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APNA POSITION STATEMENT
Violence Prevention

Introduction

Violence affects everyone, in all stages of life; regardless of age, race, or economic status (CDC, 2016). Violence is a public health issue that creates physical, emotional, psychological, and spiritual problems for those who survive. It can also have a negative effect on communities by causing economic loss, social disruption, loss of productivity, and diminished quality of life. While workplace violence has become a national epidemic, the majority of violent events occur outside the healthcare environment. Violence related to murder, rape, suicide, intimate partners, social bullying, robbery, and other forms of assault disrupt the ability of society to remain sufficiently organized and thrive. Violence is defined as:

> "the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (World Health Organization, 1996).
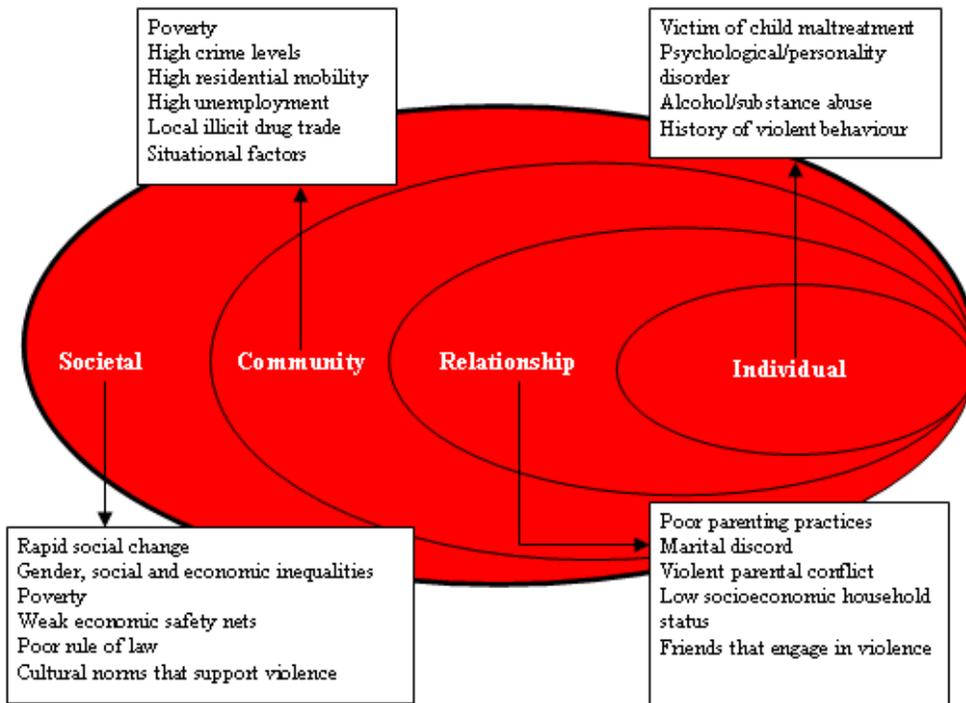
Roots of Violence

Poverty
High crime levels
High residential mobility
High unemployment
Local illicit drug trade
Situational factors

Victim of child maltreatment
Psychological/personality disorder
Alcohol/substance abuse
History of violent behaviour

Societal   Community   Relationship   Individual

Rapid social change
Gender, social and economic inequalities
Poverty
Weak economic safety nets
Poor rule of law
Cultural norms that support violence

Poor parenting practices
Marital discord
Violent parental conflict
Low socioeconomic household status
Friends that engage in violence

Image: World Health Organization, 2007

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As psychiatric-mental health (PMH) nurses, we believe that all human beings deserve to be treated with dignity and respect and we stand firm in our resolve to promote peace. PMH nurses have a role and ethical responsibility to facilitate and implement interventions and strategies to reduce and ultimately prevent violence (Healthy People, 2020). Nursing practice includes active participation in the development of policies and mechanisms that promote safety for both inpatient and community environments (American Nurses Association, 2011; Altman, Butler, & Shern, 2016). As leaders, caregivers, educators, and members of one of the most trusted professions in America, PMH nurses have the opportunity to teach and promote violence prevention approaches and strategies wherever they interface with individuals, families, and communities by:

1. Fostering safe, stable, and nurturing relationships between children and their parents/caregivers.
2. Teaching life skills to children, adolescents, and young adults.
3. Screening for the use/misuse of alcohol and other substances.
4. Reducing access to guns, knives, and pesticides.
5. Promoting gender equality.
6. Changing cultural norms that support violence.
7. Identifying victims in an effort to provide care and support.
8. Promoting suicide prevention across the lifespan.
9. Implementing violence screening in primary care, emergency departments, and mental health settings.
10. Providing resources to individuals experiencing violence.
11. Providing workplaces with resources to promote healthy environments.

Clearly, the issue of violence and violence prevention is complex and requires an interprofessional public health approach. PMH nurses are well positioned to contribute to this approach to violence prevention, including:

- Defining the problem
- Identifying risk and protective factors
- Developing and testing prevention strategies
- Assuring widespread adoption the CDC's Preventing Multiple Forms of Violence: A Strategic Vision for Connecting the Dots (2016)

Defining the Problem:

We recognize that violence is a wide-spread problem that has the potential to impact anyone, in any environment, on any given day. We acknowledge that violence occurs across the lifespan. We realize that specific populations are considered at higher risk for violence, as verified by data from multiple sources, including the National Violent Death Reporting System, Kids Count Data Center, Bureau

of Justice Statistics, Centers for Disease Control, National Coalition Against Domestic Violence, and National Center for Health Statistics. We understand that childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity (ACES Study; Perry, 2002).

