Preventing Violent and Aggressive Behaviour in Healthcare:
a literature review

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Review of Literature

Since the late 1980's there has been a concerted effort to prevent violence in the workplace however it was not until the mid-90's that government agencies have produced guidelines for violence prevention programs. A systematic approach was used to search the literature for relevant studies from: peer-review journals, government and academic reports, PubMed database, books, reference lists, websites and journal "Table of Contents". Keywords used were: "workplace violence prevention" strategies; workplace violence prevention strategies in healthcare; evaluating "workplace violence prevention programs" in healthcare; healthcare workplace violence prevention; and violence in the healthcare workplace.

Inclusion criteria were that the study describe violence prevention programs and provide specific details of interventions. After screening for pertinence we obtained 175 studies/reports for our reference list. We excluded 62 studies that were primarily epidemiological. Of the remaining 113 most described violence prevention programs in various settings:

- General application – 65
- Acute care – 17 (some mental health)
- Mental Health – 24 (some complex care)
- Complex care – 12 (some mental health)
- Community Care – 14 (some mental health)

After reading the resulting 113 articles, we screened out those only provided a description of the violence prevention program without reporting evaluations. Although a substantial list of violence prevention studies were identified, only 32 studies demonstrated the effectiveness of these interventions. The 32 articles that did some sort of evaluation of intervention were comprised of 5 environmental / administrative, 11 training, and 16 post-incident. Three of the 5 environmental/administrative intervention studies were not in healthcare settings specifically, whereas one was in acute care and another was in a Veterans Administration facility. The eleven training intervention studies were all in healthcare settings: one in nursing homes whereas the remainder were in hospitals (two in emergency departments, two in Veterans Administration facilities, three in mental health hospitals, and five giving a generic acute care description). The sixteen post-incident intervention evaluations comprised of nine studies in healthcare settings and seven studies not in healthcare (armed forces, women experiencing early miscarriage, victims of violent crime, acute burns trauma victims, police officers, and two studies of road traffic accident victims). The nine healthcare setting post-intervention evaluations were distributed as follows: six in psychiatric (forensic) hospitals, one in Veterans Administrative facilities, one in a long-term care facility, and one in community homes for developmental and psychiatric residents. Most evaluation studies did not use a control group but used a one-group pre/post design. Tables 1 to 4 provide a summary of the evaluation studies.

The evaluation studies demonstrate some consistency in perception that the greatest quantity of aggressive behaviour incidents arise from patients/clients/residents who have psychiatric or dementia illness or individuals who are in the crowded high-pressure environments of emergency department. However there is **very little mention of the integration of clinical guidelines as they relate to violence prevention and OH&S strategies**. Now that more people with psychiatric problems and dementia are living in the community rather than being institutionalized, these expanded violence prevention strategies from mental health hospitals may be applicable for community care settings. **This is a preliminary review of the literature, if you have any studies that should be incorporated, please notify OHSAH (604-775-4034) and we will include these for the benefit of all participants in the prevention of violent and aggressive behaviour in BC healthcare.**

Table 1 - Environmental & Administrative Interventions

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
Casteel & Peek-Asa (2000))	Convenience stores, liquor stores, stores with a history of robbery, small retail establishments and betting shops.	Two studies used an experimental design (one randomized and one not randomized but with a rigorous follow-up to ensure high compliance with the program). Half the studies used a pre-post intervention without a control group. In eight studies using a control group. The control group was selected by: voluntary non-participation in three studies; by absence of interventions in three studies; by sampling stores with similar environmental characteristics as intervention stores in two studies.	26 studies: 24 in the USA; 1 in Vancouver, Canada; 1 in Victoria, Australia.	14 studies multi-components; seven single-component; three ordinances; and two regulations	Many studies evaluated raw numbers of events before and after the program. Multivariate methods to control for confounding and to explore the possibility of effect-measure modification were used only in one study (Figlio & Aurand, 1991).	Between pre- and post-test: • All primary studies with multi-component programs experienced a reduction in robberies ranging from 30% to 84%. • Single-component programs ranged from an 83% reduction to a 93% increase. • Robbery reductions were larger for interventions comprising basic store design, cash control, and training. Compared to those including equipment systems.
[B] Drummond et al (1989)	Veterans Administration hospital	One group, pre-post test	Patients with histories of repeated violent events	Identified high-risk patients through a computerized program and provided "warning flags" and background information	• Mean number of disruptive patient visits • Mean number of patient disruptive incidents	• Number of disruptive patient visits decreased 42% from pre- to post-test. • Number of disruptive patient events decreased 91% from pre- to post-test.

[B] Runyan et al 2000;

[A] Figlio & Aurand (1991)	Convenience stores in Virginia	Pre-post two-group 230 convenience stores in the intervention group had two clerks on night shift. Control group of 346 stores had only one clerk on duty during the 11pm to 7 am shift.	230 two-clerk convenience stores in Virginia; 346 US one-clerk stores. Pre-intervention mid-1985 to mid-1988. Post-intervention mid-1988 to mid-1991.	Policy requiring convenience stores in Tidewater region of Virginia to employ two clerks 11 pm to 7 am (third shift). Implemented Mar 1, 1988.	Third shift robbery rates per store per year.	• Experimental group experienced 2.4% reduction in robberies; controls experienced 18.3% increase. • If no previous robberies, then one-clerk stores were robbed at a rate 0.74 times that of two-clerk stores. If previous robberies, one-clerk stores were robbed at rates 1.77 to 3.6 times that of the two-clerk stores.
Loomis et al (2005)	North Carolina workplaces	Population-based case control study. Experimental group: 105 workplaces where a worker had been killed between January 1, 1994 and March 31, 1998. Control Group, 210 industry-matched random sample at risk during the same period.	Workplaces in all industry categories except agriculture, law enforcement and the armed forces. Randomly selected 10 potential controls for each case individually matched by broad sector of industry.	Preventive measures were divided into: 1) environmental control measures related to workplace design and 2) administrative-control measures related to work practices and policies.	Risk of death of a worker due to homicide	• Environmental-measures: strong and consistent reductions in risk of homicide on job associated with bright exterior lighting (OR = 0.5). • Administrative measures: the largest beneficial effect was for staffing practices that prevented workers from being alone at night (OR = 0.4). • Combinations of 5 or more administrative measures were associated with significantly lower levels of risk (OR = 0.1)

[A] In Casteel & Peek-Asa (2000)

Table 1 - Environmental & Administrative Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
Rankins & Hendey (1999)	Acute Care	Retrospective review of security records for a 54-month period from 1992 to 1996. One-group Pre-post	An urban county Emergency Department in California	Implementation of a security system	• Weapons confiscated • Percentage of weapons in the patient care area • Reported assaults per 10,000 patients	• 24 weapons confiscated before and 40 after (p<. 001) • Percentage of weapons confiscated in the patient care area decreased from 92% before implementation to 42% after. (41% of weapons found in the patient area after implementation were brought in by ambulance patients who bypassed the security booth and metal detector). • Reported assaults per 10,000 patients did not change significantly.

Table 2 - Training Interventions

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
Arnetz & Arnetz (2000)	Healthcare workplaces	Randomized control group, pre=post. Baseline Sept 1996. Post-test Oct 1997.	953 healthcare workers in 47 healthcare work sites. 24 randomly selected for intervention group (n=585).	All worksites received the Violent Incident Form (VIF). The intervention group followed a structured feedback program where registered incidents were discussed on a regular basis with work-place staff.	• Report of incidents from Oct 1996 to September 1997 • Awareness of risk situations • How potentially dangerous situations could be avoided • How to deal with aggressive patients	• Staff at intervention sites reported 50% more violent incidents than the control sites at post-test Compared to the control group, the intervention sites: • Reported better awareness of risks (p<.05) • How to avoid dangerous situations (p<.05) and • How to deal with aggressive patients (p<.05)
Beech & Leather (2003)	Acute Care	One group pre-post.	243 Student nurses. Baseline 4 months before intervention. T2 immediately before intervention T3 3 weeks after intervention. T4 3 months after intervention.	3-day learning unit	Was staff behaviour changed and maintained: • Short term (T2) • Medium term (T3) • Long term (T4)	Maintaining personal safety: • No change to T2, but significant change at T3 and maintained to T4 Prediction and Prevention:. • No change to T2,, but significant change to T3 and maintained to T4 Practical ability: • Statistically significant increase to T2, statistically significant decrease to T3, and final score finished at a level lower than T1. Self-respect and staff rights • Statistically significant increase to T2, further increase to T3, and further statistically significant increase to T4. Provocative approach • Showed no statistically significant change to T2, but statistically significant difference to T3 and maintained to T4.

Table 2 - Training Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
Cowin et al (2003)	Acute care hospital	Two group pre-post Post-test 3 months after distribution/discussion of poster	21 nurses in mental health care unit (MHU) compared to 33 nurses in emergency department (ED)	Pre-test, then distribution of de-escalation poster with group discussion of techniques.	• Survey responses between pre and post • Survey responses between	• MHU had increases in de-escalation knowledge and awareness of de-escalation techniques although differences were not statistically significant • ED increases not statistically significant. • MHU scored significantly higher than ED at Time 1. • MHU maintained the higher score at time 2.
Fernandes et al (1999)	Emergency department	Retrospective survey of violence in the workplace	163 workers in a tertiary care hospital in Vancouver in 1996	Survey elicited respondent's perception of violence in the workplace.	• severity and associated stress related to violence in the workplace; • number of incidents in the previous year; • frequency of reporting incidents; • effect of violence on job performance, fear of patients, job satisfaction and career choice.	• 68% reported increasing frequency of incidents over time • 60% reported increasing severity of incidents • 48% reported impaired job performance for the rest of shift or rest of week after an incident • 73% were afraid of patients as a result of violence • 74% had reduced job satisfaction. • 11% of the workers no longer worked in the emergency department and 67% of these left the job partly owing to violence. • the most useful potential interventions were perceived as: 95% 24-hour security (by 95%) and a workshop on violence prevention (by 68%). • The most frequent coping strategy was seeking the support of colleagues rather than official debriefing.

Table 2 - Training Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
Fernandes et al (2002	Emergency department	Pre-post one group. Baseline survey pre-test Post-test at 3-months and 6-months post-intervention	195 workers in the emergency department responded to the survey. Baseline August 1998. 3-month follow-up February 1999. 6-month follow-up May 1999.	In Oct/Nov 1998 the emergency staff attended (in groups of 40) a 4-hour, 10 components Prevention and Management of Aggressive Behaviour Program (PMABP)	• Number of verbal assaults • Number of physical assaults	• The education significantly decreased the number of verbal (from 154 to 58) and physical assaults (from 49 to 19) at the 3-month post-test. • Violent incidents increased by the 6-month post-test (verbal from 58 to 69; physical from 19 to 46) but still below the original level.
Fitzwater & Gates (2002)	Nursing home	Quasi-experimental, two nursing homes randomly selected approximately same size, same resident population	Ten Nursing assistants, from each site.	All 20 nursing assistants asked to fill a daily assault log for ten days. Ten nursing assistants from one site provided with 4-hour education intervention	• Injury from violent resident • Received previous training in previous job • Received previous training in present job	• 90% of intervention group had received an injury from a resident compared to 60% for control group • 90% of intervention group had been trained how to handle aggressive residents (previous and/or current job) • 60% of comparison group had received previous training and 50% had training in current job • Intervention group had significant reduction in assaults from pre (avg 13) to post (avg 6) • Minimal change for comparison group from pre (avg 3.4) to post (avg 2.4) • Intervention group had responsibility for 10-24 residents compared to 8-16 for comparison group.

Table 2 - Training Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
Lavoie et al (1988)	Hospital	Survey	127 Medical Directors of Emergency Department in teaching hospitals	Survey regarding violence and security issues	• 4-point physical restraint • Consequences to use of physical restraints • Formal training • Security personnel	• 98.4% of facilities used 4-point physical restraint • 25.2% restrain at least one patient per day • 13.4% have significantly injured a patient during restraint in the last 5 years • 40.2% had formal training in recognition and management of violence • 62.2% had 24-hour security personnel • 24-hour security personnel had significant deterrent value
Lehmann et al. (1999)	Veterans Administration facilities	Survey of VA facilities and extensive documentation of training. Comparison of trained and untrained staff	166 VA facilities in USA		• Rates of aggressive incidents • Number of violence-related injuries	• Found no relationship between the proportion of staff trained and the rates of aggressive incidents or the number of violence-related injuries. • Found a negative correlation across all facilities between expenditures per day on psychiatric units and the rate of assaultive behaviour per patient
Lee et al (2001)	Psychiatric Intensive Care Units (PICUs) and regional secure units (RSUs)	Survey of a random sample of PICUs and RCUs.	338 Nursing staff in PICUs in England and Wales on 63 of 112 wards	Comparison of training between PICUs and RSUs.	• Course length • Course content	• Course length varied considerably from a half day to 21 days • The mean number of techniques taught in the initial course was 15.2. • A mean of 2.3 techniques were taught per training day. Workers in RSUs were more likely than those in PICUS to be taught: • Breakaway techniques (p=.03) • Entry to and exit from vehicles (p<.001) • Defence against weapons (p=.02) Length of training did not correlate with respondents' confidence in their ability to apply the techniques. • The mean confidence in respondents trained in the core curriculum was significantly higher than in the others (p=.015) • No difference in the mean confidence between PICUs and RSUs

Table 2 - Training Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results

Ore (2002)	Mental Health	Comparison between trained and untrained	Australian Healthcare workers Intervention group was 358 workers who completed PART between July1, 1998 and June 30, 1999. Controls were selected to closely match the intervention group by stratified random sampling with respect to age, gender, job classification, length of service, and worksite/residential type.	Professional Assault Response Training (PART) 5-day course includes:
				• Principles of behaviour intervention
				• The assault cycle
				  1) triggering event
				  2) escalation
				  3) crisis
				  4) recovery, and
				  5) post-incident depression
				• crisis communications
				• evasive self-defence techniques
				• components of accurate incident reporting
					• Number of reported injuries
					• Per capita workers' compensation payout
						• Trained workers had a higher number of reported injuries
						• Trained workers had double the compensation payout compared to untrained

Southcott et al (2002)	Acute mental health hospital	Qualitative analysis of nursing staff perceptions regarding the effectiveness and safety of breakaway and restraint techniques	Nurses in a 16-bed acute mental health intensive care unit	Analysis of 346 adverse incident reports and interviews with 19 nurses	• Perception of nurses regarding breakaway and restraint techniques	• Staff generally satisfied with training on control and restraint • Found mismatch between patterns of assault and preparation for dealing with assaults. • Perceived aspects of restraint such as establishment of holds to be problematic in application

