

## **National Task Force on Violence towards Social Care Staff**

### ***Review of research on violence towards social care staff, with special reference to services for people with Alzheimer's Disease***

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#### ***Introductory points.***

##### ***Definition of violence***

This research review suggests, that in the context of the care of older people, the occurrence of "the violent incident", in the sense understood in health and safety legislation (Royal College of Nursing, 1998) is not so much the issue as the existence of a range of "violent" **behaviour**. The words "aggression" and "challenging behaviour" rather than "violence are frequently used in the literature". Violent behaviour is variously defined to range from threats, verbal abuse, aggressive resistance and the destruction of property through biting, pinching, scratching and hair-pulling to assault and attack using a weapon (Patel and Hope, 1993; Royal College of Nursing, 1998; Keene et al., 1999; Mason and Chandley, 1999; Shah, 1999; Shah and Allen, 1999). The behaviour included may also include sexual abuse (from harassment to rape), racial abuse and theft of property. Racial abuse, in particular, may be of considerable importance in the context of this report, because of the large numbers of minority ethnic care staff in some areas working with older people, coupled with the small numbers of minority ethnic users.

##### ***"Violence" and "Alzheimer's Disease"***

Alzheimer's Disease is a form of dementia but dementia is not the only clinical condition relevant to "violence" towards care staff. Five "Ds" have been suggested as salient in the aetiology of disturbed behaviour in older people - Dementia, Delirium, Depression, Drugs and DSM-IV (basically other diagnoses, especially anxiety and psychosis) (Fulop, 1999). Depression is least likely to account for violent behaviour (Eastley and Mian, 1993). Although dementia is not the only condition in which individuals display violent behaviour, it is perhaps the most common, and has been the subject of most research.

### ***Prevalence of behavioural problems among older people***

In 1985, over 600,000 older people in Britain (see Table 1) were estimated to have behavioural problems, a proportion of which included potential violence towards others (McCreadie and Hancock, 1997; McCreadie, 1996). Around three quarters of these were living in the community. Not all of them were suffering specifically from dementia. Since 1985, when the surveys were undertaken, the population over 65 has increased, so the figures in Table 1 almost certainly under-estimate current prevalence. There is no clear evidence that aggressive behaviour leads to residential/nursing home care ( Hope et al, 1998).

**Table 1** Estimated numbers of older people (age 65 and over) with behavioural problems including those involving violence and aggression living in the community and in institutions. Great Britain, 1985.

Severity category	Total, aged 65+	
	In own home	In institutions
1.Finds it difficult to stir him/herself to do things/ often feels aggressive or hostile towards other people	59,000	-
2.Sometimes sits for hours doing nothing	76,000	29,000
3.Finds relationships with people outside the family very difficult	25,000	20,000
4.Often has outbursts of temper at other people with very little cause	12,000	19,000
5.Finds relationships with members of the family very difficult	35,000	14,000
6.Feels the need to have someone present all the time	237,000	-
7.Gets so upset that breaks or rips up things	15,000	3,000.
8.Gets so upset that hits other people or injures him/herself	28,000	36,000

**Source:** McCreadie and Hancock, 1996, Table 2. Calculated from OPCS data (Martin, Meltzer and Elliot, 1988)

### ***Settings for “violence”***

The settings in which disturbed behaviour occurs include people’s own home, day care, hospitals, residential care and nursing homes. There are around 500,000 older people in nursing and residential homes and the major disability from which they suffer is dementia. Many of these residents would, in previous times, have been in

psycho-geriatric wards in long-stay hospitals. To-day, nursing home and residential care is provided predominantly, although not exclusively, by the independent sector, and in the majority of cases homes are run for profit by individual owners. It is a very diverse sector, varying from homes with as few as three residents to homes of a hundred people. It is to be expected that there will be substantial variations in quality of care, and this is clear from a plethora of reports (Department of Health, 1995 and see for example reports from Counsel and Care: Bright, 1995; Clarke, Hollands and Smith, 1996; Bright, 1997).

