Violence and Aggression in an Inpatient Psychiatric Hospital

NS 672 - Assignment 3:
Organizational Analysis Project

Gerald Martone RN, MS
March 18, 2015

OVERVIEW:

According to the U.S. Department of Labor's Bureau of Labor Statistics (2013), state-employed Nursing Assistants have one of the highest occupational injury rates in the country. The incidence of on-the-job injuries for Nursing Assistants is surpassed only by diesel engine specialists and steamfitters.

As state employees, Nursing Assistants suffer on-the-job injuries at a rate far exceeding Firefighters, Police Officers, Construction Laborers, and Correctional Officers.

What is perhaps most ironic about the extraordinary prevalence of injuries suffered by Nursing Assistants is that they occur at the very hands of the people they are trying to help.

Across all occupations in the United States, the average rate of on-the-job nonfatal violent crime was 12.6 per 1,000 workers between the years 1993 to 1999. During this same time interval, the annual injury rate for nurses was 21.9 per 1,000 staff. The annual injury rate for various mental health workers in general was 40.7 per 1,000 employees. Most alarming however was the incidence of violent crime against psychiatric health custodial staff – 69.0 per 1,000 workers – nearly five times higher than the national average (U.S. Department of Labor, 2004).

The U.S. Department of Labor (2004) further qualifies these striking statistics by noting:

> "*As significant as these numbers are the actual number of incidents is probably much higher. Incidents of violence are likely to be underreported, perhaps due in part to the persistent perception within the health care industry that assaults are part of the job*."

According to the U.S. Department of Labor and the Occupational Safety & Health Administration (2013), one of the most hazardous places to work in the United States is in a hospital. Direct care providers in hospitals suffer injury rates much higher than construction workers and manufacturing laborers.

> "*injury rates to nursing staff in public sector psychiatric facilities from violence alone are twice as high as injury rates from all causes reported in traditionally high risk industries.*" (Love & Morrison, 2003)

As far back as 1994, the U.S. Department of Labor reported that more assaults occurred among the health care and social service sector than any other industry including Law Enforcement (1994).

In an updated follow-up report, the Centers for Disease Control and Prevention reported in Morbidity and Mortality Weekly Report (2015):

> "*Between 2012 and 2014, workplace violence injury rates increased for all job classifications and nearly doubled for nurse assistants and nurses.*"

On acute inpatient psychiatric units, a nurse has a one-in-ten chance of being injured by an aggressive patient each year (Foster, Bowers, Nijman, 2007).

> *"Currently, there appears to be a trend of increasing violence in state hospital settings, including both civilly and forensically committed populations. In fact, physical aggression is the primary reason for admission to many state hospitals."* (Warburton, 2014)

In an effort to respect the privacy of patients, hospitals are shrouded in a veil of secrecy. An information-quarantine prevents public awareness of the epidemic of aggression against direct care providers that occurs inside. In any other industry unconstrained by an ethos of confidentiality, this density of workplace violence would rise to the level of a public scandal.

In Alaska, the state's inpatient behavioral health facility, Alaska Psychiatric Institute (API), is experiencing a particularly arrant spike in violent injuries to its nursing staff. At any point in time, there at least a couple of staff that are unable to work due to injuries sustained by assaultive patients.

At the time of this writing, for example, there are twelve nursing staff at API that are out of work due to a variety of injuries; one staff member is permanently disabled with a traumatic brain injury and a cervical spine fracture, three others are on permanent disability and unable to work, another staff person has permanent damage to her eye, two staff members are currently awaiting spinal surgery, and five others are recovering from orthopedic injuries – all sustained while caring for assaultive patients.

The nursing staff at API are routinely assaulted – punched, kicked, bitten, scratched, and spit on. This is a common occurrence. On a regular basis nursing staff also experience verbal threats, derogatory remarks, racial slurs, and unwanted sexual comments.

Threats of violence and verbal aggression against nursing staff can have a cumulative impact that can be as damaging as physical assaults (Arnetz & Arnetz, 2001). According to Bowers et al (2009), violence against nursing staff contribute to low morale, high staff turnover, high incidence of sick calls, and high number of vacancies. This further perpetuates staffing shortages leading to unsafe conditions and a hazardous working environment.

The nursing staff at API privately confide their fears with each other (Anonymous (a), 2015). There is a pervasive sense of vulnerability among workers along with vivid memories of fellow colleagues that have been severely injured or disabled (Anonymous, 2014). According to an internal report prepared for the Alaska Department of Health and Social Services' Division of Behavioral Health (Dvoskin, 2014):

> *"many members of the staff, especially Psychiatric Nursing Assistants (PNA's), report feeling vulnerable to patient violence."*

Some staff report being haunted by nightmares, flashbacks, and intrusive recollections of their own encounters with violent patients (Anonymous, 2015) (Anonymous (b), 2015). Feeling traumatized by an aggressive episode is a nearly universal experience among the cadre of API's nursing professionals (Anonymous, 2014) (Anonymous (b), 2015).