Table 3 - Systemic Review of Post-incident Interventions

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
[C] Bisson et al (1997)	Acute Burns Unit	Two-group Randomized control trial, pre-post	Acute burns trauma victims. 74% male, mean age 37.9 years. No-intervention Control 76% male, mean age 36.7 years.	Single session CISD, mean 8.3 days after trauma, mean 44.3 minutes in length. Post-test 13 months after trauma.	• Impact of event scale (IES) • Hospital anxiety and depression scale (HADs)	• CISD group experienced a small increase in PTSD symptoms (-0.18) and a small increase of other symptoms (-0.13) • No-intervention control experienced a small-to-medium decrease in PTSD symptoms (0.39) and in other symptoms (0.24)
[C] Carlier et al (2000)	Police officers	Two-group non-randomized control trial, pre-post	Police officers suffering trauma, 70% males, mean age 28.9 years. No-intervention control 65% male, mean age 31.7.	Single session CISD, about 24 hours after trauma, mean sessions 41.4 minutes. Post-test shortly after debriefing (~24 hours after trauma)	• State-trait anxiety inventory version (STAI-S)	• No data obtained regarding PTSD symptoms. • CISD group experienced small-to-medium decrease in other symptoms (0.38) • No-intervention group experienced small decrease (0.01) increase in other symptoms.
[B] Carmel & Hunter (1990)	Forensic psychiatric hospital	Ecologic (comparison of training and injury rates by hospital ward not by occupation)	Nursing staff	Voluntary 16-hour nurse training program in the management of patient aggressive behaviours.	• Rates of aggressive incidents by patients • Rates of nurse injuries inflicted by patients	• No significant difference in rates of aggression in "high compliance" wards versus "low compliance wards. • Rates of nurse staff injuries were significantly higher in low compliance (20.0 per 100 staff) compared to high compliance (7.4 per 100 staff) wards.
[C] Conlon et al (1998)	Road Traffic Accidents	Two-group Randomized control trial, pre-post	Intervention group 39% male, mean age 32.9 years. No-intervention group 55% male, mean age 34.7 years.	Single session 30-min counselling, mean 7 days after trauma. Post-test mean of 99 days after trauma	• IES • Clinician-administered PTSD scale (CAPS)	• Other symptoms not measured. • Intervention group experienced a large decrease in PTSD symptoms (0.99) • No-intervention group experienced a large decrease in PTSD symptoms (0.73)

[C] **van Emmerick et al. 2002. Effect sizes: small = 0.2, medium = 0.5, and large = 0.8**

Table 3 - Systemic Review of Post-incident Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
[B] Flannery et al (1998)	Psychiatric hospital	One group, pre-post test (aggregated across three hospitals)	Employees in three Massachusetts state-supported hospitals	Assaulted Staff Action Program (ASAP) crisis intervention offered to employees assaulted by patients (one-to-one counselling, support groups, referrals to professional)	Mean number of employee physical assaults by patients	Mean number of physical assaults declined significantly in all three hospitals from pre- (31.0) to one-year post (2.4) tests.
[B] Goodridge et al (1997)	Long-term care facility	One group, pre-post test	Nursing assistants in Winnipeg, Canada	CARIE abuse prevention program: one-day workshop aimed at identifying causes of abuse, understanding caregivers' feelings, cultural perspectives, and strategies for preventing abuse and dealing with aggressive residents	• Mean employee self-reported "conflict score" measuring frequency and type of conflicts with residents • Mean employee self-reported "aggression score" measuring physical and psychological aggression experienced by employees from residents	• Mean conflict score declined significantly from pre (13.5) to post (10.2) tests. • No significant differences were found between pre- to post- aggression scores.
[B] Hunter & Love (1996)	Forensic psychiatric hospital	One group, pre-post test	Patients and employees in one Central California maximum-security forensic psychiatric hospital for men	Use of Total Quality Management (TQM) principles during mealtimes to reduce incidents (switching to plastic utensils; playing music; using patient privilege system; opening up the main courtyard to provide leisure time after lunch; training food service workers)	Total number of violent events in dining room during mealtime	One year after intervention, a 40% reduction in reported dining room violent events

[B] Runyan et al 2000

Table 3 - Systemic Review of Post-incident Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
[B] Infantino & Musingo (1985)	Psychiatric hospital	Nonrandomized, one comparison group	Psychiatric and charge aides	Aggression Control Techniques (ACT) 24-hour training on how to handle aggressive patients delivered in three phases: 1) verbal intervention procedures; 2) basic physical intervention techniques; 3) specialized instructions in restraint and control	• Percent of employee physical assaults by patients • Percent of employee assault-related injuries inflicted by patients	• Employees attending the training were significantly less likely to be assaulted than those not attending (3% vs. 37%) • No significant differences in reported assault-related injuries between trained and nontrained
[C] Lee et al (1996)	Early miscarriage	Two-group Randomized control trial, pre-post	Women experiencing early miscarriage. Intervention group mean age not reported.	Single session CISD about two weeks after miscarriage. 1-hour session. Post-test 4 months after miscarriage.	• IES (intrusion) • IES (avoidance) • HADs	• Intervention group experienced a medium-to-large decrease in PTSD symptoms (0.62) and small-to-medium decrease in other symptoms (0.37) • No-intervention group experienced a medium-to-large decrease in PTSD symptoms (0.53) and a small-to-medium decrease in other symptoms (0.37)
[B] Lehmann et al (1983)	Veterans Administration hospital	One group, pre-post test	Staff members who enrolled in one of eight training sessions	Five-hour employee training on how to prevent and manage patients' aggressive behaviours	• Knowledge • Confidence in handling potentially threatening situations	• Trainees reported increased knowledge and confidence in aggressive situations (No data given)

[B] **Runyan et al 2000;** [C] **van Emmerick et al. 2002. Effect sizes: small = 0.2, medium = 0.5, and large = 0.8**

Table 3 - Systemic Review of Post-incident Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
[B] Matthews (1998)	Community homes for developmental and psychiatric residents	Nonrandomized, two comparison groups	322 direct care workers in 32 community homes in two areas of Sydney, Australia	Critical incident stress debriefing (CSID) offered to employees who experienced a traumatic event within the past six months • Intervention emphasized restoration of coping skills and sense of control	Mean level of direct care workers' post-traumatic stress	• Comparison group 2 (26.9% of employees in area with no debriefing available) reported significantly higher levels of post-traumatic stress than those in comparison group 1 (18.2% of those in an area where debriefing was offered, but not taken) and intervention group (21.9%) • No significant difference between intervention and comparison groups at pre-test
[C] Mayou et al (2000)	Road traffic accidents	Two-group Randomized control trial, pre-post	Intervention group 57% male, mean age 29.0. No-intervention group 67% male, mean age 26.0.	Single session CISD within 24-48 hours of the accident. Session 1 hour debriefing. Post-test 36 months after accident.	• IES • Brief symptom inventory (BSI)	• Intervention group experienced a small increase in PTSD symptoms (-0.07) and small-to-medium increase in other symptoms (-0.31). • No-intervention group experienced a small decrease in PTSD symptoms (0.19) and other symptoms (0.13).

[B] Runyan et al 2000; [C] van Emmerick et al. 2002. Effect sizes: small = 0.2, medium = 0.5, and large = 0.8

Table 3 - Systemic Review of Post-incident Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
Nhiwatiwa (2003)	Forensic hospital	Two-group pre-post. All nurses had been previously assaulted in the workplace. Randomly assigned to control or intervention group.	40 Nurses who worked within four medium secure hospitals in the Independent Sector in England and Wales	Single session education on the effects of trauma and coping mechanisms	• IES • General Health Questionnaire (GHQ-28)	• No significant difference between groups at baseline • At the 3-month follow-up the intervention group had significantly higher post-intervention distress (IES) than the control group (p=0.03) • There was no significant change from baseline for the GHQ-28 between the two groups.
[B] Parkes (1996)	Forensic psychiatric hospital	One group, pre- post-test	Nursing staff of one 44-bed medium secure forensic hospital	Four-day Control and Restraint Training program to nursing staff (teaching breakaway techniques and team approaches to restraining a violent patient. One- to two-day refreshers were offered after initial training	Mean number of injuries to nurses inflicted by inmates	No significant differences in number of injuries were reported between pre- and post-tests. A small non-significant increase was reported from pre- (51) to post (68) tests.

[B] **Runyan et al 2000**

Table 3 - Systemic Review of Post-incident Interventions (continued)

Reference	Setting	Study Design	Population	Intervention	Outcome	Results
[C] Rose et al (1999)	Violent crime	Three-group Randomized control trial, pre-post with follow-up session at 6 months and 11 months after intervention. CISD group was 68.5% male, mean age 37.2 years. Education group was 75.0% male, mean age 39.1 years. No-intervention group was 82.4% male, mean age 37.3 years.	Victims of violent crime in England	Interventions where provided a mean of 21 days after trauma. Education intervention consisted of 30 minutes of discussion regarding a leaflet including information on normal reactions to traumatic events and where and when to find help. The CISD intervention was a single 1-hour session.	• IES • Post-traumatic stress disorder scale (PSS)	• Mean scores for all three groups did not differ at the 6-month follow-up • No other symptoms were measured. At the 11-month follow-up: • CISD group experienced a medium-to-large decrease in PTSD symptoms (0.61). • Education group experienced a small-to-medium decrease in PTSD (0.47). • No-intervention group experienced a medium-to-large decrease in PTSD symptoms (0.66).
[C] Shalev et al (1998)	Armed Forces	One-group pre-post	Military personnel after combat exposure. Gender not reported. Mean age 19.4 years.	Historical group debriefing within 48-72 hours after combat. Session mean of 2.5 hours. Post-test immediately after debriefing.	• STAI-S	• A small-to-medium decrease in other symptoms. • PTSD symptoms not measured.

[C] **van Emmerick et al. 2002. Effect sizes: small = 0.2, medium = 0.5, and large = 0.8**

Background

Four World Health Organization (WHO) reports provide a background of violence prevention programs and what are consensus interventions: Di Martino (2003), Wiskow (2003), Richards (2003), and Sethi et al (2003). Di Martino (2003) reports that violence in the health sector constitutes 25% of all workplace violence. He discusses the risk factors for violence in the workplace and describes the relationship between work stress and workplace violence. Wiskow (2003) compared 12 violence prevention guidelines across four countries: Sweden (1), the United Kingdom (4), The USA (2), Australia (5) and reports that the National Health Service (NHS) "Zero Tolerance" commitment to reducing risk of violence for the health workforce is the most comprehensive of all the violence prevention programs. Examples of the UK guidelines are presented in Appendix 1). Richards (2003) summarizes the different types of interventions based on the practice in the United Kingdom. Sethi et al (2003) provides a handbook for the documentation of violence prevention programs.

Criteria For Evaluating Violence Prevention Programs

Wiskow (2003) in a WHO review of international programs reports the following criteria for evaluating violence prevention programs: information reported, time frame, relevance (setting-specific), credibility, sustainability, management commitment, employee involvement, and dissemination. An effective program is setting-specific with measurable, achievable objectives within realistic timeframes.

The following series of questions are recommended as a guide for auditing (evaluating) a violence prevention program.

The <u>minimum information required in reporting</u> a violent incident in the workplace:

- Details of victim and perpetrator
- Location, date, time of incident
- Circumstances of incident - actions taken prior (risk assessment, training) and during incident (e.g., conflict resolution method attempted, etc..[de-escalation, breakaway techniques, restraint techniques)
- Details of outcome (injuries, time off, etc..)
- Action taken post-incident (medical aid, psychological aid, legal action/ consequences regarding perpetrators, follow-up on victim, reporting, tracking & analysis of incidents, review of risk assessment & training)

Series Q1 – Do the incident reports provide at least the minimum information required above?

<u>Time frame:</u>

Risk assessments must be done regularly or when there is a change in setting, work procedures or client disposition. Record analysis must be conducted at a minimum on a monthly basis.

Series Q2 –

- **Who does the assessment?**
- **What is done with assessment? (Filed, Posted, Distributed, Reviewed).**
- **How regularly are assessments reviewed?**
- **What action was taken? (e.g. prior to next home visit the worker calls client to ensure that the dog is tied up or confirms that the aggressive relative is not going to be present).**
- **Is there any documentation of warnings concerning the withholding treatment if the client refuses to act on requests to decrease risk factors?**
- **Is there any documentation regarding complaints by client concerning the threat of withholding services and whether the supervisor supported the worker's situation?**

Series Q3 –

- **Is there some evidence of documentation concerning analysis of records (i.e., minutes of JOHS discussion, action taken, etc…)?**
- **Is there documentation of post-incident responses: 1) within 1 hour of incident, 2) 24-hour follow-up; and 36-hour follow-up.**
- **Is there documentation regarding the analysis of the post-incident response? Is there evidence of pre-post measures to evaluate the effect of the trauma and the intervention?**

Relevance:

The guidelines may cover a variety of work settings.

Series Q4 -

- **Do the guidelines differentiate between settings?**
- **Do the guidelines explicitly provide case studies relevant to the work setting?** Environmental change is more relevant to stationary institutions but less relevant to outreach workers. Societal background may influence content of guidelines. Wiskow (2003) provides the following examples: 1) the USA guidelines are more relevant to violence related to guns whereas in other countries this issue is less relevant, 2) developing countries have a greater weakness in overall infrastructure of their health system and do not have many options for post-incidence response, 3) panic buttons and mobile phones may be less realistic for rural clinics and remote areas (due to lack of available service).

Credibility:

To be effective, a violence prevention program must be adequately funded and fully implemented.

Series Q5 -

- **Is implementation of violence prevention programs enforced?**
- **Are there significant examples of citations for non-compliance?**
- **Is there documentation showing that action was taken following non-compliance?**
- **Does zero tolerance receive buy-in from all sectors? What process do they have to measure this? Is the measurement process effective?**
- **What resources are made available to enable implementation of violence prevention programs? Is there a budget? How often is the budget reviewed?**
- **Are resources made available for control measures? How much is provided? Is there allowance for increase or re-distribution of budget according to changing risks?**

Sustainability:

To be effective a violence prevention program must be incorporated into all aspects of the daily schedule, systems maintained, actions documented and programs reviewed on a regular basis.

