SECURITY PROCEDURES IN A PSYCHIATRIC EMERGENCY SERVICE

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The issue of violence in the mental health setting has recently begun to gain attention in the literature. As there is not enough research on this issue to draw conclusions as to the frequency of violence in mental health settings, there is a need to gather empirical data on the frequency of violence in various settings and to investigate the causes and management of this phenomenon. This article seeks to assess the prevalence of violence and potential violence in an inner-city psychiatric emergency service using several parameters as indicators. In addition, the article seeks to outline skills necessary for the management of violent patients which includes the recognition of potentially violent behavior, a hierarchy of management techniques to prevent the occurrence of violence, and techniques specifically designed to stop violence without causing patient or staff harm. Various etiologies of violence in mental health settings are discussed and a cognitive hierarchy of aggression is presented. Legal and ethical issues surrounding the concept of forcing patients to accept treatment on the basis of their dangerousness are discussed. Finally, the question of a difference in the prevalence of violence between ethnically different patient populations is raised, along with the possible implications of such a difference. Recommendations are made for the management of the potentially violent or violent patient.

Patients come to a psychiatric emergency service for a variety of reasons. Lazare et al[1] catalogued what patients want from an emergency service with the following categories: (1) administrative (I need your administrative or legal power); (2) advice (tell me what to do about my problems); (3) clarification (help me sort out my ideas or feelings so that I can put things in perspective); (4) community triage (tell me where I can get the help I need); (5) confession (please let me assuage my guilt); (6) control (please take over and protect me from myself); (7) medical (be a doctor, diagnose and treat my problem); (8) psychological expertise (use your special knowledge to explain why I feel or act the way I do); (9) psychodynamic insight (please help me understand myself better); (10) reality contact (please help me know that I am real and not losing my mind); (11) succorance (please be warm and caring to help fill the void; (12) ventilation (I have some things I need to get off my chest); and (13) nothing (I don't want anything from the service). Of all these, the hardest one to deal with is control (please take over and protect me from myself) because this request implies a loss of control with a strong possibility of violence.

Violence is an integral part of our environment. It appears out of nowhere and invades public and private sectors with no regard to those persons it affects; violence then disappears, only to recur at an unexpected place and time. Violence that occurs in the mental health setting has this same will-o'-the-wisp quality, and, while the prevalence of serious violence appears to be greater in persons who are not thought to be suffering from psychiatric disorders,[2-4] violence in a mental health setting is just as terrifying and destructive.

Statistics on violence in the mental health setting[5] are not numerous, but a number of studies have been done attempting to define the parameters of this phenomenon. Whitman, Armao, and Dent[6] surveyed 101 therapists and found that 9.2 percent of all (6,720) patients seen in one year presented a threat to others, 1.9 percent posed a physical threat to a therapist, and 0.63 percent actually assaulted a therapist. The overall data indicated that one of every 11 patients presented an assaultive threat to others in their environment. They

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also found that 24 percent of the 101 therapists were attacked by at least one patient during the year. A ten-year study reviewed 476,152 admissions and found that 6 percent were involved in assaultive acts two weeks prior to entry into treatment.[7] Madden, Lion, and Penna surveyed 115 psychiatrists regarding assaults by patients.[5] Forty-eight of 115 psychiatrists (42 percent) reported that they had been assaulted. In all, 68 assaults were reported. Thus, with the data on violence in mental health settings being as sparse and diverse as it is, any analysis along hypothetical lines would be very difficult. Despite this problem certain valuable evidence can be gleaned from the available information: (1) there are substantial levels of violence in the mental health setting; (2) these levels of violence vary across facilities and populations; (3) the effectiveness of violence management varies across facilities; and (4) research on violence in the mental health setting lacks effective congruence and organization.

Beyond measuring the frequency of violence in a mental health setting, the causes and management of this phenomenon need careful assessment. This article involves attitudes, values, and techniques used to prevent or manage violence in a psychiatric setting.

