

# Hostages to fortune: The impact of violence on health and social care staff

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***Abstract:** Drawing upon a growing corpus of knowledge, this article examines the extent and impact of violence on health and social care staff. Whilst individual and collective strategies for preventing and avoiding violence are explored, the article also examines themes which emerge from the research literature and considers some of the complexities surrounding this area. Current policies with respect to violence against health and social care staff are the subject of reflection as are future possibilities for research.*

***Key words:** health services staff; social care staff; violence; aggression; verbal abuse.*

## **Introduction**

Violence perpetrated against health and social care staff constitutes a major cause for concern amongst policy makers, professional bodies, trade unions and employees themselves. This article, which examines the extent and nature of violence experienced by those working in the health and social care field, begins by discussing some of the problems involved in defining what is meant by violence. Research evidence is then presented to indicate the scale and nature of the problem, and some comparisons are made between the violence experienced by health and social care workers. Some of the emergent complexities from the findings are related to policy and aspects of practice. Suggestions for changing practices and possibilities for further research are also considered in the light of the research findings.

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## **Defining violence in the health and social care workplace.**

Defining violence presents many challenges since the contexts in which it occurs are complex. Individuals also have different understandings of what constitutes violence. Over the past decade, sensitivity to violence as a problem for the workplace has expanded the definitions to include a range of behaviours. The Association of Directors of Social Services defines violence as: 'Behaviour which has a damaging effect either physical or emotionally on other people' (in Kemshall and Pritchard 1996, p.162). Here violence is viewed as a continuum of abusive behaviours which do not necessarily result in physical injury. However, the diffuseness of such a definition does not fully capture the experience of abuse in terms of an individuals' subjective perception.

Individual interpretation and the context of a particular event will to some extent determine whether it is regarded as violent (Bowie, 2000). Some professionals utilise a dualistic conception of violence in the workplace. In a study of violence against professionals working in the community, GPs explained 'rational violence' by minor mental illness, and culminations of stressful social circumstances, such as marital breakdown and debt. The nature of this violence was usually verbal, unplanned, undirected at any particular individual and predictable. Most GPs were prepared to partially accept this version as an occupational hazard. In contrast, 'irrational violence' was characterized by more severe forms of mental illness and personality disorder, substance misuse, and in some cases malevolence on the part of service users. GPs considered this form of violence to be unacceptable since it was more likely to result in physical injury, was more personally directed at the professional, planned by the perpetrator and unpredictable (Gabe *et al.*, 2001).

A notion of violence is required that both allows for differential perceptions of it, while also incorporating the range of behaviours. For the National Association of Probation Officers violence includes:

A range of illegitimate or socially unacceptable behaviours which are intended to be or perceived as being threatening'. Violent behavior can take a number of different forms and have different outcomes. (NAPO, 1989, in Littlechild, 2002, p.7)

This helpful definition recognizes the existence of different abusive contexts, whilst allowing some level of interpretation of what constitutes violence on the part of the worker.

## Violence against social care staff

There is now a growing corpus of knowledge which attempts to explain the nature and incidence of violence perpetrated against social care staff, although research is still patchy in some areas (Brown *et al*, 1986; Rowett, 1986; Norris with Kedward, 1990; Bullock, 1999). Although it is difficult to be exact as to the actual incidence rates given high levels of under reporting, it seems possible that over half of social care staff experience attack or an attempted attack at least once in their career (Department of Health, 2001; Balloch *et al*, 1999). Verbal abuse appears to be widely accepted as an everyday occurrence (Grimwood and La Valle, 1993). One of the most comprehensive studies suggests that one third of social care staff report physical abuse over a three year period, and 25% over a four year period. Some 37% of social care staff had been threatened (Brockman and McLean, 2000). Pahl found that 10% of field work staff in England had been physically attacked by service users or their relatives within a twelve month period. Employees can feel that there is little point in making any complaint which will fall on semi-deaf managerial ears, although support from management following abusive behaviour from service users is valued. The professional 'culture' of social care since 1991 has been increasingly structured by a complex corporate style of managerialism, based on contractual arrangements in which service providers and purchasers are separated (Denney, 1998). Management has become dominated by the achievement of performance indicators combined with evaluating evidence of cost effective interventions that 'work' (Amann, 2000). In a climate of cost cutting and rationing of inadequate resources, the safety of staff has not been seen as a priority by management. The absence of a supportive work culture has contributed to the under reporting acknowledged above (Research Perspectives, 2000; Brockman and McLean, 2000; Balloch and McLean, 1999). However, some research does present a more complicated picture of the managerial reaction. Littlechild found managers to be understanding and responsive to the needs of those who had been traumatized by violence. Managers in this study also recognized that a supportive work environment discouraged violence (Littlechild, 2000, 2002).

