Original Article

Personal safety among doctors working in psychiatric services

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Background: Doctors working in psychiatry are exposed to different levels of threat to their own safety due to the nature of psychiatric practice. There is some evidence to suggest that those working on inpatient units and at night-time might be at increased risk of patient-related violence due to environmental factors but research in this domain is less than expected.

Methods: We carried out an online survey of personal security at work among all doctors (n=210) working in psychiatry in an English county. Our response rate was 41% and those who responded were fairly distributed in terms of gender, grade, and place of work.

Results: We found that most doctors in our sample had been verbally abused (75%), physically threatened (50%), or assaulted (30%) at work. They had little confidence (33%) in security measures at their workplaces, and were significantly unsure whether their psychiatric facilities were covered by security cameras and had sufficient light at night. Doctors who did night on-calls overwhelmingly believed that they would feel more secure if there was security staff on site (84%) and their resident on-call rooms was close to the wards (78%). It was interesting to discover that male doctors felt more secure at work but they were also more likely to have been threatened or attacked.

Conclusions: Our research is limited by a small sample and for having been carried out in one English county. It may not be generalisable to all psychiatric hospitals/trusts in the UK but it highlights the dire need for mental health trusts to improve security for doctors including exploring the possibility of employing security personnel.

Keywords: Doctors; psychiatry; personal safety; violence; security

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Introduction

From idealistic laws of Plato to the "great confinement" observed in the last century, security measures have always been a feature of the care provided to psychiatric patients for protecting themselves and others (1). This is because the context in which psychiatric practice is delivered, has a bearing on the likelihood of violence, be it on in-patient units, in out-patient settings, in accident and emergency departments, or in patients' homes. Psychiatrists from different disciplines, therefore, are likely to be exposed to different degrees of threat to their own safety.

Mental health trusts have provided health and social care services for people with mental health disorders in England since 1990 (2). They are not trusts in the legal sense but are 54 public sector corporations funded by the government and headed by boards. They provide inpatient/hospital, community and specialist mental health services for people who live in the region, although there may be specialist services that accept national referrals.

Physical violence in psychiatric hospitals can be a major problem not only because of the potential for

injury to patients and staff, but also because of the counter therapeutic effects of both violence and measures to prevent violence (3). However, there are publications addressing staff safety on psychiatric wards (4,5), about violence in the forensic & prison service (6,7) and in relation to stalking of mental health professionals (8), but little is known or written about regarding risks posed to the personal safety of doctors working at acute and community psychiatric facilities during day and night.

Levels of aggression and abuse aimed at healthcare workers may be hard to quantify but in a recent National Health Service (NHS) Staff Survey, 35.4 per cent of those who had face-to-face contact with patients said that they had experienced bullying, harassment or abuse from patients, their relatives, or the public in the past year (9). An erstwhile study of trainee anaesthetists had also highlighted that 40% among them feared for their safety in the hospital grounds, and 5% had been physically assaulted (10).

Medical Defence Unions unambiguously warn doctors about challenging behaviour from some patients and advise them to protect themselves and others by seeking advice and reporting any risk or incidents to their line-management (11). Mental health trusts also recognise risks to the staff who work with patients on wards, in community clinics and during home visits, but there has been less focus on the security risks that may be incurred by junior doctors and consultants on hospital grounds and when working out of hours.

Doctors doing resident on-calls in psychiatry tend to work alone, and often cover several sites. They reside at the same psychiatric unit where they are on-call or in a different building on the same hospital grounds during night time. Their personal security during travel between different psychiatric facilities and to other sites on hospital grounds including car parks, is a consideration that has not received sufficient focus in mental health trusts' security protocols and policies.

In the light of the above-mentioned multidimensional apprehensions and some local incidents, we decided to investigate how doctors working in psychiatry perceive and experience their safety while working at different mental health facilities in an English county. The implications of this work are not only concerning actual risks to safety, but also about appreciating doctors' perceptions of their security, as this may impact their recruitment and retention in psychiatry.

Highlight box

Key findings

- Majority of doctors working in psychiatry were threatened or attacked, had inadequate security measures in their workplace, and supported employing security personnel.

What is known and what is new?

- Evidence showed that risks to doctors were greater, and they had valid reasons for lack of confidence in their personal security at work where guidelines by mental health trust, Deanery and the Royal College were not being followed.

