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Is breakaway training effective? Examining the evidence and the reality

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Abstract

Breakaway training is a mandatory training programme for mental health staff in both NHS and private services. However, the question that remains outstanding from the recent guidance on the management of short-term violence published by the National Institute for Clinical Excellence (NICE) (NICE, 2005a; 2005b) is whether breakaway training is effective?

This paper provides a history of and evidence for breakaway training, and a study examining the content of breakaway training in one English high secure hospital is provided.

Key words

breakaway training; violence; violence reduction; prevention; training

Introduction

Violence reduction and violence management have become key policy and practice workforce priorities for mental health and other areas of workforce delivery across the UK over the last 10 years (Miller *et al*, 2007): Scottish Health Service Management Executive, 1996; Royal College of Psychiatrists (RCP), 1998; Nursing and Midwifery Council (NMC), 2001; NHS Security Management Service (NHS SMS), 2003, 2004, 2005; National Audit Office (NAO), 2003; Welsh Assembly Government (WAG), 2004; National Institute for Health and Clinical Excellence (NICE), 2005a, 2005b; National Institute for Mental Health England (NIMHE), 2004; and the Wales Audit Office (WAO), 2005.

One of the key policy cornerstones underpinning violence reduction training for mental health workers is 'breakaway training' (NIMHE, 2004; WAG, 2004; WAO, 2005). However, the effectiveness of such training has yet to be established, and at present, the practice of training staff in breakaway techniques can be at best considered a 'tradition'. As such, this practice requires careful consideration given that it is nearly 30 years ago that breakaway training spread to the NHS and private hospitals from the prison service.

The types of violence faced by staff

In undertaking this review, we attempted to determine the actual types of assaults faced by staff during their day-to-day practice. Despite headline news items by the NHS and associated bodies, we could not find any part of the NHS or any associated body that collected such surveillance data. Neither the NHS, the National Patient Safety Agency, the National Audit Offices, the Health and Safety Executive or the NHS Security Management Service were able to provide any data at all upon the type and frequency of violent attacks upon staff. Basic descriptive data, such as this, is the backbone of epidemiological research, thereby informing the development of interventional programmes – yet it is not available. Quite simply, if we do not know what type of attacks staff are facing then how can we develop training programmes to equip staff in coping with violence? Additionally, despite any lack of meaningful national representative data, it is impossible to determine whether breakaway training actually equips staff with the skills that they may need.

The history of breakaway training

In the UK, the dominant 'model' in terms of physical interventions has historically been from 'control and restraint', an approach developed for the prison service of England and Wales in the 1980s. This training was adopted by the English high secure hospitals in the mid 1980s following an inquiry into the death of a patient. Initially, this training was highly regulated by the prison service, however, the formal links between the health and prison services dissipated in the late 1980s. This led to the development of multiple variations of physical interventions that were then marketed by individuals to the health sector and by services within the health sector to other sectors including social care. The unintended consequence was that an unregulated market developed for the training in physical interventions within the UK National Health Service. Private training companies sprang up that marketed 'breakaway training' to a range of NHS and non-NHS staff. Furthermore, some staff, whether working in the NHS or in private business, began changing the techniques as they saw fit without basing such changes upon any evidence base. Issues regarding the complexity of the techniques, the student's ability to later recall the techniques, the potential for error and harm to occur to the recipient and the professional ethics of such practices were ignored by some providers. (It is important to acknowledge that there are some training providers both NHS and private that deliver high quality training based on robust training needs assessment with regular follow up).