Series Q6 -

- **How well are strategies integrated into daily work on a regular basis?**
- **Is there documentation of violence prevention drills and objective assessment by police/health authority?**
- **Is there documentation of refresher training for each worker? Is there assessment of the worker's knowledge and skill at managing violence and aggression (de-escalation, breakaway techniques, restraint techniques)?**
- **Is there documentation showing the tracking and analysis of the frequency and type of aggression incidents?**
- **Is there documentation showing action taken to rectify the factors that caused the aggression incident?**

Management Commitment:

To be effective a violence prevention program must have tangible commitment from management. Managers must ensure the development and endorsement of a written violence prevention policy including:

- Recognition of workplace violence risk and pledge to protect staff at work
- Employer's legal obligations
- Employer's goals and objectives with the program
- Details of managers' and employees' responsibilities
- Details of the local prevention and reduction plan
- Provide staff with regular updates and progress reports (in-house newsletter, annual reports on action taken and improvement measures introduced).
- Allocation of resources and appropriate authority to responsible parties.

Series Q7 -

- **Is there documentation illustrating that the policy is implemented as a living actionable program and not just a paper copy?**

Employee involvement:
Successful programs profit substantially with the experience and feedback from staff.
Series Q8 -

- **Are workers involved in the process of risk assessment and determining the best ways of using prevention measures?**
- **Is there documentation showing that staff are consulted on a regular basis through the joint OH&S committee and through surveys? (Minutes of JOHS meetings, reports of incidents and action taken)**

Dissemination:
To be effective the written program must be communicated and be accessible to all employees.
Series Q9 –

- **Are relevant sections of policy provided in a readily accessible format (card, booklet, posters)?**
- **Is the policy published on internet?**
- **Is time made available for group discussions regarding: incidents, what could be done differently, what triggers were missed, was post-incident action effective?**

Guidelines

Thirty-five current violence prevention guidelines were reviewed as current practice (see Appendix 1). All the government and union guidelines agree that risk assessment is the key to prevention of violence in the workplace. There is consensus that risk assessment must lead to violence prevention programs tailored to the particular needs of each specific healthcare setting. There is general consensus declaring that violence prevention must be based on effective implementation of three main steps: identification of the problem or hazard, evaluation of existing precautions and assessment of the risk. A violence prevention program should have the following components: 1) a risk assessment evaluating the risks arising from administrative/work procedures and environmental factors; 2) education and training of personnel to help them identify potential risks and to manage aggression; 3) Incident reporting and investigation; 4) post-incident response and follow-up to moderate the effect of the trauma; and 5) program review to determine what changes are required to make the program more effective.

Risk Factors

There is consensus regarding the risk factors for violence in the workplace. The Chappell-di Martino model focuses on the relationship between personal and environmental factors at work. The model emphasizes the

necessity of combating violence by integrated preventive action tackling all the elements involved. Most guidelines focus on environmental factors and administrative procedures as key elements contributing to the potential for violence in the workplace.

Chappell – di Martino Model Factors:

	Perpetrator (Client/patient/resident)	Victim (Worker, bystander, client)	Workplace (hospital, nursing home, community)	Work Task situation
Risk Factors	Violence history Male Youth Difficult childhood Alcohol/drugs Mental Health Stress	Age Appearance Experience Health Skills Gender Personality/temperament Attitudes & expectations	Physical outlay Organizational setting Managerial style Workplace culture Permeability from external environment	alone/in isolation with public with valuables with people in distress In school with special vulnerability

Risk Assessment

The Workers' Compensation Board (WCB) of BC (2000) defines risk assessment as a step-by-step look at the workplace and work process to: 1) determine what violence prevention measures are already in place, 2) identify potentially hazardous conditions, operations, activities, and situations that could contribute to workplace violence, and 3) determine the risk of future violent incidents.

What should be included in the risk assessment?

1) Baseline Information:

- A baseline of previous violent incidents including: the number, location, nature, severity, timing and frequency of different types of incident (BCGEU, 1998; OSHA, 2004).
- Investigations of incidents and follow-up action taken, records of injuries (WCB of BC, 2000; OSHA, 2004).
- OHS program evaluations (WCB of BC, 2000).
- Records of training (WCB of BC, 2000)
- Policies and procedures (BCGEU, 1998)
- Any violence prevention measures in place
- Security reports; security arrangements and measures; workplace security evaluations.
- Workplace environment arrangements and layout (floor plan)

2) Inspecting the workplace

A) Institutional Workplace (hospital, nursing home, health centre)

Worksite Environment (see WCB of BC 2000, Checklist B3; AFSCME, Appendix A; Vancouver Coastal 2004 Appendix B; OSHA, 2004; OHSAH, 2005)

- Lighting (Casteel & Peek-Asa, 2000;)
- Staff level and deployment (working in isolation, a buddy system or with others), peak workload times (may cause strain in public/client/resident temperament) (BCGEU, 1998; AFSCME, 1998)
- The health team skill mix meets the patients' needs. (ICN, 2000)
- Other patients
- Provision for exchange of information between staff (regarding daily conditions, client moods, flagging history of aggression, etc.) (Vancouver Coastal, 2004; AFSCME, 1998; ICN, 2000))

- General appearance and area
- Maintenance of general security systems
- Isolation
- Building perimeter
- Visibility
- Access control
- Type of equipment, tools, utensils available for use (BCGEU, 1998)
- The experience, skill and training of workers concerned (BCGEU, 1998; AFSCME, 1998)
- Security system (equipment, panic buttons, code white, and trained personnel accessible to staff in a timely manner) (AFSCME, 1998)
- Emergency response system and liaison with local police
- Entrapment areas (parking lots, elevators, washrooms, reception areas, treatment/counselling rooms, pharmacy, waiting areas, stairwells/stairs)
- General building, work station, and area designs (escape route)
- For nursing homes, psychiatric wards and mental health clinics ensure the physical environment does not have 'too much' stimuli (MacCourt, 2004; BC Ministry of Health, 2002)

B) Community Setting/Homecare (see WCB of BC 2000, checklist B4; AFSCME, 1998 Appendix A; Washington State AHS, 1996; Vancouver Coastal 2004 Appendix B; OHSAH, 2005)

- Adequate staffing in the field/community. (escorts or buddies provided in potentially dangerous situations) (AFSCME, 1998; ICN, 2000))
- Training (Are workers briefed about the area in which they will be working: gangs, drug activity, vicious animals, crime) (AFSCME, 1998)
- Are there safe places where workers can go for protection in an emergency? (AFSCME, 1998)
- Are employees provided two-way radios, pagers, or cellular phone to check-in or call for help? Arrangement for pre-visit and post-visit to office, nurse, supervisor or buddy. (AFSCME, 1998; Washington State AHS, 1996; ICN, 2000).
- Does a policy exist to allow workers to refuse service to clients in a hazardous situation? (AFSCME, 1998; ICN, 2000)
- Is there always someone who is responsible for knowing where each worker is? (AFSCME, 1998)
- Safest route for home visit
- Location of closest and safest parking
- Street lighting for parking and entrance to residence
- Safest route into residence
- Nearest public phone
- Physical hazards (barriers, broken steps, free-roaming dogs, weapons) and plan for controlling these hazards during visit
- Other people present in residence during visit
- Is client aware of the approximate time of your arrival?
- Assess mood/attitude of client and/or other people in residence, signs of intoxication, level of orientation
- Review safety routine when returning to vehicle
- Any history from referring agency regarding previous violent or aggressive behaviour
- Knowledge of triggers for violent behaviour from client (e.g., when limits set, or during specific activities)
- Is violent behaviour directed towards a particular person, or generalized?

- Are there any restraining orders against anyone in the household?
- Have threats recently been made against the client? If so, does this person have access to the client at home?

Types of Intervention:

Prevention and mitigation strategies identified in the literature can be divided into two categories: 1) **before-incident interventions** including environmental design, administrative controls, violence management strategies (training); and **post-incident interventions** including some form of psychological debriefing (counselling, Critical Incident Stress Debriefing or Cognitive Behaviour Therapy), incident reporting / tracking / analysis.

A combination of these strategies has been deemed to be the best way of preventing violence.

A) Environmental design

Richards (2003) provides an overview of environmental interventions. The following environmental interventions have been associated with a reduction in risk of violent incidents.

- **Security**: Security guards themselves have been linked with potential incidents. Recommend less police-like uniforms and training focus on defusion and a generally less aggressive response.
- **Identity cards** may allow an aggressor to track down a target
- **Uniforms** in the community may set workers up as targets.
- **Close Circuit Television (CCTV) and alarm systems:** are useful only as a part of a package of interventions as they are reactive protective devices utilised during or after an incident. Good at providing subsequent evidence but not for stopping an incident occurring
- **Panic buttons:** silent alarms to call for help
- **Mobile phone:** can be used to report in as staff make their rounds or for colleagues to check on co-workers who are in a potentially dangerous situation. Can also be used to **send coded messages** to warn others of staff in difficulty. Consideration should be given that some areas have poor radio reception – batteries should be maintained.
- **Staffing levels:** play a crucial role in violence. Shortages can cause treatment delays, frustration among patients. Staffing levels and staff qualifications in managing violence is particularly important during: patient transfers, emergency responses, meal times, at night, when patients with a history of violence or gang activity are being admitted or treated, and shift periods when aggression is heightened (sundowning)
- Emergency signalling (Liss and McCaskell, 1994) and monitoring systems, (NIOSH, 2002)
- Properly designed waiting areas to accommodate visitors and patients, (NIOSH, 2002)
- Staff restrooms and emergency exits, (NIOSH, 2002) and
- Minimal availability of furniture and other objects that can be used as weapons. (NIOSH, 2002)

B) Administrative controls: (Beech and Leather, (2003); Rew and Ferns, 2005; Richards, 2003; Sheenan, 2000)

Workplace procedures establish the work environment climate and provide the protocols for eliminating or reducing risk of violence in the workplace. Effective administrative procedures emphasize a zero tolerance policy and development of a team response to violence.

The literature indicates that the best practice violence prevention programs consist of many components and that environmental interventions are only effective when they complement administrative procedures, clinical guidelines and training. Environmental strategies and administrative procedures cannot eliminate violent incidents from patients/clients but they can reduce the risk of incidents occurring. Below is a list of measures incorporated in the various guidelines according to the setting applicable.

1) *Generic Environmental/Administrative Measures (All Settings)*

- Establish a zero-tolerance policy for violent behaviour. Require employees to report all assaults or threats. Keep log books and reports of such incidents to help determine any necessary actions to prevent recurrences. (OSHA, 2004; NHS, 2000)
- Provide sensitive and timely information to people waiting in line or in waiting rooms. Adopt measures to decrease waiting time. (OSHA, 2004)
- A flagging system established to inform float staff, new staff members or oncoming staff at change of shifts of any potential aggressive behaviour problems with clients. Identify patients/ residents/ clients with a history of aggressive or violent behaviour and communicate this behaviour to staff while maintaining confidentiality (Drummond, 1989; ICN 2000; Vancouver Coastal, 2004)
- Develop staffing patterns that prevent personnel from working alone and minimize patient waiting time, (Liss and McCaskell, 1994; NIOSH, 2002)
- Track the times of day when the threat of violence is greatest and staff units accordingly (Cohen-Mansfield et al., 1992; Dewing, 2003; Taylor et al., 1997; Martin et al., 2000; Volicer et al., 2001) The times of greatest risk occur during patient/resident transfers, emergency responses, mealtimes and at night. Areas with the greatest risk include admission units, crisis or acute care units. (OSHA, 2004)
- Develop training programs to provide skills needed to handle situations prone to violence (de-escalation, break-away techniques, restraint techniques). (Vancouver Coastal, 2004, Richards, 2003)
- Teach employees to recognize potential sources of violence (verbal and non-verbal clues that the person is stressed and may respond with violence, person may not listen to directions or requests)
- Educate personnel to deal with angry patient/residents/clients. Encourage staff members to take primary prevention steps to stop escalating aggressive behaviour.
- Provide annual staff development sessions (refreshers) on techniques for managing violent behaviour
- Establish liaison with local police and response mechanisms for police assistance when calls are made for help by a clinic or facility, and conversely to facilitate the hospital's provisions of assistance to local police in handling emergency cases. Establish working relationship with local police to set anti-violence guidelines and procedures. (Henry & Ginn, 2002; Hoag-Apel, 1999)
- Establish a team (security, admin staff, human resources, and quality assurance employees) to identify and address safety concerns
- Provide a clear statement of what is considered inappropriate behaviour at work with regard to harassment (general, racial or sexual) Make clear policies declaring harassment as a disciplinary offence (Richards, 2003)
- All incidents of threats or other aggression must be reported and logged. Records must be maintained and utilized to prevent future security and safety problems.
- Prompt medical or emotional evaluation treatment must be made available to any staff who has been subjected to abusive behaviour from a client/patient, whether in emergency rooms, psychiatric units, general hospital, or community settings. Ensure effective treatment plan for victims after incident (medical treatment; mental health debriefing/counselling; peer and manager support; time off and return-to-work)

2) *Environmental/Administrative Measures Specific To Institutions (CAL/OSHA, 1998; Mayhew, 2000 Appendix 13; National Safety Institute, 1995; Vancouver Coastal, 2004)*

- Design of facilities should ensure uncrowded service conditions for staff. Rooms for interviewing clients should ensure privacy while avoiding isolation of the staff. In psychiatric or developmentally disabled facilities, "Time Out" or seclusion rooms are needed. In emergency departments, rooms are

needed in which agitated patients or family may be separated safely to protect themselves, other clients, and staff. (National Safety Institute, 1995)

