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Violence in the Community—A Study of Violence and Aggression in Homelessness and Mental Health Day Services

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ABSTRACT

This study examined violence and aggression in five agencies providing day services in homelessness or mental health. Incident reporting was used to test the hypotheses that aggression is associated with alcohol problems, drug use, mental disorder, homelessness, history of violence, age and sex. Agency policies and patterns to aggressive incidents were explored. Three agencies provided a sufficient number of incidents for analysis (involving 30 'aggressors'). A history of violence was associated with aggression in all three agencies; alcohol problems, drug use and younger age were associated with aggression in at least one agency; no association was found for mental disorder, homelessness or sex. A degree of pattern to incidents could be discerned, with drink or drugs often involved, and exercises of authority or intervention in client altercations being particularly likely to precede aggression towards staff. A variety of incidents were reported, from verbal arguments to threats with a knife and serious physical assault. © 1997 John Wiley & Sons, Ltd.

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INTRODUCTION

Mental disorder and violence

The term 'mental disorder' is used in this article in line with the Mental Health Act 1983 to incorporate a diagnosis of personality disorder as well as a diagnosis of

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mental illness. Such diagnoses can overlap and are often not easily distinguished (see Davies, 1995, for an individual example particularly relevant to this paper). Attention is usually focused on mental illness. It should also be recognized that the medical model of mental health is not the only one (e.g. Tyrer and Steinberg, 1993).

Over the past few years, community care policy has been accompanied by a widespread public and media perception of danger posed by mentally ill people in the community reaching critical levels. This perception has been fuelled by a number of high profile murders (Zito Trust, 1995; Ritchie, 1994; Boyd, 1994; Blom-Cooper, 1995; Davies, 1995). Boyd reports that of some 700 homicides per year, about 100 offenders are subsequently referred to psychiatric care, but that the number of murders committed by recently discharged psychiatric patients is very small.

Link, Andrews and Cullen (1992) found people with mental illnesses more likely than others to be violent, even when a large number of social factors were controlled. Swanson *et al.* (1990) also found clinical factors to be significant predictors of violence (Table 1). Discounting drug and alcohol problems for now, only *severe* mental illnesses were found to be predictive of violence. Link, Andrews and Cullen's findings go further, to suggest that only people with *current* psychotic symptoms pose an elevated risk of violence. Reviews of other evidence concur (Monahan, 1992; Sellars, Hollin and Howells, 1993; Taylor, 1993a).

Drugs, alcohol and violence

The strong association between both drug problems and violence and alcohol problems and violence found in the Swanson *et al.* study can be seen in Table 1. There is a surfeit of other evidence that alcohol intake is associated with violence (Hodge, 1993; Shepherd, 1994; Taylor and Chermack, 1993). Sedative and stimulant drugs, especially with intravenous use, are also particularly associated with violence (Forshaw and Strang, 1993).

With both drugs and alcohol, distinct *chronic* effects of excess use may impact on levels of violence, as well as *acute* effects of recent intake.

Assessment of dangerousness

The assessment of dangerousness in an individual person is a very inexact science, particularly given the interactional nature of most violence. The best predictor of future behaviour is past behaviour, along with consideration of circumstances known to present increased risk (DoH, 1994; Shah, 1993). As well as alcohol, drugs and severe mental illness, other factors associated with violence include: maleness; youth; lower socio-economic status; personal history; personality; and situational,

Table 1. Percentage violent during past year by diagnosis (Swanson *et al.*, 1990)

Diagnosis	Violent (%)
No disorder	2.1
Schizophrenia	12.7
Major depression	11.7
Mania or bipolar	11.0
Alcohol abuse/dependence	24.6
Drug abuse/dependence	34.7

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cultural and social factors (Pollock, McBain and Webster, 1989; Swanson *et al.*, 1990; Maden, 1993).

Social work and violence

Research has found high levels of violence in social work settings, although under-reporting of incidents is often a problem. Predisposing and precipitating factors include: youth (of assailant); previous criminal convictions (particularly for violence); history of psychiatric admissions; recent stress; use of alcohol; and intervening to protect a third party or exercising social control (Brown, Bute and Ford, 1986; Strathclyde Regional Council, 1987; Saunders, 1987; Kedward, 1990; Leadbetter, 1993).