What is the implication, and what should change now?

- Psychiatric hospitals/trusts in the UK should improve security for doctors including exploring the possibility of employing security personnel.

Methods

We devised a survey questionnaire (*Figure 1*) about personal safety based on existing research and administered it to a group of random participants in our study as a pilot. The questionnaire contained 11 questions about demographics and doctors' perception of their personal safety at work during the day and night in different psychiatric facilities. It was duly amended following their feedback, and after approval from the medical education research ethics committee, it was sent via email to all doctors (n=210) working in psychiatry in a county-wide trust in southeast England.

Details of the respondents were summarised using numbers and percentages. Their responses to the security questions were summarised for categorical questions and using medians and interquartile ranges (IQRs). Missing responses and responses of "not applicable" were excluded when calculating percentages and therefore the total number used to calculate each percentage is also reported. Where a respondent had given a text answer to a count question (e.g., saying they had been verbally attacked "many times") this value was set to missing since it was not clear how to assign an appropriate numeric value. Results were summarised overall and separately by gender (male or female), grade (trainee or consultant), and workplace setting (community or inpatient).

Results

A total of 86 responses (41%) to the questionnaire were received. The respondents were evenly split in terms

1)	What is your main place of work?	.....			
	What is your grade?	.....			
	What is your gender?	.....			
2)	Do you feel safe within the hospital? (please tick)				
	a. During the day		Yes ☐	No ☐	
	b. During out of hours, daytime shifts (17:00–21:00)		Yes ☐	No ☐	NA ☐
	c. During night shifts		Yes ☐	No ☐	NA ☐
3)	Do you feel safe in the grounds?				
	a. During the day		Yes ☐	No ☐	
	b. During out of hours, daytime shifts (17:00–21:00)		Yes ☐	No ☐	NA ☐
	c. During night shifts		Yes ☐	No ☐	NA ☐
4)	a. Have you ever been physically attacked at work?		Yes ☐	No ☐	
	If so, how many times?.....				
	b. Have you ever been physically threatened at work?		Yes ☐	No ☐	
	If so, how many times?.....				
	c. Have you ever been verbally attacked at work?		Yes ☐	No ☐	
	If so, how many times?.....				
	d. Do you know others who have been attacked at work?		Yes ☐	No ☐	
	e. Have you had property damaged whilst at work?		Yes ☐	No ☐	
5)	a. Have you had to walk alone through the grounds at night?		Yes ☐	No ☐	
	b. Is your work site covered by security cameras?		Yes ☐	No ☐	Don't know ☐
	c. Is there sufficient lighting in the hospital grounds at night?		Yes ☐	No ☐	
7)	a. Do you have confidence in the security facilities at work?		Yes ☐	No ☐	Don't know ☐
	b. Do you think hospital management takes the security of doctors seriously?		Yes ☐	No ☐	Don't know ☐
	c. Have you seen the Trust policy regarding security?		Yes ☐	No ☐	
8)	Do concerns about security affect your approach to work?		Yes ☐	No ☐	
	If so, how?.....				
9)	Compared to working in a general hospital, do you feel:				
	More safe ☐	Less safe ☐	The same ☐	Don't know ☐	
10)	For doctors who do resident on calls: Would you feel safer with:				
	a. A personal alarm that works throughout the site		Yes ☐	No ☐	Don't know ☐
	b. Security staff on site		Yes ☐	No ☐	Don't know ☐
	c. On call walkie talkie		Yes ☐	No ☐	Don't know ☐
	d. More PMVA training		Yes ☐	No ☐	Don't know ☐
	e. On call room geographically close to the wards		Yes ☐	No ☐	Don't know ☐
	f. Porters on site		Yes ☐	No ☐	Don't know ☐
11)	Do you have any suggestions as to how we might improve personal safety for doctors working in a psychiatry?				

Figure 1 A survey of personal safety among doctors working in psychiatry. NA, not available; PMVA, Prevention and Management of Violence and Aggression.

of gender (48.2% female), grade (51.2% trainees) and workplace setting (52.9% in community settings). Overall opinions about security are summarised in *Table 1*.

