

Reducing the risk of violence to junior psychiatrists

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As mental health care services move increasingly into the community with staff working in more isolated settings, violence against staff is becoming an increasing health and safety issue. Education and training of staff to cope with potentially violent situations is a priority, equally important is the design and physical layout of the room in which potentially violent patients are seen. This audit looked at the safety features present in consulting rooms used daily, for interviewing patients, by mental health professionals. The study identified rooms which were judged unsuitable for interviewing potentially aggressive patients in, and as a result, several recommendations for safety improvements to these rooms were made.

Violence against staff in the health service is increasing (Schnieden, 1993). Concern over this issue and the absence of national guidelines for employing authorities and staff led to the Health Services Advisory Committee setting up a working party to assess and advise on this problem. The resulting document, *Violence to Staff in the Health Services*, appeared in 1987. This revealed that mental handicap and psychiatric workers are particularly at risk. In one year 25% of junior psychiatrists experience an episode of violence (Health Services Advisory Committee, 1987). One in 200 (0.5%) of those who responded had suffered a serious injury requiring medical assistance during the previous 12 months; 11% had suffered a serious injury requiring first aid; 4.6% had been threatened with a weapon and as many as 16% had been threatened verbally. A survey of British junior psychiatrists revealed 35% had been assaulted, but only 17.5% of these assaults had been reported (Kidd & Stark, 1992). Violence is disruptive, impairs organisational effectiveness and is costly in terms of staff morale and efficiency.

One method of analysing the risk of workplace violence is to examine high risk situations in day to day practice. In psychiatry one of these situations is the assessment of acute admissions. Often little is known about

the patient, who may be agitated, aggressive or uncooperative. These often tense assessments are normally undertaken by junior medical staff who may have little experience in assessing the dangerousness of patients or in managing angry and hostile patients. Violence is most likely to occur during the first few days of an admission when patients are not yet stabilised on treatment and are unfamiliar to the staff (McNeil & Binder, 1988).

One important aspect of the assessment that can be controlled, but which is often neglected, is the design of the interview room, which we therefore decided to survey. In the service studied it was the junior doctors' impression that the interview rooms commonly used for assessing disturbed patients were inadequate and placed them at unacceptable risk. The mental health service studied had out-patient and casualty facilities situated in a large city teaching hospital and an in-patient unit situated on a separate site several miles away.

The study

The audit comprised two separate studies.

Study 1

A ten item instrument was designed combining features required of an ideal, i.e. safe, psychiatric interviewing room. The instrument was simply scored using a categorical scale. As no previous research could be found covering this subject, aspects of interview room design listed in standard psychiatric textbooks, together with commonsense ideas, were chosen.

The selected features follow.

- (a) Space: the interview room should have sufficient space for three people to sit comfortably.
- (b) Telephone: a working telephone should be present.

- (c) Seating: at least three comfortable chairs should be present.
- (d) Access: the interview room should be situated close to staff, who could be summoned quickly in an emergency.
- (e) Privacy: the room should be quiet and convey a sense of privacy.
- (f) Observation: there should be a means for observing the room's occupants unobtrusively.
- (g) Layout: the seating should be arranged so that the interviewer could be seated closest to the doors and have an unhindered exit.
- (h) Weapons: there should be no potential weapons present.
- (i) Alarm bell: this should work and be within easy reach of the interviewer.
- (j) Unhindered exit: it should not be possible to lock the door from the inside. Preferably the door should open outwards or be able to be propped open if required.

Study 2

A questionnaire was distributed to medical staff working for the mental health service at the two sites asking them to rate the importance of each feature mentioned above on a three point scale (0=not necessary, 1=desirable, 2=necessary), for three different types of interview:

- (a) interviewing routine out-patients and well in-patients with no history of violence
- (b) assessing new admissions or acute referrals whose past history of aggression is unknown
- (c) assessing agitated patients or patients with a known history of violence.

Findings

Study 1. Room safety assessments

A total of 25 interview rooms were assessed, comprising general hospital out-patients (OP) 8; general hospital accident and emergency (A&E) 3; psychiatric hospital (IP) 14. The rooms at each site were grouped together and a mean score obtained for the presence of each item in the rooms at the three different sites (Table 1).

Table 1. Results of room safety survey

Survey	IP (n=14)	OP (n=8)	A&E (n=3)
Space	9	6	3
Telephone	4	9	3
Seating	9	8	3
Access	5	9	7
Privacy	8	10	7
Observation	4	7	3
Layout	9	4	7
No weapons	6	9	7
Alarm	0	0	10
Exit	4	9	5
Mean	6	7	5

Table 2. Staff questionnaire survey of features desired for interview room safety

Questionnaire	A	B	C
Space	9	10	10
Telephone	8	8	8
Seating	9	9	9
Access	7	9	10
Privacy	9	9	9
Observation	7	9	10
Layout	6	9	10
No weapons	7	9	10
Alarm	6	9	10
Exit	7	10	10
Mean	7	9	10

(A) Interviewing routine out-patients and well in-patients with no history of violence.

(B) Assessing new admissions or acute referrals whose past history of aggression is unknown.

(C) Assessing agitated patients or patients with a known history of violence.

Score: 0 not necessary; 5 desirable; 10 necessary

Study 2. Safety questionnaire:

A questionnaire return rate of 72% was obtained (22 out of 30). All medical staff grades returned the questionnaire in equal proportions. The scores for each item were collected and assigned a score on a scale of 0 to 10. (0 not necessary; 5 desirable; 10 necessary) (Table 2).