- Bright and effective lighting systems should be provided for all indoor building areas, grounds around the facility and parking areas. (National Safety Institute, 1995; Casteel & Peek-Asa, 2000; Loomis et al., 2005)
- Metal detectors should be installed to screen patients and visitors in psychiatric facilities and emergency rooms. (Rankins & Hendey, 1999)
- Counselling or service rooms should be designed with two exits and furniture should be arranged to prevent entrapment of staff. (National Safety Institute, 1995)
- Information must be clearly transmitted to the receiving unit of security problems with the patient. Charts must be flagged clearly noting and identifying the security risks involved with this patient. If patients with any disorder or illness have a known history of violent acts, it is incumbent upon the administration to demand health care providers or physicians to disclose that information to hospital staff at the onset of hospitalization. (Drummond, 1989)
- Establish a written acuity system that evaluates the level of staff coverage vis-à-vis patient acuity and activity level. Staffing of units where aggressive behaviour may be expected should be such that there is always an adequate, safe staff/patient ratio. The provision of reserve or emergency teams should be utilized to prevent staff members being left with inadequate support (regardless of staffing quotas) or overwhelmed by circumstances of caseload that would prevent adequate assessment of severity of illness. This requires identification of times or areas where hostilities take place. (CAL/OSHA, 1998; WorkCover SA, 1998; National Safety Institute, 1995)
- Staff high-risk units (e.g., admission, emergency, psychiatric) with people trained to handle violent situations (ICN, 2000)
- Where there is a well-established risk, there should be a trained response team which can provide transport or escort services or respond to emergencies without depleting or leaving another unit's staff at risk. (National Safety Institute, 1995)
- Restrict the movement of the public in hospitals by card-controlled access, (NIOSH, 2002)
- Enforce visiting hours and visitor passes (where applicable, i.e. hospitals, psychiatric institutions)
- Assign security personnel to a department on a 24 hour basis, (Lavoie et al., 1988)
- Implement a system for alerting security personnel when violence is threatened (e.g., code white, silent alarm). (NIOSH, 2002; Vancouver Coastal, 2004)
- Transfer violent patients/residents to units with higher staff ratios or with staff trained to deal with violent behaviour (ICN, 2000)
- Do not let employees enter seclusion rooms alone. (OSHA, 2004)
- No employee should be permitted to work alone in a unit or facility unless back up is immediately available. Do not let employees work alone in isolated units or units with walk-in patients (Sheehan, 2000)
- Do not allow employees to be alone with patients during intimate physical examinations (OSHA, 2004)
- Advise staff to exercise extra care in elevators, and stairwells. (OSHA, 2004)

3) Environmental/Administrative Measures Specific To Psychiatric Hospital/In-Patient Facilities (CAL/OSHA, 1998; National Safety Institute, 1995; Vancouver Coastal, 2004)

Engineering Controls

- Alarm systems are essential in psychiatric units, mental health clinics, emergency rooms, or where drugs are stored (not preventive but reduce serious injury when a client is escalating in abusive behaviour)
- Alarm systems that rely on use of telephone, whistles or screams are ineffective and dangerous. An effective system is a silent alarm that activates a distant alarm to summon help. Coded messages "code white" can direct response teams to the desired location without alerting the potential aggressor.
- Metal detection systems (hand-held or built-in) can identify persons with hidden weapons. (Rankins & Hendey, 1999)

Administrative Controls reduce hazards from inadequate staffing, insufficient security measures and poor work practices.
- Insist on plans for patient treatment regimens and management of clients that include a gradual progression of measures given to staff to prevent violent behaviour from escalating.
- Discourage inappropriate use of medication, restraints or isolation.
- Develop as part of every unit and care plan, the least restrictive yet appropriate and effective plan for preventing a client from injuring staff, other clients and self. Staff members should be instructed to limit physical intervention in altercations between patients whenever possible, unless there are adequate numbers of staff or emergency response teams, and security called.
- Assign security guards to areas where there may be psychologically stressed clients such as emergency rooms or psychiatric services.
- Policies must be provided with regard to safety and security of staff when making rounds for patient checks, key and door opening policy, open vs. locked seclusion policies, evacuation policy in emergencies and for patients in restraints. Monitoring high-risk patients at nigh and whenever behaviour indicates escalating aggression, needs to be addressed in policy as well as medical management protocols.
- Escort services by security should be arranged so that staff members should not have to walk alone in parking lots or other parking areas in the evening or late hours.
- Visitors and maintenance persons or crews should be escorted and observed while in any locked facility. Often they have tools or possessions that could be inadvertently left and inappropriately used by clients.

4) Environmental/Administrative Measures Specific To Clinics and Outpatient Facilities

Engineering Controls (CAL/OSHA, 1998; Vancouver Coastal, 2004; Casteel & Peek-Asa, 2000; Loomis et al., 2005)
- An emergency personal alarm system is of the highest priority. Triggered at the desk of the counsellor or medical staff, this system may be silent in the counselling room, but audible in a central assistance area and must clearly identify the room in which the problem is occurring. "Panic buttons" are needed in medicine rooms, bathrooms and other remote areas such as stairwells, nurses' stations, activity rooms, etc.
- Another alarm system uses a back-up paging or public address system on the telephone in order to direct others to the location for assistance through coded messages "code-white".
- Reception areas should be designed so that receptionist and staff may be protected by safety glass and locked doors to the clinic treatment areas.
- Furniture in crises treatment areas and quiet rooms should be kept to a minimum and be fixed to the floor. These rooms should have all equipment secured in locked cupboards.

Work Practice and Administrative Controls (Mayhew, 2000 Appendix 13)

- Psychiatric clients/patients should be escorted to and from waiting rooms and not permitted to move about unsupervised in clinic areas. Access to clinic facilities other than waiting rooms should be strictly controlled with security provisions in effect.
- Security guards trained in principles of human behaviour and aggression should be provided during clinic hours. Guards should be provided where there may be psychologically stressed clients or persons who have taken hostile actions, such as in emergency facilities, hospitals where there are acute or dangerous patients, or areas where drug or other criminal activity is common place.
- Staff members should be given the greatest possible assistance in obtaining information to evaluate the history of, or potential for, violent behaviour in patients. They should be required to treat and/or interview aggressive or agitated clients in open areas where other staff may observe interactions but still provide privacy and confidentiality.
- Assistance and advice should be sought in case management conferences with co-workers and supervisors to aid in identifying treatment of potentially violent clients. Whenever an agitated client or visitor is encountered, treatment or intervention should be provided when possible to defuse the situation. However, security or assistance should be requested to assist in avoiding violence.
- No employee should be permitted to work or stay in a facility or isolated unit when they are the only staff member present in the facility, if the location is so solitude that they are unable to obtain assistance if needed, or in the evening or at night if the clinic is closed.
- Employees must report all incidents of aggressive behaviour such as pushing, threatening, etc., with or without injury, and logs maintained recording all incidents or near incidents.
- Records, logs or flagging charts must be updated whenever information is obtained regarding aggressive behaviour or previous criminal behaviour.
- Administrators should work with local police to establish liaison and response mechanisms for police assistance when calls are made for help by a clinic. Likewise, this will also facilitate the clinics provision of assistance to local police in handling emergency cases.
- Referral systems and pathways to psychiatric facilities need to be developed to facilitate prompt and safe hospitalization of clients who demonstrate violent or suicidal behaviour. These methods may include: direct phone link to the local police, exchange of training and communication with local psychiatric services and written guidelines outlining commitment procedures.
- Clothing and apparel should be worn which will not contribute to injury such as low heeled shoes, use of conservative earrings or jewellery and clothing which is not provocative.

5) Environmental/Administrative Measures Specific To Emergency Rooms and General Hospitals

Engineering Controls (CAL/OSHA, 1998; Vancouver Coastal, 2004)

- Alarm systems or "panic buttons" should be installed at nurses' stations, triage stations, registration areas, hallways and in nurses lounge areas. These alarm systems must be relayed to security police or locations where assistance is available 24 hours per day. A telephone link to the local police department should be established in addition to other systems.
- Metal detection systems installed at emergency room entrances may be used to identify guns, knives, or other weapons. Lockers can be used to store weapons and belongings or the weapons may be transferred to the local police department for processing if the weapons are not registered. Hand metal detection devices are needed to identify concealed weapons if there is no larger system. Signs posted at the entrance will notify patients and visitors that screening will be performed.

- Seclusion or security rooms are required for containing confused or aggressive clients. Although privacy may be needed both for the agitated patient and other patients, security and the ability to monitor the patient and staff is also required in any secluded or quiet room.
- Bullet resistant glass should be used to provide protection for triage, admitting or other reception areas where employees may greet or interact with the public.
- Strictly enforced limited access to emergency treatment areas are needed to eliminate unwanted or dangerous persons in the emergency room. Doors may be locked or key-coded.
- Closed circuit TV monitors may be used to survey concealed areas or areas where problems may occur.

Work Practices and Administrative Controls (CAL/OSHA, 1998)

- Security guards trained in principles of human behaviour and aggression must be provided in all emergency rooms. Death and serious injury have been documented in emergency areas in hospitals, but the presence of security persons often reduces the threatening or aggressive behaviour demonstrated by patients, relatives, friends, or those seeking drugs. Armed guards must be considered in any risk assessment in high volume emergency rooms.
- No staff person should be assigned alone in an emergency area or walk-in clinic.
- After dark, all unnecessary doors are locked, access into the hospital is limited and patrolled by security.
- A regularly updated policy must be in place directing hostile patient management, use of restraints or other methods of management. This policy should be detailed and provide guidelines for progressively restrictive action as the situation calls for.
- Any verbally threatening, aggressive or assaultive incident must be reported and logged.
- Visitors should sign in and have an issued pass particularly in newborn nursery, paediatric departments or any other risk departments.
- Name-tags must be worn at all times in the hospital and emergency room. Hospital policy must demand that persons, including staff, who enter into the treatment area of the emergency room have or seek permission to enter the area to reduce the volume of unauthorized individuals.
- When transferring a hostile or agitated patient (or one who may have relatives, friends or enemies who pose a security problem) to a unit within the hospital, security is required during transport and transfer to the unit. This security presence may be required until the patient is stabilized or controlled to protect staff who are providing care.
- Emergency or hospital staff who have been assaulted should be permitted and/or assisted to request police assistance or file charges of assault against any patient or relative who injures, just as a private citizen has the right to do so. Being in the helping professions does not reduce the right of pressing charges or damages.

6) Environmental/Administrative Measures Specific To Nursing Homes (WorkCover SA, 1998; MacCourt, 2004; Mayhew, 2000 Appendix 13)
Engineering Controls

- Low stimuli (lights, colours, noise, activity) promotes calmer residents
- Music can reduce aggressive behaviour
- Pets, plants and children can make the long-term care environment more familial
- Home-like environment with "normal" facilities for bathing
- Adequate wandering paths, easy access to outdoor space
- Public access is restricted to one main entrance (especially at night)

- Walkways between resident buildings and parking areas are well lit and not surrounded by obstructions
- External doors and windows are secured after dark and checked by night duty employees and fitted with silent alarms monitored at the nursing station
- Gardens and surrounds are designed to minimise potential hiding spots for intruders
- Employees have a readily available method of raising the alarm in case of an emergency
- Employees working alone or at night have personal duress alarms
- Strategies to ensure the security and safety of wandering residents should not limit the ability for staff to escape in case of an emergency.

Administrative Controls
- A staff mix with more RNs and RPNs are required to provide the skills for working with cognitively impaired residents who are prone to aggressive behaviour
- Timely access for expert psychogeriatric consultation
- Access to psychologist to develop behavioural interventions
- Physiotherapists for maintaining mobility and coordination functioning
- Sufficient staffing and equipment (e.g., staff ratio and mechanical lifts) to prevent delays in bathing, feeding, toileting, and dressing residents
- Residents have the ability to take "time out" away from other residents
- Work practices facilitate resident privacy
- Work practices enable residents to exercise choice and a level of control over aspects of their daily activities
- The potential for aggressive behaviour is part of the nursing care plan for high risk residents
- Ensuring that staff work in pairs with high risk clients
- Integration of resident chart information and incident report information. Issues regarding aggression are included in handover meetings

7) *Environmental/Administrative Measures Specific To Community Service Workers: (CAL/OSHA, 1998; Mayhew, 2000 Appendix 14; OSHA, 2004; Vancouver Coastal, 2004; WorkCover SA, 2002)*

Engineering Controls
- In order to provide some measure of safety and to keep the employee in contact with headquarters or a source of assistance, cellular car phones should be installed/provided for official use when staff are assigned to duties which take them into private homes and the community. These workers may include (to name a few) parking enforcers, union business agents, psychiatric evaluators, public social service workers, children's' service workers, visiting nurses and home health aides.
- Hand held alarm or noise devices or other effective alarm devices are highly recommended to be provided for all field personnel.
- Beepers or alarm systems that alert a central office of problems should be investigated and provided.
- Other protective devices, such as pepper spray, should be investigated and provided.

Work Practices and Administrative Controls
- Employees should not give clients unrealistic expectations that are unlikely to be met by either the organisation or co-workers (WorkCover SA, 1998)
- During hours of darkness: (WorkCover SA, 1998)

1) Have clients turn on outside lights before employees arrive
2) Parking in areas that are well lit and not surrounded by obstructions
3) Ask client to escort employees to their car
4) Not identify vehicles with company name/logo
5) Provide flashlight and duress alarm to worker
6) Provision of continuous contact through monitored radio communications
7) Provision of security lighting in office car parks

- Employees are to be instructed not to enter any location where they feel threatened or unsafe. This decision must be the judgment of the employee. Procedures should be developed to assist the employee to evaluate the relative hazard in a given situation. In hazardous cases, the managers must facilitate and establish a "buddy system". This "buddy system" should be required whenever an employee feels insecure regarding the time of activity, the location of work, the nature of the client's health problem and history of aggressive or assaultive behaviour or potential for aggressive acts. If a buddy system is not feasible, the worker should be encouraged to request an escort (police, taxi) when uncomfortable or feeling threatened by a home visit. (CAL/OSHA, 1998; WorkCover SA, 1998; OSHA, 2004)

- Establish a daily work plan for field staff to keep a designated contact person informed about their whereabouts throughout the workday. Have the contact person follow-up if an employee does not report in as expected. (OSHA, 2004)

- Employers must provide the field staff with a personal safety education program. This program should include training on awareness, avoidance, and action to take to prevent mugging, robbery, rapes and other assaults.

- Procedures should be established to assist employees to reduce the likelihood of assaults and robbery from those seeking drugs or money, as well as procedures to follow in the case of threatening behaviour and provision for a fail-safe back-up in administration offices. The fail safe back-up system is provided in the administrative office at all times of operation for employees in the field who may need assistance.

- Police assistance and escorts should be required in dangerous or hostile situations or at night. Procedures for evaluating and arranging for such police accompaniment must be developed and training provided.

