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Doctor of Health Science

A Realistic Evaluation of Two Aggression Management Training Programmes

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This thesis is submitted in partial fulfilment of the requirements for the degree of Doctor of Health Science

The University of Nottingham

Declaration:

This thesis is my original work and has not been offered previously for any other degree or diploma.

Signature:

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Abstract

Whilst the training of healthcare staff is seen as a key element to the prevention and management of violence and aggression, questions remain as to the effectiveness of these programmes in preparing staff to apply this to clinical practice. To date there is a relative paucity of well-designed studies into the effectiveness of the training to prevent and manage violence and aggression in healthcare settings. Within this context a study was conceived to examine the effectiveness of two aggression management training programmes in preparing staff for clinical practice.

In order to provide a meaningful and evidence-based evaluation of the two programmes, Pawson and Tilley's Realistic Evaluation model was adopted for use in this study. In keeping with the chosen methodology, data was collected using a combination of methods including surveys, semi-structured interviews, and participant observation of training. A total of 64 participants were eligible for inclusion in the study; which ran over the course of a calendar year.

The research highlighted that training should have relevance to the staff group undergoing instruction. That training should be conducted wherever possible in staff groups, tackling real problems, with participants reflecting and learning from their experience and from each other. It should also provide measures of competency that describe both workplace and organisational outcomes and describe the requirements of assessment. That training should be engaging and integrate decision-making, planning, organization and skill building and cover a range of interventions. Most importantly, was the need to help staff transfer what they had learnt as part of training to clinical practice. These factors are brought together in a model of training devised as part of this study called the PROMPTS Aggression Management Training Model ©.

As the first study to apply realistic evaluation in aggression management research, it was a good fit, particularly given the growing emphasis on understanding how context influences evidence-based practice. The strengths

and limitations of the approach are considered, including how to operationalize it. This approach provided a useful interpretive framework with which to make sense of the multiple factors that were simultaneously at play and being observed through various data sources, and for developing explanatory theory about aggression management training and its implementation in practice.

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Chapter One

Introduction and Overview of Study

1.0 Introduction

The level of violence and aggression towards healthcare staff has been a concern to health professionals, policy makers and politicians for some time now (NHS Wales 2011; RCN 2008; Commission for Health Improvement 2004; National Audit Office 2003). Whilst there is some disagreement about the extent of violence and aggression faced by staff, there is an acknowledgement that anyone who works for the healthcare sector and comes into contact with the general public, is at risk from aggressive behaviour including threatening behaviour, insults, and actual assault (Healthcare Commission 2007; Linsley 2006; NICE 2006).

People who behave in ways that bring them into conflict with others make special demands on a service and its staff who are already under pressure as part of their work (Bowers et al. 2006; National Audit Office 2003; Rippon 2001). Violence and aggression raise special concern because they increase significantly the risk of injury and harm. This can have an impact on staff confidence and morale as well as on the care of patients. For the staff, persistent threats, aggravation and tension caused by potential aggressors can lead to stress-related problems, emotional burnout and result in some leaving the

services (NHS Security Management Services (NHSSMS) 2010; Di Martino 2002).

With the growing evidence of the scale of the problem, there was 55, 993 reported incidences of physical violence towards NHS staff in 2010 (NHS Survey 2010), and the damage that it causes, a number of strategic responses at a local and national level have been launched to meet the challenge. These include a range of measures aimed at reducing workplace violence and aggression as well as guidance on the use of restraint and medication management (NICE 2006; NHS Education for Scotland 2005; NIMHE 2004). However, the prevention and management of aggression is acknowledged as a specialised area of clinical practice requiring skills and knowledge to effectively and confidently contain (Hills 2008), and that training is a primary element of the strategy for combating work-related violence and aggression (NIMHE 2004).

Whilst the training of staff is seen as a key element to the prevention and management of violence and aggression, questions remain as to the effectiveness of these programmes in preparing staff to apply this in clinical practice (Paterson 2009; Stubbs et al. 2009; Beech & Leather 2006). Problems have also been highlighted in the way these programmes are evaluated and developed. Many programmes evaluate to the level of staff satisfaction to the course, and though this may be useful in improving training programmes, it does

not demonstrate if learning has been integrated within practice, or the benefits to the employing organisation, patients and staff.

To date there is a relative paucity of well-designed studies into the effectiveness of the training to prevent and manage violence and aggression in healthcare settings. There is a recognised need to develop a more systematic approach to the evaluation of aggression management programmes that goes beyond 'customer satisfaction' to allow organisations and their staff to make informed decisions as to the effectiveness of individual training programmes (Wales Audit Office 2009; Healthcare Commission 2007; Health and Safety Executive (HSE) 2006). Without such an evaluation healthcare organisations will have little, if any, reliable and valid evidence as to the effects and value of the training that they invest in (HSE 2006). They should be aware of exactly what training is needed, at what level, how it should be delivered and to whom (Hahn et al. 2006; Bubank 2004; Calabro et al. 2002).

Within this context a study was conceived to examine the effectiveness of two aggression management training programmes in preparing staff for clinical practice. The training programmes were run by two different mental health care Trusts within the East Midland Region, one serving a rural community, the other a large city.

1.2 The Aim and Objectives of the Study

1.2.1 Aim

The aim of this study was to evaluate how effectively each training programme equipped staff with the necessary skills, attitudes and knowledge to manage healthcare violence and aggression in their area of work.

1.2.2 Objectives

- To conduct an evidence-based evaluation of the effectiveness of each training programme.
- To compare and contrast the strengths and weakness of each programme
- To determine whether data collected during this study could be used as an educational resource in violence and aggression management training
- To develop recommendations for improving the training that staff receive in the management of violence and aggression

1.3 Methodological Considerations

At the time this study took place evaluation of aggression management training was an ad hoc process conforming to the needs of the moment and limited in what it sought to measure and demonstrate. In order to produce a more

meaningful and evidence-based evaluation of the two programmes, and in turn, answer the research question, Pawson and Tilley's Realistic Evaluation model (1997) was adopted for use in this study.

Realistic evaluation draws on theories and methods derived from the social sciences. It provides a distinctive account of the nature of programmes and how they work. Applications of realistic evaluation have largely focussed on evaluating initiatives in the field of social policy and more recently social work practice, however to date there is no published realistic evaluation of violence and aggression management programmes. Therefore this study is novel in its use of this methodology, which was chosen because of the direction it provided in exploring both the impact that aggression management training had on staff and the circumstances in which these were played out during training and in clinical practice. This methodology is discussed in Chapter Four.

1.4 Data Collection

Data were collected using a combination of methods including surveys, semi-structured interviews, documentary analysis and participant observation of training. This mixed approach, in keeping with the chosen methodology, provided an understanding of the two aggression management programmes, and captured the experiences and attitudes of participants. Data collection and analysis is discussed in Chapter Five.

1.5. Structure of the Thesis

Having set out the aim and objectives of the study, I will now go on and describe the structure of this thesis with an overview of each chapter. While this chapter introduces the study, subsequent chapters explore and expand upon the key elements of the topic of investigation. This begins with Chapter Two which examines the underlying theoretical constructs of violence and aggression in order to set the basis of the evaluation and management strategies employed within this study. Chapter Three offers an extensive review of the literature and sets the context in which the study takes place. Particular attention is paid to the evaluation of aggression management programmes and the importance of providing this kind of training for healthcare staff. Through the literature review I identify gaps in current knowledge demonstrating where the present research makes an original contribution. Chapter Four presents an examination of the methodological underpinnings and approach to the study and in particular its use of Pawson and Tilley's Realistic Evaluation model (1997) in investigating the topic. This is continued in Chapter Five which details how these principles have been translated into research methods for use in the study; including data collection and analysis. Chapter Six contrasts the key findings of this research to the aims of the study and the wider literature in this field. In Chapter Seven the practical and theoretical implications of the findings are discussed within the wider literature on the topic. The chapter provides the conclusion of the study before making recommendations for future training and research.

1.6 Chapter Summary

This chapter has outlined the rationale and structure of this research. It has also set out the aim and objectives of the study, and outlined the structure of the thesis. Chapter Two will now examine a range of theories that seek to explain the phenomena that is violence and aggression. This in turn provides the basis to understanding how the management of violence and aggression has developed over time (Chapter Three) and why Realistic Evaluation (Pawson & Tilley 1997) was used in the evaluation of the two training programmes (Chapter Four).

Chapter 2

Theories of Violence and Aggression

2.0 Introduction

This chapter explores the main theories of aggression which in turn provide the theoretical underpinnings and the focus of this study. Aggression is a complex behaviour that comprises of an interplay between a number of social, situational and personal factors played out by actors in different settings and is aimed at harming or injuring others (Coie and Dodge 1998). Specific reasons for aggression are complex and often include a combination of factors such as learnt and instinctive behaviours. Whilst a detailed discussion of aggression and its possible causes would be difficult to achieve in such a short chapter, the main points of the more popular theories of aggression are outlined to support the discussion on how aggression is managed in clinical practice (See Chapter Three Literature Review that follows). All the theories presented in this chapter have been used, to a greater or lesser extent, to both explain and manage aggression.

The chapter starts with those theories of aggression related to human biology, instinct and evolution. These theories presuppose that the aggressive response is innate and to some degree unavoidable and as such needs to be controlled. It then looks at those theories of aggression related to how humans respond to stimuli and experience. These theories move aggression from an innate predisposition to that of a response to external stimuli, namely frustration. The

chapter then goes on to look at those theories of aggression related to how we think and learn. These theories suggest that aggression is largely a learnt behaviour and as such can be modified and controlled. The chapter ends with an overview of the general aggression model that encompasses elements of all these theories.

2.1 Theories of Aggression

Theories of aggression can be divided into three broad headings (Monds-Watson 2011), these being:

- Theories of aggression related to human biology, instinct and evolution
- Theories of aggression related to how humans respond to stimuli and experience
- Theories of aggression related to how we think and learn.

These provide a basis on which to structure thinking of aggression and help to understand, explain and sometimes even anticipate how certain situations and experiences may be associated with behaviours and emotions. These theories will now be discussed in greater detail.

2.2 Theories of aggression related to human biology, instinct and evolution

Theories of aggression related to human biology, instinct and evolution all presuppose that the aggressive response is innate and to some degree

unavoidable and as such needs to be controlled (Krall 2007). These theories consider aggression primarily from the biological and evolutionary perspectives, but also encompass psychodynamic theory in the form of Freud's (1913; 1995) work on instinct and drives.

2.2.1 Biological theories of aggression

Research conducted on both people and animals has pointed to the important role of neurotransmitters, especially serotonin and noradrenalin, in regulating violent and aggressive behaviour. For example, studies have shown that very low levels of serotonin are related to impulsive behaviour and a subsequent higher risk of aggressive behaviours (Glenn & Raine 2008; Johnson et al. 2007; Siegel at al 2007). Data also supports the notion that decreased cerebrospinal fluid (CSF) and 5-HT metabolite, 5-hydroxyindoleacetic acid (5-HIAA) may be a biological marker of impulsivity and violence (Dolan et al 2005; Preskorn, Ross & Stanga 2004; King 2003) Furthermore, these findings suggest that 5-HT plays a role in inhibiting aggressive behaviour in persons with personality disorders and may play a role in suicide and other aggressive behaviours (Glen & Raine 2008; Dolan et al. 2005; King 2003). Similarly, high levels of the chemicals noradrenalin or dopamine within the brain are related to hyper-arousal, in which a person might quickly over-react to even the slightest apparent threat (Villion et al. 2012; Trainor & Nelson 2011; Pezawas et al. 2005).

Research (Hermans, Ramsey & Van Honk 2008; Metha, Jones & Josephs 2008; Siever 2008) has also been conducted on the endocrine system, with a focus on the sex hormones, particularly testosterone levels in men, and a person's ability to suppress and control the emotions. A number of hormones, including testosterone, progesterone, ß-endorphin, prolactin, luteinizing hormone, renin, and melatonin have been found to be involved in the mediation of aggressive behaviour (Volavka 2002).

Additional biochemical theories associated with impulsive aggression and violence involves abnormality in the dopaminergic and noradrenergic systems that are limbic in nature (Siever 2008). Abnormalities in these regions and neural pathways have been found to interfere with cognitive functioning and reasoning, antisocial behaviour, and violence and aggression. Neurological research is increasingly been used in support of biological research into violence and aggression and this will now be discussed.

2.2.2 Neurobiological approaches to understanding aggression

Neurological research in the field of neuromagnetic resonance imaging (neurological MRI scans) have found that certain areas of the brain, the limbic system and cerebral cortex in particular, have been found to control peoples responses to outside triggers (Giedd et all 2001; Pillman et al 1999). The functioning of the limbic system is hypothesised to determine the meaning a person gives to a particular situation. Thus meaning is influenced by

physiological capability to perceive incoming messages, to prioritise among competing stimuli, to interpret them in relation to stored ideas, beliefs and memories, and subsequently to respond (Siever 2008). Harper-Jaques and Reimer (1998) propose the term 'emotional circuit' to describe this interrelationship between the emotional processes of the limbic system and the neuro-cognitive processes of the frontal lobe and other parts of the cerebral cortex. Abnormalities, congenital defects, tumours, physical injury in these areas of the brain have been linked to aggressive behaviour within the sufferer (Siever 2008). For example, damage to the frontal lobes, such as that following injury to the brain, can result in impaired judgement, changes to personality, inappropriate behaviour and conduct, poor decision making, and aggressive outbursts.

What is unclear however is the extent to which these biological variables interact with social and psychological factors to produce and support human behaviour generally and antisocial behaviour specifically. The majority of biological studies, both those described here and others not included, have examined only a few isolated variables and have generally not taken into account the interrelationships between biological functioning and socio-environmental conditions (Siever 2008). Biological theories of aggression continue to be pursued as a treatment for aggression as the idea of isolating a chemical or biological function and then correcting this through the administration of a drug or corrective procedure, such as surgery, remains an attractive one (Ford, Byrt & Dooher 2010).

2.2.3 Instinct theories of aggression

Psychoanalytic theorists view emotions as instinctual urges. Suppressing these urges is viewed as unhealthy and may contribute to the development of psychosomatic or psychological disorders (Ford, Bryt & Dooher 2010; Linsley 2006; Brookman 2005). One of the first proponents of instinct theory was the psychologist Sigmund Freud (1856 – 1939). Freud considered aggression to be instinctual and consequently inevitable. According to Freud (1949), it was only through the release and reduction of tension that the person could again enjoy a more stable state of being.

Freud asserted that humans were subject to innate (inborn or instinctual) but opposing forces or drives, which he termed Eros and Thanatos (1913). Eros was the drive towards life, survival, love and joy; while Thanatos was the death drive, the self-destructive part of us (Ford, Bryt & Dooher 2010). To preserve life, Freud (1913) theorised that we directed the Thanatos or death drive outwards i.e. we harm others to avoid harming ourselves. However, this association did not explain destructive actions that occurred during the wars and armed conflict. In his latter writings, Freud (1949) identified aggression as a separate instinct, like the sexual instinct. In doing so, he challenged the commonly held belief that human beings were essentially good. Instead, he viewed aggression as an innate human quality that could be expressed when a person was provoked or abused. Freud's view fostered the use of catharsis, the release of ideas through talking and expressing appropriate emotion (1949). Freud's theory of a death instinct

contributed to what came to be known as a hydraulic model of aggression (Linsley 2006). This model proposed by Konrad Lorenz (1966) assumes that aggression builds up (like steam in a pressure cooker), and has to be released via some form of cathartic activity (such as behaving aggressively towards someone else, watching violent sport, undertaking strenuous activity, or playing war games on the PC). The catharsis provided by such activates is believed to release the pent-up negative energy associated with the instinct to aggress, leaving the person calm, relaxed and emotionally balanced once again.

Another early pioneer of instinctual aggression theory was Erich Fromm (1900–1980) an American psychoanalyst who was best known for his application of psychoanalytic theory to social and cultural problems. He understood animals and humans to share a common form of aggression that he termed benign. This was an encoded defence response that served to protect a person from threat. However, unlike animals, human beings were capable of behaving aggressively for other reasons. Fromm defined aggression in humans as any behaviour that causes or intends to cause damage to another person, to an animal, or to an object (Fromm 1974). The distinction made between humans and animals was that the human could reason. This capability provides them with options that are not available to animals; humans may foresee both real and perceived threats and adjust their behaviours and actions accordingly to fit the situation.

2.3 Theories of aggression related to how humans respond to stimuli and experience

These theories of aggression move the debate from innate responses to a perceived threat to external sources of aggression. The belief is that aggression is a predictable response to a defined stimuli, this being frustration.

2.3.1 Frustration–Aggression Hypothesis

The frustration–aggression hypothesis was first set out in the 1930s by Dollard et al. (1939) in an attempt to translate some of Freud's psychoanalytic concepts into learning theory (Bjorkly 2007). Rather than aggression being seen as a response to a perceived threat, it was proposed that aggression was the result of a person being frustrated in their attempts to meet a goal, for example, the attainment of recognition. Dollard and his associates asserted that the bulk of human aggression could be explained by a few simple ideas, primarily that the,

> *occurrence of aggressive behaviour always presupposes the existence of frustration and that the existence of frustration always leads to some form of aggression* (Dollard et al. 1939).

The frustration-aggression (F-A) hypothesis was immensely influential, and had a great impact on behavioural research in the late 1950s and 1960s. However it fell out of favour due to subsequent research which demonstrated that this assertion was not reflective of the multiple factors associated with aggressive behaviour,

particularly the influence of cognition on emotion and behaviour (i.e. the relationship between how we think, feel and act) (Linsley 2006). Likewise, people may respond in other ways, sometimes becoming passive and helpless in extreme cases. One form of this view is the concept of displacement of aggression. This is where one object of frustration is a substitute for another (Linsley 2006). For example, an employee who is subject to disciplinary action may in turn take their frustrations out on a more junior member of staff.

Contributions to frustration–aggression research developed the idea that an environmental stimulus not only had to create frustration but anger in order for aggression to follow, and that the anger need not be the result of the stimuli, but a response to another frustrating situation, such as a verbal attack (Ford, Bryt & Dooher 2010). That is not to say that anger will always lead to aggression, however, as anger can be displayed in a number of ways and, conversely, act as a motivator and medium for positive change.

2.3.2 Cognitive Neuroassociation Model

The frustration-aggression hypothesis was subsequently revised by Berkowitz (1988) who highlighted that all aggression does not necessarily arise from frustration, and queried whether frustration invariably resulted in aggression. Berkowitz (1988, 1990, 1993) produced a modified frustration-hypothesis which acknowledged the validity of Dollard's common-sense recognition of the role frustration sometimes played in aggression, but also introduced two important

variables, firstly, the role of cognitive appraisal, and secondly, the role of attribution.

Cognitive neuro-association theory not only subsumes the earlier frustration-aggression hypothesis (Dollard et al. 1939), but it also provides a causal mechanism for explaining why aversive events increase aggressive inclinations, i.e., via negative affect (Berkowitz 1989). In essence this means that to anticipate potentially aggressive encounters and understand why they occur, we have to pay attention to how people think, feel and make sense of what happens to them. Initially, an aversion event, such as pain, triggers a primitive negative response. This response is communicated from peripheral receptors, to the hypothalamus which synthesizes input from throughout the nervous system, as part of the limbic system. The limbic system mediates primitive emotion and basic drives to produce behaviours for survival associated with both fight and flight tendencies (Bushman & Anderson 2001).

At first these rudimentary feelings of fear and anger are not influenced by cognitive appraisal, other than to identify the stimulus as aversive. However, higher order cognitive processing quickly begins to take over. The current experience of physiologic sensations is associated with memories, ideas, and previously experienced expressive-motor reactions. These thoughts can act to suppress or enhance the action tendencies associated with these feelings. In a situation perceived as intentional, dangerous or unprovoked, the recipient's reaction will be intensified. The person's reaction will be further intensified if the

offender is viewed as undesirable and may lead to aggressive and violent behaviours. Furthermore, cognitive neuroassociation theory assumes that cues present during an aversive event become associated with the event and with the cognitive and emotional responses triggered by the event and over time form patterns of behaviour. Conversely, if people are motivated to do so, they might think about how they feel, make causal attributions for what led them to feel this way, and consider the consequences of acting on their feelings. Such deliberate thought produces more clearly differentiated feelings of anger, fear, or both, and forms the basis of many anger management programmes.

Furthermore, the term 'physiological arousal level' is used to describe the types of consciousness associated with engagement in difficult activities (Ramirez & Andreu 2006). Although individual levels of arousal fluctuate depending on situation and circumstance, we each have an average arousal level which varies from low to high. In other words, some people are easily aroused, prone to anxiety or sensitive to stress and some are less so. It would seem logical to assume from this that people who have a high level of arousal are more inclined to behave aggressively, however, research indicates the reverse: that actually those with very low arousal levels are more likely to behave in an anti-social or aggressive manner (Ford, Bryt & Dooher 2010). This is thought to be because individuals with a low arousal level are more inclined to seek out thrill-inducing activity, which would cause physiological discomfort to someone with a high arousal level (Siever 2008). Individuals with low arousal levels have been

consistently found to be over-represented in studies of criminality and social deviance (Siever 2008; Green & Donnerstein 1998).

In summary, whilst there are a growing number of studies showing that aversive events frequently give rise to relatively high levels of aggression and to the indications of a parallel between the effects of frustrations and aversive simulation; there are also studies that point out that frustration does not necessarily lead to aggression (Whitley & Kite 2010). As such aggression is a subjective response to a situation or series of events in which the person sees themselves as having been wronged (Sabini & Silver 1982).

2.4 Theories of aggression related to how we think and learn

In contrast to instinct theories, social learning theory focuses on aggression as a learnt behaviour. This approach stresses the roles that social influences, such as role models and reinforcement, play in the acquisition of behaviour and expression of aggression.

2.4.1 Social Learning theory

Social learning theory is perhaps the best known and most influential theory of learning and development. Proposed by Albert Bandura (1977) it added a social element to traditional learning theory, suggesting that behavior was the result of observing and imitating others (role models). This type of learning has been used to explain a wide variety of behaviors including aggression and provides a

useful set of concepts for understanding social behavior. According to social learning theory (Bandura 2001), people acquire aggressive behaviour the same way they acquire other forms of social behaviour - either by direct experience or through the observation of others. Whether aggression or some other response actually occurs depends on what consequences we have learned to expect; otherwise referred to as reinforcement. Reducing restraints on aggressive behaviour through modelling reduces the inhibitions against behaving aggressively by coming to believe that this is a typical or permissible way of solving problems or attaining goals, and, in turn, this distort a person's views about conflict resolution.

In an extension to his work, Bandura (1986: 19) claimed that for behaviour to be learnt individuals must be able to form an image of behaviour and the rewards/punishments attached to it (reinforcement). The individual will perform the behaviour at a suitable opportunity, providing the expectation of reward is greater than the risk and extent of punishment. Interestingly, social learning theorists allow for the presence of the frustration-aggression hypothesis, and recognise that frustration is likely to be a potential instigator of aggression. However, they assert that aggressive behaviours must first be learnt, rather than pre-existing as an instinctual response to frustration or other negative stimuli. Finally, this theory recognises that although a person might have learnt a particular behaviour it does not necessarily follow that they will adopt it; owing to amongst other factors, a lack of skill in a particular behaviour.

Role modelling remains a popular approach to the management of violence and aggression. This approach based on social learning theory emphasizes the importance of learning from observing and imitating role models, and learning about rewards and punishments that follow behaviour. Modelling when used alone has been shown to be effective for short-term learning, but insufficient for long lasting behaviour change if the target behaviour does not produce rewards to sustain it (Braswell et al. 2007). This is best achieved through rehearsal and reinforcement of the behaviour in real life situations in which the person receives a reward, e.g. a reduction in the person's aggression allowing them access to their children. In this way, the nurse or other health professional or therapist needs to ensure that positive peer models are available to demonstrate socially acceptable behaviour and that discussion about the rewards and consequences of specific behaviours take place. Likewise, the health professional or therapist should also work to help people develop a sense of self-efficiency, that is, the belief that the individual can work to change his behaviour and meet his goals independent of professional help.

2.4.2 Script Theory

As an extension to Bandura's work, Huesmann (1986, 1998) proposed when children observe violence in the mass media, they learn aggressive scripts. Scripts define and interpret a situation and guide behaviour. Like an actor in a play, the person selects a script and plays out a role, leaving little room for

improvisation. In this way, scripts can be seen as a sequence of actions or events often directed to achieving a particular goal or outcome (Abelson 1981). Scripts are often established at an early age, and rehearsed and refined as we get older. Through rehearsal, and depending on reward, they become a unitary concept in semantic memory governing social behaviours and actions in wide range of different social contexts (Marsh et al. 1998). Multiple rehearsals create additional links to other concepts in memory, thus increasing the number of paths by which it can be activated; they can also increase the strength of the links themselves. Thus, a child who has witnessed several thousand instances of using a gun to settle a dispute on television is likely to have a very accessible script that has generalized across many situations. In other words, the script becomes chronically accessible. This theory is particularly useful in accounting for the generalization of social learning processes and the automatization (and simplification) of complex perception-judgment-decision-behavioural processes (Ford, Bryt & Dooher 2010).

2.5 Sociological theories of deviance

Deviance theory examines why a small percentage of people do not comply with what is commonly termed socially acceptable behaviour (Dinitz et al. 1975; Clinard 1968; Merton 1936). Although socially unacceptable behaviour is not necessarily aggressive or destructive (for example, the bizarre behaviour of someone experiencing mental health difficulties), deviance theory offers a particular insight into anti-social behaviour, and can help to understand and

explain the context of clinical practice in situations where there is potential for aggressive or hostile behaviour. Whereas psychological and biological theories of aggression tend to locate cause within the individual, sociological theories of aggression generally look to the social environment to explain aggression.

2.5.1 Interactionist or Differential-Association Theory

Differential-association theory is a sociological theory about how humans develop behaviours in relation to how they interact with their environment. Proposed by Edwin Sutherland (in 1924), it has been very influential in the study of criminology and deviance (Haynie & Osgood 2005; Lainer 2004; Nelkin 2002). Differential-association theory is premised on the assertion that if someone grows up in an environment where criminal activity or aggression are valued and promoted, then the child will learn a set of values and behaviours to support such activity. Social factors associated with violence and aggression include poor coping skills, inadequate social etiquette in managing and resolving conflicts, and an inability to form and maintain meaningful relationships. Within such environments, the use of aggression to resolve disputes is both acceptable and to a degree desirable (Novaco & Taylor, 2004; Cornell, Peterson, & Richards, 1999).

2.5.2 Control Theory

Control theories of deviance originate in the work of Travis Hirschi (1969), who believed that whether an individual behaved in a deviant manner, was dependent

on the key variables, these being; attachment; commitment; involvement and belief. Fundamentally, a strong sense of attachment (strong social bounds) made it less likely that an individual would engage in deviant behaviour because of the commitment to social norms associated with attachment to their social group. Additionally, the level of practical involvement (or engagement) an individual had with their community, and how much they believed in the value system associated with that community, also decreased the likelihood of deviant behaviour.

2.6.3 Relative Deprivation Theory

Relative deprivation theory (Merton 1938) essentially describes how frustration arising from a sense of deprivation compared to others in your environment, can be linked to aggressive behaviour. Walter Runciman (1966) identified that for relative deprivation theory to be applicable, four considerations needed to be met (lack, knowledge, want, belief). These being: the person must lack 'something'; the person must know that other people have that 'something'; the person must want that 'something'; the person must believe that they can get that 'something'

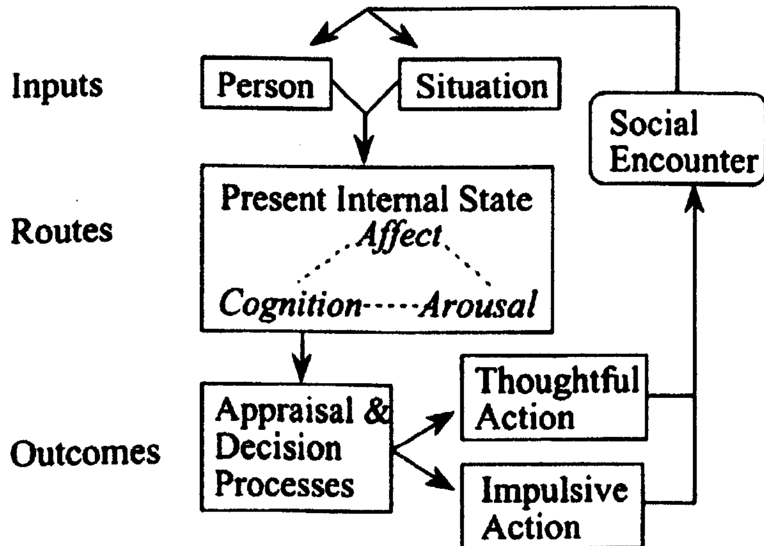
Although usually applied to groups of individuals who join up to revolt against perceived injustice (Walker & Smith 2002), this theory can also be considered in terms of the frustration felt by a single client who feels that they are being deprived of something that they are entitled.

Whilst the above theories have been useful in understanding violence and aggression they have focused on individual elements often related to the researchers discipline or field. Increasingly, there has been a move away from the use of single models to a more general model of aggression that encompasses these and other theories. This general model of aggression will be discussed now.

2.7 General Aggression Model

In order to build a broad model of aggression Craig Anderson and colleagues (Anderson & Carnagey, 2004; Anderson & Huesmann, 2003; Anderson & Bushman 2002) developed the General Aggression Model (GAM). This looked to unify the various theories of aggression into an integrated framework by which to understand the causes and conditions of violence and aggression. The GAM focuses primarily on how aggression unfolds within one cycle of an ongoing social interaction (See Figure 1 over page).

Figure 1 The General Aggression Model



(Maclink 2011)

The model comprises of three distinct but interrelated stages, these being inputs, routes and outcomes. Inputs include both person and situational factors. Person inputs include anything the person brings to the situation, such as values, attitudes, beliefs, prejudices, personality traits, drives and capabilities. Situation inputs include all external factors that can influence aggression such as, the environment, aggressive cues, and opportunities to transgress. These person and situational factors in turn influence the person's internal state, such as aggressive thoughts, angry feelings, physiological arousal levels, and brain activity, which in turn, affects the way in which the person reacts to the situation in which they find themselves.

Applied to the workplace, aggression and violence are seen as a possible outcome of negative interpersonal interactions, which are, in turn, embedded in the broader social and organisational context in which they occur. Particular attention is therefore paid to any factor that might influence the nature of the exchange between the interacting parties. Such factors extend from characteristics of the individuals involved, through the nature and motive for their interaction; to the environmental and socio-cultural context in which the interactions take place (RCP 2007). Importantly, this kind of analysis is better able to explain the underlying character of the majority of violent and aggressive incidents reported in healthcare settings (Paterson & Miller 2005) through interpretation or definition rather than mere reaction to a situation. In turn, intervention aimed to prevent or reduce violence towards healthcare staff must be informed by valid and appropriate understanding of its causes and the situation it takes place in. Adopting an understanding of violence and aggression within the healthcare context advances the traditional framing of the problem as one of either service user behaviour or staff inability to effectively manage such occurrences, to one which considers occurrences as being a function of a complex interplay between the individual, the service provider, the interaction taking place, and the environment in which the interaction occurs. Consequently, this has important implications for the training of staff in aggression management as it challenges programmes to take account of this range of activities and thinking.

The GAM is increasingly being used has a framework to research aggression (see examples Gentile et al 2011; Anderson at al 2007; and Giancola 2002) as it recognises such behaviour to be a combination of factors and has proved insightful when incorporated into assessment tools used with patients displaying this type of behaviour (James et al 2006; Sanders et al. 2000; Whittington 1998). This model reflects my own understanding of violence and aggression and was the one adopted for this study.

2.8 Summing up of the research

During the past century, social scientists and psychological theorists have attempted, through research with human and animal subjects, to learn more about the relative roles played by nature and nurture in the development of aggression. These studies have been conducted using a range of approaches often reflecting the discipline of the researcher. What is clear from the research conducted so far is that biological, cognitive, psychological and social factors all have a part to play in explaining why a person might behave aggressively, however it is difficult, if not impossible, to separate one from another. Further research is required using a framework such as the general model of aggression if aggressive acts are to be better understood from a 'real world' perspective.

2.9 Chapter Summary

This chapter has provided a brief overview of theories that have been put forward to explain aggressive behaviour. A more complete study would be beyond the limitations of this thesis; however it is clear from those theories presented that there is an overlap in thinking about the topic and that it is likely that aggression is a combination of biological, sociological and psychological processes and events; although it remains difficult at best to 'measure' these in 'real world settings'. This chapter therefore provides a foundation from which to explore workplace violence and aggression and the ways in which organisations have sought to manage such behaviour. The following chapter builds on this by providing a detailed literature review as to the violence and aggression encountered in healthcare settings and the measures and training put in place to counter this type of behaviour.

Chapter 3

Literature Review

3.0 Introduction

The previous chapter provided an overview as to the main theories that exist to explain violence and aggression. This chapter develops these ideas further and provides an understanding of the current literature surrounding the evaluation and effectiveness of aggression management programmes. It begins by describing the contextual background to this research. This is followed by a definition of violence and aggression for the purpose of the research. The incidence of violence and aggression in the workplace, and its reporting, is then examined and the consequences for those working in these environments is discussed. Particular attention is paid to the evaluation of aggression management programmes and the importance of providing training within the healthcare setting. Whilst it was not the intention to look specifically at health related violence and aggression in relationship to mental health and learning disability, much of the available literature focused on these two branches of healthcare and had a significant impact on the subsequent discussion.

3.1 The literature review process

The importance of basing health interventions on sound research findings wherever possible is an important goal in today's health service (Wade 2005; DH 2004; Greenhalgh 2004). It is difficult to overestimate the significance of this

issue in terms of health gain, cost effectiveness, consumer preference and – last but not least – in terms of professional development. Consequently, for the purpose of this review, 'studies' that were anecdotal in nature were excluded. Whilst such material provides insight into the topic, it tends to be unstructured and not evidence-based. A comprehensive literature review should involve more that the simple recitation of information sourced from previously published material (Cormack 2006; Parahoo 2006). It should aim to enhance best evidence based practice through the use of a defined methodology to identify, select and critically appraise relevant primary research studies with regard to the research question or hypothesis (LoBiondo-Wood & Haber 2006; Parahoo 2006). In the case of the research reported in this thesis, this entailed searching for research based papers addressing the effectiveness of aggression management training programmes.

To undertake the literature review, searches were completed through library catalogues (Libertas and Bids Isi Dataservices). The bibliographic databases CINAHL (Cumulated Index of Nursing & Allied Health Literature), Medline, AMED (Allied & Complementary Medicines), Mental Health Collection, PsycINFO, and BIDS (International Bibliography of the Social Sciences) were searched from 1980 onwards (where available). Other sources were health related websites including the Department of Health and the Royal College of Nursing. I also found references through publishers' catalogues and hand searches of books

and journals. Furthermore, the reference lists in all identified studies were inspected to identify further relevant studies

Keywords searched were *violence and aggression, health care, health care education, evaluation, aggression management training*, and, *perspectives of training.* The use of Boolean operators (AND/OR/NOT) narrowed down the parameters of the search (Loke, Price & Herxheimer 2007). Synonyms and alternative spellings for terms were explored to improve the scope of the search using Medical Subject Heading (MeSH) and truncation marks (?*) (Loke, Price & Herxheimer 2007). Hand searches were undertaken to bridge any gaps that arose from the inevitable limitations of electronic searching (Loke, Price & Herxheimer 2007). British sources from the last decade are dominant, although international perspectives and historical factors are influential. Bibliographies of studies and previous literature reviews were also examined for reference to other relevant primary research studies (Parahoo 2006). My main criteria in searching the literature were to include the most recent publications of aggression management training from peer review journals where possible, and books, in order to identify how this study could build on and contribute to current knowledge in this field.

The search was limited to the last thirty years, as it is only within this time that the topic area began to be explored with any conviction. This period of time was felt to be representative of the body of knowledge for the topic area being studied, an

issue that was subsequently confirmed by the findings of the research papers in this review.

3.2 Context to study

The issue of responding to and managing violence and aggression is one of the major challenges facing modern health services (NHS National Security Management Service 2010; Healthcare Commission 2007; HSE 2005). Whilst it has been a challenge to services for many years, contemporary issues are compounded by increased problems arising from substance misuse, use of weapons and an increase in violence and aggression in society generally (National Audit Office 2010). Despite this, there is limited information to guide clinicians when faced with this type of behaviour. Many reasons would seem to exist for this, not least a lack of research into the subject itself. As a consequence interventions for dealing with violence and aggression have tended to be ad hoc and at times inappropriate (McPhaul & Lipscomb 2004) and this has led to criticism of current practice, focussing on the need for increased preventative measures and the inadequacy of staff training in the prevention, management and review of aggression and violence (Viitasara 2004; Di Martino, Hoel & Cooper 2003). This is evident in repeated initiatives in many sectors whose observations and proposals often echo the conclusions of previous reports (NHS Wales 2011; NICE 2005; National Audit Office 2003). Furthermore, there is no fixed regulation or accreditation that ensures consistency in terms of the quality of these systems or aggression management training (HSE 2006). Whilst there is

a recognised need to ensure that healthcare staff receive training in the prevention and management of violence and aggression, there is no mechanism to ensure that this training is of the type and level required to meet the needs of staff and those they care for; potentially putting people at risk from harm and injury.

3.3 Defining violence and aggression

One of the difficulties in addressing violence and aggression is that the concepts are not easy to define (Linsley 2006; Nijman et al. 2005; Di Martino 2003). This is because they mean different things to different people working and living in different contexts. Behaviour that one person might find acceptable another might take offence. It is because of this that healthcare organisations and staff groups have defined violence and aggression in different ways for different purposes. However, in order to recognise, address, and prevent violence and aggression, healthcare staff must have a clear understanding of what these terms mean (International Council of Nurses 2007). This requires a definition that encompasses the different forms that violence and aggression can take, while allowing for personal interpretation and understanding.

There are a number of definitions of workplace violence and aggression, with some defining it only in terms of actual or attempted physical assault (Mayhew 2002) and others defining it as any behaviour intended to harm workers or their

organisation (Stubbs, Paterson & Leadbetter 2009). The World Health Organization (WHO 2002) defines workplace violence and aggression as,

> *'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation'* (WHO 2002; 1996).