As a result of violent attacks by patients in psychiatric hospitals there is an associated rate of post-traumatic stress disorder of 9% among direct care staff (Kidd, 2003). Even when physical injury is not present, long-term

psychological effects – not limited to post-traumatic stress disorder – have been documented in direct care providers in psychiatric hospitals (Caldwell, 1992).

There is an unfortunate misperception among API's nursing team that they are expendable (Anonymous (a), 2015) (Anonymous, 2015). It is regrettable that staff interpret events through a lens of skepticism and futility. The legacy of unchecked and crippling violence against direct care providers at API has led to rumors of indifference and neglect by their Department (Anonymous (a), 2014) (Anonymous (b), 2014).

During the first quarter of 2011, API staff suffered 102 incidents of assaults by patients. The very next quarter API logged 86 assaultive episodes against staff. This was followed by the third quarter with over one hundred assaults by patients against nursing staff (Kaufman & King, 2015). The officially recorded total for that year was 330 episodes averaging almost one assault against a staff member every day of the year.

There is a pervasive phenomenon of underreporting of aggression in inpatient psychiatric settings. Ehmann et al (2002) identified a trend of underestimated violence as high as 45% that is not being captured through formal incident reporting mechanisms.

Many reasons might account for the underreporting of violent encounters including a feeling of failure on the part of a staff member who was unable to contain an aggressive patient. Some staff may somehow feel responsible for an escalation. In addition, a culture of authority and control over patients is a mindset among psychiatric workers. Any deviation from this paradigm can be perceived as weakness or ineptness by coworkers.

> *"Aggressive or violent behavior from patients can cause staff to put their role as caregivers into question, resulting in feelings of guilt or self-doubt"* (Arnetz & Arnetz, 2001).

Formal reporting mechanisms required by hospitals and the onerous documentation standards can feel punitive and reprimanding to a victim of assault. The punishing deluge of paperwork following an assault might account for the fact that "*less than a quarter of the incidents*" of aggression are actually captured (Owen, Tarantello, Jones, et al, 1998):

> *"official data about violence and aggression very likely understate the true incidence, and that staff in some way tolerate a large number of incidents without reporting the details to administration."*

Alaska Psychiatric Institute has the single highest number of Workers' Compensation claims in the state. The on-the-job injury rate at API far exceeds any other occupation or institution in the State of Alaska by a very wide margin (Robbins, 2014). Working as a direct care provider at API is statistically one of the most hazardous occupations in the State of Alaska.

The Occupational Safety and Health Administration (OSHA) of the Alaska Department of Labor and Workforce Development recently investigated the working conditions at API. During the Inspection Dates of 07/08/2014 – 09/12/2014, OSHA determined that API was an unsafe and hazardous working environment.

On December 23, 2014, OSHA issued a number of citations and penalties to API for failing to provide:

> *"a place of employment that are free from recognized hazards that, in the opinion of the commissioner, are causing or likely to cause death or serious physical harm to employees."*

According to Citation 1 Item 1 – Type of Violation: Serious; the OSHA Citation issued a penalty of $4500 to API. The OSHA Citation further states:

"*Employees are exposed to workplace violence injuries such as concussions, fractures, and traumatic brain injuries from patient assaults as a result of the employer's failure to ensure that employees are trained and adequately protected against workplace violence. Alaska Psychiatric Institute (API) failed to take effective measures to prevent assaults to its employees. The facility's workplace violence program was not comprehensive and was ineffective. From January 2014 through June 2014 there were 92 incidents reported through Unusual Occurrence Reports to management which involve workplace violence between employees and patients*."

PROBLEM STATEMENT:

API is the State of Alaska's largest inpatient psychiatric facility. The Joint Commission on Accreditation of Healthcare Organizations has licensed and accredited API to provide acute psychiatric services for up to 80 inpatients. The hospital serves both adolescents and adult patients.

The mission of API is to provide emergency and court-ordered inpatient psychiatric services in a safe environment while arranging post-admission follow-up services and referrals to an appropriate level of care for recovery from mental illness.

The phenomenon of violence and aggression in an inpatient psychiatric setting is not unique to API. There is a substantial base of evidence and empirical studies across the United States, Western Europe, and Asia. There are numerous dimensions to the problem and countless factors have been explored in various investigations. Perspectives ranging from the characteristics of assaultive patients, the attributes and qualities of staff members that have been attacked, and the formal and informal structures of a facility have been described.