Respondents generally felt safe within the hospital/clinics during the day (98.8%), out of hours (81.7%) and during night shifts (80.8%). They also felt safe in the grounds during the day (98.8%) and out of hours (70.7%) but less so during night shifts (52.0%). Approximately 1-in-3 respondents had been physically attacked at work, half had been physically threatened, and almost 3-in-4 had been verbally attacked. Half of respondents (51.2%) did not know whether their work site was covered by security cameras, and they were evenly split (45.7% yes *vs.* 50.6% no) on whether there was sufficient lighting in the hospital grounds at night. Only one-third of participants had confidence in security facilities at work (32.9%), fewer had seen the Trust policy on security (27.4%) and slightly more felt that hospital management took the security of doctors seriously (41.8%). Doctors who did resident on calls were asked what measures would make them feel safer (see *Table 2*), and the most popular responses were: security staff on site (83.7%), on call room geographically close to the wards (79.5%) and

Table 1 Overall opinions on security

Survey questions	Data
Female	40/83 (48.2)
Trainee[†]	43/84 (51.2)
Community setting[‡]	45/85 (52.9)
Do you feel safe within the hospital/clinic …	
During the day?	83/84 (98.8)
During out of hours (if applicable)?	49/60 (81.7)
During night shifts (if applicable)?	42/52 (80.8)
Do you feel safe in the grounds …	
During the day?	83/84 (98.8)
During out of hours (if applicable)?	41/58 (70.7)
During night shifts (if applicable)?	26/50 (52.0)
Have you ever been physically attacked at work?	25/86 (29.1)
If yes, number of times	2 [1, 2], 25
Have you ever been physically threatened at work?	47/85 (55.3)
If yes, number of times	2 [0, 3], 41
Have you ever been verbally attacked at work?	62/86 (72.1)
If yes, number of times	1 [0, 3], 48
Do you know others who have been attacked at work?	62/86 (72.1)
Have you had property damaged whilst at work?	22/83 (26.5)
Have you had to walk alone through the grounds at night?	57/85 (67.1)
Is your work site covered by security cameras?	
Yes	18/82 (22.0)
No	22/82 (26.8)
Don't know	42/82 (51.2)
Is there sufficient lighting in the hospital grounds at night?	
Yes	37/81 (45.7)
No	41/81 (50.6)
Don't know	3/81 (3.7)
Do you have confidence in the security facilities at work?	
Yes	28/85 (32.9)
No	26/85 (30.6)
Don't know	31/85 (36.5)
Do you think the hospital management takes the security of doctors seriously?	
Yes	33/79 (41.8)
No	17/79 (21.5)
Don't know	29/79 (36.7)
Have you seen the Trust policy regarding security?	23/84 (27.4)
Do concerns about security affect your approach to work?	34/83 (41.0)

Data are presented as n/N (%) for categorical variables and median [IQR], N for counts; unless otherwise stated numbers reported are those who had answered yes to a given statement (with the alternative option being no). [†], the rest of the participants were consultants; [‡], the rest of participants worked in inpatient settings. IQR, interquartile range.

a personal alarm that works throughout the site (78.1%).

Responses were also examined separated by gender (see *Table 2*), grade and workplace setting (see *Table 3*). Male respondents were more likely than females to feel safe in the hospital/clinic and grounds during out of hours or night shifts and were also more likely to feel confident in the security facilities at work and management concern about doctors safely. Conversely, they were also more likely to have been physically or verbally attacked or physically threatened and for concerns about security to have affected their work. Consultants were less likely than trainees to feel safe in the hospital/clinic or grounds out of hours or during the night shift. They were more likely than trainees to have been physically attacked or threatened or verbally attacked at work, though since a time limit was not placed on this question this result may simply be a result of their longer career.

Those in an inpatient setting were more likely to have been physically attacked or threatened at work than those in a community setting. They were also less likely to feel the security facilities were adequate and more likely to say that concerns about security affected their work.