Prevention

Rowett and Breakwell (1992) define 'prevention' as prediction plus protection. They emphasize that any preventive procedures must be both feasible and effective; feasibility includes compatibility with agency ethos and other policy and procedure.

Bute (1994) recommends a 'minimum package' comprising: reporting, recording and monitoring procedures; guidelines and training on prevention and management of violence; consideration of work environments; counselling; compensation; and prosecution.

Aims

The first aim of the present study was to test whether certain characteristics of service users made them more prone to aggression (including violence). The seven characteristics considered were: mental disorder; alcohol problems; drug use; history of violence; sex; age; and homelessness.

Two areas were explored descriptively: first, ethos and policy differences relating to aggression and violence; second, whether there was any discernable pattern to the incidents.

The research was thus able to inform policy and practice of the agencies involved.

METHOD

Definitions

These are close to those suggested by Berkowitz (1993).

- *Aggression*: any behaviour, or threat of behaviour, that is intended to cause physical or emotional harm.
- *Violence*: a subset of aggression, where an attempt is made to cause actual physical harm.

Design

Five agencies took part. Names have been changed: 'The Meeting Place' and 'The Club' are both mental health day-centres. The Meeting Place is open access. Members come to The Club by professional referral only, and all have a severe and enduring mental illness. 'The Drop-In' and 'The Neighbourhood' serve homeless

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people and are open to anyone; The Neighbourhood provides for younger people. 'The Surgery' is a homeless persons' medical centre.

Violent/aggressive incident forms

A short recording form was designed, to be filled in by staff after any incidents of violence or aggression. The interactions making up an incident could involve more than one 'aggressor', and if so a form was to be completed for each individual.

The forms categorized each aggressor in terms of: mental disorder (the actual question being, 'Has he/she been diagnosed with a mental disorder or received psychiatric hospital treatment?') and acute illness at the time; alcohol problems and use at the time; drug use and use at the time; history of violence; sex; age; and homelessness, using a 'yes/no/think so/think not/don't know' format. Initials of the aggressor were asked for, to both maintain confidentiality and indicate when the same aggressor was involved in different incidents (other characteristics would show almost certainly whether it was the same person).

Open-ended questions were structured to reveal: history of violence; background factors; build-up and triggers; the incident itself; and outcomes for aggressor, victim and agency, including police involvement.

After collection of forms, incidents were categorized in terms of: verbal aggression; threat to person; threat to property; violence to person; violence to property; use of a weapon; and physical harm actually caused. The incident form also revealed whether the victim(s) were worker(s), service user(s) or property.

Profiling

A baseline profile was needed, against which to test the hypotheses. Fortunately, each agency kept a daily register of attendance, a typical week from which was analysed to determine numbers of 'user-days attendance' in each category of the seven hypothesis variables.

Agency policies

Agency policies relating to aggression and violence were collated, and further qualitative material regarding the broader issues was garnered from discussion with managers and worker teams.

After piloting, the incident data collection proper ran for 4 months.

QUANTITATIVE ANALYSIS

The time period available for reporting of incidents was limited and the number reported was quite small. Hence the categories of each variable were collapsed in order to carry out statistical analysis (see Table 2). 'Yes' and 'think so' were grouped together; and 'no', 'think not' and 'don't know'. The proportion of 'don't knows' was relatively low. Ages were also grouped to give two categories of similar size: 35 and under and 36 plus.

With the categories collapsed, three agencies (The Meeting Place, The Surgery and The Drop-In) had enough data to test the hypotheses, using a one-tailed binomial test (Siegel, 1956).

