



ELSEVIER

AENJ

www.elsevier.com/locate/aenj

LITERATURE REVIEW

# Zero tolerance: A policy in conflict with current opinion on aggression and violence management in health care

Timothy C. Wand, MHN DASNurs, Grad Dip MHNurs, MNurs\*,  
Kirsty Coulson, BSc (Nurs) Grad Cert Critical Care Nurs

*Emergency Department, Royal Prince Alfred Hospital, Missenden Road,  
Camperdown, NSW 2050, Australia*

Received 27 February 2006; received in revised form 14 June 2006; accepted 26 July 2006

## KEYWORDS

Aggression;  
Violence;  
Zero tolerance;  
Emergency department;  
Communication;  
Negotiation;  
Education;  
Training

**Summary** Aggression and violence are common in the emergency department setting. In recent years, there has been a greater recognition of this problem with State Governments in Australia responding with zero tolerance policies. This paper examines the current recommendations from nursing and medical literature with regard to the minimisation and management of aggression and violence in health care. A consistent theme throughout the literature is that early recognition and use of de-escalation strategies aimed at diffusing a volatile situation is the preferred approach. Use of restraint and a zero tolerance approach are last resort measures. It is important to have practical policies, protocols and procedures in place to manage aggression and violence in the emergency department. An emphasis on training and skill development, particularly communication and negotiation strategies, is imperative for all health care professionals.

© 2006 College of Emergency Nursing Australasia Ltd. Published by Elsevier Ltd. All rights reserved.

## Introduction

Aggressive and violent incidents are encountered daily in the emergency department (ED) setting.<sup>1–4</sup> Emergency departments are especially susceptible to aggressive situations due to an environment filled with emotional stress, and as patients can endure

prolonged waiting times, confusion and gaps in communication.<sup>5</sup> The association between aggression and violence in health care generally is a subject that has undergone extensive exploration and debate in the nursing and medical literature. The issue is particularly relevant to nursing, where the risk of exposure to violence in the workplace is high.<sup>6,7</sup> Jenkins et al.<sup>2</sup> even go as far as to state that patients and relatives in the ED, who seem prepared to be rude and offensive to nurses, are usually much less aggressive when approached by a doctor.

\* Corresponding author. Tel.: +61 02 9515 6111; pager: 80616; fax: +61 02 9515 5099.

E-mail address: [twand@email.cs.nsw.gov.au](mailto:twand@email.cs.nsw.gov.au) (T.C. Wand).

The distinction between the terms aggression and violence and at which point they unite is unclear. Sains<sup>3</sup> suggests that aggression has a component of intention whereas violence may occur accidentally. However, most violent incidents in the ED setting involve some degree of intent and therefore an aggressive element. Aggression is defined by Whittington<sup>8</sup> as “any form of behaviour directed toward the goal of harming or injuring another living being who is motivated to avoid such treatment”, while workplace violence is defined by Lynch et al.<sup>9</sup> as “any incident where staff are abused, threatened or assaulted in circumstances relating to their work, involving explicit or implicit challenge of their safety, well being or health”. In this paper the combined term ‘aggression and violence’ will be used to address the broad spectrum of verbal and non-verbal hostility, both intentional and non-intentional, that ED staff encounter. This ranges from abuse and threats to assault and physical violence.

The concept of zero tolerance originated in the United States (US) and refers to specific actions or behaviours that will not be accepted.<sup>10</sup> In the US a zero tolerance approach has been pursued on drugs, crime and more recently misbehaviour by school children.<sup>11</sup> Governments in other countries such as the United Kingdom (UK)<sup>7,12,13</sup> and New Zealand<sup>1</sup> have also embraced this approach. Australian states and territories have adopted zero tolerance policies towards violence in society generally, as well as within the health care system. This is despite the lack of evidence to suggest that a zero tolerance approach in health care is actually effective.<sup>8</sup> In fact it has been suggested that a zero tolerance approach can compound the problem of aggression and violence in health care by attributing blame to patients and encouraging intolerance by health care workers.<sup>14</sup>

