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**The Organization and Workplace  
Violence Prevention**

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James Garbarino tells the story of, a friend of his we'll call him Joe. *Joe was on his way home from a meeting one night. As he walks down the street, he finds his friend George on the street on his knees under a lamppost, and George is sort of groping around. And Joe stops and says, George, what's the matter? And George says, Well, Joe, I've lost my car keys, and I live 35 miles away, so I can't go home until I find them. Well, says Joe, let me help you. Like a good samaritan, he rolls up his sleeves and he gets down on the street and starts groping around and starts looking for the car keys. Well, some times passes, and they haven't found the keys, so Joe says, Wait a minute, George, maybe we need a is more of a behaviorist approach. So from his other pocket he pulls out some M&Ms, and he says, George, I'm going to feed you these M&Ms to get your behavior under control. Soon he's got George moving right and left, back and forth, and it's very impressive. Still no car keys. Well, says Joe, George, maybe what we need is a more psychoanalytic, psychodynamic approach, so he begins to ask George about early experiences of loss in his life. Soon George is remembering when he was four years old. He lost his teddy bear, and how this feeling of loss is flooding back to him. They process this, and George is getting great insight into his loss and attachment issues, but he still can't go home. Well, says Joe, maybe what we need is a support group. So he gets out his cell phone, and he calls other people that have lost their car keys, and they tell George how they felt when they lost their car keys. Soon George is feeling okay about losing his car keys, but he still can't go home. Well, says Joe, maybe we need an educational approach. So he brings out a book entitled *The History of the Key in Western Civilization*, and they read about the key as a symbol and a metaphor in cultural analysis and films. You know, Ingmar Bergman drew that into some of his best films, and Woody Allen echoed those themes in kind of homage to Bergman. Fascinating stuff. Well, Joe said, maybe we need a campaign to find the keys. So he puts up a banner that says find the keys, and he gives out T-shirts that say find the keys and little blue key-shaped ribbons, and they link arms and say, Find the keys! Find the keys! and they feel really empowered. Well, now they're really getting desperate because they still have not found the keys, so Joe says, All right, George, let's take a really radical approach. Where exactly were you when you dropped the keys? And George says, Oh, I was about 150 yards up the road when I dropped the keys, and Joe says, Well, why are we looking here? and George says, Well, the light is much better here.*

The relevance of this parable to workplace violence prevention may not be immediately obvious. If however we cast ourselves in the role of the helpful Joe but this time as a hospital manager and the seemingly hapless George as the direct care worker looking for a solution to the problem of patients who keep behaving violently the suggestion that (with hindsight) we have also been looking in the wrong place can be made. In this instance the wrong place has been a near exclusive focus on ameliorative interventions focused on mediating the risk of violence posed by the service user via treatment (although this often comprises only bio medical intervention) and training in restraint and latterly de-escalation for direct care staff.

That this represents the wrong place is unquestionable because multiple studies suggest that rates of violence can vary dramatically between notionally highly similar services provided by different organizations suggesting that the organization itself and its values, cultures and working practices represent key variables. If this is so why have spent so long recently looking in the wrong place?

Paterson et al. (in press) suggest we have recently been in thrall to what they described as an 'individualizing episteme'. This was the result they argue, of an unholy coalescence between neo-conservative political ideology and the near demise of social psychiatry and psychology brought about by the ascendance of biological psychiatry. Epistemes once established exercise an all-pervasive influence saturating and governing thinking rather than being held consciously but their power is exercised insidiously (Bevir 1999). Because they 'operate transparently' in providing the frames we use to locate, perceive, identify and label our social world we can be wholly blind to the influence they exert and consequently they are uniquely powerful (Shapiro 1988: xi).

Bloom (2006) proposes that psychiatry or at least many psychiatric services have experienced a form of collective amnesia that has obscured their memory of previous treatment regimes based on moral treatment and the ideals of the therapeutic community. In many respects however the process is more akin to form of collective delusion (Goode 1992) as psychiatry has been effectively blinded to the structural determinants of violence by the almost absolute dominance achieved by the individualizing episteme exemplified by bio-psychiatry.