Evaluated Intervention Studies:
Runyan et al., (2000) conducted a systematic review of administrative and environmental measures to reduce violence in the workplace. They report that few interventions were evaluated, few of the published evaluations included control groups and none incorporated randomization procedures. The review suggests that best practices for evaluations incorporate three elements:

- **Process evaluation** documents what was done in implementing the intervention and allows assessment of whether the intervention was carried out as planned

- **Impact evaluation** measures the effect of the intervention (e.g., employee skills in dealing with aggressive person)

- **Outcome evaluation** focuses on the consequences of the intervention (e.g., reduction in assaults or injury)

Casteel & Peek-Asa (2000) searched 17 databases, reference lists, and unpublished literature online. They found that all multi-component environmental intervention studies reported a percentage reduction of robberies from 84% to 30%. Single component interventions ranged from a reduction of 83% to an increase of 91%. Secondary studies reported change pre-post of robberies from a reduction of 92% to an increase of 7.6%. Robbery reductions were larger for interventions comprising: basic store design, cash control, and training. No significant association was found between robbery decrease and the follow-up period or number of interventions. The median change for pre-post non-fatal injuries was a decrease of 61%. The change in

pre-post of homicides ranged from 0% to an increase of 11%. An intervention composed of an alarm system with police patrol was the only intervention not resulting in an overall decrease pre-post in the average number of robberies. The effectiveness of any one component of multi-component interventions was not evaluated. No control for community crime or environmental factors.

Mair & Mair (2003) discuss the theory of environmental modifications in general but do not offer evaluations except to refer to Loomis et al. 2002) and Casteel & Peek-Asa (2000).

Loomis et al (2005) investigate the effectiveness of administrative and environmental interventions in a population-based case-control study of North Carolina comparing workplaces.
They controlled for confounding factors such as:
- Being located in an urban county or county with a high crime rate
- Belonging to an industry associated with high risk
- Being located in a residential or industrial area
- Being open Saturdays
- Having a high proportion of male or minority workers
- Having moved or opened within 2 years.

Loomis and colleagues found strong and consistent in homicide reduction were associated Among environmental interventions: with: bright exterior lighting, security alarms, and a combination of 5 or more environmental interventions. Among administrative interventions the largest beneficial effect was for staffing practices that prevented workers from being alone at night. A combination of 5 or more administrative interventions were also associated with significantly lower levels of risk. Administrative changes had greater impact in reducing risk than did environmental strategies.

Flannery et al. (1998) compared three state hospitals using pre-post design and demonstrated declines in frequency of assaults after implementation of a peer-help program after assault. (Mean number of physical assaults declined from 31.0 pre to 2.4 one-year post.

Drummond et al. (1989) evaluated an administrative procedure in which patients known or suspected to be **violent are flagged** by the hospital computer such that whenever their names appeared foe check-in service, a warning signal was given to allow time to summon security personnel or assign extra clinical staff to handle the patient. Data 1-tear pre and 1-year post showed a significant decline (42% decrease) in disruptive flagged patients and 91% decline in disruptive incidents.

Hunter & Love (1996) using a one-group pre-post design in a forensic hospital found a positive association of a '**total quality management approach**' and reduction of inpatient violence. Changes in lunchroom procedures were associated with a 40% reduction in mealtime incidents during the year after implementation. Interventions included: changes to plastic utensils, playing music, using a patient privilege system, opening up main courtyard for leisure time after lunch, and training food service workers

C) Violence Management Strategies

Richards (2003) provides an overview of training interventions and reports that 'training needs analysis' should be based on risk assessments and the information obtained from incident reports.
According to the WHO report by Richards (2003), good training programs typically cover:
1) Theory: understanding aggression and violence in the workplace
- causes of violence & triggers (physical illness, mental condition, alcohol & drugs, environment, denial of rights, involvement in groups/peer pressure

- recognition of warning signs (almost indiscernible twitching, avoidance of eye contact, sullenness, repetitive behaviour, alteration of body posture, clenching of fists, swearing, raised voice, close proximity)

2) Prevention: assessing danger and taking precautions
- **defusion/de-escalation** training: uses both verbal and non-verbal communication to reduce the anger of the potential perpetrator(s)

3) Interaction: with aggressive people
- **Breakaway training**:
- **Restraint techniques**:

4) Post-incident action: reporting, investigation, counselling and other follow-up.

Training

As part of the Zero Tolerance Policy (2000) in the United Kingdom, staff training is advocated as the appropriate managerial response to workplace violence prevention. This policy aligns with the. The United Kingdom "Zero Tolerance Policy" (NHS, 2000) and the International Council of Nurses (ICN, 2000) campaign to 'Say no to violence' identify training as a key factor for preventing and managing violence in the workplace. There is no consensus on course length or specific content. There is general agreement that all workers with clinical training should be able to:

- identify and prevent violent and aggressive behaviour, resolve conflicts;
- maintain hazard awareness, (NIOSH, 2002) and
- familiarize themselves with regulations and the law. (Lavoie et al., 1988)

Best practice in training indicates that all occupations and not only nursing should be involved in violence/aggression management training. Training content must reflect the particular types of violent incidents common to the specific characteristics of patients/residents/clients as well as to the environmental and administrative controls implemented in the specific healthcare setting. Training can help the worker identify dangerous situations and provide the skills to enable the worker to manage the violent incident as safely as possible. Beech and Leather (2003) report that there is little published evidence of training effectiveness. Most studies provide pre-post measures for short-term effects of increased knowledge and increased awareness. Routine evaluations of training effectiveness most often employ 'happy sheets' asking immediate subjective responses to 'satisfaction' questions. Beech and Leather argue that course attendees are typically asked to score the usefulness, relevance, and level of interest of course material. Experts in education cast doubts as to the appropriateness of these evaluation criteria because: 1) important material is not necessarily interesting; 2) what is judged irrelevant today may be vital next week; and 3) respondents whose work area changes frequently (e.g. community workers, student nurses, casual/temporary employees) may be unable to anticipate the relevance of the material to their worksite.

The UK Department of Health commission a review of training developed the following criteria for evaluating training: course content, appropriateness of taught skills, and standards of training. However, the report did not question the need for specific training regarding the management of violence or aggression.

OSHA (2004) suggests that training programs should involve all employees, including supervisors and managers. New and reassigned employees should receive an initial orientation before being assigned their job duties. Effective training programs should involve role-playing, simulations and drills. Employees should receive required training annually. In large institutions, refresher programs should be monthly or quarterly to effectively reach and inform all employees.

OSHA (2004) and WCB of BC (2000) recommend that the following topics should be covered in a general violence-prevention training program (core training):

- Definition and review of workplace violence;
- The possible medical and psychological effects of violence/aggression on workers;
- The nature and extent of risks associated with their specific jobs and the availability of post-trauma resources in the organization and in the community
- Description of the organization's workplace violence prevention policy;
- Requirements of the OHS Regulations;
- Types of violent incidents that have occurred in the workplace, and their precipitating factors;
- Risk factors that cause or contribute to assaults;
- Early recognition of escalating behaviour or recognition of warning signs or situations that may lead to assaults;
- General prevention procedures, such as not giving out worker information over the phone and minimizing risks for violence in specific workplace locations such as reception areas;
- Procedures for identifying and reporting potential security hazards (e.g., inadequate lighting in the parking lot, unknown persons loitering, door locks that are defective or have been tampered with);
- Ways to prevent or diffuse volatile situations or aggressive behaviour (e.g., setting limits, calming the aggressor, managing individuals with weapons), manage anger, escape techniques, and appropriately use medications as chemical restraints;
- Use of security staff, location of escape routes;
- A standard response action plan for violent situations, including the availability of assistance, response to alarm systems and communication procedures;
- Ways to deal with hostile people other than patients and clients, such as relatives and visitors;
- Progressive behaviour control methods and safe methods to apply restraints;
- The location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures;
- Ways to protect oneself and coworkers, including use of the "buddy system;"
- Policies and procedures for reporting and recordkeeping;
- Information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences; and
- Policies and procedures for obtaining medical care, counselling, workers' compensation (e.g., how to access defusing and debriefing), filing compensation claims, or legal assistance after a violent episode or injury.

Job Specific Training Topics

The National Safety Institute (1995) and WCB of BC (2000) state that employees who are potentially exposed to safety and security hazards should be provided **job specific training** that supplements core training with more information on the following topics specific to their units:

- How to identify risk factors that may lead to violence
- How to recognize when incidents are likely to occur
- How to recognize warning signs of escalating anger and abusive behaviour
- Knowledge of 'triggers' that escalate the potential for violence in your client/resident/patient
- How to withdraw from a tense situation
- How to access specialized team with "code white"
- Know safe work procedures to defuse/de-escalate aggressive behaviour, manage anger, and if needed, apply chemical and physical restraints (include hands-on practice)

- How to break out of a violent person's hold or grasp (include hands-on practice)
- How to locate and operate safety devices such as alarm systems
- What to do when incidents occur
- How to protect themselves and co-workers
- How to report any incidents or threats of violence
- How to establish a WCB and criminal injury compensation claim
- How to support co-workers who have experienced violence or aggression
- How to use the existing prevention procedures to control the risk of violence
- How to use the existing environmental arrangements to control the risk of violence to workers
- How to access support such as defusing and debriefing
- How to pursue legal action

MacCourt (2004) describes specific skill development training for **staff working with residents/patients with dementia**. She suggests adopting critical thinking principles covering the following topics in addition to core training:
- Dementia care and identification of delirium
- Non-physical and physical non-violent interventions for aggression
- Defusing/ de-escalating, conflict resolution, boundary skills
- Behaviour interventions
- Best practices for use of restraints (chemical and physical)

Recognition of Warning Signs
Drury (1999) describes the warning signs of potential aggression as consisting of medical factors, social factors combining in a building process consisting of two phases of pre-violent behaviour.

Medical factors:
- Head injuries
- Diabetes/metabolic disorders
- Seizures
- Psychiatric disorders
- Intoxication
- Drug overdose
- Drug/alcohol withdrawal
- Senility/adolescence
- Post-traumatic stress syndrome
- Organic brain disorders

Social factors:
- Little impulse control
- low self-esteem
- inadequate social skills
- frustration
- perceived or real-time delays in treatment
- history of violence
- in police custody/gang affiliation
- victim of crime

- distraught family/friends

Pre-violent phase 1: subtle verbal and non-verbal clues that person is under stress and may respond with violence. (Drury, 1999)
- talking rapidly
- using an angry, loud, screaming voice
- using profanity
- making aggressive or threatening statements
- boasting of prior violence
- pacing
- clenching and unclenching the hands
- frequently changing body positions
- sitting with an upper-body rocking motion.

Less subtle danger signals are: (Smith and Brown, 1997)
- explosive or dangerous anger
- pacing that is not easy to stop or redirect
- uncontrollable crying
- locking themselves in a room and not coming out
- not wearing any clothes
- bizarre, peculiar behaviour
- lighting matches
- destroying property
- hurting themselves
- threatening to hurt themselves or others

During this phase, verbal interventions usually work. Education in strategies for de-escalating a situation can provide a positive intervention.

Pre-violent phase 2: (violence is imminent)
- the person may or may not listen to directions or requests
- staff person must concentrate on remaining calm
- use emergency code (or silent alarm) to call for help without alarming potential aggressor

Evaluated Intervention Studies:

Carmel & Hunter (1990) employed an ecologic design comparing wards in a forensic psychiatric hospital according to the level of compliance in attending voluntary assault management training. Nine wards had more than 60% with training (high compliance) and they did not experience a reduction in aggressive incidents over a 1-year period compared to 18 wards (low compliance).
- High compliance group had three times fewer injuries from assaults (20.0/100 staff in low compliance versus 7.4/100 in high compliance wards).
- No significant difference in rates of aggressive incidents

Because the comparison was at the ward level, it was impossible to determine if trained employees were less likely to experience injuries than untrained workers.

Goodridge et al. (1997) used a one-group pre/post design to evaluate the effects of one-day workshop on prevention of aggression. After training there were significantly fewer conflicts with patients (mean conflict score declined from 13.5 to 10.2) and no significant declines in self-reports of aggression events

Infantino & Musingo (1985) used a non-randomized comparison group design and found:

- Staff who had training in aggression control techniques experienced fewer assaults than the untrained. (3% of trained were assaulted versus 37% of untrained)
- No significant differences in assault-related injuries between trained and untrained.
- Assaulted staff had been employed longer. Some staff received training well into the follow-up period thus confounding the temporal relationship between training and assault experiences.

Lehmann et al. (1983) documented delivery of training in a Veterans Administration hospital on management of violent behaviour. Using a pre-post around a 5-hour training workshop, they measured participants' attitudes, beliefs, and knowledge about handling violent patients. Results showed: significant increase in knowledge and confidence to deal with violent situations. However, the study did not measure any outcomes such as injury or reports of assaults.

De-escalation Technique

Cowin (2003), DelBel (2003) Distasio (1994, 2002), Richards (2003), Sheehan (2000), Smith & Brown (1997) and Vancouver Coastal (2004 Appendix F) describe the **de-escalation technique** in more detail. The following tactics are recommended when faced with an agitated and potentially violent person:

- Make sure you have an escape route if the situation escalates. Don't let the person get between you and the door. Never turn your back on the agitated person.
- Don't crowd the person's space or try to make physical contact. Keep a distance of 5-7 feet from the potential aggressor. Calm, slow deliberate movements signal to the angry person that the worker is not going to harm him/her.
- Use empathy, remain professional and objective.
- Keep your own emotions under control. Stay calm and be genuine in your attempts to hear the person's issues. Watch your body language, be aware whether your posture and gestures contradict what you are saying.
- Align yourself with the person by focusing on a common goal. Conflict avoidance skills include giving concessions to the person, trying to engage them and make them reason, giving them choices on how to end the confrontation or how a joint solution can be found. Accompany the person to a quiet, less stimulating room. Isolate the individual by getting him/her away from on-lookers that may encourage or incite the potential aggressor.
- Don't try to talk when s/he is shouting. When given a chance to say something, speak in a normal tone of voice. Check your paraverbals (tone, volume, rate, and rhythm of your speech) to ensure clarity by not contradicting the content of your words.
- Embrace silence at times as an effective verbal intervention that allows the individual time to clarify his/her thoughts and restate the message.
- Don't argue or become defensive, confrontational, or judgmental. Use reflective questioning. Put the individual's statements in your own words and check with him/her to see if you have understood what s/he meant. Use open-ended sentences that provide openings for the disturbed person to verbalize feelings.
- Let him/her express grievances, but respond selectively. Clear up misconceptions and acknowledge valid complaints, but don't react to any abusive statements. Communicate in simple sentences while showing your concern and offering realistic solutions (if appropriate).
- Set limits calmly but firmly.
- Know your limitations and call for backup (panic button, silent alarm, or coded-white message).

Evaluated Intervention Studies:

Fernandes *et al* (2002, 1999) examined the success of a violence prevention education program in an emergency department, conducting a survey prior to the delivery of a violence education program and then

again at 3-months and 6-months post-intervention. The study found that the education resulted in a significant decrease in verbal and physical assaults in the short-term following the education program, and although violent incidents increased in the longer term, they remained well below original levels.

