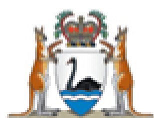

Government of **Western Australia**
Department of **Health**

Principles and Best Practice for the Clinical Care of People with Mental Health Problems Who May Be At Risk of Becoming Violent or Aggressive

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1 Introduction

Regrettably, violence and aggression are not unusual in most mental health care settings. Dealing with these incidents is a major challenge for clinicians, managers, consumers, family or the consumer's personal support person.

Fuller (2015) describes how individuals organise their daily life around their perceptions of how safe the world is, their vulnerability and their self-worth. Physical assault violates these assumptions, resulting in fundamental changes in the way they perceive and interpret the world around them.

Lanctôt & Guay (2014) looked at the literature regarding exposure to workplace violence, including sixty eight studies, and concluded that their review:

….demonstrates that there is a growing body of evidence suggesting that the outcomes of workplace violence are not only profound but multiple.

Violence has a significant impact on the victim, often with long lasting or permanent effects. Consequently, organisations carry liability and struggle to balance obligations to provide a safe environment for consumers and staff while delivering effective care (Lanctôt & Guay, 2014). If protocols and procedures are not in place to proactively guide care before, during and after violent and aggressive incidents occur, staff will inevitably feel isolated, unsupported and perhaps even fearful about going to work. Inexorably, this results in less than optimum care for potentially violent or aggressive individuals, poor experiences for other consumers, possibly discouraging them from engaging in future treatment, and a demoralised workforce.

Mental health services must consider how this impacts on family members or the personal support person who may be victims of the consumer's aggression or violence, have to deal with the aftermath or consequences and may have feelings of responsibility. In a similar way, in care settings, other consumers may be unable to escape and therefore feel vulnerable to violent or aggressive incidents and their consequences.

There is no adequate model to explain the emergence or escalation of violence or aggression in the mental health care setting. In addition to the consumer, features of the environment or system (Cooke & Wozniak, 2010) or staff may have an impact. While the focus is normally on the consumer and to a lesser extent the environment, the effects of emotional reactions by staff on the escalation of aggression is well documented, but often not readily acknowledged (Haugvaldstad & Husum, 2016). Sometimes, staff may regard the consumer as being difficult or disruptive if they perceive them as reluctant to accept professional help or are displaying aggression that staff believe is not a result of mental illness and can be controlled. Staff perception of the aggressive incident can affect their resulting emotions (Drach-Zahavy et al, 2012). This can have a negative impact on the interaction with the consumer and may, in itself, be a contributing factor towards the aggression.

2 Scope

While this document is concerned with eliminating or reducing violent or aggressive incidents using best practice and the most appropriate care, it does not address how violent or aggressive incidents should be managed physically. Other guidelines and protocols will be in place covering this topic and it may be relevant for them to make reference to this document. Also, this document does not discuss suitable medication or details of its application in the clinical care of violent or aggressive people.

It is important to acknowledge the well-established link between suicidality and violence and the significance of assessing suicide risk in any consumer making homicidal threats (Moberg et al, 2014). Therefore, this document should be read in conjunction with the *Clinical Care of People Who May Be Suicidal Policy*.

3 Values

The values underpinning this document are informed by the *WA Chief Psychiatrist's Standards for Clinical Care (2015)*, which promote care that is:

- Recovery-oriented
- Person centred
- Trauma informed
- Culturally competent
- Developmentally appropriate.

3.1 Recovery-oriented care

Recovery-oriented practice supports people in taking responsibility for their own recovery and well-being and pursuing their life goals. In any setting, when clinicians are recognising and responding to a person who may become violent or aggressive, recovery oriented care involves sharing responsibility for safety to the greatest extent possible, creating opportunities for the person to regain their self-control and supporting their autonomy to pursue their life goals.

3.2 Person-centred care

Person-centred care is based on the principles of personhood, individualised care and empowerment. In providing clinical care to people who may become violent or aggressive, it is necessary to consider the whole person within his / her social context, recognising their unique needs, experiences, values and preferences and supporting self-determination in decision making.

3.3 Trauma informed care

Many people who access mental health services have experienced trauma in their lives. Trauma-informed approaches to care assist in creating physical, psychological and emotional safety for individuals who may become violent or aggressive and should also include awareness of the emotional and physical safety of family, staff and other consumers around the person. Using least restrictive practice is one obvious way by which treatment can be delivered in keeping with this care approach.

The clinician should be aware of the significant gender differences in the way that trauma is normally experienced and in the resultant symptoms and responses. While trauma can result from many situations including while receiving health care, for early life experiences, men more often respond by using destructive behaviours whereas women frequently retreat, experience depression and commonly display classic post traumatic distress symptoms. Males tend to use addictive behaviours to distance themselves from relationships; on the other hand, females attempt to use these behaviours to maintain relationships and fill a void by 'self-medicating' the pain of abuse.

