ARTICLE

Violence and aggression in psychiatric settings: reporting to the police

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SUMMARY

Violence and aggression are relatively common and serious occurrences in health and social care and rates are higher in mental health settings. Despite the National Health Service's policy of 'zero tolerance' of such behaviour, reporting of violence and aggression against mental health staff remains low. This article considers the nature of violence and aggression against staff in psychiatric settings and the process of involving the police to ensure an effective outcome. It outlines each step, from the initial the multidisciplinary team assessment of the incident and its reporting to the police to the making of witness statements, should the case come to court. It also explains the discretionary role of the police in deciding whether to charge and of the Crown Prosecution Service (CPS) in deciding whether to prosecute. The article stresses that NHS organisations need to provide an effective, streamlined and time-efficient reporting process, as this should reduce levels of patient violence, improve staff's well-being and morale, save costs and make the working environment safer for all.

LEARNING OBJECTIVES

- Raise awareness of the underreporting to the police of incidents of violence and aggression against staff by psychiatric patients and recognise the benefits of reporting such incidents
- Develop a framework for assessment and reporting of such incidents committed to the police and to the Crown Prosecution Service (CPS), in the event of possible or actual criminal proceedings
- Develop an understanding of the role of the healthcare organisation, the police and the CPS when such incidents are reported to the police

DECLARATION OF INTEREST

None.

Violence and aggression is a relatively common and serious occurrence in health and social care settings and most mental health staff are likely to be assaulted by patients at some time. According to National Institute for Health and Care Excellence (NICE) guidelines, between 2013 and 2014 there were 68 683 assaults reported against National Health Service (NHS) staff in England, 69% of these occurring in mental health or learning (intellectual) disability settings. Violence and aggression in mental health settings occurs most frequently in in-patient psychiatric units, and most assaults in acute hospitals take place in emergency departments (NICE 2015). Some staff groups are more at risk than others. One study found that health and social care professionals had at higher risk of being exposed to violence and aggression at the workplace (https://worksmart.org.uk/health-advice/illnesses-and-injuries/violence-and-bullying/violence/which-jobs-carry-highest-risk). It found that nurses and other health professionals are second to the workers in protective service occupations such as police officers, security guards in terms of their likelihood of experiencing violence at work. Non-clinical staff such as front-desk staff and receptionists are also at risk. Experience does help protect from violent episodes, yet it does not preclude the perpetration of violence (Privitera 2005).

Violence towards mental health staff has been receiving national attention in the context of diminishing resources for an underfunded NHS. The NHS has had a 'zero tolerance' attitude towards violence since 1999 and there has been a significant increase in the number of offenders being prosecuted since 2003, when the Counter Fraud and Security Management Service (CFSMS) was set up. At present the NHS Security Management Service (NHS SMS) deals with the security of people and property across the NHS in England.

Violent incidents can have significant negative psychological impact on individuals and can affect general staff morale (Brennan 2000). These incidents are associated with substantial economic costs to the health service (NHS Security Management Service 2010), causing staff absence and hampering the efficiency of psychiatric services. They can also adversely affect other patients in the vicinity and affect public opinion about services

(NICE 2015). Yet reporting of such incidents, especially involving patients with psychiatric disorders, has historically been low (Young 2009).

What is violence and aggression?

One possible factor in poor reporting is the lack of a standardised definition of violence and aggression. A wide range of behaviours, such as verbal abuse, intimidation, physical and verbal threats, damage to property, self-harm and violence towards the self, and various degrees of actual physical harm inflicted on others, can constitute violence and aggression. The European agreement recognises that harassment and violence can be physical, psychological, and/or sexual; be one off incidents or more systematic patterns of behaviour; be amongst colleagues, between superiors and subordinates or by third parties such as patients; range from minor cases of disrespect to more serious acts, including criminal offences (HSE 2007). According to the NICE guidelines, violence and aggression refers to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether they are physically or verbally expressed or the duration of this behaviour and its intention (NICE 2015). Moreover, verbal abuse can be considered as violence if it makes the recipient feel threatened or severely distressed. This includes racial or sexual abuse and verbal harassment.

