Chapter 2

Decision Making

David Partlow

Case study

You have been dispatched to a healthcare professional admission call for a patient who has been assessed as lacking capacity and who requires conveyance to an emergency department.

On arrival, you receive a handover from the nurse in the rapid response team who informs you that the patient is an 82-year-old male who has not engaged with his own GP. He is living alone in dirty conditions and will not allow carers to enter the property to assist him.

Assessment:

- Past medical history: hypertension, high cholesterol, coronary artery disease, right bundle branch block and transient ischaemic attack (six years previously).
- Allergies: penicillin.
- Drug history: ramipril, aspirin, simvastatin.
- Social history: lives in own home, patient's wife of 50 years died five years ago, no regular family visits, carer once daily, independent in his daily activities.

On examination:

- Appearance: unkempt, wearing visibly dirty clothing contaminated with faeces. There is an overpowering and unpleasant smell within the patient's home.
- Behaviour: patient witnessed drinking milk from the bottle that is obviously beyond the use-by date. Despite trying to reason with the patient, he continues to drink it. Carer's notes indicate concerns about changes in the patient's behaviour.
- Speech: normal speech.

- Mood/thoughts: appears annoyed, the patient says he does not understand what all the fuss is about and is asking everyone to leave. He has stated he will not answer the door again to anyone because of this situation.
- Affect: not able to assess as patient does not cooperate.
- Perception: not able to assess as patient does not cooperate.
- Cognition: not able to assess as patient does not cooperate.
- Insight: not able to assess as patient does not cooperate.
- Risk: low risk to immediate harm.

Clinical observations:

- Heart rate: 62 beats/min; regular and equal bilaterally
- Blood pressure: 142/84 mmHg
- Blood glucose: 6.5 mml/l
- Respiratory rate: 19 breaths/min
- Temperature: 36.9°C
- SpO_2: 98% on room air

The patient agrees to you undertaking a set of observations. All observations are within normal ranges and there are no physical health clinical concerns from your findings. The information from the scene indicates evidence of self-neglect. The patient has no medical complaints. The patient does not consent to being assessed at the emergency department.

The Health Care Professional (HCP) says that the patient does not have capacity. They have a document indicating this and you are asked to convey the patient to the emergency department. You ask the HCP which section of the Mental Capacity Act he is using to legally convey the patient who does not consent to transport and admission to an emergency department and he replies, 'the patient does not have capacity, they are required to be conveyed under the Mental Capacity Act'.

What would you do now?

1. **Convey the patient against their will:** this would be unlawful as the patient would be deprived of their liberty. The Supreme Court of the United Kingdom (2014) makes clear that within the Mental Capacity Act a patient can only be deprived of their liberty (Section 4B) 'in order to give life-sustaining treatment or to prevent a serious deterioration in the person's condition while a case is pending before the court [of protection]' (see *P v Cheshire West and Chester Council and another*, 2014). You have clinically assessed the patient and find that there are no life-threatening features, for example, severe sepsis.

Point to note: if the patient does not have capacity and if there is no evidence of the need for life sustaining treatment, then a paramedic has no legal power to convey the patient against their will.

2. **Respect the patient's wishes and leave:** you have a duty of care for the patient and there are concerns about the patient's welfare including evidence of self-neglect. You must respect the patient's wishes but you have a duty to safeguard the patient. You should consult the patient's GP or make a referral to social services for the patient's welfare subject to the patient's informed consent (Care Act, 2014). The patient has declined any referrals.

   As it has been determined through an assessment of the individual's ability to understand information relevant to the decision and to retain that information, use this knowledge to make a decision and communicate it: that they do not have capacity and therefore you can act in the patient's best interests (Principle 4, Mental Capacity Act) and consult their GP. Follow your local policies and procedures for safeguarding.

3. **Refer to an Approved Mental Health Professional (AMHP):** information gleaned from the patient's home and the HCP indicates that the patient may require a mental health assessment. There are AMHPs 24 hours daily. Speak to the AMHP clinician to clinician and discuss your concerns and findings. If the AMHP agrees, they could apply for the warrant or use the Mental Health Act as appropriate.

   Section 135 of the Mental Health Act 1983 states:

   > 'If it appears to a Justice of the Peace [magistrate], on information on oath laid by an approved mental health professional, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder –
   >
   > **a.** has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or
   >
   > **b.** being unable to care for [them]self, is living alone in any such place' the Justice of the Peace may issue a warrant authorising any police officer to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove [them] to a place of safety with a view to the making of an application in respect of [them] under Part II of this Act [mental health assessment], or of other arrangements for [their] treatment or care.'

