

## **Research review on violence against staff in mental health in-patient and community settings**

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### **Preamble**

The Royal College of Psychiatrists' Research Unit have carried out the most authoritative work in this field in the UK. Their Guidelines (RCP 1998) are research-based, and are taken here as the best research review and recommendations about in-patient settings to that date. Publication of the Guidelines was followed by a National Audit of violence in in-patient settings, in which 96 psychiatric wards from 42 English mental health services took part. The audit findings have been analysed nationally (RCP in press, McGeorge et al. 2000). This review focuses on this work, adding additional evidence, in particular about the management of violence against staff in community settings.

### **Background**

As psychiatric bed numbers have been reduced, the proportion of people detained compulsorily under the Mental Health Act 1983 has increased (Simpson 2000). This has resulted in mental health units becoming very disturbed environments, with an increased problem of violence (McGeorge et al. 2000). In a multinational survey, 75% of 999 psychiatric nursing staff reported that they had been assaulted at least once in their career (Poster 1996). Parallel to this there has been a heightened public awareness of the very small proportion of patients who exhibit violence in the community (Taylor & Gunn 1999). This awareness has led to a culture of blame of mental health professionals when things go wrong. Mental health staff in turn exhibit more defensive practices and run more controlling services (Fernando et al. 1998, Prins 1999, Rose 1998).

## **Definitions of violence**

A wide variety of definitions of violence are found in use in English psychiatric services. While traditionally definitions of violence included only physical assault, it is more usual now to accept that some verbal threats produce as much psychological distress in staff as do some physical assaults (Flannery et al. 1995).

For any definition to lead to meaningful recording and monitoring of incidence there needs to be service-wide awareness and acceptance of that definition. The National Audit found that while 61% of trusts had a definition of violence, only 27% of these stated that all professional groups were signed up to it and about one half of trusts inducted staff in the use of the procedure (RCP in press).

## **Evidence of how violence arises in mental health settings and measures that might decrease violence/increase safety**

### *Environment*

Providing a calm, decent and secure ward environment is a key element in ward safety (RCP 1998). The National Audit found that many wards failed to meet basic standards. They were often rated as noisy, hot, dirty and smelly with unsafe designs that did not allow staff to see what was happening on different parts of the ward. (McGeorge et al. 2000). Most wards were, however, able to identify relatively quick and affordable improvements.

Availability of alcohol and other drugs in an environment has been found to be a factor in assaults on staff (Brasic & Fogelman 1999, RCP in press).

For community staff, Beale et al. (1999) found that regular risk assessment audits in relation to staff safety were not always carried out. They suggest that traceability and communication systems for staff away from base are often lacking. For community staff mobile phones, shared diaries and reporting back systems as well as emergency procedures and knowing how to access help are needed. Part of the system for reporting of incidents should be sharing information about possible hazards with other staff.

Supportive team working during assessments under the Mental Health Act is part of official safety guidance. Knowing when to call police and how to use police support is also mentioned (DH 1999).

### *Social environment*

The RCP audit found many aspects of the social environment shared by patients and staff were unsatisfactory (RCP in press, McGeorge et al. 2000). For example, 14% of patients did not agree that they had privacy using the toilet.

Boredom was a factor identified in the Royal College of Psychiatrists' Guidelines in promoting a violent environment (RCP 1998). In the audit, only about a third of service users reported satisfaction with day-time leisure and therapeutic activities, and for the evening, only one-fifth (RCP 2000).

### *Staff styles and interactions*

Some mental health settings are by nature coercive, with unwilling participants. There is little discussion in the literature of the role of issues of control and power in mental health services in exacerbating aggression, compared with the social care field (e.g. Littlechild 2000).

Whittington & Wilkes (1996a) studied the frequency with which violence by psychiatric in-patients was preceded by 'aversive interpersonal stimulation'. They found that 86% of 63 assaults were immediately preceded by the assaulted nurse having delivered an aversive stimulus to the patient, for example a demand for activity, frustration of a patient's intentions or physical contact.