Whittington<sup>8</sup> believes that a zero tolerance perspective could diminish a person’s right to express appropriate irritation or annoyance with a service and could raise the tension in staff–patient interactions. Zero tolerance may also be interpreted as a government incursion into a clinician’s right to make judgements on the meaning and benefit of individual patient behaviour and circumstances. The clinical decision making of experienced health care workers could therefore be potentially restricted by a blanket zero tolerance policy. Whittington suggests that while zero tolerance is a neat political slogan, it has the potential to disturb the subtle balance in deciding what is acceptable staff and patient behaviour in any health care interaction.

In New South Wales (NSW), for example, NSW Health<sup>15</sup> published a policy and framework document titled “Zero tolerance, response to violence in the NSW health work place”. This document requires health services to work toward “establishing and maintaining a culture of zero tolerance to violence”. The document does stipulate that it is not the intent of the policy that action be taken against people whose behaviour is a direct result of a medical condition, however, it then paradoxically asserts that abusive or threatening behaviour will not be accepted “from anyone under any circumstances”. Admittedly, the document does provide limited information and guidance on more useful strategies such as verbal de-escalation, however, this again appears to be inconsistent with the inflexible sentiments conveyed in the title ‘zero tolerance’ and calls into question the motivation for using such language.

Gray<sup>16</sup> believes that a zero tolerance policy sends all the right messages to potentially aggressive individuals, however, clinicians need to develop a better understanding of what causes aggression and violence. There is also a need to provide practical information for ‘nurses in the front line’ who are required to manage such situations.

This paper examines the literature related to aggression and violence in health care and particularly the ED. A literature search was conducted using CINAHL, MEDLINE and PsychINFO entering the terms ‘aggression’, ‘violence’ and ‘zero tolerance’. Relevant textbooks, consensus guidelines and the reference lists of retrieved publications were examined. Discussion is centred on risk factors, and assessment and management strategies. Recommendations from the literature regarding security and policy/protocol development are highlighted. Finally, the focus for education and training initiatives are identified in order to determine the most effective means of minimising and managing aggression and violence in the ED setting.

## Risk factors associated with violence and aggression in the ED

Many factors can influence the likelihood of violence in individuals, including their level of impulse control, their ability to verbalise problems and feelings, their level of empathy with a potential victim or their ability to be persuaded that their injury to others is a wrongful act.<sup>17</sup> Situational factors such as having to wait for protracted periods, noisy waiting areas, fear of unknown people or environments and excessive pain may increase the possibil-

ity of violence.<sup>4,18</sup> Aggression and violence are also commonly stimulated by elements that are often present in the ED such as limited space or provisions for privacy, crowded waiting rooms, raised noise and activity levels and raised temperature.<sup>19–23</sup> The circumstances surrounding presentation to the ED are often stressful for patients and relatives. This can be due to critical illness, end of life issues, family conflict or the perception that there are iatrogenic complications.<sup>9</sup>

It is unclear as to which demographic characteristics indicate a greater risk of aggression and violence. Kuhn<sup>5</sup> identifies young people (under 30 years) of male gender as the highest risk group, especially those with substance abuse problems. However, Secker et al.<sup>12</sup> claim that no demographic factor has been consistently associated with aggression and violence. Davidson<sup>24</sup> highlights young age and a history of violence as risk factors that consistently emerge for aggression and violence though findings with regard to gender are inconsistent. Aggression and violence can certainly arise as a consequence of an underlying physical condition.<sup>2,5</sup> The most common examples are delirium and dementia, though hypoglycemia, hypoxia, head injury, acute and chronic pain and individuals who are post-ictal also have associations with aggressive and violent behaviour.<sup>18,25</sup>