   Remember only an AMHP can apply for the Section 135 warrant.

Justin Honey-Jones

The complexity of decision making

The scenario described above may be familiar to many who read it, and there are many others that are equally challenging and prompt many a conversation in the crew room. They outline exactly why many paramedics struggle with the decision-making process with respect to attendance at mental health presentations.

As in the scenario above, we all have a right to live the life we choose; this doesn't mean that each life has to be lived in the same way or with the same core principles. We choose how we live and we choose in some cases how we die. Professionals must use their judgement coupled with knowledge of legal frameworks to make the best decision possible for the patient.

Decision making and values-based practice is therefore about balance; it is about looking at the need for action and intervention and balancing that against the wishes of the individual and the legal context within which those decisions might need to be based.

It is necessary to employ the least restrictive interventions without utilising the legal frameworks to achieve an aim that is not supported by codes of practice or case law that has developed over time. For example, the historic practice of encouraging individuals to step out of their homes in order for them to be detained within a public space is now deemed coercive and unjustifiable under the law.

In the case of *Sessay v South London and Maudsley NHS Foundation Trust* (2011), an individual was detained and conveyed to an emergency department under the Mental Capacity Act, despite there being no threat to life or serious threat to their physical state. They were subsequently assessed under the Mental Health Act and lawfully detained. The issue, however, arose as to whether the initial conveyance under the Mental Capacity Act was lawful or a breach of the individual's rights under Article 5 of the Human Rights Act. Fundamental to this case was the provision to detain under Section 4 of the Mental Health Act and the absence of any clinical factors that warranted conveyance to an emergency department. It was deemed unacceptable to convey the individual under the auspices of the Mental Capacity Act without an emergency need. This was particularly relevant because the power to assess and detain as appropriate was already within the provision of the Mental Health Act.

Decision making is complex. Individuals responding alone without knowledge of the legal complexities or a wider understanding of mental health presentations, face a very difficult task in making a determination of the most appropriate course of action. However, mental health is no different to physical health. The decision to transfer to a place where assessment and care can be provided should be made on the basis of what assessments or interventions may be required, who is best able to deliver them and whether they are required now or at a later point in time.

Fundamental then, is the generation of an understanding in the local area of what services are available to support those in crisis. Many areas are now generating

single points of contact or single points of access. A myriad of crisis cafes and respite provision are being created and as paramedics it is vital that we understand how to access such services where available and determine eligibility criteria.

First and foremost, consider the ability of an individual to consent to assessment or intervention. Consider the requirements of the Mental Capacity Act and whether there is a physical imperative that supports immediate conveyance. Work with other professionals, understand the mental health service provision and, importantly, get to know your local AMHP service. AMHPs should be consulted for their specific professional expertise on aspects of assessment and the complexities of law.

As clinicians who frequently work in an autonomous manner, it is always advisable to seek the advice of others who may have specialist knowledge that may assist in the assessment and management of any individual.

Assess the risk, engage others if possible in the decision-making process, document the decision-making process very clearly, not just the decision, consider what you plan to do and record what has been excluded and why. Never base clinical decisions on assumptions and think carefully through the likely and possible implications of the decisions you make.

Restraint

The Mental Capacity Act 2005 defines restraint as occurring when an individual 'uses, or threatens to use force to secure the doing of an act which the person resists, or restricts a person's liberty whether or not they are resisting'. This may take the form of mechanical restraint whereby a physical device is used to restrict the movement of an individual. This could take the form of straps, belts or any other device which impedes the free movement of an individual. This may be through the application of physical force, holding an individual down or by sitting on or applying physical force to restrict free movement. This may be through the application or administration of a pharmacological substance to immobilise, sedate or otherwise impede the ability of an individual to move. However, it might also be through the use of coercive language (or threat); while this form of psychological restraint might be more subtle in form, it is as restrictive as physical force and would, therefore, constitute a form of restraint.

Language is important here as organisations seeking to avoid difficult and complex subjects may prefer to use terms such as 'safe holding' to minimise the significance of any physical intervention. It is important that we understand and appreciate that any form of restrictive intervention that impedes the free movement of an individual is, in fact, restraint and as such must be managed in accordance with the appropriate legislation and the fundamental principles that should be applied to any restrictive intervention or episode of restraint. Alternative terminology does not remove the need to ensure that restrictive interventions are managed appropriately, nor does it remove organisational responsibility to ensure that staff are appropriately trained and educated.