Unfortunately, one apparent legacy of the lack of regulation is the confusion that has been allowed to develop around the exact inventory of techniques within specific 'versions' of breakaway training. Given the number of agencies offering training described as breakaway training and incorporating elements in various modified forms, it is difficult at this point to regard the term 'breakaway' as a unitary entity in a national context (Topping-Morris, 1995). Some organisations have developed manuals and protocols with accredited instructor training, along with internal and external procedures to review programme content (eg. West London Mental Health Trust). However, this situation is far from universal and breakaway training has arguably, in some respects, become a victim of its own success. The rapidity of its dissemination along with 'C&R' meant that there were inadequate mechanisms to prevent the development of a

plethora of instructor programmes, and an inherently flawed pyramidal training system was thus allowed to develop by default. In the course of our review, we came across a range of private training programmes that market their training to the NHS. The techniques being taught were sometimes described as 'evidence-based' within individual companies' literature, and some of the techniques were concerning. For example, one company's marketing brochure reports that they train staff how to breakaway from 'earring grabs'. Surely, the issue for the NHS should be whether and why staff are wearing earrings in clinical practice, not how to help staff breakaway from such holds?

Policy guidance

In England and Scotland, there is no national policy that specifies how often breakaway training should be provided. However, evidence suggests that the norm is yearly (NMC, 2001; NES NHS Education for Scotland, 2005).

Welsh policy specifies that staff should be trained and refreshed a minimum of every two years. Surprisingly, 30 years after such training was adopted by the NHS, the issue of how long the skills and knowledge taught within such training are retained, has yet to be established. Therefore, it is difficult to understand the rationale as to why England, Scotland and Wales have chosen a timescale that is at best unspecified, and at worst every two years, is difficult to understand in the absence of any evidence.

Similarly, in England and Scotland there is no national policy that specifies which techniques should be taught. Yet in Wales, the techniques are specified (Welsh Assembly Government, 2004). The 'All Wales NHS violence and aggression training passport and information scheme' specifies that the following techniques should be taught: 'hair grabs – front and back'; 'clothes grabs – single and double grabs', 'wrist grabs – single and double grabs'; and 'strangle holds – front, side and back'. However, the rationale for choosing these techniques over others (eg. punches, kicks, bear hugs, bites) is unknown. Furthermore, it is unknown why hair grabs from the side and strangle holds with the victim pinned to the floor are excluded from the list?

Economics

The NHS has no record of how much training in violence costs. However, a recent attempt by the Wales Audit Office gives an example of the large amounts of money involved.

Based upon reported violent attacks, the Wales Audit Office estimated that the cost to NHS Wales between 2003 and 2004 of violent assaults was £6.3 million. This is an estimate of the training, absence through sickness, legal services and security staff, but does not cover the costs of recruitment and retention (eg. through staff turnover). If we assume that every qualified mental health nurse requires breakaway training once yearly for one day, then the costs of training alone are enormous. Currently, there are in excess of 70,000 qualified mental health nurses per year. If we consider qualified, learning disability nurses, qualified A&E nurses, ambulance personnel and unqualified staff in these areas then we are probably approaching 200,000 days of training per year.

Current evidence base for breakaway training

NICE guidance

NICE (2005a) have published *The Clinical Practice Guidelines for Violence: The short-term management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments*. NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. NICE guidance is based upon systematic reviews, and where appropriate, meta-analysis of best evidence. Where systematic reviews are not available, then alternative forms of evidence are considered, from single randomised controlled trials gradually decreasing in the strength of the evidence to expert opinion. The NICE guidelines on violence considered the evidence for the effectiveness of prevention and training related to violence. It is beyond the scope of this paper to summarise the vast amount of information that underpinned the search strategy for the literature review that informed the NICE guidance; suffice to say that it was vast and comprehensive (NICE, 2006a).

It is important to note, that when NICE guidance steering groups compile guidance, the full information is vast. For this reason NICE release a shortened guideline that includes the main findings from the fuller review. Thus, there are usually two reviews to consider: (1) the released NICE shortened guidance, and (2) the full guidance for each NICE reviewed health area. To put this into context, the released NICE shortened guidance is 83

pages, yet the full guidance is 135 pages (NICE, 2005b). Furthermore, the full NICE guidance has 16 appendices. Appendix 5, which provides an overview of the included studies, is 266 pages alone (NICE, 2006b). The full guidance defines breakaway training as, '*Breakaway: a set of physical skills to help separate or breakaway from an aggressor in a safe manner. They do not involve the use of restraint*' (p7).