Davidson<sup>24</sup> states epidemiological studies have demonstrated that people with mental disorders are more likely to be aggressive and violent than community controls. This is attributable to acute psychotic symptoms (particularly paranoia and persecutory delusions) which indicate an elevated risk. The vast majority of people with a mental disorder, however, are not violent. Paterson et al.<sup>17</sup> conducted an extensive review of the violence literature in relation to mental health populations. They conclude that a potential link between severe mental illness and violence appears to have been established, however, the risk of violence is significantly increased when co-morbid substance abuse and/or antisocial personality traits are present. Substance abuse greatly increases the risk of aggression and violence in the total population and co-morbid personality disorder independently increases risk.<sup>24</sup> This group of patients are particularly costly for ED visits<sup>26</sup> as this is seen as being due to increased susceptibility to self-harm, accidents and to being victim of assaults.<sup>27</sup> Substance intoxication is the major risk factor for aggression and violence in the ED<sup>2,22</sup> as the reasoning capacity and inhibitions of the intoxicated patient are often significantly diminished.<sup>3</sup> The ED is therefore an environment which is predisposed to aggression and violence due to a highly concentrated mix of acute

medical, mental health and substance affected people.<sup>20–22</sup>

The frequently cited 'frustration–aggression hypothesis' proposes that frustration always produces some form of aggression.<sup>4</sup> Although simplistic, it is a solid foundation from which to understand and manage anger, which is the root cause of aggression and violence.<sup>28</sup> Unfortunately, the unpredictable and often chaotic nature of the ED setting makes it difficult to eliminate frustration encountered from inevitable waiting times. However, the theory also suggests that frustration and anger can be re-directed and discharged through more acceptable channels such as verbal expressions of distress. This provides a promising and useful avenue for nurses to obviate a potentially volatile situation from occurring.<sup>3</sup>

The intensity of this environment places considerable demands on the ED staff. Certain staff attributes have been reported as contributing to the risk of assaults such as rigid and authoritarian attitudes and lack of respect generally.<sup>24</sup> In their study of aggression toward health care staff in a UK general hospital, for example, Whinstanley and Whittington<sup>7</sup> observed that while some staff experience no aggression at all others report being repeatedly victimised. Lack of effective communication skills and communication difficulties, can cause confusion and misinterpretation of information and this can be a precursor to aggression and violence. Staff attitudes and ability, or inability, to effectively manage aggression and violence is consistently raised as a pivotal factor in determining the outcome of a potentially volatile situation.<sup>9,14,24</sup>

The Royal College of Psychiatrists (RCP)<sup>29</sup> claims that interventions can increase the potential for aggression and violence as well as decrease it. They state, "the interaction between the clinician and the patient is crucial in the assessment and management of risk. Good relationships make assessment easier and more accurate and may reduce risk". Conversely, risk of aggression and violence may be increased if the clinician–patient relationship is poor. Emotionally depleted staff are acknowledged as having reduced capacity to empathise or understand another individuals' perspective. Negative counter-transference conveyed by a clinician has the potential to create a feeling of powerlessness or a sense of demoralisation. The individual may then feel justified in their growing aggression, in order to regain a sense of self-empowerment.<sup>12,13,20</sup> Conversely, high morale settings – wards with experienced, trained staff and good leadership – report lower levels of aggression and violence.<sup>24</sup>

## Assessment of aggression and violence risk

Clinicians are concerned with the clinical reality of assessing and managing risk rather than the research task of prediction. If a clinician reaches a judgement that an individual is at risk of a particular behaviour and subsequently that behaviour does not manifest, from a research perspective the clinician has made a false positive error. However, in reality they may have been instrumental in ensuring effective preventative measures to minimise the risk, rendering their original judgement inaccurate.<sup>30</sup> Clinical risk assessment therefore does not imply predicting specific acts or outcomes, but rather it involves trying to place the person with an appropriate group that has greater or lesser total risk.<sup>31</sup> To suggest that clinicians are able to predict which individuals will become violent is similar to fortune telling, as violent behaviours derive from a complex number of causal components such as biological and genetic characteristics, personality and developmental influences and environmental factors.<sup>32</sup> The assessment of violence risk should be objective, with consideration being given to the degree to which the perceived risk can be verified. Clinicians must also be careful not to make negative assumptions based on ethnicity. Cultural factors may manifest as unfamiliar behaviour that could be misinterpreted as aggressive.<sup>33</sup>