3.4 Culturally competent care

Cultural competence enables clinicians to provide care in cross-cultural situations including with Aboriginal people, those from culturally and linguistically diverse backgrounds and people from the lesbian, gay, bisexual, transgender and intersex communities. An awareness of the cultural values and beliefs about health and illness that are held by an individual and their families is an important consideration in the way that care is provided.

3.5 Developmentally appropriate care

The best interest of the child is a primary consideration, and developmentally appropriate care is necessary. This applies in particular to those circumstances where children under the age of eighteen are cared for in adult environments, such as Emergency Departments (EDs) and adult wards.

4 Objectives

This document provides direction on best practice for WA Health Service Providers and thereby aims to enhance the clinical care of consumers who may potentially be violent or aggressive by:

- providing guidance about how clinical care may assist in the reduction, prevention and greater awareness of the likelihood of violent and aggressive acts by mental health consumers against staff and other consumers, family and their personal support person.
- reducing reliance on medication to manage incidents and reduce the use of restrictive practices.

5 Assessment and risk

5.1 Assessment

The most effective strategies to prevent or reduce violence or aggression are founded on a comprehensive evaluation of the person, which can only be achieved by a full psycho-social assessment encompassing historic, cultural and current social and psychiatric factors. The person's current mental state, history of aggression or violence, history of abuse and self-harm, developmental history, triggers and previous response to treatment are all necessary components to enable a psychiatric diagnosis and formulation. Any history concerning relevant medical or organic issues (for example trauma, drug interaction, sepsis or stroke in the elderly) should be investigated and eliminated, especially if the person's behaviour has been out of character. A physical and / or neurological examination should be conducted where relevant and an appropriate specialist should be consulted.

The clinician should demonstrate genuine empathy and try to understand as much as possible about the individual as a person, not just as a consumer, and consider how they (the clinician) would feel or react if they were in the person's place. This has to be a dynamic process of collaboration with the consumer and family or personal support person which acknowledges past experience, taking any advance directives into account when they exist. The clinician should gain an understanding of the usual context of violence or aggression for the individual, which includes their input about their feelings and behaviours when acting aggressively or violently. It is important to try to ascertain early in the process, what the consumer actually wants and expects and to also be aware of any social, family or legal difficulties. Medical issues, especially pain and discomfort, should be addressed promptly.

Seeking the consumer's opinion about what risk exists and what may reduce it can be of value as a way to involve the consumer in their own care, as a means to discover their understanding of the situation and also to encourage them to consider precursors and the outcomes of aggression or violence.

> *Encouraging clients to assess their own risk and protective factors, for example by means of semi-structured interview, gives them the opportunity to share their own perspective on the presence of each domain. This enhances client insight into the importance of specific factors, but often also brings forth previously undiscussed issues and opportunities.* (de Vries Robbé & Willis, 2017).

5.2 Risk

In providing care where there is risk of violence or aggression, inevitably there has to be a balance between the safety of the family, personal support person, mental health staff and other consumers, and the treatment and freedom of the individual receiving care. While safety is the primary consideration, it is important that care is provided using least restrictive practice. An overestimation of risk may result in unnecessary constraints on the consumer and costly interventions (Miller, 2006).

A report, *Rethinking Risk to Others in Mental Health Services* (2008), produced by a scoping group set up by the Royal College of Psychiatrists, noted as a key finding that a culture preoccupied with risk to others had emerged in the UK and that:

This concern with risk, instead of stimulating better and safer practice, appears to have had a negative impact on mental health professionals, professional practice, service users and the public.

The public and policy-makers have an expectation that accurate assessment of the risk for violence or aggression in mental health consumers should be a core skill for mental health professionals. However, all risk tools currently available have their shortcomings and the clinician should be wary of those that are simply a list of tick-boxes. Some tools are intended to guide assessment rather than just provide a list of factors. For example, the HCR-20 v3 (Historical Clinical Risk Management – 20 items) attempts to improve on simple, scored risk factor checklists for violence and is designed to be used as part of a structured professional judgement process i.e. combining the evidence base for certain risks with the an assessment of the individual. The HCR-20 is used by experienced professionals, normally in forensic settings, and provides a combination of dynamic and historical risk factors. The final risk judgement based on expert decision making which includes the context of past events, leading to a consideration of what measures could improve safety in the future.

Some factors affecting risk will be long term and unlikely to change whereas others will be more fluid and variable. There should be clear differentiation between static, immutable factors (e.g. gender, history of violence) and dynamic factors (e.g. treatment compliance, psychosocial stress), which may be modifiable. Because some aspect of the risk will normally be variable to a greater or lesser degree, risk assessment should therefore be a routine, ongoing process. Risk assessment is an evaluation of danger or threat in the present situation and not a predictor of future events. Assessment should be sensitive to the individual and should not result in unnecessary restrictions where no risk exists and should be performed in accordance with the *Chief Psychiatrist's Standards for Clinical Care; Risk Assessment and Management* (Chief Psychiatrist, 2015).