Discussion

In this county-wide study in England, we have found that overwhelming majority of participating doctors (>75%) working in psychiatry had little confidence in their personal

Table 2 Would the following make doctors who do resident on calls feel safer

Significant personal safety variables	Yes	No	Don't know
A personal alarm that works throughout the site	32/41 (78.0)	7/41 (17.1)	2/41 (4.9)
Security staff on site	36/43 (83.7)	4/43 (9.3)	3/43 (7.0)
On call walkie talkie	12/37 (32.4)	15/37 (40.5)	10/37 (27.0)
More PMVA training	12/40 (30.0)	19/40 (47.5)	9/40 (22.5)
On call room geographically close to the wards	31/39 (79.5)	6/39 (15.4)	2/39 (5.1)
Porters on site	21/43 (48.8)	11/43 (25.6)	11/43 (25.6)

Data are presented as n/N (%). PMVA, Prevention and Management of Violence and Aggression.

security at work. A significant number among them were physically threatened (50%) or attacked (30%) at work, and did not know for sure whether there was sufficient lighting or security cameras at psychiatric facilities. This is alarming because the Royal College of Psychiatrists and Deaneries approve these sites as safe for training and the relevant trust has a security policy for the safety of its mental health workforce. Our findings highlight that little progress has been made since the biggest national audit of violence (12) to date had found flaws in the design of psychiatric in-patient units, and had highlighted serious issues about inadequate staffing, poor leadership, and dissatisfaction among staff with the appropriateness of training for the management of violence.

Our finding, that doctors who work in the inpatient unit, felt particularly unsafe, is in line with existing research (13). This is a serious risk because some patients perceive psychiatric care as threatening and intrusive; and psychiatrists as the perpetrators of this perceived violence, may become targets for of their aggression. Patients can also occasionally become fixated on psychiatrists due to erotic or violent fantasies, and these abnormal attachments may lead to stalk or assault professionals. Improved training is an important way to tackle such violence in the workplace and reduces the prevalence of patient assaults. Staff members should be trained in de-escalation techniques, self-defence, and communication (14). Interactive workshops using "Whose Shoes" model have also been used to allow participants to come together and explore scenarios related to staff safety and its impact on patient safety.

In this study, we observed that male doctors felt more secure at work during day and night, but interestingly they believed that way even after having been abused and attacked more often than their female colleagues. The Royal College guidelines (12), therefore, recommend that night visits should never be made alone, and Taxis used when visiting known problem dwellings. Wearable panic button devices or portable personal alarms also enable rapid identification of location of the incident and facilitate a rapid response, increasing actual and perceived safety by clinical staff (15). Psychiatrists are advised to avoid displaying "on call stickers" or anything that identifies their vehicle; bags and any other equipment left within the vehicle be concealed; and cars are parked as near as possible to the entrance in well-lit spots. These guidelines also recommend that the car make, colour and registration number be known at the hospital reception, community base and by the employing organisation.

The causes of crisis which may give rise to violence and high-risk situations are frequently embedded in the structural arrangement of care, and the culture of services, rather than solely dependent on patient pathology (16). The relationship between staff safety and patient safety is a symbiotic one, where improvements made in one area can benefit the other (17). Therefore, creating a safe and secure work environment will help to reduce patient violence, reassure staff that their well-being is a priority and make it easier for healthcare professionals to meet patient needs (14).

Our study highlights that most doctors (84%) who did resident on calls wanted to ensure their safety by having security staff on site. This aspiration is in line with the Royal College and Deanery expectations for trainees' safety but compliance by mental health trusts can be an issue. For example, night-time porters have disappeared over the last decade and very few trusts employ security guards. Anecdotal evidence also suggests that the police are not keen to regularly attend mental health facilities unless it is related to Mental Health Act proceedings (18). Therefore, growing prevalence of security guards in health care settings worldwide, points to a need to explore their role and actions