Additionally, the full NICE guidance recommended that based upon the evidence available that,

'the following constitute the core curriculum of training courses in the UK: taking the patient to the floor; three-person restraint team; sitting and standing the patient; negotiating stairways and doors; restraining holds; roles within team; turning the patient over; breakaways; entry into and exit from seclusion; and blocking punches' (p53).

However, caution needs to be taken when considering such guidance. It is important to consider the possibility that there may be a problem of 'pooling' data, leading to conclusions that need to be carefully examined. In fact, there were only five UK studies that attempted to evaluate the effectiveness of breakaway training in mental health, of which only one found any difference: that staff felt satisfied and slightly more confident as a result of the training (Southcott *et al*, 2002). In reviewing the studies on which the NICE guidance is based upon, then it becomes clear that there is a dearth of evidence to support such training in the UK.

This clearly leads us to the conclusion that we need to go back to the beginning in studying breakaway training. Before we can determine effectiveness, we must first describe what it actually involves. Only then can we expect to develop more robust studies in the hope that the NICE and policy guidance is able to be more specific in what such training should contain, in what population, and for what level of staff?

Studies after the NICE guidance

A recent published study has examined the effectiveness of breakaway training in a real life role play scenario where medium secure ward-based nursing staff had minimal warning of what was about to occur (Rogers *et al*, 2006).

Three registered mental health nurses randomly attended the wards. Two of whom were breakaway

instructors, and one a ward manager. The participant was asked to select one from five sealed envelopes that contained a description of a breakaway technique that they would be asked to perform. They were then asked to sign a consent form for the audit. Each envelope contained one of the following scenarios: a strangle hold from the front, a strangle hold from the side, a strangle hold with a forearm from behind, a strangle hold while on the floor, and a hair grab. All but the last scenario are considered to be life-threatening events as unconsciousness can occur within seconds if enough force is applied. Each participant was given 10 seconds to think about the scenario before being given the instruction to commence. The scenario would then be enacted. When 10 seconds had elapsed, the scenario was stopped, as it was presumed that if participants were not able to escape after 10 seconds, then in reality they would probably have been either unconscious or possibly dead (if a strangle hold).

The results found that of the 50 nurses asked to participate in the study, 47 agreed (94%). All had had breakaway training. Eleven staff had received the full breakaway training more than once and 24 had at least one update since their original breakaway training course. Unexpectedly, none of the sample had used a breakaway technique in the preceding 12 months. Forty per cent (19/47) were unable to breakaway within the 10 second period. Of the entire sample, 60% of staff did not employ the correct breakaway technique. One of the staff used in the sample who did not employ the correct technique was one of the instructors used to teach breakaway training.

Most alarming, is that during this study, we observed staff trying to remember the correct technique for breaking away from a strangle hold and being unable to, resulting in a struggle. Staff often verbalised that they 'couldn't remember' what to do. This therefore, leads us to the simple question, why can't staff remember what to do following training?

Method

Aims

The aims of this study were to determine the content of breakaway training provided at Broadmoor high secure hospital, to describe the techniques that are taught, and the length of time dedicated to each technique.

Design and procedure

An observer attended a mandatory one-day breakaway training course at Broadmoor high secure hospital for new staff in early 2007. The observer covertly recorded the techniques that were taught, the length of time that each technique was demonstrated, and the length of time that the students had to then practice such techniques. The staff providing the training were unaware of the observer's role.

Ethical issues

The study was undertaken as part of an agreed strategic internal training evaluation within the hospital in order to inform a wider review of current training, and therefore was not subject to the need for ethical approval.

Setting

The high secure services at Broadmoor hospital, a directorate of West London Mental Health Trust has been delivering breakaway training programmes to its employees since 1984 and as a mandatory training requirement to all employees since 1989. Within Broadmoor hospital alone, there is on average 650 personnel trained in breakaways each year; this equates to a total number of staff trained since 1984 as being approximately 11,700. The prevention and management of violence reduction department at Broadmoor hospital has maintained a register of all staff trained as instructors. This shows that the breakaway training programme has been delivered by Broadmoor personnel to the vast majority of instructors throughout the United Kingdom and the Republic of Ireland, at Broadmoor. The register shows that 150 instructors from 35 separate organisations have been trained, and have subsequently gone on to teach the breakaway training package at their establishments.

