National directives on managing ‘violent’ patients: a critique

UNTIL relatively recently, the incidence and nature of patient aggression and violence in health care has been a neglected area of investigation. Literature on the subject has expanded since the 1980s and to date over 1,500 papers have been published (Duxbury, 2002). It is clear that there are concerns about escalating levels of patient violence towards nurses. As a result, there has been extensive research looking at the problem of patients in a multitude of health care settings who are aggressive and violent.

A number of studies have begun to highlight the negative impact of patients who exhibit such behaviour in the wider general healthcare setting (Whittington et al, 1996). A&E departments and the community have been the focus of some work, but greater investigation is warranted. Concerns about the safety of healthcare workers across all specialties are undoubtedly rising (Rippon, 2000), particularly for those working in mental health. Calls for the evaluation of present practices are noticeably increasing, and as a result of the subsequent scrutiny, a number of management issues have emerged to try and prevent patient aggression and violence (Whittington, 2000).

This paper offers a critique of three of these initiatives, highlighting that they fail to address the true nature of the problem; that is, that aggression is more common than violence. Clear distinctions need to be made between these two very different concepts. For the purpose of this review, aggression is described as a willingness (an intent) to inflict emotional or physical harm to another. Violence, on the other hand, refers to the physical use of force, which may range from the slightest unwanted physical contact to homicide (Breakwell, 1997).

Difficulties in the way that aggression is understood and managed may be the result of historical perceptions of the patient ‘aggressor’, numerous and often under-resourced changes in mental health policy, and their subsequent impact on changing priorities in practice.

Historical perspective

Aggression is not a 20th century phenomenon, but an unprecedented rise in violent behaviour has been reported in recent years (Rippon, 2000; NHSE, 1999). It is suggested by McRobbie and Thornton (1995) that this is the result of a combination of factors, including changes in society that have led to the suppression of primitive, innate reactions. According to McRobbie and Thornton there is a general atmosphere of ‘moral panic’ in society today that has been fostered by the media, despite the fact that violent acts have been witnessed through the ages.

While there have been endeavours by the government and professional bodies (RCP, 1998; NHSE,1999) to promote civilised behaviour within the NHS and to control that which is undesirable, it remains a violent world. We are surrounded by aggression and subjected to a number of negative images of this, for example, stalkers, random sex attacks on the old and young, road rage and every variety of family assault and domestic violence (Breakwell, 1997). However, despite the stresses of everyday living, the suggested correlation between mental illness and increased violence continues (Linaker and Busch-Iversen, 1995). Society pursues answers and searches to lay blame. The perceived behaviour of those who are mentally ill continues to instil public hostility and fear, particularly following a number of highly publicised crimes involving individuals with a long-term mental illness. In addition, concerns over recent community care initiatives have fuelled public anxieties (DoH, 1999). Research lends weight to this popular belief: a diagnosis of schizophrenia has been associated with increased displays of aggression and violence (Linaker and Busch-Iversen, 1995). However, debate in this area continues and it is the social nature of mental disorders that is increasingly thought to be problematic as opposed to sole individual factors or disease (Nijman et al, 1999).

Aggression and violence towards healthcare staff is not new and has been apparent since institutional care began. Adams and Whittington (1995) report that there are few staff working with mentally disordered people who have not encountered at least verbal aggression at some time. However, although the problem itself is not new, systematic study in this area is relatively recent (Rippon, 2000). Existing research has largely centred on the problems of physical violence in psychiatric settings. Today, however, verbal abuse is common in a variety of practice areas (Adams and Whittington, 1995). Possible explanations for this include restrictive involuntary policies, under-resourced community care programmes, more acutely ill people in hospital, and poor communication between staff and patients. The latter, it seems, is compounded by increasing public expectation (DoH, 1999).

One of the problems with existing inquiries into patient aggression and violence, both its cause and the efficacy of management approaches, is the emphasis that has
been given to the staff perspective only: the patient voice is rarely sought (Whittington, 2000). This approach may be part of a much broader deficit in investigative work into the social and interactive nature of the problem of patient aggression and/or violence in the health care setting.