The Emergency Department is a setting where staff frequently witness violent and aggressive incidents and are regularly required to assess risk. While this can be difficult in a busy environment, it is essential that an objective view is maintained so that the assessment is as accurate and meaningful as possible. A review of restrictive practices conducted by New South Wales Health (2017) found that the culture in some EDs was '*overtly stigmatising and discriminatory towards mental health consumers'* and that:

… frequently repeated assertions that mental health consumers are dangerous until proven otherwise result in a lowering of the threshold for the use of most-restrictive rather than least-restrictive options.

Risk assessment tools should be treated with caution and should only be one element of a full assessment, particularly those tools that require the grading of risk at one of a number of risk levels, which can often be meaningless when taken to be a predictor of future behaviour (Sigh et al, 2014). Many tools may best serve as an aide memoire for issues that should be considered as part of structured clinical judgement, but they should never be used in isolation to arrive at a simple risk rating that determines the course of action. However, these tools can be of use in determining that some level of risk exists and have value as part of a thorough

clinical assessment. Once risk has been recognised, the emphasis should not be on the attempted prediction of how and when violence or aggression will occur, but rather what can be done to effect its reduction or prevention.

Further to predictive accuracy, there are fundamental problems about the global use of risk assessment tools. For example, Shepherd (2016) has raised questions about the cross-cultural applicability, and hence validity, of some violence risk instruments for Indigenous Australians in forensic mental health decision making. While there have been some recent improvements in this area, further development of these tools is required.

5.3 Recognising potential factors for violence or aggression

Very few mental health consumers exhibit violence or aggression and there is no single clinical picture associated with their occurrence. Symptoms of mental illness are dynamic in nature and fluctuate. Therefore, when investigating the association between mental illness and any violent behaviour it is important to establish whether a person was symptomatic when the violent incident occurred and the type, nature and influence of the symptoms. Cognitive issues like impaired judgement or reasoning ability, lack of insight, a reduced threshold for aggression, impulsivity or unusual affective responses may exist as stable factors to be considered which may occur independent of symptomatic changes. There can sometimes be an unquestioning assumption about a link between mental illness and violence (Langan, 2010).

From a statistical perspective, the best predictor of violence or aggression is a history of the same; however, certain social or environmental factors may have an enormous influence. It should be stressed that the importance of those factors are based on statistical probability and therefore, by definition, will not apply in all cases. It is essential to consider any potential factors with regard to the person's physical and social context as these may be modifiable, which consequently may affect the impact a particular factor may have.

5.3.1 Serious mental illness

- Psychosis alone is a statistically significant factor in the likelihood of violence, particularly where there are issues of threat or control.
- For people experiencing paranoid psychosis, violent acts are more likely to be well planned.
- The presence of hallucinations alone does not increase the risk unless they evoke negative emotions. Command hallucinations are more likely to be obeyed if they are delusion related, associated with familiar voices or suggest personal superiority, potential benefit or self-worth.
- The more systematised the delusion, the more focussed on the target, the more likely violence will occur.
- Delusions related to threat or control (imagined persecution or manipulation) present a risk and the combination of delusion and fear presents a high risk for violence (Coid et al, 2016).

- For schizophrenia, positive symptoms are associated with a greater risk for violence. High negative symptoms, when present on their own, are associated with a reduced risk.
- For mood disorders, psychotic (positive) symptoms increase the risk for violence.
- People experiencing mania tend to be more assaultive when limits are imposed, for example restricting their movement, but they generally commit less serious acts of violence.

5.3.2 Substance abuse

Many commentators have highlighted the dramatic increase in risk for violence or aggression when there are issues of alcohol or drug abuse, which can lower impulse control. In addition, the presence of substance abuse problems can overtake a history of previous violence as the best indicator of future violence.

> *Consumers suffering major mental illness who abuse alcohol are more likely to commit violence; for substance abuse the likelihood increases significantly* (Allnutt et al, 2013).

When substance abuse occurs in combination with personality disorder the risk for violence can be elevated. People with borderline personality disorder may demonstrate risky and impulsive behaviour, exhibit self-directed aggression as a strategy to regulate intense negative feelings (e.g. anger, shame or guilt) and display reactive aggression when they feel threatened, provoked or rejected.

Alcohol and many drugs have a disinhibiting effect and increase the probability that the person may act upon violent impulses; stimulants like cocaine or methamphetamine are especially associated with disinhibition, grandiosity and paranoia and contribute towards violent behaviour.

Despite the increasing number of presentations where both mental health and substance abuse problems are present, often there is a disassociation between the two as far as treatment planning and delivery are concerned. There is a case for improved training and supervision to enable mental health clinicians to better understand and be more closely involved with the treatment and management of substance abuse problems as they relate to mental health issues. Normally, clinicians will routinely deal with consumers having this comorbidity and they should therefore be competent to provide appropriate care without over reliance on specialist clinicians within their service.