Similarly, several studies have found that seriously implemented training programs have resulted in reduction of violent incidents in psychiatric hospitals. Looking at a different prevention strategy, a study by Lavoie *et al* found that 24-hour security personnel had significant deterrent value in large hospitals. (Lavoie et al., 1988)

Lehmann, McCormick & Kizer (1999) surveyed 166 VA facilities and did extensive documentation of training. However, they found no relationship between the proportion of staff trained and the rates of aggressive incidents or the number of violence-related injuries. Their data indicates a negative correlation across all facilities between expenditures per day on psychiatric units and the rate of assaultive behaviour per patient treated on these units. The data suggests the importance of evaluating staffing levels carefully particularly when the patient population may be prone to aggression.

Although there was recognition of the importance of training clinical staff to prevent and manage assault, there is no consensus on the content and length of such training. Lavoie et al (1988) reported that only 40% of university hospital emergency departments provided any formal training on aggression management. Lehmann et al (1983) reported that training in a single VA facility improved staff members' knowledge of and performance in handling violent behaviour but the effect of training on the frequency of violent behaviour was not evaluated. Carmel & Hunter (1990) and Infantino & Musingo (1985) suggest that training in management of violence is associated with decreased rates of assaults and injury among staff.

Breakaway/Restraint Techniques

Breakaway training is only taught to people who need it with the caution not to get a false sense of security because the application of the techniques are difficult in real-time situations unless the person has a lot of experience. Topics include:

- Breaking free from holds commonly used by aggressors and the need for self awareness
- Deflecting blows or kicks
- Understanding ways of escorting people with a minimum of physical intervention

Southcott et al (2002) discovered there was no record on the incident forms of any breakaway techniques being used. Of the 19 staff interviewed, 14 reported experiencing an assault in the previous three years but only three used recognised breakaway techniques from their training.

Restraint courses: concentrate more on breakaway techniques, psychological aspects and immobilisation of patients rather than those that cause pain. Chemical restraints are only prescribed by the patients'/residents' physicians. Topics include:

- Restraining holds
- Group holds
- Taking patients to ground
- Limb control moving patients
- Separation

Evaluated Intervention Studies:

Parkes (1996) evaluated staff training in control and restraint techniques in a medium security psychiatric facility. Analysis of pre- (18 months) and post- (12 months) data found no significant differences in reported staff injuries inflicted by inmates (a small increase from 51-pre and 68-post).

Southcott et al (2002) found that during the 32-month analysis, 66 incidents of restraint were recorded on the adverse incident reports. The incidents of restraints were all compatible with guidelines provided by the Royal

College of Psychiatrists (1`998) as justifiable reasons for using restraints. Staff reported that restraint techniques were effective in the situation. The interviews identified some problematic issues with restraint techniques, such as difficulty taking clients to the floor and getting holds on. Once holds were secured, they were generally considered effective.

Wright (2003) reviewed research on the effectiveness of training in the UK regarding physical restraint. Wright reports that evidence for the effectiveness of physical restraint in reducing violent incidents is contradictory and inadequate. He argues that restraints may not be a good preventive measure but they are an important feature of an integrated organizational response to the threat of violence in the workplace..

Beech and Leather (2003) evaluated a three-day training unit for student nurses and were able to demonstrate significant improvements after training were maintained 3 months later for four factors: maintaining personal safety; prediction and prevention; self-respect and staff rights; dealing with a provocative approach. In another factor measuring practical ability, results showed that student nurses had a significant increase from baseline (4 months before training) to immediately before the training then a significant decrease after training with perceptions of practical ability 3 months after training ending up lower than at baseline. The training was comparable to core training programs covering all topics except the use of restraints. The nurses reported that the breakaway techniques were useful and that the training enabled them to prevent the escalation of violence. Beech and Leather were not sure how to explain the decreased scores in practical ability. Perhaps the student nurses obtained more respect for the practical abilities required in managing violent incidents.

Post-Incident Interventions

Post-incident interventions start with the provision of medical services if needed after a violent incident. Medical services not only manage physical injuries but also attempt to reduce psychological trauma. CAL/OSHA (1998) asserts trauma-crisis counselling or critical incident stress debriefing (CISD) programs must be established and provided on an on-going basis for staff who are victims of assaults. The "counselling program" may be developed and by in-house staff as part of an employee health service or by referral to an outside specialist. Wiskow (2003) states that post-incident responses aim to reduce the negative effects of incidents on victims. There are several types of assistance that can be incorporated: peer-support (structured feedback), counselling, psychological debriefing, CISD, or cognitive behaviour therapy.

Post-incident interventions and behavioural interventions can only indirectly prevent violent incidents by creating a supportive workplace that reduce the effect of injuries and psychological trauma on workers as a result of a violent incident and enable the worker to return to full function as safely and as quickly as possible. Although there is disagreement concerning the type of post-incident intervention most suitable for reducing the effects of violent incident trauma (e.g., psychological debriefing versus cognitive therapy), there is consensus that quick response soon after a violent incident is essential for recovery of the victim. All reports indicate that follow-up is required after interventions to determine the effect of the intervention and ensure that post-traumatic stress disorder (PTSD) symptoms are eliminated as soon as possible. For post-incident interventions it is inconclusive whether simple psychological debriefing (PD) is better than critical incident stress debriefing (CISD) or cognitive behaviour therapy (CBT). Post-incident interventions also include incident reporting, tracking and analysis as well as reviews of violence prevention measures and the violence prevention program as a whole.

Intervention studies
Structured feedback program

1. Arnetz and Arnetz (2000) report on a structured feedback program in 47 Stockholm health care workplaces (5 emergency departments, 7 geriatric, and 32 psychiatric, and 3 home health care). The intervention group were RNs and LPNs with special training in mental health and they were compared to the total population of employees within the health care system of Stockholm County Council. There was no significant difference

between intervention (24 sites) and control groups (23 sites) with regard to staff age and gender and types of patients under care. The intervention sites implemented a structured program for regular discussion with staff concerning specific violent incidents registered at the workplace.

Group discussion to focus on:

- Who was aggressive?
- The course of events
- The time, and place the incident occurred
- The nature of the incident
- Did the victim sense in advance that something was going to happen (warning signs)?
- How was the situation handled?
- How did the victim react?
- Could the incident have been avoided or mitigated in any way?

Results

- At the project's conclusion, experience with violence was lower than the baseline measurement for both groups. Data from a regional Swedish hospital for 1995 and 1997 showed relatively the same violence at both times. Stockholm psychiatric health care staff reported more violence against staff in 1997 compared to 1996.
- The decrease was relatively less for the intervention group.
- Intervention group reported more awareness of risk situations and gained better knowledge of how risk situations could be handled.
- The feedback sessions served as encouragement to register violent events (created a more accepting non-punitive attitude regarding violence towards staff).
- Unclear whether feedback sessions will actually decrease experience of violent incidents in the future.
- The use of VIF instrument may naturally lead to workplace discussions with staff. There was no significant difference between groups concerning discussion of violent incidents.
- Greater loss to follow-up in the intervention group. (Four sites were closed down during the study and three were in the intervention group).

Educational Intervention

2. Nhiwatiwa (2003) examined an educational intervention consisted of reading a booklet on effects of trauma and coping. The study incorporated a social cognitive framework to examine the relationship between change in distress symptoms (intrusion and avoidance) and whether these result from reading information on the effects of trauma and how to cope. Results showed:

- No significant differences in IES scores between the two groups at baseline
- Found a significant difference in distress score between education (higher distress levels) and control group at 3-month follow-up
- No significant difference in the change from baseline for the GHQ-28.
- Found a positive correlation (r=.310, p=0.04) between participant's rating of injury and their feeling of distress.(e.g. high level of perceived seriousness of injury associated with high levels of perceived distress).

Those in the control group appeared to be adjusting better to the assault by the follow-up. If the education booklet was ineffective then it would be expected that the trend would be similar to the control group with the mean IES scores at follow-up (6.62) lower than at baseline (12.62). The educational group mean IES scores were higher (10.40) at follow-up than at baseline (8.40). A possible explanation is that the two groups are at different stages of normal stress response when reassessed at the 3-month point. The increased knowledge from reading the educational booklet may have increased participant awareness of their symptoms (arousal) and caused them to begin working through by reprocessing what happened to them and modifying

their mental schema. On the other hand, the control group may be in the denial stage (not acknowledging symptoms) at the 3-month point.

Psychological Debriefing
3. Rick, Young and Guppy (1998) found a number of evaluations although only six had credible randomised, controlled studies. These studies reported mixed findings but generally showed no differences between those who received debriefing and those who did not. If not done properly, debriefing can have a detrimental effect. Richards (2003) found other studies that suggested that debriefing worked if the focus was on improvements within a few weeks after the event. The reason why debriefing was thought not to work is that originally it was focused on group debriefing rather than individual debriefing which now predominates.

4. Matthews (1998) examined the effects of psychological debriefing of direct care workers in community residences for persons with developmental and psychiatric disabilities in Sidney, Australia. Unavailability of debriefing counselling was associated with increased reports of PTSD among employees yet found no differences between those receiving counselling and those having access but not choosing counselling.
- no debrief available (26.9% PTSD)
- debrief available but not taken (18.2% PTSD)
- debrief taken (21.9% PTSD)
- no significant difference between groups with regard to sense of control and coping skills.

The lowest levels of PTSD were reported by workers who had debriefing available but chose not to attend the session. No significant difference in overall PTS reduction (in the week following the incident) between those receiving the intervention and those who did not. Timing of the intervention may be key to its effectiveness. One of the essential elements of critical incident stress debriefing (CISD) is the psycho-educational component providing participants with techniques for developing coping mechanisms and support systems for future use. Eight (57.1%) of the 14 debriefed workers viewed it positively and 6 (42.9%) did not feel that it assisted them in any way. Although workers may have used the debriefing evaluation to express frustration about their inability to change the frequency with which trauma occurred in the workplace, the negative evaluations more likely reflect some participants' dissatisfaction with an aspect of the intervention or its failure to meet their expectations.

5. van Emmerik et al. (2002) conducted a review of studies using single session debriefing after psychological trauma. In the 7 studies: 4 included CSID & control, 1 CSID, Education & control, 1 included 30-minute counselling & control, and 1 included a historical group debriefing but without a control group.
Results:
- <u>no-intervention</u> (controls) resulted in a medium (0.47) reduction in severity of symptoms PTSD and small (0.13) reduction in other symptoms
- <u>non-CSID</u> resulted in a medium-to-large (0.65) reduction in severity of PTSD and small-to-medium (0.36) reduction in other
- <u>CSID</u> resulted in a small (0.13) reduction in severity of PTSD and a small (0.12) reduction in other.

CSID has no efficacy in reducing symptoms of PTSD and other trauma-related symptoms and in fact detrimental in interfering with natural recovery.
Cognitive behaviour therapy (CBT) was deemed more effective. (Bryant et al. 1999; Foa et al., 1991)

Critical Incident Stress Debriefing (CISD):
There is considerable debate as to the effectiveness of Critical Incident Stress Debriefing (CISD). An example is the debate in the **Australian Psychologist** amongst Devilly and Cotton (2003, 2004), Mitchell (2004) and Robinson (2004). CISD was first proposed by Mitchell in 1983 and has gained widespread acceptance and implementation since. Van Emmerick et al. (2002) and Devilly and Cotton review the literature. Van Emmerick et al found that non-CISD interventions and no interventions improved symptoms of post-traumatic stress disorder (PTSD) but CISD did not improve symptoms. Non-CISD interventions (30-minute

counselling, education, and historical group debriefing) resulted in a medium-to-large reduction in the severity of post-traumatic stress disorder and a small-to-medium reduction in other symptoms. CISD interventions resulted in a small reduction in severity of symptoms of PTSD and other symptoms but less than the natural recovery from trauma without interventions. Van Emmerick et al. conclude that CISD has a detrimental effect. They suggest that CISD might interfere with the alternation of intrusion and avoidance that characterises the natural processing of a traumatic event. It might inadvertently lead victims to bypass the support of family, friends or other sources of support. CISD probably increases awareness of normal manifestations of distress after trauma. The exposure to trauma-related internal and external stimuli in CISD might not allow victims adequate time for habituation, thereby further sensitising them to these stimuli. CISD was not intended as a 'stand alone' intervention but rather part of a broader multi-component CISM-type intervention including: 1) training in being prepared for a crisis, 2) follow-up, and 3) referral. Brief cognitive behaviour programs (4-5 weekly individual sessions) have produced promising results containing education, and cognitive therapy.

6. The Devilly & Cotton (2003) review found that CISD was detrimental and surprisingly those offered psychological debriefing yet declining (similar to Mathew, 1998) are the most likely to be unaffected by the event in the long-term. They suggest that psychological debriefing may be more of a "morale maintenance" as a gesture of employer support rather than a clinical intervention influencing distress and symptoms.

7. Mitchell (2004) counters that CISD is only one component of critical incident stress management (CISM). Mitchell states crisis intervention is:
- a support service not psychotherapy
- an opportunity for assessment to see if people need additional services (including referrals for cognitive-behaviour therapy).

8. Antai-Otong (2001) Proposes CISD as a health promotion model for workplace violence.
Antai-Otong describes the phases of CISD:
A) Introductory phase
- review ground rules, including goals of CISD
- maintain confidentiality
- provide immediate emotional support, gained from feedback from peers
- encourage person to speak for self
- inform person that this is not psychotherapy

B) Fact phase
- clients describe what happened regarding themselves, the incident, and their behaviours during the event
- clients retell the story to promote cognitive restructure of the event and experience emotional release
- clients describe sensory perceptions during the event (e.g., smells, sounds, or sights)

C) Thought phase
- Ask participants to reveal their first thoughts during the event
- Participants affirm and validate their own thoughts and feelings
- Participants repair their (cognitive) perceptions of safety, trust, power, self-esteem, and intimacy
- Ask participants what thoughts they will carry with them.

D) Reaction phase
- ask participants to focus on their own reactions or emotions during and subsequent to the event

- assess emotional responses (crying, anger, fears, horror, guilt)
- anxiety promote order. Help participants focus on and express their feelings to gain more information about the normalcy of one's feelings and thoughts about the event. Ask "How are you feeling now?"

E) Symptom phase provides transition from emotional level to more cognitive level

F) Educational phase educating the participants about possible, common, or even "likely" stress responses) each identify personal symptoms of distress

G) Re-entry phase
- (referral information provided
- quarterly follow-up with participants is helpful in discerning efficacy and providing opportunities to refer when indicated.

