long have you been thinking this way?'
- 'Are you able to control these thoughts about hurting [the person mentioned]?'
- 'Do you think you would be able to stop yourself from hurting [the person mentioned] if you wanted to?'
- 'For how long do you think you can control your thoughts about hurting [the person mentioned]?'
- 'Have you ever purposely hurt someone in the past?'
- (If 'no') 'How close have you come to hurting someone in the past?'

Be aware of a hierarchy of expressions of intent.

- 'I wish he were dead': thought — lower risk.
- 'I'm going to kill that bastard': intention — higher risk.
- 'I'm going to stick a knife in Joe Bloggs when he comes to my cell': definite plan — highest risk.

If you believe that the individual is likely to commit serious violence against another person, then you have a legal and ethical obligation to both the patient and the potential victims of violence to try to prevent the violence (see **Ethical issues**, page 300).

Discuss your concerns and intended action with the potentially violent individual

Where possible, it is usually best to tell the patient that you are concerned about his/her threats, and that it is your duty to tell the third party about the threats that have been made against him/her. This line of action demonstrates concern for the patient and is less likely to damage the therapeutic clinician-patient relationship than taking no action.

If in doubt, seek urgent consultation with a superior or secondary mental-health services. Telephone consultation is better than none at all.

Keep careful, detailed, written notes (including notes of the results of any consultation).

Protect the third party against violence.

- Inform discipline staff (SIR — Security Incident Report).
- If the patient satisfies the criteria for mental disorder, admit and obtain an urgent transfer to the NHS (see **Liaison and referral to the NHS**, page 149).

- Take appropriate steps to make sure that the person who is the target of the threat is alerted. If he/she is another prisoner or member of the prison staff, inform the duty governor. If the potential target is outside the prison, inform the police. Once the police are informed of such a threat of violence, they too have a duty to warn that person of the risk of violence and, if necessary for the protection of the public and the individual, to discuss the threat with the local multi-agency public protection panel.
- Evidence of child abuse, where you have reason to believe that a child is at current or future risk, should be reported to the appropriate authorities (see **Child protection**, page 276).
- Inform the patient of the action you are taking. Where possible, carry out the warnings in the presence of the patient (eg telephone the duty governor in the presence of the patient). This will ensure that you talk about the patient in a considered way and will reduce the chance of the patient developing paranoid ideas about what has been said in his/her absence. However, if you believe that discussing your intentions with the patient will put you at risk, then you should warn the third party without informing the patient.

Guidance may also be available from your local multi-agency public protection panel.

Policies and training

Policies are needed on the following.

- Management of critical incidents, including debriefing, recording, staff training.
- Risk assessment.
- Staff training.
- Use of restraint.
- Prescription and administration of opiates and benzodiazepines.
- Use of restraint.

¹ Adapted from Andrew G, Jenkins R (eds). *Management of Mental Disorders*, UK edn. Sydney: World Health Organization Collaborating Centre for Mental Health and Substance Abuse, 1999; and The Bethlem and Maudsley NHS Trust, 1994, *Preventing and Managing Violence: Policy and Guidelines for Practice*. Report of Trust Working Party. London: Maudsley.

² Adapted from the dangerousness checklist in Breakwell G. *Facing Physical Violence*. London: British Psychological Society, 1989.

³ Stermac. Anger control treatment for forensic patients. *Journal of Interpersonal Violence* 1986; 1: 446–722.

⁴ Royal College of Psychiatrists. *Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units*. Council Report CR41. London, 1995.

Food refusal and mental illness

Complaints of food refusal are common in prison and place a moral strain on all staff involved. Support for staff involved is needed. Categories of food refusal that have been identified^{1,2} relate to the following areas.

- Frustration or protest:
 - To draw attention to political or other beliefs.
 - Often determined to pursue the action to the end.
 - Death is not the objective; there is hope that the demands will be met.
 - Not considered to be suicide under English Common Law.
- Bargaining tool:
 - Action is one of a set of negotiations about, for example, prison life.
 - Compromise possible if a 'reasonable offer' is made.
 - If no offer is made, food refusal may eventually be abandoned.
 - Not considered to be suicide under English Common Law.
- Unclear aims/gain attention:
 - Maybe anger: 'I'll die and you'll be sorry'.
 - Typically of short duration.
 - Lack of clear conditions for ending action.
- Suicidal aims:
 - Death is the desired objective.
 - May have already expressed the intention to die but lacks access to other means.
 - Usually associated with mental disorder (eg severe depression), but where it appears not to be, this is the most complex situation legally.
- Medical reasons:
 - Mental illness: most commonly depression, schizophrenia or anorexia nervosa.
 - Physical illness, eg cancers, delirium.