This ample evidence base is, however, lacking in practical remedies and actionable recommendations. Causes have been examined, contributing factors have been identified, and descriptions of the unique circumstances have been provided. What is found wanting are practicable solutions.

In order to address workplace violence in psychiatric hospitals, it is important to analyze all dimensions of the problem. At a quick glance, it might appear that an immediate expansion of programming and an increase in staffing might provide a quick remedy. But these enhancements come at a price.

An increase of direct care staff at API would require an increase in the operating budget. This is an unlikely scenario at a time of financial belt-tightening for the State of Alaska. The state government is anticipating a multibillion dollar deficit.

As much as 90 percent of Alaska's General Fund comes from petroleum revenues. Unfortunately both the price of oil and the production of oil have decreased substantially in recent months. The State of Alaska's last fiscal budget was forecasted at a time when the price of oil was $110 per barrel. Oil prices have recently dropped to as low as $50 per barrel at the start of 2015.

Department commissioners have been asked to submit scenarios for a reduction of their operating budgets anywhere from five to eight percent. Out of Alaska's 24,000 state employees, a downsizing of more than 300 positions is expected.

To propose remedies for decreasing violence and aggression at API that have substantial budget implications is unrealistic at this time. By examining all aspects of the problem, it is hoped that meaningful measures can be implemented that do not necessarily incur financial burdens. Increased safety does not necessarily mean increased cost.

The violence equation has several variables and inputs. In an attempt to rally some meaningful conclusions from the vast evidence base on aggression in psychiatric settings, select findings from the relevant research base will be organized under three separate domains; 1) characteristics of the aggressor, 2) characteristics of the victim, and 3) characteristics of the environment.

CHARACTERISTICS OF THE AGGRESSOR:

The vast majority of psychiatric patients are not violent. It is a small minority of people with mental illness who account for a disproportionately high number of incidents. Of aggressive episodes in an inpatient setting, only 6% of psychiatric patients were responsible for 71% of assaults (Barlow, Grenyer, Ilkiw-Lavalle, 2000).

"Most people who are violent are not mentally ill and most people who are mentally ill are not violent".

(Anderson & West, 2011)

From the technical literature it appears that aggressive behavior on the part of people with mental illness is not entirely unpredictable. In fact the best predictor of violence is a past history of violence. Over 90% of aggressive inpatients have a history of assaults towards others (Flannery, Juliano, Cronin, et al, 2006).

"The main clinical finding is that previous violent behavior was significantly associated with the risk of repeated violent episodes." (Grassi, Biancosino, Marmai, et al 2006)

More than 75% of assaultive episodes are perpetrated by patients that have two or more prior incidents of physical aggression (Grassi, Biancosino, Marmai, et al 2006).

Predicting violence on the basis of demographic variables (age, ethnicity, gender) and clinical dimensions (diagnosis, psychopathology) has yielded conflicting data and inconsistent results (El-Badri & Mellsop, 2006).

The research on gender and inpatient violence has revealed some counterintuitive findings. During periods of hospitalization, females can be more aggressive than males (Ehmann, Smith, Yamamoto, et al, 2001). Several studies have identified higher rates of assaultiveness among women than their male peers (Davison, 2005). Men however are more likely to cause injury than their female counterparts.

In addition, women are more likely to be assaulted by women and men are more likely to be assaulted by men (Davison, 2005).

In terms of age, patients identified as being most at risk of being aggressive are under 32 years old. They are often actively psychotic at the time of being violent (Barlow, Grenyer, Ilkiw-Lavalle, 2000). The most frequent form of aggression is physical and the most frequent victims are staff.

No consistent findings have been identified with regards to ethnicity (Davison, 2005) (Whittington & Wykes, 1994).

In assaultive episodes, one of the most commonly identified diagnoses was schizophrenia although comorbid substance abuse disorders are a significant compounding factor (Davison, 2005).

Serper et al (2005) reported that patients with a past history of substance abuse – even though not intoxicated at the time of the assault – committed significantly more aggression than patients with schizophrenia.

Regardless of diagnostic category or corresponding psychopathology, patients were most at risk of being assaultive during the acute phase of their illness (Bowers, Allan, Simpson, et al, 2009).

"Our finding that nearly 70% of the aggressive episodes took place within the first week of admission is consistent with the view that stage or phase of illness, in terms of acuity or remission, is a useful predictor of violence." (El-Badri & Mellsop, 2006)

A similar finding was revealed in three-year prospective study of the characteristics of aggressive behavior in an acute psychiatric ward by Mellesdal (2003):

"Nearly 20% of the aggressive episodes occurred during the first 24 hours of a stay and 54% during the first week."