Results

Training structure

The training day consisted of an introduction to violence and aggression as well as prevention. For the nature of this paper we were concerned with the actual techniques that were taught. The training day comprised of seven and a half hours training. In this time, 21 different techniques were taught covering hair pulls, strangles, clothes grabs, wrist grabs, bear hugs and 'full nelson' (see **table 1**). The training consisted of two demonstrations by the trainers for each technique followed by student practice.

Table 1: Breakaway techniques taught with demonstration and practice time

Technique	Demo 1 (Duration)	Demo 2 (Duration)	Participant practice	Total (Duration)
1. Hair pull from the front (palm)	4	3	10	17
2. Hair pull from the front (radius)	3	3	10	16
3. Hair pull/ear grab – same side	5	4	9	18
4. Hair pull/ear grab – opposite side	3	3	7	13
5. Hair pull/collar grab from rear (turning in)	3	3	8	14
6. Hair pull/collar grab from rear (turning out)	4	4	8	16
7. Straight arm strangle standing from the front	6	4	7	17
8. Straight arm strangle/trapezium grip from the rear	3	3	7	13
9. Straight arm strangle on floor – knees astride	8	6	7	21
10. Straight arm strangle on floor – from the side	6	4	5	15
11. Straight arm lapel grab	6	4	8	18
12. Bent arm lapel grab	6	5	8	19
13. Wrist grab single handed – same/opposite side	2	2	4	8
14. Wrist grab double handed – thumbs up/down	2	1	3	6
15. Wrist grab (both sides) – thumbs up/down	1	1	2	4
16. Wrist grab taking aggressor to floor – same/opposite side	7	7	10	24
17. Bear hugs	2	1	3	6
18. Full nelsons	2	1	3	6
19, 20 and 21. Close proximity techniques (three separate methods)	7.5	7.5	15	30
	Total 80.5 minutes	Total 66.5 minutes	Total 134 minutes	Total 375 minutes

Demonstration time

The total demonstration time for all techniques was 146.5 minutes (8,790 seconds). Thus, the mean average demonstration time per technique was six minutes and 58.57 seconds (418.57 seconds).

Practice time

The total practice time for all 21 techniques was 134 minutes. Thus, the mean average practice time for students per technique was six minutes and 22.86 seconds (382.86 seconds).

Separate components

Of the 21 techniques there was a total of 104 component parts, as each technique is made up of smaller component parts. For example, for a hair pull from the front, the first component part is a sideways stance. The total supervised practice time for all techniques was 134 minutes (8,040 seconds). Thus, the mean average student practice time per component part was one minute and 25 seconds (84.53 seconds).

Average training time per technique

Overall, therefore the mean average time, which includes two demonstrations and student practice time per technique, was 13 minutes and 22.86 seconds (802.86 seconds).

Discussion

The results of the training review at Broadmoor hospital led to a review of the training that was being offered to staff, and has resulted in a comprehensive restructuring of the training that is provided. It is not plausible to train staff in 21 different techniques, containing 104 component parts in seven and a half hours, and then expect them to be able to recall and apply such techniques any time in the next year with little or no notice.

Breakaway training has become mandatory tradition in mental health. However, this review causes considerable alarm. This paper has reviewed the evidence for breakaway training as currently provided to NHS staff and has found that there is little if no evidence supporting wide scale training programmes. The systematic review undertaken as part of the NICE review only found that staff were satisfied with the training and felt slightly more confident as a result. We do not know how long such effects last and whether confidence in the absence of evidence is an appropriate training outcome. The study undertaken by Rogers *et al* (2006), found that staff who were trained in breakaways were not easily able to recall the techniques in a clinical environment with little notice. In fact, it could be questioned whether the training actually causes harm, as some staff were focusing on trying to recall what to do, instead of breaking away from a dangerous situation. It is possible that breakaway training may actually inhibit a person's natural responses when being strangled, in favour of a taught response, which they cannot recall.