Identifying Risk and Protective Factors:

We acknowledge that there are multiple reasons why one person experiences and/or perpetrates acts of violence, while others do not. We also understand that the goal of violence prevention is to decrease risk factors and increase protective factors (CDC). To that end, we believe that each PMH nurse must become familiar with potential risk and protective factors associated with violence and solicit specific data when assessing an individual or family seeking care.

We understand that agitation (a notable risk factor) often precedes violence. People who present to hospital emergency departments (EDs) during psychiatric emergencies often become agitated. Recognizing early warning signs of agitation can preempt violence (Scheck, 2011; Zeller, 2010; Bowers, 2014a). For example, Richmond et al. (2012) studied patient aggression in the ED and reported success in replacing restrictive methods of treating agitated patients with non-coercive interventions that included engagement, collaboration, and de-escalation.

PMH nurses have the opportunity to educate individuals about violence, violence prevention, and risk and protective factors in a variety of settings and circumstances including inpatient settings, emergency departments, schools, sports programs, substance use treatment centers, club houses, private practices, integrated primary care settings, military clinics, etc.

Developing and Testing Prevention Strategies:

We believe that patient-centered, trauma-informed, recovery-oriented practices are an integral element of violence prevention. PMH nurses are in an excellent position to work with individuals, their friends, and family members on strategies to identify and resolve intolerable feelings in a non-violent manner, using evidence-based best practices. A growing body of evidence supports the concept that PMH nurses can prevent violence by actively engaging with individuals in the milieu and identifying signs

of distress (Polacek et al., 2015). Connecting with people in distress via therapeutic relationship strategies (Hamrin et al., 2009) and focusing on trying to meet each individual's unmet needs (Orlando, 1961) may prevent unnecessary frustration and anger that often triggers violence. An approach that is sensibly cautious, yet not overly reactive or controlling is most effective, because imposition of restrictions exacerbates the problem of violence (Bowers et al., 2009).

Implementation of restraints, seclusions, medications over objections, and special observations may become necessary in acute situations to prevent violent behavior. These last resort measures or safety interventions are often considered to be containment measures (Bowers, 2014). Coercive measures based on control are in direct conflict with patient-centered, trauma-informed care. Nurses can't control the behaviors of others, but they *can* control their response to those behaviors (Allen, 2014). Nurses can demonstrate care and advocacy through active listening and respectful, therapeutic interactions. Nursing interventions that prevent violence include offering support and removing the elements of violence: target, trigger, weapon, and state of arousal (Bailey, 1977). Violence can be prevented when nurses recognize what constitutes a state of arousal for the individual, eliminate or diffuse environmental hazards and triggers, and develop care plans to reduce contact with other individuals who serve as targets (Ray, 2011). Nurses can interact and engage with individuals to build human connections and develop trust, which facilitates communication and helps people to understand their illness and work toward recovery.

In addition, PMH nurses are also well equipped to serve as role models in the recognition and prevention of lateral and horizontal violence in the workplace through the use of adaptive, non-violent communication practices. Nurse leaders can create and support nursing education and workplace policies that do not tolerate aggression or violence in any form (Dillon, 2012). A survey conducted by the Emergency Nurse's Association (2011) found that higher commitment to violence mitigation from hospital administration, ED management, and the presence of reporting policies (especially zero-tolerance policies), were correlated with less physical violence and verbal abuse. Leaders can also implement and support collaborative, relationship-based, trauma-informed and recovery-oriented models of care that may reduce violence (Barker, 2001; Bowers, 2014; Perry, 2002; Koloroutis et al., 2007; Greene et al., 2008; Mahoney, 2012; SAMHSA, 2016).

More recommendations for classroom and workplace violence prevention:

o Dillon recommends clear workplace policies, which define workplace aggression, the reporting system, and a "zero-tolerance" policy for such acts with consequences.
o Robertson recommends "delineating progressive disciplinary measures…with prevention as the cornerstone of effective incivility management (2012, p. 25).
o Workplaces should lead by "building positive peer pressure for pro-social behavior," (2010, p. 19); further, "instituting programs which reward peace-developing behavior fosters civility, care and empathy in the workplace" (Dillon, 2010, p. 20).
o Cognitive Rehearsal is recommended as an evidence-based intervention to address incivility and lateral violence (Griffin & Clark, 2014). Cognitive Rehearsal involves didactic instruction, identifying phrases and rehearsing appropriate responses with continued practice. Griffin & Clark (2014) provide an outline of common uncivil behaviors by nurses with corresponding appropriate cognitive rehearsal responses (2014, p. 540).
o Assuring Wide-Spread Adoption the CDC's Preventing Multiple Forms of Violence: A Strategic Vision for Connecting the Dots (2016):

The theme of engagement in violence prevention carries over from inpatient settings to community outpatient settings, where PMH nurses often encounter intimate partner violence, sexual violence, elder abuse, suicidality, and homicidality. The World Health Organization (WHO, 2010; 2016a-c), the Centers for Disease Control (CDC, 2016), and the Substance Abuse and Mental Health Services Administration (SAMHSA) provide extensive online resources to guide PMH nurses to prevent violence and its consequences so that individuals, families, and communities can live in peace.

Conclusion:

Trusting relationships between PMH nurses and individuals, families, and members of the community are essential elements in the effort to prevent most types of violence. Through these relationships, PMH nurses are positioned to be at the forefront of violence prevention efforts by assessing risk factors, providing counseling and education, and acting as role models while actively working to change cultural norms related to violence. These efforts by PMH nurses will help to make the world a safer place to live.

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