### ***Focus of research review***

The emphasis in this research review will be on violent behaviour in communal settings employing social care staff. However, since, on the coal-face, there is little difference between “nursing assistants” and “social care staff”, considerable reference will be made to the relevant health literature. It is important to note (see Table 1) that many more older people live in the community than in residential care and abusive situations may arise in relation to family members, or paid carers. There is evidence that day care is used more by older people with severe behaviour problems (Levin, Moriarty and Gorbach, 1994). While there is a body of research relating to family members (McCreadie, 1996), little relates, as far as has been identified by this review, to paid social care staff in day care or in domiciliary settings (Balloch, McLean and Fisher, 1999).

### ***Methodological issues***

This is a notoriously difficult area to research satisfactorily (Royal College of Psychiatrists, 1998; Shah, 1999). No research involving other human beings can meet fully scientific criteria for minimising bias. The main problems concern being able to generalise on the basis of different pieces of research of varying quality which may vary in definitions, sample sizes, study design, methods of investigation and data collection, explanatory factors and analysis (Pahl, 1999; Shah, 1999; Shah and Allen, 1999). A particular problem relates to research evidence from abroad; specifically the United States is a deceptively similar society and culture from the United Kingdom notably in the institutional arrangements for health and social care, and in the size, for example, of residential facilities for the care of older people. On the other hand, it would be foolish to ignore American research. American and other non-UK sources are asterisked in the bibliography to emphasise the source of the evidence.

## ***Research questions***

The research questions that have been considered are:

- 1. What is known about the extent and type of violence towards care staff by older people?**
- 2. What is known about the reasons for violence? What is known about the circumstances in which violence is most likely to occur?**
- 3. What is known about the consequences of violence?**
- 4. What measures are needed to prevent and manage and reduce violence?**
- 5. What longer term research is needed?**

### ***1. What is known about the extent and type of violence towards care staff by older people?***

Verbal aggression, aggressive resistance and physical aggression are common problems in patients with dementia (Eastley and Mian, 1993; Patel and Hope, 1993; Martin, McKenzie and Ames, 1994; Freyne and Wigley, 1996; Gormley, Rizwan and Lovestone, 1998; Allen-Burge, Stevens and Burgio, 1999; Fulop, 1999; Hope et al., 1999; Keene et al., 1999; Shah and Allen, 1999). These problems are widely found in long term care settings (Pillemer and Moore, 1989; Shah, 1992; Eastley et al 1993; Goodridge, Johnston and Thomson, 1996a; Moniz-Cooke, Millington and Silver, 1997; Gates, Fitzwater and Meyer, 1999; Jackson, Templeton and Whyte, 1999). They are also found in family care (Gilleard, 1984; Levin, Sinclair and Gorbach, 1989; Hamel et al, 1990; Ware, Fairburn and Hope, 1990; Paveza et al, 1992; Pillemer and Suito, 1992; Cahill and Shapiro, 1993; Coyne et al, 1993; Hinchcliffe et al, 1995; Chappell and Penning, 1996; Eastley and Wilcock, 1997; Hope et al, 1998; Coen et al, 1999).

Prevalence data about violence towards staff is generally unreliable due to differences in research methodology (see above). The totality of violent behaviour is under-reported (Eastley and Mian, 1993; Penna, Paylor and Soothill, 1995; Freyne and Wigley, 1996; Brennan, 1999; Pahl, 1999; Shah, 1999). Where violent incidents are reported, a small number of individuals *may* account for the majority of episodes of violence or for the more severe ones (Shah, 1992; Clark, Lipe and Bilbrey, 1998).

The majority of violent episodes that are reported in communal settings are mild (Eastley and Mian, 1993; Patel and Hope, 1993; Freyne and Wigley, 1996; Gormley, Rizwan and Lovestone, 1998), with perhaps up to 25% resulting in a visible injury (Eastley et al., 1993) and a minority of these being severe.

There is minimal information on violent behaviour towards staff in the community. NISW data (Balloch et al, 1999) suggests that the problem of violence towards home care staff (working largely with older people?) affected about a quarter of these respondents, but very largely in the form of verbal abuse. All residential staff were more likely to be attacked physically (particularly in Scotland) and verbally, but staff working with older people were less vulnerable than those working with other client groups.