Presentation

Prisoners making protests make sure that staff know about the refusal. Those with a personality disorder, are depressed or psychotic may stay in their cells more and may not come out for association. Those with delusions of persecution may conceal their food refusal. Other prisoners are often the first to know.

Considering the possible alternative explanations

Is the refusal genuine? The individual may be buying food from others and refusing food provided by the prison. Staff may be concerned when a prisoner misses a meal only to find that he/she is eating later. Is the individual being bullied or in debt?

Consider a possible physical illness. Many physical conditions lead to loss of weight and/or loss of appetite, eg cancers, cirrhosis, diabetes, hyperthyroidism, sprue, tuberculosis, tropical infestations.

Consider a physical illness leading to symptoms of mental illness and food refusal.

- Infectious illness, epilepsy, metabolic changes and many other conditions may cause delirium, especially in older patients or those with dementia. Symptoms of delirium may include suspiciousness, confusion and agitation (see **Delirium — F05**, page 41).
- Some medications may produce symptoms of depression (eg β -blockers, other antihypertensives, H₂-blockers, corticosteroids).

Assessment

- How long has the individual been refusing food or liquids?
- Is the individual refusing all food, some food, or food and liquids?
- Does anyone know some of the reasons the individual is refusing food?

Carry out a physical examination if the patient consents.

- Measure and record their current weight. The body fat index must be taken following accurate weight and height measurements.
- General observations: oral hydration, blood pressure (postural drop?), tissue turgor, muscle wasting.
- Routine blood tests: full blood count (FBC), U&E, LFTs (talk to the local hospital chemical pathologist).

- Urine osmolality.

Assess for suicidal intent (see **Suicide assessment and management**, page 204).

Consider an early psychiatric opinion. Even if the individual has a reason for refusing food, it is important to have a psychiatric evaluation before there is doubt about the capacity of the individual to refuse food and/or treatment.

Disorders that may lead to food refusal include the following.

- Psychotic states such as schizophrenia, where persecutory beliefs that the food is poisoned are possible (see **Acute psychosis** and **Chronic psychosis**, pages 11 and 36).
- Depressive illness (see **Depression**, page 47).
- Anorexia nervosa (see **Eating disorders**, page 60).
- Dementia (see **Dementia**, page 43).

Legal context

It is vital to be aware of the relevant legal framework and to operate within it. It will be necessary to consult the relevant Prison Service guidance (DDL (96) 01) and if food refusal persists, to obtain legal advice from the Prison Service and to discuss the situation with the NHS Trust or Primary Care Trust and the Prison Service area manager before the question of loss of capacity arises. The Prison Service headquarters, including the press office, may need to be informed. Legal advice is required in all cases and especially if it is believed that the food refusal is being undertaken as a means of suicide in the absence of mental disorder.

Other Prison Service documents that provide relevant standards and guidance are on *Treatment without Consent, Emergency Treatment, Restraint, Seclusion and Transfer of Prisoners to a Treatment Facility*. The Human Rights Act is pertinent.

Common law in England and Wales

Under the common law of England and Wales the provision of nutrition and hydration by artificial means constitutes medical treatment. No adult may be given medical treatment in the absence of their consent unless they lack the capacity to accept or refuse that treatment and it is in the patient's 'best interests' to administer the treatment proposed and the patient has not made a valid advance statement refusing treatment. An adult is presumed to have capacity until it is demonstrated that they do not. Demonstrating this involves an assessment about whether any aspect of the individual's ability to take in and retain treatment information, to believe it and to weigh it in the balance with regard to risks and needs has been sufficiently compromised to render them lacking capacity.

It is possible for capacity to fluctuate. In such cases, it is good practice to establish while the person has capacity their views about any clinical intervention (including compulsory feeding or hydration) that may be necessary during a period of incapacity and to record these views. The person may wish to make an advance refusal of certain types of treatment.

If it is concluded that the individual has capacity, then the staff should respect the decision to refuse food or liquids unless the individual changes their mind or a worsening mental disorder or other condition leads to a loss of capacity. This also applies to the provision of other medical treatment to prolong the individual's life.

If it is concluded that the individual lacks capacity, then it is lawful to treat in the individual's 'best interests', subject to any valid and applicable advance refusal of treatment. Best interests are not confined to best **medical** interests. Other factors that may need to be taken into account include the patient's values and preferences when competent, their quality of life, their spiritual and religious welfare and their own financial interests. Where there is doubt about an individual's capacity or best interests, obtain legal advice (for a more detailed discussion of capacity and consent to treatment, see page 300).