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Table 2. Profiles of aggressors compared with general attendance profiles

	'The Meeting Place'			'The Surgery'			'The Drop-In'		
	Attendance profile (%, $n=184$)	Aggressors (%, $n=10$)	Sig	Attendance profile (%, $n=145$)	Aggressors (%, $n=9$)	Sig	Attendance profile (%, $n=336$)	Aggressors (%, $n=11$)	Sig
Drink problem:									
'Y'	6	10	NS	65	89	NS	38	73	‡
'N'	94	90		35	11		62	27	
Drug user:									
'Y'	9	60	‡‡‡	39	89	‡‡	41	36	NS
'N'	91	40		61	11		59	64	
Mental disorder:									
'Y'	63	60	NS	34	44	NS	33	27	NS
'N'	37	40		66	56		67	73	
Homeless:									
'Y'	5	–	NS	76	100	NS	81	82	NS
'N'	95	100		24	–		19	18	
History of violence:									
'Y'	19	70	‡‡‡	37	78	‡	11	82	‡‡‡
'N'	81	30		63	22		89	18	
Age:									
$\leqslant 35$	48	80	‡	41	67	NS	55	45	NS
$\geqslant 36$	52	20		59	33		45	55	
Sex:									
M	67	80	NS	83	89	NS	87	100	NS
F	33	20		17	11		13	–	

‡$p<0.05$; ‡‡$p<0.01$; ‡‡‡$p<0.001$

Clients with *mental disorders* were not over-represented as aggressors in any of the agencies. Three caveats should be added to this. First, this result is limited to these particular agencies. Second, deeper analysis of the data by type of disorder was not possible. It may be that certain severe illnesses do present increased risk. However, the few diagnoses of aggressors that were provided were mostly of personality disorder. Third, no agency should be complacent about the possibility of someone who becomes acutely ill causing serious harm in a one-off incident.

At The Drop-In, clients with *alcohol problems* were over-represented as aggressors. There was no statistically significant result for The Surgery, but eight of the nine aggressors had a drink problem and in all cases the aggressor had been drinking prior to the incident.

Drug users were over-represented as aggressors at The Surgery and The Meeting Place.

The strongest result was that clients with a *history of violence* were over-represented as aggressors at all three agencies.

Males were a substantial majority in all the agencies, so it would be difficult to demonstrate a significant result. Nevertheless, they were (non-significantly) over-represented as aggressors in all three agencies.

Younger people (35 or under) were over-represented as aggressors at The Meeting Place.

Nowhere was *homelessness* associated with aggression.

Overall, the direction of the results and their relative strengths generally accords with the literature, although not even a modest effect was found for mental disorder.

DESCRIPTIVE ANALYSIS

The Meeting Place

The Meeting Place has a straightforward policy for dealing with violence or disruption. Drink and non-prescribed drugs are strictly disallowed. Violence or threatening behaviour is unacceptable. Anyone who does not keep to these rules will be asked to leave. If they refuse, a ban of 3 days is automatically imposed. In serious cases, an emergency meeting (for users and workers) is held and any bans are decided upon. Bans should be recorded in the incident book. If someone breaks a ban, it is automatically increased. Minimum staffing levels are explicit. The Meeting Place also offers a rolling programme of groups, including anger management.

Eight incidents were reported, involving ten aggressors. Incidents were characterized by aggressive reactions to disruptive behaviour, ongoing personal dislikes, and arguments between users. There was only one case of violence, and an intervening worker met no resistance.

As might be expected given the strict policy, no aggressors had been using drugs or alcohol at the time of the incident, except one who was thought to have taken cannabis. Furthermore, only one was considered to be acutely mentally ill at the time.

The incidents were dealt with by the workers, asking aggressors to leave for the day if appropriate. An emergency meeting was called only once, resulting in a ban of 3 months.

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The Surgery

People may use The Surgery when intoxicated, but may not bring intoxicating substances in. There is an accident book and a log book where incidents should be recorded. Minimum staffing levels are clearly stated for different situations. Personal alarms are situated in the consulting rooms.

Users of the centre may be asked to leave for antisocial behaviour, and in serious cases the police may be involved, but users will not be banned for more than 1 day, as they are at other centres. As a medical centre, The Surgery is in a special position and any user banned from there would be very unlikely to receive primary healthcare elsewhere.

Nine incidents were reported, each with a single aggressor, eight involving aggression towards staff. In four cases there was violence to the person and in two physical harm was caused.

In one incident the aggressor was considered to be acutely ill. Of the two individual diagnoses of mental disorder provided, one was of acute/chronic anxiety, the other was of personality disorder (aggressor in three incidents).

