Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dévouée aux soins de qualité

POSITION PAPER

Trainee Safety in Psychiatric Units and Facilities

A Moscovitch, MD[1]; GA Chaimowitz, MB ChB, FRCPC [2]; PGR Patterson, MD[3]

This position paper has been revised by the Canadian Psychiatric Association's Standing Committee on Professional Standards and Practice and approved for republication by the CPA's Board of Directors on June 2, 2009. The original position paper was developed by the Standing Committee on Professional Standards and Practice and approved by the Board of Directors on March 31, 1990.

The literature on assaultive behaviour against staff, initially quite limited, has continued to grow. Some early studies indicated that the problem warrants serious attention. In three frequently quoted studies[1-3], Tardiff reported that approximately 10 per cent of patients admitted to hospital had been assaultive prior to or at the time of admission. In another study of patients hospitalized for more than one month Tardiff established that assaults were five times as frequent as suicide attempts or self destructive behaviour[4]. Career rates of assaults against psychiatrists are reported to be in the range of 40 to 50 per cent[5]. Another survey of 101 psychotherapists (psychiatrists, psychologists, and social workers) reported 24% being assaulted during the previous year and 74 per cent assaulted at least once in the past[6]. Further studies have attempted to delineate the characteristics of patient on staff assaults[7-9].

The issues of trainee safety and minimum security standards in training facilities have been discussed by the Residents' Section of the CPA over past several years. In the limited literature dealing specifically with residents, Ruben reported that 48 per cent of residents surveyed were assaulted during their training [10]. In a more recent study by Fink and Dubin, 42 per cent of psychiatric residents reported being subjects of assaults by patients [11]. In a New Zealand study 67% of postgraduate trainees had been threatened and 39% physically assaulted[12]. Clinical clerks are also at risk of being assaulted by patients[13].

Although initially lacking systematic data, we suspected the Canadian experience was not substantially different. Like all frontline workers dealing with potentially violent patients, residents are in a position of high risk for assault. Compounding the difficulties was the general feeling among residents that assaults were characteristically under reported, an impression which is

[1] University of Calgary, Calgary, Alberta.
[2] Assistant Profession, McMaster University; Staff Psychiatrist, Hamilton General Hospital, Hamilton, Ontario.
[3] University of Western Ontario, London, Ontario.

fairly well substantiated in the literature. Lion concluded that five times as many assaults occurred as were formally reported[14]. According to anecdotal reports, concerns raised by residents are often minimized by other residents and the hospital administration, and at times blatantly ignored and rejected. Without elaborating at length, possible reasons for this may include defenses of guilt, self blame, counterphobic attitudes, and fear of criticism and repercussion from hospital and/or departmental authorities.

To assess the magnitude of this problem among psychiatric residents in Canada, all members in training registered with the CPA were surveyed.[15] The survey included 211 residents, and we obtained an overall response rate of 64.5 per cent. Of the respondents, 40.2 per cent reported being assaulted by a patient at least once, 12.5% twice and 3.3% three or more times during their training. Of the residents assaulted, only 73.6 per cent reported the incident(s) formally to the hospital and/or departmental authorities. Close to 40 per cent of the respondents reported making a presentation to hospital and/or departmental authorities requesting improvement of safety standards. However, less than one quarter of those felt that the response to their concerns was acceptable. Only 51.5 per cent of the respondents reported receiving training in dealing with violent patients, and less than 25 per cent felt that residents were adequately trained in this area. Only 35.1 per cent indicated that they felt that the facilities for interviewing patients in their hospitals were safe, and 83.3 per cent indicated that they would like to see an improvement in physical settings. Almost 80 per cent wanted improvement in education and training of staff, while 44.4 per cent felt that they would like to see an improvement in staffing arrangements. An overwhelming 97.7 per cent indicated that they would like to see CPA guidelines for minimum security standards in training facilities. In a USA survey two thirds of residents are undertrained or felt undertrained in dealing with violent patients[16].

The following guidelines were developed by the Residents' Section of the CPA and the Council on Education and Professional Liaison, adopted by the CPA Board of Directors and updated in 2008. They are intended to provide a framework for minimal standards and act as guidelines that can be used for plans for improvements at the policy and organizational levels. The guidelines are based on the principle of creating an environment in which the safety of patients and staff can be assured while pursuing therapeutic goals. These guidelines address issues of education and training, physical setting, staffing and implementation. Each psychiatric training facility should have clearly developed policies that cover these aspects.

I. Training and Education

1. At the outset of their residency residents should have comprehensive training in dealing with violent patients.
2. Nursing and security staff and mental health personnel should also receive training in proper methods of handling violent patients.
3. Further systematic studies should be conducted in the following areas:
    a. early recognition of the potential for aggressive behaviour;
    b. appropriate management of violent patients;
    c. effectiveness of training in increasing safety;
    d. predisposing factors for violence against staff.