Similarly, the NHS Counter Fraud and Security Management Service (CFSMS), a special health authority within the NHS who has overall responsibility for the management of violence and aggression within the healthcare sector, use the following definition:

> *'The intentional application of force to the person, without lawful justification, resulting in physical injury or personal discomfort'* (CFSMS 2006: 4).

Both these definitions highlight that workplace violence consists of not only physical violence such as assault/attack, but also nonphysical violence including verbal abuse, bullying/mobbing, sexual or racial harassment, and threats. However, what they fail to take into account is unintentional violence resulting from illness or injury, or where a patient's mental capacity is impaired. This is

addressed by the NHS Health Development Agency (2002) definition of workplace violence:

> *'Any incident, in which a person working in the healthcare sector is verbally abused, threatened or assaulted by a patient, member of the public, or work colleague, in circumstances relating to his or her employment'* (NHS Health Development Agency 2002: 4).

This definition recognises that violence and aggression can come from a number of sources, including that perpetrated by co-workers, supervisors and other health care staff (Mayhew & Chappell 2002); that it need not result in physical injury; and is a problem encountered as part of working practice (Di Martino 2003). Therefore, for the purposes of this research, this definition was used.

3.4 The incidence of violence and aggression within healthcare

The true incidence of workplace violence in the healthcare setting is difficult to estimate (Farrell, Bobrowski & Bobrowski 2006; Lanza, Zeiss & Rierdan 2006; Duffield & O'Brien-Pallas 2002). Differences in definitions of workplace violence and aggression, the scope of the healthcare industry and significant under-reporting of violent incidents by healthcare workers make compilations of data regarding the prevalence of violence near impossible (Natioanl Audit Office 2010; Flannery et al. 2007; Walsh 2001). However, statistical indicators would suggest that violence and aggression in the healthcare setting is on the increase, and that

all staff who have direct contact with patients and their relatives are vulnerable to such behaviour as part of their professional and job role (Viitasara 2004; Lawoko, Soares & Nolan 2004; Whittington 1997).

Studies have reported a wide range of incidence rates of workplace violence, between 20%-90%. This is due to variablilities in definition of violence used, the time frame observed, and the sectors studied. Nonphysical violence is far more prevalent than physical violence, and is more likely to occur to workers in health care and other service sectors, than workers in other areas (WHO 2002).

In 2000, the Department of Health conducted a national survey into the reported incidences of violence and aggression in NHS trusts and authorities in England (DH 2001). A total of 84 273 violent or abusive incidents were reported. This was an increase of some 24 000 over the previous year 1998–99 (the only other occasion on which this sort of information had been collected on a national basis). In 2001 they conducted a follow-up survey which showed a further 13% increase to 95 501 reported incidents (DH 2002). Reasons given for the increase included better awareness of reporting, increased hospital activity, higher patient expectations, and frustrations due to increased waiting times. In 2002–2003, the number had again risen to 116 000 (Health Services Commission 2003). Within this study the average number of incidents for NHS mental health and learning disability trusts was reported as being almost two and a half times the average for all other trusts, despite evidence that staff working in mental health units were much less likely to report verbal abuse as part of the job. This trend of increase in

violence on healthcare staff was further demonstrated by the Commission for Healthcare Improvement who conducted a survey of healthcare staff of which 203 911 responded (CHI 2004). It was found that 15% of these respondents had experienced physical violence at work in the previous year – usually from patients or their relatives – and that 37% had experienced harassment, bullying or abuse, again from patients or their relatives, over the same period. In 2009 the NHS Security Management Service commissioned a follow-up study to ones described above, to assess whether this picture had changed over time. According to figures published in the NHS Survey (NHSSMS 2010), the total number of reported physical assaults – not including verbal abuse – on all NHS staff was 60 385 in 2004 – 2005. This fell in 58 695 in 2005 – 2006 and to 55 709 in 2006 – 2007, but rose by 284 in 2007 – 2008 to 55 993.

Although there is a high risk of workplace violence across all healthcare occupations, most indicators suggest that it is the nursing profession that is most at risk, closely followed by ambulance and medical staff. Although it could be argued that this is because the number of nurses is far higher than that of other professional groups in healthcare, by examining the percentages of assaults by professional groups a measure of the incidence is obtained. This was shown in a survey of healthcare personnel across all departments of a general hospital by Whittington et al. (2002) who found that 21% had been physically assaulted over a one-year period, but that nurses at all levels were more likely to be assaulted than any other occupational group. The 2004 British Crime Survey similarly showed that female nurses had at least four times the average risk of job-related

violence and threats when compared with the average rate across all occupations (Budd 2004).

There would seem to be two main reasons why members of the nursing profession are reported to suffer the most attacks in the workplace. First, as was discussed previously, nursing staff are by far the biggest occupational group working in health care and thus the most likely to be the highest reporting profession. Secondly however, nurses spend most of their working day in direct contact with patients carrying out traditional nursing duties such as supervision of patient activities, monitoring patient whereabouts, administering medication etc. This exposes them to more contact time with patients and, consequently, increases the risk of attacks, and this is demonstrated by the higher incidence reporting in this professional group.

Furthermore, in the researcher's own area of clinical practice, professionals in the mental health sector have an increased risk of being exposed to workplace violence that is perpetrated by service users or patients (Bowers et al. 2007; Lowako et al. 2004; Clark 2002). The *"Promoting Safer and Therapeutic Services: Implementing the National Syllabus in Mental Health and Learning Disability Services"* (NHS Counter Fraud and Security Management Service 2005) detailed that in the year 2004/2005 a total of 43 301 physical assaults were reported in the areas of mental health and learning disability services. It was stated that this figure is considerably higher than those reported in other areas of

the NHS. Furthermore, although this is already an exceedingly high figure, it does not include reports of verbal aggression and intimidation.

Although aggression occurs frequently in psychiatric hospitals, most incidents do not involve serious violence or physical injury and most incidents are perpetrated by a small subgroup of chronically aggressive patients (Nicholls et al. 2006; Ehmann et al., 2001). Regardless of its nature or aetiology however, violence and aggression in psychiatric hospitals threatens the well-being and safety of patients and staff, and represents a substantial burden to administrators. The reporting of violence and aggression incidents is important to help identify and analyse trends in this type of behaviour both locally and nationally. This in turn informs practice and helps to establish a baseline for measuring improvement.

3.5 The reporting of healthcare violence and aggression

Under-reporting of violence at work is a major issue in the health sector (Ferns & Chojnacka 2005; Occupational Safety and Health Administration 2004; May & Grubbs 2002). According to the International Council of Nurses (2003), only one fifth of violence related cases are officially reported. Under-reporting of the occurrence of violence and aggression has been attributed to the absence of formal channels designed to record this information, lack of time, reluctance to fill in forms, fear of being blamed, embarrassment and an acceptance of violence and aggression as part of the job, while others fear that violent and aggressive behaviour from patients reflects their professional failure to manage challenging

situations appropriately (Linsley 2006; Ferns & Chojanaka 2005; Di Martino et al. 2003). Others do not report incidents simply because they do not believe that anything will come of it, either in terms of prosecution or feedback from their employer, and therefore feel reporting is a waste of time. Failure to address under-reporting of incidents is a major concern because it means that available data are incomplete, and the success or otherwise of strategies implemented to reduce violence will only be partially known (Mayhew & Chappell 2002).

Resistance to more accurate reporting has also come from some managers and hospital administrators who have sought to portray services in a positive light for fear of litigation and penalty for not achieving service improvements in a competitive market (McGregor 2006). Reporting of incidents also require an investigation and a response. Busy managers may discourage staff to report near misses, incidents that do not result in injury or harm, believing that even if they were to find fault, there was little they could do to affect change. Likewise, some managers may actively discourage staff from reporting near misses if it meant greater expenditure; it being cheaper to do nothing, despite legislation compelling them to do so.

Criticism has also been levelled at the reporting forms used (Scottish Executive Health Department 2007) and their inability to capture the necessary data required of clinical practice. For example, whilst persistent abuse may be assumed to have a detrimental effect on staff and those that they care for, it is

difficult to quantify the emotional distress caused by violence and aggression in the workplace. International research aimed at estimating the cost of workplace violence and stress (WHO) concluded that there are too many uncertainties and factors to consider, such as being able to identify the reasons for staff absence that limit such reporting.

The final observation to make concerning the violence and aggression to which all healthcare personnel are exposed is that serious assaults resulting in physical injury remain rare (NHSSMS 2010). While assaults can and do take place in healthcare settings, it remains the case that verbal aggression and threats of violence are much more common than actual physical violence. The repercussions from the latter can be more traumatic than the initial aggression for some staff though and there affect should not be under stated. Whatever its exact form, however, the fact remains that healthcare workers are disproportionately at risk of workplace violence.

3.6 The effects of violence and aggression on staff

The consequences of violence and aggression on the wellbeing of staff are becoming well documented. The cost of violence encompasses the victim, staff team and entire organisation (NICE 2006), though the psychological and emotional effects of minor incidents, such as fear, anxiety and reduced confidence (Millington, 2005) can be the equal of major ones (Needham, 2005) involving the more obvious physical injury and subsequent medical attention.

Reactions to aggression and threat vary from individual to individual and it is difficult to predict how a person may react to the threat of violence. There are however a number of studies that have shown that negative reactions are common following physical and verbal aggression and include anger, shock, fear, depression, anxiety, stress, sleep disruption, tearfulness, hyper alert state and dread of returning to work (Kindy et al. 2005; Zernicke & Sharpe 1998). These in turn can lead to more profound and disabling disorders such as post-traumatic stress disorder (Inoue et al. 2006; Chaloner 1995; Kindy et al. 2005; Chen et al. 2005; Whittington & Higgins 2002; Brennan 2001; Zernicke & Sharpe 1998). Emotional reactions from being attacked can take the form of rage, anxiety, a sense of helplessness, irritation, fear of returning to the location of the incident, and feelings and thoughts that something should have been done to prevent what happened. Violence and aggression also has ramifications beyond those directly involved. Research has shown that witnessing violence and aggression may lead to fear of violent incidents, and as such has similar negative effects to being personally assaulted or attacked (Hoel, Sparks & Cooper 2001).

Additionally, the exposure to physical violence is not solely confined to psychological reactions for the individual. Most psychological processes result in a behaviour and therefore adverse psychological changes resulting from an attack are also associated with behavioural reactions and change, such as social withdrawal. In turn, this can affect social relationships at work, as well as those relationships outside of work (DH 2006). Indeed, individuals who were frequently

exposed to violence at work have been found to have higher rates of absenteeism and provided a lower standard of care than those who were not exposed (DH 2001). Furthermore, marital problems and inability to become involved in social activity have also been reported (Poster & Ryan 2005; Williams 2002; Lindow & McGeorge 2000).

Aggression and violent incidents can be a source of substantial stress for healthcare staff. Research has indicated that aggression and violence affects staff both physically and psychologically, with verbal aggression, at times, being more detrimental than physical aggression. Preparing staff to manage aggression and violence through formal training may reduce these effects (Bowers 2006; Walsh & Clarke 2003). The benefits of staff training to manage aggression and violence are discussed in section 3.12 of this chapter.

3.7 Contributing factors

Violence and aggression within the healthcare workplace seems to have its origins in a number of factors. From the perpetrators' perspectives, emotional issues (such as fear or frustration) may lead some service users to react to their situation by expressing anger at the treatment provided – for example, general discomfort arising from being kept waiting in a crowed room can cause anger and upset in some individuals. Violent situations can also be exacerbated by certain medical conditions or the influence of alcohol or drugs (Scott & Resnick 2006).

It has been observed that not all staff are at equal risk of being attacked however. Several authors have found that it is recently employed staff and in turn less experienced staff who are more likely to be assaulted as compared with more experienced staff who have worked within an area for a number of years (Rose 2007; Ayranci et al 2006; Catlette 2005; DuHart 2001). This implies that attacks do not occur at random and that certain staff will be selected by the violent individual for attack. Cunningham et al (2003) in a survey of 512 mental health staff working in inpatient units found that during a six month period 83.3% of staff had been verbally threatened, 64.7% had been physically assaulted, and 38.8% had been injured. Staff that had been assaulted and injured during the six-month period were significantly younger, had more frequent contact with service users and were less experienced in working in the mental health field. These findings are supported by Lowako and colleagues (2004) who found similarly that staff younger in age and staff with less experience of working in mental health were more likely to be victims of patient violence and aggression.

Several studies (Bowers et al 2007; Duxbury 2002; Rix & Symour 1988) have found that nursing assistants were more likely to be victims of patient aggression and violence than registered nurses. An explanation for this is that nursing assistants are in more frequent contact with patients despite their relative lack of experience and training and are increasingly taking on the supervision and wellbeing of service users, as qualified staff take on more administrative roles (Green & Robinson 2005; National Audit Office 2003), thereby putting them at

greater risk. Surprisingly, gender has not been associated with the risk of violence (Nachreiner et al 2007; Gates, Fitzwater & Telintelo 2001). However, this is probably in part because many studies have not controlled for gender differences in the sectors where male and female nurses work. There are also a number of research studies to suggest that males are more prone to violent and aggressive behaviour than females (Sturrock 2012; Flood 2005; Esplen 2006). The difference in male violence is usually ascribed to the role of male as aggressor; governed by social norms and expectations which in part supports and gives licence to such behaviour (Morris 2007; Ruxton 2004; Laing 2001).

Staff attitude is another important issue (Duxbury 2003; Trenoweth 2003; Gudjonsson et al 2000). Aggressive verbal and nonverbal behaviour on the part of staff can escalate the patients distress and violent behaviour. When staff act in a controlling manner, patients are more likely to use aggression and violence to regain control (Linsley 2006). Thus staff who are authoritarian, disrespectful, or inflexible in their approach are more likely to provoke aggressive behaviour.

Locked units, inflexible unit structures, and non-therapeutic milieux can increase the risk of assaultive behaviour by suggesting that aggressive behaviour is acceptable or expected (Bowers et al. 1999). Overly strict unit structure may render staff unable to respond to service users empathically. In turn, service users may perceive the unit as coercive, controlling and threatening and feel their behavioural options are limited to disruptive, desperate, or violent acts (Bowers

et al. 1999). Such settings, it is suggested, can provoke the very behaviour they are intending to control.

There have also been changes in the way that services are provided that may increase both the likelihood and severity of assaults. For instance, more people work in the community, visiting people in their own homes or work in geographically isolated sites, making the summoning of help in difficult situations a problem (Chapman & Styles 2006; Wells & Bowers 2002; Brennan 2001). Form of employment (full-time or part-time working), working hours (day or night), work activities/tasks, organisational change (e.g. downsizing), and workload have also been studied (Quinlan 2007; Richards 2003; Noak et al 2002), and are factors that may increase or decrease exposure and risk to healthcare violence and aggression. Likewise, rising levels of client expectations, the redesign of the delivery of patient-centered care towards managed care, and increased level of acuity of patients (Cvitkovich 2005; Magin et al 2005; WHO 2003; Caskey 2001), may all contribute to violence and aggression and its management. Larger societal factors, such as changing societal norms around the acceptance of aggression may have an impact on the risk of workplace violence (International Council of Nurses 2007; Kennedy 2005). Factors leading to the destabilization of a community can spill over into the health care setting causing distrust, suspicion, and confrontation between patients and health care workers (Henry & Ginn 2002). These include high levels of violent crimes, drug use, gang activity,

low levels of community resources, the downsizing of the economy, or high poverty rates (Anderson 2006, 2002; Curbow 2002).

3.8 Predicting violence and aggression

A number of studies have tried to determine which patients are more likely to become violent. Demographic variables such as age, sex, race, marital status, education and socioeconomic level have not proved useful in predicting violent behaviour (Ontario Nurses Association 2003; Di Martino 2002; WHO 1996). In contrast, psychiatric diagnosis has often been correlated with assaultiveness (Mullen 2006; Swanson et al 2006; Trenoweth 2003). However, the ability of this to predict violence is complicated by the fact that many patients have more than one diagnosis. In addition, patients may have different clinical symptoms depending on the severity and acuity of their illness (Choe, Teplin & Abram 2008; Mayhew & Chappell 2002; McNeil 1998). Thus a patient's diagnosis is suggestive at best. In general, research indicates that two populations of patients are at increased risk of violence (Hartvig 2010). Firstly, those patients with active psychotic symptoms, particularly those related to perceived threat or overriding of internal controls, such as delusions or thought control. Secondly, patients with substance abuse disorders present as being an increased risk of exhibiting violent and aggressive behaviour. This is particularly significant in comorbid substance abuse has an added effect in increasing the risk of violence for people with major psychotic symptoms.

Although knowledge about the patient's history is important in evaluating risk for violence, it is also important to assess the patient's current clinical condition and situation. There are a number of early warning signs of increasing agitation that include physical and verbal signs of increasing anxiety, pacing and excessive body movement, increase in volume and tempo of voice (Needham et al. 2004; Bowers, Alexander & Gaskell 2003; Morales & Duphorne 1995). Studies report that correlates of violent behaviour include a variety of behavioural and cognitive cues such as conceptual disorganisations, loud verbalisations, tension, mannerisms and posturing, hostility, suspiciousness, uncooperativeness, hallucinatory behaviour, unusual thought content, excitement and disorientation (Winstanley & Whittington 2004; Skinner & Brewer 2002; Erdos & Hughes 2001).

Finally, situational and environmental factors are also believed to play a role in escalating patient behaviour from potential to actual violence (National Institute for Occupational Safety and Health 2006). This includes aspects of the physical facilities and the presence of staff and other patients. For example, several studies have found that the number of violent incidents is greater when patients move or gather in groups, are overcrowded, lack privacy, or are inactive (OSHA 2002; Carlson et al. 1989).

Although there has been some progress in determining reliable predictors of violence, a completely accurate prediction of patient violence is not possible. For this reason it is important that staff be taught and alert to symptoms of increasing

risk and agitation that could lead to violent behaviour, and learn how to intervene appropriately. A number of standardised risk assessment tools are available (Sturrock 2012) and promoted in clinical practice; consequently their use often form an important part of aggression management training programmes.

3.9 Current practices in the management of violence and aggression in clinical practice

According to the literature there are a number of interventions that can be employed when managing a potentially aggressive incident, these include: early intervention; the monitoring of self and our contribution to the situation (i.e. whether our presence is escalating and adding to the situation); providing options and choice (Di Martino, Hoel & Cooper 2003); avoiding physical confrontation (Whittington & Shuttleworth 2008); maintaining a distance; and exercising empathy for the persons' situation (Linsley 2006). The evidence suggests that these should form a fundamental part of aggression management training and are highlighted as good practice within a number of national policy documentation (NICE 2006).

Primary prevention involves the creation of a physical and social environment that minimises stress and triggers to aggression. Risk assessment and the use of staffs' interpersonal skills to identify precursors of aggression are examples of this. If aggression does occur, it may be diffused by use of appropriate communication skills, including de-escalation techniques (Linsley 2006). In

contrast, physical or 'controlling' means of managing acts of aggression are often used as secondary preventative measures for example, the use of seclusion and restraint (Bowers 2006; Paterson 2005; Duxbury & Whittington 2005). Although de-escalation and other strategies are frequently used they may not always be the final intervention made use of by staff to manage violence and aggression, but are commonly used in combination with other interventions. The type of interventions used can depend on the experience of staff involved, the safety of the situation and the underlying philosophy of care of the unit (Bowers 2006; Duxbury 2002).

In a study by Duxbury (2002), the nature and management of aggression and violence in 221 incidents on three acute mental health units was examined. A positive relationship was found between the type of patient aggression and violence and the interventions used. Despite that 70% of incidents involved verbal aggression (verbal abuse or verbal threats), and violence accounted for only 13.5% of the incidents, more controlling interventions such as seclusion and restraint were used in 47% of incidents, medication in 25 % of incidents and verbal intervention alone in 22% of incidents. Given that the majority of incidents were verbal in nature and a high number of incidents involved controlling interventions, suggests that methods in managing patient aggression and violence continue to be underpinned by traditional philosophies of care (Duxbury 2002).

Wynn (2004) in a retrospective study over a five and a half-year period in a Norwegian university psychiatric hospital, found that there were 797 episodes of physical restraint, 348 episodes of pharmacological restraint and 88 episodes of seclusion. Whilst the study examined patients' characteristics and the interventions used, Wynn suggests physical restraint may have been used more often for patients who were dangerously violent, or there was a fear of injury. In one fifth of emergencies leading to seclusion, failure to calm the patient led to pharmacological restraint being administered. In less than 3% of emergencies leading to restraint and seclusion, patients were initially restrained pharmacologically.

In a study by Parkes (2003), 750 aggressive and violent incidents were reported during a three-year period from four mental health units. Of these aggressive and violent incidents, 48 involved physical aggression against other patients, 214 involved deliberate self-harm, 69 involved destructive behaviour, 92 involved physical aggression at staff, and 324 involved verbal aggression. For these incidents, seclusion was used in 137 incidents, medication was used in 197 incidents, and restraint was used in 169 incidents. Controlling interventions such as seclusion, or restraint, were commonly used for violent incidents directed at staff.

Lowe and colleagues (2003) examined the importance of different types of interventions used by staff in managing aggression and violence in acute mental

health admission units in a single specialist NHS Trust. One hundred staff were sent questionnaires with 10 scenarios on aggressive and violent incidents and 10 accompanying statements. The response rate was 72% with findings indicating that limit setting was highly important in managing aggression. Nursing staff with more experience made less restrictive judgements, therefore suggesting that increased knowledge may lead to increased confidence, thus enabling highly experienced staff to manage patients in less restrictive ways.

Further evidence regarding the role of staff perceptions and knowledge in determining their use of particular aggression management strategies comes from Foster, Bowers and Nijam (2007). Their study of aggressive incidents in five UK acute in-patient psychiatric wards suggested that staff were over-estimating the seriousness of patient aggression when staff were threatened, and as a result were potentially over-reacting with controlling management means. It appears then, that staff reactions may relate more to their beliefs and perception of the seriousness of the behaviour in question.

Several authors argue that the most restrictive measure needs to be the very last measure utilised by staff and that policies and guidelines on care must reflect this value (Johnson & Delaney 2006; NIMHE 2004; Cricton & Calgie 2002; Whittington & Wykes 1996). Sullivan writing in 1998 contested that physical contact skills are the nurses' last resort and that education for nurses needs to incorporate prediction of escalation, de-escalation skills, negotiation skills, verbal

intervention skills, limit setting skills and ongoing one-to-one skills and support. These sentiments are echoed by the International Society of Psychiatric Mental Health Nurses (ISPN) (2006) who recommends that conflict resolution, problem solving and de-escalation are the primary response tools for an escalating situation and that restraint and seclusion must be understood as a last resort; this latter point is reflected in aggression management training and within policy documentation. There is however, an inherent danger in attempting to claim a totally restraint/seclusion free mental health environment as the consequence may be the "insidious escalation in use of medication management" (Paterson 2005: 21).

Viable alternative responses to physical restraint do exist (Johnson & Delaney 2006; Leadbetter & Paterson 2004; Bowers et al. 1999). Indeed, the insistence that restraint is used as a means of last resort implies the existence of such alternatives and their desirability. For example, involving the patient in discussions on how to best avoid seclusion and restraint is an extremely valuable exercise if the opportunity arises during the course of admission (Nolan & Citrome 2008; Bowers et al 2006; Morales & Duphorne 1995). There are also a number of potentially beneficial pre-escalation strategies. These include: approaching patients with caution, not startling the patient, avoiding provocation whenever possible, being aware of your facial expression and posture (neutral being best), the use of calm, respectful language, open ended sentences, avoiding challenges and promises, removing of dangerous objects from your

person, being aware of exists, avoiding vulnerable positions (don't turn your back), use of distraction and redirection and finally being firm but compassionate (Nolan et al. 2003; Leadbetter & Paterson 2004; Distasio 1994). Again these are skills that are covered or form the basis on which violence and aggression management training are developed.

The use of 'therapeutic holding' as a form of control and restraint for individuals who have a learning disability is explored as an option by Stirling and McHugh (1998) and advocated by the British Institute of Learning Disabilities (BILD 2001). This technique is defined as one where the staff member utilises physical touch and holding as a method for aiding the patient in gaining control of themselves. A therapeutic holding technique is not recommended as a part of the de-escalation process in mental health care because the primary target for de-escalation is often the angry, psychotic or mentally unwell person who is unlikely to respond positively to an invasion of their body space. In fact, the escalating mental health patient may require considerably more body space than usually accepted in one to one encounters (Davidhizar & Newman 1997).

3.10 National Policy and Guidance

It is only within recent times that specific guidance, policy and practice indicators for the management of violence and aggression have been developed. Most of the national policy and guidance relating to the management of violence and aggression is aimed at mental health and learning disability services and care

provision. When reviewing policy responses to violence and aggression in services 'zero tolerance' is a concept that is often referred to. The origins of the term zero tolerance in the context of violence in the NHS is interesting. The phase does not appear with the launch of the then new strategy to tackle violence in the English NHS announced in 1998 (DH 1999). At this time NHS Trusts were charged with ensuring that any incident of violence against staff was reported and properly recorded. They were also tasked with establishing relationships with the police and prosecution services in order to pursue sanctions in cases of violence against staff. By April 1999 Trusts were, in addition, required to set targets for reducing 'the growing threat of violence against staff' by 20 per cent by 2001 and by 30 per cent for 2003 (DH 1999: 5). It was not until October 1999 that such initiatives were officially subsumed under the heading of zero tolerance and to a large extent re-launched as the 'zero tolerance zone campaign'. An accompanying resource pack entitled 'We don't have to take this' was also produced (DH 1999). Frank Dobson, then secretary of state for health, stressed:

> *'Staff working in the NHS go to work to care for others. They do not go to work to be victims of violence. Aggression, violence and threatening behaviour do not go with the job and will not be tolerated any longer'* (p2).

Zero tolerance was official Department of Health policy from 1999 until its replacement by a much broader programme of activities coordinated by an

Executive Agency of the NHS Counter Fraud & Security Management Service (CFSMS) in 2003. This followed a report by the National Audit office in 2003 which found that while some progress had been made in protecting NHS staff from violence, although four-fifths of Trusts had failed to meet the zero tolerance target of a 20 per cent reduction in violent incidents by April 2002.

Following on from this, the CFSMS produced a strategy document in 2003 entitled 'A Professional Approach to Managing Security in the NHS.' This document was produced with the objective of introducing minimum standards of security management across the NHS in England. One of the key components of this strategy is the provision of conflict resolution training for staff. This required employers to implement mandatory conflict resolution training for staff working in acute and primary care services (CFSM 2004). This non-physical intervention training aimed to improve interactions and provide staff with the skills required to prevent conflict escalating to aggression and/or violence (CFSMS 2004). Also in the same year, the National Institute for Mental Health in England published their guidance, Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health Inpatient Settings: Mental Health Policy Implementation Guide (NIMHE 2004). This was designed to offer guidance to mental health service providers in order that they may review their current policies and procedures relating to education, training and practice in the safe and therapeutic management of aggression and violence.

In October 2005 to ensure the standardisation of training across the UK, the NHS Security Management Service introduced the first national syllabus for non-physical intervention training in mental health and learning disability services (Paterson & Miller 2005). At the time of publication it was recognised that variable low-risk alternative strategies to improve service user and staff safety did exist and were already being implemented in some services. For example, The British Institute of Learning Disabilities (BILD) had contributed to significant practice changes aimed at raising awareness, challenging stigma and improving safety, including a voluntary accreditation structure for training providers (Allen 2000 a, b).

The implementation of the standard syllabus was augmented by The National Institute for Clinical Excellence (NICE 2005) guideline 25 Management of Violent (Disturbed) Behaviour in Adult Psychiatric In-patient Settings which reviewed the salient literature and made a number of recommendations for practice in relation to impacting factors. This document provides recommendations which include the need to address the environment and alarm systems, antecedents, warning signs and risk assessment, training, working with people from diverse backgrounds, de-escalation techniques, observation, physical interventions, seclusion, rapid tranquillisation, and practices in Accident and Emergency departments. This guidance can also be applied to other services to aid the development of robust violence reduction strategies. Again the need to undertake a full and proper risk assessment was highlighted. It stated that all mental health

services providers should ensure that their services have a full risk management strategy for assessing risk and preventing violence.

The need to work with service users more closely was also highlighted within the guidance (NICE 2005). This requires service users with the potential for violence and aggression to be treated with dignity; their needs assessed; and the opportunity to be, as far as possible, involved in the planning and execution of their own care (Hahn et al 2006). This recognises the clients' right to make decisions for themselves and take responsibility for their actions and behaviour. Current practice requires greater sensitivity to the social environment and the advocacy needs of patients and their families. Enabling people in care to take risk, make choices, and keeping them safe is a difficult balance however. Central to this debate is the need to evaluate therapeutic interventions in combination with considerations of public and private safety. The ill effects that may occur from a wrong decision may include loss of esteem, anger and alienation while the benefits are the protection of the client and others from harm (Berg & Hallberg 2000).

The management of violence and aggression in the workplace is a highly complex multi-factorial issue, which involves significant commitment from management and staff in order to successfully define, analyse and provide solutions, in accordance with the level of risk. It should also be appreciated that not all violence and aggression can be prevented. Due to the nature of workplace

violence and aggression and the range of relevant factors such as unpredictability, mental health issues, stress and environmental factors, the risk of violence and aggression cannot be eliminated. Thus, where the violence cannot be prevented, staff must be aware of the range of control measures including policies and procedures, one of which should involve training requirements. This will enable them to manage the situation to a reasonable conclusion, minimising the risk to themselves and others of violence and/or aggression. Training and ongoing educational needs for staff need to be tailored to the individual needs of staff and those that they care for rather than a blanket acceptance that all staff will follow a set educational package.

3.11 Aggression management training in the health and social care sector

Aggression management training has been used to prepare staff to care for aggressive patients for a number of years now (HSE 2006; Bowers 2004; Duxbury & Paterson 2005). Components of previous published training programmes have included legal issues regarding the management of aggression and violence and the safety of staff (Deveau & McGill 2007; Hurlebaus & Link 1997; Whittington & Wykes 1996), the stages of aggression (Jonikas et al 2004), the triggers of aggressive behaviour (Linsley 2006; NIMHE 2004) the promotion of self awareness in the response of aggression behaviour (Foster, Bowers & Nijman 2007); interventions in response to aggressive and violent behaviour (Bowers 2003; Calabro et al. 2002; Hurlebaus & Link 1997; Whittington & Wykes 1996; Goodykoontz & Herrick 1990; Martin 1995; Infantino

& Musingo 1985); reporting and monitoring strategies (Infantino & Musing 1985); self-care and support following an aggressive incidents (Goodykoontz & Herrick 1990; Whittington & Wykes 1996); and lone and team working (Martin 1995). This training has generally been specific to the speciality and required staff to be regularly updated. Within mental health and learning disability services the focus of training has been on the understanding, description and treatment of violent and aggressive patients (Elliott 1997). Essential elements of aggression management courses include risk assessment, de-escalation skills, communication skills and physical restraint skills whilst ensuring the care, welfare and safety of all involved (BILD 2006; Beech & Leather 2003; Caraulia & Steiger 1997; Delaney 1996; Toppings-Morris 1995).

Clinton, Pereira and Mullins (2001) claim that de-escalation skills are particularly vital to the nursing staff who work in a close observations, intensive management or psychiatric intensive care setting. The authors' recommended areas for nursing education and training are on cultural awareness and sensitivity, advanced risk assessment, violence response, de-escalation, control and restraint as well as divisional tactics. Delaney (2001) also reiterates the 'critical-ness' of staff education in lowering restraint usage and states that de-escalation and other non-coercive therapies should be aimed at helping staff to individualise their care of patients. De-escalation has also been a tool of mental health nursing for many years (Duxbury 2003; Hastings, Thompson-Heisterman & Farrell, 1999; Paterson, Leadbetter & McComish, 1997; Sullivan, 1998; Stevenson, 1991). For

the purposes of this study, de-escalation is defined as a gradual resolution of a potentially violent and or aggressive situation through the use of verbal and physical expressions of empathy, alliance and non-confrontational limit setting that is based on respect. The education of this skill, as an important factor in the development of a therapeutic relationship, has long been an essential part of the curriculum for Mental Health and Learning Disability Nursing (NMC 2004). Whilst the use of de-escalation skills is highlighted and advocated by both practitioners, healthcare bodies and professional groups; physical interventions often form the assessed components of aggression management training programmes (Grey and McClean 2007; Snell et al 2005; Parkes 2003) and it is argued here perpetuate the use of such skills above more less evasive forms of intervention, such as de-escalation.

The length of training programmes has also varied. While some aggression management programmes have been presented for one day over a course of four months (Goodykoontz & Herrick 1990) others have spanned over one (Whittington & Wykes 1996), three (Infantino & Musingo 1985) or 10 days (Patterson et al. 1992) consecutively. Although little is reported on the teaching methods used for these programmes, the most common methods have been video aids (Hurlebaus & Link 1997), a written text (Calabro et al. 2002), role plays (Morrison & Love 2003; Calabro et al 2002), lectures, demonstrations and discussions (Morrison & Love 2003).

Training in aggression management has been recommended for all staff regardless of discipline (Morrison & Love 2003; Whittington & Wykes 1996; Martin 1995; Grainger & Whiteford 1993; Rosenthal, Edwards & Ackerman 1992; Thackeray 1990). As far back as 1987 the Health Service Advisory Committee recommended that training in the prevention and management of violence should be available to all staff groups who come into contact with patients and relatives and not only those working in high risk areas (HSAC 1987: 7). Ten years later this advice was further developed (HSAC 1997) by suggesting that staff managers also need training (to learn how to manage incidents and perhaps in order to gain a better appreciation of the training), and by specifying content for different levels of training. In addition to this they also provided guidance for employers on violence and aggression in the health-care sector, suggests that 'good training programs' are 'appropriate for all groups of employees at risk from violence' and these programs should include: (i) theory – understanding aggression and violence in the workplace; (ii) prevention – assessing the danger and taking precautions; (iii) interaction – with aggressive people; and (iv) post-incident action – reporting, investigation, counselling and other follow up (Health Service Advisory Committee 1997: 19).

This was supported by the Royal College of Nursing (1998: 29) and other professional bodies, who advised employers to provide appropriate training and education for their staff '... commensurate with the degree of risk they face'. Beale et al (1998) suggest that training in aggression management should start

during the induction and orientation process and be repeated (refreshed) regularly. In their guidelines for mental health settings, the Royal College of Psychiatrists (1998) suggested that training for all staff should include self-awareness and knowledge of risk factors.

Chappell and Di Martino (2000) also endorsed regular, up-to-date training as part of a battery of preventive strategies and measures that include selection and screening of staff, information and guidance-giving, work organization and job design, defusing incidents and post-incident de-briefing. Indeed, many authorities now advocate appropriate staff training not as a stand alone solution but as part of a comprehensive, coordinated health and safety response to the phenomenon of work-place violence (Beale et al., 1998; Bowie, 2000; Cembrowicz & Ritter, 1994; Cox & Leather, 1994; Dickson et al., 1994; Hoel, Sparks, & Cooper, 2001; HSAC, 1997; Royal College of Psychiatrists, 1998).

In 2005 The Health and Safety Executive undertook a UK study on the violence and aggression training received by healthcare staff. Entitled, Violence and Aggression Management Training for Trainers and Managers (HSE 2005) the research sought to identify the competencies that made for good aggression management training. The report highlighted that training should be undertaken on a need basis and equal to the risk faced by staff as part of their job; that training should be set within an organisational framework, in line with local and national policies and procedures on dealing with violence and aggression; that

training include a range of primary preventative strategies which did not rely upon teaching physical interventions alone; and that training be subject to on going evaluation and in line with good practice indicators. The latter was to be achieved through the interpretation and evaluation of best practice examples and reports where they existed and compared against an individual organisations needs and resources.

3.12 Evaluation of Aggression Management Training Programmes

To date there is a relative paucity of well-designed evaluation studies into the effectiveness of the training to prevent and manage violence in healthcare settings. A report by the National Audit Office (2003) concluded that although there was lots of evidence of training in violence management being offered to staff within Healthcare there was little evidence based information regarding its effectiveness. Many programmes evaluate to the level of staff reactions to the course (Duxbury 2002, Healthcare Commission 2007; McGeorge 2007) and though such evaluation can be useful in improving training programmes, it does not demonstrate how learning has been integrated into practice or the benefits to the employing organisation, patients and staff. Routine evaluations of training effectiveness most often employ evaluation forms asking immediate subjective responses to 'satisfaction' questions. Beech and Leather (2003) argue that course attendees are typically asked to score the usefulness, relevance, and level of interest of course material.

The fact that substantial variability exists between the different training programs suggests that programs lack standardization; however, it is also consistent with recommendations that staff training programs be individually tailored to the specific needs of the particular setting, context, or patient population (Anderson, 2002; Wright, 1999). Unsatisfactory results form these studies do not necessarily mean that the programmes are inadequate, but highlight the importance of the need for alternatives for frontline staff in addition to providing educational programmes (Collins 1994). Furthermore, much of the training in aggression management is undertaken by private companies who are reluctant to undertake and share evaluations of their courses:

3.13 The need for evaluation

Planning, implementation and evaluation are all essential components of aggression management training programmes. The planning and implementation stages of any aggression management programme are vital for ensuring successful outcomes. Effective planning and implementation allows staff to look ahead towards the most appropriate evaluation activity (each stage informs the other). The planning and implementation phases of an aggression management training programme, however, are only part of the process and therefore should always be monitored and followed up by an evaluation phase. Not to do this would in most cases invalidate what had gone on previously, as well as provide no real means with which to measure the position, validity, outcomes or success of the programmes as they progress (Chapman et al. 2009). When conducting

training, most providers do not usually take into account the entire constituent parts of a programme process (HSE 2006). It is more likely to be the planning phase that receives the most attention. It is rare to see evidence of evaluative process in training programmes of this kind. This might well explain the dearth of literature offering effective examples of aggression management training, especially with regard to evaluation.

Properly conducted evaluation can help tailor services to meet needs of users and can identify areas which need improvement. It can also be used to help support the case for funding. Showing that services work well and meet client needs can help attract further support. Evaluation can be used (Dowie et al 1996): to help in the design of services, to assess how well the services are working, and to find out whether services are effective

Another important point to remember about the advantage of evaluating programmes of activity is that it allows practitioners to design and implement new ones. They can learn from the strengths and weaknesses of previous programmes. Reviewing previous programmes then becomes an integral part of aggression management work as practitioners become more conversant with evaluative techniques. This helps to avoid the situation where the failure of aggression management programmes is attributed purely to failure of staff to comply or perform as expected. Evaluation also informs the development of

programme methodology, ensures that ethical practice is adhered to and helps to assess the training activity in relation to its impact on clinical practice.