As an absolute principle, restraint should only be applied as a last resort. Inappropriate, poorly applied restrictive interventions have been seen to cause significant harm, both physically and emotionally, and as a leading cause of deaths while in police custody.

Legal position

In certain circumstances, where the immediate situation and the potentially serious consequences of inaction dictate, common law does allow for the application of restraint in order to take immediate control of a dangerous situation. For example, when there is potential for serious harm to occur if no action is undertaken, if perhaps an individual is threatening to jump from a bridge. In such circumstances, it is acceptable to act on the belief that it is more likely than not that the individual lacks the capacity to make a decision and it is therefore best to take immediate action to restrain in order to preserve life. However, with all cases where restraint is applied it must be appropriate in character, proportionate to the risks involved and applied for the least possible time (NICE, 2015).

The Mental Capacity Act enables actions to be taken in a person's best interests where they lack capacity, for example, where restraint is needed to save the patient's life or prevent significant deterioration, and force used must be proportionate to the likely seriousness of harm to the patient. Again, restraint must be appropriate in character, proportionate to the risks involved and applied for the least possible time.

Restraint is permitted only if the person using it has reasonable belief that it is required to prevent harm to the incapacitated person, and if the restraint used is proportionate to the likelihood and seriousness of the harm. Section 6 (5) of the Mental Capacity Act is very clear in that the provision of restraint and any subsequent deprivation of liberty cannot be an action for which Section 5 provides any legal protection. Section 5 of the Mental Capacity Act makes it very clear that clinical interventions can be undertaken to support the care and treatment of an individual who lacks capacity, but that this must be on the basis of a detailed assessment of capacity and best interests.

The Mental Health Act (1983) further provides for the application of restraint to support those who are lawfully detained or liable to be detained against their wishes. It must be noted here though that while police officers can use restraint in order to enforce admission under Section 6 of the Mental Health Act, police officers must make the determination and cannot be compelled to do so.

The provision of restraint is therefore lawful under certain circumstances but is fraught with complications and must therefore be used with extreme caution.

Restraint should only be used:

- When absolutely necessary and when all other measures including communication, engagement and de-escalation have been exhausted
- In order to deliver clinical interventions necessary to save the patient's life or to prevent significant deterioration and be in their best interests
- Proportionately to the risk of harm
- In a form which is as minimally restrictive as possible
- With minimum force for the shortest period possible.

It is also vital that clear and detailed documentation is kept to record the episode of restraint, with a clear rationale for its application, the method used and the associated timings to demonstrate when it was applied and released.

Risk Factors

Due to the physical nature of restraint a number of risk factors are associated and should always be considered.

Foremost is the absolute requirement to avoid prone restraint, this places a physical restriction on the mechanisms of respiration and can lead to positional asphyxia (Department of Health, 2014). It is the responsibility of the clinician to not only ensure that they do not use prone restraint, but that they also intervene whenever it is used by others. It is important to note that the clinical responsibility for the health and welfare of the individual remains with the lead clinician, irrespective of whether they, or others, are responsible for the application of restrictive interventions.

In addition, should the individual subject to any restrictive intervention be under the influence of alcohol and/or any other substance, the impact of this on the individual must be carefully considered. It is never sufficient to consider the current level of intoxication or to ascertain what has been drunk at initial presentation. Alcohol is absorbed at different rates, based on size, weight, gender and a range of other factors. Levels of intoxication rise over time and therefore an individual may become far more intoxicated even after they have stopped drinking.

Children

When considering the provision of any restraint or restrictive intervention in children, as with adults, any actions taken must be appropriate, proportionate and applied in the least restrictive manner for the shortest period possible.

While the Mental Capacity Act does not apply to children under 16 years old, children can consent to clinical interventions when they have been assessed as being capable of making a reasoned decision.

The paramedic will need to take into consideration a number of factors when assessing a child's capacity to consent, including:

- The child's age and maturity.
- The child's understanding of the proposed intervention, including what it might deliver alongside key risks both short and long term.
- The ability of the child to understand the information provided and to use this to formulate and express an opinion,
- The child's ability to understand alternative options that may be available.