Most violence risk assessment tools were developed on high risk populations, usually with people who had already committed serious offences. They were not designed to be applied to all patients. They are a supplement to good clinical practice, not a substitute for it.<sup>34</sup> Reservations about violence assessment tools relate to doubts over their ability to account for the complexity and diversity of human behaviour.<sup>35</sup> Kettles et al.<sup>36</sup> found in their review of violence risk assessment tools that the most noted weakness was the subjective nature of the tools used, the diversity of tools was also noted. Another problem was the reluctance to adopt tools designed by others, regardless of reliability or validity. The recently compiled National Institute for Clinical Excellence (NICE) guidelines<sup>33</sup> state that violence risk assessment tools and structured clinical judgement should be used in a consistent way however no 'gold standard' risk assessment tool could be recommended.

The power to predict a single event (such as violence) occurring in the future is limited. The vast number of risk factors and the dynamic interplay between them provides far too many possibilities to be useful in predicting which individuals will become aggressive or violent. It is far more helpful for clinicians to evaluate immediate individual

and environmental risk factors and then develop a management strategy to control these risks or minimise recurrence.<sup>37</sup> Rather than focus simply on the assessment of aggression and violence risk, clinicians may be better advised to concentrate more so on addressing individual needs. When assessing a patient who presents a risk of dangerous behaviour, the clinician should also aim to make the patient feel safer and less distressed as a result of the interaction.<sup>29</sup>

## Management strategies for aggression and violence in the ED

The unambiguous message from the literature, contrary to the notion of zero tolerance, is that early recognition and the use of sound interpersonal skills to diffuse a volatile situation is the safest and most effective approach in aggression and violence management. De-escalation, or talking a person down, involves the use of psychological techniques aimed at calming a distressed individual and redirecting them to a more comfortable emotional space. The components of de-escalation involve an assessment of the immediate situation and verbal and non-verbal communication strategies designed to facilitate cooperation and problem solving skills. A clinician facing a potentially violent individual should convey the message that he or she is willing to work collaboratively and to seek alternatives to solving the perceived problem.<sup>24</sup> Using de-escalation techniques does require increased cognitive demands in an already demanding environment,<sup>1</sup> however, there is considerable evidence to suggest that people can learn how to better manage an aggressor.<sup>3</sup>

Violence rarely erupts suddenly. Frequently aggression and violence follows a period of mounting tension. In a typical scenario, the person first becomes angry, then resists authority and finally becomes confrontational and overtly violent. While it is necessary to deal with aggression and violence, it is preferable to identify the signs of impending violence and to intervene before it manifests.<sup>21</sup> Clinicians must be aware of circumstances where a potential for conflict exists. Negotiating openly for cooperation on initial contact with an individual greatly diminishes the potential for further difficulties. The risk of a personal battle, the 'dominance reciprocal', between the clinician and patient is particularly high with resistive individuals and must be consciously avoided.<sup>38</sup> Wherever possible, there should be an avenue for compromise in the management of challenging behaviour as attempts to force treatment on people usually leads to further resistance.<sup>39</sup>

Pearson<sup>40</sup> describes nurses as the humanisers of the health care team. He suggests that patients expect nurses to be 'with them' emotionally and physically. Nurses support individuals as they try to make sense of and come to terms with the situation they face. It is essential for nurses to work at developing effective interpersonal skills just as it is critical to continually hone clinical skills directly related to physical care. The Code of Ethics for Nurses in Australia<sup>41</sup> reinforces "the development of confidence and trust in the relationship between nurses and the people for whom they care" as a fundamental component of nursing practice. Establishing trust and developing rapport on initial contact with a patient should therefore be viewed as core business for nurses in the ED. Support, reassurance and gaining trust is especially important with people who are difficult or reluctant to accept treatment. Nurses need to be attentive listeners and respond sensitively. A conciliatory manner and supportive statements are required rather than condescension.<sup>42</sup> Nurses must also be particularly mindful of their own non-verbal communication, avoiding vocal qualities that may convey sarcasm, frustration, anger or an overly authoritarian manner.<sup>39</sup>