5.3.3 Childhood experience

Several researchers have reported a strong association between childhood maltreatment and later violence and victimisation in adulthood for those people who display violence or aggression.

- Childhood antecedents of adult violence are often suffering parental brutality, fire-setting and animal cruelty.

  It is now well established that people with mental disorders are more likely to have been victims of violence and abuse (and / or to have witnessed it as children) than the general population, and that they continue to be at increased risk of being a victim of violence. (Khalifeh et al, 2015).

- The greater the number of different types of early maltreatment the more extensive the violence in adulthood for violent individuals (Coid et al, 2016).

5.3.4 Self-harm

Self-harm has been linked to an increased risk for violence. Sahlin et al conducted a study which demonstrated a link between self-harm and an increased risk for violent offences for both sexes:

> *DSH [deliberate self-harm] could be viewed as an early behavioural marker of difficulties with emotional and behavioural regulation that, independently of co-occurring psychiatric disorders, may increase the risk of committing violent crimes* (Sahlin et al, 2017).

5.3.5 General considerations

- Threats are more likely to be carried out if they are made to someone who is known, are made face-to-face or are introduced late in a controversy rather than in the initial heat of a confrontation.
- Either anger or fear often precede violence and may manifest in behavioural and physiological indicators characteristic to the individual:

  … the behaviours resulting from more persistent personal traits such as threatening language and increased motor activity are better predictors of assault (Angland et al, 2014).

- The cluster of personality traits associated with violence includes: impulsivity, intolerance of frustration or criticism, commitment of repetitive antisocial acts (e.g. driving recklessly); self-centeredness and projection of blame onto others.

5.3.6 Systemic issues

There may be issues around the care delivery system that contribute to the consumer's frustration and hence the likelihood of aggression or violence. For example, hospital admission and discharge procedures that are not consumer centric, long bed waiting times and lack of service provision or capacity would all fall into this category.

Mental health services must regularly review service configuration and provision to determine if they contribute to the risk of consumers becoming violent or aggressive and, if so, develop and monitor strategies to maximise safety.

6 Planning care

As part of the care planning process, three important questions should be addressed:

- What is it that needs to be known about the person?
- What does the person want to happen?
- To what extent are the person's problems solvable at this time?

Known violent or aggressive consumers should have a management plan in place that identifies triggers that may initiate these behaviours together with suitable prevention and de-escalation strategies and the consumer's responsibilities. The plan should be shared (and updated) in a timely way with other departments or agencies where the consumer is likely to present.

In addition to things that may trigger violence or aggression there may be protective factors that diminish the likelihood that they will occur. These should also be considered both in assessing risk and also for inclusion in a personal safety plan (see below) to guide the consumer, family and clinician in the future. This plan, focusing on the ability of the individual to positively protect and maintain their own safety, is a preferred approach to the more traditional care plan, which usually details risk, often with no practical strategy to avoid it. Where comorbidity exists there should be an integrated plan.

Miller (2006) advocates the early exploration of possible protective factors as a non-threatening and engaging approach, which leads to the client opening up and provides more information for a comprehensive assessment than in traditional risk-oriented assessments. Also, from a forensic perspective, Rennie & Dolan (2010) maintain that:

> *Recognition of protective factors should be an essential part of risk management and interventions to reduce reoffending.*

6.1 Safety Planning

In planning treatment for suicidal people, Jobes (2016) talks about the value of planning what the person will do to keep safe, rather than addressing what they should not do. Similarly, in planning to avoid violence or aggression, there should be a focus on what positively needs to happen to maintain safety. Where comorbidity exists there should be an integrated plan.

Safety plans support recovery and self-determination and should be developed collaboratively with the consumer, their family or personal support person. The safety plan does not have to be a stand-alone document but can be incorporated as part of the treatment, support and discharge plan outlined in the *Mental Health Act 2014* or as part of a crisis plan in PSOLIS; however, it must be clearly identifiable. Meaningless plans that are vague or unrealistic or are constructed building block fashion from generic paragraphs do not serve any purpose.

The safety plan should be revised and updated at points of significant transitions in care or change / deterioration in clinical state as these represent times of potential increased risk, and it should be re-visited as part of any post-incident review. The consumer, their family and personal support person should be invited to participate in formal, multidisciplinary meetings to develop and review the safety plan. Opportunities should be provided for them to meet, either separately or together, with key clinicians prior to and after the meetings.