CHARACTERISTICS OF THE VICTIM:

In order to fully investigate the violence equation, the characteristics of the victim must be included. Although analyzing the casualties of aggression runs the risk of 'blaming the victim', it is important to view violence as a dynamic interaction.

In attempting to discover a 'proneness' to aggression, Whittington & Wykes (1994) found little evidence that certain staff member were more prone to assault than others. There were no consistent demographic traits that could consistently identify violence-prone staff members. In fact, Whittington & Wykes (1994) note that in a psychiatric hospital about 6 to 7% of all staff are assaulted over a 3-month period.

Among the personality traits and communication styles that might predispose a staff member towards an aggressive encounter with a patient, rude and patronizing behavior, inability to listen, and poor communication skills were found to be a liability (Hamrin, Iennaco, Olsen, 2009). In addition, fear of patients, excessive caution, and "patient-avoiding" behavior are contributing factors (Wallis, 1987).

In addition to belittling or condescending attitudes, Davison (2005) noted:

"Certain staff attributes have been reported as increasing the risk of being assaulted, namely rigid, authoritarian and custodial attitudes, and a lack of respect towards patients."

Staff members who demonstrated empathy and authentically relate to patients' suffering experienced fewer aggressive encounters (Harmin, Iennaco, Olsen, 2009). Treating patients with dignity and respect, humility and a calm demeanor, and avoiding power struggles were essential qualities.

In the final report of the internal consultation for API conducted by Dvoskin (2015), the author notes:

"In my opinion, API is significantly, and at times dangerously understaffed. When staffing in inadequate, staff members become fearful of patients; and as a result, they may spend too much time in the nursing station and not nfrontational ways, which would allow them to avoid many of the circumstances in which they end up having to use enough time interacting with their patients. Understaffing also reduces the ability of staff to intervene early in non-co force."

In terms of experience and age of nursing staff, some retrospective studies have identified correlates. Hamrin et al (2009) and Whittington & Wykes (1994) noted that staff members of younger age as well as those with less experience were more at risk for victimization in aggressive inpatient encounters.

Morrison et al (1998) reported that staff satisfaction with the hospital and the culture of their unit was the single most important variable in their perception of violent encounters. In the case of API, this is a particularly relevant

finding as many of the nursing staff experience frustration and resentment towards hospital administration due to the extraordinary amount of mandatory overtime that is imposed:

> *"during the last quarter of 2014, there had been a very frequent use of involuntary overtime, with predictable negative effects upon staff morale, fatigue, irritability, and anger."* (Dvoskin, 2015)

Mandatory overtime at API was meant to be an emergency measure to provide safe staffing during extraordinary circumstances. Regrettably involuntary overtime has become a routine scheme for staffing the hospital. It is an almost daily strategy to compensate for API's critical shortage of direct care personnel breeding resentment as well as fatigue.

For fiscal year 2015 thus far, API had to resort to scheduling over 18,200 hours of overtime just to provide sufficient nursing personnel to maintain its core staffing levels. This overtime was in addition to over 12,965 hours of non-permanent nursing staff during the same 9-month period; July 1, 2014 – March 15, 2015.

CHARACTERISTICS OF THE ENVIRONMENT:

Violence encountered by direct care providers is compounded by the patients' experience of the quality of care. In the Arnetz & Arnetz (2001) investigation of patient-precipitated aggression, the authors state:

> *"The results of this analysis suggest that the violence experienced by health care staff is associated with lower patient ratings of the quality of care."*

Aggression can be self-perpetuating. Negative perception of the ward environment can be conducive to developing violent behavior in patients. Aggressiveness towards staff leads to "patient-avoiding" (Wallis, 1987) and diminished quality of care. Neglect of patients and denial of their needs intensifies their negative experience of hospitalization. This vicious cycle increases threats and violent behavior leading to a feedback loop reinforcing staff anger, resentment, and increased fear of patients (Arnetz & Arnetz, 2001).

> *"Violent behaviors are more likely to occur when patients reside in a poorly structured milieu with undefined rules and excessive unscheduled time."* (Corrigan, Yudofsky, Silver, 1993)

Structured activities can provide patients with important prompts about the expectations of appropriate behavior and normalizing cues for interpersonal demeanor. Corrigan, Yudofsky, and Silver (1993) further note:

> *"The interactional rules and intrinsic rewards available in structured activities result in fewer assaultive episodes and less disorganized behavior."*

Introducing more structure and boundaries decreased violence on inpatient psychiatric units that had been lax on programming and daily routines (Flannery et al, 2006).