Comment

The designed instrument proved easy to administer and provided a rapid assessment of interview room safety, which showed good face and construct validity. It became clear that the out-patient interview rooms were the most suitable in design to interview potentially aggressive patients. However, in practical terms this could not be achieved due to the

lack of nursing staff, the nature of out-patient work, and the closure of the department after 5 p.m. The A&E interview areas scored poorly because of their isolated position from other staff, especially at night (when most psychiatric assessments take place) and when as a matter of economy the A&E treatment area closest to the interview room is closed. Patients are accordingly interviewed in cubicles which are cramped, have inadequate seating and provide little privacy. The junior psychiatrists therefore have to make a decision, prior to seeing the patient, on whether to sacrifice a confidential atmosphere for a safe one. This area was the one in which there was the greatest difference between what the doctors indicated they needed and what they actually had to work with. This is a cause for concern as A&E is where junior psychiatrists are most likely to assess patients who are disturbed and potentially violent. Unfortunately because this is on a separate site to the in-patient unit it is unlikely that any psychiatric trained nurses would be available to assist in the assessment and management of patients and it would not be possible to have access to their notes prior to the assessment. This places every junior psychiatrist in a vulnerable situation and at an increased risk of assault; physical security measures should therefore be at a high level.

The interview rooms in the in-patient units all scored poorly apart from one. The interview rooms in the intensive care unit were particularly unsafe, given that the most disturbed patients are admitted and assessed there. One of the most worrying findings was the frequent presence of potential weapons in many of the interview rooms (40%); these ranged from a pair of scissors to a three foot wooden spiked pole. In the psychiatric unit some of the interview rooms were used as store rooms for wards due to lack of space.

It appeared that little thought had been given to the location and design of interview rooms on the acute admission wards, as many of them were located on the first floor adjacent to the dormitories and isolated from the nursing areas. The one exception was a ward concerned with inner city admissions which had added a new interview room in the day area – this room scored the highest of all on the instrument. This had occurred as an obvious response to the very high number of aggressive and agitated patients on this ward.

In the staff questionnaire survey, unsurprisingly, for the first group (routine out-patients, well in-patients) staff were prepared to accept fewer safety features, and concentrated on those aspects of an interview room conducive to providing a warm, friendly environment. As the perceived dangerousness of the patient group increased, the desirability of having increased safety features was felt to be necessary by all those completing the questionnaire. In particular, it was felt that when agitated patients or those with a known history of violence, were interviewed an interview room should maximise safety with regard to space, access, layout, weapons, alarm and ease of exit.

The two studies together indicated a large disparity between features available in an ideal situation and the actual availability of safe interviewing facilities, confirming the junior doctors' feeling that the interview rooms they used were unsafe in which to interview agitated or potentially aggressive patients.

Conclusion

Violence in psychiatry is a sporadic but disturbing event. Unhappily it is often accepted as part of a junior psychiatrist's lot. We suggest that because violent behaviour is infrequent and difficult to predict, interview room safety and the provision of a safe working environment is often overlooked as an important variable in reducing and managing violent incidents. This study goes some way to providing an instrument for room safety audit which brings these issues to the fore.

Employers should note that there is a statutory duty under section 2 of the Health and Safety at Work Act to identify the nature and extent of risk and to devise measures to ensure a safe workplace.

Recommendations

- (a) We recommend an audit of room safety in all facilities where medical staff may be asked to assess potentially violent or aggressive patients.
- (b) All interview rooms should be located close to staff areas and incorporate the features discussed above, namely alarm buttons, spy holes, etc. and should be regularly checked for potential weapons.
- (c) Violent incidents should be monitored

and logged as recommended by the Royal College of Psychiatrists and the information regularly reviewed and acted upon.

- (d) Sensible precautions should be taken as discussed above to minimise the danger of an assault on staff.

Outcome

This audit was presented at a time when the trust was actively considering how to improve safety for all the staff working in mental health services. The audit showed that a large part of the problem was due to building design and the recommendations of the audit are to be incorporated into the future upgrade plans for the wards. Another measure taken by the trust to improve the safety of staff was to ensure that the paths and car parks around the site were well lit and clear of undergrowth. Personal alarms have been issued as well as training in how to use and respond to them, in addition to training in how to avoid difficult situations and how to handle them if they do occur.

A written policy with the A&E department was agreed and a cubicle that was considered the safest for psychiatric assessment was allocated. Nursing staff would accompany the psychiatrist when interviewing the patient or if the patient was considered of greater risk one of the security officers would be called. Private telephone facilities where telephone conversations would not be overheard by patients were agreed. The discussions leading up to this policy identified the lack of training that A&E staff as well as the security staff had in terms of 'breakaway' and 'control and restraint'. Staff in these departments are now

to receive training from the regional secure training unit in these techniques. Currently the psychiatric registrars are looking into how information concerning patients presenting in casualty can be made available to assist in the assessment of dangerousness.

The Directorate of Psychiatry is now further considering the safety of staff in the community. It is intended that this audit is repeated in a year's time to assess progress in the areas outlined above.

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References

- HEALTH SERVICES ADVISORY COMMITTEE (1987) *Violence to Staff in the Health Services*. London: Health and Safety Commission.
- KIDD, B. & STARK, C. R. (1992) Violence and junior doctors working in psychiatry. *Psychiatric Bulletin*, **16**, 144-145
- MCNEIL, D. E. & BINDER, R. L. (1991) Clinical assessment of the risk of violence among psychiatric in-patients. *American Journal of Psychiatry*, **148**, 1317-1321.
- SCHNIEDEN, V. (1993) Violence against doctors. *British Journal of Hospital Medicine*, **50**, 6-9.

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