BACKGROUND

During the past year the authors have worked with the staff of a psychiatric emergency service provided by an inner-city general medical hospital on the south side of Chicago (Jackson Park Hospital) in an attempt to formulate a comprehensive program for the safe management of violent patients. The service was responsible for providing psychiatric emergency services (including crisis intervention, rape counseling, referral for inpatient hospitalization, and certification for involuntary hospitalization) to a population of 700,000. The area, known as subregion 12, consists of six city planning areas: South Shore, Chatham-Avalon, Roseland, Southwest, Southeast, and Beverly-Morgan. The first four areas are primarily inhabited by black residents with 25 percent of the population on welfare.[8]

In August 1976, the number of patients seen was approximately 140[8] compared with 293 patients (neither number counting return visits) seen in August 1979. Thus, it is clear that the utilization of the psychiatric emergency service has increased over a three-year period. In looking at a three-month sample (August, September, and October 1979) with regard to patient loads, percentage of patients agitated, and percentage of patients needing to be restrained by four-way leather restraints, one finds that a total of 687 patients was seen with 140 (20 percent) presented in an agitated manner, and that 106 among that agitated group were so out of control that they had to be physically restrained (15.6 percent of the total sample).

With this patient load and the prevalence of agitation among them, it was the goal of the authors to systematically interweave specific interpersonal communicative modes, behavioral structuring, and martial art techniques with the established policies and procedures of the psychiatric emergency service[8] in an attempt to adequately manage patients so out of control that they demonstrated behavior harmful to themselves or others.

MANAGEMENT OF VIOLENT PATIENTS

The first step in managing violent patients was the education of the staff in the ideas and concepts necessary to successfully interact with hostile, agitated, psychotic, and combative patients. Five two-hour inservice educational seminars were presented to introduce and reinforce the core material necessary to increase staff confidence and efficiency in this area. In addition, weekly group and individual training sessions were held throughout the year as patient load and activity permitted.

The next step was systems analysis and the interweaving process, which were necessary to incorporate the core material into the treatment procedures of the psychiatric emergency service. The systems analysis consisted of isolating each step of those patient-staff interaction patterns which characterized the routine procedures of the service and interweaving specific communicative modes, appropriate behavioral structuring procedures, and martial arts techniques to secure patients and staff from milieu violence. Each patient entering the emergency psychiatric service must interact with at least three of the four crisis intervention team members. The nurse performs the triage: taking the patient's temperature, blood pressure, pulse rate, respiration rate, and immediate medical history and evaluating the patient's general physical condition. Next, a technician completes an intake interview and turns the patient over to the psychiatrist. At this point the patient is evaluated and a dis-

position is made. If the patient has to be transported to another facility, he will then come into contact with the fourth member of the core crisis-intervention team—the driver. At each of the interaction points mentioned above, two communicative modes dominate. First, the staff intervenes in the patient's crisis to help him maintain use of appropriate defense mechanisms and coping strategies. Second, staff communicates to staff for the purpose of evaluating the patient's behavior and potential behavior.

There is a third communicative mode used at the point of entry into the psychiatric emergency service system that conveys the milieu values and attitudes of the service and people who staff it. The search of the patient's person before the triage communicates a number of crucial realities to staff and patient: (1) this is a controlled environment; (2) no one is allowed to hurt himself or others; and (3) although we are strangers, a certain amount of intimacy is necessary.

The search has the very practical value of relieving staff anxiety when dealing with patients that evidence violence potential. The value of the search should not be underestimated, as more than 1,000 contraband items confiscated from patients in one year's time consisted of: over 150 knives, one gun, numerous razors and other sharp instruments, as well as marijuana, cocaine, phencyclidine (angel dust), and other illicit drugs. In a service where of the 350 to 400 monthly referrals, 35 to 40 percent come from the Chicago Police Department; the search has proven its value.

As each point of staff-patient interaction requires specific communicative modes, each of these points also requires a certain level of behavioral structuring. For 70 to 80 percent of patients seen in the psychiatric emergency service, behavioral structuring consists of nothing more than an adequately calming interview (succorance, clarification, advice, reality contact, ventilation, community triage, psychological expertise, and psychodynamic expertise). But for the remaining 20 to 30 percent of the patient load, a calming interview was only the first in a series of attempts to help the patient structure his behavior in an appropriate manner. Characteristically, these 20 to 30 percent were the violent, destructive, agitated, hostile, combative, homocidal, suicidal, and occasionally psychotic patients. The lack of limits inherent in the use of a calming interview to help these patients hold together may actually lead to an increase in decompensation. In these cases, the staff escalated the behavioral structuring procedure using contractual and limit-setting techniques, respectively. Half of these patients could respond to the contractual techniques, but the other half required limit setting, usually in the form of physical restraints.