Finally, we need to ask whether the training that we provide staff in dealing with violent assaults actually equips them with the realities of violence within their workplace. The majority of violence within the NHS is most likely from kicks or punches. Yet, we are teaching staff breakaway techniques that are to be employed once someone has 'hold' of a member of staff. This does not mean that some breakaway techniques are not needed, however, we need to determine what else is needed first. For any training program to be effective, it must be based on a robust training needs analysis, which includes incident analysis and discussion with the staff involved. Interventions taught must be relevant to the operational setting in which they will be deployed. The techniques must be proportionate to the threat presenting, and in order to be effective must be simple to learn and recall under pressure, while achieving the desired outcome of harm minimisation. There is an urgent need for researchers and policy makers to address the current situation.

This paper does not aim to disregard breakaway training as an intervention. The objective is to prompt a review of the training curriculums currently offered in order to ensure that the desired outcome of harm minimisation is achieved. It is therefore necessary to redefine the term breakaway training. This term is currently used to describe a catalogue of interventions aimed at escaping from a situation. This will range from techniques aimed, for example, to release the grip of a confused frail elderly patient. A primary objective in this intervention is to ensure the risk of harm to the patient is minimised. The technique deployed in this scenario would not be appropriate if the individual was required to escape from a life threatening situation, for example, being strangled by a fit young man who is expressing intent to kill.

The response deployed by staff in any situation arising in a clinical setting will be dependent on multiple physical, psychological, environmental and situational variables including, for example:

- the threat impact factors, size, strength, intent of assailant etc.
- staff members' confidence
- predictability/regularity of the service users' behaviour
- staff members' previous experiences

- the relationship with the patient
- availability of support from others
- clear organisational policy guidance
- appropriate training.

In order to provide interventions that can be contextualised in a legal and ethical framework, the intervention currently referred to as breakaway needs to be described more accurately in order to assist training providers and services to ensure that the interventions taught are appropriate to the presenting risk, and relevant to the role of the staff member. Legally, staff have a right to a safe working environment and can utilise interventions that are necessary and proportionate to protect themselves and others. Within a care setting, this right under statutory legislation is not altered, however, ethical considerations promote a balance with maintaining the safety of the service users. Breakaway techniques therefore need to be addressed on two levels: low level interventions aimed at disengaging from a situation that does not present a serious risk of harm and higher level interventions that demand a prompt escape from a situation that is likely to result in

injury or even death. Providing staff with the physical skills necessary to respond in such circumstances is arguably essential, as without a structured approach, ethical and legal conflict could occur, potentially resulting in a greater harm occurring. However, if such physical skills are being taught, they must be effective in practice. In order to be effective, the skills must be easy to learn, and recall when necessary.

The future

Given that we have allowed breakaway training to become the main form of dealing with violent assaults over the last 30 years without any credible evidence, the urge to ‘hang on’ to it due to its historical relevance has to be abandoned. It may be possible to refine and modify these courses, however, until we know the reality of NHS and non-NHS violence, it is rather pointless investing all our efforts and resources into a ‘tradition’. A considerable research programme lies ahead, which has natural researchable questions and designs (see **table 2**). The question is whether policy makers and those responsible for ensuring the safety of the workforce are prepared to invest funding in order for this to happen?

Table 2: Research questions and designs for the future

Question	Design
1. What is the reality of violence to staff? Specifically, what type of violence do staff face and how often?	Epidemiological survey
2. What might be done to prevent such violence occurring in the first place? Does it work?	Systematic review of literature
3. For violence that cannot be prevented, what physical skills are available that might help staff?	Survey
4. How effective are such available physical skills in an emergency situation?	Randomised controlled trial
5. What is the best method of teaching staff these physical skills?	Randomised controlled trial
6. How long do such training effects last?	Randomised controlled trial
7. How often is refresher training needed?	Randomised controlled trial
8. How can we demonstrate that such reformation of violence training for staff has benefits to individuals, the NHS and society as a whole?	Economic evaluation, user satisfaction studies

Is breakaway training effective? Examining the evidence and the reality

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