Advance directives

Even where the individual lacks capacity, consideration must be given to any advance directive that the patient may have made. Also known as a 'living will', an advance directive specifies how the individual would like to be treated in the case of future incapacity. Under the common law, it is now clear that an advance refusal of treatment that is valid and applicable to subsequent circumstances in which the patient lacks capacity is **legally binding**. An advance directive may be verbal as well as written. The law concerning advance directives is evolving. Where an advance directive is in existence, it is prudent to obtain legal advice early about its validity and the current law (for more information, see **Consent**, page 168).

Coexisting mental illness: use of the Mental Health Act

A patient may be transferred to a psychiatric hospital for treatment under the Mental Health Act when they are suffering from mental illness of a nature and/or degree that makes it appropriate for them to be detained in a psychiatric hospital for treatment and the need for such treatment is urgent (see **Use of the Mental Health Act**, page 163). Sometimes this will be the

case even though the patient retains the capacity to consent to or refuse treatment. Capacity should be assessed separately from the presence or absence of mental illness.

Such transfer may enable the individual to be fed or rehydrated against their will once the individual is in the psychiatric hospital as a medical treatment for mental disorder under the provisions of the Act, if the food refusal is a symptom, consequence or manifestation of the mental disorder. For example, this would be the case if the food refusal was a symptom of severe depression or anorexia nervosa with impaired insight.

In this context, it is important to remember that advance directives may be overridden by the Mental Health Act to the same extent that the competent wishes of a detained patient may be overridden by the Mental Health Act.

Principles of management: all patients

- Assess and record the patient's physical and mental condition daily. Record an assessment of capacity regularly.
- Assess suicidal thoughts regularly and consider a management plan, including the use of current prison self-harm protocols. Suicidal intent, delusional content and energy to attempt suicide may all fluctuate.
- Obtain a psychiatric opinion early. Even where the doctor does not consider mental illness to be likely, an assessment is needed to confirm this formally and to assess capacity (see below).
- Inform the individual of the natural history of food or fluid refusal, including type of deterioration and pain. The Prison Service Dear Doctor Letter (96)1 is helpful. Leave food where the patient can eat it at meal times.
- Discuss with the patient the issues of capacity and refusal. Discuss confidentiality. Help the patient to plan the future. If appropriate, help the patient with any grievances and problems (eg help with writing to relatives, or access to a lawyer). Consider assisted visits for relatives. Provide information in ways that he/she can understand, if necessary in the patient's own language.
- Maintain a caring and professional attitude to the patient, eg address the individual in the manner preferred by them (first name or as Mr/Miss X). Especially where hunger strikes occur in the context of power struggles between staff and a prisoner, it is important for healthcare staff to maintain a degree of independence and not be drawn into seeing the individual simply as a trouble-maker.
- Act early to avoid having to discuss what might happen when the patient may have lost the capacity to determine their own future. Consult early and consult widely. Seek second opinions. The patient's family and lawyer should be contacted in addition to prison and healthcare staff.
- Involve a dietitian from the Local Trust, wherever possible.
- Hold regular multidisciplinary conferences. It is essential that all those involved in care are aware of any advance directive.
- Keep legible contemporaneous records.
- Ensure that support networks are in place for staff, relatives and those close to the patient.

Additional management advice for individuals where mental illness is present

Referral

- Request an early psychiatric opinion to assess both the capacity and mental state. Assessment should be obtained urgently, initially by telephone or fax (see **How to refer urgently**, page 153).
- If the patient requires transfer to a hospital, coordinate the mental-health teams and the medical teams, and agree where the prisoner would be housed. Exceptionally, a transfer to a general hospital for treatment under common law may become necessary.
- Discuss future transfer to a treatment facility with the Home Office Mental Health Unit early.
- If the prisoner has a high-security category, discuss the case with the prison and with Prison Service security managers.
- Maintain a care plan.

Additional advice and support for the patient

- Some patients, often those who are depressed, will take a little food that they particularly like. Pressure to finish what is in front of them is unlikely to help. Encourage drinking fluids, especially those containing vitamins such as fruit juice and milkshakes.
- Patients who have delusional ideas that the food is poisoned may eat packaged food that they open themselves.

Medication

If medication is accepted, doses may need reducing in the presence of liver or kidney impairment. Liver function tests do not correlate well with impairment of drug metabolism. Consult a specialist.

Additional management advice for adults where mental illness is not present

In the majority of cases, there is only partial food refusal. Close monitoring of eating and drinking may lead the patient to refuse more. Often, negotiations will achieve a mutually acceptable agreement without loss of face on either side. Nearly all food refusers start to eat again on their own.

The individual may wish to consider an advance directive about treatment at any time during food refusal. The individual's lawyer or probation officer should be contacted to arrange a visit. The right of access to legal representation is covered by the Human Rights Act.