There has been no research into the extent of violence and verbal abuse **towards** older people living in residential/nursing homes by staff in the U.K., although there have been a small number of ethnographic studies (McCreadie, 1996) and there is considerable evidence of abuse available in various enquiry reports (Martin, 1984; Harman and Harman, 1989; UKCC, 1994; Clough, 1999; Bright, 1999a; Camden and Islington Community Health NHS Trust, 1999). Research in the United States and Canada has found excessive use of restraint and verbal and other forms of emotional abuse common (Pillemer and Moore, 1989; Goodridge, Johnston and Thomson, 1996).

## ***2. What are the reasons for violence? What is known about the circumstances in which violence is most likely to occur?***

The reasons for violent behaviour can initially be examined by four inter-related areas: the violent individual, the recipients of violence, the nature of the institution and the environment in which the violence takes place.

### **The violent individual**

Research has been inconsistent in terms of linking violent behaviour with the age, gender, cognitive impairment or dependency of the older person (Eastley and Mian, 1993; Shah, 1995; Eastley and Wilcock, 1997; Beck et al, 1998; Gormley, Rizwan and Lovestone, 1998; Keene et al., 1999; Shah, 1999).

### **The recipient of violence**

Neither the NISW studies (Balloch et al, 1998; Pahl, 1999), nor other research, indicate that it is helpful to try and draw up a profile of the “typically assaulted” staff member in terms of characteristics such as age, gender, experience or ethnic background, although racial abuse is by definition directed at members of minority ethnic groups (Clough, 1999).

### **The nature of the institution (e.g. size, ownership)**

There is no evidence that the size, ownership status or cost of an institution bears any relation to the existence of violent behaviour in residents. There is much evidence from tribunal and public enquiry reports that in some communal settings, care standards may fail dramatically and/or an aggressive culture may develop (Martin, 1984; Harman and Harman, 1989; Wardaugh and Wilding, 1993; Camden and Islington Community Health NHS Trust, 1999; Clough, 1999; Glendenning, 1999). Warning signs have been cited as: complaints by staff and relatives, run-down establishments, apparent staff stress, alcohol consumption by staff, “closed institutions” and too much staff autonomy. (Harman and Harman, 1989; Clough, 1999). Enquiries repeatedly stress both the absolute failure of management, and the inward-looking culture of the institution. It is abundantly evident from these reports that peer group culture has the potential to subvert as well as support. The connection between an abusive staff culture and violence **by** residents towards staff does not appear to have been explored systematically.

### **The built environment**

There is considerable evidence that environmental factors such as noise, lighting, privacy and decorative standards are important in reducing fear and anxiety and in providing a positive environment for staff to work in (Netten, 1994a; Royal College of Psychiatrists, 1998; Marshall, 1998; Shah, 1999; Mason and Chandley, 1999).

### **The whole context**

However, it is the combination of these various factors that seems to be most significant. There are powerful arguments for suggesting that the nature and extent of any disturbance, as in “normal” living, is a complex product of triggers and responses. How people, whether they are social care staff or family members,

respond to disturbed behaviour is immensely important in affecting the level and outcome of disturbance.

*“The syndrome of dementia is multifaceted, with many variables, including environmental factors, impacting on the response and behaviour of the person with dementia” (Archibald, 1999)*

*“Physical aggression in people with dementia is not simply due to the disease process, but is affected by many factors including the expectations, training and tolerance of carers; the care environment; physical illness or discomfort; and the personality of the aggressor. These problems must be taken into account, and modified where possible.” (Jackson G A, Templeton G J and Whyte J (1999)*

The *context* in which violent behaviour occurs therefore constitutes a more productive focus of understanding and potentially gives proper weight to the interactive nature of violence, understanding it as a product of both user behaviour, staff behaviour and wider contextual factors. The research problem is to understand what explains negative interactions between staff and users, and which user, staff and environmental characteristics distinguish the situations in which violent behaviour occurs, giving due emphasis to the complex inter-relationships of the various factors. The topic covers a range of behaviour by *individuals* towards *individuals*, in different settings and circumstances, with varying consequences, and there may therefore be a number of different explanations.

