Violence on psychiatrists: preventing future increases

Psychiatrists suffer the highest rate of violence compared with other specialities; current developments are likely to increase this.

Against a backdrop of generally reported 'rage' phenomena, health staff are at higher risk from work-related violence than the general public. The rates are rising, to which the government has responded by commissioning reviews and launching the NHS zero tolerance zone campaign in 1999 (NHS Executive, 1999). In the legal context, the Lord Chancellor has advised the imposition of a 'sentence which has a deterrent component' for assaults on NHS staff. Clinical services meanwhile have to make daily decisions about when, whether and how to treat the violent patient. The Prime Minister, visiting the Royal London Hospital recently, endorsed a 'red card' scheme operating there, by which persistently violent patients are banned for 1 year after a formal warning ('yellow card').

ASSAULTS ON PSYCHIATRISTS

The red card scheme explicitly excludes psychiatric patients and those judged on assessment to be mentally ill, because of the difficulty in unambiguously attributing blame to such individuals. However, psychiatrists experience more violent incidents than any other hospital speciality. In a 1987 report, psychiatrists had eight times the number of major injuries, three times minor injuries and twice the number of threats with weapons and verbal threats by comparison with those working in general medicine (Health Services Advisory Committee, 1987).

Depending upon length of time surveyed recent reports show between 17 and 60% of psychiatrists have been assaulted (Madden et al, 1976; Fottrell, 1980; Health Services Advisory Committee, 1987; O'Sullivan and Meagher, 1998; Davies, 2001). Only half of all assaults may be reported.

In June of this year the Medical Defence Union-Medix released details of a nationwide survey of physical assault on doctors which was carried out in March 2001. Of the 1044 respondents, 23% had been assaulted at work in the past 5 years (Monaghan, 2001). In 70% of cases the perceived cause of the assault was unrelated to any medical condition and was the result of issues such as having to wait and drunkenness. It may be misleading to assume that assault is an occupational hazard in psychiatry without examining how much is the result of illness and how much is the result of antisocial behaviour. This spectrum of assault also needs to be seen in perspective since other health personnel such as student nurses and ambulance staff have higher rates of serious assaultive injury than psychiatrists (Health Services Advisory Committee, 1987).

TRAINING

Psychiatric trainees receive safety advice from the Royal College of Psychiatrists on such issues as dress, behaviour, personal privacy, personal alarms and safety training, including physical methods of restraint and breakaway techniques. Violent incidents involving trainees are monitored at College approval visits.

The evidence is that trainees neglect mundane measures, such as safe arrangement of furniture in interview rooms, going ex-directory, calling on porters for night chaperoning and using mobile phones or alarms. It may therefore be more relevant to monitor these than attendance at formal training courses. Likewise, the College has incorporated ideas about violence prevention into building development and design recommendations, such as use of closed circuit TV and alarm systems, 24-hour receptions and single entrance facilities, but many of the buildings in which psychiatry operates are old and unable to be brought up to the required standard.

PROTECTION AND PREVENTION

Studies of violence on psychiatrists have served to eliminate some stereotypical assumptions as to when and how assaults or threats occur, but have given few clues as to what may be protective or preventative. Most psychiatric assaults occur in general adult psychiatry with very few in forensic psychiatry. They occur typically in normal working hours with a peak mid-morning, most commonly when a patient is seen urgently, and usually when accompanied by another member of staff rather than alone (O'Sullivan and Meagher, 1998; Davies, 2001).

The doctor is likely to be relatively inexperienced and the assault occurs irrespective of gender, attendance at an aggression management training course or knowing that the assailant has a previous history of staff assault. Assailants are more likely to be young, male, from the lowest socioeconomic class, previously known to the doctor and with a history of previous violence, and to have a diagnosis of personality disorder, substance or alcohol abuse or schizophrenia. Most such assaults are not reported to management despite being documented in the case notes, perhaps illustrating the blurred line between 'routine' illness behaviour and legally culpable assault.