Garnham<sup>28</sup> provides useful and practical advice on understanding and dealing with aggression and violence. He promotes the principle of early recognition and identifies the significance of well-developed non-verbal and verbal interpersonal skills. Some broader strategies to assist clinicians are also highlighted and summarised as follows; Wherever possible, allow the person some time and space, as he or she may just need to 'sound off'. Demonstrate concern and an interest in providing help. Acknowledge the persons' feelings, even if you do not agree. Reassure the person in an attempt to manage anxiety and distress. If possible, make concessions. Make deliberately friendly approaches. Avoid provocative or threatening comments or gestures. Avoid being overly confrontational. Communicate your thoughts and intentions clearly. Personalise yourself by reminding the person of your role and relationship to them. Offer some alternatives or a range of solutions. Emphasise that their health is your concern, however, providing he or she with access to good health care is difficult without cooperation.

Rallis-Peterson<sup>42</sup> recommends that the ED have 'greeters' to direct patients and family members and to keep patients informed about delays. She also suggests that EDs form a coordinated response team for patients who are out of control or threatening toward staff. Once a situation escalates toward a critical point it is frequently referred to as

a behavioural emergency. Expert consensus guidelines on the treatment of behavioural emergencies developed by Allen et al.<sup>43</sup> recommend beginning with the least paternalistic approaches—verbal intervention, offering food, beverage or other assistance or voluntary medication before moving to strategies that are more intrusive. The authors state that the main difficulty with a behavioural emergency is that an intervention is required but there is often a standoff between the individual at the centre of the incident and those responsible for managing it.<sup>43</sup> Physical restraint is a final response to imminent dangerous behaviour when less restrictive measures fail or are not appropriate.<sup>44</sup> Many violent individuals back down when confronted by a coordinated team response. A demonstration of team unity protects individual team members from being singled out and also allows the aggressor an opportunity to back down and rationalise that they would retaliate were the odds not so overwhelming.<sup>21</sup> Guidelines published by the American Psychiatric Association and the American Psychiatric Nurses Association<sup>45</sup> state that restraint, when used properly, can be a life saving and injury sparing measure. It is an emergency response to protect the person in imminent danger of harming themselves or others. The challenge is to employ an approach that ensures safety while maintaining individual dignity and avoids the inappropriate use of restraint.

An important consideration is that physical restraint and rapid sedation carry a significant risk of injury to staff and patient.<sup>24</sup> Clinicians may under-appreciate the detrimental physical and psychological effects of restraint and sedation. Emphasis on immediate safety should not involve excessive force or injudicious use of medication. A heavy-handed approach may adversely impact perceptions of care and limit the chances of successful treatment.<sup>46</sup> The use of restraint alone does little to reduce the level of agitation or aggression in a patient if the reason for that initial aggression has not been addressed. Restraint, both physical and chemical, can be seen as coercive and may cause trauma and endanger both patients and staff.<sup>1,20,21,39</sup> It is noteworthy that the aim of Occupational Health and Safety Legislation is to promote the health, safety and welfare of people at work and overrides all other legal statutes and regulations. Restraining a patient without a pre-arranged and coordinated response is therefore ill advised as it places in jeopardy the safety of the patient and staff members. Clinicians must, therefore, consider their own safety as a priority and not place themselves at risk of becoming a casualty.<sup>39</sup>