Ironically the ascendancy of biological psychiatry as *the* dominant treatment paradigm may have been at least in part a response by psychiatry to critics from sociology and radical psychiatry in seeking to reassert its historical dominance by claiming equal status to its oft times distant cousin medicine. Unfortunately casualties along psychiatry's journey in search of respectability as a branch of medicine have included a collective loss of interest in the therapeutic community as a means of treatment, a consequent failure to understand the role of collective disturbance and sometimes it appears the ability to recognize when cultures have ceased to be therapeutic and have become corrupted (Wardhaugh and Wilding 1993).

The root causes of our recent blindness to the significance of the role played by the organization in violence prevention may thus lie in part with changes at a macro level in the dominant ideological and political paradigm in our society and their influence upon, and interaction with, changes in the dominant paradigm within psychiatry. Bloom (2006) suggests this blindness can disable us so completely that we fail to recognise a phenomena she describes as parallel processing. Smith (1989:13) observes that '*When two or more systems – whether these consist of individuals, groups, or organizations – have significant relationships with one another, they tend to develop similar affects, cognition, and behaviors, which are defined as parallel processes*'.

The presenting problems of service users can thus evoke or exacerbate tendencies within the organization particularly where the organization itself is under stress.

**Parallel Processing and the roots of aggression and violence** (Adapted from Bloom 2006)

**Service User**

**Chronically Stressed Organization**

Feeling unsafe	Fear of service users and management
Problems with managing anger and aggression	Chronic frustration and anger Feelings can be vented towards services users
Learned helplessness	Feelings of helplessness in the face of complexity of service user problems dysfunction of the culture
Hyper arousal	Increasingly crisis orientated service leading to feelings of hyperarousal amongst staff and a climate of anxiety in the service
Hyper vigilance	Increased emphasis on control measures leading to more conflict with service users
Memory problems disassociation	Experienced staff leave taking with them the memory of previous approaches
Poor communication skills	Communication breaks down between teams and between disciplines increasing levels of frustration
Poor conflict resolution skills	Interpersonal conflicts increase generating further hostility that is mirrored by relationships between service users
Problems with relationships	Teams become fragmented and split leading to inconsistent management and possibly more aggression from service users
Poor self esteem	Emotional exhaustion leads to burnout and an inability to emotionally engage decreasing clinical effectiveness. Staff feel deskilled.

An early if rarely recognized upon casualty of psychiatry's whole hearted embrace of biomedicine was however mental health nursing itself (Hunter 1956). Stripped of any pretence regarding parity of esteem with psychiatry, the previous partnership of equals dissolved at least in relation to violence prevention, by the privileging of biological and thus scientific knowledge over social psychology and relationship building, nurses in many settings became the handmaidens not only of the psychiatrist but of bio-psychiatry itself.

The result was unfortunate, self esteem diminished, knowledge base devalued and in some settings such as London latterly near overwhelmed by decreases in the number of acute beds and rising acuity and co-morbidity in those admitted to antiquated and

understaffed services nurses retained however their almost complete power over the day to day lives of those they cared for (Patrick et al 1989). This simultaneous lack of power and status and complete control when combined, produced a situation described by Wardhaugh and Wilding (1993) as one of dangerous ambivalence. All too readily nurses could displace their unmet needs for self esteem, power and control into their relationships with service users. Where such displacement took the form of over controlling behaviour by staff it increased the risk of service user non-compliance and the likelihood of counter aggression in turn.

In the UK one consequence of a perceived rise in violence was the proliferation of training in physical interventions designed to better control the perceived rise in physical violence. Unfortunately given the none too subtle endorsement of the legitimacy of coercive approaches by dint of receiving training that expedited their ability to enforce compliance it appears that staff in many settings routinely misused restraint. In such corrupted cultures (Wardhaugh and Wilding 1993) care became subordinate to the preservation of order (Martin 1984). Similar problems were however also reported in services for people with a learning disability (Commission for Social Care Inspection / Health Care Commission 2006). Such approaches if analysed from the perspective of the public health approach advocated by the World Health Organisation were of course fundamentally flawed because they focused on secondary and tertiary prevention to the exclusion of primary prevention (Paterson et al. 2005).