3.14 Chapter Summary

This chapter has examined workplace violence, including patient-perpetrated violence in healthcare settings. Increasingly, violence and aggression is being seen as largely preventable (Occupational Safety and Health Administration, 2004). Accordingly, healthcare organizations are expending considerable resources in the hopes of reducing the actual and potential costs that are associated with patient-perpetrated violence and aggression (Farrell & Cubit, 2005). What is also clear is that training is often held to be a primary element of the strategy for combating work-related violence. Indeed for many Trusts and other Healthcare organisations, training programmes in aggression management are now an essential feature of organisational life. For these reasons, programmes need to be evaluated to determine their effectiveness and justify their continuation (Paterson, Turnbull & Aitken 1992). The question is no longer "should we train?" but "is training worthwhile and effective?" A second, equally important question emerging from this study is 'what should training evaluations evaluate'? It is no longer sufficient to rely on expert opinion and judgements of what is effective or ineffective training; all training must be evaluated and underpinned by evidence about its effectiveness.

To date there has been a paucity of well-designed studies into the effectiveness of the training to prevent and manage violence in healthcare settings. With this in mind, the following study was developed and asked the question how effective was each training programme in preparing staff for coping with violence and aggression they might encounter as part of their role?

Chapter 4

Methodology

4.0 Introduction

In the previous chapter, the literature review examined the provenance of aggression management training programmes in health and social care and concluded that there was a paucity of evaluative studies into the effectiveness or otherwise of aggression management training for healthcare staff. This justified the aim of this research which was to evaluate how effectively the two aggression management training programmes in this study equipped staff with the necessary skills, attitudes and knowledge to manage healthcare violence and aggression in their area of work. To examine this aim effectively required the selection of an appropriate methodological approach.

After considering a range of methodologies realistic evaluation was chosen as the most effective approach and the chapter continues with a description of the key principles of realistic evaluation (Pawson and Tilley 1997) before detailing how these principles have been translated into research methods for use in the current study. Applications of realistic evaluation have largely focussed on evaluating initiatives in the field of social policy (Rycroft-Malone & Bucknell 2010; Norris & McCahill 2006; Pawson & Tilley 1997) and recently in health and social work practice (Kazi et al. 2008; Regehar, Stern & Sklonsky 2007; Tolson et al. 2006), but the literature review revealed no realistic evaluation of aggression management programmes. Consequently this study is original in its use of the

methodology, which was chosen because of the direction it provides in exploring not only the impact that aggression management training has on staff but the circumstances in which these are played out in clinical practice. The chapter also provides an explanation for why certain methods and strategies were employed whilst others were rejected and discusses the ethical dilemmas associated with conducting the research. From this base, it is shown how instruments suitable for use within this research were developed and the processes of data collection and analysis are then described in chapter that follows this (Chapter 5).

4.1 Methodology

In order to safeguard against common scepticism, the possibility, and actuality of knowledge needs to be demonstrated by identifying sound means and methods of acquiring that knowledge (Reed & Proctor 1995). Hughes and Sharrock (1990) suggest that it is necessary for philosophical issues to be regarded as the preliminary ones that need to be addressed in order that sound methods for enquiry can be laid down in advance of the research itself. They go on to state that although research methods may well be treated as simply instruments, in fact they operate within sets of assumptions. Epistemology of this kind is concerned with what we accept as knowledge – how we know what we know. More strictly speaking it is the branch of philosophy 'that investigates the possibility, limits, origin, structure, methods and validity (truth) of knowledge' (Delanty & Strydom 2003: 4). Its primary focal point may be said to be demonstrating how and why we may be certain of (or even sceptical of), the

world in which we live. In other words, epistemological theories seek to ascertain the possibility of 'true' knowledge based on secure foundations, in contrast to 'true' knowledge based on erroneous foundations or erroneous knowledge based on secure foundations (Richards 1999). These debates consequently lead to the choice of research paradigm which in turn has implications for the choice of methodology and method of data collection and analysis.

Traditionally these questions have been responded to from two divergent paradigms, those of positivism and interpretive research (Lincoln & Guba, 1985). This in turn has had an impact on the way that researchers have viewed and approached their studies and their choice of methodology and data collection. This is because Positivist and Interpretivist paradigms look at the world from different perspectives and as such require different instruments and follow different procedures to collect and analyse the type of data that they desire. Sarantakos (1998) suggested that the extent to which a paradigm influenced the choice of methodology and method was the result of three main distinctions between them, these being: 'how they perceive reality, how they perceive human beings and what they perceive as the nature of science.'

Whilst this study used Pawson and Tilley's (1997) Realistic Evaluation Framework to structure the research, it was conducted within an interpretivist paradigm. An underlying premise of this is that the subject matter of the social sciences (that is, people and their social world) does differ from the subject

matter of the natural sciences. A key difference being that the objects of analysis of the natural sciences (atoms, molecules, gases, chemicals and so on) cannot attribute meaning to their environment. However, people can and do. As a result of this, many interpretivist researchers express a commitment to viewing events and the social world through the eyes of the people that they study. Trauth (2001) elaborates on this when she discusses the factors that influence a researcher's decision to adopt a particular approach. She argues that choice of approach is governed by the, 'research problem; the researcher's theoretical lens; the degree of uncertainty surrounding the phenomena; the researcher's skills; and academic politics' (Trauth 2001: 4).

The management of violence and aggression can be seen as a social construct (Kiriakos et al 2012) and its meaning subject to changes in social norms across time and geographical areas. The use of a pure experimental design, such as a randomized control trial, was rejected outright both on practical and moral grounds. Even if it were somehow possible to control all the variables over the course of the study it was not perceived as morally acceptable to randomly assign staff to either a 'to be trained or control' group especially when violence management training is deemed to be mandatory. Instead what was needed was a methodology and methods that would reflect and in part capture the complexities of the topic and the real world in which the people and events were played out. It was for this reason that I turned to the social sciences and eventually decided upon the use of realistic evaluation.

4.2 Evaluation

Evaluation is recognised as a research approach in its own right and is used extensively in both health and education to maintain and improve the quality of programmes. In its broadest sense, evaluation is a systematic process to understand what a programme does and how well the programme does it (Weiss 1998). Furthermore, it is the examination of events or conditions that have (or are presumed to have) occurred at an earlier time or that are unfolding as the evaluation takes place. In order to do this, these events or conditions must exist, must be describable, must have occurred or be occurring. Evaluation then is retrospective in that the emphasis is on what has been or is being observed, not what is likely to happen (as in forecasting) (Rossi, Lipsey & Freeman 2004: 10).

There is some degree of disagreement in the distinctions often made between the terms 'evaluation' and 'assessment'. Some practitioners would consider these terms to be interchangeable, while others contend that evaluation is broader than assessment and involves making judgements about the merit or worth of something or someone. When such a distinction is made, 'assessment' is said to primarily involve characterisations – objective descriptions, while 'evaluation' is said to involve characterisations and appraisals – determinations of merit and/or worth. Merit involves judgements about generalised value, while worth involves judgements about instrumental value.

Evaluation is said to be 'useful' when it provides feedback that can be understood and used by a variety of audiences, including staff, managers, client-groups and other interested parties (Rossi, Lipsey & Freeman 2004); often in regards to whether a programme as achieved its intended goals or not. Whilst assessing the outcomes of a service, intervention or programme, is important, outcomes can mean different things to different people. If a service has specified goals or objectives then an obvious outcome is to access whether these have been achieved. A serious shortcoming of this tight objectives-linked approach is that services and interventions involving people are notorious for having unintended and unanticipated consequences (either in addition to, or instead of, the planned ones). Increasingly, researchers are using different approaches to evaluation, whilst many of these maintain an element of outcome evaluation; they seek to evaluate other elements of the programme or intervention.

4.3 Evaluation of training

The model of training evaluation by Kirkpatrick (1959, 1976) is credited with revolutionizing the thinking on training course evaluation and is still the most influential and commonly used (Greene et al 2005; Stake & Abma 2005; Huebner & Betts 1999). This model is structured around four levels (Reaction, Learning, Behaviour, and Results); each measuring complementary aspects of a training course. At the most basic level one, evaluation tends to take the form of gauging student satisfaction with a particular teaching session and is usually captured on evaluation forms, completed by students at the end of a teaching

session or module. This level of evaluation is useful for teachers or programme planners to know if the students liked the content and the way that is was presented, so that changes can be made if necessary. Level two attempts to take the feedback further by checking whether participants' knowledge has improved. This may be evaluated through various assessments, such as written assignments or observations of practice. The third level seeks to establish whether participants have applied their learning in practice, usually through direct observation and job performance measures. Level four estimates the value of the training on the organisation and whether it as improved the services delivered. An advantage of identifying levels of evaluation is that the model alerts the evaluator to the need to address more than one level for a comprehensive approach. However this model of evaluation is now considered outdated; as Kraiger et al (1993: 319) argued, approaches to evaluation that include 'reaction measures' or indicators of how students rated the quality of training delivered, place too much importance on behavioural or cognitive measurement and in doing so provide an incomplete profile of learning. Gagne (1984) similarly argued that attitudes should be included as learning outcomes on the grounds that attitudes can determine behaviour. Accepting such criticisms, Barr et al. (2000) elaborated on Kirkpatrick's (1967) original model to include the modification of attitudes as a learning outcome for a review of interprofessional education. What Kirkpatrick (1967) and others had missed is that such evaluation models focus on the programme itself, as if all programmes are delivered in the same way and the circumstances in which participants' practise are likewise identical. This

important issue is addressed within a Realistic Evaluation framework (Pawson & Tilley 1997) and would be the main consideration in choosing this approach for use in this study.

4.4 Selecting an approach to evaluation

The development and expansion of evaluation theory and practice is at the core of several different disciplines. It is important to scrutinize theories, approaches, and models used in evaluation (research) as well as evaluation philosophical underpinnings to research, as it is these that govern and inform the means and methods by which evidence is collected and analysed.

Greene (2001: 984) differentiated between four genres of formal evaluation: post-positivism, utilitarian pragmatism, constructivism and critical social sciences. The first is said to promote the values of 'efficiency, accountability, cost-effectiveness [and] policy enlightenment', where quantitative methods such as experiments and quasi-experiments are employed based on a positivist ontology which subscribes to an epistemology that relies on secessionist principles that begin with a theory of causal explanation. A pragmatic approach to evaluation was promoted by Patton (1997) who emphasised the importance of utility to the stakeholders, such as mid-level managers and on-site administrators (Greene 2001). Patton (1997) had listed fifty-eight types of evaluation, claiming that the list was not exhaustive. Each type has a specific focus and defining question or approach. A judgement focus for instance, questions a programme's merit or

worth whilst a descriptive focus asks what happens in a programme without making a cause and effect analysis. The constructivist or interpretivist approach, that Greene (2001) attributed to Stake (1995), but which was also strongly promoted by Guba and Lincoln (1989), values the understanding of personal experience, which is sought through qualitative methods such as case studies and open-ended interviews. Greene's (2001) final epistemology of critical social sciences, promotes values such as empowerment, social change and critical enlightenment through stakeholders' participation in the qualitative research process, which begins with their involvement in setting the evaluation agenda and continues through to interpretation and action.

Guba and Lincoln (1989) categorised evaluation approaches in terms of 'generations'. Using educational research as an example, they described the first generation of evaluation as the measurement of school children's test scores, seen in the work of Rice and Binet, and Galton (in Guba and Lincoln 1989) during the late 19th century, where the role of the evaluator was technical. The pupil's achievements were the focus of the evaluation. A criticism of this approach is that reading and writing scores alone do not always take into account the numerous factors affecting a child's education such as socio-economic and cultural background. However it is important to note that such evaluations continue to be used today. They may be used to provide statistics on the number of students achieving a particular grade or educational standard numerical standard. The second generation, according to Guba and Lincoln

(1989) was characterised by descriptions of patterns of strengths and weaknesses in relation to stated objectives, so the focus moved from the student to objectives of their programme (e.g. Tyler 1976). Stake (1967) however argued that descriptions neglected an alternative aspect of evaluation, namely, judgement. Until the emergence of this so-called 'third generation', which retained both the technical and descriptive functions, evaluators had presented findings, but made no judgement upon them.

Although Guba and Lincoln (1989: 21) argued that , 'there was no right' way to define evaluation', they were critical of the commitment to the scientific paradigm of inquiry, and the tendency towards 'managerialism' that they perceived in the first three generations. By 'managerialism' they mean the situation in which the 'manager', commissioner of an evaluation, or sponsor stands outside of the process and therefore, if a failure in the programme is identified, other personnel are blamed. Since the manager also decides the extent to which the results will be published, Guba and Lincoln (1989) argued that the stakeholders, or those affected by the evaluation results, will be disempowered. So a lack of attention to the question of whose values would dominate an evaluation or how value differences might be negotiated, became a problem to be addressed by the next (fourth) generation. Guba and Lincoln (1989) made their contribution to the fourth generation within a constructivist paradigm, which is defined by a relativist ontology in asserting that there exist:

'multiple, socially constructed realities ungoverned by any natural laws, causal or otherwise (Guba and Lincoln 1989: 84).

In contrast to working within a positivist paradigm the researcher becomes close to the participants, negotiating with stakeholders, such as trainers, throughout each stage of the research process in a way that seeks to educate and empower all involved. An evaluation based on constructivist beliefs would focus on the process or internal dynamics of the programme, rather than the outcome. A problem with the constructivist view is that it takes no account of the social structures and political context that are independent of an individual's reasoning. In view of this omission, the approach may be appropriate in limited circumstances.

From the above critique, it was clear that I found neither a positivist nor a constructivist approach appropriate to evaluating aggression management training. Rather I considered evaluation based in a realist paradigm to be more suitable and I now explore this further.

4.5 Theory-driven evaluation

As forerunners to realistic evaluation, Chen and Rossi (1981) advocated, 'theory-driven', evaluation, which seeks to identify how or why a programme outcomes are achieved. Theory-driven evaluation has been created in many different ways and used for a number of purposes (Funnell 1997; Schon 1997; Weiss 1995;

1997; Lenne and Cleland 1987). In some evaluations, the programme theory has been developed largely by the evaluator, based on a review of the literature on similar programmes; through discussions with key informants, or through the observations of the programme itself (Lipsey and Pollard 1989). In other evaluations, the programme theory has been developed primarily by those associated with the programme, often through a group process. Many practitioners advise using a combination of these approaches, must notable, Pawson and Tilley (1995), the originators of Realistic Evaluation. Within this diversity, it is possible to identify two board clusters of practice. In some programme theory evaluations, the main purpose of the evaluation is to test the programme theory, to identify what it is about the programme that causes the outcomes. This sort of programme theory evaluation is most commonly used in large, well-resourced evaluations focused on such questions as, does this program work? And should this pilot be extended? These theory testing evaluations wrestle with the issue of causal attributions – sometimes using experimental or quasi-experimental designs in conjunction with programme theory and sometimes using programme theory as an alternative to these designs. Such evaluations can be particularly helpful in distinguishing between theory failure and implementation failure (Lipsey 1993; Weiss 1997).

The other type of programme evaluation is often seen in small evaluations done at the project level by or on behalf of project managers and staff. In these cases, programme theory is more likely to be used for formative evaluation, to guide

their daily actions and decisions, than for summative evaluation. Such program theories are often not concerned with causal attribution (Donaldson, 2007; Donaldson & Lipsey, 2006; Lipsey, Rossi, & Freeman, 2004; Patton, 2008). Although this type of programme theory does not show the relationships among different components, these relationships are sometimes explored in the empirical component of the evaluation. Although some of these evaluations pay attention to the influence of external factors, there is rarely systematic ruling out of rival explanations for the outcomes. Many of these evaluations have been developed in response to the increasing demands for programmes and agencies to report performance information and to demonstrate their use of evaluation to improve services. In these circumstances, programme theory evaluation has often been highly regarded because of the benefits it provides to programme managers and staff in terms of improved planning and management, in addition to its use as an evaluation tool.

4.6 Realistic Evaluation

Realistic evaluation is form of theory driven evaluation, developed by Pawson and Tilley (1997) based on the philosophy of critical realism. Critical realism is an important perspective in modern philosophy and social science (Archer et al. 1998, Robson 2002), but is to a large extent absent in the field of health service research and in particular aggression management. Critical realism was developed as an alternative to traditional positivistic models of social science as well as an alternative to post-modern approaches and theories of constructivism.

The most influential writer on critical realism is Roy Bhaskar (1978, 1989, and 1998) and this is acknowledged by Pawson and Tilley in their work.

A key premise to critical realism is that the concepts of truth and falsity do not provide a coherent view of the relationship between knowledge and object. Rather, knowledge is a social and historical product. Mancias and Secord (1983) emphasised the complexity of the real world, where more complex layers of reality are found to explain other levels. This means that participants' actions will be embedded within the social organisation of the National Health Service, the hospital or community environment, as well as their own personal experiences of health care. Indeed Pawson and Tilley (1997) contended that:

> *A programme is its personnel, its place, its past and its prospects* (Pawson and Tilley 1997: 65).

Realist evaluation seeks to identify how and why programme outcomes are achieved. Before the time that Pawson and Tilley (1997) developed realistic evaluation, Palmer's research (1975) into the behaviours of offenders, suggested that, rather than asking what works for offenders as a whole, a more relevant question is,

> Which methods work best for which types of offenders under what conditions or in what type of settings (Palmer 1975: 150)

In their Realistic Evaluation, Pawson and Tilley (1997) translated this notion, to argue the importance of finding out:

> *What works for whom in what circumstances* (Pawson and Tilley 1997: 220)

And further that:

> *It is not programmes which work, as such, but people co-operating and choosing to make them work* (Pawson and Tilley 1997: 36)

In this view, it will not be possible to say that the training does or does not work, because the context, in which the training takes place, along with the mechanisms by which participants learn, must be taken into account. This is not the same as identifying confounding variables as in experimental research, where these are eliminated as far as possible to ensure validity. On the contrary, in realist evaluation, the mechanisms and contexts form part of the explanation. In the present study, the training will be undertaken by different people in different settings, at different times etc., resulting in different outcomes.

Rather than seeking causation and generalisation as an end-product, as in succession theory, or the 'specification of the constructions held by the

multiplicity of stakeholders' (Pawson and Tilley 1997: 118), to which constructivists are committed, a realist evaluator searches for 'cumulation' (Pawson and Tilley 1997: 119). By 'cumulation' they do not mean simply completing a series of studies with reliable evidence that can be applied universally, but the need to develop 'middle-range theories' defined by Merton (1968: 39) as:

> *Theories that lie between the minor but necessary working hypotheses that evolve in abundance during day-to-day research and the all-inclusive systematic efforts to develop a unified theory that will explain all the observed uniformities of social behaviour, social organisation and social change* (Merton 1968: 39).

Concepts of truth and falsity do not provide a coherent view of the relationship between knowledge and its object. Rather, knowledge is a social and historical product. So, knowledge of facts gained from research do not simply speak for themselves and the task of science is to invent theories or explanations to explain the real world. Pawson and Tilley (1997) summarised the notion of 'theory' from the work of Merton (1968), Boudon (1980) and Sayer (1984), to identify a range of meanings of the term, including:

Methodology, general orientations, empirical generalisations, hypotheses, explanations, paradigms, causal propositions and middle range theory (Pawson and Tilley 1997: 120).

The choice of method open to the realist evaluator is pluralistic. Pawson and Tilley (1997) argued that it is perfectly possible to carry out realistic evaluation using a variety of data collection methods but the selection should be made with reference to the proposed theories or explanations.

Pawson and Tilley (1997) described the logic of realist evaluation as follows:

The basic task of social inquiry is to explain interesting, puzzling, socially significant regularities. Explanation takes the form of posting some underlying mechanism, which generates the regularity and thus consist of propositions about how the interplay between structure and agency has constituted the regularity. Within realist investigation there is also investigation of how the workings of such mechanisms are contingent and conditional, and thus only fired in particular local, historical or institutional contexts (Pawson and Tilley 1997: 71)

Realists, further argued Pawson and Tilley (1998):

Build upon mechanisms, contexts and outcomes, whilst theorists of change rely on the distinction between program activities and early, intermediate and longer term program outcomes (Pawson and Tilley 1998: 84).

Realist explanation, therefore, is based on the proposition that causal outcomes follow from mechanisms acting in contexts. A realist evaluation cycle involves framing theories which identify and explain regularities, deriving hypotheses concerning what might work for whom in what circumstances, testing these through multi-method data collection and analysis, which can them inform further generalisations and lead to revision of theory and new hypotheses. Thus, we begin by expecting measures to vary in their impact depending on the conditions in which they are introduced and actioned.

Theory includes proposition on how the mechanisms introduced by an invention into pre-existing contexts can generate outcomes. This entails theoretical analysis of mechanisms, contexts, and expected outcomes. This can be done using logic of analogy and metaphor. The metaphor of the 'mechanism' is used to explain how a programme may or may not work. The step is taken from asking whether a programme works to what it is about the circumstances of the programme that makes it works. The second step consists of generating "hypotheses". Typically the following questions would be addressed in the hypotheses: 1) what changes or outcomes will be brought about by an intervention, 2) what contexts impinge on this, and 3) what mechanisms (social,

cultural and others) would enable these changes, and which one may disable the intervention. A mechanism explains what is responsible for the 'regularity' (Pawson and Tilley 1997: 71) or outcomes found in the results of the study. The relationship between causal mechanisms and their effects is not fixed but contingent (upon the context in which the mechanisms are activated) (Sayer 1984: 107). As Pawson (2002) has argued, some programmes may work for some people, some of the time. The third step is the selection of appropriate data collection methods. In this step it might be possible to provide evidence of the intervention's ability to change reality. Based on the result from the third step, we may return to the programme (the intervention) to make it more specific as an intervention of practice. Next, but not finally, we return to theory. The theory may be developed, the hypotheses refined, the data collection methods enhanced, etc. This process is articulated and illustrated in the formation of context, mechanism, outcomes or CMOs which will now be explored in greater depth below.

4.7 Context, mechanism-outcome pattern configuration

Realistic evaluation stresses four key linked concepts for explaining and understanding programmes: 'mechanism', 'context', 'outcome pattern', and 'context-mechanism-outcome pattern configuration'. Context-mechanism-outcome pattern configurations (CMOs) comprise models indicating how programmes activate mechanisms amongst whom and in what conditions, to bring together mechanism-variation. The sign of good evaluation is that it is able

to explain the complex signature of outcomes (Mark et al, 2000) arrived from this process.

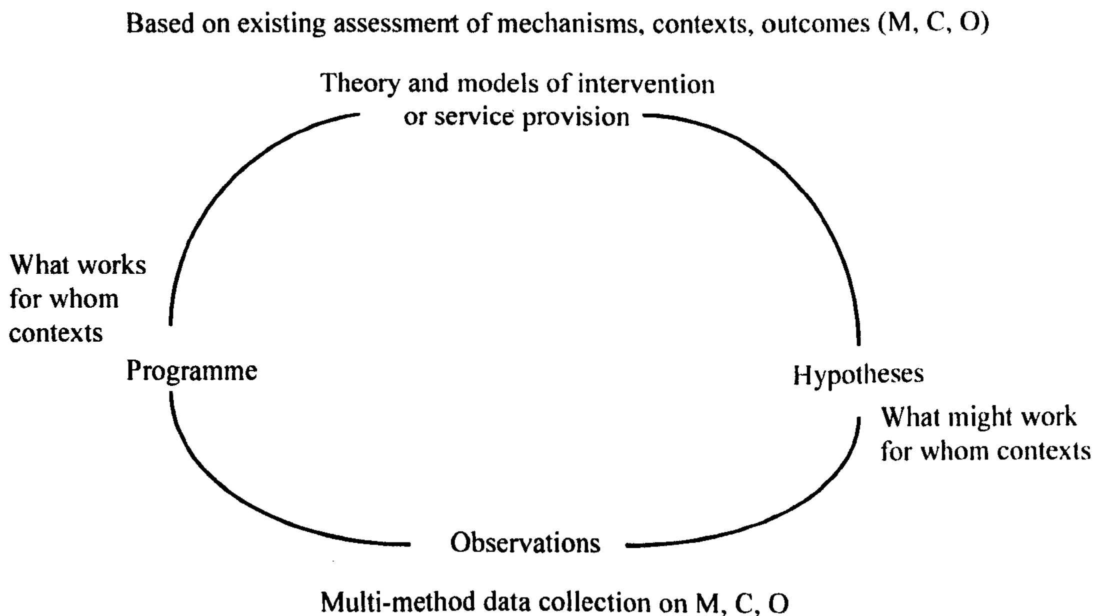


Figure 2: The realistic evaluation cycle (Pawson & Tilley, 1997; Kazi, 2003)

A CMO configuration is a proposition stating what it is about an initiative which works for whom in what circumstances. This *process* of how subjects interpret and act upon the intervention stratagem is known as the programme 'mechanism' and it is the pivot around which realist research revolves. The metaphor of the 'mechanism' is used to explain how a programme may or may not work. The step is taken from asking whether a programme works to what it is about the circumstances of the programme that makes it works. By 'works', it is meant the beneficial impact on the participants of the individual programmes. It would be insufficient to suggest a programme works just because of its introduction into a clinical area. In this view, it would not be possible to say that

aggression management programmes work or don't work, because the context in which the education takes place, along with the mechanisms by which participants learn must be taken into account. This is not the same as identifying confounding variables as in experimental research, where these are eliminated as far as possible to ensure 'validity'. On the contrary, in realist evaluation, the mechanisms and contexts form part of the explanation.

Identifying the crucial programme mechanisms is only the first step in a realist evaluation. It is also always assumed that they will be active only under particular circumstances, that is, in different contexts. Contexts describe those features of the conditions in which programmes are introduced that are relevant to the operation of the programme mechanisms. Realism utilises contextual thinking to address the issues of 'for whom' and 'in what circumstances' a programme will work. In the notion 'context' lies the realist solution to the panacea problem. For realism, it is axiomatic that certain contexts will be supportive to the programme theory and some will not. And this gives realist evaluation the crucial task of sorting the one from the other.

Programmes are almost always introduced into multiple contexts, in the sense that mechanisms activated by the interventions will vary and will do so according to saliently different conditions. Because of relevant variations in contexts and mechanisms thereby activated, any programme is liable to have mixed outcome patterns. Outcome - patterns comprise the intended and unintended

consequences of programmes, resulting from the activation of different contexts. Realism does not rely on a single outcome measure to deliver a pass/fail verdict on a programme. Nor does it make a hard and fast distinction between outputs (intermediate implementation targets) and outcomes (changes in the behaviour targeted). A realistic evaluation researcher is not just inspecting outcomes in order to see if an initiative (implementation) works, but is analyzing the outcomes to discover if the conjectured mechanism/context theories are confirmed.

4.8 End point

In the critical realist world view, aggression management programme outcomes cannot be explained in isolation; rather, they can only be explained in the sense of a mechanism that is introduced to effect change in a constellation of other mechanisms and structures, embedded in the context of pre-existing historical, economic, cultural, social and other conditions.

In this way, effectiveness of the programme is apprehended with an explanation of why the outcomes developed as they did, and how the programme was able to react to the other underlying mechanisms, and in what contexts. This analysis provides not only evidence of effectiveness, but also an explanation that helps to develop and to improve both the content and the targeting of future programmes.

As part of this process critical realism places an importance on the social world in which people move, and that to understand the behaviour, values and

meanings of any given individual (or group), account must be of the culture in which they operate. The objective then is to display the social organisation of activities, as they are revealed through involvement in the natural setting of the activity. The researcher's attention is directed towards participants' subjective perceptions of their own experiences with the aim of presenting these perceptions clearly and understanding their basic structure and meaning through a process of interpretation (Field & Morse, 1994). The critical realist tries to make sense of what people are doing by asking 'What's going on here? How does this work? How do people do this? And hopes to be told by people about 'the way we do things around here' (Pawson & Tilley 1997). To this end realistic evaluation does not attempt to verify pre-existing theory; rather it focuses on the discovery of theory.

By studying social phenomenon within the context of realistic methodology the emphasis is on coming to terms with the meaning and experience of those being studied within their natural circumstances, that is the sense and the experiences participants use to construct, maintain and negotiate courses of social action. The implications of this position are far reaching. The accounts that participants give to their actions are indexed to particular situations (i.e. time, space, place etc.), and though similarities may exist between each other's accounts, they tend to conceal complex, local-specific meanings. The similarity is the outcome of glossing (Code 1996) whereby in everyday life we employ a range of taken for granted rules (i.e. unsaid and tacit norms and conventions), which we fail to

acknowledge or avoid discussing. Second, the application of social rules (i.e. acceptable behaviour within a given situation) requires individuals to make judgements about meanings (i.e. social etiquette and engagement). However, there can be no definitive means by which we can arrive at such judgments; indexicalibility inhibits generalisations because there are no privileged accounts, and it undermines explanations because rules do not have an objective existence outside the situated accounts. Instead, rules are resources upon which people routinely draw in the situated nature of their activities.

4.9 The researcher perspective

The methodology of this study places me in the role of both researcher and subject with the interaction between these roles being dynamically intertwined, at times converging and overlapping, necessitating critical awareness of the multiple identities I will have in the research process (Alvesson & Skolberg 2000). This required commitment and level of participation are particularly compatible with the realist paradigm and as I am a familiar participant in the study environment the methodological approach necessitated a reflexive approach. This was considered an important contribution to the validity of the study and to rendering the findings more reliable. Not only would using this method potentially bolster the validity of the data collected but there were more pressing ethical considerations to be heeded.

I consider it philosophically obtuse to deny the existence of, and thus impossible to divorce my personal experiences as a researcher and educator and nurse from the research situation. By accumulation of educational, professional and life experiences I inevitably bring my own cultural perspectives to the project (Hardy & Mulhall 1994) and my personal relations to it. Therefore it is of crucial importance and entirely necessary to explicitly identify my own inner conflicts and beliefs and to use them as an essential part of the data being collected. I recognised my situatedness and relatedness to the subjects and field of study and was acutely aware of the potential to privilege one form of knowledge i.e. my position, over another was a concern. I recognised my own objective position within the field of study and not accept individual accounts at face value. The field of study was filtered through my theoretical and realist perspective, and as a consequence reflected my personal history and dispositions. Thus by the act of participation I will have had an effect on the study (Hammersley & Atkinson 2007) and conversely the study will have had an effect on me (Coffey 1999).

Critiques of insider researcher approaches focus on the context of the research as being too 'familiar' thereby by inhibiting interpretations of behavioural patterns and sociocultural groups. The lack of 'reality shock' (Kramer 1974) may result in commonplace behaviours being ignored and the development of a 'nothing happened syndrome'. Whereas Spradley (1979) argued that 'the most productive relationship occurs between a thoroughly enculturated informant and a thoroughly unenculturated ethnographer' (p58). Critiques of the emic approach

suggest the potential for bias is based on the use of a familiar language where key signals can be overlooked, a superficial analysis due to the tacit patterns the researcher takes for granted, and finally the informant's discomfort which can distort the informant-researcher relationship. However, as a point of balance it was noted that research undertaken for the personal development of the insider researcher may be seen as less threatening (Sandelowski 2000), as in examples of studying for higher degrees.

Having spent a number of career years working in the field of study I openly acknowledged my personal beliefs, values and prejudices. This enabled me to make the 'familiar' strange and remain open to possible alternative meanings throughout the project and also arising from the data. It was considered morally indefensible and pragmatically impossible to attempt to conceal my purpose for entering the working culture of the training world. It would have produced more problems than it would have solved as professional relationships, based on trust, would have been confused and the quality of the data compromised.

4.10 Summary

The above brief exposition of the characteristics of realism and realistic evaluation, demonstrates how realism as a philosophy of science and realistic evaluation as a methodology have been constructed to stand between the poles of positivism and relativism. Whilst offering a middle way, however, realism does not claim a privileged access to the truth (Sayer 2000). Nevertheless, at the

same time it is possible to offer one approach as superior to the other. In this thesis I argue that for the purposes of this study, realist evaluation is superior to experimental designs and those based upon wholly constructivist perspectives for the reasons discussed above.

Prior to explaining my reasons for selecting Realistic Evaluation (Pawson and Tilley 1997) as the methodology for the present study I reviewed some of the many possible choices available to the evaluation researcher. Rather than confirming the general opinion that aggression management training is a 'good thing', the methodology of realistic evaluation helps to explore the conditions under which such a programme might work. The following chapter will provide an outline of how the overall management of data was achieved by describing the methods used for data capture and analysis.

Chapter 5
Data Collection and Analysis

5.0 Chapter Overview

Having described the methodological underpinnings of the study in the previous chapter, I now go on to discuss how I collected and analyzed the data. In keeping with the chosen methodology (see previous chapter) the study was conducted using a mixture of methods, including semi-structured interviews, questionnaires, and direct observation of training. These will be discussed separately for ease of presentation. A detailed account of my approaches to data analysis is provided. The data analysis methods adopted was that of thematic analysis advocated by Bryman (2008) and the 3-stage approach to data construction and thematic networks advocated by Attride-Stirling (2001).

The chapter starts with a general introduction to the design of the study. It then discusses the process by which I gained ethical approval. The formulation of the contexts, mechanisms and outcomes (CMOs) used in this study is then discussed. Data collection methods are then explored before detailing how the mixed data sets were analyzed. The chapter ends with a discussion as to the validity and reality of the study.

5.1 Introduction

In thinking about study design, one of the challenges faced was the need to be confident that outcomes in terms of aspects of participant capability could genuinely be attributed to features of the training provided. An important question

for this study was not which training was best, but 'what worked for whom in what circumstances'? Although I was unable to describe conditions prior to, or in the absence of, the training, I was nevertheless eager to assess which of their features seem to be associated with key outcomes and with what strength of effect. The over-archiving aim of this study was to develop a methodology for evaluating the effectiveness of the two training programmes in equipping staff with the necessary skills, attitudes and knowledge to manage healthcare violence and aggression in their area of work. This is an area in which the existing literature suggests there is a paucity of research. The research sought to:

- Produce an evidence-based evaluation of the effectiveness of the two training programmes.
- Compare and contrast the strengths and weakness of each programme
- Determine whether the data collected during this study could be used as an educational resource in violence and aggression management training
- Develop recommendations for improving the training that staff receive in the management of violence and aggression

In Chapter Three it was shown that much of the existing research has been done on aggression management using quantitative methods within a positivist paradigm. The result of this emphasis is that there is little understanding of the

mechanisms and processes through which aggression management activities are created in the training of staff and then used in clinical practice. The objectives of the research described here were to reveal the complexities of this activity through focusing on aggression management training and its effectiveness in preparing staff to cope with this behaviour in clinical practice.

Within this context, a decision was taken to adopt a more flexible research design using Pawson and Tilley's (1997) framework of Realistic Evaluation (the philosophical underpinnings of which were discussed in the previous chapter). This approach was appropriate as notions surrounding aggression management training and its usefulness were exploratory rather than concrete. The logic of realistic evaluation led to the development of five 'mini' but interconnected studies designed to collect data concerning outcomes, mechanisms / intervention and context over the course of a year and are described below.

Before going further with this chapter it is important that the issues relating to the ethical standing of the study be discussed and an account given as to how ethical permission for the study was obtained.

5.2 Ethics

The following four ethical principles governed this research study, dignity, autonomy, beneficence, and justice (Beauchamp & Childress 2001). The first two principles, dignity and autonomy, acknowledged the person as an individual and

requires people with diminished autonomy, for example, those detained under a Section of the Mental Health Act, to be provided with special protection. It also requires that participants give informed and valid consent to participate in the research and that they be allowed to withdraw from the study at any time. The second principle of beneficence requires the researcher to protect individuals by seeking to maximize anticipated benefits and minimize possible harms. This requires the researcher to carefully examine the design of the study and reduce the risk to participants by changing the design of the study if necessary. The final principle of justice requires that the researcher treat participants fairly and as equals.

As the researcher I strove to protect the rights, privacy, dignity and wellbeing of those taking part in the study treating participants as I would want to be treated myself. I ensured that I observed workplace policy and procedure and was respectful of the wishes of those that I interviewed and came into contact as part of the study. Participation in the study was voluntary and based on informed consent; participants had the right to withdraw their consent at any time and all data was anonomised to further protect the individual.

5.2.1 Ethical approval

Ethical approval was granted by the University of Lincoln in September 2007 (for the initial study from which this work developed, including the development and

piloting of the research instruments) and again in January 2008 (for the main study including the participant survey).

Ethics approval was also sought and granted in April 2008 from the NHS Multi-centre Research Ethics Committee (MREC). The original proposal was accepted provisionally, on the requirement that specific key questions were addressed and some minor points of clarification made. A copy of this correspondence and approval are included in Appendix A.

Having gained ethics approval from both my employing University and MREC I then had to comply with the research governance procedures. This included becoming a honorary member of staff for each Trust in order to collect data from the various training sites and clinical work areas.

5.2.2 Ethical considerations

Realizing that the data collection process may be a rare opportunity for staff to discuss sensitive and complex issues, consideration was given to their wellbeing. Participants were encouraged to contact their staff support and counseling services in the event of an upsetting disclosure.

Whilst the research involved no physical intervention it may well have involved an affective component. When recalling possible incidents of violence and aggression some of the participants might have become emotionally upset.

There was the moral issue of whether I should be encouraging participants to expose themselves without knowing much about their past experiences and possible unresolved conflicts. Therefore, where issues of concern emerged, or apprehension over the wellbeing of the respondent or others occurs, data collection would cease. The welfare of the respondent takes precedence, ensuring support is provided where necessary (Streubert & Carpenter 1999).

5.2.3 Ethical procedure

All participants were fully informed of the purpose of the research through an information sheet and consent form which was sent out with the pre-course questionnaire. Participants were assured that any responses that the researchers received would be anonomised and kept confidential, and were informed that participation in the course evaluation was voluntary and individuals were free to withdraw from the research at any time without being penalized or disadvantaged in any way.

Participants were assured that the study was being conducted for scholarly research purposes only and that under no circumstances would their names or identifying characteristics be revealed except where incidences of bad practice were highlighted. In addition, the researcher assured participants that the interview questions had 'no right answer' and that the goal of the interview was to discover their perspectives on aggression management strategies and

techniques and the effectiveness of their training in preparing them for such encounters.