Lancee et al. (1995) found that the limit-setting style of nursing staff can make a difference to psychiatric patients' levels of anger. Prins (1999) notes that staff sometimes fail to distinguish between actions in service users that is illness-driven, and actions which have a rational explanation which is not taken into account, thus provoking a negative response. The National Audit found staff over-response to patients to be a precipitating factor to violence – giving injections and backing people into corners were given as examples (RCP 2000).

There is little discussion of the use of medication for behaviour control in the psychiatric research literature on staff safety. The National Audit (RCP in press) found that a sizeable number of non-staff (ie. service users and visitors) reported that the use of unnecessary medication and seclusion were used as threats to control behaviour.

Another trigger for violence is access to staff. Service users taking part in the National Audit frequently stated that staff did not spend enough time talking to patients. Half of service users reported that they had been able to see their key

worker when they wanted, and 44% that staff had been around to talk to them if they felt upset (McGeorge et al. 2000).

### *Staffing levels and mix*

Low staffing levels are perceived to compromise safety on wards, particularly at night. The mix of staff has also has its effect. The need for trained staff and for regular staff who are familiar with the service users and the ward procedures – as opposed to agency staff – are also factors in levels of violence (RCP in press).

### *Service culture*

The National Audit found that although some aspects of inter-staff communication, such as staff handover procedures, were satisfactory in most places, only 47% of nurses felt that their complaints were taken seriously by managers (RCP 2000). An illustration of the lack of backing from managers was given in the National Audit:

*‘There is a problem with drink and drugs on the unit, but staff feel their hands are tied because there is no backing from managers or some consultants and even the police.’* Nurse (Quirk et al. 2000)

Beale et al. (1999) found that discrepancies in perception between managers and practitioners lead to poor policies and lack of safety procedures in community services, and that senior management commitment led to safer working policies and practices. Freyne & Wrigley (1996) found that **acknowledgement** by managers of staff difficulties is an important element of support to staff in a violent work setting.

Fernando et al. (1998) document what they describe as the rise of ‘hard’ thinking among the growing profession of forensic psychiatry, leading to over-controlling practice.

### *Culture/race issues*

Evidence of institutional racism in mental health services is a factor in black service users’ experiences of psychiatry (Browne 1997, Fernando ed. 1995, Fernando et al. 1998). Research consistently finds that members of minority ethnic groups receive more controlling services, more medication and fewer community and talking treatments. Black service users have reported on the effect of stereotyping, for example ‘I wonder if they expect me to attack them’ (Wilson & Francis 1997).

Addressing issues of race and culture, and in particular combating institutional racism, has an essential place in improving staff/patient interactions. Recommendations abound, but are more complex than can be usefully

summarised here. See Fernando et al. (1998) Fernando ed. (1995) Prins (1993) SNMAC (1999) Woodley (1995) .

### *Features of individual patients*

One aspect of the literature on violence and mental health is concentration on identifying features of those who perpetrate violence, particularly in relation to diagnosis. It is now agreed that while most people who use mental health services exhibit similar levels of violence to their neighbours, there is a very slightly enhanced risk with individuals with some diagnoses, particularly if there is a dual diagnosis including substance misuse. As in other fields, the best predictor of violence is previous violent behaviour (Langan 1999 for a summary, plus other sources in the bibliography). Mental health service users are far more often the victims than the perpetrators of violence (Critchon ed. 1995). The National Audit found that one third of non-staff (patients and visitors to the ward) had experienced violent behaviour on the ward, but 72% of non-staff had been given no guidance on dealing with this, and only 47% said that they knew how to summon help. However, Wallace et al. (1998) conclude that 'The risk of a serious crime being committed by someone with a major mental illness is small and does not justify subjecting them, as a group, to either increased institutional containment or greater coercion'.

For individuals with known potential risk to others, improving risk assessment is identified as a key issue. Poor risk assessment and management was found to be the most frequent factor identified in 14 key mental health homicide inquiries (Parker & McCulloch 1999). Grounds (1995) notes that the amount of worry that staff have about a person and the actual risk that they pose are not the same: risk assessment can distinguish this. Calling in forensic experts to assess risk when people are living at home has also been identified (Shepherd 1995). Campbell & Lindow (1997) give recommendations on involving service users in risk assessment.