## Education, training and policy/protocol development

Education and training in aggression and violence management allows for the development of greater confidence and comfort in managing volatile situations and can be invaluable in circumventing aggression and violence. Understanding the causes and the cycle of aggression and violence assists ED staff to effectively assess and observe for potential violence and choose appropriate methods of intervention.<sup>1,8,9,12,19</sup> Training should also include guidance on documentation and post-incident support for both staff and patients.<sup>9</sup> Lee<sup>1</sup> warns that an emphasis on physical control techniques, such as restraint and sedation, in aggression and violence management training may lead to staff being less likely to employ interpersonal strategies which are not automatic and require greater cognitive input in an already demanding situation. Sains<sup>3</sup> suggests that training in this area should concentrate on understanding violence and aggression in addition to practical strategies of de-escalation, breakaway and restraint.

Clearly articulated policies, protocols or guidelines on aggression and violence management are an important source of information for health care professionals. They provide a framework and both practical and medico-legal reassurance.<sup>21,22,39,47</sup> However, in their study of aggression and violence in mental health care, Delaney et al.<sup>48</sup> report that policies and guidelines on aggression and violence were viewed by nurses as inconvenient to access and time consuming to read. Providing adequate security to the ED is also viewed as important. It conveys a message to staff that they are valued and that the administration or health service is concerned about their welfare. The public should also be informed that unwarranted aggression could lead to the withdrawal of treatment and/or criminal prosecution.<sup>3</sup>

Jenkins et al.<sup>2</sup> have several recommendations for interventions aimed at improving the response to aggression and violence in EDs. The authors suggest that all EDs should have formalised protocols for dealing with abusive patients and accompanying persons. All incidents should be recorded as this adds weight to requests for action to deal with the problem of aggression and violence. All staff should receive training in strategies to deal with difficult and aggressive people, particularly de-escalation techniques for potentially troublesome situations. Training may also include self-defence and breakaway techniques. Patients and their relatives should always be kept routinely updated on their ongoing management and on waiting times.

The administration of health services must also demonstrate to their staff that they are prepared to identify, exclude or even prosecute offenders. Finally, Behr et al.<sup>13</sup> believe that access to health care is based on a relationship of good faith. Withholding care or services may therefore be justifiable in circumstances where the actions of an individual undermines the benefit of their own treatment, results in a diversion or depletion of resources to the detriment of others or violates the autonomy and rights of health care professionals and other patients.

## Conclusion

It is clear from this review of the nursing and medical literature that a zero tolerance response to aggression and violence in health care is largely impractical for clinicians in the ED. The key attributes required to manage incidents of aggression and violence effectively and safely in the ED are a comprehensive understanding of the numerous factors associated with aggression and violence and the core interpersonal skills required to defuse such situations. Rather than employ a zero tolerance approach, clinicians must first demonstrate a willingness to listen, negotiate and problem solve. Therapeutic engagement and the establishment of rapport are essential components of nursing practice. This activity is particularly pivotal in the busy ED setting as patients and their significant others are frequently faced with prolonged waiting times and a high stimulus environment. The risk of aggression and violence in the ED is compounded by these variables and the combination of acute physical, mental health and substance affected people.

Proficiency in the early recognition, de-escalation and safe restraint of aggressive individuals when it is required, can only be obtained through practical and continuing education and training and the development of local procedures. Policies and guidelines should be in place to direct and inform members of the ED team, however, the decision on how to act in a particular situation must rest with clinicians and an assessment of the individual situation. Potentially aggressive and violent individuals must be informed of the consequences for their actions, and the administration of health services are recommended to convey this message through appropriate signage and security measures. Clinicians working in the ED also need to be reassured that they can seek legal recourse for being the victim of aggression and violence. Recognition of the problem of aggression and violence in health care by government bodies

is welcomed, however, practical initiatives such as funding for education and training programs are required rather than misleading political rhetoric.

This manuscript has been peer reviewed.

## Competing interests

None declared.

## Funding

None declared.