5.3 The development of CMOs for this study

Demonstrating the effectiveness and impact of healthcare education and training programmes is complex and requires an evaluation design that not only gathers reliable and valid evidence but also enables such evidence to be translated into useable guidance regarding the content and delivery of aggression management training (NIMHE 2004; BILD 2001).

Pawson and Tilley (1997) have given examples of realistic evaluation with reference to crime prevention and shown that the installation of closed circuit television cameras (CCTV) alone does not reduce crime. Rather, the cameras work by instigating a chain of reasoning and reactions in potential criminals. Realist evaluation is therefore about developing theory of the mechanisms through which the potential criminal thinks about CCTV, and the contexts needed to trigger such thinking. However, as Pawson and Tilley (1997) emphasized, the goal of realistic evaluation is not to construct theories per se, but to help programme and policy makers in their decision making. Translating Pawson and Tilley's ideas into aggression management training requires a recognition that any given programme will only bring about a change in clinical practice if triggered by particular mechanisms acting in context, e.g. if the conditions are right. It is the identification, analysis and explanation of these issues that will

assist stakeholders, staff and trainers in taking forward aggression management training.

To begin evaluating a programme using the principles of realist evaluation, the researcher frames theories in terms of propositions about how the mechanisms are triggered. Pawson and Tilley (1997: 88) called such theories, ''folk theories' suggesting that they develop from people's experiences. These are developed further upon analyzing the data derived from the chosen methodology, which may be qualitative or quantitative, or both. Each Context Mechanism Outcomes (CMO) construction (see previous chapter for underpinning theory as to their construction) forms the basis of a 'mini-experiment'. Through a measurement of a series of CMOs it should be possible to deduce the features of contexts that allow different mechanisms to work to achieve particular outcomes. Thus 'transferable lessons' may be learned (Pawson & Tilley 1997: 90).

The development of meaningful CMOs requires a great deal of skill on the part of the researcher. He or she must have a knowledge and understanding of the subject that they are to investigate and explore. In explaining their meaning of theory, Chen and Rossi (1983) suggested that evaluators should use their prior knowledge and experience of the varying circumstances surrounding the programme and build this into the investigation. As an aggression management trainer and mental health nurse, I put my knowledge and experience to develop the first CMO configuration of the study (Box 1 below).

Box 1: The CMOs used as part of this study.

	Context	Mechanism	Outcome
CMO 1 **RELEVANCE**	The training provides a link to clinical practice and staff can relate to what is taught with actions taken back on the job.	Staff value and see the relevance of the training they receive and readily engage with the instructors and activities during the course of the programme.	Staff have confidence in the techniques taught and knowledge gained from the course and are able to incorporate these into their clinical practice.
CMO 2 **CAPABILITY**	Staff are able to articulate and demonstrate a range of knowledge and skills with regards to the management of violence and aggression as a consequence of the training that they receive.	This knowledge and range of skills is equal to the level of risk faced by staff in clinical practice and is again reflected in the confidence displayed by staff in their willingness to intervene in an escalating situation.	Staff employ a range of skills and strategies when managing escalating patient aggression appropriate to situation and its safe management.
CMO 3 **CONFIDENCE**	Staff are allowed to practice and develop their aggression management skills within the clinical environment in order to maintain a level of competence in their use.	Staff are supported and encouraged to practice their aggression management skills within the clinical environment.	Staff report a confidence in their knowledge and skills as a result of them having been allowed to practice these since completing the course.
CMO 4 **ATTITUDE**	Staff display a more positive attitude to the management of violence and aggression as a result of the training that they receive.	Staff employ and are more ready to engage in preventative measures and seek alternative strategies when managing violence and aggression in their work area.	The use of physical interventions is reduced as is the number of reported violent incidents.
CMO 5 **ORGANISATIONAL SUPPORT**	Staff feel supported by the organization for which they work and see evidence of this support in policy and practice when exercising aggression management strategies.	This feeling of being supported encourages staff to take control of escalating situations of aggression by having clear guidance and understanding as to what is expected of them in managing an aggressive incident.	Staff are confident in what they have to do and feel supported by the employing organization, again leading to early intervention and better management of an aggressive incident.

5.3.1 CMO One: Relevance

A person's commitment to learning relies on a confidence and belief that the learning is first achievable, and secondly that it has relevance to their role; the way in which the teaching and assessments are designed and managed, is an important part of the learning and development process and should reflect these two core conditions (James and Biesta 2007). The first CMO was built upon the assertion that in order for staff to be able to manage violence and aggression they need to acquire the **relevant** skills and knowledge (Bowers et al. 2006; Health and Safety Executive 2006; Patterson and Duxbury 2006) for use back in clinical practice. This mechanism proposed that if the training had relevance to staff and to their practice, they would be able to make sense of what was taught and use it back in the job. The outcome of this would be that staff readily incorporated skills and knowledge learnt as part of the course into their practice. The context in which this mechanism is triggered is that staff see a **relevance** in what is being taught and actively engage with the training.

5.3.2 CMO Two: Capability

A key measure of the success of any training programme is the extent to which a staff member exits the programme with a perceived **ability**, self-belief and confidence that they have the necessary knowledge, skills and understanding to be able to deal and cope with the conflict situations that they might face in the work environment (HSE 2006; Welsh Audit Office 2005; Keogh 2001). Put simply, staff should feel more **capable** of handling incidents of violence and

aggression following training than they did before attending the training. This CMO proposed that staff would be able to articulate and demonstrate a range of knowledge and skills with regards to the management of violence and aggression as a consequence of the training they had receive and that this knowledge and range of skills was equal to the level of risk faced by staff in their area of work.

5.3.3 CMO Three: Confidence

The third CMO suggested that staff grew in **confidence** in managing incidents of violence and aggression owing to the training they had received. This in itself has a number of facets which were explored as part of the study; namely the extent to which trainees thought the content of training had practical **utility** and was **transferable** (Bowers 2010; Duxbury 2007; McKenzie 2003) to the workplace; the extent to which trainees were able to make use of skills taught back in clinical practice; and the **confidence** and **support** to try out new ways of working back in clinical practice.

5.3.4 CMO Four: Attitude

It has been suggested that aggression management training has the potential to challenge and change staff attitudes to the management of violence and aggression in clinical practice (Bowers et al. 2006; Duxbury and Whittington 2005; Duxbury 2003; McKenzie 2003). The fourth CMO proposed that there would be a change in staff **attitude** towards the management of violence and aggression owing to the training that they had received, and that this meant they

were more likely to pursue preventative rather than reactive strategies in the management of violence and aggression; highlighted as good practice in the literature review (for example; NHSSMS 2006; Patterson and Duxbury 2006; BILD 2001).

5.3.5 CMO Five: Organizational Support

The fifth and final CMO suggested that staff needed to be **supported** by the organization for which they worked in order to maximize the effects of training and aid transfer of skills and knowledge from classroom to practice setting. Support and endorsement from management can greatly enhance training results; this latter point is highlighted as important in the aggression management training literature (See Chapter 3). This final CMO recognizes that in order for aggression management to be affective then it requires organizational and managerial support and that staff recognize and acknowledge this as part of their work.

The development of CMOs in this study followed a self-evident logic, or as Outhwaite (1987:19) called realism a 'common-sense' approach. It made 'sense' that training should meet the requirements of participants and that participants could use what they had learnt in clinical practice. In order to achieve this required an understanding of the needs of the participants and be reflected in the relevance of what was taught and assessed as part of training. End user utility

would be the measure by which the success or otherwise of the training would be judged.

Some CMOs (see Box 1 below) were rejected on formulation, for example, the CMO below suggests that patients respond differently to staff because of the training they had received.

Box 1: Rejected CMO Configuration

Context	Mechanism	Outcome
Staff respond to violence and aggression in a more measured and informed way based on the training that they received.	Patients have a greater confidence in the ability of staff to deal with aggression and are more willing as a consequence to engage with staff when troubled or upset.	The use of physical interventions is reduced as is the number of reported violent incidents.

This above all the other CMOs proposed highlighted a potential difficulty with the realistic approach. While it is possible to propose a plausible CMO such as this one (and, indeed, proposing CMO configurations alone is an important development), the specificity of the proposition can make data collection problematic. For instance, in this CMO data would need to be collected that not only demonstrated that the programme had an effect on the way that participants responded to their patients, but also how patients responded to them, and that

this was somehow attributable to the training that participants had received. Of course, this is more a realization of the limits of researcher than a criticism of the approach itself. I struggled to devise a means of data collection that would capture and reflect the relationship between the different components of the proposed CMO. The approach does require a far more stringent data collection than the one I could provide if the theory was to be translated into confirmed results, otherwise they would remain postulations about what might have occurred or be occurring rather than what actually happened. This is not to say that the CMO generated is not valid one, but required a greater level of expertise than I could supply at the time of the study.

What did became evident over the course of the study is that more than one mechanism may be at work at any one time to effect change associated with the identified outcomes, and furthermore, that activation of the mechanisms depends upon the context in which participants are placed and work.

5.4 Study design

In keeping with the chosen methodology the study was completed in multiple stages (Pawson and Tilley 1997) using a combination of data collection methods including semi-structured interviews, questionnaires, field work and participant observation (see Box 2 below). Each approach can be critiqued in respect of the depth of data that was generated, the experience and skills of the researcher, the likelihood of meeting the aims of the study and the time available (Morse & Field

1995). The data collection began in March 2008 and was completed in early January 2009. The study was divided into four phases (see Box 2 on the next page), each containing a mini study or studies.

Box 2: The Four Stages to the Study

PHASE	DATA COLLECTION METHODS USED WITHIN THIS STUDY
Orientation	• A comprehensive literature review (chapter 3) • Familiarization with programme material • Semi-structured interviews with stakeholders and lead trainers
Pre-course	• Administration of Questionnaire 1 one month before training (to ascertain participants' feelings, opinions and attitudes towards violence and aggression and its management).
During training	• Administration of Questionnaire 2 on the morning of training (participants' expectations of the course and how they were prepared for training). • Direct observation of training and participant feedback and comment on teaching and learning. • Administration of Questionnaire 3 on completion of training (what participants felt they learnt from the course and what they felt might be useful in their work).
Post-course	• Administration of Questionnaire 4 three months after completion of training (what they used in practice having attended the course). • In-depth interviews with a range of participants from across the two programmes three months after completion of training.

Mixed methodology, or triangulation as it is otherwise called, is broadly defined by Denzin (1978: 291) as "the combination of methodologies in the study of the same phenomenon." A mixed approach is considered as having been adopted where the mixing of methods occurs within paradigms, sampling, data collection, or analytic techniques (Greene et al 2005). Mixed methodology of this kind is philosophically congruent with the view that research paradigms exist upon a continuum rather than being competitively divergent (Rich & Parker 2003). The strength of such an approach is that the same issue can be explored from different and consequently fuller perspectives offering a greater understanding of the phenomena under investigation (Patton 2001; Glesne & Peshkin 1992) Each data collection method used represents one stage of a larger process; as Creswell (2007) has emphasized, data collection is not a discrete and separate task, but rather, "...a series of interrelated activities aimed at gathering good information to answer emerging research questions" (p. 118). One of the reasons for adopting realistic evaluation for use in this research is that it encourages and supports the use of mixed approaches.

5.5 Gaining access to participants

Once the services had agreed to participate in the study, the first step was for me to visit the two Trusts to meet with key staff and explain the research in more detail. It was through these initial meetings that the various stakeholders were identified and permission to interview them sought. Practical issues such as my attendance at training days were also discussed as was my role within the

research and matters of confidentiality and reporting and dissemination of findings. These meetings were an opportunity for the researcher to gain a greater understanding of the aggression management programmes under investigation and to start to familiarize myself with the trainer providers. Notes taken of these meetings provided valuable information that fed directly into the research evaluation process.

Negotiating access to a range of participants from both programmes was critical to the success of my data collection. The first step in gaining access was to identify the gatekeepers who were in positions to either enable or block access. I began with meeting with senior administrators with the two Trusts to explain the study and garner their support. They fully endorsed my proposed study, provided me with the relevant background information, and suggested strategies for engaging with participants' participation in interviews and identified opportunities for observation both in training and in practice settings. Using the information letter about the study I provided them, they emailed various people to tell them of my study and their cooperation in it.

5.6 The use of semi-structured interviews in this study

Interviewing, a commonly used method in qualitative research, tends to refer to in-depth, semi or loosely structured forms of interviewing (Mason 2002). Although widely used, interview data are considered useful if treated as a contextual account and not a reproduction of reality (Green and Thorogood 2004). Different

people represent reality in different ways (what works for whom in what circumstances). In this study, I chose to conduct face to face personal interviews with participants to hear accounts of their experiences of aggression management training and what value it held for them in clinical practice. In addition, I was interested in identifying any conflicts or tensions arising in trying to put into practice skills and knowledge learnt as part of attending the programmes.

Semi-structured interviews were first conducted with stakeholders (N=6) and the Lead Trainers (N=4) for the two programmes in the orientation phase of the study to establish the content and need for training. The interview guide was based on the Health and Safety Executives Training Needs Analysis Framework (HSE 2006) and sought to understand how each of the programmes had been commissioned and developed.

A second set of semi-structured interviews were conducted in the post course phase of the study with participants from the two programmes (N=24). The aim of these interviews was to explore the experiences of participants in greater detail. A semi-structured interview schedule was used to ensure further exploration of key issues initially investigated with the questionnaires, concentrating on those which appeared to be most important to the participants. Focus was on the participants' perceptions and thoughts of the training and how useful and pertinent were the skills learnt in clinical practice. Participants were also encouraged to elaborate on any issues of particular importance or relevance to

themselves. The interviews were based on the purpose of the study and my previous experience of working as an aggressive management programme instructor and were prepared in advance. In the course of the interview I asked additional questions on the basis of the information gained through participant observation in the field. Purposive sampling was employed to ensure participation from individuals with relevant knowledge/experience.

Interviewing offered a number of advantages as a data collection method for this study. I selected this method because I considered that it would enable participants to express their perspectives and opinions on their experiences of aggression management training. The interviews focused on various themes identified from literature (allowing fluidity) and included mostly open-ended questions allowing the participant to express their feelings, emotions, attitudes, and opinions freely (Hoskins & Mariano 2004). I wanted to be able to question participants about their experiences, to explore various dilemmas that might be raised as they talked, and to gain insight into challenges encountered in the various contexts of their practice. I learned, for example, how organizational supports for aggression management in the two Trusts had been developed over the years, such as formation of a training department dedicated to this type of training and the how the two programmes had been developed.

5.6.1 Pilot interviews

I piloted the interview schedule in order to determine if my questions could be understood by participants and to solicit feedback. I also wanted to ascertain the extent to which the conversation flowed naturally. I also wanted to identify approximately how long the interview would take and make sure that the technical aspects of my recording system worked well. Pilot interviews were conducted with two trainers not related to either programme that I know through personal acquaintance. My choice of using the two trainers for the pilot was a pragmatic one. Both informants provided feedback at the end of the interview process. Some minor adjustments were made to the wording and sequencing of the questions.

Additionally, it was important that the questions were clearly worded and asked what I wanted to learn (Patton 2002; Berg 2001). I conducted and read the transcripts of the two trainers, and evaluated the responses to ensure that my interview questions were garnering the responses needed to address the research questions. I re-wrote two of the questions to make them clearer and removed one question which participants felt was repetitive.

5.6.2 The interview process

Each participant was interviewed once for about 40 minutes to an hour. The interviews were conducted using a conversational style (Patton 2002) and were conducted with trainers and participants of the two programmes. I encouraged

free flowing conversation with prompts as appropriate using the interview guide as an aide memoir. I often checked off or made notes beside questions as a reminder to myself that they had been raised as the conversation proceeded. In total, 24 interviews were conducted with those that had undergone training (12 from each Trust). Participants were interviewed at their practice settings which hopefully allowed them to not only be more comfortable, but also minimized the power differential between the interviewer and the interviewee.

Before beginning each interview, I explained the study to participants using the information letter that they had been sent, and I then obtained their signed consent to participate. All interviews were audio-taped and I made occasional notes by hand on the interview schedule. After the interview, I wrote general impressions in my research journal as well as key insights and points to pursue in subsequent interviews. All interviews were prearranged to suit both parties particularly the interviewees. Participants chose when and where they liked to be interviewed.

Although the interviewer used a pre--planned script, quite often, supplementary questions and analytical themes were generated through the interview session. At the end of each interview, participants were asked if they would like to receive a copy of the transcript, or, if not that, a summary of the interview. Only one person requested the full transcript and two a summary of the transcript. When I followed up these with participants, none had changes to make. The purpose of

this offer was to affirm participant input and to support transparency in the interview process (Murphy and Dingwall 2003).

All data was secured on a remote computer with duplicates made on portable devices, locked away free form interference and hard paper copies of the data stored in an equally secure place away from the original files.

5.7 The use of the questionnaires in the study

Four questionnaires were used in total. These were administered:

- One month before training (to ascertain participants' feelings, opinions and attitudes towards violence and aggression and its management) (Appendix B) as part of the pre-course phase.
- Morning of the training (participants expectations of the course and how they were prepared for training) (Appendix C).
- End of training (what participants felt they learnt from the course and what they feel might be useful in their work) (Appendix D).
- Three months after completion of training (what they used in practice having attended the course) (Appendix B).

The questionnaires were employed to obtain factual information in support of the interviews undertaken with participants and observations of training. The purpose of the questionnaires was to contextualize participants' responses to the semi-structured interviews as part of the triangulation of data.

The questionnaires aimed to examine participants' opinions of the training (with a view to improving it for future learners) and to investigate the impact of the training on their levels of knowledge and **confidence** in the subject as well as the **impact** and **utility** of the training on their practice and attitudes towards the management of violence and aggression and **capability**.

5.7.1 Questionnaire 1 and 4 (Pre and Post Training)

This was the same questionnaire administered pre (Appendix B) and post training. The questionnaires were an adaptation of the Management of Violence and Aggression Scale (MANVAS) (Duxbury 2003; 2002) and sought to measure the attitudes of participants regarding the causes of aggression, and ways in which to manage such behavior. This instrument is a well-used validated measure with acceptable psychometric properties. The items in the MAVAS are underpinned by the three broad models of causation (Duxbury 2002):

- The internal model: in which aggression is seen as being largely to factors within the aggressive person, such as mental illness or personality.
- The external model: in which aggression is regarded as being mainly caused by factors in the person's physical or social environment, such as the physical layout of the ward, or the way in which the ward is governed by the staff.

- The situation/interactional model: in which factors in the immediate situation, such as the interaction between the patient and others, especially staff members, are seen as the most important issues to be addressed.

It was hypothesized (CMO 4 Attitude) that participants who received the training would shift their views from seeing internal factors as being largely responsible for aggression, to demonstrating greater understanding of the impact of external, situational and interactional factors. As a result of this shift 'in thinking' participants would become more positive about the use of therapeutic relations in aggression management and more inclined to non-intrusive interventions.

In addition to the 13 statements about the causes of aggression and violence, reflecting the models highlighted above, 14 statements relating to different approaches to aggression management are included. 13 additional questions were included by the researcher reflecting the importance of teamwork and co-ordination in the management of violence and aggression, another factor highlighted in the literature as being important to the decision to use alternatives to physical interventions (See Chapter 3). Finally, a qualitative question was included which asked what techniques/skills the participant found most useful when managing an aggressive incident in clinical practice.

Participants give their views on each statement on a visual analogue scale, by marking a 100-millimeter straight line. The anchors at the extremes of the MAVAS are 'strongly agree' (given a value of 0) and 'strongly disagree' (given a value of 100). A low score therefore indicates agreement with a statement (Duxbury 2003).

The post-course questionnaire was designed to test the duration of any changes in knowledge, attitudes or practice which might potentially have been observed. Initially responses to the questionnaires were anonymised and entered into an SPSS version 14 data base and analyzed using descriptive statistics. Analysis was carried out on a question-by question basis and descriptive comparisons made. The mean response to each question was calculated and compared using independent two-tailed t-tests. Parametric tests are deemed appropriate for visual analogue scales, as they produce ordinal data (Kinner & Gray 1999).

5.7.2 Questionnaire 2

This questionnaire (Appendix C) looked at participants expectations of the training they were about to undertake and perhaps more importantly what support and preparation they had been given prior to coming on the programme. Participants were asked to rank in order of relevance topics that were to be covered as part of the training, the extremes being 'very relevant' and 'not at all relevant'. Topics included physical interventions, post incident support and models of aggression. This questionnaire was developed in line with

recommendations made by the National Audit Office (2003), Health and Safety Executive (2006) and the NHS Security Management Service (2006) as to the core content areas that should be considered when designing and delivering violence and aggression management training. Analysis was again done on a question by question basis in order to produce ordinal data in support of the findings of the interviews and observations of training.

5.7.3 Questionnaire 3

This questionnaire (Appendix D) sought participants' views on the standard and mode of teaching. Evaluating participant reactions to the training involved gathering information on the participants' subjective experiences of the course; including how much participants have enjoyed the training programme. This was developed in accordance to recommendations made by the Centre for Health Services Research (2004) and took into account the core content areas identified in Questionnaire 2. Again an analysis was done on a question by question basis in order to produce ordinal data in support of the findings of the interviews and observations of training. Evaluating participant learning involves assessing whether participants have met the learning objectives and gained knowledge and skills and includes assessing whether participants are able to effectively transfer the knowledge and skills into their work practice. A qualitative question was included. It asked participants to list in order of importance the key lessons that they would be taking away from the learning. Although this does not demonstrate directly any impact in practice it does allow the participants to clarify the meaning

of the learning in their own words and what was important to them. In this sense it gives an indication of what they are taking away from the learning to incorporate in to their professional development and practice.

5.8 Observation of training

I also had considerable opportunity to observe the day-to-day activities, running and management of the two aggression management programmes and to a lesser degree health care locations. I managed to attend a total of six, four day courses (three in each Trust) over the time of the study. These observations provided a context for the trainer-participant interactions and also questioning of both parties as the training unfolded and were incorporated into the researchers' field notes. Observation included behavior and circumstances in which the behavior took place and wrote the summary reports immediately after each observation.

While I selected the method of personal interviews to elicit participants' perspectives on whether and how their training prepared them for clinical practice, I applied observational techniques to see how their provision of information and interaction with participants reflected aspects of the programme. Rather than applying a structured checklist approach to collect observational data, I was open to discovering how participants in their particular setting went about putting into practice what they had learnt as part of their aggression management training.

Observation enables the researcher to collect information which is not filtered through the views of participants and to record information as seen (Creswell 2003). Because the participants were new to the aggression management training and not necessarily a conscious construct as participants went about their learning, observing their interactions with the programme and its instructors was deemed an appropriate adjunct to interviewing them. Observation methods allow the researcher to record unremarkable aspects of everyday life that 'interviewees might not feel worth commenting on and the context within which they occur' (Green and Thorogood 2004: 132). The unusual and unanticipated can, however, also be captured (Creswell 2003). As noted by Mason (2002), through observation, the researcher can 'experience and observe at first hand a range of dimensions in and of the setting' (p84).

Field notes were recorded by hand during the observation event and fuller notes were typed up immediately after. Whilst I did not use a predefined list of items to tally what I had observed, I did use a series of broad headings as advocated by Spradley (1980:78) to guide my observations; these included, Space, location of the research; Actor, the people taking parting the setting; Activity, the actions of people; Object, things located in the setting; Act, single actions of participants; Events, what is happening in the setting. I consistently recorded features of the training and the characteristics of the people present and how the trainers delivered each session. I remained as unobtrusive as practically possible; the

impetus here was to determine if there any contradictions between what had been said to me and what I actually observed. Typical and atypical events were observed and the salience and importance of each was noted, this involved also being aware of my own tacit expectations and assumptions (Bourdieu 1990), thus recording what Sandelowski (1998) refers to as the 'facts of the experience'. More particularly, I concentrated on looking for evidence of whether and how trainers enabled staff to engage and be part of the learning experience, for example, inviting questions from participants.

In all cases, written informed consent was obtained from participants in the training setting prior to observing. They were informed of why I was present, the purpose of my study and asked if they had any objections to my being present as an observer. After I had explained the study and addressed any questions they had, I asked them to sign a consent form.

5.9 Analysis of the combined data sets

Thematic analysis was used in the management of the combining of the different data sets and will now be discussed. Thematic approaches to data analysis are arguably the most common (Holstein and Gubrium 1995) and gain credence from Holloway and Todres (2003) who advocate that a thematic approach to analysis should be considered as a basis for all qualitative analysis.

It was not possible, nor desirable; to establish categorical distinctions at the outset of my analysis therefore preselected categorization was not imposed upon the data sets arbitrarily. Avoidance of using such a preconceived perspective set of categories at the inception of the analytical process was considered prudent and necessary. This not only allowed me the freedom to be sensitive to emerging issues and key themes, it also increased the trustworthiness of the data by reducing potential biases I may have unwittingly contributed to.

Braun and Clarke's (2006) approach to thematic data analysis, albeit represented here in an artificially linear format (see Box 3 over the page) for the purposes of clarity and explanation was much more iterative and reflexive in reality.

Box 3: Phases of Thematic Analysis (Braun and Clarke 2006)

Phase		Description of the process
1	Familiarizing yourself with the data	Transcribing data, reading and re-reading the data, noting down initial ideas.
2	Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collecting data relevant to each code.
3	Searching for themes	Collating codes into potential themes, gathering data relevant to each potential theme.
4	Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of analysis.
5	Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating definitions and names for each theme.
6	Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract samples, final analysis of selected extracts and data, relating back to the research question and literature, producing scholarly report for analysis.

All data referred to was selected and labeled with access to the full transcriptions and data sets and therefore reference to the context which it was derived was possible. In managing the data set I adopted the terms used by Braun and Clarke (2006) and accepted the definitions proposed as follows:

- Data corpus: all data collected
- Data set: all data from the corpus used for analysis and may consist of many individual data items and/or may become all instances in the corpus where a specific topic is referred to.
- Data item: individual pieces of data collected
- Data extract: individual coded chunk of data from a data item

The primary analysis took more of a free association stance where I could respond to the data sensitively and critically by setting free any fixed assumptions I may have had. Achieving this depended almost entirely on inferring meaningful distinctions from data, thus the overriding analytical emphasis initially was the creation of categories based on distinct features within the whole of the data set. This involved a reflexive engagement with the whole data corpus to establish the data set (Alvesson and Skoldberg 2000). At this point the transcripts and other data sets were given codes.

I repeatedly read the data set varying reading sequences to reduce any potential selection bias posed by sequential or chronological order reading (Dey 1993). I

interrogated the data by asking searching questions such as who? What? When? Where? Why? and What? (Braun and Clarke 2006). Reading in this way involved making notes about what the data was telling me and what it could potentially mean.

Each transcription was dealt with as a data item and analyzed in the same manner resulting in a long list of key data extracts. I assigned a category code to each data extract conveying context rather than attributing numerical value, thus giving significance and making sense. These labels formed provisional headings which I was able to confirm or reject in subsequent reading. Each extract conveyed an element which embraced distinct features within the text or data set.

Braun and Clarke (2006) stipulate two ways in which to identify themes, these being inductive and theoretical approaches. An inductive approach, similar to grounded theory, extracts themes which are strongly linked to the data (Patton 2002) and may bear little relation to the questions asked of the participants. This approach is not driven by theoretical interests or analytical preconceptions and would not try to fit data into pre-existing frames. It is therefore, data-driven. Conversely, theoretical approaches tend to be researcher-driven. Data coding therefore is undertaken for either a specific question (theoretical approach) or the requisition can evolve through the coding process (inductive approach).

Thematic analysis also focuses on a specific level at which themes are identified these being either a semantic (or manifest) level or at a latent level (Boyatzis 1998). The semantic level involves identifying themes with explicit meanings in the data. This is a surface analysis of what the participant has said and rarely explores any further. Graneheim and Lundman (2004) see categories as the concepts of a semantic level of analysis as this essentially, for them, portrays what the data is saying, where attempts are made to comprehend the significance of data patterns through progression from description to interpretation (Patton 2002). In comparison at the latent level of identification of the 'underlying ideas, assumptions, conceptualizations, and ideologies', which shape the semantic content of the data, are made known and that 'analysis within this latter tradition tends to come from a constructionist paradigm' (Braun and Clarke 2006: 84). Thus the latent approach seeks to reveal features that give meaning. However, both levels of thematic analysis deal with interpretation, albeit at a variation in depth and level of abstraction, and have potential value in their combination to produce meaningful outcomes. In this way, and in order to achieve a thorough analysis, I chose to combine these thematic principles ensuring analytical flexibility and responsiveness in an attempt to avoid prejudging subsequent analysis and perhaps precluding particular lines of development.

The unit of analysis is text based on the semi-structured interviews, field notes and observations supported by the data generated by the questionnaires

employed in this study. The essence of my analytical approach was collapsing and disaggregating data to identify data extracts and formulate categorical codes which were more readily analyzed unencumbered by pre-conceived theoretical interests and without trying to fit data into pre-existing frameworks. This means that in my analysis the construction of latent themes involves the reinterpretation of accumulated outcomes identified and interpreted from an early stage (Graneheim and Lunderman 2004). These themes were then scrutinized against the five CMOs used in this study and the extent to which they matched or contradicted the proposed configurations. Analyzing meaning in context and also through comparison implies that both processes are necessary for an adequate elucidation and interpretation of the data. This is why themes have to be meaningful both internally homogenous (data understood in context) and externally heterogeneous (data understood through comparisons) (Patton 2002). The fit between data and the developing themes were subject to continual adjustment as my analysis shifted in light of the data, its emphasis and direction. In this way I did not regard 'meaning' as a fixed 'thing' but a concept entirely dependent on context and related to the positions, perspectives and negotiations between different observers (Dey 1993), the researcher and the researched.

It was essential that I considered data within context as a means of situating action and thus grasping its wider social import. This was why it was important for me to observe the participants in the training environment. The mandate to consider context may seem paradoxical since, for the purposes of comparison, it

is miscarry to abstract data from its immediate context. I found that using abstraction in this way was a powerful means to greater clarity and precision when making comparisons and thus I was able to consider the data from an entirely different perspective. By adopting this approach in this way it was possible to elicit a more detailed inspection of the data by extracting and ordering the data through broad preliminary distinctions. This allowed me the possibility of developing analysis in a variety of directions, as the data demanded, rather than by predetermined routes I may have ascribed, and vice versa.

Familiarity with the data initially focused my attention on participants' stated values and beliefs about the training. Categorical coding resulted from identification of commonalities in the form of conceptual themes which were subsequently refined as patterns emerged to form Basic Themes. This was achieved by re-turning to re-examine the data, grouping across the data set and identifying relationships between them (Graneheim & Lundman 2004). Additionally, re-exploring the data also involved being able to differentiate and distinguish data as similar or related, as well as clearly different. Data was also scrutinized for any contradictions and divergence, thus potential dissonance between what the informants verbally expressed and events subsequently observed and revealed. Having the ability to make comparisons and any potential interrelations within each Basic Theme gave me confidence in the comprehensiveness of the analysis. These Basic Themes then formed the basis

for conceptualizing Organizing Themes, the second stage in the construction of e thematic network (Attride-Stirling 2001).

The third stage in the construction of the thematic network involved the relatedness and integration of the Organizing Themes emphasizing the interconnectivity until a Global Theme is constructed. To achieve the development of the Global Theme I followed a process whereby tangible connections and interactions, and formal relations of similarity and difference were explored and a conceptual label applied. Decisions were made as to the probable, improbable, possible and impossible judgments I applied to assigning and linking Organizing Themes to constructing each Global Theme. Data analysis thus involved reflection and systematic sifting and comparisons between developing and competing themes to produce my Global Themes (Attride-Stirling 2001). Drawing from grounded theory, I continued with the process of constant comparison until I no longer saw the emergence of new thematic categories of significance – what is referred to as theoretical saturation. Theoretical saturation is said to occur when no new insights are found, new themes identified, or new issues about a category of data arise (Bowen 2008).

5.10 Internal validity

Internal validity confidently shows that the findings are consistent with the participants' perception of reality. It is important to recognize that people construct multiple realities and that reality is constantly changing (Merriam,

1998). A key component of this construction of reality was myself, as the researcher. The researcher in a qualitative study is the primary research instrument, and I was integral to strengthening internal validity by offering as many varied interpretations of the data as possible in order to faithfully represent the participants' reality.

Charmaz (2005), a leading proponent of grounded theory, emphasizes the importance of reflexivity to the researcher. This means that the researcher is not considered an objective observer but rather one who is aware of the interpretive lens which he or she brings to the analysis and to sample selection. According to Charmaz, 'what observers see and hear depends upon their prior interpretative frames, biographies, and interest as well as the research context, their relationships with research participants, concrete field experiences and modes of generating and recording empirical methods (2005: 509). With an openness to learn what participants had to tell me about their experiences of aggression management training, I read and reread interview transcripts and observational accounts. While doing so, I was continually questioning what I brought to the analysis and the filter through which I interpreted the data.

I was particularly concerned about my partial, but certainly not full, familiarity with the context in which aggression management is undertaken and also the knowledge and experience related to the issues of aggression management training that I brought to the analysis. It was essential that I be constantly aware

of how this prior knowledge rendered my interpretation of the data. I needed to challenge first impressions and pay deliberate attention to data which diverted from emerging themes – a key aspect of this was constant comparison (see 5.13 above). For example, while many participants' comments reflected functional aspects of aggression management, others reflected aggression management not as a concrete set of skills but rather as different ways of knowing including those not dependent on the content of the training. This was critical as an insight as I deepened my exploration of the extent to which participants' engagement with notions of aggression management reflected various dimensions of the available literature as discussed in chapter 3.

5.11 External validity

External validity is also referred to as generalizability, and it's concerned with to what extent the findings of a study can be applied to other situations (Merriam & Simpson, 2000). Realistic Evaluation is concerned with what works for whom in what circumstances and it is therefore suggested that it is the reader's and not the researcher's task to speculate on how the findings can be applied to other situations. I have provided enough detail and commentary throughout this study so that readers can visualize similar situations and consequently they might be able to better connect with my findings, and see how what I am describing might apply to them.

5.12 Reliability

The issue of reliability relates to whether or not the findings of a study would be the same if the research were replicated (Merriam & Simpson 2000). Reliability is a foundational concern in quantitative research, as the goal is to affirm that no matter how often the study is conducted, using the same parameters and methodology, it would yield the same results. It is very difficult to achieve this consistency when conducting a realistic evaluation of a programme as we are dealing with individual realities and individual interpretations, which are different for each person. Merriam and Simpson (2000) posited that the real question in regard to reliability is "whether the results are consistent with the data collected" (p. 102). I used triangulation by including multiple data sources and peer examination as two techniques to address the issue of reliability. A third strategy is the audit trail (Lincoln & Guba, 1985) which is a detailed account of the research process. I used journals, field notes, and kept detailed records on the data analysis process, in order to maintain a comprehensive audit trail. My journals included personal reflections that occurred throughout the research process. I noted the reasons behind the choices I made, such as why I grouped coded data in one way rather than another, what my thought process was behind the words I chose for coding and categories, and ultimately how I chose to present my findings. This journal included questions that I had; and I also outlined my decision making processes from data collection to the final discussion of findings. Throughout the data analysis process, and the discussion

of my findings, I continually reviewed the current literature on this topic to ensure that my findings resonated with what has already been identified.

5.13 Trustworthiness of findings

Establishing the trustworthiness of findings from qualitative research is hotly contested in general, and more specifically, within the context of research relevant to health practice. According to Mays and Pope (1995), 'As in quantitative research, the basic strategy to ensure rigor in qualitative research is systematic and self-conscious research design, data collection, interpretation, and communication' (p 109). Much of the debate about assessing the quality of qualitative research centres on the extent to which criteria should parallel or differ from that used in assessing quantitative research.

Spencer et al. (2003) have drawn a distinction between practical research and scientific research – an argument originally made by Hammersley (2007). Spencer et al. have asserted that in contrast to scientific research's aim to contribute to knowledge primarily accessed by researchers, practical research, such as the kind reported here, 'aims to produce knowledge of practical use to practitioners or policy-makers who assess the findings in terms of relevance, timeliness and validity – being judged according to the plausibility of the findings in relation to *practical knowledge* and *experience*' (italics in original) (Spencer et

al. 2003: 30). Furthermore, is the requirement that research be 'Rigorous in conduct through the systematic and transparent collection, analysis and interpretation of qualitative data' (p20) .

In this chapter, my goal has been to demonstrate how I, as the researcher, have strived to achieve a standard of rigor by describing how I systematically and transparently conducted my study. In striving for rigor in my study, I compared and contrasted data from my multiple data sources, noting with memos the convergence and divergence of emerging themes from cases within and across different sources of data.

5.14 Summary

The advantage of using realistic evaluation in this research is that it recognizes that looking at outcomes is not enough; that each programme is dependent on the way it is introduced, delivered and managed. It is concerned with what works, for whom, in what circumstances, and that this is better explored through multi method data collection and analysis. Whilst no one method will necessarily provide a valid account of how the training made a difference to participants and those they provide care for, an incremental approach using different methods to document changes at different stages of participant learning can build a more robust picture of impact and effectiveness both in terms of clinical practice and knowledge (Silverman 2000). In this respect it is necessary to not only explore the impact of the learning (participant survey and observation) but to track how

participants apply this learning to practice (semi-structured interviews) through articulation and exploration of the proposed CMOs. Chapter 6 will now report of the findings from the study.

Chapter 6

Findings

6.0 Introduction

The purpose of this chapter is to clearly present the findings of the study to the reader. Analysed findings are summarised under the headings used to describe the five CMO configurations discussed in detail in the previous chapter (Chapter Five). Findings from the semi-structured interviews and observation of training produced volumes of rich data. Within the data are clear descriptions of how participants viewed the training. What they thought about this, and the factors which impacted upon it. Aiming for a true representation of the experience of participants' of training direct quotes from the transcripts are included in the findings. Questionnaire data is reported on and incorporated into the text using narrative commentary, graph or diagram. Presenting data in this way offers the reader a better insight into the experience of those participants who took part in the study. Inevitably, there is some overlap between stages in attempting to present a coherent overview of the topic under investigation. To avoid repetition, findings have been included only once, even if they have relevance to more than one CMO. The chapter ends with a summary of the findings.