Communication problems between different service providers and inadequate care planning have been found as frequent factors in mental health homicide inquiries (Parker & McCulloch 1999). Lipscombe (1997) illustrates this by noting the lack of information on risk posed by individuals in the care of a homelessness mental health team in London in the 1990s. Prins (1999) states a concern based on homicide inquiries in mental health that staff do not keep accurate records of violent incidents on individual case files, so that they are forgotten over time.

### *General conclusions on making improvements*

The National Audit findings made it clear that building new wards was not a sufficient response to reducing violence in unsuitable environments. McGeorge

et al. (2000) suggest that although resources will be needed for example to improve training or increase activity to alleviate boredom, many of the issues highlighted can be addressed now and relatively inexpensively. For example: reorganising the ward routine; increasing face-to-face contact between nurses and service users; improving information sharing with service users; altering the ways staff interact with service users; changing the use of space. These changes do not necessarily cost money or require a new ward.

### **Factors which suppress reporting**

Dealing with violence and aggression is felt to be part of the job by some mental health workers in all settings (Poster 1996, Prins 1999). However, the National Audit found that this view was not acceptable to many staff (McGeorge et al. 2000).

Reporting was suppressed by the following factors:

- incidents were not considered serious enough (Beale et al. 1999), (although serious incidents were not always reported [Owen et al. 1998]);
- reporting procedures were too time-consuming (Beale et al. 1999);
- there was lack of agreement on definitions of violence or awareness of the reporting system (RCP, in press).

### **Impact of different kinds of violence on staff**

Reaction to various kinds of threats and assault varies with the individual and context, rather than with the kind of threat or assault. Paterson et al. (1999), in their review of the effects of violence on nursing staff, suggest that 'A critical incident may be defined as any incident which can be perceived to have sufficient emotional stress to overcome the usual coping mechanisms of the persons involved'.

Reid et al. (1999) found that community staff were less demoralised by violence than ward staff, although a third of community staff did state that it was a stress factor, especially when they were visiting alone. Ryan (1997) found that residential staff in the community were at greater risk than other community mental health staff because of their greater direct contact with service users.

### **Usefulness of various support and debriefing**

Paterson et al.'s 1999 review found that the main impediments to support from organisations are:

- a culture of blaming the victim;
- lack of consensus on effective responses;
- staff skill deficits.

In common with much other research evidence, the National Audit found that most ward staff felt supported by immediate nursing colleagues, though less so by other members of the multi-disciplinary team or management (McGeorge et al. 2000). Coffey (2000) found that shared office premises was important for community staff, so that they could access peer support. Good supervision was named as the other main source of support.

A particular issue highlighted by the National Audit was unacceptable national variation in the nature and extent of collaborative working between mental health services and the police and crown prosecution services (CPS). Staff in some services felt that the police should press charges against patients more often (RCP in press). One of the audit's national recommendations was that there should be a nationally agreed framework describing links and procedures that should exist between mental health services and the police and CPS.

Chaloner (1995)'s recommendations for support after an incident based on research on the experience of violence in various healthcare settings are:

- effective communication within the team;
- calling special debriefing meetings (if possible using a facilitator from outside the immediate incident location);
- the offer of counselling;
- recognition that everyone present may need support;
- consequences of violence should be included in training;
- practical advice should be available (about prosecution, insurance claims etc.).

### **Recommendations about training**

The National Audit found that 34% of participating staff reported that they had not received any training in the last five years that was directly related to the management of violence, and less than half felt that training had equipped them adequately to prevent and manage violence (RCP in press, McGeorge et al. 2000). Although research findings agree that nursing staff bear the brunt of dealing with violence in mental health in-patient settings, there are recommendations that all regular participants need training in safety: students (Grenade & Macdonald 1995), administrative staff (Kooperman et al. 1998), non-clinical staff (RCP in press), researchers (Lawrinson & Harris 1994, Monahan et al. 1993) as well as more obvious staff members such as nurses, psychiatrists, psychologists and occupational therapists.