This health promotion model provides immediate emotional support, education about normal stress reactions, and may reduce the risk of chronic and disabling emotional and physical consequences. The CISD is an element in the CISM program, an integrated and comprehensive multi-component program whose goals involve a series of crisis intervention procedures to address the spectrum of psychological trauma and PTSD. In comparison, the CISD model is a single-structured intervention whose goal is to promote a sense of psychological closure with regard to a critical incident or traumatic experience.

The basis of the CISD is prevention. Early intervention includes:
- immediate emotional support
- education about normal stress reactions
- symptom reduction
- appropriate referrals.

De-briefing is not psychotherapy, but rather an opportunity to process the experiences and put them in perspective. Management support is crucial for the success of CISD.
- Organizational leaders are responsible for providing the time necessary to process events
- Sanctioning the efforts of the CISD conveys management concern about staff well-being
- Responding proactively is likely to reduce injury and stress.

9. Bendersky Sacks B, Clements PT & Fay-Hillier T. (2001) examined the use of CISD after traumatic workplace events. Bendersky Sacks et al assert that stress-debriefing approaches offer nurses opportunities to deal with personal reactions to violence and provide support for others, including clients, who encounter similar situations. Preventive health-promotion models enable psychiatric nurses to effectively resolve and cope with violent or traumatic incidents and reduce their deleterious effects. CISD mitigates traumatic stress, accelerates the recovery process and potentially restores employees to normalcy following a traumatic event. CISD is one formal intervention within the broader category of critical incident stress management (CISM) which is a collection of comprehensive, multi-component crisis-response technologies. The field of critical incident stress management is open to advanced practice nurses who seek to apply their crisis-intervention expertise within a non-traditional role and workplace setting.

Critical Incident Stress Management (CISM)
10. Robinson (2004) states that CISM is based on crisis intervention and is neither therapy nor treatment. He says the Devilly & Cotton critique was based on studies of CISD applied to communities after a disaster. CISM is a multi-component approach to in the workplace for staff support incorporating:
- education
- individual support
- group meetings (including CISD)

- organisational consultation
- family support
- referral and
- follow-up.

In work-based programs CISM:
- Educates staff about stress, trauma, and support facilities
- Tracks staff following incidents
- Ensures that an assessment procedure is operating
- Ensures appropriate interventions ensue
- Follow-up individuals after interventions and
- Refer them to ongoing counselling where appropriate.

Cognitive Behavioural Therapy (CBT)

11. Bryant et al 1999 evaluate CBT and supportive counselling techniques by indexing the relative efficacy of prolonged exposure and anxiety management in the treatment of acute stress disorder.

Method: Forty-five civilian trauma survivors with acute stress disorder were given five sessions of:
1) <u>prolonged exposure</u> (N=14),
2) a <u>combination of prolonged exposure and anxiety management</u> (N=15), or
3) <u>supportive counselling</u> (N=16) within 2 weeks of their trauma.

Forty-one trauma survivors were assessed at the 6-month follow-up.

Results:
- Fewer patients with prolonged exposure (14%, N=2 of 14) and prolonged exposure plus anxiety management (20%, N=3 of 15) than supportive counselling (56%, N=9 of 16) met the criteria for PTSD after treatment.

- There were also fewer cases of PTSD in the prolonged exposure group (15%, N=2 of 13) and the prolonged exposure plus anxiety management group (23%, N=3 of 13) than in the supportive counselling group (67%, N=10 of 15) 6 months after the trauma.

- Chronic PTSD in the supportive counselling condition was characterized by greater avoidance behaviours than in the pro-longed exposure condition or the prolonged exposure plus anxiety management condition

Conclusions: Findings suggest that PTSD can be effectively prevented with an early provision of cognitive behaviour therapy and that prolonged exposure may be the most critical component in the treatment of acute stress disorder.

	Prolonged exposure (PE)	PE +Anxiety management	Supportive Counselling
At Post-treatment			
% with PTSD	14%	20%	56%
At Follow-up			
% with PTSD	15%	23%	67%

No significant difference in outcomes between PE and group having PE plus anxiety management.
Anxiety management did not significantly add to the gains by prolonged exposure. Gains primarily from habituation of anxiety through prolonged exposure and modification of maladaptive beliefs through cognitive therapy that mediated adaptation.

12. Foa et al (1991) compare CBT and counselling in the treatment of PTSD in rape victims.
Rape victims with posttraumatic stress disorder (PTSD; N= 45) were randomly assigned to one of four conditions:

- **stress inoculation training (SIT),** The <u>first session</u> was devoted to information gathering through the initial interview. The session terminated with breathing exercises to diminish anxiety that may have been elicited by the interview. During the <u>second session</u>, the treatment method was described to the patient, a rationale for treatment was given, and an explanation for the origin of fear and anxiety was presented. The **next seven sessions were devoted to instruction in coping skills**. During the <u>third and fourth sessions</u>, the patients were taught deep muscle relaxation and controlled breathing. In the <u>fifth session</u>, they were taught thought stopping to counter ruminative or obsessive thinking (Wolpe, 1958). The <u>sixth session</u> was devoted to cognitive restructuring (Beck, Rush, Shaw, & Emery, 1979; Ellis, 1977), the <u>seventh</u> to guided self-dialogue (Meichenbaum, 1977), the eighth to covert modeling, and the <u>ninth</u> to role playing. No instructions for exposure were included.
- **prolonged exposure (PE),** First <u>two sessions info gathering</u>, the <u>next seven sessions</u> were devoted to reliving the rape scene in imagination (imaginal exposure). Patients were instructed to relive the assault by imagining it as vividly as possible and describing it aloud using the present tense. The patient repeated the rape scenario several times for a total of 60 min per session. The patient's narratives were tape-recorded, and patients were instructed to listen to the tape at least once daily as homework. Additional homework involved in vivo exposure to feared and avoided situations judged by the patient and the therapist to be safe.
- **supportive counselling (SC),** gathering information through the initial interview in the <u>first session</u> and presenting the rationale for treatment in the <u>second session</u>. **During the remaining sessions, patients were taught a general problem-solving technique**. Therapists played an indirect and unconditionally supportive role. Homework consisted of the patient's keeping a diary of daily problems and her attempts at problem solving. Patients were immediately redirected to focus on current daily problems if discussions of the assault occurred. No instructions for exposure or anxiety management were included.
- **wait-list control (WL).** Participants were informed that they would receive treatment in 5 weeks. During this period, they were contacted by a therapist, between assessments, to determine whether emergency services were required. Following an assessment at the end of the waitlist period, patients were randomly assigned to either PE or SIT.

Treatments consisted of nine biweekly 90-min individual sessions. Measures of PTSD symptoms, rape-related distress, general anxiety, and depression were administered at pre-treatment, post-treatment, and follow-up (M = 3.5 months post-treatment). All conditions produced improvement on all measures immediately post-treatment and at follow-up.

Drop out rates not significantly different across groups. No difference across groups in the initial severity of symptoms.

SIT produced significantly more improvement on PTSD symptoms than did SC and WL **immediately following treatment**. Post hoc analysis of post-treatment data indicated SIT patients demonstrated less **avoidance** than those in SC and WL. SIT & PE improved all three PTSD symptoms (avoidance, intrusion and arousal) whereas the SC and WL group only improved on arousal. On all symptoms (depression , anxiety, not only PTSD) the SIT patients showed the least pathology at post-treatment. All groups improved between pre and post. SIT and PE groups improved significantly between pre and post. None of the groups changed significantly between post and follow-up.

At follow-up (3.5 months later), PE produced superior outcome on PTSD symptoms.

<u>Rationale:</u>
Techniques in SIT produce immediate relief (anxiety management) but after treatment is terminated some patients don't continue the techniques.

Techniques in PE produce temporary high levels of arousal because patients are asked repeatedly to confront the trauma memory. The learned skills lead to permanent change in rape memory and hence to durable gains. The emotional processing (changes in trauma memory) result in:

- habituation to feared stimuli
- re-evaluation of the probability of threat in feared situations
- changes in the negative valence associated with fear response.

The implications of these findings and direction for treatment and future research are discussed.

The decrease of depression and anxiety in the wait-list group suggests that mere contact with a therapist is sufficient to ameliorate non-specific distress but not PTSD symptoms.

	SIT	PE	1) SC	WL
At Post-treatment				
% of patients showing significant improvement (2SD)	71%	40%	18%	20%
% meeting PTSD diagnostic criteria	50%	60%	90%	100%
At Follow-up				
% of patients showing significant improvement (2SD)	67%	56%	33%	Not included
% meeting PTSD diagnostic criteria	45%	45%	Not included	Not included

Appendix 1 – Current Guidelines

Thirty-three current violence prevention guidelines were reviewed as current practice:

- American Federation of State, County and Municipal Employees (APSCME) 1998 (Healthcare workers and social service workers)
- American Industrial Hygiene Association (AIHA) 2005
- BC Government and Service Employees' Union (BCGEU) 1998
- BC Ministry of Health (Elderly Mental Health – complex care) 2002
- California OSHA (Healthcare and community service workers) 1998
- Canadian Centre for Occupational Health and Safety (CCOHS) 2001 (2nd Edition)
- Central Sidney Australia Area Health Services 2001
- UK Department of Health:
  - Withholding treatment 2001
  - Social Care Staff 2001
  - Action to take in relation to the environment 2000
  - Health and Safety Executive (HSE) guide for employers 2004 (reprint)
  - National Health Service (NHS) Zero tolerance 2000 (Community, Mental Health)
  - National Institute for Mental Health in England (NIMHE) 2004
- International Council of Nurses (ICN) 2000
- Mayhew 2000 Australian Institute of Criminology Handbook
- Mid Western Area Health Service NSW Australia (general hospital inpatient setting) 2003
- National Institute for Occupational Safety and Health (NIOSH)
  - Risk Factors (NIOSH 1996)
  - Hospitals (NIOSH 2002)
- National Safety Institute in USA (healthcare workers in institutional and community settings) 1995
- Occupational Health and Safety Agency for Healthcare (OHSAH) Healthcare Education and Learning Program (HELP) 2005
- Occupational Safety and Health Administration (OSHA)
  - Late-night retail establishments 1998
  - Healthcare and social service workers 2004
- Office of the Inspector General (OIG) Evaluation of OSHA 2001
- Registered Nurses Association of Nova Scotia (RNANS) 1996
- University of California at Davis 1999
- University of New South Wales 2001 (three reports including guidelines regarding bullying)
- Vancouver Coastal Health Authority 2004
- Washington State Affiliated Health Services (AHS) Community workers 1996
- WorkCover (South Australian Equivalent to WCB) 2002
  - Managing the risks of violence at work in aged care facilities
  - Managing the risks of violence at work in home and community based care
- WCB of BC 2000

Appendix 2 – Example of comprehensive guidelines
UK (Zero Tolerance) Violence Prevention Programs:

A. Managing violence against staff working in the NHS
Aims:
1. To get over to the public that violence against staff working in the NHS is unacceptable and the Government (and the NHS) is determined to stamp it out
2. To get over to all staff that violence and intimidation is unacceptable and is being tackled.

One in seven of all reported injuries at work in NHS Trusts are physical assaults by patients or visitors. Particularly vulnerable to these assaults are: nurses, ambulance and A&E staff and carers of psychologically disturbed patients.

Managers' responsibility is to:
- Ensure staff working in the NHS know that their safety comes first.
- Encourage staff to report every incident, including verbal abuse and to seek assistance when involved in a violent situation.
- Reassure staff that they do not have to cope alone with violence or that violence is not a part of their job.
- Support workers when they are involved with the police and during any prosecution that may follow.
- Ensure that staff is kept informed of progress once a case has been reported to the police (Resource Sheet 2).
- Help staff apply for compensation through the Criminal Injuries Compensation Authority (CICA) or the NHS Injury Benefit Scheme.
- Inform staff and the public what becomes of the violent offender. Ensure that the local press are informed when attackers are prosecuted.

By April 2000, all NHS Trusts are required to have systems in place to record incidents of violence against staff and have published strategies for reducing such incidents. A national target is to reduce incidents of violence against NHS staff by 30 percent by 2003.

Beech 2001 describes a case to show how violent incidents occur without the victim receiving support nor anyone filling out an incident form. Much is still required to change attitudes of NHS staff from accepting violence as part of their job to taking action that will support co-workers and reduce the recurrence of violence in the workplace. Policies and procedures must be in place to ensure that the victim is not blamed and that the perpetrator is dealt with appropriately. The zero tolerance campaign ensures that staff receive full protection under the law. The Government sent notices to magistrates that they are encouraged to respond decisively to criminal behaviour such as an assault on a nurse, and impose sentences that include a deterrent component. For more than three months the Lord Chancellor has been appealing with mixed results to magistrates to impose tougher sentences on people who assault healthcare staff. Examples have been reported of the outdated views of some magistrates who consider violence towards health staff as 'part of the job'. **See NHS 2000 Case studies and examples of good practice Part I- Sheet 4 and Part II.**
The UK zero tolerance program also incorporates the following guidelines:
- Managing violence against staff working in the NHS
- Managing violence in mental health
- NIMHE mental health policy guide
- Managing violence in the community

B. Managing violence in mental health (NHS 2000)

The general principles of the NHS zero tolerance policies and procedures apply with particular emphasis for:

- Ensuring all members of staff who work in mental health settings receive training in appropriate interpersonal skills, managing aggression and personal safety that emphasizes prevention and continual assessment of risk;
- Ensuring the training is appropriate to the context and is provided by experts;
- Making provision for line managers to receive the same training as their team, to ensure consistency of approach; and
- Ensuring that all members of staff are provided with regular refresher training.

De-escalation or **defusion** is the term applied to a combination of verbal and non-verbal interactions which can, when used appropriately reduce the threat of violence, including the patient's anger and return them to a more calm state of mind. Summary of de-escalatory skills:

- Maintain adequate distance;
- Move towards a safer place, avoid corners;
- Explain intentions to patients and others;
- Try to appear calm and self-controlled;
- Ensure own non-verbal communication is non-threatening;
- Engage in conversation, acknowledge concerns and feelings;
- Ask open-ended questions;
- Ask for any weapons to be put down (not handed over)' and
- Know how to call for help in an emergency.

Staff are to be aware of local policies and procedures regarding physical interventions (restraints) and the use of medications for dealing with violence. **See case studies of good practice in mental health settings**.