Increasing calls to examine the multidimensional complexities of this problem highlight these concerns (Nijman et al, 1999) and open the way for greater exploration of multiple perspectives, locally and nationally. This will require taking into consideration the broader cultural and political climate of present day psychiatry, so change will not happen overnight.

**Changing psychiatric policy and practice**

Changes in psychiatric policy and practice since the first review of mental health nursing in 1968 (Ministry of Health, 1968) have been radical and have had an obvious impact upon patient care. For example, there is now a clear difference in the provision made for caring for patients in the community and for those in institutional care – the former attracting greater resources as a result of changing government priorities (DoH, 1999).

The lack of input into the in-patient psychiatric and general setting may be part of the problem faced by staff dealing with aggressive patients. For example, it is increasingly recognised that there are flaws in the methods of staff training; a dearth of nursing philosophies; poor patient involvement in care provision and planning, and difficulties with staff retention and sickness (Wright et al, 2000).

The role of the mental health nurse in the acute sector remains particularly undefined and, as a result, it has been argued (Gournay, 2001), their work is regarded as being ineffective. In many recent reviews of mental health nursing, the role of the practitioner is not only under scrutiny but also the acute mental health setting itself (DoH, 1999). There is disparity in the provision of acute care, which may be in a district general hospital (and which is deemed inappropriate), and that given in one of the few remaining mental hospitals. Several reports have expressed disquiet about the environment in both acute psychiatric and general hospitals (DoH, 1999; DoH, 2000).

In the psychiatric sector there is some confusion among both practitioners and managers over the function of acute specialist services. This may, in part, account for the numerous policies and guidelines that have emerged in recent years (DoH, 1999; Wright et al., 2000). Each has demonstrated interest on the subject of patient aggression and/or violence in the health care setting.

**National directives**

Attempts to address the difficulties associated with patient aggression and violence have resulted in a number of research-based initiatives and/or ‘scoping’ exercises. Three in particular are timely and of particular relevance to the problem:

- A report from the Royal College of Psychiatrists on the management of imminent violence in mental health services (RCP, 1998).
- A report from the National Health Service Executive on zero tolerance to violence in the wider NHS (NHSE, 1999).
- A UKCC consultation exercise and survey that resulted in the publication of a full report (Wright et al, 2002).

The report from the Royal College of Psychiatrists (1998) comprised a set of guidelines that were welcomed to some extent at the time, although they placed emphasis on strategies for the containment and management of violent patients. This is a response that could largely be expected given the discipline promoting the guidelines and which, moreover, are generally based upon quantitative findings and empirical research. While the views of stakeholders, including patient and nursing groups, were surveyed in the preparation of this document, much of it focuses on the review of only 68 papers. Half of these looked at research on chemical and physical restraint and seclusion, while the remainder examined environmental factors and predictions. The impact of violence on the staff-patient relationship is hardly mentioned and rarely studied, despite this being an issue viewed to be problematic by the patients surveyed.

A further worrying omission is the only slight recognition given to the nature of the problem and, despite increasing concerns, the incidence and impact of verbal abuse is not addressed. Rather the word ‘violence’ is used throughout and remains a consistent theme.

In contrast, guidelines proposed by the NHSE (1999) appear to place the sole responsibility for the development of aggression and violence on the patient, and nurses are seen as the undisputed victims. Such an attitude does little to encourage staff or service providers to examine deficits in practice or communication. The maintenance of security and the self-preservation of staff are clearly a major concern of this initiative. Because the report uses the terms ‘violence’ and ‘aggression’ interchangeably the incidence of verbal abuse is not able to be clearly identified.

Proposals in the NHSE report that policies on the management of patient aggression and violence should focus on a non-tolerance philosophy and that they should be implemented by 2000 were unrealistic and, as such have been poorly adhered to. It was not advocated that these policies be based on an evaluation of existing provision or local problems, nor were concerns over funding, overstretched resources, staff sickness or poor nurse retention satisfactorily addressed.

The UKCC consultation document appeared to be the most comprehensive in that it attempted to address the multidimensional nature of the problem and the

**REFERENCES**


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response, but the subsequent report is somewhat disappointing. A major flaw once again is the lack of a structured evaluation of approaches used in current practice to manage patient aggression and violence, despite recommendations to do so. ‘Given the absence of high quality studies, we believe that the DoH should commission quality research into the safety, effectiveness and professional acceptability of de-escalation techniques, seclusion, physical restraint and other methods of managing violent incidents. Evidence derived from these studies should directly inform training and practice. Given the absence of current definitive evidence, we offer templates for policy and training and recommend, more generally, the widespread adoption of the guidelines of the Royal College of Psychiatrists’ (Wright et al, 2002, p10).