## References

- Lee F. Violence in the A&E: the role of training and self efficacy. *Nurs Stand* 2001;15(46):33–8.
- Jenkins M, Roche L, McNicholl P, Hughes D. Violence and verbal abuse against staff in accident and emergency departments: a survey of consultants in the UK and Republic of Ireland. *J Accid Emerg Med* 1998;15(4):262–5.
- Sains J. Violence and aggression in A&E: recommendations for action. *Accid Emerg Nurs* 1999;7(1):8–12.
- Lau J, Magarey J, McCutcheon H. Violence in the emergency department: a literature review. *Aust Emerg Nurs J* 2004;7(2):27–35.
- Kuhn W. Violence in the emergency department. *Postgrad Med*; online 1999 [cited on 3 January 2006]. Available from: [http://www.postgradmed.com/issues/1999/01\\_99/kuhn.htm](http://www.postgradmed.com/issues/1999/01_99/kuhn.htm).
- Farrell G, Cubit K. Nurses under threat: a comparison of content of 28 aggression management programs. *Int J Ment Health Nurs* 2005;14(1):44–53.
- Whinstanley S, Whittington R. Aggression towards health care staff in a UK general hospital: variation among professions and departments. *Issues Clin Nurs* 2004;13(1):3–10.
- Whittington R. Attitudes toward patient aggression amongst mental health nurses in the zero tolerance era: associations with burnout and length of experience. *J Clin Nurs* 2002;11(6):819–25.
- Lynch J, Appleboam R, McQuillan P. Survey of abuse and violence by patients and relatives towards intensive care staff. *Anaesthesia* 2003;58(9):893–9.
- Sughrue J. Zero tolerance for children: two wrongs do not make a right. *Educ Adm Q* 2003;39(2):238–58.
- Verdugo R. Race-ethnicity, social class and zero tolerance policies: the cultural and structural wars. *Educ Urban Soc* 2002;35(19):50–75.
- Secker J, Benson A, Balfe E, Lipsedge M, Robinson S, Walker J. Understanding the social context of violence and aggressive incidents on an inpatient unit. *J Psychiatr Ment Health Nurs* 2004;11(2):172–8.
- Behr G, Ruddock J, Benn P, Crawford M. Zero tolerance of violence by users of mental health services. *Br J Psychiatry* 2005;187:7–8.
- Duxbury J, Whittington R. Issues and innovations in nursing practice. Causes and management of patient aggression and violence: staff and patient perspectives. *J Adv Nurs* 2005;50(5):469–78.
- NSW Health. *Zero tolerance: response to violence in the NSW health workplace. Policy and framework guidelines*. Sydney: NSW Department of Health; 2003.
- Gray J. Zero tolerance dilemma: the problem of violent and aggressive patients. *Nurs Stand* 2002;16(27):13.
- Paterson B, Claughan P, McComish S. New evidence or changing population? Reviewing the evidence of a link between mental illness and violence. *Int J Ment Health Nurs* 2004;13(1):39–52.
- WHO. *Treatment protocol project. Management of mental disorders*. 4th ed. World Health Organisation Collaborating Centre for Evidence in Mental Health Policy; 2004.
- Cowin L, Davies R, Estall G, Berlin T, Fitzgerald M, Hoot S. De-escalating aggression and violence in the mental health setting. *Int J Ment Health Nurs* 2003;12(1):64–73.
- Duxbury J. An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: a pluralistic design. *J Psychiatr Ment Health Nurs* 2002;9(3):325–37.
- Kao L, Moore G. The violent patient: clinical management, use of physical and chemical restraints, and medicolegal concerns. *Emerg Med Pract* 1999;1(6):1–24.
- Lyneham J. Violence in New South Wales emergency departments. *Aust J Adv Nurs* 2000;18(2):8–17.
- Sarnese P. Assessing security in the emergency department: an overview. *J Emerg Nurs* 1997;23(1):23–6.
- Davidson S. The management of violence in general psychiatry. *Adv Psychiatr Treat* 2005;11(5):362–70.
- Muir-Cochrane E, Wand T. Contemporary issues in risk assessment and management in mental health. *The Australian and New Zealand College of mental health nursing monograph series*. Greenacres South Australia: ANZCMHN Inc.; 2005.
- Drake R, Mueser K. Psychological approaches to dual diagnosis. *Schizophr Bull* 2000;26(1):105–18.
- Gournay K, Sandford T, Johnson S, Thornicroft G. Dual diagnosis of severe mental health problems and substance abuse/dependence: a major priority for mental health nursing. *J Psychiatr Ment Health Nurs* 1997;4(2):89–95.
- Garnham P. Understanding and dealing with anger, aggression and violence. *Nurs Stand* 2001;24(16):37–42.
- Royal College of Psychiatrists (RCP). *Assessment and clinical management of risk of harm to other people*. The Royal College of Psychiatrists special working party on clinical assessment and management of risk. London: Royal College of Psychiatrists; 1996.
- Doyle M, Dolan M. Violence risk assessment: combining actuarial and clinical information to structure clinical judgements for the formulation and management of risk. *J Psychiatr Ment Health Nurs* 2002;9(6):649–57.
- Reid W. Risk assessment, prediction and foreseeability. *J Psychiatr Pract* 2003;9(1):82–6.
- Woods P, Reed V, Robinson D. The behavioural status index: therapeutic assessment of risk, insight, communication and social skills. *J Psychiatr Ment Health Nurs* 1999;6(2):79–90.
- National Institute for Clinical Excellence (NICE). *Violence: the short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments*. London: National Institute for Clinical Excellence; 2005.
- Maden A. Practical application to structured risk assessment. *Br J Psychiatry* 2001;178(5):479.
- Stein W. The use of discharge risk assessment tools in general psychiatric services in the UK. *J Psychiatr Ment Health Nurs* 2002;9(6):713–24.