In the patients requiring physical restraints, the authors recommend the use of specially selected and developed martial art techniques for the safe controlling and restraining of violent patients. (The authors hold advanced degrees in karate with 18 years of combined experience in various martial arts and were able to draw directly from this knowledge to adapt the appropriate techniques.) Since the restraining of patients is at best a risky business, the chief fear being injury of the patient or staff, the martial art techniques were welcomed as a safeguard for all those involved in the restraint process. The techniques taught to the staff were designed for strictly defensive use (Figures 1 through 5). They enabled the staff to more effectively control the most violent of patients, as well as to defend against the attacks of the combative ones. The results of the training in martial art restraint techniques were seen on practical and psychological levels. Practically, injuries to patients being restrained were cut to almost nil, paralleling the reduction (but not the extinction) of staff injuries. Psychologically, the staff commented on their increased feelings of confidence in dealing with violent patients. This feeling of staff security also seems to help patients feel safe in the milieu.

DISCUSSION

Examination of the causes of violence in the mental health setting tends to focus on the violent patient or the provocative environment (ie, staff transactions), as a means of explaining its occurrence. The description of the violent patient's personality constellation varies due to the unpredictability of the phenomenon; but some useful, albeit general, observations can be submitted. A patient suffering from an acute psychotic episode can be so out of control that he must be restrained for his own safety and to prevent him from leaving in such a fragmented state[9] that he is unable to care for himself. Borderline and alcoholic patients in crisis can present very explosive and combative

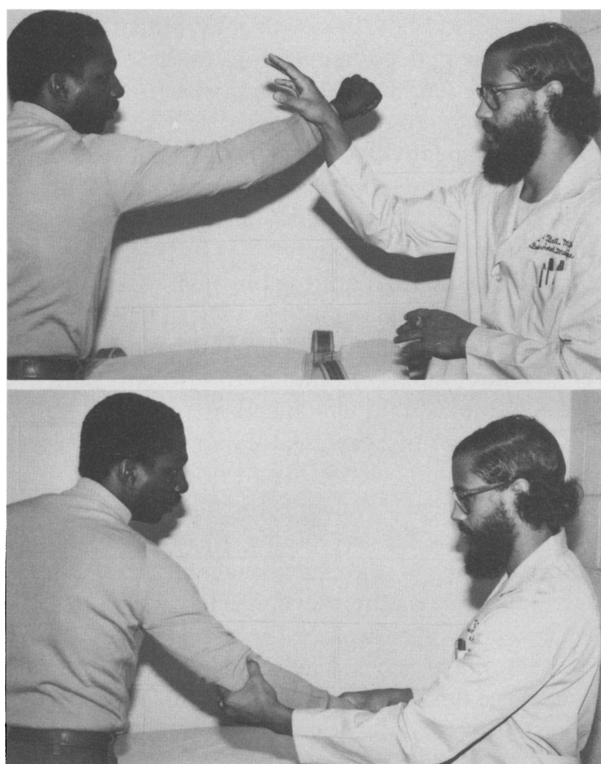

Figure 1. Mock patient throws right jab at staff member who steps, blocking with the right hand (top). Staff member grabs mock patient's right wrist with his right hand and grabs the mock patient's right elbow at the distal end of the humerous bone just above the epicondyles (bottom)

behaviors. Patients with developmental disabilities often present as a "time bomb" that can enter a state of frenzy[9] at any time. Some patients, fearing their impulses to hurt themselves or others, act out in a manner to attract external controls or limits, and may occasionally request restraints. In addition to individual patient dynamics, there is an overlapping effect the mental health setting has on patient violence. In fact, the treatment environment, principally the staff, seems to play a more integral role in the provocation of violence than first suspected. Madden et al[5] reported that many of the 115 psychiatrists they interviewed thought they may have had a role in provoking an assault on themselves. Others point to problems in patient/staff communication prior to, during, and subsequent to patient violence, as being the key to violence in the mental health setting. Prior to patient violence, the inattention of the staff to early warning signals can begin a distortion of communication patterns between staff and patients, and staff to staff. Prior to and during patient violence, the communication patterns of patients and staff are maximally strained, possibly further increasing the patient's anxiety, lessening his control over violent impulses, and leading to an incident which could injure staff and/or the patient.[10] Staff "splitting" is another problem frequently linked to patient disseension and epidemic violence. When poor morale or staff conflict issues are passed on to the patients, the therapeutic milieu is destroyed. Violent patients are not controlled effectively, and other patients may resort to violence to protect their territorial integrity.[11] Cornfield et al[10] surmise that the threatening patient provokes a counter transference from the staff, resulting in staff reactions which encompass improper therapeutic distance, denial, and over-intellectualization. These intrapsychic defenses can impede efficient handling of violent and potentially violent situations. On the other side of the coin is the belief that the expectation of and preparation for violence may represent a self-fulfilling prophecy and, thus, lead to the violence that was sought to be prevented.[12]

