Anti-bullying policy in child and adolescent psychiatric units

Stephanie Sommers and Lucia Whitney

Bullying is a common problem. There has been much written on the subject, mainly relating to schools. In this study a questionnaire was sent to 66 child and adolescent psychiatric units in the UK, 50 (75%) were returned. The units were surveyed on frequency of bullying, whether an anti-bullying policy was in place and whether difficulties had been encountered setting up the policy. An anti-bullying policy was present in only 10% of units. Further research is needed on bullying and appropriate and effective methods of dealing with it on child and adolescent psychiatric units.

Bullying is a problem not uncommonly experienced by children. Whitney & Smith (1993) found that approximately 10% of middle school children were bullied weekly, with about half of that number being bullies. The sequelae of bullying may be short and long term. Parker & Asher (1987) found peer rejection in childhood a strong predictor of difficulties later in adulthood. In addition, adults who were bullied may be vulnerable to anxiety, depression and loneliness (Olweus, 1993). Bullying has been reported as precipitating deliberate self-harm in children (Kennedy, 1995, personal communication) and a small number of suicides which have been widely reported in the national media. Later in their lives bullies have a higher rate of problem behaviours such as criminality and alcohol abuse (Olweus, 1993).

Anecdotal evidence would suggest child and adolescent units are not exempt from bullying. The serious consequences for both victim and bully make it vital that such units have an effective way of dealing with incidents of bullying and provide an atmosphere in which it is not tolerated.

In spring 1996, The Thorneywood Child and Adolescent In-patient Unit in Nottingham began to set up an anti-bullying policy. A literature search revealed a substantial body of papers on bullying and anti-bullying policies in schools and some papers examining bullying in institutions and residential care. However, there was a lack of literature relating to child and adolescent psychiatric units.

We decided to survey units across Great Britain to establish whether anti-bullying policies were felt to be necessary and the proportion of units with a policy in place. Another aim of the survey was to learn from the experiences of different units, particularly looking at difficulties encountered and how these were resolved.

The study

A questionnaire was posted to 66 child and adolescent psychiatric units in Great Britain, followed by a reminder.

The questionnaire comprised three sets of questions:

(a) The first set asked the age and residential status of patients and whether an anti-bullying policy was in place. The perceived prevalence of bullying was measured on a scale of bullying occurring never, rarely, sometimes or often.

(b) The second section was answered by those who did not have a policy. It explored whether a policy was felt to be necessary. If they were developing a policy they were questioned regarding any difficulties experienced.

(c) Finally, if a policy was in place, the third section enquired about its development, implementation and evaluation.

Findings

We received 50 replies, a response rate of 75%. Of these, eight were not included in our analysis as the units had either closed or were functioning solely as an out-patient facility.

The majority of the units (65%) catered for children aged 12 or over, 17% dealt with the under 12s. Residential units accounted for 25%, day units for 17%, with the remaining 58% being a mixture of both.

In only 10% of units was an anti-bullying policy in place, while 71% of units had a policy on standards of behaviour. Regarding the perceived frequency of bullying one unit thought that bullying never took place on the unit, 37% of units reported bullying as occurring rarely, 56% as sometimes and 5% stated bullying happened

https://doi.org/10.1192/pb.22.9.557 Published online by Cambridge University Press

often. There was no correlation between residential status and frequency of bullying, or between the age of the children and frequency of bullying.

Of those units which did not have an anti-bullying policy, 27% thought a policy was necessary with 70% of these planning one. That is 18% of all the units without a policy were planning one. None of the units with a policy reported that bullying occurred never or rarely in comparison to 43% of units without a policy. In units without a policy where bullying occurred sometimes or often, 38% felt a policy was necessary.

Comment

An anti-bullying policy was present in a small number (10%) of units, however a larger number of units (71%) had a standards of behaviour policy. A considerable group of units did not feel that an anti-bullying policy was necessary or helpful. They believed bullying was best dealt with by a policy on standards of behaviour, community meetings and individual nursing care plans. One unit remarked, "Bullying is part of maladaptive behaviour and should not be addressed separately".

Successful interventions in schools involved the use of specific anti-bullying policies which have been multi-level in nature (Olweus, 1993; Smith & Sharp, 1994). Research in Canada by Pepler *et al* (1993) looking at the effectiveness of an intervention programme which had developed comprehensive behaviour policies but not specific anti-bullying policies, found only a small change in the amount of bullying.

Regarding the relationship between perceived frequency of bullying and the use of anti-bullying policies several trends emerged. Units with an anti-bullying policy reported higher perceived frequencies of bullying. In units without a policy, 28% thought one was necessary, however, if the unit reported bullying as occurring often or sometimes this figure rose to 38%. The reason for this is not clear, there being several possible explanations:

(d) It may reflect true differences in the amount of bullying occurring within units, and those with a high level of bullying developing an anti-bullying policy as a priority.

(e) It may indicate differing levels of recognition of the problem. In units where preventing bullying was a topical issue staff awareness of incidents may have been raised.