The law recognises that the experience and perception of threats and violence may differ between individuals. In England and Wales, charges can be brought if the intent of a threat is to cause intimidation and fear of violence. The Health and Safety Executive includes both threats and assaults to staff as violence in the workplace (HSE 2007). In their guidance, physical assaults include assault without injury, assault with minor injury and actual wounding; threats include verbal threats made to or against an individual.

The incidence of violence and aggression in psychiatric settings

In the UK, the National Audit of Violence found that a third of in-patients in psychiatric units had been threatened or made to feel unsafe while in care (Shinkwin 2007). This figure rose to 44% for clinical staff and 72% for nursing staff working in these units. The level of such violence in the UK is high compared with many other countries, and there seems to be a high degree of tolerance among staff, as evidenced by the difference between actual incident levels and reporting levels (Bowers 2011).

Understanding violence and aggression in psychiatric settings

Violence and aggression involves complex behaviour related to clinical as well as psychosocial and behavioural factors (Raja 2005). The nature of the violence and the individual's mental state and capacity to understand the consequences of their actions are important considerations. Challenging behaviour in psychiatric patients can be due to a variety of biopsychosocial determinants. It can encompass a wide range of non-verbal, verbal and physical behaviours that make it difficult to deliver good care safely. It is important to emphasise that even though a relatively small fraction of psychiatric patients are violent, the rates of violence are still high compared with the general population (Inter-university Consortium for Political and Social Research 1994). The high-risk patient subgroups include younger males, substance misusers, patients with psychosis and those who are non-adherent to treatment (Inter-university Consortium for Political and Social Research 1994; Tardiff 1997). In-patient settings can be particularly risky as patients are likely to be very unwell, are often treated against their will and are placed in restricted, tense environments with other unwell people. Precipitants of challenging behaviour can differ in patients who have an acute medical condition, dementia or intellectual disability.

Why is it important to report violence?

There are clear advantages in reporting non-trivial assaults to the police (Wilson 2012). This can have benefits for patients, staff, and the wider community and society. Victims of violence by patients suffer many of the same physical and psychological sequelae as victims of street crime (Erdos 2001). Clinical staff have the right to feel safe and be protected in their working environment. This is in the public interest, as it enables them to deliver public healthcare effectively. Patients may also be at risk of violence from fellow patients. They often lack the capacity to report such incidents to the police, or feel too intimidated to do so. Patients have a right to personal safety in psychiatric care settings and the services have a duty to provide this. Failure to safeguard vulnerable patients is a failure of the duty of care and can expose the care provider to criticism and even legal challenges.

However, it is important to understand that prosecution may not be desirable or even feasible in many cases. The main factor to consider in this is whether involving the criminal justice system has clear advantages in the future management of risk. Formal recording of incidents and prosecutions can assist with sentencing and obtaining restriction orders, which in turn can help appropriate diversion

to forensic psychiatric services. This is essential in the management of very high-risk patients who need higher levels of containment. Often the lack of such reporting and prosecution leads to underestimation of risks and lowers the chances of successful referral to forensic care. Prosecution also sends out the message that the safety of mental healthcare professionals is taken seriously by employers and the wider society (Davison 2005).

What are the barriers to reporting violence and aggression?

The proportion of incidents reported to the police tends to be very low in mental health settings, and the proportion actually followed up is even lower. (Young 2009; Antonius 2010). A variety of factors contribute to the underreporting of violent incidents by clinical staff. These include the perception that such incidents are inevitable part of their professional lives and so are simply occupational hazards (Bowers 2011). Lack of awareness of their right to safety at work, lack of awareness and knowledge of institutional procedures and policies regarding handling violence and a culture of poor reporting at all organisational levels can all be contributing factors. Staff may not report incidents if they feel unsupported by the management or they fear criticism for doing so (Spencer 2003). In addition, many agencies lack reporting requirements or subtly discourage reporting because of time constraints and the associated bureaucratic burden (Anderson 2011).