Referral

Request a psychiatric opinion early to assess capacity, exclude mental illness and establish a working relationship with the psychiatric team. Relationships are maintained, and good medical practice is more likely when a physician is consulted early. The care plan should make clear the legal issues surrounding the refusal to feed and the reasons for not intervening.

Transfer to hospital may include the following.

- Facilitate visits from relatives and friends.
- Enable specialist rehydration and physical care to be given if the individual changes their mind.
- Enable the patient to be made comfortable in their terminal condition.
- Carers should have discussed where the patient wishes to die.
- It is essential to make clear to the general hospital staff (preferably in writing) when arranging transfer the current assessment of the patient's capacity, the purpose of the transfer to hospital and full details of any advance directive the patient has made, if these are known to anyone in the prison.
- Once the prisoner is at the hospital, clinicians there will continue to assess capacity as part of their management of the patient, taking account of any advance directive. In the absence of any such advance directive, at some stage they may decide that the patient no longer has capacity, in which case they may then decide to administer treatment without the patient's consent if this is in the patient's best interests.

Resources for patients and primary support groups

Agencies that may support individuals in alternative ways of protesting include the following.

Board of Visitors

The Prisoners' Advice Service: 020 7405 8090 (Monday–Friday, 9:30 am–5.30 pm)

(Provides free legal advice and information to prisoners in England and Wales about their rights, the application of prison rules and the conditions of imprisonment)

¹ Williams J. Hunger strikes: a prisoner's right or a wicked folly. *Howard Journal* 2001; 40: 285–296.

² Bennett S. The privacy and procedural due process rights of hunger-striking prisoners. *New York University Law Review* 1983; 58: 1157–1251.

Dirty protests

Why do people make dirty protests?

People may make dirty protests for a variety of reasons.

- They may be making a political or personal protest.
- They become involved in power struggles, seeking a goal such as a transfer to another prison, and they are unprepared to recognise boundaries or authority. This pattern is much more commonly seen in prisoners with a personality disorder. Lack of cognitive and negotiating skills can lead rapidly to a prisoner progressing from normal accommodation to segregation and a dirty protest.
- Mental illness is less common but does occur. Other disorders, such as a brain tumour, are also possibilities. Prisoners may have both mental illness and a personality disorder.

Assessment

Because of the possibility of mental illness and other disorders, a full assessment is essential. Dirty protests should be assumed to be manifestations of health problems until proven otherwise. Dirty protests may also result in infections.

Healthcare staff engaged in assessing and then attempting to meet the healthcare needs of a prisoner on a dirty protest face a very unpleasant task. Facilities should be made available to allow staff to conduct a full assessment. Examinations of a prisoner's health should be held in adequate conditions, in circumstances that allow the prisoner to express him/herself freely and by a healthcare professional who is competent in assessing their mental state. An interview room is required. The prisoner's inmate medical record (IMR) should be to hand (and read) before the examination and the results of the examination entered into it. Observation of the patient alone, without talking to him/her, is never sufficient. Guidance on conducting a mental state assessment can be found on the disk .

While it is very important that the prisoner's mental state is regularly assessed, the frequency of such assessments and the need for a physical examination should be assessed on clinical grounds. If the healthcare worker has any concerns around the prisoner's mental health and/or if there is any record on the IMR of previous mental-health problems, he/she should arrange for a specialist assessment to be undertaken as soon as possible.

Management

All prisoners

- It may be possible for the protester to protest in another way. The Board of Visitors, chaplain and probation officers are likely to be able to represent the protester to others.
- Health staff should try not to be drawn into conflicts between the protester and prison staff. A neutral stance can be helpful if the protester starts to self-harm and requires medical treatment. A calm, caring, professional attitude may reduce tension on all sides.
- The physical health of the individual should be monitored. This may require specialist input from local NHS Trust staff. Early discussions with outside staff may be more efficient than more urgent discussions later. In offering these health interventions, the individual's capacity to consent or refuse consent should be considered (see **Consent and capacity**, page 168).
- Subject to considerations of confidentiality, the security implications of medical management should be discussed with prison staff.
- Caring for prisoners engaged in dirty protests is unpleasant and challenging for staff. Even where psychiatric staff have confirmed an absence of mental illness, they may be able to provide support to staff who remain in direct contact with the prisoner.

Prisoners with mental illness and/or personality disorder

The key principles of management are set out in **Management of prisoners with complex presentations and very difficult behaviours** (page 202). Multidisciplinary assessments, enhanced care plans and follow-up are likely to be indicated.

Resources for patients and primary support groups

Agencies that may support individuals in alternative ways of protesting include the following.

Board of Visitors

The Prisoners' Advice Service: 020 7405 8090 (Monday–Friday, 9:30 am–5.30 pm)

(Provides free legal advice and information to prisoners in England and Wales about their rights, the application of prison rules and the conditions of imprisonment)