Gender has also been seen as relevant (Department of Health, 2001) given that the social care workforce is highly gendered, women workers accounting for one million of the 1.1 million total social care workforce. Social workers and probation officers, however, are the only occupational groups within the social care field with a significant minority of men (Simon *et al*, 2003). Of the seven social care staff murdered at work by service users since 1984, all but one (Jonathan Newby) have been women. Women working in probation often believe that service user abuse is directed against them as women and not as professionals. In describing verbal abuse a female probation officer said:

A lot of it I feel is aimed at women, and what I tend to feel is aimed at me as a woman.  
(Denney and O'Beirne, 2003, p.55)

Research over a considerable period has demonstrated how experiences of institutional racism can strain relationships between service users and staff. (Denney, 1992). Racism

Table 1  
Verbal/physical abuse and feelings of fear experienced by professionals in the community

	Probation Officers (n=507)	GPs (n=447)	Anglican Clergy (n=386)
	%	%	%
Verbal Abuse	90.7	75.6	70.0
Assaults(physical and sexual perpetrated within the last to years)	8.5	10.3	11.8
Feeling afraid of being a victim of violence when engaged in work	73.0	65.9	40.0

Source ESRC study of violence against professionals (Gabe et al, 2001)

seen by service users as existing within social care agencies and the criminal justice system, can lead to the generation of anger directed against front line employees. In a recent study of Black and Asian offenders on probation, 50% of those who claimed to have been stopped and searched for no reason felt angry, annoyed and ‘picked on’. Almost one quarter (24%) of respondents also felt embarrassed, ashamed, degraded, or upset (Calverley *et al*, 2004). Some 75% of Black and Asian social care staff experienced racism from service users or their relatives in their current job (Davey, 1999). Race and ethnicity impacts on the nature and frequency of physical and verbal abuse perpetrated against staff (Department of Health, 2001).

## Violence and professionals in the community

In depth research into the everyday reality of fear and violence with respect to social care staff is relatively scarce when compared with other groups. Comparable studies have examined how professionals deal with violence on a day to day basis and can illuminate some of the complexities experienced by social care staff. One of the twenty research projects in the Economic and Social Research Councils’ (ESRC) Violence Research Programme explored the violence perpetrated against NHS GPs, probation officers, and Anglican Clergy. All three of these professional groups are involved with the personal lives of individuals, many of whom are vulnerable, in a state of distress, and living in various states of poverty (see Table 1).

The ESRC study reported that although probation officers experienced a lower level of physical violence when compared with other groups, they were more likely to be afraid at work. Verbal abuse was experienced by 90% of probation officers.

This could lend weight to the idea that constant verbal abuse created greater fear than physical violence. Professionals described attack and abuse as happening with great speed and often in surprising and unexpected circumstances. Probation officers reported that rooms were often too small and unmonitored which gave rise to feelings of vulnerability. Management often seemed unable or ill prepared to address problems relating to the personal safety of staff, whilst a plethora of largely over bureaucratized and inefficient procedures existed to assess the risk that offenders posed to the general public. Time pressures act as a barrier to the full implementation of safety procedures (Gabe *et al.*, 2001).