Box 4: Key to Participant Coding

Code	Explanation
INT	Participant Interview followed by their identity number
INSM	Interview Senior Manager
INLT	Interview Lead Trainer
FN	Field Note
Q1,2,3,4	Questionnaire 1, 2, 3,4

6.1 Relevance of Training

The first CMO proposed that training provided a link to clinical practice and that staff could relate what was taught with actions taken back on the job. In order to make this happen participants need to see the relevance of the training as it related to them and readily engage with the instructors and activities during the course of the training. The outcome would be that staff had confidence in the techniques taught and knowledge gained from the course and were able to incorporate these into their clinical practice.

The provision of aggression management training was welcomed by all participants who felt that such behaviour presented a real risk to staff working in mental health and learning disability services. Many of the participants reported that they were '*looking forward to the training*' (FN12) as the management of violence and aggression formed 'an *important part of their work*' (INP7). The general perception of those interviewed was that violence and aggression were

on the increase and that staff needed a range of skills with which to tackle *'the problem'* (FN18).

Whilst training was mandatory for all staff working in the clinical environment, it was predominately nursing staff that attended the training. In some ways, this is unsurprising as nursing staff make up the majority of the workforce and are most likely to look after patients who display disruptive and aggressive behaviour.

The literature attests to the importance of preparing staff for training (Lawson, Heaton & Brown 2010; Quinn 2007; Lawson 2005; Welsh & Swann 2002). Only five of the participants reported having had their training needs discussed with them prior to commencing the course. All five participants held a managerial position in their respective organization and were responsible for the supervision and wellbeing of staff. These discussions were undertaken by the participants' line manager and stressed the need to keep up-to-date with developments in the field, particularly those

> '*... concerning changes to legislation and the reporting and recording of incidents.*' (Team Manager, Learning Disability: FN6)

A number of participants' seemed ill informed as to the training they were about to undertake. For example;

Researcher: 'What are you hoping to get from attending the course?'

Participant: 'The physical stuff. I already do a number of martial arts.'

He then proceeded to demonstrate to me some of *'his moves'* which he believed *'would be useful in practice.'* (Newly employed Care Assistant Learning Disabilities: FN19)

And

'I'm not sure what to expect, I've never done anything like this before.' (Newly employed Care Assistant Mental Health: FN26)

Eight of the participants reported that they had only found out the week before coming on the training that they had a place on the course. This was as a result of an illness or inability of another staff member to attend.

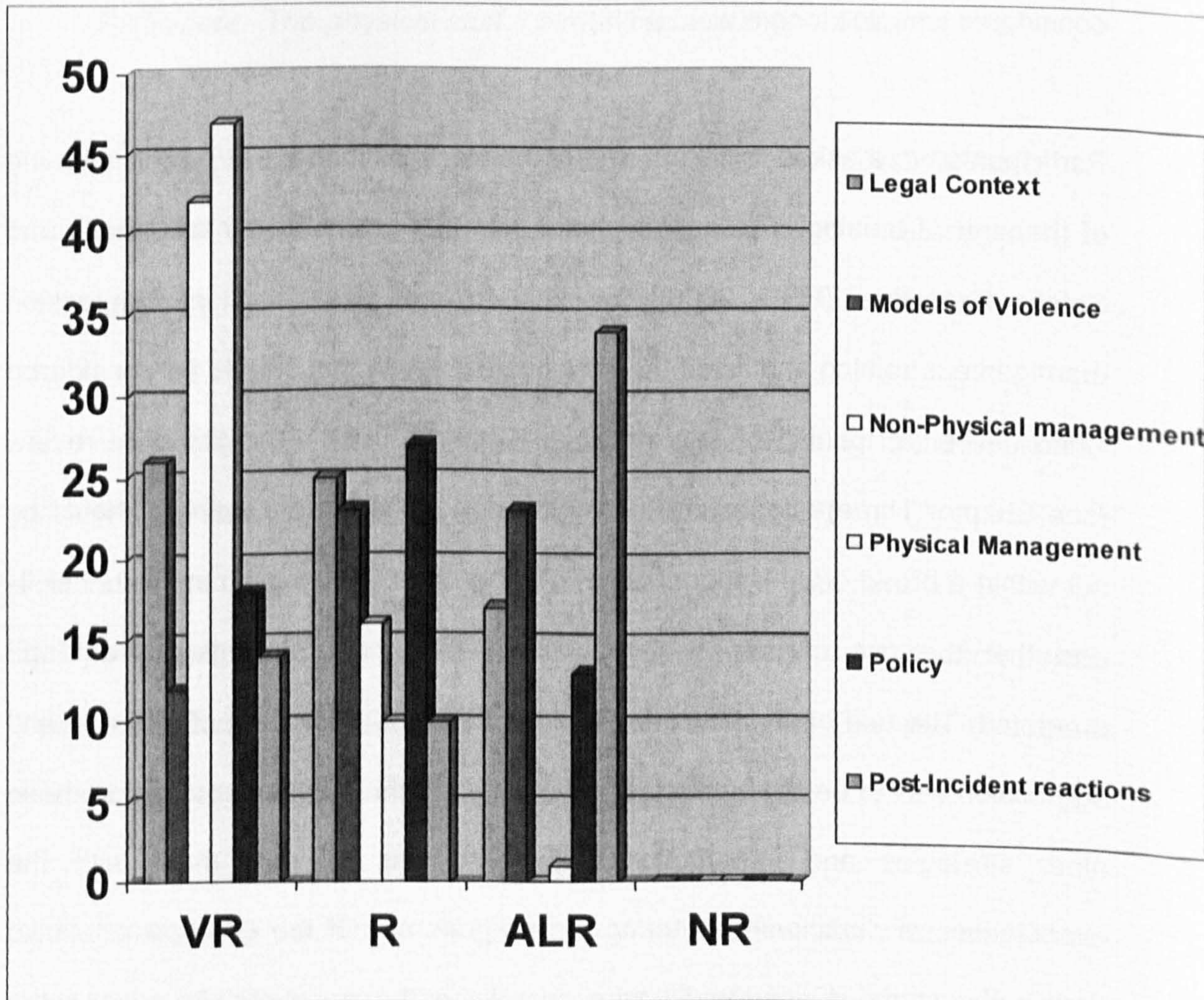
Other than being physically fit there was no specific ability or knowledge requirement of participants. Any concerns regarding health or fitness were dealt with by the respective Occupational Health Department.

A number of participants interviewed (n=9) argued that the risk of being involved in an aggressive incident or experiencing an actual assault whilst in service was such that it needed to be acknowledged much early than it was and incorporated into staff induction packages. A number of participants (n=17) reported that they

had had to wait up to six months before being able to access training, which they considered was 'too long a wait' (FN9).

Participants were asked to fill out and complete questionnaire 2 on the morning of the start of training. The questionnaire was that promoted by the Health and Safety Executive (HSE 2006) for use in the evaluation of aggression management training and listed the core content areas that should be considered when delivering training of this kind (see Chapter Five). The literature review (see Chapter Three) suggested that aggression management training should be set within a broad organisational context rather than focusing on individual skills and that the use of non-physical skills management strategies should be promoted. The use of physical interventions in the management of violence and aggression was to be seen as a last resort and taught in context alongside these other strategies and interventions. However, this did not meet with the expectations of participants entering the programme. Of the 64 eligible to take part in the study, 47 of the 51 who completed the questionnaire ranked the teaching of physical management skills as being most relevant to their training (see Table 1 below).

Table 1: Relevance of training content



VR = Very Relevant; R = Relevant; ALR = A Little Relevant; NR = Not at all Relevant

Whilst training in non-physical management was considered very relevant by participants (N=42), physical management skills were ranked as most relevant (N = 47). This sentiment was echoed in the responses that participants gave to the question included at the end of the survey; what did the participant hope to get most from attending the training? Invariably participants wrote about the

development and use of breakaway techniques, restraint and the safe physical management of an aggressive client.

> *'I want to know how to restrain properly and not hurt anyone.'* (Care Assistant Mental Health: Q2R23).

And;

> *'I want to know how to restrain patients safely, in a controlled environment.'* (Staff Nurse Learning Disabilities: Q2R28)

Furthermore;

> *'I want to know how to get out of a situation as quickly as I got into it. It's important that staff know how to get away from service users when they're being attacked.'* (Care Assistant Mental Health: Q2R6)

The development of such skills was often associated with an increased level of confidence.

> *'I hope to have a clear understanding of control and restraint, and be confident in using these skills in clinical practice.'* (Staff Nurse Mental Health: Q2R8)

And

'I expect to become more confident in the use of control and restraint and to be able to manage violence and aggression more comfortably'. (Care Assistant Mental Health, Older People: Q2R45)

Participant expectation and preparation needs to be managed if learning outcomes are to be realised. This will be discussed in greater depth in the following chapter.

Both training programmes were up to date and in keeping with guidance set out by relevant bodies or groups (e.g. Promoting Safer and Therapeutic Services. Implementing the National Syllabus in Mental Health and Learning Disability Services (NHS Security management Service 2005). However, the timing and the depth to which a topic was explored varied between programmes and was often set by those leading the training. Invariably this involved personal and professional judgment gained from '*experience of having worked within the* field" (INT6) and not necessarily based on research or any form of evidence base.

Programme context included both practice orientated outcomes, e.g. select the most appropriate means of breakaway for a given situation, and knowledge based outcomes e.g. 'describe the possible reasons why a person might act in an aggressive manner.' The teaching of physical interventions, e.g. breakaway techniques, dominated both training programmes.

Both training programmes were set and delivered within an instructional framework from which there was little divergence by trainers. This meant that content was not always appropriate for learners, neither relating to their existing knowledge, role or skill level.

> *'I thought there was going to be a lot more physical stuff than there was. I agree that there was quite a lot of it, but a lot of it was just practice. I thought they could have shown us a few more techniques. There wasn't enough on strangling and the hair pulling was very unrealistic. Hair pulling from the front; hair pulling from the rear! When someone's pulling your hair they're trying to punch or kick you at the same time.'* (Care Assistant Learning Disabilities: INP21)

And

> *'They've not mentioned the community once. I keep telling them that I'm a community worker and that all I really want to know is how to protect myself and get away. I'm not even a nurse; if it wasn't for the fact that it's mandatory I wouldn't attend.'* (Community Occupational Therapist Learning Disability Services: FN35)

There was at times a disparity between what was required of participants (as laid out in the course objectives) and course content. For example the course

objectives required participants to demonstrate an understanding and use of de-escalation techniques, although these were neither taught in any great depth nor assessed. Furthermore, some participants had trouble *'making sense of what was being asked of them'* and the sequencing of material. It was not always clear, for example, what the stated purpose was for each learning activity.

Training was not always sensitive to the training characteristics of the adult learner in general (i.e. learning styles and preferences). Trainers reported that it was difficult to overcome the tradition of didactic teaching and rote learning.

> *'I didn't train to be a teacher. This is the way that I was trained to deliver the programme'* (Trainer Mental Health: INT4)

Whilst the aims and objectives of each training programme were stated at the beginning of each course and revisited at the end of training no attempt was made to link these directly with the various activities of the programme in a way readily understandable to staff. Staff were left to make their 'own connection' at times.

There was also some question about how achievable the objectives were when considered against the time frame in which the programmes were run. Time allocated for training did not always allow for topics to be covered in sufficient depth to meet the learning needs of the participant nor for practice of

techniques/skills to be had other than a run through. This in turn put pressure on the participant.

> *'I would have liked more time to practice my skills as we're being assessed on these. They can't expect you to be good at something if they don't give you the time to practice. I'm really worried about not passing the assessment.'* (Recently appointed Care Assistant Learning Disabilities: FN15)

And

> *'Too much information was piled into one session; the theory stuff seems to be crammed in as and when they've got a spare moment'* (Staff Nurse Mental Health: FN41).

Some of the participants felt that there were aspects of the course that had already been adequately covered in other training they had previously attended, for example:

> *'I covered a lot of this in my nurse training, particularly the bits regarding the law.* (Recently Qualified Staff Nurse Learning Disabilities: FN38)

And

'Some of this was covered in the vulnerable adult training we did only the other month. (Care Assistant Learning Disabilities: FN60)

Although participants appeared generally very engaged with the day, limitations of some staffs' level of experience seemed to restrict their ability to participate in some of the exercises.

'I can't always relate to what they're taking about as I've not been long in post.' (Care Assistant Mental Health: FN43)

And

'Whilst I'm enjoying the course, it's a bit difficult to keep up as I've only been with the Trust a couple of months'. (Care Assistant Mental Health: FN84)

Neither training programme took account of or reflected the diverse needs of service users such as gender, race, ethnicity, and religious background, physical and mental ability, unless directly asked for by the participant. The assumption was made by trainers that this would be covered in other areas of staff training and development.

Written materials were offered in support of learning and teaching (namely national guidelines) and use of the internet and web sources encouraged. The expectation from the trainers was that staff would read around the subject although this was never verified and fed back or built upon during training.

> *'The best we can do is give them an insight into aggression management; and point them in the right direction. They (the participants) need to read around the subject and practice what they've been taught in their own work areas'* (Trainer Mental Health: INT3).

Both programmes took place at a designated training suite which was divorced from the clinical practice area; in a large hall devoid of furniture and having in situ safety mats. This led participants to speak about the unrealistic nature of the training.

> *'If only we had all this space. They ought to come and see our ward we don't have enough room to restrain. Sometimes we have to wait for the patient to come out of a room and attack us before we can make a move. It's a case of grabbing what you can and then sorting yourselves out later. Unbelievable.'* (Care Assistant Mental Health Acute Services: INP2)

And, more succinctly,

> *'I've never restrained in a hanger before!'* (Care Assistant Mental Health: FN29)

A large number of participants' (n=26) also spoke of the unrealistic way in which physical skills were taught and assessed. A 'learn-by-numbers' approach was adapted in the teaching of breakaway and restraint. This meant that techniques were broken down into their composite parts and taught as a series of actions, to be replicated on command, by number. Likewise, participants' (n=17) criticized the way in which the patient was portrayed as cooperating when in reality most were resistive to physical interventions. For example, once having broken away from an attacker it was unlikely that this would be the end of an aggressive incident, and that people were likely to actively fight an effort to restrain. Participants (n=26) felt that training did not reflect the realities of clinical practice and demonstrated a lack of understanding on the part of trainers as to the requirements of staff.

Competence was gauged as having been achieved when the participant was able to replicate a move or technique to a level satisfactory to the trainer. In the absence of any knowledge/theory based assessment this again ensures that the focus of training and subsequent evaluation was on the acquisition of a prescribed set of skills/techniques. This said, limited opportunities existed during

the training for participants and instructors to assess progress and gain/give feedback. This was often done in a piecemeal fashion when it was undertaken and often in the form of a compliment, *'well done'*, *'you did that well'*, *'nearly there'*. This has a number of implications, namely how are students to gauge their progression over the period training and whether or not that they are working to the required standard.

If a participant did not engage with the programme or was identified as having *'failed to reach the required standard'* the recommendation would be for further training with a report of their *'performance'* sent back to their manager. Of particular concern would be issues of safe practice in terms of safety to self and others.

> *'Trainers pick up very quickly if there is a problem with staff, concerns are reported back to their respective managers, poor attitude towards the course suggests a poor attitude in practice'* (Trainer Mental Health: INT2)

Each programme had a team of designated trainers attached to it. A small number of these were employed on a full time basis to administer and run the programmes, whilst other trainers are *'drafted in'* from clinical practice on a session/need basis.

Both trainers and participants believed that it was important for aggression management trainers to be in contact with practice in order to maintain clinical competence. A certain degree of *'credibility'* was attached to this particularly where the Trainer was concerned.

> *'You need to be credible ... staff have to have faith in what you show them, they need to be confident that the techniques and skills that we show them work in practice, otherwise they won't use them. It's great when you can say that I used this last week and it worked'* (Mental Health Trainer: INT3).

And

> *'They (the participants) like to hear that you've used them in practice and that they work. It doesn't do your rating bad either to let them know that you haven't lost it'* (Trainer Learning Disabilities INT5)

Trainers working in practice areas felt that it also helped them to understand how policies were being interpreted on the ground and the pressures that staff faced when putting training into practice. These trainers also reported feeling more confident in their teaching of clinical skills; in particular the teaching of more recently developed techniques e.g. changes to break away.

For the participants in this study, the benefits of hearing the lived experiences of trainers were that they reportedly remembered the content of these sessions more easily and as a consequence paid more attention to what was being said. Participants felt '*more comfortable*' in asking and answering questions and talking through issues relating to clinical practice with trainers based on '*real life*' experiences than discussing theoretical components of the training.

> '*I felt that I could contribute to the discussion and relate things more readily when we talked about practice situations*'. (Staff Nurse Mental Health: INP12)

And

> '*It made more sense and was easier to follow (talking about clinical practice) than talking about the theory part*' (Health Care Support Worker Mental Health: INP17)

All the trainers had a nursing background, and it was this that they drew upon when talking about their experiences of using the taught techniques, reinforcing the message that violence and aggression is something that is largely encountered and dealt with by nurses in clinical practice.

Participants reported that they valued the enthusiasm and commitment of those who delivered the programmes. In all cases, these individuals were people who believed very strongly in the subject and who had, mostly, been involved in putting the training together.

Participants were encouraged to complete Questionnaire 3 on exiting the training (Appendix D). 64 questionnaires were given out with 54 returned (see Box 5 overpage). Taken at face value it would appear that participants enjoyed their training and valued it as a programme of study. These results ran contrary to findings from the interviews and field work. This emphasises the importance of going beyond 'tick box' satisfaction type questionnaires (See Chapter 3).

Box5: Results of Questionnaire 3

Statement of Training	Strongly Agree	Agree	Disagree	Strongly Disagree
The instructor was an able communicator	5	47	2	
The instructor retained my interest	4	49	2	
Sessions were paced appropriately	7	44	3	
Overall, the instructor(s) assisted my learning	12	42		
The aims and objectives of the course were clear	10	39	5	
The teaching methods employed were appropriate to the subject matter	5	48	1	
The course material was well structured and easy to understand	12	41	1	
The subject matter was developed logically	10	38	6	
The instructor related the subject matter to practice and current evidence	6	46	2	
The instructor stimulated my interest in the subject	5	49		
The instructor encouraged me to think about and question matters covered	7	44	3	
The explanations given by the Instructor were clear	5	47	2	
The Instructor emphasised key points	5	46	3	
The Instructor pointed out links to previous topics studied	9	42	2	
The visual aids used were clear and helped me understand the matter covered	5	47	2	
The aim of objectives were made clear at the start of the training	10	39	5	
The training meet the aim and objectives as stated	4	49	1	

Participants' reactions to the two aggression management training programmes were almost universally positive, although this was not necessarily down to the way in which the courses were delivered or taught. A number of participants enjoyed the training as it allowed them to catch up with *'old friends'* and *'to*

socialize'. They particularly seemed to value the additional perspectives and insights they gained from *'swapping stories'* from practice and the camaraderie of other colleagues. This would seem to be a common phenomenon to vocational training of this kind and if promoted could be used to foster peer support back in clinical practice. This and the other points raised in this section will be further explored in the discussion chapter of the dissertation.

6.2 Knowledge and skill accumulation

The second CMO configuration suggests that the staffs' knowledge and skill base is increased as a consequence of training and that while they may not be able to put this into practice straight away, staff are able to articulate and give voice to what it is they learnt and draw upon this knowledge and skill base as needed.

Two main outcomes were expected by those trainers interviewed (N=6) of participants: participant recognition that everyone within the health service could make a difference in reducing violence and aggression; and the understanding that meeting the needs of patients was central to this role. Safe practice based on evidence was the means by which to make this happen. While learning about breakaway and restraint formed an important part of the content, they were considered subsidiary to these two main points:

> *'I'm not worried what staff go away with as long as they understand that they can make a difference'* (Trainer Mental Health: INT1)

'People have the right to be treated with dignity and respect. Their needs should be central to everything that we do' (Trainer Learning Disability Service: INT5).

Trainers felt that the aggression management training acted as a framework which brought together elements of practice that are familiar to participants but which are focused in a tighter way enabling staff to make sense of the many complexities of this activity, for example, the assessment and management of risk and risk taking.

Training did little to support organizational and team practices and procedures but instead focused on individual performance in relation to the development of physical skills. This was very much the expectation of participants (FN2, 3, 4; INP4, 10, 12) and one played out by the trainers who without exception enjoyed teaching these the most.

'I enjoy teaching physical interventions the best. It's what the staff enjoy as well. If they look like they're going to sleep there's nothing like a bit of physical activity to wake them up' (Trainer Mental Health: INT3)

And

'Staff wouldn't find the course interesting without the physical stuff. You can only cover so much theory before people start switching off' (Trainer Learning Disabilities: INT4).

And

'It's very difficult when you are actually training a full course on physical interventions to still keep in people's heads that this is the last thing that you do, everything else comes first, to get people to train in something that we don't want them to use is difficult, it is a last resort. It is hard' (Lead Trainer Mental Health: INT2)

Asked what skills/knowledge the participant would be able to use from the course in clinical practice, all but three of the participants cited the use of a physical intervention methods/management.

'Everything I was taught especially holding techniques and exchanges' (Staff Nurse Learning Disabilities: Q3R10).

'Effective use of C & R and breakaway' (Staff Nurse Mental Health: Q3R6).

'Clear communication when physical intervention is necessary' (Care Assistant Learning Disabilities: Q3R32).

'New seclusion hold' (Staff Nurse Mental Health: Q3R40).

This was further echoed when participants were asked about the most important skill they had learnt during their time on the course.

'The effective use of breakaway techniques' (Care Assistant Mental Health: Q3R27).

'How to safely restrain someone' (Staff Nurse Learning Disabilities: Q3R18).

'How to get a young person onto their knees and then to the floor if they resist and how to get out of a strangle hold.' (Staff Nurse Mental Health: Q3R22)

'Being precise and quick when undertaking physical techniques' (Unit Manager Learning Disabilities: Q3R42)

'Breakaway' (Staff Nurse Mental Health: Q3R28).

Additional comments about the training included regular ongoing training, being taught alternative team approaches for physically restraining patients, being taught negotiation skills and gaining broader skills in managing difficult patients such as those with personality disorder or duel diagnosis:

> *'I thought that there would be more on de-escalation techniques. These weren't really covered in any great depth' (Staff Nurse Mental Health: Q3R31).*

> *'I can't see me using a lot of what I learnt as it just wasn't relevant to what I do!' (Staff Nurse Mental Health: Q3R15)*

Participants were asked how they thought aggression management training could be improved. Participants identified three key training skills used in managing aggression and violence. First verbal communication and interpersonal skills to manage the situation were emphasized.

> *'You need good communication skills in order to be able to de-escalate a situation. There was not enough of this in the course I attended.' (Staff Nurse Mental Health: Q3R29)*

Second, having a greater range of skills to respond physically to violence when attacked than those that were taught:

Sometimes the restraint techniques (those taught as part of the training) don't apply for example with a patient who corners themselves into a wall ... you need to be prepared for all situations' (Health Care Support Worker Mental Health: Q3R11)

'At the end of the day you need skills to meet the worse case scenario' (Health Care Support Worker Learning Disability: Q3R37)

Third, having team management skills whereby multiple staff could be swiftly assembled at the scene of an aggressive incident.

'A lot of time you're dealing with these situations as a team, drawing on staff from other areas for support. Coordinating all of this is difficult as you have to think about the other patients as well as the person that you're dealing with.' (Staff Nurse Mental Health: Q3R28)

Trainers were adamant that the programmes provided training of a high quality and that they provided staff with the knowledge, skills and techniques needed to approach aggression management within their work areas. However, '*staff would need to practice these skills on return to practice in order to become fully competent*' (INST6). This has implications as to the utility and transfer of skills beyond the training environment and places a great emphasises on participants

for their use and success in the clinical setting. This point will be explored further as part of the discussion chapter that follows.

6.3 Transferability of knowledge and skills

The third CMO proposed that staff needed to be allowed to practice their skills and exchange ideas about aggression management having completed their training in order to avoid becoming de-skilled.

There were no clear links and strategies to support the end goal (transfer) of training to the clinical environment; in particular there was a lack of performance indicators regarding desired behaviour back in the job. The emphasis was on staff to take what they had learned and incorporate this within their own practice and thinking. No support or suggestions were offered as to how this could be achieved or the possible barriers staff might encounter when attempting to do this.

The majority of participants stated that they did not feel confident in carrying out techniques learnt, with many having difficulty recalling information back in the workplace. This caused participants a degree of concern particularly with regards to their improper use in practice.

> *'Having been on the course it's important that you carry out the correct methods when dealing with clients, otherwise there could be some serious*

comeback. People could get hurt or injured if you did it wrong and you could get sued' (Staff Nurse Mental Health: INTP16).

Only six of those interviewed said that they had been able to put their learning into practice. The examples given ranged from very specific incidents (involving some sort of physical intervention), to more general ways of relating to people and understanding situations. Where positive responses had been reported as a result of training these were in relation to participant knowledge and attitudes to aggression management with regards to prevention strategies and techniques.

The most frequently cited barrier (N=16) to putting learning into clinical practice was considered to be an inability or unwillingness of existing staff to change their current ways of working.

> *'Trying to change things round here is impossible, people tend to stick to their old ways'* (Staff Nurse Learning Disabilities: INP7)

There were also difficulties ensuring commitment from some colleagues. Two reasons would seem to account for this. Colleagues would not always see the relevance of their training to their area of practice or sometimes could not see beyond their own clinical priorities.

'Many people think they know and understand aggression management, often based on years of experience and it isn't acceptable to say they don't, as many staff may well already have a good knowledge gained from working within the field. It is therefore hard to effect change and develop new ways of thinking and practice particularly if staff don't see the value and worth of what is being proposed' (Unit Manager Mental Health: INP22).

Participants who had attended training, but then had no opportunity to put their learning into practice (e.g. because they had not experienced any aggressive behaviour) felt less confident about their ability to use their skills effectively.

Most clinical areas have two trainers attached to them; however on closer examination this predominately refers to in-patient and community home type settings. This, it was perceived, helped the transfer of skills learnt from the classroom to the clinical practice area, with trainers providing help and advice by working alongside staff in practice. Trainers were also seen as champions for the programme and were expected to *'take every opportunity to promote good practice'*.

Several trainers commented on the great variability in the standards of practice in clinical areas. As one trainer commented (INT2),

'The service has gone through considerable changes and reconfigurations and there's been a considerable pressure out there, and I accept that. However, there's good and bad in everything. Some wards provide excellent care, whilst some are not so good. So in terms of skills and putting them into practice it's not always happening. There's a lot of outdated practice going on, nurses continue to take on a custodial role'.

The training teams have started to build on staff support issues and now regularly visit clinical areas to assess patients and offer advice on dealing with particular incidents and how to adapt the system to individual situations.

In the absence of skills and knowledge learnt from undertaking the training, staff would draw on past experience to manage aggressive behaviour.

> *'You learn from experience how to respond to people'* (Staff Nurse Learning Disabilities: INP4)

And

> *'I know that I haven't worked for the Trust for that long, but having worked in health care for nearly twenty years, you know when someone is building up and how to bring them down, or get out of the way'* (Care Assistant Mental Health: INP6)

A number of participants (N=11) considered that assessment, observation and management of aggressive patients/clients are both an individual and a team responsibility. Awareness of potential triggers, knowledge of individual patients and using handovers to convey information about new patients was also considered a critical part of the ongoing assessment process and constituted a routine component of professional nursing practice.

Great importance was placed on good team work when dealing with an aggressive incident, including having a full complement of staff. Staff reported feeling more confident and ready to intervene and try out less invasive practices when they felt they had the trust and support of their colleagues.

> *'You need to be confident that if something does happen then you have the backup of your colleagues'* (Staff Nurse Learning Disabilities: INP7)

> *'There are times when I let things go as I don't trust the staff that I'm on [duty] with to back me up'* (Care Assistant Mental Health: INP22)

The notion of trust was confined to those colleagues that had proven themselves in clinical practice. Such proof often took the form of making judgments about a person's ability measured against performance in real life situations. Those who

had demonstrated a level of competence were trusted and sought out by other members of staff when the potential for aggression presented.

The need to intervene early was also emphasized, with senior nurses availing themselves of opportunities to provide junior staff with education about cue recognition, nursing interventions and de-escalation skills.

> *'Staff, particularly junior or new members of staff need to feel support when faced with challenging situations such as violence and aggression. It's important that senior staff lead the way and demonstrate and promote good practice'* (Staff Nurse Mental Health: INP9)

The need to have an individual approach and recognise individual differences and preferences was also highlighted and acknowledged.

> *'It's about treating people individually. What works for one doesn't necessarily work for another'* (Staff Nurse Mental Health: INP3).

A good relationship appeared to give respondents an understanding of the patient, allowing them to detect changes in the patient's behavior which were suggestive of possible aggression and violence and guiding actions with specific individuals. Most importantly, this relationship also appeared to give respondents

the confidence to intervene and try out new approaches and techniques to reduce potential violence and aggression.

Participants were asked their views about common aggression management strategies, including interpersonal and physical or 'controlling' means of management. Staff felt *"that there was a need to be trained in the physical aspects of patient management'* as it allowed staff a degree of control over a situation, much more so than using de-escalation techniques. This *'control'* helped instill a sense of *'confidence'* and *'purpose'*.

> *'I can't stand hanging around waiting for something to happen. You know when a person is going to kick off, it's much safer for them and others to get in there quickly and sort the matter out. Too much time is spent trying to talk them down. Clients have too much say. Some treat this place like a holiday camp. They have to understand that they can't treat staff in this way and get away with it* (Care Assistant Mental Health: INP22).

And

> *A lot of the time it's easier to physically remove the patient than let them wind the others up. Dealing with dementia patients it's sometimes the only thing you can do. It really is undignified to ignore someone taking off their*

trousers in the day room and not do anything (Care Assistant Mental Health: INP8)

Another important area identified by staff was the need for managerial support when putting training into practice and effecting changes. Staff needed to feel that they had the support of their manager when trying out new techniques and feedback. All too often staff felt that they lacked support and that they were '*trying to do things in isolation*'.

> '*It's often the case that the police will bring an aggressive patient to the unit then leave ... the patient will arrived handcuffed in the custody of three or four police officers ... they'll take the cuffs off and leave myself and two female health care support workers to deal with the situation. I'm not blaming the unit manager but a lot more could be done to ensure the safety of staff.'* (Staff Nurse, Mental Health: INP15)

6.4 Attitude

The fourth CMO configuration proposed that staff developed a more positive attitude to the management of violence and aggression as a result of the training and as such were more willing to engage in preventive actions and seek alternative strategies to managing violence and aggression in their work area.

Participants were invited to complete an adapted version of the Management of Aggression and Violence attitude Scale (MAVAS) (Questionnaire 1) three months prior to and following training. Participants gave their views on each statement on a visual analogue scale. The anchors at the extremes of the MANVAS are 'strongly agree (given a value of 1) and 'strongly disagree' (given a value of 5). A low score therefore indicates agreement with a statement. The development of the MANVAS has been elsewhere (Duxbury 2003) and explored in Chapter 4 Data Collection and Analysis. Of the 64 eligible to take part in the study, 41 participants completed the questionnaire both before and after training (See Table 2 below).

Table 2: MANVAS Scores

Question Number	N	Mean before training	Mean after training	SD	*t*	*P*
Q1 Patients are aggressive because of the environment they are in	41	51.39	49.34	4.049	3.240	.002
Q2 Other people make patients aggressive or violent	41	49.17	48.29	3.579	1.571	.124
Q3 Patients are commonly become aggressive because staff do not listen to them	41	52.22	51.59	3.706	1.096	.280
Q4 It is difficult to prevent patients from becoming aggressive	41	72.02	74.22	3.273	-4.295	.000
Q5 Patients are ill because they are aggressive	41	57.32	56.10	3.657	2.135	.039
Q6 Poor communication between staff and patients leads to patient aggression	41	44.54	43.98	4.019	.894	.377
Q7 There are types of patients that are aggressive	41	45.10	43.66	3.828	2.407	.021
Q8 Different approaches are used on the ward to manage aggression	41	40.80	39.39	3.521	2.572	.014
Q9Patients who are aggressive should try to control their feelings	41	46.46	45.22	4.116	1.935	.060
Q10 When a patient is violent seclusion is one of the most effective approaches	41	61.59	62.54	4.098	-1.486	.145
Q11 Patients who are violent are restrained for their own safety	41	54.15	51.46	3.356	5.106	.000
Q12 The practice of secluding patients should be discontinued	41	57.88	56.63	3.441	2.315	.026
Q13 Medication is a valuable approach to treating aggressive and violent behaviour	41	54.32	54.22	3.852	.162	.872
Q14 Aggressive patients will calm down if left alone	41	59.17	57.93	4.259	1.870	.069
Q15 Negotiation should be used more effectively when managing aggression and violence	41	31.83	32.24	3.860	-.688	.496

NB, low scores indicate agreement; high scores indicate disagreement with that statement

Question Number	N	Mean before training	Mean after training	SD	*t*	*P*
Q16 Restrictive environments can contribute towards aggression	41	23.39	22.71	4.198	1.042	.304
Q17 Expressions of anger do not always require staff intervention	41	45.24	43.54	4.718	2.317	.026
Q18 Physical restraint is sometimes used more then is necessary	41	48.46	48.83	4.218	-.366	.659
Q19 Alternatives to the use of containment and sedation to manage physical violence could be used more frequently	41	31.12	31.20	3.830	3.830	.598
Q20 Improved one to one relationships between staff and patients can reduce the incidence of aggression	41	25.98	25.41	4.330	.561	.676
Q21 Patient aggression could be handled more effectively	41	41.29	41.39	4.420	-.098	.690
Q22 Prescribed medication can sometimes lead to aggression	41	59.39	60.51	4.371	-1.122	.683
Q23 It is largely situations that can contribute toward the expression of aggression by patients	41	40.63	40.07	4.056	.561	.633
Q24 Seclusion is sometimes used more than necessary	41	45.68	45.37	4.310	.317	.673
Q25 Prescribed medication should be used more frequently for aggressive patients	41	56.07	55.93	4.542	.206	.838
Q26 The use of de-escalation is successful in preventing violence	41	26.71	26.15	4.038	.890	.379
Q27 If the physical environment were different, patients would be less aggressive	41	48.56	48.32	4.306	.363	.719
Q28 How confident are you in your capability to deal with verbal abuse originating from colleagues	41	23.73	23.04	3.471	.000	1.000
Q28 From Managers	41	54.59	55.37	4.327	-1.155	.255
Q28 Other staff	41	32.39	31.63	3.719	1.134	.264
Q29 How confident are you in your capability to deal with verbal abuse from service users	41	21.05	20.85	3.458	.361	.720

Question Number	N	Mean before training	Mean after training	SD	*t*	*P*
Q30 How confident are you in your colleagues ability to come to your assistance during an incident and to be sympathetic and supportive afterwards?	41	23.07	23.39	3.719	-.513	.611
Q31 How confident are you in your Trust's capability to tackle violence and aggression	41	48.61	49.17	3.458	-.790	.434
Q32 How anxious are you about the possibility of personally experiencing some form of violence and aggression whilst at work	41	67.37	67.61	3.959	-.337	.738
Q33 The team in which I work is clear about what they are trying to achieve when managing an aggressive incident.	41	36.10	36.90	4.544	-1.251	.218
Q34 We know that we can rely on one another when managing an aggressive incident	41	19.93	19.63	4.630	.436	.665
Q35 We meet together sufficiently frequently to ensure effective communication and co-operation.	41	37.95	38.10	4.118	-.187	.853
Q36 People in the team are quick to offer help to try out new ways of doing things	41	40.73	40.88	4.297	-.223	.825
Q37 There is a feeling of trust and safety within the team.	41	29.78	29.66	5.018	.216	.830
Q38 We are enthusiastic about innovation within the team	41	22.85	23.00	4.297	-.276	.791
Q39 We can safely discuss errors and mistakes in the team	41	30.37	29.95	5.018	.651	.519
Q40 We work supportively together to get the job done within my team	41	20.44	20.59	4.210	-.266	.792

Whilst there was no significant differences recorded in the MANVAS before and after training; a number of themes did emerge from the survey. Namely, that staff views on the management of violence and aggression remained largely unchanged despite having undergone training. This suggests that training had little impact on the way participants thought about the management of violence and aggression and that these were formed and established elsewhere as part of clinical experience and a wider educational approach.

Participants would seem to agree that there are things that can be done in order to prevent patients from becoming aggressive (Q4). That improved one to one relationships between staff and patients can help reduce the incidence of aggression (Q20).

There would seem to be some agreement amongst participants that restrictive environments can contribute towards aggression (Q16) and that patient aggression could be handled more effectively (Q21), despite different approaches being used (Q8).

Prescribed medication would seem to have a part to play in the management of aggressive patients (Q25), although there is recognition that in some cases it could make the matter worse (Q22).

There would seem to be disagreement amongst participants as to the use of seclusion (Q10), although, for some, it remains an appropriate means of managing an aggressive person (Q12), despite a suggestion that it is used more than necessary (Q24). Likewise, the use of restraint would seem to be supported by some participants (Q11), although there is a suggestion that it is used more than is necessary (Q18).

There would seem general support for the use of non-physical approaches to management and recognition that expressions of anger do not always require staff intervention (Q17); that non-physical methods could be used more frequently (Q19) and that the use of de-escalation is effective (Q26). There was also a general consensus that negotiation could be used more effectively (Q15).

Staff would seem confident in their ability to deal with verbal abuse originating from colleagues, suggesting that there exists a degree of trust between staff members (Q28A). However, staff would seem less confident in their ability to deal with verbal abuse originating from managers (Q28B), and that from other staff (Q28C). Staff would seem to be confident in their ability to deal with verbal abuse from service users (Q29); although, staff would seem to lack a degree of confidence in their Trusts' ability to tackle violence and aggression (Q31). Participants appeared to not worry about the possibility of experiencing some form of violence and aggression whilst at work, suggesting a feeling of security in their job role (Q32). Staff would seem to be able to rely on the people they work

with when managing an aggressive incident (Q34) and are generally supportive of each other when managing violence and aggression; although it may not always be clear what they are trying to achieve as a team when managing an aggressive incident.

6.5 Organizational Support

This final CMO suggested that in order for aggression management to be affective then it required organizational and managerial support and that staff recognize and acknowledge this as part of their work.