Research in health settings, and into abuse towards family members in domestic settings, as well as in residential settings stresses the importance of “triggers” in relation to violent behaviour (Shah, 1999). Resistance to help with eating, hygiene, dressing and toileting is common in dementia (Patel and Hope, 1993; Burns and Hope, 1997; Fulop, 1999; Shah, 1999; Hope et al, 1999; Keene et al., 1999) and conflict between residents and staff can be frequent in residential/nursing home/hospital care (Pillemer and Moore, 1989; Goodridge, Johnston and Thomson, 1996a; Freyne and Wrigley, 1996; Moniz-Cook et al, 1998; Gates, Fitzwater and Meyer, 1999; Saveman et al. 1999). A survey of 577 staff in 57 nursing homes in the United States, which controlled for different factors, found that patient aggression was the most important factor in explaining conflict with patients (Pillemer and Bachman-Prehn, 1991). Balloch et al (1999) found that most violence towards home care workers occurred in the context of providing personal care. It is therefore possible that there is an inter-acting cycle in which residents anticipate a problem and are

aggressive towards staff who in turn are upset and aggressive towards residents who respond aggressively and so on:

*“ (If) the majority of aggressive episodes occur during personal care or patient redirection.. this....supports the view that aggressive behaviour in dementia patients is more frequently a defensive response to perceived threat than an expression of anger. It is likely that the presence of paranoid delusions increase the probability that the approach of a carer is misinterpreted as a threat. (Gormley, Rizwan and Lovestone, 1998)*

If violence towards staff is in part an outcome of staff behaviour towards residents, then explanations are needed for variations in staff behaviour. How staff engage with and respond to the older person can be crucial in both generating and resolving conflict (Hughes and Wilkin, 1987). The following examples come from a Swedish study of abuse of older people:

*“The care-giver held the care-receiver and threatened him when he tried to hit the care-giver”*

*“The patient kicked the care-giver, who hit her back in the face”*

*“The care-giver was fed up and snapped at the patient who shouted back”*

(Saveman et al, 1999)

A small study of dementia patients in a single home in the U.S.A., found that aggressive patients were treated more forcibly by staff than non-aggressive ones (Meddaugh, 1993). A recent survey of nurses in elderly care found both a high rate of aggression towards them from the older people in their care (largely punching, kicking, grabbing and slapping) as well as a high use of various forms of restraint (Brennan, 1999).

There is a large volume of research which bears on related issues such as quality of care, staff stress, morale and burn-out and training. The following issues relating to staff and influences on **their** behaviour other than those directly related to personal contact are highlighted in the literature: :

*(i) the nature of the labour force and their conditions of employment.*

The residential sector in particular, is marked by low pay, unsociable hours and poor status, although some variation might be expected by location and alternative work opportunities (Peace, Kellaher and Willcocks, 1997; Garner, 1998). Care staff may come from under-privileged social backgrounds, which may include, particularly in

urban areas, being a member of a minority ethnic group; they may have considerable family demands of their own. It is important to recognise the key importance of these sub-cultures in shaping attitudes and values to the care of older people (Tellis-Nayak and Tellis-Nayak, 1989). The context of long-term care is an encounter between their sub-culture and the older person who is “being put aside”, however gently, by family members and “society”:

*“Two parties, both powerless, little respected, and hardly recognized by society are made to face each other in a difficult setting not of their own making. They are bound in an intimate association, but enjoy little intimacy. Neither party controls the institutional environment in which they exist, neither can break the negative cycle, and so the problem feeds on itself...There are indeed exemplary nursing homes that break the cycle (of) severe staff attrition, sagging morale and indifferent care. These homes create an institutional structure that remains sensitive to staff needs, nurtures their idealism and values their central role. They boost their self-esteem and foster a family spirit that compensates for the troubles of their personal world. They evoke their loyalty and devotion” . (Tellis-Nayak and Tellis-Nayak, 1989).*