The safety plan should:

- recognise the individuality of risk by identifying specific triggers and circumstances that may compromise safety, allowing the safety plan to be used proactively and in a preventative way to avert escalation to aggression or violence.
- describe how responsibility for safety will be shared by specifying agreed actions and roles for the consumer, their family, personal support person and clinician in implementing the safety plan.
- formulate strategies to reduce risk and enhance safety which also:

    - take into account the views of the consumer and their family and their personal support person in identifying which interventions are likely to work
    - link strategies to the consumer's strengths and their recovery / life goals
    - explore distractions that the consumer has identified to reduce the likelihood of violence or aggression
    - enhance the consumer's capacity to keep himself / herself safe
    - empower parents / guardians to safeguard the child / adolescent by being active participants in the safety plan.

- identify the actions to be taken, when and by whom in the event of a crisis.
- identify how the consumer, their family, personal support person and the clinician will regularly monitor the person's safety.
- detail the responsibilities of the clinician for follow up.
- schedule times for regular reviews of the safety plan at times where it is identified that safety arrangements may need to be reviewed and at times that are recognised to be periods of heightened risk.

Risk can never be completely eliminated and positive risk management, which recognises all decisions carry some element of risk, should be integral to the process of safety planning. This approach, which builds on the consumer's strengths and enhances their recovery, is based on a trusting therapeutic relationship and uses least restrictive practice. It involves:

- working alongside the consumer and their family and personal support person, weighing up the potential benefits and harms of possible actions,
- being willing to take a decision that involves an element of risk where the potential benefits outweigh the risks, and
- communicating this decision, together with the rationale, to all involved.

While shared responsibility for safety is a principle that underpins the response to people who may be at risk of becoming violent or aggressive, there will be situations where the consumer lacks the decisional capacity to assess the implications of their actions. In these circumstances, a clinician has a clear duty of care to intervene in the best interests of the individual to support their safety and that of others. Reduced capability for, or outright rejection of, engagement in care should be regarded as a risk factor in its own right, prompting further exploration of strategies to maintain safety.

When agreement regarding decisions in the safety plan cannot be reached with consumers, their families and personal support person, their views are to be acknowledged, decisions discussed with them and continued efforts made to assist the individual's responsibility for their own safety and the safety of others. The differing views and reasons for decisions are to be documented in the clinical record.

The content of the safety plan is to be shared with the consumer, their family and their personal support person. If any aspect is not to be communicated, the reason for this decision is to be documented in the clinical file. On discharge, the safety plan, or the contents, in the form of a discharge plan, should be available promptly and include currently identified risks.

7 Delivering care

Much can be done to reduce the likelihood of violent or aggressive events occurring. Suitable assessment, adequate preparation, clinician self-awareness about how they are delivering care and how they appear to others, awareness of the consumer's current situation, their needs and their expectations, can all contribute towards safer care that is more likely to be effective. The practitioner needs to have organisational ability and be capable of developing strategies that work in practice with the flexibility to adjust them as circumstances dictate.

Sometimes, the possibility of violent or aggressive incidents occurring can be reduced by the clinician paying attention to how they are perceived by the consumer. The approach taken may not only have an effect short term, but may also influence whether a person is likely to engage willingly with services in the future. Clinicians should adopt an engaging, non-confrontational approach, with regular contact giving the consumer feedback, keeping them informed and honouring any promises made about future contact. The clinician should avoid giving opinions on issues and grievances beyond their control.

It is important that the clinician is conscious of their own mood, tolerance level and potential behaviour in difficult situations (and considers non-verbal cues they may be conveying, like voice tone and pitch). An aggressive posture and sustained eye contact are to be avoided. If an honest self-appraisal suggests problems, it may sometimes be better to withdraw and hand over to someone else. The clinician should be aware of their own attitude, how engaged they are with the person and any countertransference emotions. They should present as non-judgemental and have considered (and ideally reconciled) any barriers that may impede an open minded approach. Being constantly alert to both verbal and non-verbal cues from the consumer will help to maintain an appropriate response. There should be a focus on the behaviours, not the personal characteristics of the individual.

Keeping the consumer informed about their current situation and what to expect, for example the anticipated course of their treatment, ward routines, who each staff member is, waiting times, when they will be seen by a clinician again or how to initiate contact, all make a tremendous difference to how the consumer perceives the care being provided, and often how they are likely to respond to it. As part of involving the consumer in planning their care, reviewing violent or aggressive incidents with them can assist in future prevention. During interactions with the consumer the clinician should:

- be frank and open and continuously consider the question '*what do we need to know about this person*?'
- encourage discussion about any issues sooner rather than later
- practice active listening and ask meaningful, relevant, open questions while encouraging responses and remaining alert to verbal and non-verbal cues
- be aware that revealing some information may indirectly affect family or a personal support person
- be aware of any deterioration in the consumer's mental state and also treat unexpected improvement with caution:

> *Many mentally ill individuals who become violent toward others, like many suicidal patients, do so when they appear to be resolving their acute illness and are discharged prematurely, in retrospect* (Freedman et al, 2007).