Each of the two Trusts had a culture of responding to this type of initiative, and a track record of work improvement and innovation (as demonstrated in the depth of their training portfolios and annual reports). Both Trusts recognized the importance of reducing the incidence of violence and aggression, and that the prevention and management of such behaviour was the responsibility of all staff.

> *Everyone should recognize that they have a role in reducing workplace violence and aggression and that prevention is better than cure* (Trust Senior Manager, Mental Health: INTSM2).

And

'Training staff in violence and aggression management is important because of the effect that such behaviour can have on staff and those they care for ... personal and patient safety is essential'. (Trust Senior Manager: INTSM5).

Furthermore

'Staff should not fear coming to work ... they should be able to care for people and be cared for, without worrying about being attacked. The promotion of a safe and therapeutic environment is an important key to prevention' (Trust Manager Learning Disability: INSM1).

Despite the high profile attached to such training, neither Trust had sought to undertake a training needs analysis, either of their staff or organization, before or since the commissioning of the two programmes. Both aggression management programmes had been 'bought off the shelf' in order to meet statutory obligations regarding the safety and wellbeing of staff and patients. Contracts had been awarded on the basis of cost, an adherence to recognized national standards and an affiliation and trainer accreditation to a national body, for example BILD. In this sense the needs of the organization had been considered but not necessarily those of the staff.

Training was seen as a key strategy in reducing violence and aggression. All stakeholders agreed that there were benefits from promoting and supporting aggression management training, particularly in terms of increasing staff confidence.

> *'It's important that all staff working in high risk areas have the necessary skills and knowledge to deal with a range of situations and that they are able to practice safely and with confidence* (Senior Manager Mental Health: INSM3).

Training did little to emphasize and demonstrate the organizational context of aggression management. Whilst content included reporting procedures and how information was processed and used to take action, it did not demonstrate how the organization was progressing and learning from actions taken.

Training was mandatory for all clinical staff regardless of grade or profession in both Trusts. There was overwhelming recognition as to the value, importance and 'necessity' of aggression management training being afforded mandatory status. In doing so, it ensured the sustainability of the two programmes in the medium to long term, for example, funding and release of staff to attend training.

'It's important that violence and aggression training be given a high priority to ensure that staff get the training that they deserve and are supported in accessing this' (Trust Manager Learning Disabilities: INTSM1).

It is noteworthy that the mandatory status of aggression management training may have influenced how staff responded to the training provided. This could have meant that staff were less than interested in what was happening and were instead simply motivated to pass the course. As one participant put it,

'... its enough that you've got to attend these things without having to jump through hoops as well'. (Staff Nurse Mental Health: FN49)

Although all stakeholders expressed interest in the long-term effects of the aggression management training, none of the interviewees indicated that they were involved in long-term impact evaluations of their programmes. Stakeholders seemed satisfied in the knowledge that the training fulfilled the Trusts' legal and statutory obligations, although those interviewed had difficulty articulating exactly what these were, other than to provide a

'safe working environment for staff ...that staff are prepared appropriately for their roles, including the management of violence and aggression. ' (Senior Trust Manager Mental Health: INTSM6)

Each Trust was keen to point out that there had been a reduction in the number of reported incidences of violence and aggression since the introduction of the training. This was cited as a key criterion when measuring the success of a programme by several of the stakeholders interviewed and one highlighted as being important within the literature.

> *'This is an important performance indicator for the Trust and one which is monitored by outside agencies, including service user groups. It's important that we can demonstrate as a Trust that we are taking action to reduce levels of violence and aggression' (Senior Trust Manager Mental Health: INTSM3).*

To what extent this reduction in reported incidences was directly attributable to the training provided and not some other extenuating factor was debatable however, as no real evaluation of the impact of training on clinical practice had been undertaken by either Trust.

Since the instigation of the training in both Trusts a copy of the incident report forms are now sent to the lead trainers for evaluation and monitoring. The idea behind this initiative is that additional training and support can be made available to those areas that demonstrate need. One manager interviewed hinted that it may have an alternative purpose; that it:

'acted as a policing service' to check up that proper techniques were being followed ... or at least to ensure that staff were filling out the forms correctly' (Trust Senior Manager Learning Disabilities: INSM4)

6.6 Chapter summary

The study provided an opportunity to examine a wide range of issues relating to aggression management training. Through a multiple method approach, the following research highlighted several themes which will now be explored as part of the general discussion in the chapter that follows. The findings suggest that there is a need to provide training in the management of violence and aggression and that this is something welcomed by participants. Whilst the training of staff is seen as important, questions remain as to the effectiveness of such programmes in preparing staff to deal with such behaviour in clinical practice. The importance of preparing and supporting staff in training was also highlighted, as was the need to support knowledge and skill transfer.

Chapter 7

Discussion

7.0 Introduction

The over-arching aim of this study was to evaluate how effective the two aggression management training programmes were in preparing staff for coping with violence and aggression they might encounter as part of their role. This is an area in which the existing literature and policy papers suggest there is a paucity of research (See Chapter Three Literature Review). To this end, the study sought to fill the gap between the research cataloging training content and the use of taught skills back in clinical practice. The findings chapter showed the extent to which this aim was achieved. In this chapter the researcher will discuss how the study has added new knowledge to the field of aggression management training.

The chapter begins with an overview of why and how the study was conducted. There then follows a discussion of the key findings in relation to the aims of the study and the wider literature in this field. It will also explore as part of this discussion the application of realistic evaluation as a methodological framework for an evaluation of aggression management training. Following this a reflection on the use of a realistic evaluation informed evaluation will be provided before conclusions are summarized and recommendations for further research and practice are made. The final section concludes the study and discusses my own personal learning from conducting the research.

This study is original because to my knowledge it is the first to use the principles of realistic evaluation (Pawson & Tilley 1997) to evaluate aggression management training. In using such an approach it not only allowed the researcher to uncover *what* participants had gained in the way of learning and new skills, but also *how* this had been, or not been achieved. A key element of this was the design of the study, which followed the participant journey through training and back into clinical practice.

7.1 Summary of the Study Problem

The level of violence and aggression towards healthcare staff has been a concern to health professionals, policy makers and politicians for some time now (Commission for Health Improvement 2004; National Audit Office 2003; RCN 2007). Whilst there is some disagreement about the extent of violence and aggression faced by staff, there is a recognition that anyone who works for the healthcare sector and has contact with the general public, is at risk from such behaviour (Healthcare Commission 2007; Linsley 2006; RCN 2004).

With the growing evidence of the scale of the problem and the damage that it causes, a number of strategic responses at a local and national level have been launched to meet the challenge. These include a range of measures aimed at reducing workplace violence and aggression as well as guidance on the use of restraint and medication management (NICE 2008). The prevention and management of aggression is acknowledged as a specialized area of clinical

practice requiring skills, knowledge and a positive attitude to effectively and confidently manage (Johnson & Delaney 2006), and that training is often held to be a primary element of the strategy for combating work-related violence and aggression (NIMHE 2004).

The provision of aggression management training was welcomed by all the participants in the study who felt that such behavior presented a real risk to staff working in mental health and learning disability services. The need to provide such training is reinforced in the literature (Needham 2006; Paterson 2006; McCue 2004), by professional bodies (RCN 2007; RCP 2006; NIMHE 2004) and by the mandatory status that is attached to aggression management training.

Whilst the training of staff is seen as a key element to the prevention and management of violence and aggression; questions remain as to the effectiveness of such programmes in preparing staff to deal with such behavior back in clinical practice (Mental Health Act Commission 2005; Paterson et al 2008). Problems have also been highlighted in the way such programmes are evaluated and developed. Many programmes evaluate to the level of staff satisfaction to the course, and though such evaluation can be useful in improving training programmes, it does not demonstrate how learning has been integrated into practice or the benefits to the employing organization, patients and staff.

It is important to note that offering training in aggression management has become the most common employer reaction for reducing violence and aggression against health staff (DH 2006). Awareness campaigns, encouraging employees to report and to monitor violence and aggression, and the introduction of personal training on aggression management are common to many schemes around the world (WHO 2006). What we do not understand fully is the impact of aggression management training on the safety of workers. Whilst such training may serve to minimize the legal liability of employers it may not provide the necessary safety for staff. Also, such training, while potentially helpful, often places the burden of minimizing and managing such behaviour on the shoulders of staff themselves (WHO 2006, 2000; Stanko 1996).

There is a recognized need to develop a more systematic approach to the evaluation of aggression management programmes that goes beyond 'customer satisfaction' to allow organizations and their staff to make informed decisions as to the effectiveness of individual training programmes (Healthcare Commission 2007; McGeorge 2007). Without such an evaluation healthcare organizations will have little, if any, reliable and valid evidence as to the effects and value of the training that they invest in (Health and Safety Executive 2006). They should be aware of exactly what training is needed, at what level, how it should be delivered and to whom (Brooker et al. 2002). To date there is a relative paucity of well-designed studies into the effectiveness of the training to prevent and

manage violence and aggression in Healthcare settings (See Chapter Three Literature Review for further evidence in support of this statement).

7.2 Summary of Methodology

This study utilized realistic evaluation principles to evaluate two aggression management programmes run by two Mental Health and Learning Disability Trusts in the East Midlands region. Realist evaluation is a form of evaluation research that draws on the theories and methods of the social sciences to identify the extent to which, and at what cost, a programme achieves its intended goals. Grounded in the philosophy of realism it is situated between the extremes of positivism and relativism it recognizes that the world is an open system, played out by actors, in different settings, at different levels, that interact to form mechanisms and contexts (Chen & Rossi 1981). Realistic evaluation is based on the proposition that causal outcomes follow from mechanisms acting in contexts. A realist evaluation cycle involves framing theories which identify and explain regularities, deriving hypotheses concerning what might work for whom in what circumstances, testing these through multi-method data collection and analysis, which can them inform further generalizations and lead to revision of theory and new hypotheses. The question asked of traditional experimentation is 'Does this work' or what works?' the question asked within realistic evaluation is 'what works for whom in what circumstances?' (Pawson and Tilley 1997: 220). Because causal mechanisms are always embedded within particular contexts and social processes, there is a need to understand the complex relationship

between these mechanisms and the effect that context has on their operationalisation and outcome. Pawson and Tilley (1997) sum this up as: context (C) + mechanism (M) = outcome (O). Because these relationships are contextually bound, they are not fixed; that is, particular interventions/programmes/innovations might work differently in different situations and circumstances. Rather than identifying simple cause and effect relationships, realistic evaluation activity is concerned with finding out about what mechanisms work, in what conditions, why, and to produce which outcomes? Realistic evaluation was particularly relevant to evaluating the two aggression management programmes in this study, as it is well suited for interventions where outcomes are determined through stakeholder action and interaction, which in turn is likely to be influenced by social and cultural and organizational norms back in clinical practice.

Realist evaluation is increasingly being used in the healthcare sector (Porter and O'Halloran 2009), recognizing that programs and interventions requiring behavioral change, such as those played out in aggression management training, operate within a complex social and cultural context, and that the operating context plays an important role in determining impact (Scott et al 2008; Byng et al 2005; Pawson et al. 2005). In such circumstances, the traditional approach of evaluating success based on whether or not a pre-defined outcome is achieved does not provide decision makers with sufficient information to assess the value of the program outside the context in which it was tested. The research question

called for an understanding of how aggression management training was being conducted and what sort of impact it might be having on clinical practice; i.e. what were clinicians able to take from the training and incorporate into their clinical practice. In trying to understand the training being offered to clinicians I was concerned with the approaches used to promote learning (mechanisms), within the two training programmes (context), and what impacts this resulted in (outcomes); i.e. what worked or not. Fundamentally, I was interested in finding out: what worked, for whom, why and in what circumstances? Further details of this methodology are presented in Chapter Four.

7.3 Summary of study design

The evaluation was conducted in four stages corresponding to the four components of the realist evaluation cycle (theory, hypotheses generation, observations, and program specifications) as described by Pawson and Tilley (1997). These stages were undertaken sequentially with each stage feeding into and informing the next.

7.3.1 Stage one: theory

The first stage of the study was to undertake a comprehensive search and review of the literature looking at the different types of training that healthcare staff had received in the management of violence and aggression with the aim of identifying potential CMO configurations. By focusing the review specifically on

the healthcare sector, the information collected was considered to be context specific. Further details of the literature review are reported on in Chapter 3.

In addition to the literature review, the researcher interviewed stakeholders (n=6), that is senior managers responsible for the commissioning and administration of the two aggression management training programmes with the objective of understanding how the two programmes had been commissioned. These meetings also provided an opportunity for the researcher to gain a greater understanding of the aggression management programmes under investigation and to start to familiarize himself with the trainer providers. Notes taken of these meetings provided valuable information that fed directly into the research evaluation process and the formulation of the CMOs. Reporting of this can be found in Chapter 5 Data Collection and Analysis.

7.3.2 Stage two: hypotheses generation

The second (hypotheses generating) stage involved rephrasing the CMO configurations theorized in stage one as 'hypotheses' for testing in stage three. In the end, five CMOs were formulated for use in the study. The first of these CMOs looked at the relevance of what participants were taught; the second CMO looked at participants' knowledge and skills developed over the course of the training; the third CMO looked at how participants used these knowledge and skills back in clinical practice; the fourth sought to capture any changes in participants' attitudes towards the management of violence and aggression as a

result of having attended the training; the fifth and final CMO looked at the organizational support available to participants in putting what they had learnt into practice. See Chapter 4 Methodology for a fuller description of the CMOs used in this study and their formulation.

7.3.3 Stage three: evaluation

The CMOs developed in stage two were tested during stage three. This consisted of a number of 'mini studies' using a combination of data collection methods including questionnaires, semi-structured interviews, documentary analysis, field work and participant observation. See Chapter 5 Data Collection and Analysis and Chapter 6 Findings.

7.3.4 Stage four: programme specifications

The fourth and final stage was to analyze the findings. This was done by reviewing the potential CMO configurations from stage one in light of the findings in stage three. The CMO configurations that were supported with regularity formed the basis for possible explanations as to why certain outcomes were or were not achieved; and this is discussed here.

7.4 Discussion of findings

I will now discuss the findings from the previous chapter in relation to the five CMOs highlighted above. Findings will be discussed in relation to the literature review (Chapter 3) and with regard to the broader literature on aggression

management and training. It is important to note that no previous studies have identified *how* aggression management training prepares and supports staff to deal with violence and aggression they may encounter as part of their role back in clinical practice.

7.4.1 CMO One: Relevance

The first CMO proposed that if staff saw relevance in what was being taught then they would actively engage with the training and readily incorporate new skills and knowledge into their clinical practice. It was 'hypothesized' (Pawson & Tilley 1997) that training that participants regarded as irrelevant to their clinical practice, counter to their personal or professional values, or actively destructive to either their own well-being or that of their clients, would be rejected or in part dismissed. Whilst previous studies have examined training content against national guidelines (Lawson 2009; Paterson et al. 2006; Tansey 2003), this is the first study to the researcher's knowledge, to look at the relevance of what is being taught from the viewpoint of those actually undergoing aggression management training.

The need to provide training in the management of violence and aggression has been driven by a number of factors none more so than staff themselves (Wales Audit Office 2007; Health Care Commission 2007; Bowers et al. 2006), and it is therefore important that staff receive training that they perceive as being important and relevant to them. The findings of this study supported the

hypothesis that staff were more likely to engage with training that had relevance and meaning to them and their clinical practice.

Training preparation and support prior to staff attending training was found to be an essential mechanism. Despite the high profile attached to such training, neither Trust had sought to undertake a training needs analysis, either of their staff or organization, before or since the commissioning of the two programmes. The literature attests to the importance of undertaking a training needs analysis both of the organization and staff prior to the commencement of training (European Commission for Education 2007; Barbazette 2006; Pierre 2001). Only five of the participants reported having had their training needs discussed with them prior to commencing the course; with some only finding out the week before that they had a place on the course. This meant that many of the participants felt ill prepared for the training they were to receive. It is important that staff understand the training that they are being sent on and the reasons for this; they also need to clear on what is expected of them on their return to work having attended training (Pollard 2007; Estall 2004; Anderson 2002). A needs assessment provides the information that is usually necessary for designing training programs. The basic purpose of a training needs analyses being to identify the knowledge and skills that people must possess in order to perform effectively on the job, an to prescribe appropriate interventions that can close these gaps_(Gupta 1999: 8).

Both aggression management programmes had been 'bought off the shelf' in order to meet statutory obligations regarding the safety and wellbeing of staff and patients. Contracts had been awarded on the basis of cost, an adherence to recognized national standards and an affiliation and trainer accreditation to a national body, for example BILD. In this sense the needs of the organization had been considered but not necessarily those of the staff.

This type of 'stand alone' solution to an otherwise complex problem has been criticised within the literature as failing to meet the needs of those undergoing training (HSE 2006; Occupational Safety and Health Administration 2004; Workers' Compensation Board of British Columbia 2000). Some studies have shown that members of staff who have received training in violence and aggression management are more likely to be assaulted after they have received such training (Verdun-Jones et al. 2006; Sullivan 2005; Mayhew 2003). There are a number of possible explanations for this including staff feeling overly confident after training, particularly when dealing with violent situations, which may be beyond the range of the new skills they have acquired.

Whilst the training was mandatory, and reportedly for all members of staff, it was predominately nursing staff who attended the aggression management training provided by the two Trusts. In some ways, this is unsurprising as nursing staff make up the majority of the workforce and are most likely to look after patients who display disruptive and aggressive behaviour. Likewise, all the trainers in this

study had a background in nursing, and it was this that they drew upon when talking about their experiences of using the taught techniques, reinforcing the message that violence and aggression is something that is largely encountered and dealt with by nurses in clinical practice.

A number of participants interviewed (n=9) argued that the risk of being involved in an aggressive incident or experiencing an actual assault whilst in service was such that it needed to be acknowledged much early than it was and incorporated into staff induction packages. Some participants reported having to wait up to six months before commencing training (n=4); which they felt put them at a heightened risk of violence and aggression. The timing and provision of training is highlighted as an important consideration in the literature when planning and delivering training of this kind; the 'general rule' being that it should be consummate to the level of risk faced by the individual staff member ; with priority being given over to those considered to be at high risk (Foster et al. 2007; HSE 2006; NHS Health Development Agency 2002).

The way in which the two training programmes were taught was considered to be an important mechanism in this study. Whilst other studies have concerned themselves with course content and the subsequent impact of learning on clinical practice (Stubbs et al. 2009; Bowers 2006; Beech & Leather 2006), this is the first study to investigate how aggression management training was delivered and taught.

Both training programmes were up to date and in keeping with guidance set out by relevant bodies or groups (e.g. National Institute of Clinical Excellence (2006); CFSMS Training syllabus (2007). This policy and guidance provides a range of topics in which staff should be instructed including the recognition of anger and potential aggression, carrying out observation, risk assessment and management, de-escalation skills and physical intervention techniques (e.g. breakaway); and includes elements important to other parts of service delivery e.g. clinical governance, leadership, and patient safety. Whilst this guidance provides a framework by which to plan and carry out training, it is left to the different organizations to decide the timing and depth to which a topic is explored. In practice these issues were decided upon by the lead trainers for the two programmes based on personal and professional judgment. Invariably this meant the teaching of physical skills such as breakaway and restraint, which dominated the teaching of both programmes, at the expense of other approaches and techniques (i.e. de-escalation strategies).

Both training programmes were set and delivered within an instructional framework from which there was little divergence by trainers. This meant that content was not always appropriate for participants, neither relating to their existing knowledge, role or skill level. For example, the use of breakaway techniques and the summoning of help were often taught from the prospective of

those working 'on the wards' and ignored the needs of those working in the community.

Limited opportunities existed during the training for participants and instructors to assess progress and gain/give feedback. This was often done in a piecemeal fashion when it was undertaken and often in the form of a compliment. It was reportedly hard for participants to gauge how they were doing and assess the value of what they had learned. Timely and appropriate feedback can provide opportunities for people to self-monitor their progress and make good any shortfall in their learning (Race 2009). Furthermore, people work more effectively when they know what they are working towards and how they will be assessed (Wehwein 2007). The literature further suggests that people welcome feedback that 1) explains how they are doing, 2) rewards their achievement as appropriate, and 3) offers suggestions for how they can improve (Nicol & Macfarlane 2006).

The use of simulated exercises dominated the teaching of both programmes, and is a common feature of aggression management training (HSE 2006; Farrell & Cubit 2005; NIHME 2004). Their use is intended to promote a sense of realism to the activities presented during training and provide participants with the opportunities to develop knowledge and skills needed for specific contexts, jobs or roles (Martin 2007; Bloor et al. 2004; Calabro et al. 2002). Participants complained of the unrealistic nature of these exercises and they way in which they were used in the course. Care needs to be taken to ensure that any activity

provided meets the requirements of the programme and can be transferred to the workplace and is therefore a realistic representation of the knowledge and performance/competence required back on the job and not provided piecemeal.

Another important factor that frequently emerges in descriptions of learning that support knowledge construction relates to the degree of authenticity contained within a learning environment (Soeren et al. 2011; Verdun-Jones et al. 2006; Ilkiw-Lavalle et al. 2002). Both programmes took place at a designated training suite divorced from the clinical practice area. No provision was made to simulate a clinical environment with the training of breakaway and restraint taking place in a large hall devoid of furniture and having in situ safety mats. Participants' spoke of the unrealistic nature of this and how this impacted on their learning; with many having difficulty relating what they saw to clinical practice. The importance of the learning environment is supported by Pawson and Tilley's (1997) argument that:

> 'subjects will only act upon the resources and choices offered by a programme if they are in conducive settings' (Pawson and Tilley 1997: 216).

The literature supports the contention that immersion in realistic simulated environments is a helpful and powerful tool for gaining the experience and generating the self-confidence needed to solve real life problems (Van Soeren at al. 2011; Galloway 2009; Gaba 2004). Practice in real world settings allow events

to be played out and rehearsed in a safe and supportive environment from different viewpoints enhancing learning and understanding of the situation. This is achieved through active participation and modelling of events that the participant is likely to encounter as part of clinical practice rather than from books and passive observation (Van Soeren et al. 2011; Galloway 2009; Gaba 2004). By constructing authentic activities in realistic settings practitioners are encouraged to employ decision making skills and problem solving as they would in clinical practice without the risk of injury and harm and embodies many of the strengths of traditional training programmes while minimising their intrinsic limitations. This increased confidence and versatility of skills is likely to have a positive effect on both performance and patient care.

Such learning environments should preserve the full context of the situation and allow for the natural complexity of the real world. The concept of authenticity however is a deeply contested one (Gredler 2008; Harrington 2002; Jonassen 1994); an authentic activity has reference to context, motivation, task, feedback, working patterns and interaction. Just how these factors interact with each other is still uncertain, but it is clear from the literature that the factors require to be carefully managed and promoted if successful learning is to take place and should be borne in mind when planning and delivering training.

Training and assessment did little to support organizational and team practices and procedures, again highlighted in the literature has being important (Hills

2008; Jonker et al. 2008; Hesketh et al 2003), but instead focused on individual performance in relation to the development of physical skills. Competence was gauged as having been achieved when the participant was able to replicate a move or technique to a level satisfactory to the trainer. In the absence of any knowledge/theory based assessment this again ensures that the focus of training and subsequent evaluation was on the acquisition of a prescribed set of skills/techniques.

Other than the use of simulated exercises, trainers tended to be didactic in their teaching, with an over reliance on PowerPoint as a means of conveying information and knowledge. Written materials were offered in support of learning and teaching (namely national guidelines) and use of the internet and web sources encouraged. The expectation from the trainers was that staff would read around the subject although this was never verified and fed back or built upon during training.

There have been many studies that have looked at what constitutes a good training experience. These studies offer insights into training effectiveness, patterns of learning and broad explanations as to what works best from the viewpoint of those undergoing training. This research highlights the need for engagement between trainer and trainee and importance of problem-solving and creativity. This is underpinned by humanistic values and principles which view people as active and resourceful agents capable of progression through the

programme. This research demonstrates that people learn more effectively when they are actively engaged in pedagogic activity, through discussion, dialogue and argumentation (Mercer and Littleton 2007).

A range of classroom activities have been suggested in the literature to encourage learners to become more actively involved in their learning and to engage in discourse and reflection (Leipen 2012; Reichmann 2010; Wehwein 2007). These activities include critical incidents, autobiographies, self-assessment and appraisal of learning and problem-solving; all highlighted as important elements in the development of clinical practice (RCN 2008).

It is noteworthy, within the context of the study, that the mandatory status accorded aggression management training may have influenced how staff responded to the training provided. This could have meant that staff were less than interested in what was being taught and were instead simply motivated to pass the course

7.4.2 CMO Two: Knowledge and skills acquisition

The second CMO configuration suggests that staff knowledge and skill base is increased as a consequence of training and that while they may not be able to put this into practice straight away, staff are able to articulate and give voice to what it is they learnt and draw upon this knowledge and skill base as needed. Previous studies have found that staff knowledge increases following training

(Morrison 2005; Wright 2003; Calabro et al. 2002). In keeping with these studies, the aggression management training programmes evaluated in this research led to significant gains in knowledge; however this was largely contained to the use of breakaway and restraint.

Whilst knowledge significantly increased following aggression management training, this research has also moved beyond examining knowledge and investigated the impact of skill acquisition from training. The aggression management training used here also led to significant gains in skills required in managing aggression and violence. However, this again was in relation to those skills used as part of breakaway and restraint (See Findings Survey 3: Page 154--). Neither set of findings would seem surprising given that much of the teaching and assessment was focused on the use of breakaway and restraint.

Whilst this research has replicated in part the findings of other studies in which knowledge and skills increased following aggression management training, this research has advanced this further and is the first to examine the extent to which participants felt capable of managing violence and aggression in practice having attended training. A key measure of the success of effectiveness of any programme of instruction should be the realization within a delegate that training has provided them with a healthy sense of belief in their capacity to perform and to cope with the work situations that they might face (HSE 2006). Whilst 78% of those surveyed on exiting the training reported that they did feel capable of

dealing with violence and aggression back in clinical practice, they did not necessarily attribute this to the training they had just received.

Participants were also asked how they thought aggression management training could be improved. Participants identified three key skills used in managing aggression and violence that they would like instruction on. First verbal communication and interpersonal skills to manage an aggressive situation were emphasized. Second, having a greater range of skills to respond physically to violence when attacked than those taught currently. Third, the teaching of de-escalation skills, which many of those surveyed (n=44) thought was lacking from the current training. Additional comments about the training included regular ongoing training, being taught alternative team approaches for physically restraining patients, being taught negotiation skills and gaining broader skills in managing difficult patients such as those with personality disorder or duel diagnosis. This replicated the findings of other studies (Bowers 2008; Patterson 2007; Hantikainen 2000) and demonstrates a need for a wider range of training. A number of participants (n=7) also suggested that training be giving in dealing with aggressive relatives and friends; a recognition that violence and aggression does not only come from the patient, but people that staff come into contact with as part of carrying out their work (Linsley 2006).

It has been argued that the present format of training on the management of violence and aggression in the UK still perpetuates the use of less therapeutic

strategies (Paterson 2008; Duxbury 2007; Bowers 2006); this study has done nothing to refute this. The current emphasis on reactive management training is often used as a replacement for, rather than an adjunct to, properly designed and individualized training strategies, which also induct staff into the values, aims and practices of the agency. The promotion of therapeutic relationships is necessary if aggression is to be handled more effectively (Bowers 2012; Patterson 2008; Duxbury 2002). Training content has to be examined and wherever necessary redress any imbalance in terms of content areas associated with positive benefits (i.e. the relative lack of emphasis upon both verbal intervention and de-escalation skills).

7.4.3 CMO 3: Transfer of skills from training to clinical practice

The third CMO proposed that staff needed to be allowed to practice their skills and exchange ideas about aggression management having completed their training in order to avoid becoming de-skilled. Training needs to be delivered in such a way that practical benefits to the workplace can be observed and to enable the employees to be able to transfer their new knowledge and skills to the benefit of all of the key stakeholders (Chiaburu & Lindsay 2008:199). This research followed up staff in aggression management on their perceived use of skills back in the clinical environment and was the first study to look at the mechanisms that supported transfer and utility of skills in clinical practice.

This study found no clear links and strategies to support the end goal (transfer) of training to the clinical environment following training; in particular there was a lack of performance indicators regarding desired behavior back in the job. The emphasis was on staff to take what they had learned and incorporate this within their own practice and thinking. No support or suggestions were offered as to how this could be achieved or the possible barriers staff might encounter when attempting to do this. Competence was gauged as having been achieved when the participant was able to replicate a move or technique to a level satisfactory to the trainer. In the absence of any knowledge/theory based assessment this again ensures that the focus of training and subsequent evaluation was on the acquisition of a prescribed set of skills/techniques at the point of completing the training.

As practice implies doing, it carries the notion that learning as knowing in practice requires the development and mastery of skills at work in order to become proficient in their use (Cook & Brown 1999). While Calabro and colleagues (2002), Duxbury (2004) and Bowers (2008) found that following aggression management training staff had a strong intent to use the skills learned from training, their studies did not follow up staff to investigate whether they able to use what they had learnt in clinical practice. In this study, only six of those interviewed said that they had been able to put their learning into practice. The examples given ranged from very specific incidents (involving some sort of physical intervention), to more general ways of relating to people and

understanding situations. Participants who had attended training, but then had no opportunity to put their learning into practice (e.g. because they had not experienced any aggressive behaviour) felt less confident about their ability to use their skills effectively.

Parallels can be drawn between the findings of this study and those of the Thorn Programme which was run over a three-year period between 1992 and 1995 in an experimental mode. Nurses were recruited to the course, which ran over one academic year, with students coming one day a week into the classroom. The skills taught in that classroom day were then practiced during the remainder of the working week with their case-load in their work setting. To reinforce skills acquisition, the course also involved students making audio-tape recordings of their interactions with patients, and carrying out assessments using the methods that had been taught on the programme. Findings from this period (Kavannagh et al. 1993) showed that graduates quickly stopped using the skills acquired during training, or used them in a modified fashion. This was attributed in part to a lack of confidence on the part of person to carry out the skills once support and validation had been removed.

Another area that has not previously been studied is the barriers faced when putting their new found knowledge and skills into practice. The most frequently cited barrier (N=16) in this study to putting learning into practice was considered to be an inability or unwillingness of existing staff to change their current ways of

working. There were also difficulties ensuring commitment from some colleagues. Two reasons would seem to account for this. Colleagues would not always see the relevance of their training to their area of practice or sometimes could not see beyond their own clinical priorities.

Previous studies have indicated that training in aggression management increases staff confidence (Haines 2005; Wright 2003; Goldenhar et al. 2002). However, a gap in this knowledge exists as to whether or not staff remained confident in the use of skills back in practice. In this research, the majority of participants stated that they did not feel confident in carrying out techniques learnt, with many having difficulty recalling information once back in the workplace. This caused participants a degree of concern particularly with regards to their improper use in practice.

Participants were asked their views about common aggression management strategies, including interpersonal and physical or 'controlling' means of management as part of this study. Previous research has found that the severity of aggression increased the likelihood of certain clinical interventions used. Whilst all those interviewed in training (n=24) recognized that '*restraint should be a last resort*', a small number of those interviewed (n=4) admitted that it was often seen as the only means of managing a situation. This runs contra to the underlying principles of aggression management training (NHSSMS 2006), which

include the use of least restrictive interventions, the use of verbal de-escalation as a primary technique, and the use of restraint as a last resort.

This research was also the first to examine what skills participants used when dealing with violence and aggression other than those covered in their training. Interpersonal skills were frequently identified by participants, in particular in relation to abilities in communication and in the development of relationships. These skills may be considered as the most important staff factors as they relate to the development of therapeutic relationships that are central to the clinical role in nursing (Fritscher 2009; College of Nurses of Ontario 2006; Freshwater 2002). Although some of the responses were about generalized communication, respondents emphasized the ability to express things in an appropriate way; for example, how the staff member talked to a patient. However, in this context, respondents were most concerned about the importance of staff remaining calm and in control of themselves. This seemed to be linked to self-awareness, in the sense that skilled nursing staff were regarded as being able to monitor how they presented themselves, and model a calm concern. Interpersonal skills training were identified by the participants as a major training need for their colleagues and there is some evidence that interpersonal skills can be improved by training (Stephen et al. 2011).

A great emphasis was also placed on the importance of the nurse-patient relationship in reducing and managing health care violence and aggression by

those interviewed. The literature also attests to the value of nurse-patient relationships in providing nursing care (Benner, 1984; Rew & Barrow, 1987; Doyle, 1996; Olsen, 1997). However, in the context of this study, this relationship was also of perceived protective value in a potentially violent situation. A good relationship appeared to give respondents an understanding of the patient, allowing them to detect changes in the patient's behaviour which were suggestive of possible aggression and violence and guiding actions with specific individuals. Most importantly, this relationship also appeared to give respondents the confidence to intervene and try out new approaches and techniques to reduce potential violence and aggression.

Importance was also placed on good team work when dealing with an aggressive incident, including having a full complement of staff. Again, this is an area highlighted as being essential to the management of violence and aggression in the literature (Ford et al. 2010; Russell et al. 2009; Linsley 2006). Staff reported feeling more confident and ready to intervene and try out less invasive practices when they felt they had the trust and support of their colleagues. The notion of trust was confined to those colleagues that had proven themselves in clinical practice. Such proof often took the form of making judgments about a person's ability measured against performance in real life situations. Those who had demonstrated a level of competence were trusted and sought out by other members of staff when the potential for aggression presented. Taking these

responses as a whole, one of the implications for training is that nurses should be, as far as possible, released for training in teams rather than as individuals.

Another important area identified by participants in this study was the need for managerial support when putting training into practice. Staff needed to feel that they had the support of their manager when trying out new techniques when back in practice. These findings echo those found within the change management and service improvement literature (Pearson 2008; NHS Modernization Agency 2005; Bevan & Plsek 2003) which stress the need for managerial support in effecting change and carrying initiatives forward; as Rosner (1999) stated:

> 'The most effective programs train workers in new behaviors and then train managers to support employees as they apply learning daily' (Rosner, 1999: 43).

All those interviewed (n=24) welcomed the support and supervision of aggression management trainers in clinical practice. This was seen as a positive mechanism that helped with the transfer of knowledge and skills from classroom to clinical practice. In addition to providing skills enhancement it promoted a sense of teamwork, peer support and sharing. It also addressed contextual issues and environmental factors associated with aggression once it occurred. Trainers working in practice areas felt that it also helped them to understand how policies were being interpreted on the ground and the pressures that staff faced when

putting training into practice. These trainers also reported feeling more confident in their teaching of clinical skills; in particular the teaching of more recently developed techniques e.g. changes to break away. Unfortunately, this scheme of work was restricted to in-patient settings. For adult learning to occur, new information needs to be a regularly presented to staff (Tobin 2009). A possible line of enquiry for future research could be to look at the feasibility of aggression management training employed and conducted in clinical practice within teams.

Integrating literature and the findings of this study suggest that there are contradictions between the social control functions and the nurse patient relationships which nurses, literature and policy aspire. Staff from this study struggled to articulate what it was to manage an aggressive incident in practice other than the use of physical intervention. Staff would busy themselves with containment and immediate management of a situation. This would then conflict with their role of care giver and lead to confusion between themselves and the patient as to their role. An amount of therapeutic dissonance has culminated in minimal therapeutic interventions. Whilst in contrast some nurses do engage in therapeutic strategies outside of their controlling activities. Role ambiguity and professional uncertainty of nurses is confirmed by little guidance as to the therapeutic interventions which should be adopted in clinical settings. This highlights the need for staff to be trained in a range of interventions other than the use of physical skills and stresses the importance of intervening early to de-escalate a potentially aggressive incident. Any such training should highlight the

therapeutic nature of the approach adopted and how it meets with the care and wellbeing of person.

7.4.4 CMO 4: Attitude

The fourth CMO configuration proposed that staff developed a more positive attitude to the management of violence and aggression as a result of the training and as such were more willing to engage in preventive actions and seek alternative strategies to managing violence and aggression in their work area.

This was investigated using the Management of Aggression and Violence Attitude Scale (MAVAS) devised by Duxbury (2001) which had been used in several previous studies (Duxbury 2008; 2002; 2001) with mixed findings (for a more detailed discussion of the MAVAS please refer to Chapter 5, page --).

Whilst no significant differences in participants attitudes towards the management of aggression and violence were recorded between the start and completion of training the findings did suggest that there was general support for 'controlling' means of managing aggression (medication, restraint and seclusion), although participants thought that non-physical methods could be used to a greater extent. This could be considered a sign of ineffective training as staff would appear blinkered to the range of interventions open to them when managing this type of situation.

Throughout the literature the use of non-physical methods of managing aggression is advocated (Bowers 2011; Patterson 2007; NICE 2005) and that this should be reflected in aggression management training (NICE 2006; Health Care Commission 2005; Sainsbury Centre for Mental Health 2004). According to other research, higher levels of staff education are not necessarily associated with a better quality of nursing care (Cheung 2010; Robyn et al. 2010; Hantikainen 2000); nor is nurse education necessarily associated with improved knowledge, practice or attitudes (RCN 2010; NMC 2008; Chief Nursing Officer's Report 2006).

This latter point is hardly surprising given that attitudes are defined as enduring systems of beliefs formed over time through experience; often from an early age (Kosar 2006; Randal 2002; Zimbardo, and Leippe 1991). Furthermore, attitudes are not directly observable in themselves, but they act to organize or provide direction to actions and behaviors that are observable (Zimbardo, and Leippe 1991). It is highly questionable then, that a four day training programme of aggression management is likely to change staff attitudes in any significant way, and that these were likely to be formed elsewhere as part of a person's life experience and wider learning. What we might be better testing for is whether the person has the 'right' or 'caring attitude' prior to undertaking training. This in itself would be a tall order and would bring a number of difficulties, e.g. what to do if the person was not found to have a caring attitude?

7.4.5 CMO Five: Organizational support

This final CMO suggested that in order for aggression management to be affective then it required organizational and managerial support and that staff recognize and acknowledge this as part of their work. Again, this is the first time that this has been investigated.

In line with this multi-factorial perspective, it is now generally recognized that what is needed in tackling workplace violence is an integrated organizational perspective, and one that should be identified and played out in training. As with the management of any other occupational health hazard, it is a problem solving or control cycle that underpins this integrated organizational approach to workplace violence (HSE 2006; WHO 2002; Runyan et al 2000). Essentially, this entails examining what might be done before incidents start, as they unfold, and afterwards, at the level of the individual employee, the work group or team and the organization as a whole. Managerial and organizational support is integral in moving the debate from an individual concern to that of the organization and that this should be reflected in the training that staff receive (Wright 2008; Patterson 2006; Mayer 2000).