It is important to note that consent is not valid if any form of coercion is applied and that a parent cannot override the decision of a Gillick-competent child (NSPCC, 2020). This means that a child under the age of 16 can consent to their treatment if they are believed to possess sufficient intelligence, competence and an understanding of what's involved in their treatment. It is though very important to include parents in the decision-making process and particularly so when a child is deemed as not being competent.

De-escalation

Throughout the process of de-escalation it is vital that you consider the needs of the individual and that you are conversant with the methods you use to communicate, verbally or otherwise. If an individual is in crisis and suffering from significant issues of self-esteem and self-worth they may perhaps be angry or belligerent. Responding in a similar way merely reinforces that sense of self-loathing and negative self-image in the individual. It is therefore important when communicating with patients in crisis that reflecting negativity is avoided, that the paramedic uses a calm, reassuring tone, is non-judgemental and takes time to acknowledge the pain that the individual is experiencing.

The College of Policing (2020) describes the use of Betari's Box: the mechanism by which we are affected by the way we respond to others. It proposes that if we adjust our behaviour, it will in turn support adjustments in others' behaviour towards us (Figure 2.1). The core principle behind Betari's box is that we have free will in terms of how we interact with others, and therefore, we can choose to be positive, irrespective of how others are behaving towards us or how we might be feeling inwardly.

In this way, our attitude affects our behaviour which in turn affects our attitude and so the cycle continues. In simple terms, when we feel negative, we behave in a negative way towards others. Negative thoughts trigger negative behaviour, whether consciously or otherwise. This may take the form of verbalised behaviours but can also be demonstrated in non-verbal ways through body language or demeanour. Conversely, positive thoughts trigger positive behaviour. Again, this may be demonstrated in a verbal or non-verbal way.

Our behaviours, whether negative or positive, are then reflected in those we interact with and subsequently, their reaction is reflected back to us. We can therefore become

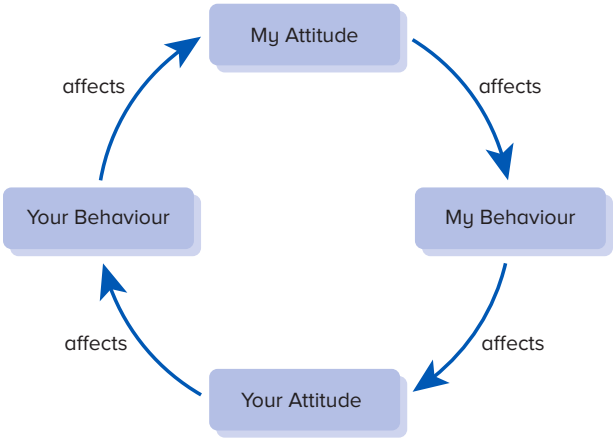

Figure 2.1 Betari's box.

stuck in a cyclical pattern of behaviour and if we can consciously change our attitude, we can break the cycle and regain control.

Understanding how our attitude can impact on the behaviour of others is therefore crucial; we must first be aware of how we are feeling and ensure that our behaviour is controlled and does not become a mere reflection of our thoughts. When confronted by negativity, we can choose to respond in kind or to take control of our attitude and behaviours to break the negative cycle and stop it from developing.

Relating this back to the initial Case Study, we must consider how our approach may need to be adapted to ensure that we do not create a negative cycle in our engagement with the individual who has not previously accepted support from his GP or agreed to attempts by healthcare professionals to enter his premises to support him. Communication is key, as is the degree of empathy with which we approach the situation. Understanding the needs, and fears of this individual is an important first step in supporting them to make an informed decision and allaying the fears and concerns that they may have which may be creating a barrier to accepting the help that is being offered.

Suicide

Unfortunately, as paramedics we will be called upon to attend incidents that involve attempts by individuals to end their own life. We will also be called to verify or recognise death in such circumstances. In 2019, 5,691 people took their own life in England and Wales (ONS, 2019). Approximately three-quarters of registered deaths were men (4,303 deaths) with a male suicide rate of 16.9 deaths per 100,000 which is the highest rate since 2000.

While this book is focused on mental health, it is important to note that over 65% of those who die by suicide are not known to mental health services. While an important factor, suicide of itself is not a mental health issue and activities associated with prevention

must be based on a broader consideration of factors associated with socioeconomic deprivation.