II. Physical Setting:

1. The physical layout of facilities for interviewing and treating patients should be safe and secure:
    a. Psychiatric interviewing rooms in emergency departments should be located in close proximity to the nursing station to ensure the availability of immediate assistance, if required.
    b. Interviewing rooms should have an accessible, functional alarm system which if activated produces an immediate and adequate response.
    c. Rooms should be devoid of dangerous objects. Furniture ideally should be securely fastened to the walls and/or floor. Doors should open outwards or revolve, and should not be lockable from the inside, nor capable of being barricaded. Consideration should be given to having two doors for interview rooms.
2. Ideally, interviewing rooms should have setups for visual and/or auditory monitoring.
3. Sleeping quarters and offices for residents need to be secure from unauthorized intrusions.
4. A clear policy for restraining practices should be available in each facility, and restraints should be available in areas where violence can potentially occur.
5. Each facility should have an easily identifiable alarm code that indicates a potential or actual assault. An adequate number of staff, physically suited and trained, should be available for immediate response.

III. Staffing Arrangements

1. Appropriate security personnel should be available for assistance if the patient has a history of violence, or should the resident suspect there is the potential for aggressive behaviour.
2. Police officers who bring in assaultive patients should be requested to remain available until the assessment is completed or until hospital security personnel have taken over. Police officers or security personnel should

be expected to remain in close proximity while such patients are in the interviewing room or the emergency department.

3. A sufficient number of personnel with appropriate physical attributes and training should be available to respond to assault alarms.
4. Provisions should be made for security staff to be available in those instances where it is deemed necessary. Proper coverage should be available either for interview situations or when staff is required to move about in unobserved areas of the hospital.

IV. Implementation

1. Each facility should have a clearly defined, recognized authority responsible for the local implementation of security guidelines, and for documentation, support and follow up once an episode of violence against staff has occurred. In training facilities, such a committee should also report to the departmental Postgraduate Education Committee.
2. Prompt, formal documentation and reporting of assaults should be encouraged.
3. Clear guidelines should be available for follow up and support of assault victims. Each incident should be dealt with in an open fashion, and the resolution thereof should be acceptable to all parties involved.
4. Mechanisms should be established whereby residents have further recourse if minimum safety standards have not been met.
5. Residents or any other trainees should not be assigned to facilities that have an ongoing history of inappropriate safety standards. While insuring patient care, staff safety should always be taken into serious consideration. Residents or any other trainees should not be coerced into seeing potentially violent patients unless appropriate steps have been taken to maximize their safety and reasonable safety standards have been implemented.
6. If, after due consideration, a resident decides that she/he wishes to charge the assaultive patient, the hospital and university should provide them with the requisite logistical and emotional support.

Further systematic studies, discussion and attention to these matters are required. Although trainee safety is not just a psychiatric issue, insufficient attention has been paid to date to the unique features of psychiatric training with respect to dealing with potentially violent individuals.

Areas of particular concern are reasonable safety standards in training facilities, quality of training regarding management of violent patients, availability of appropriate assistance and support and departmental and institutional support in this matter.

References

1. Tardiff K, Sweillam A. Assaultive behaviour among chronic inpatients. Am J Psychiatry. 1982;139 (2):212 215.
2. Tardiff K. Characteristics of assaultive patients in private hospitals. Am J Psychiatry. 1984;141(10):1232 1235.
3. Tardiff K, Sweillam A. Assault, suicide and mental illness. Arch Gen Psychiatry. 1980;37:164 169.
4. Tardiff K. Survey of five types of dangerous behaviour among chronic psychiatric patients. Bull Am Acad Psychiatry Law. 1982;10(3):177 182.
5. Madden DJ, Lion JR, Penna MW. Assault on psychiatrists by patients. Am J Psychiatry. 1976;133:422 425.
6. Whitman RM, Armeo BB, Dent OB. Assault on the therapist. Am J Psychiatry. 1976;133:426 431.
7. Ryan EP, Hart VS, Messick DL, Aaron J, Burnette M. A prospective study of assault against staff by youths in a state psychiatric hospital. Psych Serv. 2004:55(6):665—70.
8. Flannery RB Jr. Precipitants to psychiatric patient assaults on staff: review of empirical findings, 1990–2003, and risk management implications. Psychiatric Q. 2005:76(4):317-26.
9. Flannery, R. B., Hanson, M. A., Rego, J. & Walker, A. P. (2003). Precipitants of psychiatric patient assaults on staff: preliminary empirical inquiry of the assaulted staff action program (ASAP). Int J Emerg Mental Health. 2003:5(3):141–6.
10. Ruben I, Wolcon G, Tamamato J. Physical attacks on psychiatric residents by patients. J Nerv Ment Dis. 1980;168:243 245.
11. Fink DL, Dubin WR. Threats and assaults against psychiatric residents. Presented at the American Psychiatric Association Annual Meeting; 1989, San Francisco (CA).
12. Coverdale J, Gale C, Weeks S, Turbott S: A survey of threats and violent acts by patients against training physicians. Med Education. 2001:35(2)154–9.
13. Waddell AE, Katz MR, Lofchy J, and Bradley J. A Pilot Survey of Patient-Initiated Assaults on Medical Students During Clinical Clerkship. Acad Psychiatry. 2005:29(4):350-3.
14. Lion JR, Snyder W, Merrill GL. Underreporting of assaults on staff in a state hospital. Hosp Community Psychiatry. 1981:32:497 498.
15. Chaimowitz GA, Moscovitch A. Patient assaults on psychiatric residents: the Canadian experience. Can J Psychiatry. 1991:36(2):107-111.
16. Schwartz TL, Park TL. Assaults by patients on psychiatric residents: a survey and training recommendations. Psych Services. 1999:50(3):381-3.