This may be compounded by lack of faith in an adequate response by the police and criminal justice system: the low proportion of criminal sanctions following reporting possibly supports this view. Incidents of offending behaviour by people with psychiatric and intellectual disabilities in healthcare settings should be assessed for potential prosecution against the same Crown Prosecution Service (CPS) criteria, and be dealt with through the criminal justice system in the same way, as similar incidents by any offenders or suspects in the community (National Policing Improvement Agency 2010; Wilson 2012). Yet obtaining prosecution of psychiatric in-patients has historically been very difficult, possibly because of the reluctance on the part of the CPS to view prosecution of such incidents to be in the public interest. However, the CPS code states that any offence committed against a person, especially if serving the public (e.g. social care or healthcare professionals), should be seen to be in the *common* public interest, which should increase the chances of prosecution (Crown Prosecution Service 2013: para. 4.12.c).

Moreover, the police may give such incidents lower priority if the perpetrator is already in a 'place of safety' and is mentally unwell, subject to a section of the Mental Health Act 1983 and in need of ongoing treatment. The police are making efficiency savings that require all reported incidents of violence and aggression, regardless of whether the suspect is mentally ill, to be triaged on the basis of the individual's potential risk to others and loss of evidence. Other systemic factors, such as police officers' own misperceptions regarding prosecution of people with mental disorders, their workload and time constraints are also likely to contribute.

Clinical decision-making concerning reporting of incidents

All non-trivial incidents of violence should be reported to the police: this might include threats, intimidation or actual violence. The nature of the incident, the level and impact of harm caused, and the immediate and future benefits of reporting are all factors that need consideration. Incidents of low-grade aggression can justify reporting to the police if sustained over a period of time; reports should be supported by clear documentation of events. The victim's perception of the threat or harm is central. The detention status or the mental state of the patient should not be a barrier to reporting or giving a statement.

When an act of significant violence or aggression occurs, there needs to be an urgent multidisciplinary team response involving senior managers and clinicians. The victim's safety must be ensured and decisions made about the immediate management of the patient's behaviour to prevent further incidents. Good clinical documentation should be made, describing the incident as well as the views of the victim and the patient. It is paramount that events are not just documented, but that a proper assessment of the nature and cause is carried out using psychodynamic formulations. This can be very valuable not only for future risk management, but also for writing psychiatric court reports in cases of prosecution.

The decision to report an incident to the police should not be left to the victim alone: colleagues and senior managers should also be involved and should support the victim throughout. Teams should make their expectations clear to the police at the point of reporting, i.e. whether they are seeking a caution or an actual charge. It is perfectly justifiable to request a caution, if the team feels that it may act as a deterrent to future offences.

Some patients exhibit recurrent patterns of aggressive behaviour, and repeated cautions fail to have the intended deterrent effect. In such cases behaviour analysis can be helpful and the patient's ability to regulate

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their behaviour should be assessed. For example, significant intellectual disability can make it difficult to learn from experience, and the impulsivity associated with some personality disorders can interfere with behaviour control. Such factors will determine methods of further management, and the decision needs to be taken as to whether a restriction order or even a custodial sentence (rather then repeated cautions) should be recommended. As such patients may pose higher forensic risks, this could facilitate referral to more secure units. However, if someone is already on a restriction order or has an intellectual disability and is unlikely to ever be considered for a custodial sentence, then the CPS may have less interest in pursuing another prosecution.

How to improve the reporting of incidents and influence their outcomes

All psychiatric staff should be trained in reporting violent or aggressive incidents to the police as part of their risk management training. It is important that professionals understand the benefits of this and are trained correctly to do so (Anderson 2011). Staff should be aware of their right to report harassment or violence at work to the police with a view to criminal prosecution or, failing that, civil proceedings. Understanding the roles of the police and the CPS can greatly improve the process. Support for the victim from the higher management of an organisation and a good collaborative working relationship with the local police can increase the chances of getting the desired response. Psychiatric services and the police can increase mutual awareness and knowledge of their roles, which can improve communication between them and improve outcomes.