In the internal consultation conducted by Dvoskin (2015), the author observes:

> *"In addition, it quickly became evident to me that API does not provide enough hours of active treatment in the day of an average patient at API, resulting in boredom, more disruptive behavior, and less effective treatment."*

At the same time, over-stimulating environments can be provocative and activating. In Corrigan, Yudofsky, and Silver (1993), the authors cite:

"Research has shown that residential units that are visually or aurally over-stimulating may exacerbate psychosis. Thus the treatment setting must be structured by unit rules so that levels of sensory stimulation are moderate to low. To accomplish this goal, televisions, stereos, and musical instruments should be restricted to soundproofed areas."

The culture of many inpatient psychiatric settings tends to emphasize control and the projection of authority as a necessary safeguard against chaos. There is an untested assumption that lax structure, poorly asserted limits, and flexible rules will promote disruption and a milieu prone to conflict. The research findings on this topic are inconsistent.

In a literature review on psychiatric ward rules and the question of rigid enforcement of limits versus flexibility, Alexander and Bowers (2004) conclude:

"Several studies advocated high structure to modify aggression, but an almost equal number concluded that rigid environments engender patient violence. The literature is divided in respect of the pros and cons of high structure, and needs to be more firmly grounded in evidence. This division of opinion means that we cannot establish whether rigid or flexible environments are the best way of managing psychiatric wards."

An important facet of the violence equation is the correlation of coercive measures and staff injuries. The physical act of secluding or manually restraining patients is an intervention fraught with an inclination towards injury. Most injuries in psychiatric hospitals occur while physically restraining patients.

In the experience of API, this has also proven to be the case. During the last two quarters of 2014, almost 91% of staff injuries occurred while restraining patients (King, 2015). It would seem to follow that if there was a reduction in the number of physical restraints, there would be a reduction in the number of staff injuries.

In an effort to reduce coercive measures, an urban psychiatric hospital in San Francisco implemented a hospital-wide working group dedicated to this task (Forster, Cavness, Phelps, 1999). Comparing the 12-month period before the campaign with the following 12-month period after the effort, the hospital reported a reduction in the annual rate of restraints of nearly 14% and a decrease in the duration of restraints by over 54%. This coincided with a reduction in staff injuries of almost 20% during the study period.

In another investigation of measures to decrease the restraining and secluding of psychiatric patients, Donat (2002) observed that a gradual increase in the number of direct care staff resulted in a reduction of coercive interventions. The author reported:

"Over a 2-year period, increases in the number of staff members relative to the number of persons receiving care were significantly related to decreases in reliance on seclusion and mechanical restraint for managing challenging behavior problems."

The relationship between staffing levels and aggressive incidents in psychiatric hospitals is a complex equation. Although the majority of scientific literature supports improved staff to patient ratios as part of a violence reduction effort, there are conflicting findings in some of the research (Lewis Lanza, Kayne, Gulliford, et al, 1997).

One explanation for unchanged aggressiveness during times of ample staffing might be that documentation of incidents is likely to be improved (Bowers et al, 2009). This could represent a reporting bias. Another explanation is correlation rather than causation. In some of the research literature, psychiatric units that were experiencing greater acuity were assigned more staff. The staff-to-patient ratios were adjusted to accommodate the presence of increasingly labile patients. Therefore the causal path was in the opposite direction (Bowers et al, 2009).

Citing Bowers et al (1987) and Owen et al (1998), Hamrin, Iennaco, Olsen, (2009) state:

> *"Examining the relationship of patient and staff ratio to inpatient unit violence, researchers reported that periods of aggression occurred when there were fewer staff members in the milieu, there was an absence of regular staff, or when patients were unfamiliar with staff (temporary staff)."*

In a comparative analysis on a psychiatric intensive care unit, Björkdahl, Heilig, Palmstierna, et al (2007) found a decrease, however slight, in the occurrence of violence-related staff injuries when a higher staff to patient ratio was instituted. What is particularly interesting about their findings is that the amount of violence on the particular unit did not decrease, only the amount of staff that were injured.

The International Journal of Social Psychiatry further corroborated these findings noting that adverse incidents were more likely during time of high regular staff absences (Bowers, Allan, Simpson, et al, 2007) indicating that consistent staffing is critical for violence reduction in inpatient psychiatry.

In the internal consultation for API, Dvoskin (2015) observed:

> *"API is seriously understaffed. This finding is more important that all other findings in this report combined. The shortages are especially serious in regard to direct care staff at all levels, including PNA's, nurses, psychiatrists, and other clinical staff including psychologists and social workers."*

The initial days of a psychiatric admission typically represent a period of higher acuity and increased volatility. If a patient becomes violent, it is more likely to occur during the early phase of their hospitalization. Noting this correlation, Bowers et all (2009) recommend increased staffing ratios during new admissions.