36. Kettles A, Robinson D, Moody E. A review of clinical risk and related assessment in forensic psychiatric units. *J Psychiatr Ment Health Nurs* 2003;5(3):3–12.
37. Brinded P, Earthrowl M. Mood disorders and forensic psychiatry. In: Joyce P, Mitchell P, editors. *Mood disorders: recognition and treatment*. Sydney: UNSW Press; 2004.
38. Shea S. *Psychiatric interviewing. The art of understanding*. 2nd ed. Philadelphia: W.B. Saunders; 1998.
39. Wand T. Duty of care in the emergency department. *Int J Ment Health Nurs* 2004;13(2):135–9.
40. Pearson A. The essence of advanced nursing is being there. *Nurs Mirror* 1984;159(8):16.
41. ANC, RCNA, ANF. *Code of ethics for nurses in Australia*. Australian Nursing Council, Royal College of Nursing Australia, Australian Nursing Federation; 1998.
42. Rallis-Peterson D. When a patient turns violent. *RN* 2001;64(5):32–5.
43. Allen M, Currier G, Hughes D, Reyes-Harde M, Docherty J. The expert consensus guidelines series: treatment of behavioural emergencies. *Postgrad Med* 2001;(Suppl.):1–88.
44. Karas S. Behavioural emergencies: differentiating medical from psychiatric disease. *Emerg Med Pract* 2002;4(3):1–20.
45. American Psychiatric Association and the American Psychiatric Nurses Association. *Learning from each other: success stories and ideas for reducing restraint/seclusion in behavioural health*; 2003 [cited on 3 August 2005]. Available from: <http://www.apna.org>.
46. Currier G. Drug selection: management of psychotic agitation in the emergency service. *Psychiatr Issues Emerg Care Settings* 2002;1(1):3–11.
47. Antai-Otong D. Proactive response to workplace violence: nurses' roles in health promotion. *Tex Nurs* 1998;72(8):4–7.
48. Delaney J, Cleary M, Jordan R, Horsfall J. An exploratory investigation into nursing management of aggression in acute psychiatric settings. *J Psychiatr Ment Health Nurs* 2001;8(1):77–84.

Available online at [www.sciencedirect.com](http://www.sciencedirect.com)