(f) These results may also suggest that units with the highest levels of bullying have implemented policies but they may be ineffective and so bullying has not significantly decreased.

There has been much research into development, implementation and evaluation of anti-bullying policies in schools, but little on the subject relating to child and adolescent psychiatric units. We believe that there can be specific difficulties planning a policy on a psychiatric unit. Development of policies on the units were in all cases multi-disciplinary with approximately 50% involving the children on the unit. Of units currently developing a policy, two had met with such difficulties that at the time of the survey it was not possible to continue, but details were not given.

Some units with anti-bullying policies had found time and finance a difficulty. An identified problem for all the professionals involved was to prioritise the task of developing a policy due to clinical pressures upon them. For a policy to be effective and consistently implemented it is important for all groups to feel they have some ownership of the policy. This may include the need for extra funds to pay staff to attend meetings during their off-duty time.

The nature of the patient group also presents specific problems. One unit found that there was a reluctance to implement the policy as members of staff wished to make allowances for the bullies as 'they had problems too'. It can also pose difficulties when patients are a mix of children with behavioural difficulties and acute psychiatric disorder to implement the policy appropriately. It is important to be seen to be fair while taking into consideration the child's mental state. The high turnover rate of patients on units may cause problems in maintaining the initial impetus and promoting the policy among the children, both of which have been shown necessary for policies to be effective as a major component of them is peer pressure.

The evaluation of an anti-bullying policy has been shown to be essential, but none of the units surveyed appeared to be regularly evaluating their policy. This may have been due to pressure on time or that the level of bullying on the unit was not objectively established before the implementation of the policy and so evaluation could not effectively be performed.

Discussion

There is a need for research in this area. It is not unreasonable to think that if children are bullied on psychiatric units they will not wish to stay and engage in therapy. Reid (1983) found that a fifth of persistent school absentees gave bullying as a reason for continued absence. It is unclear whether the research findings in schools can be extrapolated to psychiatric units, if they can,

https://doi.org/10.1192/pb.22.9.557 Published online by Cambridge University Press

however, this has important implications for our practice. In our opinion the following are of particular importance:

(a) Basic information such as the baseline frequency of bullying on psychiatric units and the proportion of incidents of which staff are aware are not known. It may be levels are higher than in schools due to the characteristics of the children who are admitted, or lower due to the unit's philosophy or skill of the staff.
(b) Studies in schools have shown single level interventions and behavioural policies are not in themselves sufficient to address bullying. Research is needed to establish whether on psychiatric units an anti-bullying policy is necessary or whether a standards of behaviour policy and individual nursing care plans are sufficient to significantly decrease the level of bullying.
(c) If anti-bullying policies are needed it will be necessary to adapt current guidelines on how to develop, implement and evaluate an anti-bullying policy as these are all aimed at the school environment and do not take into account the specific problems associated with psychiatric units.

Acknowledgements

We thank John Pearce, Professor of Child and Adolescent Psychiatry, Academic Department, Queens Medical Centre, and Paul Cawthron, Consultant Child and Adolescent Psychiatrist, Thorneywood Adolescent Unit, Nottingham.

References

OLWEUS, D. (1993) *Bullying at School*. Oxford: Blackwell.
PARKER, J. G. & ASHER, S. R. (1987) Peer relations and later personal adjustment: are low-accepted children at risk? *Psychology Bulletin*, **102**, 357–389.
PEPLER, D., CRAIG, W., ZEIGLER, S., *et al* (1993) A school-based anti-bullying intervention: preliminary evaluation. In *Understanding and Managing Bullying* (ed. D. Tattum). Oxford: Heinemann Educational.
REID, K. (1983) Retrospection and persistent school absenteeism. *Educational Research*, **25**, 110–115.
SMITH, P. K. & SHARP, S. (1994) *School Bullying: Insights and Perspectives*, London: Routledge.
WHITNEY, I. & SMITH, P. K. (1993) A survey of the nature and extent of bullying in junior/middle and secondary schools. *Educational Research*, **35**, 3–25.

Stephanie Sommers, *Registrar in Psychiatry, Nottingham Healthcare NHS Trust, and* *Lucia Whitney, *Consultant Child and Adolescent Psychiatrist, Rivermead, Belper, Derby DE56 1UU*

*Correspondence

Attendees at a primary care-based mental health promotion drop-in clinic

Social and clinical characteristics and outcomes

Chris Gilleard and Ros Lobo

This paper describes the social and clinical characteristics of patients who attended a mental health promotion drop-in clinic that was set up in a primary care group practice. From consideration of the characteristics of the patients, the problems they presented with and the results of the consultations, we argue that there is a viable role for mental health promotion as a form of primary prevention of mental health problems, distinct from an extended treatment or therapeutic role. It is open to question whether the particular way we delivered the service is necessary to achieve such an objective and we draw attention to some of the constructive criticisms the primary health care team made at the final evaluation of the project.

https://doi.org/10.1192/pb.22.9.557 Published online by Cambridge University Press