C. Mental Health Policy Implementation Guide (NIMHE, 2004) 37 pages

The positive practice standards set out in this guidance have been developed to support mental health service providers and to enable them to review their current policies and procedures relating to education, training and practice in the safe and therapeutic management of aggression and violence.

Aggression and violence can be predicted and is often preventable. However, in the past, greater emphasis has been placed on skills development relating to the physical management of aggression and violence rather than skills development in:

- Recognition, prevention and de-escalation.
- Organisational, environmental and clinical risk assessment.
- Risk management.
- Care Programme Approach and Care Co-ordination.
- The use of advanced directives or negotiated care plans.

Staff, service users and carer groups identified a number of issues which influence the development of violent incidents including:

- Lack of access to privacy;
- Lack of access to open space and fresh air;
- Boredom;
- Inadequacy of staffing levels and staff mix;
- Lack of opportunity to participate in therapy;
- Social activities; and
- Poor staff attitudes.

Positive Practice Standards:

1. All staff must receive recognition, prevention and de-escalation skills awareness training as part of an organisational induction programme. (content based on organisational risk assessment relating to incidence of workplace aggression and violence).
2. Mental health service providers must ensure that all policies, procedures, education and training programmes promote **recognition, prevention and de-escalation** as the first line approach when responding to aggressive behaviour. **Physical interventions** should be viewed as a final option in a hierarchy of therapeutic interventions.
3. All multi-disciplinary team members must receive clinical risk assessment/management, including ethnic and cultural awareness, education and training as part of an organizational induction programme. They should attend regular (at least every two years) update programmes as part of their continuous professional development.
4. Assessment and the management of risk is an essential part of the care and treatment provided for service users and is an integral part of the Care Programme Approach (CPA), care co-ordination, and the Single Assessment Process for Older People. It is essential that on admission a clinical risk assessment of all individuals is carried out and a risk management plan is put in place. This should be conducted in collaboration with the service user and their carer wherever possible.
5. Risk assessment and risk management plans should be regularly reviewed with the service user and their carer wherever possible. Plans should record known triggers to aggressive/violent behaviour based on previous history and discussion with service users and their carers/families. Changes in levels of risk should be regularly recorded, communicated and risk management plans changed accordingly.
6. Mental health service providers should ensure that systems are in place to regularly review multidisciplinary team staffing levels and skill mix on inpatient wards/units. This is to ensure that they provide sufficient capacity to provide a safe and therapeutic environment for all, as well as providing

dedicated time to staff to spend with service users their carers and families to engage in therapeutic and social activities.

7. Mental health service providers should work in collaboration with service users and, where appropriate, their carer(s) to develop individualised advanced directives so that future interventions, wherever possible, meet the specific needs and wishes of service users as part of their overall package of care.

8. Clear and effective communication is an integral part of prevention and de-escalation of aggression and violence, but is of greater importance for people who have hearing or visual impairment, cognitive impairment or whose first language is not English. Mental health service providers must ensure that education, training, policies and procedures emphasise the need for clear and effective communication with all service users. Where necessary this will involve access to interpreters and staff with specific communication skills (e.g., signing).

Board level responsibilities

As part of clinical governance, a named Board member should be responsible for overseeing the development, implementation and regular review of policies and procedures relating to the safe and therapeutic management of aggression and violence. Policies should cover:

- Recognition, prevention and de-escalation strategies.
- Risk assessment and management.
- Approaches for actual management of aggression and violence.
- Use of extra care areas or low stimulus environments.
- The use of seclusion.
- Race Relations Amendment Act (2000).
- Human Rights Act (1998).
- Anti-discrimination and anti-bullying.
- The use of medication and rapid tranquilisation.
- Physical care and observation during and post restraint.
- Basic life support.
- Health and safety policies in accordance with the Health and Safety Legislation.
- Post incident support, review and reconciliation.
- Root cause analysis and sharing lessons learned.
- Recording, Reporting, Monitoring and Audit.

See detailed positive practice standards for:

- Service user involvement
- Families and carer involvement
- Black and minority ethnic groups
- Age awareness
- People with learning disability and mental health problems
- Recording and reporting
- Development and delivery of education and training
- Education and training – trainers
- Education and training – staff
- Physical care and observation during restraint
- Environmental safety
- The use of pain in the management of actual violence
- Clinical audit and monitoring
- Post incident support, review and reconciliation.

D. Managing violence in the community (NHS, 2000)

Working in the community has been taken to encompass work that is carried out at patients' or clients' homes, on the street or elsewhere outside a Trusts' control, within public venues, such as schools or community halls, and in mobile units. It also covers travel between venues and any handover or reporting to other staff on arrival at NHS premises. General policies and procedure of the NHS zero tolerance guidelines apply. Some safety procedures for working within health centres and clinics are also included, but not the security or design of those buildings.

In addition to general violence prevention procedures managers will provide policies including:
- An explanation of emergency procedures including arrangements for security assistance from the police;
- Inclusion of different aspects of community working, encompassing travelling, lone working and home visits;
- Provision for hospital-based staff making occasional home-visits;
- An explanation of local reporting procedures, including critical incident review and near misses;
- Statement on support for staff in the event of an incident;
- Information on post-incident support;
- A commitment to cultivating good relations with the local police and Crown Prosecution Service (CPS) in order to pursue cases of violence; and
- A demonstration that the policy has been implemented.

Most community staff work in close-knit teams that meet together regularly and share information. Managers and staff should:
- Arrange for all initial contacts where little information is available to be made at clinics rather than at home;
- Ensure that information which affects the safety of healthcare staff is readily available at all times to staff who need it;
- Require and facilitate sharing of information between different community teams and between hospital wards and community teams, when staff safety may be compromised;
- Facilitate sharing of information with general practitioners, other NHS Trusts and other agencies such as social services;
- Maintain links with local police to acquire up-to-date information on problem locations;
- Maintain a 'flagging' system on patient records or computer files which indicates that further information should be obtained before home visits are made. (Ensure that this system does not infringe patient's rights; and
- Ensure that 24-hour cover by senior management remains accessible to all staff, especially to those working out of hours.

If potential problems are identified regarding community care patients/clients, relatives or locations, managers can implement the following list of precautionary measures:
- Arrange patients/clients to be seen at clinics rather than at home, if at all possible;
- Arrange for another member of staff or a reliable relative of the patient/client to be present during the visit (e.g., if a member of staff is vulnerable to sexual harassment while visiting a member of the opposite sex);
- Provide a Trust driver, or a taxi if appropriate, in areas where cars might be vandalised, or staff have to go through unsafe areas to make visits;

- For a severe problem, arrange for a senior member of staff to write to the household and inform all managers that there must be no visits made to the address, and to make alternative arrangements to provide care;
- Negotiate agreement between the police, social services, mental health and ambulance Trusts on effective and consistent procedures for the detention of patients under the Mental Health Act that ensure the safety of all staff (vital to prevent staff from different agencies clashing during emergencies because of different procedures or priorities);
- Organise support across different Trusts or agencies [e.g., such arrangements exist between midwives and ambulance services or police, and between Community Practice Nurses (CPNs) and social services); and
- Maintain and adhere to a list of types of incident, that community staff working alone are not allowed to attend (e.g., pub fights, domestic violence, overdoses and certain problem locations).

Training:
Staff working in the community should know that their safety comes first. They should not be in situations that make them feel unsafe. However, if they are in unsafe situations they need to know how to deal with them. **Defusion training is the most suitable approach for equipping staff to deal with the frustration and aggression of patients, family, friends and bystanders**.

In training, particular attention should be given to:
- Ensuring that all members of staff who work in the community receive appropriate training in interpersonal skills, managing aggression and personal safety that emphasises prevention and continual assessment of risk;
- Ensuring the training is appropriate to the context and is provided by experts;
- Making provision for line managers to receive the same training as their team, to ensure consistency of approach;
- Ensuring that all members of staff are provided with regular refresher training; and
- New staff are trained and made aware of procedures at the earliest opportunity.

Traceability away from base:
A major concern for staff working in the community is that they should be located by their work team if a problem occurs. Maintaining effective communication channels is essential for staff working in the community. Measures to minimise any risk to their safety should include:
- Providing panic-button alarms and appropriate two-way communications systems such as mobile phones;
- Operating protocols for informing staff that a colleague is away from their base, where they have gone and their approximate return time. Procedures for reacting to failed protocols should be in place. (Many employers have set up 'buddy systems' whereby staff keep in contact with an assigned colleague); and
- Maintaining up-to-date records of the make, colour and registration number of the vehicles used by individual members of staff each day, whether personally owned or lease cars. This should be discussed and agreed with staff.

Provision for small clinics and health centres:
Managers and staff working in small health facilities need to ensure that:
- Reception staff are never left isolated. Reception staff can be vulnerable when having to deal with aggressive visitors or patients who come in, including those who are under the influence of drugs or alcohol;

- As far as possible, one person is not opening or locking premises alone in darkness, particularly if drugs or other target items are known to be kept on the premises;
- Procedures are in place for checking on staff regularly if they work alone with patients;
- Consulting and treatment rooms are arranged so that staff can be nearer to the door than their patients; panic alarm systems are easily accessible to staff working alone and that these give a clear indication of where an emergency is occurring and are tested regularly;
- Reception areas are arranged in such a way that members of the public do not have access to clinical rooms without passing by reception; and
- When out of main operating hours or when there are fewer staff on site, that staff use clinical rooms which are in close proximity to each other and reception.

Home visits:

Lone workers such as staff making home visits should take steps to minimise risks to their safety. Local managers should ensure there is a designated member of staff with specific responsibility for ensuring quick responses when a staff member does not report when expected. Before setting out on a home visit staff should:

- Get as much information as possible about the patient/client, their families and the location to be visited;
- Wherever possible, phone or write to make appointments for visits, ensuring that people know who you are and what your role is. If staff are unable to keep an appointment at the agreed time, they should let the patient/client know;
- Follow team procedures to ensure that another member of staff knows where they are going and when they should return. Make sure they know if the itinerary changes; and
- If possible, schedule visits to problem areas for particular times of the day, such as the morning when parents are around taking children to school, and when drug activity and drunkenness should be minimal.

When travelling staff should:

- As far as practicable, **not** display 'on call' stickers or anything that identifies the vehicle with a healthcare professional;
- Lock their vehicle **while** driving; and
- Drive with bags, drugs and equipment concealed so that they are not seen as they park

When arriving at a patient/client's home, staff should:

- Assess the situation as they approach and not enter a location if they have doubts about their safety. Make an excuse not to go in if the person answering the door gives any cause for concern (e.g., if they are drunk, if the client is not in, or a potentially dangerous relative is present);
- Stand well clear of the doorway after ringing or knocking, Stand sideways on so that they present a narrow, protected target' show identity badges;
- Follow occupants in when entering houses and other buildings;
- Remain aware of the environment and maintain escape routes in case problems arise; and
- Treat patients/clients courteously, remembering that they are in their own home and you are the guest.

See good practice studies in "Managing violence in the community" resource sheet.

E. Withholding treatment from violent and abusive patients in NHS Trusts (NHS, 2001)

Trusts have to balance their own ability to deliver effective care and treatment with the needs of the patient and there will be circumstances in which it would be reasonable as a last resort to withhold treatment.

If a decision is made to withhold treatment, then it must be made in the context of a defensible local policy and procedure applied to the facts of the individual case. Trusts should consider and take legal advice on the legal implications of such decisions, and should be able to justify them by reference to supporting evidence. Withholding treatment will only be appropriate when violent or abusive behaviour is likely to:

- Prejudice any benefit the patient might receive from the care or treatment; or
- Prejudice the safety of those involved in giving care or treatment; or
- Lead the member of staff offering care to believe that s/he is no longer able to undertake his/her duties properly (this might include incidents of racial or sexual abuse); or
- Result in damage to property inflicted by the patient or as a result of containing him; or
- Prejudice the safety of other patients present at the time.

Withholding of treatment shall not be an option for:

- Patients who, in the expert judgement of a relevant clinician, are not competent to take responsibility for their action (e.g., an individual becomes violent and aggressive as a result of an illness or injury);
- Patients who are mentally ill and may be under the influence of drugs and/or alcohol;
- Patients who, in the expert judgement of a relevant clinician, require urgent emergency treatment; and
- Other than in exceptional circumstances, any patient under the age of 16.

Where treatment is given to violent and aggressive patients, Trusts must ensure that staff are aware of local procedures for giving such treatment (i.e., these might include the use of medication, physical intervention, or security personnel to be in attendance and/or involvement of the police).

Post-incident action following the decision to withhold treatment from a violent or abusive patient:

- The decision is recorded in the patient's medical and nursing notes and the patient must be informed of this. (Data protection law must be complied with)
- A senior manager should confirm that all procedures have been complied with, issue a letter to the patient's GP and forward a formal withholding of treatment letter to the Trust's Chief Executive for issue. A copy should be sent to the Trust's Head of Security
- Where appropriate, other local NHS service providers, and as a matter of good practice other agencies, should be informed of the decision to withhold treatment from the patient,

For best practices policy see case study of Barts and the London NHS Trust.

Appendix 3 - Resource List (Alphabetical)

Handbooks:

Canadian Centre for Occupational Health and Safety. **Violence in the workplace: Prevention guide (2nd Edition)**. Hamilton, ON: Canadian Centre for Occupational Health and Safety, 2001. ISBN 0-660-18472-9.

Mayhew C. **Preventing client-initiated violence: A practical handbook**. Canberra: Australian Institute of Criminology, 2000. ISBN 0-642-24171-6. Downloaded April 2005 from URL: www.aic.gov.au/publications/rpp/30/RPP30.pdf.

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Boyd N, Malm A, & Mitchell J. Responding to aggression in Long-Term Care: Lessons from five case studies. Healthcare benefit Trust report to WCB of BC. Downloaded April 2005 from URL:
http://healthcare.healthandsafetycentre.org/PDFs/healthcare/aggression_april2004.pdf.

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Appendix 4 – Resource List (By Setting and By Content)

General

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ABOUT THIS DOCUMENT

The Occupational Health and Safety Agency for Healthcare (OHSAH), which operated from 1998-2010, was a precursor to SWITCH BC. Conceived through the Public Sector Accord on Occupational Health and Safety as a response to high rates of workplace injury, illness, and time loss in the health sector, OHSAH was built on the values of bipartite collaboration, evidence-based decision making, and integrated approaches.

This archival research material was created by OHSAH, shared here as archival reference materials, to support ongoing research and development of best practices, and as a thanks to the organization's members who completed the work.

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