The report by Wright et al (2002) raises a number of points that it fails to address. While the gist of the recommendations is to evaluate present practices to inform policy and training, there are no suggestions as to how this might be achieved. The focus continues to be on training as opposed to the logistics and practicalities of evaluation. This appears to result in practices being advocated that perpetuate the use of, and reliance upon, existing and unevaluated approaches, particularly restraint, seclusion and rapid tranquillisation. Furthermore, suggestions are based upon a reactive model that this report in fact criticises and, finally, while advocating the need for a more in-depth sociological analysis of the interplay between issues such as negative interpersonal staff and patient relationships and paternalistic regimes is required, these, it seems, may be a fundamental part of the problem and the real cause of patient aggression and violence in the psychiatric in-patient and the broader health care setting.

**SUMMARY POINTS**

- Explanations for the causes of patient aggression and violence are largely based upon psychological theory
- The multidimensional nature of patient aggression and violence on a variety of practice settings need to be addressed and more integrated perspectives adopted
- The management of aggression and violence in health care is under great scrutiny. Present strategies tend to incorporate traditional methods such as seclusion, restraint and the administration of medication, noticeably in the psychiatric setting
- Policies, national directives and training initiatives perpetuate the use of reactive strategies, are poorly implemented and rarely based upon an evaluation of the complexties of the problem in any specific area
- The need for a more in-depth sociological analysis of the interplay between issues such as negative interpersonal staff and patient relationships and paternalistic regimes is required. These, it seems, may be a fundamental part of the problem and the real cause of patient aggression and violence in the psychiatric in-patient and the broader health care setting.

**Conclusion**

While each of the above initiatives aims to highlight the problems associated with aggression and violence in health care, there are a number of deficits common to them all. First, frequent references are made to violence when in fact the nature of the problem is more commonly associated with aggression. This is one key area that does need some attention given that aggression is reported to be more frequently encountered than violence (Duxbury, 2002). It is argued that definitions of aggression and violence have been, and continue to be, problematic, leading to inconsistencies in both research and practice (Rippon, 2000). This may result in a focus upon physical interventions rather than consideration of alternative means of management. For example, there is a distinct lack of attention given to ineffective nurse-patient interaction. Consequently, there is a lack of direction in fundamental policies and guidance on the essence of mental health nursing or, in fact, on the expanding general nursing role. Second, while each initiative is welcomed in that the extent of the problem within a range of health care arenas is beginning to be acknowledged, there seems to have been little collaboration between professional bodies in formulating guidelines.

Third, all three initiatives are consistent in that they fail to address the contextual and specific problems of each practice area or specialist field based upon strategic and local evaluation. Blanket policies are not the answer and the broad and sometimes inappropriate guidelines often do not address the true nature of the problem, either regionally or, more importantly, locally. Instead, they perpetuate the apparent poor implementation of policies in practice. Furthermore, the proposed guidelines make only limited attempts to address the lack of breadth of training or the need to evaluate it. The structure of many courses on the management of aggressive behaviour partly perpetuates reactivity.

The issue of training is presently under scrutiny, in addition to problems identified with local policies on the management of aggressive and violent patients (Wright et al, 2000). While a de-escalation of aggression is positively and actively encouraged in some initiatives today (Wright et al, 2002), this approach continues to support a reactive philosophy. Communication skills are utilised only when aggression is displayed.

Approaches to managing aggression and violence should not only incorporate an exploration of the true nature, cause and management of patient aggression and violence within specific clinical contexts, but should also take a more in-depth look at broader contributory issues. These include the organisational culture and political climate of the healthcare arena in which nurses and patients communicate and interact. Such an approach will enable the development of training, the formation of a nursing philosophy and policy that is specific to the needs of individual practice areas, and to the practise of the fundamental skills of therapeutic relationships. An impetus for the development of the latter, sadly, appears to be lacking (DoH, 2000).