The need for a total organisational response which eschews victim blaming has however gradually been recognised. Increasingly the organisation has been identified as a potential focus for intervention in reducing violence (Turnbull and Paterson 1999). In the US the National Association of State Mental Health Program Directors (1999) called on services to:

*“Conduct root-cause analysis to understand their entire system of care, including interactions between individuals and staff that precipitate seclusion and restraint events.”*

The Royal College of Psychiatrists / Health Care Commission National Audit of Violence (2003) suggested that the risk of aggression and violence could be reduced if services address the following key areas:

- Ø Unsafe physical environments
- Ø Inadequate staffing
- Ø Overcrowding and the client mix
- Ø Substance misuse
- Ø Boredom
- Ø The quality of training offered to staff

More recent initiatives under the auspices of the National Institute of Clinical Excellence (2005) and National Institute for Mental Health in England (2004) have stressed the need for changes to working practices, physical environments and the culture of in-patient

services. David Colton's (2004) work is particularly interesting. Having reviewed eighty publications describing attempts to reduce the use of physical restraint and seclusion (many of which found reductions in overall rates of violence as an unexpected side effect) he identified a series of common themes. Committed engaged leadership was critical but not enough in and of itself. Organisations required robust quality assurance mechanisms that identified minimum performance criteria and demanded their achievement. Staff required training but not simply in the techniques of de-escalation and restraint (although these were sometimes needed) but also in the core values of the organisation and in how to realise primary prevention including recognise and manage their own attributions. A coherent and evidence based regime of care that sought partnership with its service users was necessary that enabled individualised treatment planning including crisis prevention and active learning from incidents. This regime must be provided in an appropriate environment that was not overcrowded, understaffed or poorly ventilated.

The International Labor Organization (Chappel and DiMartino 1998) have advocated that organisations seeking to respond to the issue of violence need to adopt what they have termed 'high road' approaches (ILO 2000). These approaches are based on the concept of the 'smart' i.e. learning organization (Dowd 1999). The organisation is construed as an active entity that learns via continual reflection on its performance. In the context of violence prevention this reflection encompasses every aspect of organisational role but starts with the development of an explicit philosophy as a statement of the organisations values. Such philosophies may be contained within an organisations vision statement Murphy and Bennington-Davis (2005:5) provide several examples including,

To create a place of absolute safety and respect for the staff and the people we serve

To work in an environment where restraint and seclusion are unnecessary and where the alternatives of respect kindness safety and education replace them

The means by which such values are transmitted into practice is however, not left to chance. A project management model informed by theory such the Balanced Scorecard model whose development is generally credited to Kaplan (Niven 2003) is used to establish whose expectations must be met (Dowd 1999). The approach provides a set of principles along with techniques for analysing and crucially improving an organization's performance in four general areas. These are financial performance, customer care, organisational learning and internal processes. The methodology breaks high-level strategies down into four aspects objectives, measurements, targets and initiatives. Data collection systems are then applied across the organisation to monitor the behaviour of all staff up to and including senior managers. These will typically include the behaviour of staff towards each other and the behaviour of direct care staff towards service users.

Conclusion

A increased emphasis on the need to focus on the role played by the organisation in violence prevention does not imply that interventions that engage with individual pathology in the form of intra-psychic issues, such as the impact of trauma are unimportant. Instead it further emphasises the need for consumers to have access to skilled and qualified staff equipped to engage in appropriate treatments in environments that facilitate rather than hinder such work. However, in stressing primary prevention it suggests that such interventions should be complemented by interventions that seek where necessary to transform the culture of services such that its potential function as a therapeutic agent in its own right is accorded equal priority (Paterson et al. 2008).

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