Table 3 Opinions about security summarised by gender

Survey questions	Female (n=40)	Male (n=43)
Trainee[†]	25/39 (64.1)	16/43 (37.2)
Community setting[‡]	21/40 (52.5)	22/43 (51.2)
Do you feel safe within the hospital/clinic …		
During the day?	39/39 (100.0)	42/43 (97.7)
During out of hours (if applicable)?	22/29 (75.9)	26/30 (86.7)
During night shifts (if applicable)?	19/26 (73.1)	22/25 (88.0)
Do you feel safe in the grounds …		
During the day?	37/38 (97.4)	43/43 (100.0)
During out of hours (if applicable)?	18/27 (66.7)	21/29 (72.4)
During night shifts (if applicable)?	10/23 (43.5)	15/25 (60.0)
Have you ever been physically attacked at work?	9/40 (22.5)	16/43 (37.2)
If yes, number of times	2 [1, 2], 9	2 [1, 2], 16
Have you ever been physically threatened at work?	19/39 (48.7)	27/43 (62.8)
If yes, number of times	1 [0, 2], 17	2 [0, 3], 23
Have you ever been verbally attacked at work?	27/40 (67.5)	34/43 (79.1)
If yes, number of times	1.5 [0, 3], 20	1 [0, 4], 27
Do you know others who have been attacked at work?	31/40 (77.5)	29/43 (67.4)
Have you had property damaged whilst at work?	5/38 (13.2)	17/43 (39.5)
Have you had to walk alone through the grounds at night?	24/39 (61.5)	32/43 (74.4)
Is your work site covered by security cameras?		
Yes	7/38 (18.4)	11/42 (26.2)
No	8/38 (21.1)	13/42 (31.0)
Don't know	23/38 (60.5)	18/42 (42.9)
Is there sufficient lighting in the hospital grounds at night?		
Yes	16/38 (42.1)	20/40 (50.0)
No	20/38 (52.6)	20/40 (50.0)
Don't know	2/38 (5.3)	0/40 (0.0)
Do you have confidence in the security facilities at work?		
Yes	9/39 (23.1)	18/43 (41.9)
No	11/39 (28.2)	14/43 (32.6)
Don't know	19/39 (48.7)	11/43 (25.6)
Do you think the hospital management takes the security of doctors seriously?		
Yes	12/38 (31.6)	20/39 (51.3)
No	8/38 (21.1)	9/39 (23.1)
Don't know	18/38 (47.4)	10/39 (25.6)
Have you seen the Trust policy regarding security?	10/39 (25.6)	11/42 (26.2)
Do concerns about security affect your approach to work?	14/39 (35.9)	19/42 (45.2)

Data are presented as n/N (%) for categorical variables and median [IQR], N for counts; unless otherwise stated numbers reported are those who had answered yes to a given statement (with the alternative option being no). [†], the rest of the participants were consultants; [‡], the rest of participants worked in inpatient settings. IQR, interquartile range.

to inform policy and training in the UK. There is evidence to suggest, in a retrospective audit published in Australia (19), that most common reasons for security guard call-out/attendance were related to patients threatening/harming staff, threatening/harming themselves, needing physical or chemical restraint, and for de-escalation.

Hospitals are known to employ different types of security officers, including police officers, persons directly employed by the hospital, and persons employed by an outside security agency (19). They frequently work alongside nurses and the tools at their disposal include physical restraints, although they do not have the authority to use them without clinicians' authorization. Their labour may also include the mundane, such as being called to open a locked door or provide card access for clinicians. Nonetheless, their presence on psychiatric units might give rise to ethical questions, by patients and their careers, about where does the health begin and the policing end, or the health ends and the policing begins in their deployment (20). The demarcation is not always simple because there are times when the dichotomy of health and policing is redefined; the security team goes "hands on" and the patients might struggle along with their rights being infringed (21). Furthermore, each security model might have disparities in terms of culture, level of training, chain of command, or relationship with clinical staff.

Our study has limitations including having a small sample, based in a single county, potential recall bias, and may not be generalisable to all hospitals/trusts in the UK. However, it highlights the important issue of personal safety of medical staff working in psychiatry that has not been officially reviewed since 2005 (12). Furthermore, workplace patient-related violence is associated with post-traumatic stress disorder, absenteeism, frequent staff turnover, and reduced productivity among healthcare workers (22). The financial losses ensued by healthcare systems through such violence are also well documented in several studies (23). Therefore, understanding the dangers involved in working in psychiatric hospitals and trusts, and actively working to address and mitigate them, is the best way forward for healthcare providers to protect doctors working in psychiatric services and the patients they treat.

Conclusions

There are serious risks to the personal safety of doctors working in psychiatric services in the UK. Mental health trusts must protect doctors from workplace violence by urgently taking suitable security measures including exploring the use of security personnel.

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Footnote

Data Sharing Statement: Available at https://jhmhp.amegroups.com/article/view/10.21037/jhmhp-23-34/dss

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Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. This study does not need IRB approval or informed consent as there are no patients involved.

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