Several papers have identified insufficient communication by mental health staff as a common problem (e.g. Angland et al, 2014) and a study by Ilkiw-Lavalle & Grenyer (2005) revealed disparity in the perceived quality of communication between consumers and staff where significantly fewer staff than consumers thought communication was a problem. Clinicians should ensure that their communications with consumers are clear and that there is a common understanding of what is being said by each party.

The consumer's perspective should be sought on how they came to be in their present situation and what they hope (or fear) may happen now. Also, the knowledge and experience of family members and the personal support person should not be overlooked. The clinician should make a conscious effort to understand the person's culture and values and consider how these may affect their behaviour, reaction or response to treatment. While an empathic non-confrontational approach should be used, boundaries should be set where necessary.

In a study where forensic inpatients provided their experiences of limit setting:

> *An empathic interpersonal style was considered to be important when setting limits; this involves listening and finding out what is happening for the patient and causing them to be acting in a way that is problematic. An authoritative approach (fair, respectful, consistent, and knowledgeable) was experienced positively by patients and was found to enhance cooperation* (Maguire et al, 2014).

Non-clinical administrative or support staff should also be provided with adequate training, support and periodic debriefing concerning engagement with consumers,

which should address topics such as showing respect, recognition of warning signs, de-escalation techniques and common countertransference emotions. Poor interactions with administrative or support staff can have negative consequences for subsequent clinician contact or damage previous work by the clinician to establish a good relationship.

7.1 Recognising the consumer's needs as a person

The clinician should take a person centred approach based on care, compassion, collaboration and respect to empower the consumer by offering choice wherever possible. For example, when someone is held on a secure ward, giving them the opportunity to have short, accompanied leave almost immediately (wherever possible) with the prospect of returning to an open ward within a few days if all goes well, can be a practical demonstration of empathy for the person's needs and can help build trust and respect.

There may also be opportunities to have a positive influence on behaviour where aggression or violence has been a learned and reinforced coping strategy compensating for poor interpersonal skills or social abilities. McGuire et al conducted a meta-analytic review of structured programmes for adolescents and adults who demonstrated repeated aggression or had been convicted of personal violence:

> *Emotional self-management, interpersonal skills, social problem solving and allied training approaches show mainly positive effects with a reasonably high degree of reliability* (McGuire et al, 2008).

The practitioner should recognise how each service user's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression). Clinicians should try to anticipate the impact of the regulatory process on the consumer, for example, being formally detained, having leave refused, having an appeal fail or being in a very restricted environment and not being allowed to leave the building. Clinicians should also consider any personal factors occurring externally, for example, family disputes or financial difficulties that may affect a service user's behaviour (NICE, 2015).

7.2 Family and personal support person

The family or personal support person can be at high risk for suffering the consequences of aggression or violence and, in cases of murder, are commonly the victim. Regular communication with the family and personal support person, ensuring they have a copy of the safety plan and seeking their help where necessary sends the message that their involvement is important. If they have been subjected to violence or aggression, this can also provide a level of support and in return can present unexpected insights or information to inform treatment.

Service users and their personal support person should always be involved in decisions about care whenever possible. Involving family and the personal support person can also provide historic information, for example about domestic violence, which may lead to an opportunity to provide education or support:

> *We do not do enough to educate and prepare families and caretakers on how to manage violence* (Freedman et al, 2007).

In addition, being aware of how the family or personal support person are faring can assist the clinician's judgement about respite care (where appropriate) to enable long term on-going care at home to be maintained.

The family and personal support person should be recognised as bringing relevant experience and genuine expertise to the assessment and management of risk. Their input should never be ignored. However, because the experienced clinician will routinely be judging the risk for violence, their professional judgement about safety should not be surrendered purely on the wishes of the family, for example to allow the person to return home if there are real issues of concern (Resnik, 2012). If the clinician does not agree then they should make extra efforts to view the situation objectively, seeking advice from senior colleagues if necessary.

8 Service policies, protocols and culture

Features of the environment or the care delivery system can sometimes contribute to people behaving violently or aggressively. A busy ED, for example, may create difficulties for recognising mental health issues or may mean that mental health consumers will not receive appropriate care quickly, which may lead to frustration and anger. A good reference that includes mental health inpatient service environmental and care delivery recommendations has been produced by the Royal College of Psychiatrists (2015).

Where possible, service settings should avoid excessive stimulation and waiting areas should be comfortable. Consumers' views on this are important to gain an understanding of what the environment is like from their perspective. The process by which consumers are seen should not include any unnecessary delays or repetitive requests for information. They should be kept informed if there is likely to be a significant delay before being seen, in which case they should be offered food and something to drink. When violent or aggressive situations escalate, and safety permits, consumers should be engaged separately from other service users to minimise any impact.

The importance of good communication cannot be overstated. Services have responsibility to lay the foundations for effective communication and should:

- create a culture of positive communication
- ensure clinicians are aware how and when information should be shared
- ensure staff are aware what is, and is not, appropriate self-disclosure.