*(ii) the nature of care work*

“Bed and body work” (Foner, 1994; Lee-Treweek, 1994; Peace, Kellaher and Willcocks, 1997; Clough, 1999) is intimate, demanding, unpleasant, domestic. It involves staff in a frequent – but not easy - encounter with death and dying (Norman, 1987; Hockey, 1990). But, at the same time, staff care about and empathise with the suffering of older people and their diminishing quality of life (Foner, 1994). This does not make for a straightforward work situation. Task-centred, rather than person-centred care has continued to dominate nursing care. An observational study in North Wales found that despite nurses’ commitment to communication and activity with patients, those in long-stay care received very little attention from staff over and above help with physical care(Nolan, Grant and Nolan, 1995). A focus on practical tasks, rather than inter-personal relationships, may be less stressful. Researchers have not explored sufficiently the extent to which there is an inherent conflict between these two aspects of care. As suggested in the celebrated early article by Menzies(1970), staff may handle anxiety by “depersonalising” unpleasant tasks(Chappell and Novak, 1992).

*(iii) staffing levels/resources.*

Turnover and sickness rates in residential care can be high (Schneider et al, 1997). Research on the quality of care of older people with dementia in 13 local authority homes found that adequate staffing levels were particularly important in bearing on the behaviour of residents (Netten, 1994b). In this research, one highly rated home employed 74 different agency staff in six months in order to maintain staffing levels!

*(iv) staff characteristics.*

In the family care context, differences have been clearly identified between the existence of problems and the extent to which they are found burdensome by carers (Gilleard, 1984; Levin, Sinclair and Gorbach, 1989). As Fulop (1999) writes: *“like beauty, disturbed behaviours are in the eye of the beholder.”* Research on physical and verbal abuse of older people, with or without dementia, is remarkably consistent in drawing attention to the problems of the abuser and/or to the dynamics of longer term relationships between the two parties (McCreadie, 1996). A similar dynamic may operate in relation to paid staff, although no research on this has been found.

*(v) the importance of management.*

It is widely acknowledged that poor quality management results in poor quality residential care (Hughes and Wilkin, 1987; Sinclair, 1988; Centre for Policy on Ageing, 1996; Moniz-Cook et al, 1998; Bright, 1999; Clough, 1999).

*(vi) staff support and supervision*

The failure to support and supervise staff, and to involve them in decision making is stressed in many studies (Wardaugh and Wilding, 1993; Kitwood, 1997; Mason and Chandley; 1999; Clough, 1999). Stevenson (1999), in a review of lessons from child care for the protection of older people in residential settings, writes:

*“We should not minimise the difficulties of maintaining, sometimes over a long period, respect and individualised concern for some residents who have lost (or nearly lost) the capacity to respond. A culture which encourages discussion by staff about their feelings may humanise a process which can easily turn into “warehousing”; abuse thrives when care is depersonalised” (Stevenson, 1999).*

*(vi) education and training.*

Staff often lack both general qualifications and particular training on the job (Eastley et al 1993; Netten, 1994). They are mostly not trained to manage violent behaviour (Eastley et al, 1993; Moniz-Cook et al, 1998; Royal College of Nursing, 1998;

Brennan, 1999). It would seem that the absence of specific training is more important than the absence of qualifications (Norman, 1997; Mason and Chandley, 1999)

### ***3. What is known about the consequences of violence?***

The costs of violent behaviour may be felt in terms of staff absence, sickness rates, turnover and wastage, and crisis management. Employees can take legal action against their employers for failing in their duty of care (Royal College of Nursing/NHS Executive, 1998). All these have financial costs. Scottish researchers argued that “the incidence of general practitioner callouts, neuroleptic prescribing and hospital referrals combined make significant demands on the resources of the NHS” (Jackson, Templeton and Whyte, 1999).