Risk factors

There are a number of risk factors associated with suicide which should be considered during any assessment (Harding, 2019). These include where an individual (Harris, 2018):

- Has made previous attempts to end their life
- Has a family history of suicide
- Has been diagnosed with mental health problems
- Has recently been discharged from psychiatric hospital (the first week and in particular, the first three days are a particularly high risk period)
- Is socially isolated, this is particularly important when considering social isolation in the elderly
- Has been unemployed for more than one month, this is particularly important when periods of economic hardship occur through recession or in response for example, to the COVID-19 pandemic
- Is homeless (The Office for National Statistics data for 2017 showed that 13% of deaths among homeless people were due to suicide and that suicide was the second most common cause of death for homeless people)
- Has a debilitating or terminal illness.
- Identifies as LGBTQ2+. While national data is not held it is widely accepted that members of the LGBTQ2+ community experience a significantly higher risk of suicide.

There is also a strong correlation and link between physical and mental health. Just as poor physical health can lead to a deterioration in mental health, the opposite is equally true.

Those suffering from mental ill-health are far less likely to receive treatment or to be in receipt of any formal physical health assessment; they are also less likely to self-present to health services and are therefore much less likely to have underlying conditions identified at an early stage. Consequently, they are less likely to receive help with poor lifestyle choices and more likely to smoke, consume alcohol and have a less healthy diet.

There are also significant correlations around social inequity and deprivation, both in terms of increasing the associated risk factors for both poor physical and mental health and also in respect of fewer opportunities to access services that may assist in providing effective intervention.

It is, therefore, far too complex to suggest that poor physical health creates the environment in which poor mental health can flourish, or whether it is the other way around, but we can say that one cannot be considered without the other.

While some suicides may appear to be spontaneous, and leave loved ones with significant feelings of anguish and despair, others follow a change in behaviour in the individual over a period of time (Rethink Mental Health, 2021).

- Expressions of hopelessness or helplessness – it is incredibly difficult for individuals who are struggling with their mental health to be able to see any positives in life or any hope for the future.
- An overwhelming sense of shame or guilt – many individuals feel that they have low worth and with that, a real sense of being weak and less able than others.
- A dramatic change in personality or appearance – many individuals begin to outwardly reflect how they feel about themselves and their worth. Giving up washing, shaving, or concern for outward appearance – in essence, mirroring in appearance how they perceive themselves to be.
- Behaving 'out of character' – behaving in a way that they would not ordinarily do.
- Altered eating or sleeping habits. An inability to sleep and reduction in appetite leading to weight loss is common.
- A serious decline in college or work performance – this could be due to an inability to concentrate or through a belief that work or performance no longer matter.
- A lack of interest in the future – a clear inability to see a time when things will be better may be present.
- Written or spoken notice of intention to end own life – this would clearly be a significant concern and may indicate a significant escalation in the level of risk.
- Giving away possessions or putting affairs in order – may indicate a finalisation of planning.
- Sudden unexplained 'recovery' – some individuals may appear positive when they have made the final decision to end their life, the pain and anguish are sometimes lifted as the individual is at peace with the decision. This may then be reflected with a sudden positive improvement in appearance and behaviour without any perceived reason.

It is important to stress that the risks, and associated behavioural changes, may not always be present; it is therefore vital that we encourage conversations around mental health and suicide, such that it becomes OK to *not* be OK and it becomes OK to ask for help.

Communication

For paramedics, the determination of risk is incredibly important and phrasing a conversation with an individual who may be considering, or may have attempted to take their own life, is a crucial part of that assessment.

We, as paramedics have probably all heard colleagues state that they 'don't know what to say' in these situations, when in reality they often just need to listen and to try to understand.

The following is a suggested framework for conversations; it is not a checklist and should not be used as such. When discussing suicide with an individual in distress, it is important that the conversation happens in a safe environment in a way and at a pace that meets the needs of the individual.

Suicide is complex; suggested changes in behaviour may or may not be present, therefore making a determination of the associated risk is incredibly difficult and any tool used to support the evaluation of risk must be used carefully. When assessing the level of risk it is important to consider four factors: intent, plans, actions and protective measures. These factors form the IPAP Suicide Risk Assessment Tool which can be used by a non-mental health professional to identify and assess suicidal risk (Table 2.1). The IPAP assessment tool should be used to help inform immediate management on scene, not as part of a long-term measure of the patient's condition (JRCALC, 2019). This tool forms part of a wider holistic assessment of the individual and should be used to inform the decision making along with other pertinent factors which may increase the risk of suicide.

Remember!