It was the authors' experience that agitated and possibly imminently violent patients were best handled by the anticipation of violence and the prevention of violence before it occurred. The anticipation of violence was aided by the cognitive hierarchy of aggression which was developed from martial arts experiences and psychiatric/psychological training. Aggression was conceived as a general term covering all forms of behavior aimed at exerting control or mastery over objects, self, or situations, and was not viewed either as a positive or negative phenomenon. Lowest in the aggression hierarchy are activities involving alertness, curiosity, attentiveness, and explorative behavior. Next comes self-assertion, which is the attempt to establish, maintain, and expand one's boundaries or integrity while not intruding into territory not one's own. The next level of aggression is the expression of dominance which implies the capacity to exert an influence on the behavior of other people or groups in an intended direction (power). The foundation of this dominance tends to be grounded in coercion—with the expectation of great rewards or great punishments for certain kinds of behavior and the ability and readiness to exert this power. When this dominance is legitimatized by legal, professional, or social mandates, it is known as authority.[13] Finally, towards the top

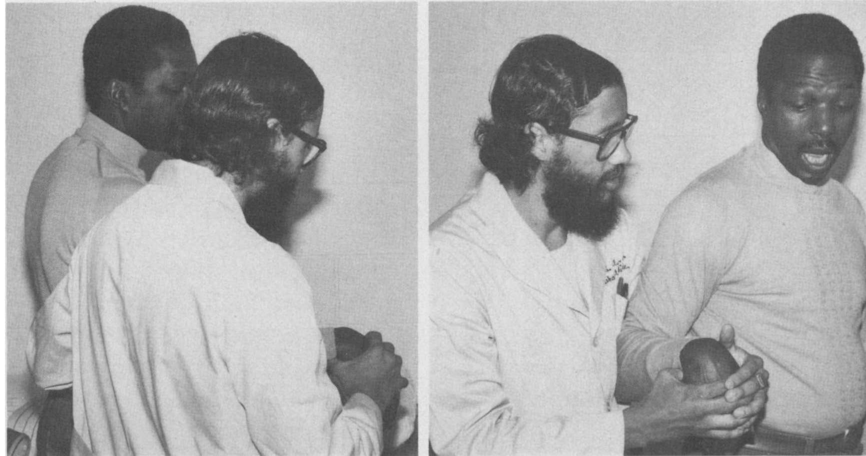

Figure 2. Staff member circles to the right of the mock patient while flexing the patient's right wrist—still maintaining a grip on the mock patient's right elbow (left). Staff member tucks the mock patient's right elbow into the crook of his own left elbow and uses both hands to hyperflex the mock patient's right wrist causing enough pain to protect the staff member and prevent further patient violence. This "come along" does not produce permanent damage or pain, and can be so applied as to cause pain only when the patient struggles to free himself from the staff member's control (right)

of the hierarchy is hostility, which implies behavior or attitudes intending to hurt or destroy an object or the self. The etiology of hostility may come either from the need to obtain a goal (eg, pleasure as in sadism, war to gain survival needs), the need to hurt or destroy whatever frustrates a goal-directed activity such as self-assertion, exploration, dominance; or the need to protect oneself from a threat or actual trauma. Finally, when the injury or destruction of an object, self, or situation is the end rather than the means to an end, the type of aggression expressed is hatred. This cognitive hierarchy[14] was taught both in a theoretical framework through the use of didactic lectures and from an experiential framework through the use of martial arts training and on-the-job experience with patients exhibiting the range of aggressive behaviors. Once the range of aggressive behaviors could be accurately identified without either under- or overreacting, it was then possible for the staff to intervene in an attempt to prevent violence using a hierarchy of management techniques ranging from a calming interview (providing empathy, giving the patient some distance between himself and the examiner, giving reassurance, having an attitude of helpfulness and calmness), the use of psychotrophic medication (pleasant tasting liquid concentrates), contractual and limit setting techniques, relative seclusion, and finally physical restraints.

Figure 3. Two staff members apply "come along" to mock patient to ensure complete control over the violent patient.