The consequences of violence may harm staff, either physically or psychologically, but they may also harm the older person, and, in communal settings, have an impact on the quality of care being provided and cause upset to other residents, thereby perhaps reinforcing the problems. The wide under-reporting of violent episodes perhaps indicates that staff take the majority of incidents in their stride, although the recent research published in the Nursing Times suggests that the use of restraint in response to aggressive behaviour may be much wider than is generally acknowledged (Brennan, 1999). Research into psychological disturbance among workers in four different settings found low rates in all settings, but a strong relationship between staff disturbance and staff reports of resident aggression (Macpherson et al, 1994). This may mean that staff are upset by aggression, but it could equally mean that upset staff provoke aggression, or as the authors suggest that upset staff are more likely to report aggression. .

A Canadian study, using multiple regression techniques in their data analysis, found that behaviour problems of patients were not significant in relation to stress on nursing assistants compared with other factors, notably workload and the absence of support at work (Chappell and Novak, 1992). On the other hand, Pillemer and Bachman-Prehn (1991), also using multiple regression, found that verbal abuse increased with staff burn-out and patient aggression, and decreased with increased age of staff. Physical abuse – which included excessive use of restraint – increased with burn-out, patient aggression and conflict with patients. No other factors – which

included type of home, and education, qualifications and experience of staff, were significant.

#### **4. What measures are needed to prevent and manage violence?**

*"It is the social and the built environment which are, to a large extent the "treatment" for dementia". (Marshall, 1997)*

In terms of aiming to prevent and minimise incidents of violence, there is much support in the literature for better understanding of why patients might be aggressive, of the importance of good practice in relation to the social and the built environment, (including activities and the management of time), appropriate staff training in anticipating, defusing and, in the last resort, handling violence and of appropriate staff support (Pillemer and Bachman-Prehn, 1991; Eastley et al., 1993; Pillemer and Hudson, 1994; Marshall, 1997; Royal College of Nursing, 1998; Royal College of Psychiatrists, 1998; Shah and De, 1998; Lawlor, 1999; Saveman et al, 1999; Nolan, 1999; Archibald, 1999; Mason and Chandley, 1999; UKCC, 1999).

Although training is widely emphasised, the difficulties of providing it should not be under-estimated. In recent research in 17 residential homes, there were over 500 staff, nearly a quarter of whom had left within 16 months (Schneider et al., 1997). In another study of 13 homes 75% of staff had received no in-service training (Netten, 1994). Nor will training necessarily be taken up or lead to changes in staff behaviour (Moniz-Cook, Agar, Silver et al, 1998). Arguably the provision of induction training and on-going, on the job support and guidance may be more relevant (Pillemer and Hudson, 1993; Moniz-Cook et al., 1997), so long as this reflects best practice; induction by existing staff provides opportunities for the handing on of both good and poor practice (Hughes and Wilkin, 1987).

Simple flow-chart guides about handling resistance to care, or physically or verbally abusive behaviour, such as those suggested in the United States for nurses (Chou, Kaas and Richie, 1996; Potts, Richie and Kaas, 1996) would be easily adaptable to the UK context. It is most important that the training, in both content and delivery, is salient to the staff and the help that they want (Goodridge, Johnston and Thomson, 1996b; Gates, Fitzwater and Meyer, 1999). Many training aids are available from the Dementia Services Development Centre at Stirling University, including a recent guide to responding to difficult and aggressive behaviour for staff in residential and nursing

homes (Chapman, Jackson and McDonald, 1999) and guidelines for clinical practice in managing behavioural aspects of dementia(Archibald, 1999).

Other training may be more appropriately directed at managers, in view of the crucial influence they have on their staff and the ethos of the home (Hughes and Wilkin, 1987; Sinclair, 1988; Centre for Policy on Ageing, 1996; Moniz-Cook et al, 1998; Bright, 1999; Johnson, Cullen and Patisos, 1999). Staff need for support from managers has been identified as significant in reducing stress (Penna, Paylor and Soothill, 1995; Centre for Policy on Ageing, 1996; Gates, Fitzwater and Meyer, 1999).