In all nine incidents the aggressor had been drinking, and in eight drugs had been used. Other situational and trigger factors were apparent: being barred from other agencies; being refused service, either because it was the wrong time or because of antisocial behaviour; 'hanging around' outside the building, often drinking.

The police were involved once, when an individual was 'laying siege' to the surgery entrance. He was moved on and there were no charges.

In both cases where physical harm was caused, both drink and drugs had been taken; in one case the aggressor had a mental disorder, but was not considered acutely ill. In both cases the victim was another service user who was hit without provocation (in one case for refusing to give a cigarette). Staff intervened and the police were not called; in one case it was specifically stated that the victim did not want them involved. In both cases people hanging around outside were seen as a problem, and so management of this was to be reviewed.

The Drop-In

People may use The Drop-In when intoxicated, but may not bring substances in. Incidents and concerns should be logged in the 'day book', and a report form sent to Probation Headquarters. There is a risk assessment slot in team meetings, where the length of any bans are decided upon. There is thorough Probation Service guidance on violence. Personal alarms are provided for all workers.

Towards the end of this research, further work was done on the violence policy, with the emphasis on making it more specific to the particular centre. Outcomes included a stricter banning policy, the installation of a security door and bullet-proof glass at the hatch, and closer liaison with the police, for which procedural guidelines were drawn up. Staff feedback suggested that the new policy resulted in a marked decrease in incidents of serious aggression.

Eleven incidents were reported, each with a single aggressor. The pattern was similar to that at The Surgery, except for lesser extent of drug use, greater use of the police and use of bans.

In nine cases aggression was directed at workers. In six cases there was violence to the person, in three violence to property (breaking windows, throwing furniture and

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crockery), in one a weapon was used (a soup bowl), and in three physical harm was caused.

In one incident the aggressor was considered to be acutely ill. The only individual diagnosis of mental disorder provided was of personality disorder (aggressor in three incidents).

In six incidents the aggressor had been drinking, in only one had drugs been used. In eight cases the aggressor was being asked to leave, either because he was banned or because of antisocial behaviour.

The police were involved six times. For certain barred individuals there was a policy to call the police as soon as they arrived; this accounted for three cases. In the other three cases the police were called during or immediately after the incident.

All three cases where physical harm was caused involved a punching/kicking assault on another service user, and in one furniture and crockery were thrown around as well. In each case, drinking had preceded the assault, in one drug use, and in another the aggressor had a diagnosis of personality disorder. Other background and precipitating factors were withdrawal of other services, dispute over drug dealing, verbal aggression preceding the assault, and trying to come in when banned. In each case staff intervened. In one incident this resulted in a worker being threatened, and in another a worker was punched in the face. In each case the police were called; in one this resulted in an arrest and charge of affray, in another it took 1 hour for a lone WPC to arrive. Other outcomes were the banning of aggressors, closure of the centre for 2 days of reassessment, and expediting the installation of a security door.

The Neighbourhood

The Neighbourhood was a temporary project that closed part-way through this research. During this uncertain period for the project there were difficulties of communication and this research was not afforded high priority. Incident forms were not completed; two forms were filled retrospectively for two serious incidents that had been logged.

No written policy on violence and aggression was available.

In both incidents drugs had been taken and a background factor was that the aggressor was trying to come off heroin. In the first case, alcohol had also been consumed and the aggressor was already barred, in the second the aggressor suffered with a mental disorder (diagnosis and whether acutely ill unknown). The first incident was an unprovoked punching and kicking attack on a worker; the two were separated before any physical harm was done. The worker did not want to press charges; he had done so before and did not want the stress of a court appearance. The police were not called. The project was closed for 1 week for reassessment and the door policy was tightened up. The second incident started with verbal aggression when breakfast was not available; the aggressor was asked to leave. He returned 20 minutes later with a knife and held the place hostage for about 45 minutes. In this time he also spray-painted the building and other users. He eventually left after much persuasion. The police were not informed until 2 days later. The project was again closed for a week for reassessment and the door policy tightened up. The aggressor was barred.

The Club

The Club had no incidents to report.

