Violence? Which violence?

Jonathon E Lynch looks at violence in relation to mental illness – in particular, the violence suffered through harsh treatment and social exclusion.

Mental ill health remains a somewhat uncomfortable and even taboo subject for many people. The subsequent mystique ensures that distressed and unwell individuals, and, especially, those who behave in dangerous ways – the 'raving mad' – are useful resources for news media and film-makers, due to the perennial market for danger and excitement.

In-depth studies of serious violence reveal that the number of homicides by those who use mental health services actually decreased slightly after 'community care' (itself now almost a pejorative term) was ushered in on a large scale in the 1990s. Serious unprovoked assaults do occur, though they are mercifully rare in this country, and reports often use terms such as 'madman' and 'maniac' before much is known about events. Fear of murder by a stranger may often be linked to sensationalised reports that effectively portray mentally ill people as homicidal by virtue of their ill health and imply, incorrectly, that this is the case for all sufferers. Although the odds of falling victim to any stranger may themselves be tiny, Department of Health research indicated that we were 13 times more likely to be murdered by a stranger who was 'normal' than one who was mentally ill (Jeffery, 1998). Such figures could seem amusing were it not for the actual impacts of such occurrences on victims, their relatives, and perpetrators and their families.

The effects of portrayals

The effects of negative and especially dangerous portrayals are varied, but some are worthy of note here in the context of violence and victimisation. One study found that two-thirds of community based patients saw the general public as definitely afraid of people with mental health problems (Rose, 1996). It is easy to reject people who are either visibly or known to be mentally ill, and this creates further social exclusion – the government's Social Exclusion Unit (SEU) produced a lengthy document on the very issue of exclusion and mentally ill people (SEU, 2004). Exclusion makes it easier for children (and some adults) to harass mentally ill people in streets, in shops, and even in their homes. Ask community mental health professionals about violence and their clients, and many will reply that harassment and even violent victimisation are persistent problems.

If you or I were harassed or threatened, we might well go to the police, but just as many citizens use words like 'nutter' and 'loon' publicly and with impunity, so do some police officers, and reporting victimisation from and to people perceived as hostile can be an ordeal that is best avoided. As Skolnick and Fyfe (1993) pointed out, being mentally ill may increase the likelihood of being subjected to excessive force by the police, and mental ill health features in some controversial cases where it has been alleged that excessive force was used (Green and Ward, 2004).

Asylum?

The vast majority of mental health units do experience violence from some patients, but it is usually occasional rather than frequent in nature, or a small number of patients account for the vast majority of incidents. Although most incidents in most units are not serious, some are, and a small number have even been fatal. In such settings victims are predominantly either staff who provide care frequently or other patients. Staff receive training to manage such episodes, but many courses are surprisingly narrow in perspective and short in duration.

Inconsistency is explained by the lack of regulation of courses, a stark contrast to the standardised training provided in HM Prison Service for example, though the methods used there are not without critics. In order to provide some clarity amid a chaotic and increasingly contentious field, the National Health Service's *National Institute for Clinical Excellence* (NICE) issued a guide for the management of certain incidents in mental health units and A&E departments earlier this year (NICE, 2005). Though comprehensive and well focused, and also laudable in the sense that it could be interpreted as an end to the non-interventionist stance of central government on the use of force on mentally ill people in care settings, the much awaited clarity simply isn't there in relation to some crucial matters.

The use of pain-infliction is perhaps the most prominent anomaly. Numerous training courses for mental health professionals include pain-compliance techniques. The NICE guide makes it clear that it is accepted that these are used, but suggests that pain has no therapeutic value and its application is only justifiable for the immediate rescue of someone in danger (p.8). Applying pain may be necessary at times, but the guide fails even to give examples of what form this might take. There is scant mention of the legal and complex ethical issues despite the blatant potential for negative consequences inherent in the 'interventions'.

What then is the message for inpatients? Perhaps it is that those who are in charge of their care can and

will hurt them in order to ensure (or attempt to ensure) compliance with their requests. In *health care*, such issues are in urgent need of debate because one person's force is another's violence. The weak and the wicked (or criminal) 'use violence', while those with state-sanctioned authority 'use force'. It is not contested here that state employees should passively accept harm to themselves or others, rather that both recipients and users of force should be afforded some measures of protection by clear methods of regulation of the use of force, and pain-infliction in particular.

Try looking for 'pain' in the literature and preparatory texts of health care professionals (or those relevant to any roles involving some 'duty of care'). There is mention only of the unwell patient 'in pain'. The infliction of pain is to be found in the literature on torture and human rights abuses. The Howard League for Penal Reform (HLPR, 2002) has spelled out its concerns about the use of similar techniques on young prisoners.

As part of its independent submission to the United Nations Committee on the Rights of the Child, the HLPR undertook research into the treatment of young people in prison, and raised matters in accordance with relevant articles of the Convention. Restraint methods were addressed under Article 37: "No child shall be subjected to torture or other cruel, inhuman or degrading treatment".

Linking pain-compliance techniques with torture may seem profound, but much greater discussion and clarity are required to protect patients and others from violence, as well as to protect staff from dismissal and litigation arising from physical interventions. The practices within mental health care require attention and transparency. As primary recipients of violence some mentally ill people are in a deep rut of disadvantage and vulnerability. Little wonder then that some refer to themselves as 'survivors' of the mental health care system.

■

Jonathon E. Lynch *is a research student in the Department of Sociology, London School of Economics and Political Science.*

References

Green, P. and Ward, T. (2004) *State Crime: Governments, Violence and Corruption.* Pluto: London.

Howard League for Penal Reform (2002) *Children in Prison: Barred Right.* HLPR: London.

Jeffery, C. (1998) 'Speaking Out', *Nursing Times* 94, 50, 21.

NICE (2005) *Violence. The short term management of disturbed/ violent behaviour in psychiatric in-patient settings and emergency departments.* London: NICE. www.nice.org.uk

Rose, D. (1996) *Living in the Community.* Sainsbury Centre for Mental Health: London.

Skolnick, J. and Fyfe, J. (1993) *Above the Law.* Free Press: New York.

Social Exclusion Unit (2004) *Mental Health and Social Exclusion.* Social Exclusion Unit: London.

In health care, such issues are in urgent need of debate because one person's force is another's violence.