In addition, investigating the relationships between times of day and episodes of assaults can provide guidance for enhancing the workforce and allocating limited personnel. In the graph below (Kaufman & King, 2015), the peaks in violent incidents at API indicate a bi-modal distribution:

For the fiscal year 2014, it appears that late mornings and early evenings experience the highest numbers of assaults. Traditional change-of-shift times do not coincide with these peaks in violence. One might conclude that the staggering of shifts of some workers and/or the use of non-traditional starting times for select staff could result in an overlap of nursing personnel during the most critical times of day without increasing the overall number of staff positions.

One example of this could be the Admissions Screening Office Psychiatric Nursing Assistant (ASO-PNA) or a floating or roving Psychiatric Nursing Assistant. By instituting a non-traditional shift starting at 10:30am until 07:00pm, the peak hours of aggression would be better covered. This would permit some surge capacity for other unexpected needs throughout the hospital during times of greatest demand.

RECOMMENDATIONS:

The ample research findings cited above indicate that violence in an inpatient psychiatric setting is not entirely unpredictable. These are not random events. They are not unexpected, accidental, or erratic.

By capitalizing on the three domains explored above; 1) characteristics of the aggressor, 2) characteristics of the victim, and 3) characteristics of the environment, recommendations can be derived that do not necessarily have substantial budget implications. Rather than demanding more resources, is there a way to reallocate existing resources to attend to the various dimensions of workplace violence at API?

Harmin et al (2009) concluded that knowledge of patient risk factors should assist in the design of a milieu and treatment setting. A revitalized approach and reinvigorated programming schedule can structure a unit with the conditions that have been proven to reduce aggression and violence.

Although an increase in staffing at API is unlikely in the near future, a strategic redeployment, reassignment, or reallocation of existing personnel might be a practical remedy in the short-term.

As described above, a small minority of patients are responsible for the majority of violence. These patients can be most reliably predicted on the basis of prior history of assaults.

Since most violence occurs during the first 24 hours of admission – and even more within the first week of admission – it might seem prudent that API should reinstitute an acute admissions unit.

This rearrangement could be accomplished by designating one of the existing adult units as the acute admissions service. At-risk patients would be preferentially admitted to this acute inpatient ward.

> *"Psychiatric intensive care units have an important role to play in the management of acutely disturbed patients."* (Davison, 2005)

Davison (2005) further notes that:

> *"Geographical restraint essentially involves moving the patient to an environment where they can be more safely managed."*

In a review of interventions to decrease restraint and seclusion (Stewart, Van der Merwe, Bowers, et al (2010), the researchers attributed the adoption of a psychiatric intensive care model in reducing the amount of restraint hours per month in half and a decrease in the number of seclusion hours by an even greater degree. Reductions in the numbers of staff injuries were also reported in this review.

Less demanding, chronic, and non-acute patients at API could remain on the other unit or be admitted directly to this less-acute service. According to Arango, Calcedo Barba, González-Salvador (1999):

> *"Nonviolence seems easier to predict than violence."*

There is currently no stratification of psychiatric acuity at API. Although there are two adult admissions units, there is no differentiation of diagnoses, volatility, or risk of aggressiveness. Both units divide human resources evenly while managing similar portfolios of psychopathology.

By designating one of the units as capable of receiving more acute patients – as well as particularly troublesome new admissions – API can stratify risk.

> *"All mental health services maintain a safe and effective process of treatment and rehabilitation through the stratification of patients according to the risk they present."* (Kennedy, 2002)

Rather than merely concentrating potentially assaultive patients in one place, an acute inpatient service should be organized according to the predictable factors outlined above. By developing a psychiatric intensive care unit based on the wealth of empirical findings and research, an inpatient service would be one of design rather than default.

Capitalizing on the notion of 'security mapping' (Kennedy, 2002), the ample evidence base should be used to assist with designating a predetermined patient acuity, specifically selecting staff, and deliberately structuring the unit's programming.

If a stratification of psychiatric acuity at API were to be contemplated, the core staffing levels of the acute versus a non-acute ward could be reevaluated. In keeping with the constraint of budget neutral interventions, the stratification of acuity might permit the transfer of one or two current core positions from the non-acute ward to the intensive treatment unit.

As cited above, nursing staff that are less experienced in dealing with psychiatric patients – as well as younger in age – have been shown to be more at risk when confronted with aggressive patients. In considering the designation of an acute admissions service at API, the appointment of nursing staff should heed these factors in the voluntary selection and reassignment of the workforce.