When an incident is reported, the police should gauge the nature of the offence, taking into account the harm caused and the pattern of offending behaviour (National Policing Improvement Agency 2010). For matters that would only be heard in a magistrates' court, the police have the discretion to decide whether to charge or not; for more serious cases this is a CPS decision. The police reach their decision on the basis of their assessment of whether a crime has been committed and whether the incident requires intervention by the criminal justice system for the protection of the public. Before forwarding a case to the CPS, the police would consider two main factors: the public interest and the evidential threshold. The public interest criterion asks whether prosecution is the most appropriate course of action. For the evidential threshold to be met, it must be more likely than not that both the 'guilty mind' (*mens rea*) and the act itself can be proved. For most crimes it is necessary to show that the suspect intended, or was reckless in, their actions.

According to the CPS code, prosecutors must be satisfied that there is sufficient evidence to provide a realistic prospect of conviction and pursuance of conviction is in the public interest (Crown Prosecution Service 2013: paras 4.4 and 4.7). There is no presumption either in favour of or against the prosecution of a mentally disordered offender. Each case must be considered on its own merits, taking into account all available evidence. A balance is to be struck between the need for diversion and treatment, and prosecution to safeguard the public. Understanding the position of the police and the CPS can improve the clinical team's decision-making and the quality of and confidence in reporting.

Additional aspects of reporting

Providing a statement about the patient's fitness to be detained

If a patient is being arrested, the responsible clinician and treating team may need to provide a statement about the person's fitness to be detained in police custody. Liaising with the custody officer and forensic medical examiner (FME) in more complicated situations can help clarify questions concerning mental state and capacity and identify the appropriate place of safety and any ongoing treatment. Often, issues relating to personality disorder or substance misuse must be taken into account.

The patient's fitness to be interviewed

The police may request information about a patient's fitness to be interviewed. This does not require the patient to have a normal mental state, but they must be able to have a meaningful discussion with the police and to tolerate it without experiencing harm. The patient should have support when interviewed, as it can be a stressful event. This could be provided by the hospital staff, the patient's family or mental health advocates. It is helpful to explain to the patient beforehand why the actions are being taken.

Providing victim and witness statements

The police may request a personal statement from the victim. The victim and any witnesses should have the support of colleagues or staff when giving a statement. This can be an intimidating experience, especially if they are anxious about the consequences of reporting or feel covert pressure from the police or others to press charges. Such pressures are not acceptable and they should be challenged and addressed through close liaison with psychiatric staff. As mentioned above, it is helpful if the individuals and the team are clear about their expectations

MCQ answers
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of subsequent police action, i.e. whether to have the patient removed, cautioned or charged.

The police may also seek reports from the treating team to support referral of a case to the CPS. Although NHS psychiatric services are not bound to provide psychiatric reports to the police, a statement outlining reasons for further action may be helpful to both agencies, especially if prosecution is being sought in the public interest. This is suggested in the National Policing Improvement Agency's latest guidance (2010). Basic information about the patient's diagnosis and treatment should be provided and it is often helpful to have locally agreed templates for such statements. After gathering all this information, the police would decide whether the incident merits further action and whether the case should be forwarded to the CPS.

The Crown Prosecution Service (CPS)

If the case is forwarded to it, the CPS can call the responsible clinician as an expert witness to present a psychiatric report to the court, to aid the court's understanding of the nature and degree of any psychiatric disorder or disability and its potential role in the offending behaviour. This is an opportunity to clarify important factors that may assist the judge in understanding the clinical perspective on the patient and assist the court in passing judgment. In some high-risk cases, a list of any offences on the Police National Computer (PNC) can be requested by staff in psychiatric settings through the police or multi-agency public protection arrangements (MAPPA) if appropriate for risk management, and balancing the rights to confidentiality against clinical need and risk management. The responsible clinician's report can make recommendations in relation to further psychiatric management, diversion from custody and involvement of in-reach services in case of a custodial sentence. Non-forensic psychiatric clinicians called on to provide expert witness reports can greatly benefit from discussing these options with forensic colleagues when the risks are high.