### **Violence against staff in hospitals.**

Violence in UK National Health Service hospitals is now generally recognised as a major cause for concern by health service unions, professional bodies, health care workers and managers. This concern is supported by empirical evidence. The Department of Health survey of recorded violence against all NHS staff, reported by NHS Trusts, indicates that reports of violence increased by 30% between 1998-1999 and 2000-2001. The evidence for 2001-2002 indicates a further increase of reported incidents of 13%, compared with 2000-2001 (National Audit Office, 2003).

In a survey of consultants in accident and emergency departments in the UK and Republic of Ireland, researchers found that the main causes of violence was patient misuse of alcohol, long waiting times, and recreational drug use. Nurses were most likely to be the victims. Staff were regularly verbally and physically abused and more likely to be assaulted in inner city areas. Documentation of incidents was poor whilst perpetrators were rarely convicted (Jenkins *et al.*, 1998).

Responses to a self administered questionnaire completed by staff in the Johannesburg Hospital Trauma Department indicated that significant levels of stress had occurred post trauma in the 40% of staff who had been physically abused. A high degree of professional 'burn out' was reported by half of the respondents who had experienced violence while at work (Crabbe *et al.*, 2004).

Studies estimating the prevalence of violence against staff in general hospitals suggest that high rates of violence occur. In these studies nurses again are more likely to be physically assaulted and abused than other professionals (Whittington *et al.*, 1996; Wells and Bowers, 2002). Winstanley and Whittington found that 27% of health service workers had been assaulted, and 23% had been threatened by patients over a one year period. Institutional averages obscure much higher levels of victimisation in specific hospital departments. Some 43% of nurses (both staff and enrolled) had been assaulted in the previous year, compared with 13.8% of hospital doctors (Winstanley and Whittington, 2004).

Violence in NHS Trusts is severely under-recorded even though staff may discuss

incidents informally amongst themselves. Although all staff are expected to report all violence, the evidence suggests that this happens infrequently which reduces the Trusts' capacity to estimate the level of risk (O'Beirne and Gabe, 2005).

Research into workplace violence has also been conducted in the area of psychiatric care. The Royal College of Psychiatrists examined 68 pieces of research relating to the management of impatient violence. All these studies met rigorous methodological criteria. The impact of the intervention under review was measured against a control group who had received some other form of treatment. One of the most significant findings was that wards with trained and experienced staff working well together with good leadership and high staff morale tend to be less violent. Few of the papers gave details of how restraint and seclusion was applied, whilst definitions of restraint changed over time and between countries. Consequently the research concerning psychiatry suggests that there is a grey area between coercion and the voluntary acceptance of restraint (Royal College of Psychiatrists, 2003).

## **The policy response**

Policy making in this area has mostly been reactive in direct response to a specific attack by a service user. There are five pieces of legislation which have a direct bearing on violence at work:

- *The Health and Safety at Work Act 1974* places a duty on employers as far is practicable to be responsible for the health, welfare and safety of their employees while at work.
- *The Management of Health and Safety at Work Regulations 1999* require employers to assess risks and make arrangements for their employees' health and safety at work through effective planning, organization, monitoring, and review.
- Under the *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995* it is incumbent upon employers to notify their enforcing authority of any accident at work to an employee resulting in death, major injury or incapacity for normal work for three or more days.
- *The Safety Representatives and Safety Committees Regulations 1977(a)* and *The Health and Safety (Consultation with Employees) Regulations 1996* require employers to inform and consult with employees on matters relating to their health and safety.

This area of law appears to be complex, vague and difficult to implement. Planning, review, monitoring and notification of incidents although essential, are measures with little practical use in the immediate aftermath of abuse.

The response of government at both national and local level to violence against social care staff has been limited and piecemeal although it should be acknowledged

that some initiative has been taken. The National Task Force on Violence Against Social Care Staff was given a remit to reduce the incidence of violence against workers, both staff and volunteers, in social care settings, and put in place systems to sustain a reduction in future. The government, through the recommendations of the National Task Force, set a 25% reduction target for violence against social care staff (Department of Health, 2001).