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The Club has a relatively stable, membership-only user group. When a person applies for membership, the mental health worker nominating him/her is asked for assurance that he/she 'does not display aggressive, disruptive or difficult behaviour . . . especially if this is the result of a personality problem rather than a mental illness'. Although members may use The Club under the influence, they may not if intoxicated, and substances are not allowed on the premises.

There is also a clear and very strict policy on violence.

Overview of descriptive results

Much of the aggression directed at staff came about when they were involved in intervening or controlling (such as asking someone to leave after antisocial behaviour directed at other clients). This accords with results from other social work studies (Strathclyde Regional Council Social Work Department, 1987; Brown, Bute and Ford, 1986).

Although a number of individual users have been involved as aggressors in more than one incident (up to a maximum of three), there is little evidence that particular individuals are causing havoc across the city. Of the 32 aggressors recorded, there were 21 different individuals. Only two individuals were recorded as aggressors in more than one agency: both those at The Neighbourhood were also aggressors at The Drop-In.

Certain agency and policy factors are likely to be influential in reducing levels of violence, e.g. being well established with a relatively stable user group and staff team, avoidance of intoxication, and having a strict policy on the unacceptability of aggression. However, whereas the policy factors here might work well at somewhere like The Meeting Place or The Club, they might serve to exclude the particular client group aimed for by somewhere like The Surgery, The Drop-In or The Neighbourhood.

Particular issues arising

Incident reporting. First, there is benefit in a straightforwardly *structured* format for the reporting of incidents. Rather than a blank page in an incident book, a simple form or guidance would clarify what information is required.

Intoxication. If an agency is trying to serve people who may well attend having used drugs or alcohol, what can be done to reduce the danger of violence? General principles around prevention apply (Breakwell, 1989; Bute, 1994), although workers should be clear about the limitations of trying anything other than the most basic reasoning with an intoxicated user. Non-aggressive norms and atmosphere built up overall are likely to be more effective in preventing violence by intoxicated users than are individual interventions (Taylor and Chermack, 1993). Dealing with intoxicated users should be part of training on aggression.

Carrying of weapons. Only one incident reported here involved the deliberate carrying of a dangerous weapon (the knife used in the prolonged threat at The Neighbourhood). However, other incidents have occurred outside of this 4 month period. In the pilot study an incident was reported of a user of The Surgery brandishing a hatchet. Between the pilot and the start of the data collection period a user of The Club came in carrying a replica gun. Finally, around the time of this

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study there were two murders very close to home for the agencies involved here. There was a fatal stabbing of a care worker in a local hostel for people with mental health problems in October 1993 (Davies, 1995). And in May 1995 one resident of the local nightshelter stabbed to death another resident in the town centre.

The availability of a weapon (even if ostensibly carried for self-defence) can be of utmost importance, both as a cue to violence and as a means by which that violence can become far more serious (Breakwell, 1989, p. 54). The Club is currently the only agency with a ban on the carrying of weapons written into its violence policy. Although this would not prevent anyone walking in with a weapon, it would at least provide a clear principle from which to try to dissuade a user from even drawing a weapon (as in the incident at The Surgery). Consideration would then need to be given to whether the police should be involved if a user brandishes a dangerous weapon without directly threatening anyone.

Problems around the entrance. There have been problems at The Surgery and The Drop-In, as well as with the two incidents at The Neighbourhood. There is no ideal solution. The Drop-In has gone for the installation of a security door, which should be effective on its own terms, but may bring associated problems in terms of alienation; The Surgery has decided to concentrate on its management of the area around the entrance, which approach may have little scope for real impact. In either case, difficulties outside the building link into the next issue.

Liaison with the Police. Some research has identified this as an important preventive organizational strategy (Breakwell, 1989, p. 65). It needs to be compatible with the agency ethos, but the development of a mutually understanding relationship with the police might enable a more proactive approach to be taken, particularly with some of the problems just mentioned. it might also encourage a quicker and more helpful response when the police are called in. The Drop-In have indeed found their new procedural guidelines on liaison with the police, the result of considerable negotiation, to be very useful.

To conclude briefly, it is worth remembering that the vast majority of people use community services such as these without being overly aggressive. However, some very serious incidents were reported, and there is every indication that issues around violence need to be considered thoroughly *in the context* of the particular service the agency is trying to offer.

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