Each of the two Trusts had a culture of responding to this type of initiative, and a track record of work improvement and innovation (as demonstrated in the depth of their training portfolios and annual reports). Both Trusts recognized the importance of reducing the incidence of violence and aggression, and that the prevention and management of such behaviour was the responsibility of all staff, supported by the organization in the form of policies and procedures; the provision and support of training initiatives; prevention and reporting schemes; and strategic management of the problem. However, the actual training did little to emphasize and demonstrate the organizational context of aggression management. Whilst content included reporting procedures and how information was processed and used to take action, it did not demonstrate how the organization was progressing and learning from actions taken. Participants found it difficult to articulate the extent to which their respective Trusts involved themselves in the management of violence and aggression.

However, the breath and depth of stakeholder involvement was seen as key to ensuring sustainability of the aggression management agenda and programmes by those stakeholders interviewed. This includes a teaching, learning, practice agenda and a corporate, organizational, strategic agenda. It was considered necessary to involve stakeholders at each level to sustain momentum, and by way of contrast, a lack of organizational support or strategic integration was thought to jeopardize the learning and transfer of aggression management skills.

The UK National Skills Task Force (NSTF, 2000:37) reinforces the crucial role of managers:

> 'the capability and commitment of managers and key workers throughout an organisation's hierarchy are the most important factors in determining the provision and effectiveness of workplace learning (both formal and informal)'.

Although all stakeholders expressed interest in the long-term effects of the aggression management training, none of the interviewed indicated that they were involved in long-term impact evaluations of their programmes. Stakeholders seemed satisfied in the knowledge that the training fulfilled the Trusts' legal and statutory obligations (NHSSMS 2006; NICE 2008; HSE 2006).

To reinforce the importance of the role played by line managers in the training and evaluation process it is recommended that clear lines of accountability are built into the process and are monitored on a regular basis. This could involve documenting their input throughout the process – from need identification, to evaluating the success or otherwise of programmes.

There was overwhelming recognition by those stakeholders interviewed (n=6) as to the value, importance and 'necessity' of aggression management training being afforded mandatory status. In doing so, it ensured the sustainability of the

two programmes in the medium to long term, for example, funding and release of staff to attend training.

Each Trust was keen to point out that there had been a reduction in the number of reported incidences of violence and aggression since the introduction of the training. This was cited as a key criterion when measuring the success of a programme by several of the stakeholders interviewed and one highlighted as being important within the literature (HSE 2010; International Council of Nurses 2008; WHO 2004). To what extent this reduction in reported incidences was directly attributable to the training provided and not some other extenuating factor was debatable however, as no real evaluation of the impact of training on clinical practice had been undertaken by either Trust.

7.5 A model of Aggression Management Training

How we prepare staff to manage such incidents as violence and aggression is open to question. One debate that can be had from the findings of this study is the need to balance the requirements of education and training. Training is often seen as the attainment of skills and competencies often associated with a job or role whereas education refers to the acquisition of knowledge and the ability to problem solve (Eraut and Hirsh 2007). What this study has demonstrated is that staff require both education and training if they are to successfully manage violence and aggression as part of their clinical practice.

The first question when constructing a model of aggression management training is what should staff be trained in? It would not be possible to legislate against all the different situations that a staff member may encounter as part of their clinical practice. Drawing on the General Model of Aggression (Chapter 2, Page 26) aggression and violence are seen as a possible outcome of negative interpersonal interactions, which are, in turn, embedded in the broader social and organisational context in which they occur. Any response to violence and aggression would include factors that extend from the characteristics of the individuals involved, through the nature and motive for their interaction; to the environmental and socio-cultural context in which the interactions take place (RCP 2007). This in turn means that any intervention to reduce or manage violence and aggression is at best a collective response played out within a given situation in which the safety of all those involved is met and managed.

There are a number of interventions open to the clinician when managing aggressive behaviour, these are highlighted within the literature review of this dissertation and include the following:

- de-escalation skills,
- communication skills
- interpersonal skills
- problem solving
- creating a therapeutic milieu

- teamwork
- breakaway
- physical interventions

Each intervention can be further broken down into a series of 'mini-interventions', for instance, de-escalation skills include:

- early intervention
- the use of low-arousal approaches
- identification and reduction of possible stressors and triggers
- maintaining autonomy and dignity for the patient
- provision of options and choices
- constant assessment of interventions
- avoiding physical confrontations
- provision of a safe environment.

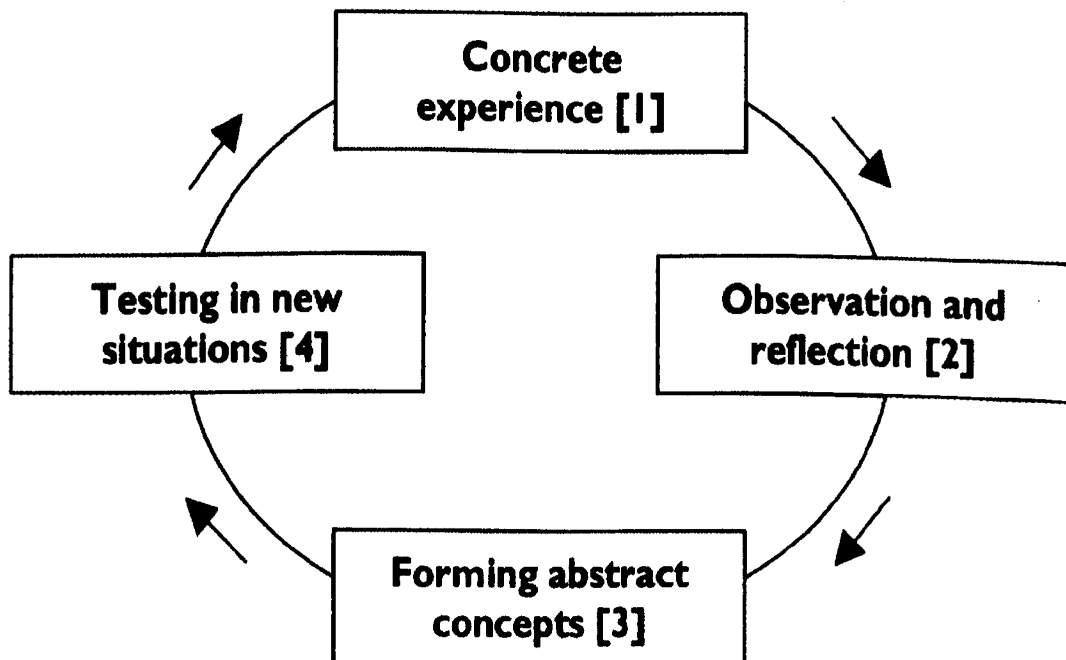
Whilst there is an acceptance that strategies to protect staff will need to include training in physical skills, there is also a recognition that staff should be able to draw upon a much wider range of interventions and strategies beyond that which is currently taught as part of aggression management training. Evidence from this and other research suggest that training should address defusing threatening situations, self-protection, team roles, when and how to seek assistance, staff and patients' rights, reporting mechanisms, risk assessment and the creation and

maintenance of a therapeutic milieu. These skills would be impossible to teach over several weeks let alone a four day training programme such as those described in this research.

The second question we encounter when constructing a model of aggression management training is one of pedagogy. Experimental learning has become firmly established in nursing and midwifery curricula and is based on the works of David Kolb (1976, 1981, 1984,1995). At its simplest, experiential learning is learning that results from experience. As Stephen Brookfield (1983:16) has commented, writers in the field of experiential learning have tended to use the term in two contrasting senses. On the one hand the term is used to describe the sort of learning undertaken by students who are given a chance to acquire and apply knowledge, skills and feelings in an immediate and relevant setting. Experiential learning thus involves a, 'direct encounter with the phenomena being studied rather than merely thinking about the encounter, or only considering the possibility of doing something about it'. This sort of learning, as in this study, is usually sponsored by an institution and might be used on training programmes for professions such as aggression management training.

The second type of experiential learning is 'education that occurs as a direct participation in the events of life' (Houle, 1980: 221). Here learning is not sponsored but accessed by the people themselves, achieved through reflection upon everyday experience. Kolb and his college Richard Fry (Kolb & Fry 1975)

created what he termed an experiential learning model out of four elements: (1) concrete learning experience, (2) observation and reflection, (3) the formation of abstract concepts and (4) testing in new situations. He represented these elements in the form of a circle (see below).



Kolb and Fry (1975) argue that the learning cycle can begin at any one of the four points – and that it should be approached as a continuous spiral. However, it is suggested that the learning process often begins with some kind of concrete experience, professional or personal, that the student considers interesting or problematic. Observations and information are gathered about the experience and then the student reflects upon it, replaying it over again and analyzing it until certain insights begin to emerge in the shape of 'theory' about the experience. The implications from this conceptualization can then be utilized to modify existing practice or to generate new approaches to it.

Malcolm Knowles drew on the concept of experimental learning and other learning theory, most notably Action Learning (Marquardt 1999) whereby people work and learn together by tackling real issues and reflecting on their actions, to form his Andragogy of Adult Learning Theory.

> Andragogy assumes that the point at which an individual achieves a self-concept of essential self-direction is the point as which he psychologically becomes an adult. A very critical thing happens when this occurs: the individual develops a deep psychological need to be perceived as being self-directing, he experiences a tension between that situation and his self-concept. His reaction is bound to be tainted with resentment and resistance.
>
> It is my own observation that those students who have entered a professional school or a job have made a big step toward seeing themselves as essentially self-directing. They have largely resolved their identity-formation issues; they are identified with an adult role. Any experience that they perceive as putting them in the position of being treated as children is bound to interface (sic) with their learning.
>
> (Knowles, 1978:56)

Andragogy is based on the following assumptions:

1. Adult learners bring life experiences to the learning process that should be acknowledged.

2. Adults need to know why they need to learn something, and how it is relevant to their lives.

3. Experiential, hands-on learning is effective with adult learners.

4. Adults approach learning as problem-solving.

5. Adults learn best with the topic is of immediate value to them in their lives.

Knowles 1990:57

Information collected during this study supported the assumptions of the andralogical approach of Knowles and others regarding the training process. In addition, the following basic premises were advanced.

1. **The training process is important.** Although the conveyance of information and training of skill sets were important components of the training, so to was the means by which this was achieved. This research stressed the importance of not just delivering information to participants, but also providing them with opportunities for 'hands-on' experiences that had relevance to their clinical practice.

2. **Participants in training programs need experiences that require progressively more active participation in, and responsibility for, their own learning.** Learning should include opportunities for practicing decision making, recognizing one's own learning needs, identifying resources to meet those needs, and planning and organizing one's own learning.

3. **Participants need opportunities to broaden their learning and support to transfer their learning to clinical practice settings.** This includes development of skills and strengthening self-efficacy in clinical practice.

7.5.1 The PROMPTS Model of Aggression Management Training ©

The following model is based on the basic premises given above and findings from this study and provides a framework by which to think about and provide aggression management training.

Prepare	Time needs to be spent preparing staff prior to the training starting. It is important that staff understand the training they are being sent on and the reasons for this; they also need to be clear as to what is expected of them on their return to work having attended the training.
Reflect	Participants should be encouraged to reflect on their current practice and identify personal strengths and weaknesses, learning objectives and goals. Effective training identifies and addresses issues important to the learner, while building on learner strengths.
Orientate	The Trainer orientates participants to the training materials, programme objectives and goals. The **relevance** of the training is emphasized and aligned to the clinical practice of those undergoing the training. The training includes opportunities for active participation by the learner, while recognizing and drawing on the knowledge and experience of the learner. Learning is facilitated through peer exchange, and is culturally and ethnically meaningful.

	The trainer endeavors to provide an **authentic** environment in which the training is to take place. Ideally, this would be in the participant's place of work.
Motivate	The trainer, enables, enhances and encourages participation in the training by adopting a range of teaching styles and feedback. The training integrates decision-making, planning, organization and skill building. It models and reinforces workplace ethics and codes of practice. Learners are challenged to take responsibility for their own learning.
Practice	Participants are given time to practice and master skills and knowledge before putting them into a work environment. The training increases the participant's knowledge about the subject matter, and reinforces worthwhile values and principles

	Opportunities exist for feedback and reflection. Incentives to mark learning milestones are incorporated into training. There is recognition and reporting of participant progress.
Trial	Participants should be afforded the opportunity to trial new skills and knowledge and feedback and modify skills and interventions as appropriate as part of their clinical practice. This should be done through a process of meaningful evaluation being mindful to celebrate success. On-going assessment and participant-based feedback is critical to the success of any training session
Support	Continuing support is offer and provided by trainers and the organization for which participants work both in terms of training, resources, policy and procedure. Participants are acknowledged and recognized for their contributions by the larger community.

The above model is based on the andralogical approach of Knowles (1990) and findings from this study. It is untested and would undoubtedly benefit from further development, evaluation and research. However clear messages have emerged from this study and are incorporated into the model. Any training provided should be focused on both the needs of the participant and the organization for which they work. Training should be based on active participation and should seek to maximize participant involvement. Training should have relevance to the staff group undergoing instruction and promoted in the clinical environment. The training should be conducted wherever possible in staff groups, tackling real problems, with participants reflecting and learning from their experience and from each other. It should provide measures of competency that describe both workplace and organisational outcomes and describe the requirements of assessment. Training should be engaging and integrate decision-making, planning, organization and skill building and cover a range of interventions. Staff should be given the opportunity to trial and embed learning and skills in clinical practice before seeking further advancement. Success should be celebrated at each point. Above all, any training package should allow flexibility in the design of the training to meet the needs of those undergoing the training.

7.6 A review of the use of realistic evaluation in this study

This study was the first to the researcher's knowledge to use realistic evaluation to examine aggression management training. Other researchers will need to refine the approach. There are both strengths and weakness to this method that

deserve consideration. The theory on which the evaluation methodology is constructed is innovative and holistic, but there are problems in translating this into practical research results, although these are not insurmountable (Adams 2005). The requirements of data collection are far more specific using this methodology (Davis 2010); notably, that each of the elements of context, mechanism and outcome require careful validation if they are to be proven. It is relatively easy to propose plausible CMO configurations but much harder to collect useful or valid data for all three, particularly where time and resources are limited as in this case. A good understanding of general contextual issues allows appropriate mechanisms to be proposed (Gill & Turbin 2004). Viewed in this way, it is not possible to say that aggression management programmes work or don't work, because the context in which the training takes place, along with the mechanisms by which participants learn must be taken into account. This is not the same as identifying confounding variables as in experimental research, where these are eliminated as far as possible to ensure 'validity' (Soni 2010). On the contrary, in realist evaluation, the mechanisms and contexts form part of the explanation. In the present study two different but at the same time similar aggression management programmes were played out by different people in different settings, within different institutions at different times, and so on, resulting in different effects. The extent to which aggression management programmes have an impact on clinical practice, will be dependent upon the contextual conditions in which they are delivered in training and deployed in practice. Using CMO configurations is a useful method of testing out how a

measure might be working and in what circumstances it might not work (Pawson & Tilley 1997). Indeed, as more research is conducted in this manner, it should be possible to identify common aspects of context that are important to trigger desired mechanisms. This is an important step to building up a body of useful data about what works well within aggression management training.

7.7 Limitations

This study is dependent upon the use of qualitative methodology with its inherent complexities of validity and reliability (Brink, 1991). The researcher accepts the importance of methodological rigor in qualitative methodology as outlined by Rose, Beeby & Parker (1995). Aspects which effect validity and reliability have been minimized through reflexivity (use of field notes (Holloway & Wheeler, 1996) and respondent validation (Appleton, 1995)). In qualitative methodology judgments are made by the researcher about data and its representation, therefore potential subjectivity is acknowledged. Whilst attempting to maintain a neutral position it is acknowledged that the nature of the researcher - respondent relationship impacts upon data collection and analysis (Too, 1996). The researcher have previous experience of working in acute services may have influenced respondent role, behaviour and performance. Investigator bias is acknowledged as a limitation, although attempts to overcome error and demonstrate reliability were employed (the use of external review of the interview questions and coding). The personal nature of qualitative methods are subject to

critical appraisal, hence the researcher has demonstrated attempts to represent truth-value.

Whilst experiences accounted are real to the respondents, the generalisability of findings can be perceived as a limitation. Thinking critically about generalisibility (Silverman, 2000) the characteristics of the research setting may indeed differ from an inner city area, or where the acute ward is part of a large service sited in one location. However, staffing levels, patient populations, experiences and day-to-day care closely corresponds with those described in other literature. This suggests that the characteristics of the nurses' work are not dissimilar to some other acute wards.

However, this study does not claim wide generalizations and explain all nurses' experiences of acute psychiatry. To accurately describe the impressions of the nurses interviewed and explore their experiences of practice in the research setting sheds light on the social context. Consequently, as studies of nurses' impressions of their work in acute psychiatry are rare, this investigation succeeds in increasing knowledge of the phenomenon. Examination of how the findings of the study are meaningful to other professionals is established further in the conclusion.

7.8 Personal reflection

I began this study by reflecting on my role as a clinician, nurse educator and aggression management trainer and committed to embracing the insider researcher perspective as I believe that it enabled a more comprehensive comprehension of the field of study and the participants involved. Advocating a reflexive approach I locate myself within the study, and by judicious use of refelxity I anticipated a level of success. Embedding myself in the project exposed my vulnerabilities both as a researcher and in my academic role, and I found that undertaking a major research project whilst still turning up for work every day was a challenge.

Having been involved in the training of aggression management for a number of years this project has had me confront some of my own unsubstantiated presuppositions, assumptions and practices. Only through the course of this project have I been able to develop a deeper appreciation of what these different perceptions are and the impact these differences have had on the way I perceive aggression management should be. At times I have been both acutely self-aware and painfully self-conscious. The fact that I was a 'Doctorial Candidate' and Lead Researcher had me cast in the role of 'expert' by those that ran the training, a position that was both shocking and inaccurate!

Inevitably I reflect on what I might have done differently in this project knowing what I know now. Two things stand out for me. First, I think that I took too much

on, whilst I had experience of small research studies, nothing prepared me for this. Secondly, the number of times I thought I knew something and had a grip on a subject, to be surprised by how much more there is still to learn. These complexities I have tussled with are entirely of my own making and primarily relate to the philosophical underpinnings and methodology use in this research.

7.10 Conclusion

Managing aggressive and violent behavior has become an essential skill, pertinent to all healthcare staff that has contact with the public through the course of their work. The need for staff to be properly trained in managing aggressive and violent behavior has been recognized both in policy and legislation. It is fundamental to the success and effectiveness of such training that programmes are designed or selected and delivered on the basis of a sound understanding of what is actually needed. Both sets of training programmes had been commissioned from outside agencies not necessarily with an understanding of what was needed but in order to meet with legal and professional duties. Whilst this may provide a straightforward and simple solution to a training requirement it was apparent from this and other recent studies (Bowers 2011; Harris & Leather 2011) that the training did not always meet the needs or expectations of staff. A large number of participants felt that the training lacked relevance when viewed against work patterns and behaviors back on the job.

As a minimum, employers should provide training and education for their staff in line with national guidelines and good practice, and that this should be commensurate with the degree of risk they face. Whatever measures are put in place to manage violence and aggression they should be fit for purpose that is it should reflect local need, both of staff and service user. It should contain learning outcomes so participants are clear as to what is to be achieved and its content should be as up to date with current thinking. Likewise, its content should be supported by evidence wherever possible; delivered by creditable staff committed to a model of care based on respect for the individual and other key principle. Above all it should be responsive to feedback and allow for the concerns of staff to be played out. Ideally, aggression management should be embedded in clinical practice, introduced and supported as part of staff development and linked to job role. It should be focused on the needs and safety of the patient and incorporate other elements of good practice, such as risk management.

Workplace violence now attracts significant academic, legal, managerial, and governmental attention and concern. As the corresponding research effort into the subject has grown, so too has the level of sophistication in our understanding of it. Rather than identifying and responding to individual factors of violence and aggression (of the kind described above) there has been a refocusing on the social and organizational roles, procedures, and processes which frame and contextualize acts of individual aggression and violence. In this way, managing

workplace violence and aggression entails a simultaneous focus on everything from security measures, through individual, team and organizational work practices, to organizational policies, codes of practice and arrangements for everything from job and work design to post incidence support and counseling. Together they demonstrate the need for strategic action which is not focused on single point interventions (i.e. training) but adopts a broader perspective and intervention strategy in the successful prevention, management and reduction of workplace violence and aggression.

It should not be assumed that one off aggression management training will equip staff with the skills and knowledge to manage aggression. While there is no quick fix remedy for the lack of transfer the solution requires such things as improved trainee problem solving skills (Bowers 2011), closer correspondence between the content of training and the way the 'organization works' and better management (i.e. integration) of the training function with other organizational systems and ways of working. It is important to think about the wider aspects associated with the design of effective instruction. What the trainer must respect are the differences and limitations between individuals in terms of the way in which information is attended to, processed, understood, retained, recalled and used, as well as differences in motivation and other issues associated with their attitude towards instruction and learning. How information is structured, documented and delivered and presented is extremely important for the quality of learning and degree of transfer that can occur.

If aggression management training is to move forward in a consistent and effective manner then this needs to be built on a sound evaluation of existing programmes. Without this evaluative activity, there are concerns that aggression management training may fail to meet the needs of staff and those that commission the training. There is a need to assess the level and extent to which programmes have and are achieving their objectives, as well as ensuring efficient and cost-effective use of resources. Realistic evaluation of the kind described here would seem to offer a viable alternative to more established means of investigation e.g. RCTs, in investigating aggression management training programmes, as it provides more realistic conceptions of the factors involved in the introduction and maintenance of complex healthcare interventions than experimental methods that confine themselves to artificial notions of unilinear causality. In turn, this means that realistic evaluation can shed light on the processes essential to the success and sustainability of those interventions in a much more localised and meaningful way. The criteria against which training is to be evaluated needs to be broader, more meaningful and add value in terms of indicating the impact of training on both individual and organization health. In addition, the criteria must have a utility in terms of informing decision making about the design, delivery or indeed the continuation of particular forms of training. Evaluation must go beyond whether people 'enjoyed' the course but involve deeper level phenomenon which link into other major issues in healthcare (i.e. utility of taught skills in clinical practice).

7.11Recommendations for future research and training

Despite the limitations of this and the other research conducted so far into aggression management training, it is reasonable to believe that the evidence base is sufficient to indicate what is likely to constitute good practice that is clinically, logically, ethically and medico-legally defensible (NICE 2008; HSE 2006; NHSSMSE 2005). It may be that confining research to quite modest goals rather than attempting the pursuit of a complete model of aggression management training is actually the most feasible way forward, although the standardization of measures of violence, larger studies, and longer- follow up periods in such research would be a significant improvement on the present situation.

7.11.1 Recommendations for future research

- Realistic evaluation provided a useful interpretive framework with which to make sense of the multiple factors that were simultaneously at play in the aggression management training describe here. It is suggested that future research concern itself with individual programmes highlighting what worked, for whom, in what circumstances; ensuring that lessons learnt are shared between interested parties for the benefit of all.
- This research argued against a 'one size fits all approach' to aggression management training. Whilst off the shelf training packages are useful they are none-the-less limited. Evidence needs to be gathered with

respect to the need for particular forms of training (i.e. specialist and non specialist).

- Training needs analyses should be promoted and pursued amongst staff groups.
- The evidence from this research suggests that end user utility should be the final arbiter of whether training has proven effective and that the success of any training should be measure by the extent to which staff can take what they have learnt and put it in to practice.
- Rather than measuring attitude, it might be more feasible to measure a person's motivation by a desire to replicate a skill back in clinical practice over time.
- The feasibility of aggression management training being delivered in clinical practice should be explored; alongside with on the job training and support, which this study suggested participants welcomed and found beneficial.
- A trialing and evaluation of the PROMPTS Model of Aggression Management Training © should be undertaken and reported on.

Recommendations for future training

- Training content has to be examined and wherever necessary redress any imbalance in terms of content areas associated with positive benefits (i.e. the relative lack of emphasis upon both verbal intervention and de-escalation skills).

- 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 if it is to have relevance to staff.
- Both knowledge and skills should be assessed as part of training.
- The design of training must address issues associated with the transfer of skills and knowledge back to clinical practice.
- On-the-job supervision should be used to reinforce the new skills learned in the training courses and ensure each worker continues to put them into practice.
- The learning should be patient/client focused
- The learning should develop the prerequisites of teamwork
- The learning should be interactive
- The learning should be case or scenario based
- Above all, the learning should reflect the realities of clinical practice as best it can

References

ANDERSON, C. Workplace violence: Are some nurses more vulnerable? *Issues in Mental Health Nursing, 2002, 23*(4), 351-366.

ANDERSON, C. Training efforts to reduce reports of workplace violence in a community health care facility. *Journal of Professional Nursing, 2006,* 22(5), 289-295.

ANDERSON, C. and BUSHMAN, B. Human aggression. *Annual Review of Psychology*, 2002, 53(1), 27-51.

ANDERSON C., CARNAGEY, N. L. and EUBANKS, J. Exposure to violent media: The effects of songs with violent lyrics on aggressive thoughts and feelings. *Journal of Personality and Social Psychology,* 2003, 84, 960-971.

ANDERSON, C. and HUESMANN, L. R. Human aggression: A social-cognitive view. In M. A. HOGG and J. COOPER (eds.), *Handbook of social psychology.* London: Sage Publications, 2003, pp. 296-323.

ALVESSON, A. and SKOLDBERG, P. *Reflexive Methodology: New vistas for qualitative research.* London: Sage, 2000.

ATTRIDE-STIRLING, J. Thematic networks: an analytic tool for qualitative research. *Qualitative Research.* 2001, 1, (13), 385 – 405

AYRANCI, U., YENILMEZ, C., BALCI, Y. and KAPTANOGLU, C. (2006) Identification of violence in Turkish health care settings. *Journal of Interpersonal Violence.* 2006, 21 (2), 276–296.

BARR, H., FREETH, D., HAMMICK M, KOPPEL, I. and REEVE S. *Evaluations of Interprofessional Education: A United Kingdom Review for Health and Social Care.* A review commissioned by the British Educational Research Association. Published by The United Kingdom Centre for the Advancement of Interprofessional Education, 2000.

BEAUCHAMP, T. L. and CHILDRESS, J. F. *Principles of Biomedical Ethics*, 5th Ed. New York City: Oxford University Press, 2001.

BEECH, B. and LEATHER, P. Workplace violence in the healthcare sector: A review of staff training and integration of training models. *Aggression and Violent Behavior.* 2006, 11, 27-43.

BERG, B. L. *Qualitative Research Methods for the Social Sciences.* Boston: Allyn and Bacon, 2001.

BERG, B. L. and HALLBERG, C. A. Psychiatric nurses' lived experience of working with inpatient care on a general team psychiatric ward. *Journal of Psychiatric and Mental Health Nursing.* 2000, 7, 323–333.

BERKOWITZ, L. Frustrations, appraisals, and aversively stimulated aggression. *Aggressive Behavior.* 1988, 14, (1), 3-11.

BERKOWITZ, L. On the formation and regulation of anger and aggression: A cognitive-neoassociationistic analysis. *American Psychologist.* 1990, 45, (4), 494-503.

BERKOWITZ, L. Pain and aggression: some findings and implications. *Motiv. Emot.* 1993, 17, 277–93.

BHASKAR, R. A. *Scientific Realism and Human Emancipation*, London: Verso, 1987.

BHASKAR, R. A. *Reclaiming Reality: A Critical Introduction to Contemporary Philosophy*, London: Verso, 1989.

BHASKAR, R. A. *Philosophy and the Idea of Freedom*, London: Blackwell, 1990.

BINDER, R. L. and McNEIL, D. E. Staff gender and risk of assault on doctors and nurses. *Bulletin of the American Academy of Psychiatry and the Law*. 1994, 22, 545–550.

BJOKLY, S. *Psychological theories of aggression: Principles and application to practice*. New York Springer, 2006.

BLOOR, R., McHUGH, A. PEARSON, D. and WAIN, I. A training course for psychiatric nurses in Russia. *Nursing Standard*, 2004, 18, (39), 39–41.

BOWEN, D. Research through participant observation: a creative solution to the measurement of consumer satisfaction/dissatisfaction among tourists, *Journal of Travel Research,* 2002, 41, (1), 4-1.

BOWERS, L. A critical appraisal of violent incident measures. *Journal of Mental Health.* 1999, 8, (4), 339-349.

BOWERS, L. The expression and comparison of ward incident rates. *Issues in Mental Health Nursing*. 2000, 21, (4), 365-374.

BOWERS, L., ALEXANDER, J. and GASKELL, C. A trial of an anti-absconding intervention in acute psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*. 2003, 10, (4), 410-416.

BOWERS, L, ALLAN, T., SIMPSON, A., NIJMAN, H. and WARREN, J. Adverse incidents, patient flow and nursing workforce variables on acute psychiatric wards: *The Tompkins Acute Ward study: International Journal of Social Psychiatry*. 2007, 53, (1), 75-84.

BOWERS, L. NIJMAN, H. and ALEXANDER, (2003). *A European perspective on managing violence in psychiatry*. The EViPRG experience: Rivista, 2003

BOWERS, L., NIJMAN, H., ALLAN, T., SIMPSON, A., WARREN, J. and TURNER, L. Prevention and Management of Aggression Training and Violent Incidents on U.K. Acute Psychiatric Wards, *Psychiatric Services*. 2006, 57, (7), 1022-1026.

BOWERS, L., NIJMAN, H. and PALMSTIERNA, T. The Attempted and Actual Assault Scale (Attacks). *International Journal of Methods in Psychiatric Research*. 2007, 16, (3), 171-176.

BOWERS, L., SIMPSON, A., EYRES, S., NIJMAN, H., HALL, C, GRANGE, A. et al. Serious untoward incidents and their aftermath in acute inpatient psychiatry: The Tompkins Acute Ward Study: *International Journal of Mental Health Nursing*, 2006, 15, (4), 226-234.

BOWERS, L., WHITTINGTON, R., ALMVIK, R., BERGMAN, B., OUD, N. and SAVIO, M. A European perspective on psychiatric nursing and violent incidents. Management, education and service organization. *International Journal of Nursing Studies*. 1999, 36, (3), 217-222.

BOWIE, V. *Defining violence at work: a new typology*. In M. GILL, B. FISHER, and V. BOWIE (eds). Violence at Work: Causes Patterns and Prevention. Devon: William Publishing, 2002, pp1 – 20.

BOYATZIS, R. E. *Transforming qualitative information: thematic analysis and code development*. London: Sage, 1998.

BRAUN V and CLARKE, V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006, 3, (3), 77 – 101

BRENNAN, W. Dealing with verbal abuse. *Emergency Nurse*. 2001, 9, (5), 15–17.

BRITISH INSTITUTE OF LEARNING DISABILITIES (BILD) (2001) *Code of practice for trainers in the use of physical interventions*. Kidderminster: British Institute of Learning Disabilities, 2001.

BROOKFEILD, S. D. *Adult Learners, Adult Education and the Community*, Milton Keynes: Open University Press, 1983.

BROOKMAN, F. *Understanding Homicide*, London: SAGE Publications Ltd, 2005.

BRYMAN, A. *Social Research Methods*. Oxford: Oxford University Press, 2008.

BUBANK, D. Assertiveness training to prevent verbal abuse in the OR-home study programme. *AORN* J. 2004, 79, 148–64

BUDD, T. *Violence at work: findings from the British Crime Survey*. London: Home Office Information and Publications Group, 1999.

BUFKIN, J. L. and LUTTRELL, V. R. Neuroimaging studies of aggressive and violent behaviour: Current findings and implications for criminology and criminal justice. *Trauma, Violence, and Abuse*. 2005, 6, 176–191.

BUREAU OF LABOUR STATISTICS. *Nursing, psychiatric, and home health aides*. U.S. Department of Labour, 2008.

BUSHMAN, B. J. and ANDERSON, C. A. (2001) Is it time to pull the plug on the hostile versus instrumental aggression dichotomy? *Psychol. Rev.* 2001, 108, 273–79.

CALABRO, K., MACKEY, T. A. and WILLIAMS, S. Evaluation of training to prevent and manage patient violence. *Issues Ment Health* Nurs. 2002, 23, (1), 3-15.

CARAULIA, A. P. And STEIGER, L. K. *Nonviolent crisis intervention: Learning to diffuse explosive behaviour*. WI: CPI Publishing, 1997.

CARLSON M, MARCUS-NEWHALL, A. and MILLER, A. Evidence for a general construct of aggression. *Pers Soc Psychol Bull*. 1989, 15, 377–389.

CARMEL H and HUNTER, M. Staff injuries from patient attack: Five years' data. *Bulletin of the American Academy of Psychiatry & the Law*. 1993, 21, (4), 485–493.

CARMAL H and HUNTER, M. Compliance with training in managing assaultive behaviour and injuries from inpatient violence. *Hospital and Community Psychiatry*. 1990, 41, (5), 558–560.

CARLETTE, M. A descriptive study of the perceptions of workplace violence and safety strategies of nurses working in level I trauma centers. *Journal of Emergency Nursing*. 2005, 31, (6), 519–525.

CASKEY, C. Workplace violence. Clinical Laboratory Science. *Journal of the American Society for Medical* Technology. 2004, 14, (2), 95-100.

CENTRE FOR HEALTH RESEARCH. *Constructing questionnaires based on theory of planned behaviour: A manual for Health Services Researchers.* Newcastle: The University of Newcastle, 2004.

CHAPMAN, R. Educational Psychology and Mixed Methodologies. *Accident and Emergency Nursing.* 2006, 14, 245–249.

CHEN, H. T. and Rossi, P. H. The multi-goal theory driven approach to evaluation, a model linking basic and applied social science'. In H. E. FREEMAN and M. A. SOLOMON (eds.). *Evaluation Studies Review Annual.* Beverly Hills, CA: Sage, 1983.

CHOLE, J. Y., TEPLIN, L. A. and ABRAM, K. M. Perpetration of violence, violent victimization, and severe mental illness: balancing public health concerns. *Psychiatric Services.* 2008, 59, (2), 153-64.

CLARK, T. Debate on mental illness and violence was oversimplified: *BMJ: British Medical Journal.* 2002, 325, (7375), 1300-1301

CLINARD, M. B. and MEIER, R. F. *Sociology of deviant behavior.* London: Sage, 1968.

COFFEY, A. *The Ethnographic Self: Fieldwork and the Representation of Identity.* London: Sage, 1998.

COIE, J. D. and DODGE, K. A. Aggression and antisocial behaviour. In W. DAMON (Series ed.) and N. EISENBERG (Vol. ed.) Handbook of child

psychology, Vol. 3: *Social, emotional, and personality development*. New York: Wiley.1998, pp. 779 – 862.

COMMISSON FOR HEALTH IMPROVEMENT. *Commission for Health improvement Staff Survey*. London; Commission for Health Improvement, 2004.

CORMACK, D. *The Research Process in Nursing*. 5th edn. London, Blackwell Publishing, 2006.

COUNTER FRAUD & SECURITY MANAGEMENT SERVICE (CFSMS) Conflict Resolution Training. Implementing the national Syllabus. London: CFSMS, 2004.

COUNTER FRAUD & SECURITY MANAGEMENT SERVICE (CFSMS) *A Professional Approach to Managing Security in the NHS*. London: CFSMS, 2003.

COWIN, L., DAVIES, R., ESTALL, G. BERLIN, T., FITZGERALD, M., and HOOT, S. De-escalating aggression and violence in the mental health setting.*Int J Ment Health* Nurs. 2003, 12, (1), 64–73

CRAWFORD, A. SAUL, E. W., MATHEWS, S. and MAKINSTER, J. *Teaching and Learning Strategies for the Thinking Classroom*. New York: Open Society Institute, 2005.

CRESWELL, J. W. *Research Design: Quantitative, Qualitative, and Mixed Methods Approaches*. Thousand Oaks: Sage, 2003.

CRESWELL, J. W. *Educational Research*. London: Prentice Hall, 2007.

CRICHTON, J. H. M. and CALGIE, J. "Responding to Inpatient Violence at a Psychiatric Hospital of Special Security: A Pilot Project", *Medicine, Science and the Law*. 2002, 42, (1), 30-33.

CROTTY, M. *The Foundations of Social Research: meaning and perspective in the research process*. London: Sage, 2003.

CUNNINGHAM, J., CONNOR, D. F., MILLER, K. and MELLONI, R. H. Staff Survey Results and Characteristics That Predict Assault and Injury to Personnel Working in Mental Health Facilities. *Aggressive* Behavior. 2003, 29, (1), 31-40.

CURBOW, B. Section 4: Origins of violence at work. In Cooper C, Swanson, N (Eds) *Workplace violence in the health sector: State of the art*. Geneva: International Labour Office, 2002.

De BONDT, R. Spill overs and innovative activities. *International Journal of Industrial Organisation*, 1997, 15, (1), 1 – 28.

DELANEY, K. R. and JOHNSON, M. E. Keeping the unit safe: mapping psychiatric nursing skills. *Journal of the American Psychiatric Nurses Association*. 2006, 12, (4), 198-207

DELANTY, G. and STRYDOM, P. (eds.). *Philosophies of social science: The classic and contemporary readings*. Berkshire: Open University Press, 2003.

DEPARTMENT OF HEALTH. *Cross Government Drive to Stop to Stop Violence Against Staff Working in the NHS: NHS Zero Tolerance Zone* (HSC 199/226). London: DH, 1999

DEPARTMENT OF HEALTH. *Research for the Patient Benefit Working Party – Final Report*. London, DH, 2004.

DEPARTMENT OF HEALTH. *The NHS Staff Survey 2008 - 2009*. London: DH, 2010.

DEPARTMENT OF HEALTH and DEPARTMENT FOR EDUCATION & SKILLS. *Guidance for Restrictive Physical Interventions: How to Provide Safe Services for People with Learning Disabilities and Autistic Spectrum Disorder.* London: DH, 2002.

DEVEAU, R. and McGILL, P. *As the last resort: reducing the use of restrictive physical interventions.* Tizard, Canterbury, University of Kent, 2007.

DEY, I. *Qualitative Data Analysis: A User-Friendly Guide for Social Scientists.* London: Rutledge, 1993.