All patients entering the psychiatric emergency service were requested to sign a written consent to psychiatric emergency room treatment. If the patient refused to sign, an immediate evaluation as to the patient's danger to self or others was made, and if the patient was found not to be harmful to self or others, he was asked to leave. If the patient was found to be overtly dangerous to self or others, or in such a state as to be unable to provide for his basic physical needs so as to guard himself from serious harm, that patient was certified by a psychiatrist and forced to comply with psychiatric emergency service intervention, which culminated in transferring the patient to a state hospital where

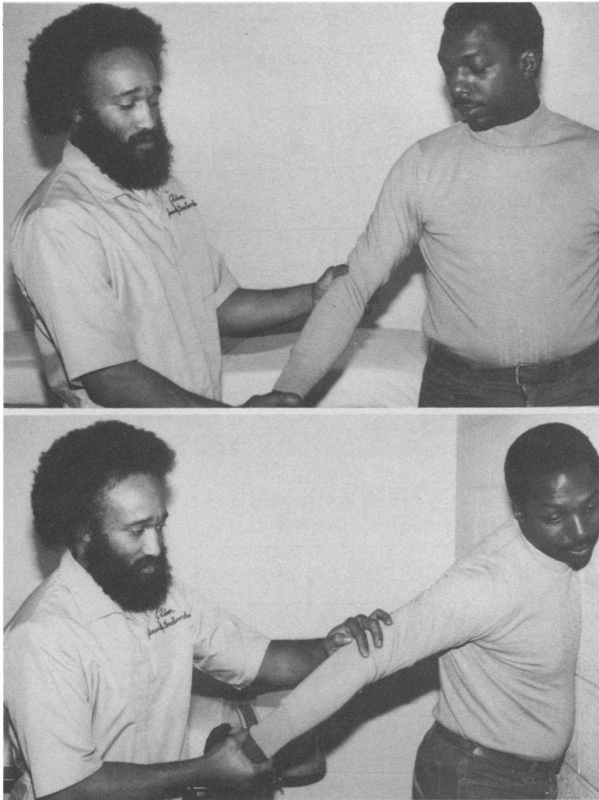

Figure 4. Staff member grabs mock patient's right arm in the proper fashion to prepare to apply an "arm bar" to enable the staff member control over the patient's body movement (top). Staff member applies "arm bar" to mock patient's right arm while using his body weight to force the patient up against the wall where the patient is immobilized. Note the hyperflexed right wrist of the mock patient which aids in controlling the patient (bottom)

the certificate was used to initiate the legal process of commitment. For patients who had signed the voluntary psychiatric emergency room treatment form, it is the authors' contention that forcing the patient to comply with the psychiatric emergency service intervention is only justified when the patient needs to be prevented from causing physical harm to himself or others, or is in such a state as to be unable to provide for his basic physical needs so as to guard himself from serious harm (which meant that all patients forced not only agreed to treatment, but were also certifiable by Illinois standards). Clearly, this is a subjective clinical evaluation subject to over or under reactions, and, therefore, is the subject of great controversy.[15-17]

It is the authors' belief that mentally ill patients should not be allowed to, directly or indirectly, cause physical harm to themselves or others in an attempt to preserve patients' legal rights. While actual removal of such rights is based on court decision rather than psychiatric judgement, the first step in the removal of those rights is a psychiatric decision and it is within the clinical purview of psychiatrists to initiate those steps without incurring legal action against themselves while acting in good faith. Fortunately, the law concurs. It must be emphasized that the decision to begin the process of legally forcing patients to accept treatment in an attempt to prevent them from harming themselves or others is the responsibility of the psychiatrist, as is the monitoring of services delivered, so as to prevent staff from inappropriately using power, authority, or restraining techniques to meet staff needs rather than to serve the purpose of treating psychiatric patients. This is best accomplished by the establishment of strong leadership in the staff group. A professional hierarchy must exist demonstrating respect for authority and employee rights. As the interpersonal milieu between the director and line staff will be transferred to the analogous situation of the milieu between the line staff and patient, the care of the staff interpersonal milieu cannot be overemphasized if the staff is to appropriately deal with such anxiety provoking issues as hostility and violence. Finally, despite a concerted effort to ensure that a patient's rights and dignity are respected regardless of his or her psychiatric condition, however, certain individual incidents (involving patients or staff) are unavoidable and cannot be legislated or influenced. Among such were the accusation of rape made by an acutely psychotic patient while she was in restraints and the staff's documentation that an elderly confused patient came to the service with $200 (his life's savings), but when he arrived at the state facility for hospitalization his money was missing. These occurrences, whether shown to have been the responsibility of an individual staff member or the product of a psychotic patient's confusion, have an extremely demoralizing effect on the staff and are best turned over to legal authorities for investigation.