DIAGNOSIS

When the diagnosis is an organic or schizophrenic disorder the response to an assault tends to be internal, namely medication, confinement, changes to hospital routines, or transfer of care to another consultant. When the response is external — involving police, litigation or forensic transfer — the diagnosis is most likely to be substance or alcohol abuse or personality disorder.

Although psychiatrists may be attuned to disturbed behaviour as a feature of mental illness, they are more adept at picking up suicidal intentions than those of harming others. Common risk factors for violence, such as threats and access to an identified victim, purchase of a weapon and premeditated violent thoughts, are infrequently enquired after. One study of psychiatric admissions revealed 1 in 4 had violent thoughts directed at specific individuals, 1 in 10 owned weapons and 1 in 20 carried them (Sanders et al, 2000). This highlights the truism that the psychiatrist's primary skill is in eliciting details of the individual patient's subjective distress rather than in defining pure risk management and public safety issues.

Of the diagnostic categories most commonly associated with assault, all or most patients with schizophrenia are treated by psychiatrists. The management of doctor-related violence from these patients is historically one of the core skills of psychiatry, backed up by measures such as emergency medication and use of the Mental Health Act. However, of those potentially diagnosable with personality disorder or drug or alcohol dependency only the self-selected few who are actively seeking help for their problem are seen by psychiatrists. These disorders have until recently been viewed as only peripherally and ambivalently 'psychiatric'.

A recent confidential enquiry underlines this (Department of Health, 2001). Of those who committed the most extreme form of violence — homicide — 1 in 20 had schizophrenia but 1 in 3 had personality disorder, alcohol or drug dependence. Most of the latter were not in touch with the health service and were dealt with by a prison sentence not psychiatric disposal. It is persons not diagnostic categories who are responsible for behaviour. Contact by psychiatrists with some dangerous or violent individuals does not mean psychiatrists should be held responsible for all individuals falling into the same descriptive category.

Under the zero tolerance initiative, the government is increasingly sanctioning better use of the criminal justice system in general hospital settings and in general practice. An NHS circular tackling violence to GPs speaks of abolishing unrealistic expectations of what health services can provide. It allows of exclusion from 'normal arrangements and locations' and financial incentives for practices that do not strike off violent patients. In turn, violent patients irrespective of diagnosis are in the top four problems GPs most commonly refer to psychiatrists (the other three are psychotic, severely depressed or alcoholic patients).

WHY PSYCHIATRY?

Why is it that in psychiatry the pressure is currently towards greater inclusiveness of potentially violent individuals? The government's White Paper 'Reforming the Mental Health Act' outlines proposals which include the possible compulsory detention of people whose sole diagnosis is drug or alcohol dependency, or who have been diagnosed as having 'dangerous, severe personality disorder'. The emphasis is on the protection of others rather than on the health or treatability of the individual who has been detained. If these proposals become law, those individuals would initially be admitted onto acute general adult psychiatry wards, making such wards more dangerous for staff.

This seeming attempt to make psychiatrists agents of public order is likely, if it succeeds, to increase the already major problems in recruiting to the speciality. In addition, trusts or health authorities will have greater difficulties in fulfilling their statutory duties under the Human Rights Act 1998 to ensure the security of mental health care staff. HM

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KEY POINTS

- New initiatives to stamp out work-related violence towards staff in the NHS involve excluding patients from normal services.
- Violence is intrinsic to some psychiatric disorders but not all violence on psychiatrists is illness behaviour.
- Apart from schizophrenia, the patients with most risk of violence are those with personality disorder or substance or alcohol abuse, of whom psychiatrists currently see a small proportion.
- There is pressure to render psychiatrists responsible for more of these individuals, including detaining them compulsorily under new proposals for reform of the Mental Health Act 1983.
- These moves, if successful, are like to increase rates of violence on psychiatrists, making recruitment into the speciality even more problematic, and will challenge trusts' and health authorities' ability to fulfil their obligation to provide a safe working environment in mental health.