Assessment tools can be used to understand care needs, including behaviour problems, in everyday practice(Patel and Hope, 1993; Norman, 1999; Briggs and Askham, 1999; Keene et al., 1999). Their more widespread use would be valued by managers of long-term care facilities (Johnson, Cullen and Patisos, 1999). They may help in promoting “timely intervention” (Fulop, 1999). On-going assessment of behaviour may have benefits in raising staff awareness of aggression and its causes(Sival et al., 2000). Currently, there appears to be much variation in approaches to assessment and widespread neglect of many key areas relevant to older people’s needs, including their behaviour (Shah, 1999; Stewart, Challis, Carpenter and Dickinson, 1999). There are at least twenty different scales currently in use (Shah, 1999). There is current international work on assessment to which Britain is contributing as part of the Department of Health outcomes of social care (OSCA) programme. The assessment tools can be used by nursing and non-nursing care staff, social workers etc. and give guidance for best practice (www.interrai.org)

Pillemer and Bachman-Prehn (1991) write in relation to their study of abuse of patients by staff:

*“The findings of this study do not imply that staff are villains. Rather, they are attempting to work in highly stressful, difficult environments. Steps to reduce this stress and to improve the ability of staff to resolve conflicts in more positive ways have the potential to bring about substantial improvements in nursing home care”*  
(p.91)

A successful programme in the United States brought together staff and family members in order to promote better communication and through that improved quality of care; this programme is particularly interesting for its emphasis on cultural and

ethnic differences and differences in values (Pillemer et al., 1998). It has been suggested that care staff might benefit from some of the strategies used by family carers - anticipation of problems, determination of the older person's wishes, discussion of emotional reactions, communication and attention to the practical details of care (Fulop, 1999, quoting Larson, 1986). Staff may be helped by training based on the contributions of clinical psychology to the management of difficult behaviours in residential and community settings (Levin, Moriarty and Gorbach, 1989). Training using the Antecedents, Behaviours, Consequences (ABC) analysis and advice about consistency between staff on different shifts have been highly valued by care staff (Levin, personal communication). Some people with dementia may have a very adverse reaction to a member of staff who reminds them of a teacher who hit them or a violent family member from years ago (Levin, personal communication). Research which focused on individually tailored interventions for older people with behavioural problems living in the community and their care-givers established both a reduction in the behavioural problems and an improvement in the psychological morbidity of their family carers (Hinchcliffe et al, 1995).

Well-designed environments are seen as important for both residents and staff (Marshall, 1997; Royal College of Nursing, 1998). Music (of the right kind!) may be generally beneficial (Briggs and Askham, 1999) and help reduce aggression (Clark, Lipe and Bilbrey, 1998). Some behavioural techniques may be useful (Allen-Burge, Stevens and Burgio, 1999) although "there is seldom one intervention that will work for one person all the time" (Archibald, 1999). Drug regimes can both promote violence (Evans, 1999) and help alleviate specific symptoms (Hinchcliffe et al, 1995; Gormley, Rizwan and Lovestone, 1998). But while medication may be helpful, the overall evidence in its favour is not very convincing despite its extensive use (Fulop, 1999; Ballard and O'Brien, 1999; Shah, 1999; Jackson, Templeton and Whyte, 1999). The use of tranquillisers has been described as "dangerously high" in some homes (Schneider, 1997).

The official view is that restraint is " a last resort when alternative methods of therapeutic behaviour management have failed" (Royal College of Nursing, 1999). Useful guidance on restraint has been provided for the nursing profession (Royal College of Nursing, 1999) as well as for social care staff (Counsel and Care, 1992; Counsel and Care, 1993; Centre for Policy on Ageing, 1996) The use of restraint is also discussed in inspection reports on residential care for older people by the Social

Services Inspectorate (Department of Health, 1995). Guidance issued for health staff working in the community may be useful in the social care context in promoting best practice in reducing the risks of violence (Royal College of Nursing, 1998).

Eastley et al. (1993) argued that closer links between the residential sector and psycho-geriatric services were “urgently needed”. Jackson, Templeton and Whyte (1999) argue for “specialist care input, such as supernumerary mental health nurses assisting in behaviour management within the independent care sector” and consider this would constitute a better use of NHS resources.