The inpatient care setting should be able to accommodate regularly occurring co-morbidity issues normally encountered in the consumer population, whether this is substance abuse or general physical health problems. Costly disconnects in treatment because consumers have to attend different departments or organisations should be avoided where comparatively minor expenditure on equipment or training would make this unnecessary.

Services should plan for the fact that violent or aggressive incidents will occur and have local policies and guidelines in place to ensure that staff and the environment have been adequately prepared to minimise their likelihood. Much can be done in this regard:

> *There is clear international evidence that high-performing health services require clinical and collaborative leadership and a patient safety culture* (NSW Health, 2017).

Local service policies should address the following:

- A person centred philosophy should prevail within the service. McDonnell (2010) advocates a person-centred approach in managing aggressive behaviour in older adults where dementia may be a factor. Low arousal techniques with someone who is confused or agitated, like distraction by questions about an earlier time in the person's life which is likely to be remembered, can often avert aggression.
- The service should have clear, readily available guidelines in place to advise how the likelihood of aggressive and violent incidents can be minimised or managed, including those incidents between consumers.
- Service management should overtly support staff in dealing with aggressive or violent incidents, both as a general service culture and specifically in post incident support, debriefing and review as a matter of course.
- A multi-disciplinary / team approach should be adopted for all important care decisions. The treating team should determine the important participants in the consumer's care (including stakeholders from external agencies) and ensure that they are always present for clinical reviews or case conferences.
- Service users should be offered appropriate psychological therapies, physical activities, leisure pursuits and groups, and support for communication difficulties.
- The physical environment should be clean, uncluttered and undamaged and should be improved or optimised wherever possible, for example, using unlocked doors, enhancing the décor, simplifying the ward layout and ensuring easy access to outside spaces and privacy.
- Violent or aggressive consumers should not be repeatedly allocated to the same clinicians.
- Service management should reinforce to staff that teasing, bullying, unwanted physical or sexual contact or miscommunication between consumers should be recognised early and dealt with promptly.
- Staff should be trained to recognise risky behaviour and, for inpatient services, have a realistic search and seize policy in place to remove weapons with the cooperation of local police.
- Staffing numbers and the level of staff experience should be adequate to deliver care effectively and safely. Reduced nursing levels, inadequate nursing breaks or shortages of medical staff have a direct effect on consumer care and also an effect on staff wellbeing and morale, which has a secondary impact, further resulting in less than optimum care being delivered. In addition to having safety consequences, these shortcomings

can contribute to consumer frustration and consequentially to hostile reactions.

- Services should prompt clinicians to be constantly aware of what is and is not a safe environment and what action to take, for example by advising clinicians to call for help early and stay at a safe distance until it arrives.
- To minimise the risk for violence and aggression, both the service and the individual clinician have responsibility to adopt a proactive approach to maintain safety. There should be an organisational commitment to safe working and an intolerance of unsafe conditions or practices. Clinicians should maintain continuous awareness and alertness and evaluate people and situations for risk as a routine part of their practice.
- A culture focused on safety should be promoted, for example advising clinicians that late clinic appointments be avoided, especially when the clinician sees the consumer alone.
- An open, non-blaming dialogue between staff and management about service design and practices that limit safety should be encouraged. Services should endorse a culture that questions the effectiveness of the service to minimise risk.
- Safety plans (or that content within other plans) should be discussed at clinical handovers to increase staff awareness about triggers, risks and the best interventions.
- Timely post incident feedback and debriefing should be provided for both consumers and staff and this feedback should be utilised to effect improvements.
- Service managers should be vigilant for the warning signs of staff stress or inability to cope and take action to deal with the situation. Support should be provided promptly but sensitively when this is encountered e.g. use of staff wellness programs.
- Services should have clear guidelines concerning early decision making about sedation (where this may be appropriate); these should address monitoring, awareness of current medical condition and potential adverse effects.

Transfer or transition of care is a crucially important time for effective communication and information sharing. Services should regularly audit the content of General Practitioner discharge letters to ensure details of risk, indicators of relapse and the safety plan are included.

Communication processes should take account of diverse mental health governance structures (e.g. different policies and standards) which can handicap good communication and hence compromise continuity of care. Services should continually seek to improve information sharing between stakeholders by the use of plans and the communication of alerts and collateral risk information. Memoranda of Understanding between mental health services, other agencies and NGOs that promote information sharing, while also highlighting policy and practice differences, can help reduce siloing of information and minimise risk.

It is vital that important information is recorded not just in the clinical record, but also in PSOLIS so that it is available across services (including afterhours), to MHERL (the Mental Health Emergency Response Line) and RuralLink, to mental health staff in EDs, to other regions and, through the Co-Response Team to the Police. Safety plans, management plans and crisis plans can be effective ways of communicating important information.