To be selected to work on a newly created service should connote distinction. A minimum requirement of relevant psychiatric inpatient experience as well as tenure and seniority at API will confer stature to these appointments. It will also inspire newer staff and encourage retention by a ladder of progressive opportunities.

The research on aggression on psychiatric units identifies the vital importance of a steady and consistent cadre of direct care providers. A reliably constant, stable, and experienced team of nursing professionals can be readily found among API's existing units. They will be a crucial factor in ensuring safety and reducing aggression at the hospital.

The appalling crisis of workplace violence when caring for the mentally ill is endemic in inpatient psychiatry. From the research literature, this appears to be a global phenomenon. The experience at API is not entirely unique nor disproportionate in comparison to other acute psychiatric settings.

It is regrettable that the extraordinary prevalence of workplace injuries in psychiatry is often overlooked or dismissed as an occupational hazard of being a care giver. The prevailing sentiment is that it comes with the job.

The reality of the problem is iterative but not incremental. As one staff member is injured, another recovers or separates. The cumulative impact is never experienced as a culmination. There is no flashpoint. There is no apogee. And there is no outrage.

Like a frog in a slowly boiling pot, we fail to heed the dangerously warming water.

REFERENCES:

Alexander, J, Bowers, L (2004). Acute psychiatric ward rules: a review of the literature. *Journal of Psychiatric and Mental Health Nursing*. 11:623-631

Anderson, A, West, SG (2011). Violence Against Mental Health Professionals: When the Treater Becomes the Victim. *Innovations in Clinical Neuroscience*. 8(3):34-39

Anonymous (a) (personal communication), October, 2014

Anonymous (b) (personal communication), October, 2014

Anonymous (personal communication), December, 2014

Anonymous (personal communication), January, 2015

Anonymous (a) (personal communication), February, 2015

Anonymous (b) (personal communication), February, 2015

Arango, C, Calcedo Barba, A, González-Salvador, T, Calcedo Ordóñez (1999). Violence in Inpatients with Schizophrenia: A Prospective Study. *Schizophrenia Bulletin*. 25(3):493-503

Arnetz, JE, Arnetz, BB (2001). Violence towards health care staff and possible effects on the quality of patient care. *Social Science and Medicine*. 52:417-427

Barlow, K, Grenyer, B, Ilkiw-Lavalle, O (2000). Prevalence and precipitants of aggression in psychiatric inpatient units. *Aust N Z Psychiatry*. Dec;34(6):967-974

Bowers, L, Allan, T, Simpson, A, Jones, J, Van Der Merwe, M (2009). Identifying Key Factors Associated with Aggression on Acute Inpatient Psychiatric Wards. *Issues in Mental Health Nursing*. 30:260-271

Bowers, L, Allan, T, Simpson, A, Nijman, H, Warren, J (2007). Adverse Incidents, Patient Flow and Nursing Workforce Variables on Acute Psychiatric Wards: The Tompkins Acute Ward Study. International Journal of Social Psychiatry.53(1):75-84

Caldwell, MF (1992). Incidence of PTSD among staff victims of patient violence. *Hospital and Community Psychiatry*. 43:838-839

Corrigan, PW, Yudofsky, SC, Silver, JM (1993). Pharmacological and Behavioral Treatments for Aggressive Psychiatric Inpatients. *Hospital and Community Psychiatry*. 44:2:125-133

Davison, SE (2005). The management of violence in general psychiatry. *Advances in Psychiatric Treatment*. 11:362-370

Dvoskin, JA (2015). Unpublished internal consultation for Alaska Department of Health and Social Services, Division of Behavioral Health. March 17, 2015

Donat, DC (2002). Impact of improved staffing on seclusion/restraint reliance in a public psychiatric hospital. *Psychiatric Rehabilitation Journal*. 25(4):413-416

Ehmann, T, Smith GN, Yamamoto, A, McCarthy, N, Ross, D, Au, T, et al (2001). Aggression in treatment resistant psychotic inpatients. *Journal of Nervous and Mental Disorders*. 189:716-721

El-Badri, SM, Mellsop, G (2006). Aggressive behavior in an acute general adult psychiatric unit. *Psychiatric Bulletin*. 30:166-168

Flannery, RB, Juliano, J, Cronin, S, Walker, A (2006). Characteristics of Assaultive Psychiatric Patients: Fifteen-Year Analysis of the Assaulted Staff Action Program (ASAP). *Psychiatric Quarterly*. 77:239-249

Forster, PL, Cavness, C, Phelps, MA (1999). Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. *Archives of Psychiatric Nursing*. 13(5):269-271