One of the problems with creating targets is that, given the present state of knowledge, it is unclear what it is that is being measured or what might be reduced. Although the National Task Force has recommended the achievement of full and accurate baseline data on violence to workers, no indication is yet available as to how this data is to be collected, and how violent incidents are to be quantified and categorised. It would seem premature to consider establishing targets for the reduction of violent incidents without some credible benchmark data of the actual level of violence in various social care settings. The recording and monitoring of violent events and the subsequent analysis of 'what happened' should enable organizations to understand the contexts of violence. Attention can then turn to exploring these contexts in order to understand how best to proactively intervene. In gathering data to create a baseline measure to meet targeted reductions in violence, it is unclear how incidents will be classified. Knowing that service users constitute a threat of violence does not assist us in knowing which service users are dangerous.

The importance given to a self audit tool appears to symbolically place the onus for dealing with violence on the individual worker. Whilst social care employees have a responsibility to take every possible precaution to protect themselves, self-audit procedures should not deflect attention from the protective role of employing authorities. A different policy approach has been taken with respect to NHS staff. In 1999 a government campaign was launched to make the NHS a Zero Tolerance Zone (Department of Health, 1999; NHS Executive, 1999). Since then, all NHS Trusts have been required to produce a policy on the management of work-related violence, defined in accordance with that produced by the Health and Safety Commission (Health and Safety Executive, 1997).

## **Some emergent themes**

A complex picture emerges when any attempt is made to compare the nature and extent of violence against social care and health staff. It is difficult to draw firm conclusions from the research given the varying methodological approaches, time periods, definitions of violence, and categorizations of staff which are present in the literature (Denney and Stanko, 2000). Particular problems emerge when quantitative measures relating to the incidence of violence to staff are considered.

Despite these difficulties some observations can be made. The incidence of

violence and abuse varies between occupations. Rates of verbal abuse suffered by social care staff (75%) are comparable with GPs and Anglican clergy, but lower than that experienced by probation officers. Although violence perpetrated against nurses appears to be rising, violence directed at NHS GPs, another front line group of professionals who are vulnerable to attack, does not appear to have increased significantly over the last decade (Gabe *et al.*, 2001). Doctors working in hospitals are less likely to be assaulted than nurses. The incidence of minor injuries appears to be higher for nursing staff working in accident and emergency departments or psychiatric hospitals, compared with health staff in other areas of work. Averaging of incidents can underestimate the extent of victimisation in particular areas of work (Standing and Nicolini, 1999; Winstanley and Whittington, 2004). As with health care, social care workers in the field of psychiatry and residential work are more likely to be assaulted than those working elsewhere. The research also suggests that violence is under reported in health and social work settings (Pahl, 1999; O'Beirne; and Gabe, 2005). Locality also seems to be a common factor which affects the incidence of violence. Working in an inner city appears to increase the possibility of assault (Gabe, et al, 2001; Jenkins et al, 1998).

Another theme running through the research is the lack of attention given to staff training on this topic. At the time of writing the new requirements for the degree in social work in the UK do not include protection against violence and personal risk management. In service training offered to social care staff is haphazard and often follows in the wake of an attack. Few courses offered to social care staff have been evaluated for their usefulness, other than through satisfaction surveys administered when participants exit the course. There is little evidence that 'training works' in preparing staff to challenge and minimize threat. Mandatory training should include consideration of how staff have successfully diffused violent situations in specific social care contexts. Attention should also be given to what staff can expect in terms of support from their management and agency (Littlechild, 2002; O'Hagan, 1997). Research in the training of health care staff is slightly more abundant and could be used to inform social care courses. Personal safety training courses have been offered by NHS Trusts to help staff cope with violence, but their content is generic and applicable to managing violence in any work setting (Bleetman and Boatman, 2001). The existing research on the effectiveness of violence training suggests that while most personal safety courses promote confidence to cope with aggression, levels of recall and application of training advice vary, and are likely to depreciate over time (Ozer and Bandura, 1990; Calabro and Williams, 2002).

An important finding from the research in both health and social care suggests that the affects of assault, threat and verbal abuse are felt over long periods in both personal and work life. Verbal abuse and threat can have as profound and long lasting an effect as physical assault (Crabbe, 2004; Gabe et al, 2001; Pahl, 1999; Littlechild, 2000).