Last, it has been reported that the prevalence of violence (eg, homicide rates for nonwhites are 8-15 times greater than those for whites[18]) is higher for blacks,[4] and the question of a greater prevalence of violence in inner city psychiatric emergency

Figure 5. Mock patient being placed into four-way leather restraints grabs the restraint cuff in an attempt to thwart the procedure (top). Staff member applying pressure to the mock patient's hand while holding the wrist in an attempt to cause flexion of the wrist (center). Flexion of the mock patient's wrist accomplished with the attending inability to securely grip any object which will allow the continuation of the process to restrain the mock patient (bottom)

services serving blacks remains. This study found empirical evidence that 15.6 percent of patients seen in a three-month sample had to be restrained and over the year over 150 knives, one gun, and numerous razors and other sharp instruments were confiscated from a predominately black patient population. While the authors believe the majority of patients seen were not dangerous[19] and decry the need to act as policemen by searching patients, the need to restrain approximately one-sixth of the patients seen and the appearance of a dangerous weapon at a frequency of at least one every other day emphasize the need of this procedure. In an attempt to preserve respect for patients' privacy, patients were told that everyone who wished service had to be searched. If the patient refused, but did not appear to be certifiable, he was invited to leave the area and return after a few minutes to be searched. As a predominately black staff was treating a black patient population, there seemed to be no problem in establishing and maintaining good patient-staff rapport although the staff employed police-like techniques. Searching is clearly a sensitive issue for inner-city residents. The authors suspect that results would have been different if the staff had been white due to the racism which sometimes arises when there is an interracial staff/patient mixture.

Thus, the issue of whether or not there is a higher prevalence of violence in a black psychiatric patient group is a very delicate one; if it turns out there is a higher incidence, there could be several ramifications: (1) It is dangerous to treat black patients, therefore, treatment facilities might use this conclusion to exclude black patients from their facility. (2) It is a racist expectation that black patients are more violent and this racist attitude is communicated to the patient with attending avoidance of doing anything (such as exerting limits) to make the patient "go off" and thus perpetuating a pattern of violence. (3) Black psychiatric patients are more dangerous; therefore, treatment facilities must employ severe police-like treatment techniques in order to adequately deal with the problem. (4) Black psychiatric patients are more dangerous but, as mental illness is a myth, they should be jailed rather than treated. (5) Black patients are more dangerous and the etiology of this dangerousness needs to be investigated and prevented. If this dangerousness is related to a lability of affect and impulse controls secondary to a type

of "combat fatigue," perhaps it could be better thought of as "survival fatigue" in inner-city black psychiatric patients.

RECOMMENDATIONS

By way of summation the authors would like to share some of the concepts learned from research and experience that may serve as successful focusing points for the management of violent patients:

1. Mental health professionals may be familiar with theories concerning aggression and violence, but few have adequate training or expertise in predicting and managing the overt expression of hostility—violence. Clinicians need to learn techniques to specifically manage violent patients and protect themselves from harm. Martial arts training in the use of specific defensive and controlling techniques is helpful in obtaining these goals.

2. Empathy plus observation leads to anticipation, the most important concept one can learn in controlling patient violence.

3. Do not be afraid to manipulate the environment to help a patient maintain use of appropriate defensive mechanisms and coping strategies, such as asking a provocative family to leave the area, placing the patient in a quieter area where the phenomenon of aggression contagion is less likely, transferring a provocative staff member, who consistently approaches patients with an "edge," thus inciting an escalation in aggression, to a less sensitive area.

4. If you are afraid of a patient, do not pretend not to be, but let the patient know you will control yourself and the patient if necessary.

5. Violent patients want limits (no one likes being out of control).

6. Violent patients should never be left alone with only one staff member.

7. Do not threaten a patient with restraints but when restraint is needed use maximum force necessary rather than being ambivalent about the process.

8. At all times tell the patient in a fashion clear and understandable to the patients what you are doing and why. He may not always like your actions or the reasons for your actions, but he will accept them.

9. Treat your violent patients as you yourself would like to be treated were you out of control, ie, with respect and dignity. This gives one a firm foundation in respecting patients, which is communicated and engenders rapport.

10. Never place a potentially violent patient in a position which would give him the feeling of being trapped. While you might feel more comfortable closer to the door in order to make a quick exit in case of trouble, it is actually better to give the patient a way out rather than have his back to the wall.

11. When setting limits on a patient, give him some room to cooperate while at the same time "saving face."

12. Restraints should only be used to teach a patient a lesson, never to punish.

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