The role of the organisation

Developing a culture of appropriate police reporting is important for any psychiatric service. Building good collaborative working relationships with local police colleagues can improve the process significantly in terms of both outcomes and time spent. The organisation should cooperate with the police and CPS in the event of possible or actual criminal proceedings. Individual staff involved in this process should be provided with administrative support, access to relevant health records, provision of paid time off to prepare for court hearings, to attend court proceedings (if required as an expert witness) and to submit a claim for compensation of time or expenses. Support from the organisation's legal team could be sought in cases where the organisation disagrees with the police or CPS decisions.

Conclusions

Overall, reporting of violence and aggression towards mental health staff remains low and needs to improve to fulfil the NHS's policy of 'zero tolerance' of such behaviour. Consequences of such incidents, if not dealt with adequately, can be devastating, not only in terms of physical injury or psychological trauma to the victim, but also in terms of morale and staff performance, especially if those affected are left feeling isolated and unsupported (Brennan 2000). NHS organisations are responsible for keeping staff safe by identifying and managing risks and by taking action when incidents occur. Their clinical services can work in close partnership with local police services to create a pathway for appropriate reporting of incidents, with clear expectations of the response of the police and the CPS. Good information flow between the agencies based on a trusting working relationship is important. Using the expertise of forensic psychiatric colleagues for guidance should be considered in high-risk cases. Liaison arrangements with local police services and the CPS can also allow for MAPPA to be put in place and potentially lead to reduction in levels of violence in psychiatric settings by making the process of managing violence and aggression more effective and time efficient (National Policing Improvement Agency 2010; Wilson 2012). Its main principles may be relevant to other organisations, such as acute and ambulance trusts, that provide services (e.g. medical care) for people with mental illness. Dialogue and effective working arrangements with the local police service can have a far-reaching impact on reducing staff stress and sickness levels, improving staff morale, reducing associated costs to the NHS and making the working place safer for both patients and staff.

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MCQs

Select the single best option for each question stem.

1 Definition of violence:
- a is standardised
- b only includes actual physical harm
- c can include verbal abuse if it makes the recipient feel threatened or severely distressed
- d at work as described by the Health and Safety Executive does not include verbal threats made to or against the individual
- e includes assault with minor injury and wounding but not assault without injury.

2 Of the following, the statement least likely to be associated with underreporting of violent incidents in mental health settings is:
- a staff perceive that violent incidents are an inevitable part of their work and that mental health professionals should be able to care for themselves
- b staff lack awareness and knowledge of institutional procedures and policies concerning the handling of violence
- c staff may not feel the need to report such incidents as they already feel supported enough by their team and the management
- d time constraints and the bureaucratic burden of reporting can discourage reporting
- e staff are worried that reporting will damage the therapeutic relationship.

3 In reporting an incident to the police so that they can decide whether to proceed with criminal proceedings, the report needs to include all except:
- a the nature of the offence
- b the level of harm caused to victim
- c whether the offence is part of a series or pattern of offending behaviour
- d the potential for future similar risk
- e the detention status of the patient.

4 Of the following professionals, the group most likely to experience violence and aggression from patients is:
- a nurses
- b consultants
- c trainee doctors
- d healthcare assistants
- e administrative staff.

5 In deciding whether or not to charge, the police take into consideration all of the following except:
- a evidence of whether a crime has been committed
- b whether the incident requires intervention by the criminal justice system for the protection of the public
- c whether an impaired mental state affected the individual's criminal responsibility – i.e. the ability to understand the consequences of their alleged offending behaviour and determine right from wrong
- d whether there is a realistic prospect of conviction
- e the detention status of the patient.