The avoidance of violence and threat would appear to be a common response in



social care work (Stanley and Goddard, 2002). Workers adapt their individual violence avoidance strategies to the work situation. Some Anglican priests for instance have windows strategically fitted in order that they can observe casual callers. Probation officers situate furniture so as to ensure that they have access to a door in case of an attack (Gabe *et al.*, 2001). The research also points to possible preventative strategies for avoiding violence which could be utilized throughout organizations. Listening to service users is important as they have a considerable amount to teach social care staff about what causes violence. The research suggests that delays with appointments are frustrating and can lead to anger. Attention to the physical environment is also a significant factor in reducing risk. The layout of waiting areas, lighting, the reduction of irritating noise, privacy in interviews, and lack of interruptions can all assist in preserving the dignity of the service user, whilst concomitantly reducing the possibility of attack (Gabe *et al.*, 2001; Littlechild, 2000; Department of Health, 2001).

In relation to child protection, one possible example of good practice has been developed in New Zealand with the introduction of Area Dangerous Situations Teams. These teams act as a resource to ensure that the effects of working in a difficult situation are minimized. This would be accompanied by systematic reviews of service users thought to pose a threat (Stanley and Goddard, 2002).

## **Gaps in the research**

Research thus far conducted has focused upon the perceptions and understandings of the professional. Any study actively seeking to understand the perpetration of violence from the perpetrators perspective could potentially have positive benefits. Until this occurs research is concerning itself with only half the story. More research needs to be conducted into the kinds of resources utilized by social care staff to counter aggression. Such knowledge could assist other staff in feeling that they can not only challenge abuse, but seek the emotional and management support to counter its impact. Moreover, there are those employed in social care situations that may be excluded by recording and monitoring exercises, for example, reception staff.

Little is known about how managers are influenced and influence the construction of protocols and procedures intended to address violence against health and social care staff, and more research needs to be carried out on the tensions in residential care work that might give rise to violence. This has a relevance to staff working with adult service users as well as young people.

In addition, specific research needs to be carried out into racially motivated violence. Health and social care employees often absorb anger and frustration created by institutionalized racism in the wider society. With regard to gender, the professional impact of fear and avoidance of potentially violent men also requires further and more detailed consideration.

## Conclusion

Although not covering all the research in the area, this article has suggested that the ramifications of abuse and violent attack can extend into professional practices. Ultimately, the fear of violence could affect the safety of vulnerable service users. Research in both the health and social care fields suggests that professionals in publicly funded health and care agencies work in an atmosphere which can be secretive and unsupportive, as exemplified in the inability of professionals to fully discuss attacks made against them. How far health and social care workers can be regarded as 'hostages' in threatening situations is open to debate. One of the possible criticisms of viewing the position of workers from this standpoint is that it over-individualises the response of workers to violence. It is important to create understandings about fear of violence which place the organization in the pivotal position. Violent incidents can be seen as the outcome of the concurrence of a number of factors and circumstances, some of which are directly under the control of the organization, and some of which relate to the characteristic of the individuals involved, that is the assailants and the employees (Standing and Nicolini, 1997).

It is also important not to base discussions in a context of negativity, which ignores the countless occasions that health and social care workers have enabled individuals to live healthy and well protected lives (Ferguson, 2002). There is now a recognition on the part of government and employers, that professional safety is vital to the delivery of high quality health and social care services (Littlechild, 2002). It has also been argued that there is a growing research base upon which safer practice can be built. The creation of a blame culture, constantly fuelled by tabloid hysteria will only increase the fear already experienced by those who daily intervene in complex crises. Any resulting shift to fortress professional practice would create further mistrust of service users and patients whilst contributing to panic. However, managerial practices which can only offer actuarially based risk management are patently attempting to contain a situation in which staff feel vulnerable to attack.

The importance of attempting to understand the manner in which differentiated professional contexts of violence can shape both individual and organizational responses to violence cannot be overstated. The evidence presented above suggests that a large proportion of professionals are aware of the potential for violence in the workplace, but experience powerlessness when attempting to manage their own safety.

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