Suicidal thoughts are not always rational, but that does not in any way mean that those concerns and beliefs are not very real. Suicide is not always about ending life; it can also be about ending pain.

The important point to make here is that for a person in crisis, conversation, human kindness and empathy are important and taking time to make a difference is also important.

- It's OK to ask
- Being that person who cares is all it may take
- You are not going to make it worse by caring.

Further resources are available from the National Suicide Prevention Alliance at https://www.nspa.org.uk/ and the Zero Suicide Alliance at https://www.zerosuicidealliance.com/

Table 2.1 IPAP suicide risk assessment tool.

Intent	• When trying to evaluate the level of intent, ask the individual if they are feeling suicidal. A myth exists that asking this question somehow increases the likelihood that they will subsequently complete the act of taking their own life. This is simply not true, asking the question is vital in understanding whether the individual has had or is currently suffering from suicidal thoughts. • Ask how intrusive the thoughts are. Do the thoughts come and go? Are they pervasive? Do they think about suicide daily? Are they unable to experience periods of time when the thoughts are not present? • Ask the individual whether they have thought about suicide previously; if so, what stopped them from following through with those thoughts? If they have made previous attempts, ask about those attempts and when they occurred.
Plans	• If the individual has a clear intent, the level of risk is clearly increasing; it is then important to understand whether the individual has developed a plan by which they would take their own life. • Again, it is OK to have that conversation. Asking an individual about their plans is a vital part of the dialogue and does not in itself increase the risk. • Ask the individual if they have formulated a plan and what that plan might be. Is the plan realistic and fully formed such that it could be carried out?
Actions	• If the individual has clear intent and a formulated and viable plan, the level of risk is again increased. • It is then important to understand what actions, if any, have been taken towards completion of the plan. Has the individual written any letters or closed bank accounts? Have they taken action to put their affairs in order? • Has the individual taken actions to advance the plan? Have they stockpiled medications? Have they purchased items that would be required to carry out the plan or otherwise taken actions to ensure that the plan can be activated?
Protective measures (LACK of these increases risk)	• Finally, consider protective measures and preventative factors. If the individual has considered suicide in the past, what stopped them? Is that factor still in existence or has there been a change in the individual's support network? • Does the individual have coping mechanisms or a support network? Don't be judgemental about what this may consist of. For some, the protective measure may be family or friends, but for others this will not be the case. For many, family is a significant part of the disordered thoughts of the individual, in that they truly believe loved ones will be better off without them. They may also feel that they are the source of personal or financial problems and therefore believe that by ending their life they are removing the source of the problem.

Note: always consider the above in conjunction with other known risk factors such as age, gender, employment status and significant life events (e.g. relationship breakdown, divorce, bereavement, childbirth, unemployment or economic difficulties).

Source: informed by the *JRCALC Clinical Guidelines*, 2019.

Suicide bereavement

Bereavement of any kind is painful; loss is difficult to come to terms with and emotions and grief are difficult to deal with. Loss through suicide is acknowledged as being particularly complex. Emotions associated with the loss are combined with a sense of shock and an inability to comprehend why it has happened. For some, this comes with feelings of guilt or shame and an inability to talk or communicate with those who have a shared understanding of loss through suicide (McDonnell et al., 2020).

Stigma associated with loss by suicide may lead to individuals feeling isolated; they may also wish to deny that they have been bereaved through suicide through shame or cultural religious beliefs (Pitman et al., 2018).

It is, therefore, an important role of paramedics who attend at the point of death to manage the initial interaction with loved ones, to support them as they struggle to come to terms with what has happened and to ensure that they consider the needs of those left behind. Paramedics must be mindful that they are present at the best and at the worst of times. As such, what they say and do is incredibly impactful and will stay with the bereaved for the rest of their lives.

Supportive organisations and useful contacts

- Suicide Bereavement UK: https://suicidebereavementuk.com/
- Survivors of Bereavement by Suicide: https://uksobs.org/
- Losing someone to Suicide (MIND): https://www.mind.org.uk/information-support/guides-to-support-and-services/bereavement/bereavement-by-suicide/
- Cruse Bereavement Support: https://www.cruse.org.uk/understanding-grief/grief-experiences/traumatic-loss/coping-when-someone-dies-by-suicide/
- Samaritans: https://www.samaritans.org/about-samaritans/research-policy/bereavement-suicide-services/
- Support After Suicide Partnership: https://supportaftersuicide.org.uk/

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