Finally, it has been claimed that our understanding of dementia is currently undergoing a “quiet revolution” as greater attention is paid to the individual identity of the older person (Kitwood, 1997). If dementia is understood as a disability, whose behavioural manifestations require particular types of response from others, the requirements of care-givers become clearer, if more demanding. It becomes possible to see a bridge between best practice and the inevitable shortcomings of care-givers. The Domus schemes, which epitomise this approach and are designed for people with severe dementia and challenging behaviour, emphasise staff needs, recreational and activity programmes and high staff/resident ratios. Given these conditions, there is minimal negative interaction between staff and residents and an increase in the morale and well-being of staff (Lindesay et al., 1991).

## **6. What longer term research is needed?**

Far more research has been encountered in the preparation of this review than was anticipated, largely because of its evident topical interest and the relevance of the health literature to the problem. A very detailed review of the psychiatric literature, which leans heavily on North American research, has just been published with over 280 references (Shah, 1999). Further research, preferably with a comparative, control study or experimental design on the following topics would be helpful in throwing further light on the problem of violence towards social care staff:

### *(i) Staff/older person interactions and staff coping strategies.*

Studies of the nature of interactions between older people and care staff in both residential/nursing home/hospital and domiciliary/day care settings. The emphasis of the research would be to understand better successful staff coping strategies in

relation to problematic behaviour, how staff themselves explain these and whether they relate to staffing/management variables .

*(ii) Differences between homes.*

It is a key question to explain differences in levels of violence between institutions with comparable user populations. Some of the research reviewed in this paper could be usefully built on. A systematic approach is needed which compares apparently similar homes perhaps in terms of size, ownership, staff/patient ratios and resident characteristics, and seeks to explain differences in level of behaviour problems. Homes could also be specifically compared in terms of activities, including music, alternative therapies and opportunity for spiritual and religious practices.

*(iii) Differences between people with dementia and other conditions which may involve violent behaviour*

It would be valuable to try and find out whether violent behaviour is displayed by patients without dementia, and in what circumstances. Violent behaviour is displayed by older persons without dementia, especially stroke patients who hit out at those giving most personal care, and upon whom they most depend. It would be valuable to compare frequency and type of violent behaviour between older people with different conditions and staff responses to it

*(iv) Assessment of behavioural problems.*

An investigation of the extent to which day centres/residential care/nursing homes with dementia patients assess individuals for behaviour problems which may lead to stress on both family and paid carers and the extent to which staff are involved in these assessments and their outcomes. This could then be the base for research which introduces and evaluates the impact of more systematic assessments.

*(v) Staff support, education and training*

Introduction and evaluation of experimental induction and on-going supervision schemes for staff with measurement of impact on staff and on quality of interaction with users over a sustained period of time. Recent training packages to counter abuse of residents by staff (available from Action on Elder Abuse) could be used and independently evaluated.

## **Conclusion**

Despite the relative absence of rigorous research in this area, and the need to be suitably tentative about research findings (Archibald, 1999 p.239), there is a remarkable consistency in the commentaries. It comes down to this. In the final years of life, personal needs can be very complex; varying degrees of physical and mental incapacity may render the individual more dependent on others and result in the loss of earlier coping strategies. Problem behaviour, in disability, as well as in health, is increasingly recognised, and understood, as a way of communicating personal need. Paid carers, no less than family members, are faced with a critical human challenge about valuing the individual in these circumstances. At one extreme, "moral concern is neutralised" (Wardaugh and Wilding, 1993), and the other person's humanity degraded (Martin, 1984; Bright, 1999; Clough, 1999; Glendenning, 1999; Camden and Islington Community Health Services NHS Trust, 1999). At the other, individual value is nurtured (Lindesay et al., 1991; Centre for Policy on Ageing, 1996; Clarke, Hollands and Smith, 1996; Peace, Kellaheer and Willcocks, 1996; Kitwood, 1997; Norman, 1999). Whether we are carer, or cared for, we can all be both "saints and monsters" (Foner, 1994), stretched in our relationships with others by our own individual needs and capacities. It would seem that only very careful attention to the nature of the support systems and structures within which people work, and families care, will prevent the inter-personal conflicts which may result in violence to our fellow human beings.