Wright (1999) has reviewed the current literature on physical restraint training for in-patient settings, and makes the following recommendations about what such training should include:

- verbal and non-verbal techniques of de-escalating potentially violent situations;
- ethical considerations in physical management of violence;
- legal aspects of physical management of violence;
- emphasis on the protection of the patient's dignity and respect for the patient;
- potential dangers in the restraint procedure;
- techniques for safe disengagement from assault (breakaway techniques) and separating of fighting patients;
- emphasis on post-incident care for all involved.

Beale et al. (1999) found that many community staff had no recent training in safety. Those that had, found that the physical methods they were taught were not appropriate for the conditions of community work. They found that training should include information about what trauma reactions staff should expect in themselves and others and what support is appropriate. Their respondents also commented that 'bought in' trainers were often unfamiliar with their particular working conditions.

Shepherd (1995) found that ongoing professional training in modern methods of mental health care was also important, to prevent staff from lapsing into institutional practices. The Standing Nursing and Midwifery Advisory Committee (1999) recommends that nurses should be trained in both risk assessment and risk management. Styles of intervention by staff is another type of training suggested by evidence presented earlier.

### **Evidence of training that has been monitored and found to be effective**

Mental health literature contains several examples of training programmes, but less about evaluated training (e.g. Kemshall & Pritchard 1999).

Whittington & Wykes (1996b) followed 42 nurses after a training day to learn strategies for coping with violent psychiatric patients, compared with a larger control group. Rate of assaults on staff were on average 31% lower on all staff on wards where some staff were trained, with greater improvements where more than half of staff were trained. However, this study does not give details of the training content.

Wright (1999) notes that patchy research has been done into the efficacy of control and restraint methods, however, there is some research on Control &

Restraint as derived from the prison service and widely used in mental health services – from which he finds:

- a decrease in both the number of assault-related injuries and assault-related sick leave;
- high level of confidence in the techniques learned;
- positive and significant changes in trainees' knowledge and behaviour;
- reduction in in-patient violence;
- one research study found slightly increased injuries because of tendency to 'freeze' and types of attack different from those covered in the training;
- decrease in number of restraint-related head and face injuries to patients.

The benefits of training can, however, be lost if there is no locally agreed strategy for managing actual incidents (RCP 2000).

*Although C & R training I received equipped me to deal with violent situations, time and again when an incident occurs on the unit, the ensuing melee is often disorganised and chaotic, with a lack of leadership and designated roles.* Nurse (Quirk et al. 2000)

Two of Wright's key recommendations are that such training is undertaken only by properly accredited staff, and that time must be made available for initial training and updates, commensurate with role and contact with patients and the work environment. This concurs with the audit's recommendation that 'there should be national guidance about the content, length, and frequency of training and refresher courses for **all** staff who work in places where violence is known to occur' (RCP, in press).

### **Suggestions of targets or proxy indicators that might be used to monitor violence reduction**

#### *Initial targets to get systems in place*

- Environmental safety audit eg. using the RCP environmental audit checklist.
- Staff safety:
  - mobile phones to be available for all community staff;
  - reporting procedures to be included as part of all staff induction;
  - sources of emergency help for isolated staff found.
- Organisational systems:
  - baseline figures for staff and patient injuries, staff sickness due to injury and prosecutions following crimes against staff to be established;

- home visit reporting arrangements for community staff to be established;
- systems to be set up for staff who have experienced threats and violence to receive support;
- targets to be set for staff training (linked into national recommendations that are based on evidence of 'who needs what').

*Ongoing targets for regular audit*

- Annual environmental audit of service.
- Audit of application of debriefing procedures against national standard.
- Level of prosecutions to decrease.
- Number of injuries received by staff and patients to decrease.
- Injury-related staff sickness to decrease.
- Monitoring of staff initial and refresher training.
- Monitoring of compliance with home visit reporting arrangements.
- Monitoring of staff awareness of existence of support systems.

**What research is required in the longer term**

- The use of medication in the context of violence: there has been little investigation into the use of medication for behaviour control rather than symptom relief in mental health care.
- Therapeutic effects and effectiveness of various forms of violence reduction and management.
- The therapeutic effects of C & R.
- Patients' views in relation to comparing various restraint methods with non-restraint interventions.