Foster, C, Bowers, L, Nijman, H (2007). Aggressive behavior on acute psychiatric wards: prevalence, severity and management. *Journal of Advanced Nursing*. 58: 140-149

Gomaa, AD, Tapp, LC, Luckhaupt, SE, Vanoli, K, Sarmiento, RF, Raudabaugh, WM, Nowlini, S, Sprigg, SM (2015). Occupational Traumatic Injuries Among Workers in Health Care Facilities – United States, 2012-2014. *Morbidity and Mortality Weekly Report*. 64(15);405-410

Grassi, L, Biancosino, B, Marmai, L, Kotrotsiou, V, Zanchi, P, Peron, L, Marangoni, C, Vanni, A, Barbui, C (2006). Violence in psychiatric units. *Social Psychiatry and Psychiatric Epidemiology*. 41:698-703

Hamrin, V, Iennaco, J, Olsen, D (2009). A Review of Ecological Factors Affecting Inpatient Psychiatric Unit Violence: Implications for Relational and Unit Cultural Improvements. *Issues in Mental Health Nursing*. 30:14-226

Kaufman, P, King, E (2015). Personal Communication. February, 2015

Kennedy, HG (2002). Therapeutic uses of security: mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment*. 8:433-443

Kidd, B (2003). The psychiatrist's response to imminent violence. *Psychiatric Bulletin*. 27: 283-284

King, E (2015). Personal Communication. March 31, 2015

Lewis Lanza, M, Kayne, LH, Gulliford, D, Hicks, C, Islam, S (1997). Staffing of Inpatient Psychiatric Units and Assault by Patients. *Journal of the American Psychiatric Nurses Association*. 3;2:42-48

Love, CC, Morrison, E, AAN Expert Panel on Violence (2003). American Academy of Nursing Expert Panel on Violence Policy Recommendations on Workplace Violence. *Issues in Mental Health Nursing*. 24:599-604

Mellesdal, L (2003). Aggression on a psychiatric acute ward: a three-year prospective study. *Psychological Reports*. June;92:1229-1248

Morrison, E, Morman, G, Bonner, G, Taylor, C, Abraham, I, Lathan, L (2002). Reducing staff injuries and violence in a forensic psychiatric setting. *Archives of Psychiatric Nursing*. 16:108-117

Owen, C, Tarantello, C, Jones, M, Tennant, C (1998). Violence and Aggression in Psychiatric Units. Psychiatric Services. 49;11:1456

Björkdahl, A, Heilig, M, Palmstierna, T, Hansebo, G (2007). Changes in the Occurrences of Coercive Interventions and Staff Injuries on a Psychiatric Intensive Care Unit. *Archives of Psychiatric Nursing*. 21(5):270-277

Robbins, M. Personal Communication. 2014

Serper, MR, Goldberg, BR, Herman, KG, Richarme, D, Chou, J, Dill, CA, Cancro, R (2005). Predictors of aggression on the psychiatric inpatient service. *Comprehensive Psychiatry*. 46:121-127

Stewart, D, Van der Merwe, M, Bowers, L, Simpson, A, Jones, J (2010). A Review of Interventions to Reduce Mechanical Restraint and Seclusion among Adult Psychiatric Inpatients. *Issues in Mental Health Nursing*. 31:413-424

U.S. Department of Labor (2013). Bureau of Labor Statistics. Economic News Release. Table 4: *Number, incidence rate, and median days away from work for non-fatal occupational injuries and illnesses involving days away from work by selected worker occupation and ownership*:

http://www.bls.gov/news.release/osh2.t04.htm

U.S. Department of Labor (2013). Occupational Safety & Health Administration. *Caring for Our Caregivers: Facts About Hospital Worker Safety*:

https://www.osha.gov/dsg/hospitals/documents/1.2_Factbook_508.pdf

U.S. Department of Labor (2004). Occupational Safety & Health Administration. *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers*. OSHA 3148-01R 2004: www.osha.gov

U.S. Department of Labor (1994). Violence in the workplace comes under closer scrutiny. Bureau of Labor Statistics. *Issues in Labor Statistics*. 94-10

Wallis, D (1987). Satisfaction, stress, and performance: issues for occupational psychology in the 'caring' professions. *Work & Stress*. Volume 1: No 2:113-128

Warburton, K (2014). The new mission of forensic mental health systems: managing violence as a medical syndrome in an environment that balances treatment and safety. *CNS Spectrum*. July 2014:1-6

Whittingon, R, Wykes, T (1994). Violence in psychiatric hospitals: are certain staff prone to being assaulted. *Journal of Advanced Nursing*. 19:219-225