9 Education and learning

Adequate professional development for staff requires a culture of learning at all levels of the organisation that encourages and supports continuous improvement, attaches importance to research evidence, nurtures reflective practice and critical thinking, values employee contributions and fosters experimenting with new ideas. This should occur in a framework of team and system based organisational learning (Morgan, 2013), strongly supported by senior service management; individual learning alone is not sufficient and is frequently adopted for the wrong reasons i.e. cost rather than efficacy.

Clinicians and service managers should be aware that certain skills are required to assess why and when behaviour is likely to become aggressive or violent and to be able to avoid or defuse situations. Services should actively support clinicians to develop these skills and not expect that staff will have this awareness intuitively. The importance of employing people with the right attitude and values is of paramount importance.

Mental health services, regardless of setting, should proactively put processes and procedures in place to ensure that all clinicians who are likely to encounter violent or aggressive consumers are competent in assessment and clinical management. Training has a role, but only alongside the development of sound clinical skills in daily practice.

Clinical supervision is one component of professional development and support for staff engaged in clinical work. All clinical and managerial staff engaged in clinical work require supervision relevant to their experience and expertise.

> *Services should be providing clinical supervision for all clinicians and in different forms, and should not be restricted to junior or less experienced clinicians* (NSW Health, 2017).

In a stressful situation with consumers, sometimes staff can feel that they have been insulted or their professional judgement has been threatened, and while this may be a normal reflexive reaction, it is essential that it is recognised as such and that an effort is made to react objectively. This ability may not be gained simply by exposure to a number of violent or aggressive incidents, when the person’s immediate physiological response, or fight-or-flight reaction, may easily mask cognitive resources. Staff should be provided with regular, practical training using typically difficult scenarios where they have an opportunity to experience and analyse their own reactions and countertransference feelings and then adaptively rehearse and develop responses. Recognition and management of these feelings should be delivered as an education subject in its own right, not provided as an adjunct to the physical management of violence and aggression.

Trauma informed care and its significance (based upon the consumer's previous experience) in comprehending triggers for aggression and violence should be understood by all clinical staff. This will not be achieved by training alone, it requires mentorship and regular reinforcement. This is an example of where the knowledge and experience of consumers and their personal support person can make a valuable contribution to training.

Service management should seek out, and give credence to, what clinicians believe will improve their practice and work collaboratively with them and support them to achieve that goal.

While much can be learned from looking back at adverse events, including near misses, much can also be learned from good practice. Mental health services should have processes in place to systematically learn both from adverse events and also from situations regarded as exemplars of good care. The appropriateness of the service response should be reviewed and ways examined by which it could have been improved to identify common factors or patterns that may be amenable to practice and service change.

The Centre for Mental Health & Safety (2013) developed a framework to review the care of a clinically important sample of patient suicides and homicides where the risk had been rated as low less than seven days before a fatal event. The key findings were:

- It is feasible to develop a framework with which to assess the quality of the risk assessment process.
- In using this framework, the overall quality of risk assessment and management was unsatisfactory in just over one third of the cases reviewed.
- The essence of good risk assessment and management is that they are individual to the patient.

While this research primarily refers to risk, it also makes recommendations relevant to assessment and management which support the idea that a suitable framework can be effective in guiding best practice and setting practical standards for clinical care in dealing with violence and aggression. Local services should go beyond simple statements about intolerance to violence and aggression and should proactively establish such frameworks to actively guide best practice.

10 Gauging the effectiveness of local processes and practices

Services should identify those initiatives with the greatest potential for impact on frequency and severity of violent and aggressive incidents and monitor their effectiveness as part of quality improvement to self-evaluate what is and is not working in each service setting.

Sources of quantitative data can be utilised as part of the evaluation process, such as physical assaults data. Other examples could include:

- Work health and safety hazard reports
- Results of safety and security audits and vulnerability audits
- Workers compensation data
- Patients not treated or discharged from hospital due to aggressive incidents
- Near miss events and reviews of Root Cause Analysis reports
- First aid records
- Review of duress alarms logs
  (NSW Government, 2015).

Qualitative data could include staff member interviews and / or surveys on staff perceptions about personal safety to ascertain how safe or unsafe they feel. Surveys that explore inpatient consumers' feelings of safety and risk about violence or aggression could provide insight into how the facility is operating.

Quality improvement indicators could include:

- the number and content of patient complaints
- the number of violence vulnerability audits conducted and where they were conducted
- the number of improvements instigated as a result of the audits
- the percentage of incidents that resulted in changes or additions to clinical protocols, staff training / orientation, the environment, incident response protocols or other existing risk control measures
- the percentage of assaults reported to police.

When identifying performance indicators to be used as part of an evaluation process, a balance of qualitative, quantitative, positive and negative performance indicators gives the clearest picture on the effectiveness of local violence prevention and management strategies.

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