DI MARTINO, V. *Workplace violence in the health sector: Country case studies.* World Health Organization: Geneva, 2002

DI MARTINO, V. HOEL, H. and COOPER, C. L. *Preventing Violence and Harassment in the Workplace.* Dublin: European Foundation for the Improvement of Living and Working Conditions, 2003.

DISTASION, C. A. Distasio. Violence in healthcare: institutional strategies to cope with the phenomenon. *The Health Care Supervisor.* 1994, 12, (4), 1–34.

DOLAN, M. ANDERSON, I. M. and DEAKIN, J. F. W. Anderson I M & Deakin J. F. W. Relationship between 5-HT function and impulsivity and aggression among male offenders with personality disorders. *British Journal of Psychiatry.* 2001, 178, 352–359.

DOLLARD, MILLER et al. *Frustration and aggression*, Yale University Press, New Haven, 1939.

DUFFIELD, C. and O'BRIEN – PALLAS, L. The causes and consequences of nursing shortages: a helicopter view of the research. *Aust Health Rev.* 2011, 26, (1), 186-93.

DuHART, D. T. *Violence in the workplace, 1993–99* (NCJ Publication No. 190076). Washington, DC: Bureau of Justice Statistics, 2001.

DUXBURY, J. An evaluation of staff and patient views and strategies employed to manage inpatient aggression and violence on one mental unit: a pluralist design. *Journal of Psychiatric Nursing.* 2002, 9, 325 – 337.

DUXBURY, J. Testing a new tool: The Management of Aggression and Violence Attitude Scale (MAVAS). *Nurse Researcher.* 2003, 10, 39–52

DUXBURY, J. and WHITTINGTON, R. Causes and management of patient aggression and violence: Staff and patient perspectives. *JAN Journal of Advanced Nursing.* 2005, 50, (5), 469-478.

EHMANN, T. S., SNITH, G. N., YAMOMOTO, A. McCARTHY, N. et al. Violence in treatment resistant psychotic inpatients. *Journal of Nervous and Mental Disease.* 2001, 189, (10), 716-721.

ERAUT, M. and HIRSH, W. *The Significance of Workplace Learning for Individuals, Groups and Organisations.* Oxford: University of Oxford, 2007.

ERDOS, B. Z. and HUGHES, D. H. Emergency Psychiatry: A review of Assaults by patients against staff at Psychiatric Emergency centres. *Psychiatry* services. 2001, 52, (9), 1175-1177.

ESPLEN, E. *Engaging Men in Gender Equality: Positive Strategies and Approaches. Overview and Annotated Bibliography, October.* Brighton, UK: BRIDGE, Institute of Development Studies, University of Sussex, 2006.

EWERT, D. and GRACE, K. Adult education for community action. In A. WILSON and E. HAYES (eds.), *Handbook of adult and continuing education* (new ed.). San Francisco: Jossey-Bass, 2000, pp. 327 – 343.

FARRELL, G. A., BOBROWSKI, C. and BOBROWSKI, P. Scoping workplace aggression in nursing: Findings from an Australian study. *Journal of Advanced* Nursing. 2006, 55, (6), 778-787.

FARRELL, G. A. and CUBIT, K. (2005) Nurses under threat: A comparison of content of 28 aggression management programs. *International Journal of Mental Health Nursing.* 2005, 14, (1), 44–53.

FERNS, T. and CHOJNACKA, I. Reporting of incidents of violence and aggression toward NHS staff. *Nursing Standard.* 2005, 19, (38), 51 - 56 .

FINNEGAN, G. Using documents. In R Supsford & V Jupp (eds) *Data Collecetion and Analysis.* London: Sage, 1996, pp. 138 -51.

FLANNERY, R. B., MARKS, L., LAUDANI, L. and WALKER A. P. "Psychiatric patient assault and staff victim gender: fifteen-year analysis of the Assaulted Staff Action Program (ASAP)", *Psychiatric Quarterly.* 2007, 78, (2), 83-90.

FLOOD, M. Men's Collective Struggles for Gender Justice: The case of anti-violence activism. In *The Handbook of Studies on Men and Masculinities.* Eds M. KIMMEL, J. HEARN, and R.W. CONNELL, Thousand Oaks, CA: Sage, 2005.

FORD, K., BYRT, R. and DOOHER, J. *Preventing and Reducing Aggression and Violence in Health and Social Care*. London: M&K Publishing, 2010.

FOSTER, C., BOWERS, L. and NIJMAN, H. Aggressive behaviour on acute psychiatric wards: prevalence, severity and management. *Journal of Advanced Nursing*. 2007, 58, (2), 140-149.

FREETH, D., HAMMICK, M., KOPPEL, I., REEVES, S., and BARR, H. *A Critical Review of Evaluations of Interprofessional Education*. Learning and Teaching Support Network. London: Health Sciences and Practice, 2002.

FREUD, S. *Totem and Taboo*. London: Routledge, 1913, 1995.

FREUD, S. *An outline of psychoanalysis*. New York: Norton, 1949.

FROMM, E. *The anatomy of human destructiveness*. Greenwhich: Fawcett Crest, 1973.

FULLER, A. and UNWIN, L. Learning as apprentices in the contemporary UK workplace: creating and managing expansive and restrictive participation. *Journal of Education and Work*. 2003, 16, 407-426

GABBA, D. The future vision of simulation in health care. *Quality and Safety in Health Care,* 2004, 13 (Suppl 1), 2-10.

GALLOWAY, S. J. Simulation techniques to bridge the gap between novice and competent healthcare professionals. *Journal for Issues in Nursing,* 2009, 14, (2), 1-9.

GATES, D., FITZWATER, E. and TELINTELO, S. Using Stimulations and Standardized Patients in Intervention Research. *Clinical Nursing Research*. 2001, 10, (4), 387-400.

GIANCOLA, P. R. Alcohol-related aggression in men and women: The influence of dispositional aggressivity. *Journal of Studies on Alcohol*, 2002, 1, (63), 696–708.

GIEDD, J. N., BLUMENTHAL, J., MOLLY, E. And CASTELLANOS, F. X. Brain imaging of attention deficit/hyperactivity disorder. *Annals of the New York Academy of Sciences*, 2001, 931, 1036–1045.

GLENN, A. L. and RAINE, A. The neurobiology of psychiatry. *Psychiatric Clinics of North America*, 2008, 31, (3), 463 – 475

GOODYKOONTZ, L. and HERRICK, C. A. Evaluation of an in-service education program regarding aggressive behaviour on a psychiatric unit, *Journal of Continuing Education in* Nursing, 1990, 21, (3), 129–33.

GRANEHEIM, U. H. and LUNDEMAN, B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 2004, 24: 105 – 112.

GREEN, B. and Robinson, L. Reducing violence in a forensic mental health unit: a seven-year study. *Mental Health Practice*. 2005, 9, (4), 13-21.

GREEN, J. and THOROGOOD, N. *Qualitative Methods of Health Research*. London: Sage, 2004.

GREEN, R. G. and DONNERSTEIN, E. I. *Human Aggression: Theories, Research, and Implications for Social Policy*. London: AP Publishing, 1998.

GREENE, J. Dialogue in evaluation; a relational perspective. *Evaluation*, 2001, 7, (2), 181–203.

GREENE, J. C., KREIDER, H. and MAYER, E. Combining qualitative and quantitative methods in social inquiry. In B. SOMEKH and C. LEWIN (eds.), Research methods in the social sciences. London: Sage, 274–281, 2005

GREENHALGH, T. The new ethics. *British Medical Journal*, 2004, 328, (15), 651.

GUBA, E. and LINCOLN, Y. S. Fourth generation evaluation. Beverly Hills: Sage.

GUBRIUM, G. and HOLSTEIN, J. *Handbook of interview research: Context and method.* Thousand Oaks, CA: Sage, 2001, 675 - 694.

GUDJONSSON, G. H., RABE-HESKETH, S. and SZMUKLER, G. Management of psychiatric in-patient violence: patient ethnicity and use of medication, restraint and seclusion. *British Journal of Psychiatry,* 2004, 184, 258 *-262.*

HAHN, S., NEEDHAM, I, ABDERBALDEN, C, DUXBURY, J and HALFERNS, R. The effect of a training course on mental health nurses' attitudes on the reasons of patient aggression and its management. *Journal of Psychiatric and Mental Health Nursing*, 2006, 13, 197-204.

HAHN, S., ZELLER, A., NEEDHAM, I. KOK, G. , DASSEN, T. and HALFENS, R. Patient and visitor violence in general hospitals: A systematic review of the literature. *Aggression and Violent Behavior*, 2008, 13, (6), 431-441.

HAMMERSLEY, M. The issue of quality in qualitative research. *International Journal of Research & Method in Education*, 2002, 30, (3), 287 – 305.

HAMMERSLEY, M and ATKINSON, P. *Ethnography: principles in practice* (3rd ed.). London: Routledge, 2007.

HARDY, M. & MULHALL, A. *Nursing Research Theory and Practice*. London: Chapman & Hall, 1994.

HARPER-JAQUES, S. and REIMER, M. Biopsychological management of aggression and violence. In M. A. BOID and M. A. NIHART (eds) *Psychiatric Nursing*. New York: Lippincott-Raven, 1998.

HARTVIG, P., ROALDSET, J. O., MOGER, T. A., OSTBERG, B. and BJORKLY, S. *The first steps in the validation of a new screen for violence risk in acute psychiatry: The inpatient context*. Geneva: European Psychiatry, 2010.

HEALTH CARE COMMISSION. *Healthcare Commission National Audit of Violence 2006-7 Final Report - Working age adult services*. London, Health Care Commission, 2007.

HEALTH SERVICES COMMISSION. *A Safer Place to Work: protecting NHS hospital and ambulance staff from violence and aggression*. London: The Stationary Office, 2003.

HENDRICKS, S. Contextual and individual factors and the use of influencing tactics in adult education program planning. *Adult Education Quarterly*, 2001, 51, (3), 219-235.

HENRY, J. and GINN, G. O. Violence prevention in healthcare organizations within a total quality management framework. *Journal of Nursing Administration*, 2002, 32, (9), 479-486.

HIZAR, D. and NEWMAN, J. When touch is *not* the best approach. *Journal of Clinical* Nursing. 1997, 6, (3), 203 – 206.

HERMANS, E., RAMSEY, N. and VAN HONK, J. Exogenous testosterone enhances responsiveness to social threat in the neural circuitry of social aggression in humans. *Biological Psychiatry*, 2008, 63, 263–270

HILLS, D. Relationships between aggression management training, perceived self efficacy and rural general hospital nurses' experiences of patient aggression. *Contemporary Nurse*, 2008, 31, (1), 20 - 31.

HOLLOWAY, I. and TODRES, L. The status of method: flexibility, consistency and coherence. *Qualitative Research*, 2003, 3, 345 – 357.

HOLSTEIN, J. A. and GUBRIUM, J. F. Holstein. The Active Interview. Thousand Oaks, CA: Sage, 1995.

HOSKINS, C. N. and MARIANO, C. *Research in Nursing and Health: Understanding and Using Quantitative and Qualitative Methods*, 2nd ed. London: Springer Publishing Company , 2004.

HOULE, C. *Continuing Learning in the Professions*, San Francisco: Jossey-Bass, 1980.

HOUSE, E. *Evaluating with Validity*. London, Sage, 1980.

HEALTH AND SAFETY EXECUTIVE (HSE) (2005) *Health services industry programme 2004/05: Management of violence and aggression in healthcare*. London: HSE, 2005.

HSE (2006) *Violence and aggression management for trainers and managers: A national evaluation of the training provision in healthcare settings*. Sudbury: Health and Safety Executive Books, 2006.

HUEBNER, A. J. and BETTS, C. S. Examining fourth generation evaluation: Application to positive youth development. *Evaluation*, 1999, 5, (3), 340–358.

HUDGES, J. and SHARROCK, W. *The philosophy of social research* (3rd edition). Harlow: Longman, 1990.

HURLEBAUS, A. and LINK, S. The effect of aggressive behaviour management programme on nurses levels of knowledge, confidence and safety. *J Nurs Staff Dev*, 1997, 13, 260–5.

ILLKIW-LAVALLE, O., GRENYER, B. F. S. and GRAHAM, L. Does prior training and staff occupation influence knowledge acquisition from aggression management training program? *International Journal of Mental Health Nursing*, 2002, *11: 233–239.*

INTERNATIONAL COUNCIL OF NURSES. Guidelines on coping with violence in the workplace. Geneva: ICN, 2007.

INTERNATIONAL LABOUR OFFICE, INTERNATIONAL COUNCIL OF NURSES, WORLD HEALTH ORGANISATION, and PUBLIC SERVICES INTERNATIONAL. *Framework Guidelines for Addressing Workplace Violence in the Health Sector.* Geneva: International Labour Office, 2008.

INTERNATIONAL SOCIETY OF PSYCHIATRIC MENTAL HEALTH NURSES (ISPMHN). *Guidelines for the provision of advice and training in the prevention and management of conflict, aggression and violence -codes of practice.* London: ISPMHN, 2006.

JAMES, D. and BIESTA, G. *Improving learning cultures in further education.* Oxon: Routledge, 2007.

JOHNSON, D. J., SANDERSON, H., BRAIN, R. A., WILSON, C. J. and SOLOMON, K. R. Toxicity and hazard of selective serotonin reuptake inhibitor antidepressants fluoxetine, fluvoxamine, and sertraline to algae. *Ecotoxicol. Environ. Saf.* 2007, 67, (1), 128–39.

JOHNSON, M. E. and DELANEY, K. R. Keeping the Unit Safe: A Grounded Theory Study: *Journal of the American Psychiatric Nurses Association*, 2006, 12, (1), 13-21.

JONIKAS, J. A., COOK, J. A., ROSEN, C., LARIS, A. and KIM, J. B. Brief reports: a program to reduce use of physical restraint in psychiatric inpatient facilities. *Psychiatric Services, American Psychiatric Association*, 2004, 55, 818–20.

KAMALI, M., OQUENDO, M. A. and MANN, J. J. Understanding the neurobiology of suicidal behavior. *Depression and Anxiety*, 2001, 1, (14), 164–76.

KAZI, M. A. F., PAGKOS, B., TOMASELLO, N., MILCH, H. A. and BORTHWICK, A. *Real-time Evaluation of a Community Intervention for Vulnerable Young people*. Paper presented at Society for Social Work & Research 12th. Annual Conference, Washington D.C, January 17-20, 2008.

KAZI, M. A. F., BLOM, B., MOREN, S., PERDAL, A. L. and ROSTILA, I. Realistic Evaluation for Practice in Sweden, Finland and Britain. *Journal of Social Work Research and Evaluation*, 2002, 3, (2), 171 – 186.

KEMMIS, S. and McTAGGART, R. Participatory Action Research. In N. K. DENZIN and LINCOLN, Y. S. (eds.) *Handbook of Qualitative Research*. Thousand Oaks: Sage Publications, 2000, pp. 567 – 605.

KEOGH, P. *The Nature and Extent of Workplace Violence Experienced by Social Care Workers*. Dublin: Irish Association of Care Workers, 2001.

KINDY, D., PETERSON, S and PARKHURST, D. Perilous work: Nurses' experiences in psychiatric units with high risks of assault, *Archives of Psychiatric Nursing*, 2005, 19, (4), 169-175.

KING, J. A., TENNEY, J., ROSSI, V., COLAMUSSI, L. and BURDICK, S. Neural substrates underlying impulsivity. *Annals of New York Academy of Science*, 2003, 1008, 160–169.

KINNEAR, P. R. and GRAY, C. D. *SPSS for Windows Made Simple*, 3rd ed. Hove: Psychology Press Ltd, 1999.

KIRKPATRICK, D. L. Techniques for evaluating training programs. *Journal of American Society of Training Directors*, 1959, 13, (3), 21–26.

KIRKPATRICK, D. L. (1975) Techniques for Evaluating Training Programs. In D. L.

KIRKPATRICK D. L. and KIRKPATRICK, J. D. Evaluating Training Programs (3rd ed.). San Francisco, CA: Berrett-Koehler Publishers, 2006.

KIRIAKOS, X. RUSSELL, A. and MURPHY, D. Management of people with challenging behaviour. *Advances in Psychiatric Treatment*, 2001, 7, 109 – 116.

KNOWLES, M., S. *The Adult Learner: a Neglected Species* 2nd edition, Houston: Gulf Publishing Company, Book Division, 1978.

KNOWLES, M., S. *The Adult Learner: a Neglected Species* 4th edition, Houston: Gulf Publishing Company, Book Division, 1990.

KNOWLES, M. S., HOLTON, E. F. and SWANSON, R. H. *The adult learner: the definitive classic in adult education and human resource development.* Houston, Texas: Gulf Professional Publishing Co, 2000.

KOLB, D. A. & FRY, R. Towards an applied theory of experiential learning. In C. L. COOPER (ed.) *Theories of Group Processes.* London: John Wiley & Sons, 1975, pp. 33 – 58.

KOLB, D. A. *The Learning Style Inventory: Technical Manual*, Boston, Ma.: McBer, 1976.

KOLB, D. A. Learning styles and disciplinary differences. in A. W. CHICKERING (ed.) *The Modern American College*, San Francisco: Jossey-Bass, 1981.

KOLB, D. A. *Experiential Learning*, Englewood Cliffs, NJ.: Prentice Hall, 1984.

KOLB, D. A., OSLAND, J., and RUBIN, I. *Organizational Behaviour: An Experiential Approach to Human Behaviour in Organizations*, 6th ed. Englewood Cliffs, NJ: Prentice Hall, 1995.

KRAIGER, K., FORD, J. K. and SALAS, E. Application of Learning Outcomes to New Methods of Training Evaluation. *Journal of Applied Psychology*, 1993, 78, 311 – 328.

KRALL, R. Human Violence and its Alternatives. *International Journal of Neuroscience* , 2007, 41, 271-286.

KRAMER, M. *Reality Shock: Why Nurses Leave Nursing.* St Louis: Mosby, 1974.

LAING, L. Routine Screening for Domestic Violence in Health Services. *Australian Domestic & Family Violence Clearinghouse Topic Paper,* 2001.

LANZA, M. L., ZEISS, R and RIERDAN, J. Violence against psychiatric nurses: Sensitive research as science and intervention. *Contemporary Nursing,* 2006, 21, (1), 71-84.

LAWSON, T. HEATON, T. and Brown, A. *Education and training* (2nd ed.) Basingstoke, Palgrave Macmillan, 2010.

LEADBETTER, D and PATERSON, B. Developing an agency approach to safe physical intervention. *Nursing and Residential Care,* 2004, 6, (6), 280–283.

LINCOLN, Y. and GUBA, E. *Naturalistic inquiry.* New York: Sage, 1985.

LINSLEY, P. *Violence and Aggression in the Workplace: A Practical Guide for All Healthcare Staff.* Oxford, Radcliffe, 2006.

LoBIONDO-WOOD, G. and HABER, J. *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice.* Sixth Edition, St Louis, Missouri: MOSBY Elsevier, 2006.

LOKE, Y. K., PRICE, D, HERXHEIMER. Cochrane Adverse Effects Methods Group. Systematic reviews of adverse effects: framework for a structured approach. *BMC Med Res Methodol* , 2007, 7, 32.

LORENZ, K. *On Aggression.* New York: Harcourt, Brace & World, Inc, 1966.

LOWE, J., KENNEDY, J., HARRISON, J., HILLS, T., BLUGLASS, R. Putting aggression into context: an investigation into contextual factors influencing the

rate of aggressive incidents in a psychiatric hospital. *Journal of Mental Health*, 2003, 8, 159-170.

LAWOKO, S., SOARES, J. J. F. and NOLAN, P. Violence towards psychiatric staff: a comparison of gender, job and environmental characteristics in England and Sweden. *Work and Stress*, 2004, 18, (1), 39 – 55.

MABRY, C. and WILSON, A. *Managing power: The practical work of negotiating interests.* Proceedings of the 42nd annual Adult Education Research Conference (pp. 263-267). East Lansing, MI: Michigan State University, 2001.

MACLINK. *Psychology of Violence*. Maclink, 2011.

MAGIN, P. J., ADAMS, J. SIBBRITT, D. W., JOY, E. and IRELAND, M. C. Experiences of occupational violence in Australian urban general practice: A cross-sectional study of GPs. *The Medical Journal of Australia*, 2005, 30, 183, (7), 352-356.

MARQUARDT, M. J. *Action Learning in Action: Transforming Problems and People for World-Class Organizational Learning*. Palo Alto: Davies-Black Press, 1999.

MARTIN, T. and DARREN, M. Clinical perceptions of personal safety and confidence to manage inpatient aggression in a forensic psychiatric setting. *Journal of Psychiatric and Mental Health Nursing*, 2006, 13, 90–99.

MASON, J. *Qualitative Researching.* London: Sage, 2002.

MAY, D. D. and GRUBBS, L. M. The extent, nature, and precipitating factors of nurse assault among three groups of registered nurses in a regional medical centre. *Journal of Emergency Nursing*, 2002, 28, 11-7.

MAYHEW, C. Occupational violence in industrialised countries: types, incidence patterns and 'at risk' groups of workers. In M. GILL, B. FISHER and V. BOWIE (eds). *Occupational Violence in Industrialised Countries*. London: William Press, 2002.

MAYHEW, C. and CHAPPELL, D. *Occupational Violence in the NSW Health Workforce: Establishment of Baseline Data*, report to *Taskforce on the Prevention and Management of Violence in the Health Workplace*, Sydney: NSW Department of Health, 2002.

MAYHEW, C. and CHAPPELL, D. *Prevention of occupational violence in the health workplace. Taskforce on the prevention and management of violence in the health workplace*. Discussion paper No. 2. The University of New South Wales, Australia: School of Industrial Relations and Organisational Behaviour and Industrial Relations Research Centre, 2001.

MAYO, A. What are the latest trends in training and development?, in *Reflections on the 2005 Training and Development Survey*, London: CIPD: 2005, 18–20.

MAYS, N. and POPE, C. Assessing quality in qualitative research. *BMJ*, 2000, 320, 50-2.

MCGREGOR, G. A clearer picture of abuse. *Nursing Times*, 2006, 102, 24, 11.

MCKENZIE, B. *Psychological approaches to longer-term patients presenting challenging behaviors*. In D. BEER, S. PEREIRA and C. PATON (eds.) *Psychiatric Intensive Care*. London: Greenwich Medical Media, 2001.

McNEIL, D. E. Empirically based clinical evaluation and management of the potentially violent patient. In P. M. KLEESPIES (ed.) *Emergencies in mental*

health practice: Evaluation and management. New York: The Guilford Press, 1998, pp. 95 – 116.

McPHAUL, K. and LIPSCOMB, J. *Conceptual and methodological issues in measurement of work organization and workplace violence.* Paper presented at the American Psychological Association/NIOSH Workplace Stress Conference, Toronto, 2003.

MEHTA, P. H., JONES, A. C. and JOSEPHS, R. A. The social endocrinology of dominance: Basal testosterone predicts cortisol changes and behaviour following victory and defeat. *Journal of Personality and Social Psychology*, 2008, 94, 1078–1093.

MERCER, N., and LITTLETON, K. *Dialogue and the Development of Thinking: a sociocultural approach.* London: Routledge, 2007.

MERRIAM, S. and SIMPSON, E. *A Guide to Research for Educators and Trainers of Adults.* Malabar, FL: Krieger Publishing, 2000.

MERTON, R. K. The Unanticipated Consequences of Purposive Social Action. *American Sociological Review* 1, 1936, 12, (6), 894–904.

MILLER, C. M., FREEMAN, M. and ROSS, N. *Interprofessional Practice in Health and Social Care: Challenging the Shared Learning Agenda*, London: Arnold, 2001.

MONDS-WATSON, A. Understanding aggression and resistance. In B Taylor (Ed) *Working with Aggression and Resistance in Social work.* Exeter, Learning Matters, 2011.

MORALES, E. and DUPHORNE, P. L. Least restrictive measures: alternatives to four-point restraints and seclusion. *Journal of Psychosocial Nursing and Mental Health Services*, 1995, 33, (10), 13–16.

MORGAN, D. G., STEWART, N. J., D'ARCY, C., FORBES, D. and LAWSON, J. Work stress and physical assault of nursing aides in rural nursing homes with and without dementia special care units: *Journal of Psychiatric and Mental Health Nursing*, 2005, 12, (3), 347-358.

MORRIS, P. T. Women Are Not Islands: Engaging men to empower women. *Critical Half*, 2007, 5, (1), 38 – 43.

MULLEN, P. E. Schizophrenia and Violence: from correlations to preventative strategies. *Advances in Psychiatric Treatment*; 2006, 12, 239–248.

MURPHY, E. and DINGWELL, R. *Qualitative Methods and Health Policy Research*. New York: Aldine de Gruyter, 2003.

NACHREINER, N. M., GERBERICH, S. G., RYAN, A. D. and McGOVERN, P. M. Minnesota Nurses' Study: Perceptions of Violence and the Work Environment. *Industrial Health*, 2007, 45, 672 – 678

NATIONAL ADUIT OFFICE. *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression.* Report prepared by the comptroller and auditor general. HC 527. London: National Audit Office, 2003.

NATIONAL ADUIT OFFICE. *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression.* London, National Audit Office, 2004.

NATIONAL ASSEMBLY FOR WALES AUDIT OFFICE. *Protecting NHS Staff from Violence and Aggression.* Cardiff, National Assembly for Wales, 2009.

NATIONAL INSITUTE OF CLINICAL EXCELLENCE (NICE) *Violence: The short-term management of disturbed belabour in in-patient psychiatric settings and emergency departments*. London; NICE, 2006.

NATIOANL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (NIMHE). *Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings*. London; NIMHE, 2004.

NEEDHAM, I., ABDERHALDEN, C., DASSEN, T., HAUG, H. J. and FISCHER, J. E. The perception of aggression by nurses: psychometric scale testing and derivation of a short instrument. *Journal of Psychiatric and Mental Health Nursing*, 2004, 11, (1), 36–42.

NEEDHAM, I. ABDERBALDEN, C. HALFENS, R., FISCHER, J. and DASSEN, T. Non-somatic effects of patient aggression on nurses: a systematic review. *Journal of Advanced Nursing*, 2005, 49, 283-296.

NHS SECURITY MANAGEMENT SERVICE (NHSSMS) *Promoting Safer and Therapeutic Services – Implementing the national syllabus in mental health and learning disability services*. Leeds: DH, 2005.

NHS COUNTER FRAUD AND SECURITY MANAGEMENT SERVICES (NHSCFSMS). *Tackling Violence against Staff*. Leeds: NHSCFSMS, 2006.

NHS EDUCATION FOR SCOTLAND. *Standards for Training in the Prevention and Therapeutic Management of Violence In Adult Mental Health Settings*. Edinburgh: NHS Scotland, 2005.

NHS HEALTH DEVELOPMENT AGENCY. *Violence and Aggression in General Practice*. London: Department of Health, 2002.

NHS SECURITY MANAGEMENT SERVICE (NHSSMS) *Cost of violence against NHS staff 2007/2008*. Leeds: NHSSMS, 2008.

NHS SECURITY MANAGEMENT SERVICE. *Violence against front line NHS staff*. Leeds: NHSNSMS, 2010.

NHS WALES. *Prevention of violence and aggression. Case management of service of primary care*. Cardiff: Welsh Government., 2010.

NICE. *Violence: The Short-Term Management of Disturbed/Violent Behaviour in Psychiatric In-patient and Emergency Departments Guideline*. London: DH, 2006.

NICHOLLS, T. L., BRINK, J. DESMARAIS, S. L., WEBSTER, C. D. and MARTIN, M. L. The Short-Term Assessment of Risk and Treatability (START): A prospective validation study in a forensic psychiatric sample. *Assessment*, 2006, 13, 313-327.

NIJMAN, H., BOWERS, L., OUD, N. and JANSEN, G. Psychiatric nurses' experiences with inpatient aggression. *Aggressive Behaviour*, 2005, 31, 217 – 227.

NOAK, J., WRIGHT, S., SAYER, J., PARR, A. M., GRAY, R. W., SOUTHERN, D. and GOURNAY, K. The content of management of violence policy documents in United Kingdom acute inpatient mental health services. *Journal of Advanced* Nursing, 2002, 37, (4), 394-401.

NOLAN, K. A., CZOBOR, P., ROY, B. B., PLATT, M. M., SHOPE, C. B., CITMORE, L. L. and VOLAYKA, J. Characteristics of assaultive behaviour among psychiatric inpatients, *Psychiatric Services*, 2003, 54, (7), 1012 - 101

NOLAN, P., DALLENDER, J., SOARES, J., THOMSEN, S. and ARMETZ, B. Violence in mental health care: The experiences of mental health nurses and psychiatrists. *Journal of Advanced Nursing*, 1999, 30, 934-941.

NORRIS, C. and McCAHILL, M. CCTV beyond Penal Modernism?, *British Journal of Criminology,* 2006, 46, 97-118.

ONTARIO NURSES' ASSOCIATION. *Violence in the Workplace: A guide for ONA members.* Toronto: Ontario Nurses' Association, 2003.

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION. *Guidelines for preventing workplace violence for health care and social service workers* (No. OSHA 3148-04R). Washington, DC: U.S. Department of Labour and U.S. Department of Health and Human Services, 2004.

ORTENBALD, A. A typology of the idea of learning organization, *Management Learning*, 2002, 33 (2): 213–230.

OUTHWAITE, W. *New Philosophies in Social Sciences.* London: MacMillan, 1987.

PARAHOO, K. *Nursing Research: Principles, Process and Issues.* 2nd edn. Palgrave Macmillan, London, 2006.

PARKES, J. A Three-year Study of the Nature and Management Untoward Incidents in a Medium Secure Unit. *Medicine, Science and the Law*, 2003, 43 (1): 69-74.

PATERSON, B. Thinking the unthinkable: A Role for pain compliance and mechanical restraint in the management of violence? *Mental Health Practice*, 2005, 8, (7), 18-23.

PATERSON, B. Violence towards Mental Health Nurses in England and the Nature of the Policy Response: A Frame Analysis. *Journal of Risk and Governance*, 2009, 1, (2), 125 - 136.

PATERSON, B. and DUXBURY, J. Developing a perspective on restraint and the least intrusive intervention. *British Journal of Nursing*, 2006, 14, (22), 1235-1241.

PATTON, M. Q. *Practical Evaluation* Sage, Beverley Hills, California, 2008.

PATTON, M. Q. *Utilization Focused Evaluation: The New Century Text (3rd Ed.)*, London: Sage Publications, 1997.

PATTON, M. Q. (2002) *Qualitative Research and Evaluation Methods.* Thousand Oaks, CA: Sage, 2002.

PAWSON, R. and TILLEY, N. Realistic Evaluation. London: Sage, 1997.

PETERSON, R. *Training Needs Analysis in the Workplace.* Kogan Page Practical Trainer Series, 1992.

PEZAWAS, L., MAYER-LINDENBERG, A. DRABANT, E. M. VERCHINSKI, B. A., MUNOZ, K. E., KOLACHANA, B. S., EGAN, M. F., MATTAY, V. S., HARIRI, A. R. and WEINBERGER, D. R. 5-HTTLPR polymorphism impacts human cingulate-amygdala interactions: a genetic susceptibility mechanism for depression. *Nat Neurosci*, 2005, 8, 828–834.

PILLMAN, F., ROHDE, A., ULLRICH, S. DRABA, S., SANNEMULLER, U. and MARNEROS, A. Violence, criminal behaviour, and the EEG: Significance of left hemispheric focal abnormalities. *Journal of Neuropsychiatry and Clinical Neuroscience*, 1999, 11, 454–457.

PRESKORN, S. H., ROSS, R., STANGA, C. Y. Selective Serotonin Reuptake Inhibitors" In H. SHELDON, H. PRESKORN, H. P. FEIGHNER, C. Y. STANGA and R. ROSS. *Antidepressants: Past, Present and Future*. Berlin: Springer, 2004, pp. 241–62.

QUINN, F. M. and HUDGES, S. *Principles and Practice of Nurse Education*. 5th ed. London: Nelson Thornes, 2007.

QUINLAN, M. Organisational restructuring/downsizing, OHS regulation and worker health and wellbeing. *International Journal of Law and Psychiatry*, 2007, 30, (4-5), 385-399.

RAMIREZ, J. M. and ANDREU, J. M. Aggression, and some related psychological constructs (Anger, hostility, and impulsivity. Some comments from a research project). *Neuroscience and Biobehavioral Reviews*, 2006, 30, 276-291.

ROYAL COLLEGE OF NURSING (RCN). *Work-related violence: A RCN tool to manage risk and promote safer working practices in health care*. London: RCN, 2008.

REED, L and PROCTOR, S. (eds.) *Practitioner Research in Health Care*. London: Chapman & Hall, 1995.

REGEHER, C., STERN, S. and SHLONSKY, A. Operationalising evidence-based practice: The development of an institute for evidence-based social work.

Research on Social Work Practice, 2007, 17, 408-416.

RICHARDS, J. *Management of workplace violence victims.* Joint Programme on Workplace Violence in the Health Sector: International Labour Office; International Council of Nurses; World Health Organization; Public Services International, 2003.

RIPPON, T. J. Aggression and violence in health care professions. *Journal of Advanced Nursing,* 2001, 31 (2), 452-460.

RIX, G. SEYMOUR, D. (1988)) Violent incidents on a regional secure unit. *Journal of Advanced Nursing,* 1988,13, 6, 746-751.

ROSE, J. L and CLEARY, A. Care staff perceptions of challenging behaviour and fear of assault. *Journal of Intellectual & Developmental Disability,* 2007, *32,* (2), 153–161

ROSSI, P and FREEMAN, H. *Evaluation: a Systematic Approach.* Beverly Hills, California: Sage, 1985.

ROSSI, P. LIPSEY, M. W. and FREEMAN, H. *Evaluation: a systematic approach* (7th ed.). Thousand Oaks: Sage, 2004.

RUXTON, S. Conclusion. In *Gender Equality and Men: Learning from Practice.* Ed. Sandy Ruxton, Oxford: Oxfam GB, 2004.

RYAN-NICHOLLS, K. and WILL, C. Rigour in qualitative research: mechanisms for control. *Nurse Researcher,* 2009, 16, (3), 70–85.

RYCROFT-MALONE, J. and BUCKNELL, T. *Models and Frameworks for Implementing Evidence-Based Practice: Linking Evidence to Action*. Oxford: Wiley-Blackwell, 2010.

SABINI, J and SILVER, M. *The moralities of everyday life*. London: Oxford University Press, 1992.

SANDELOWSKI, M. Whatever happened to qualitative description? Research in Nursing & Health, 2000, 23, 334 – 340.

SANDELOWSKI, M. Writing a good read: Strategies for re-presenting qualitative data. *Research in Nursing and Health*, 1998, 21, 375 – 382.

SARANTAKOS, S. *Social Research*. (2nd Ed). China: Macmillan Publishers, 1998.

SAYER, R. A. *Realism and social science*. London: Sage, 2000.

SCOTT, C. L. and RESNICK, P. J. *Patient suicide and litigation*. In Textbook of Suicide Assessment and Management. Edited by R. I. SIMON, R. E. Hales, and ARLINGTON, V. A. New York, American Psychiatric Publishing, 2006, pp. 527–544.

Scottish Executive Health Department. *Standard and Guidelines on the Management of Violence and Aggression*. Edinburgh, Scottish Executive Health Department, 2007.

SIEGEL, A., BHATT, S., BHATT, R. et al. The neurobiological bases for development of pharmacological treatments of aggressive disorders. *Current Neuropharmacology,* 2007, *5*, 135–147.

SIEVER, L. J. Siever, L. J. Neurobiology of aggression and violence. *American Journal of Psychiatry*, 2008, 165, 429–442.

SILVERMAN, D. *Doing qualitative research: A practical guide*. Thousand Oaks, CA: Sage Publications, 2000.

SKINNER, N. and BREWER, N. The dynamics of threat and challenge appraisals prior to stressful achievement events. *Journal of Personality and Social Psychology*, 2002, 83, 678-692.

SORK, T. *Planning educational programs*. In P. CUNNINGHAM and A. Wilson (eds) Handbook of adult and continuing education, San Francisco: Jossey-Bass, 2000, pp. 171-190.

SPENCER, L., RITCHIE, J., LEWIS, J., and DILLON, L. *Quality in Qualitative Evaluation: A framework for assessing research evidence*. London: Cabinet Office, 2003.

SPRADLEY, J. P. *The Ethnographic Interview*. Fort Worth, Texas: Harcourt Brace Jovanovich College Publishers, 1979.

STAKE, R. E. The art of case study research. Thousand Oaks, CA: Sage, 1995.

STAKE, R. E. and ADMA, T. A. Responsive evaluation. In S. MATHISON (ed.) *Encyclopaedia of evaluation*. Thousand Oaks: Sage, 2005, pp. 376–379.

STREBERT, H. J. and CARPENTER, H. J. *Qualitative Research in Nursing: Advancing the Humanistic Imperative*, 2nd edn. Philadelphia: Lippincott, 1999.

STIRLING, H. and McHUGH, M. Developing a non-aversive intervention strategy in the management of aggression and violence for people with learning disabilities using natural therapeutic holding. *Journal of Advanced Nursing*, 1998, 27, (3), 503–509

STURROCK, A. Assessing the risk of aggression and violence among service users. *Mental Health Practice*, 2012, 15,(5), 20 – 28

STUBBS, B. PATERSON, B. and LEADBETTER, D. Physical Interventions: A review of the literature on its use, staff and patients views and the impact of training, *Journal of Psychiatric and Mental Health Nursing*, 2009, 16, (1), 99-105.

SULLIVAN, P. Care and control in mental health nursing. Sullivan P (1998) Care and control in mental health nursing. *Nursing Standard.*, 1998, 13, (13-15), 42-45.

SWANSON, J. W., SWARTZ, M.S., VAN DOM, R. A. et al. A national study of violent behavior in persons with schizophrenia. *Archives of Gen Psychiatry*; 2006, 63, (5), 490–9.

TAMKIN, P. *The Contribution of Skills to Business Performance*, DfES Report RW39, Brighton: Institute for Employment Studies for DfES, 2005.

TRAINOR, B. C. and NELSON, R. J. Neuroendocrinology of Aggressive Behaviour. *Handbook of Neuroendocrinology,* G. Fink et al. editors, Elsevier: San Diego, CA, 2011, pp 509-520.

TRAUTH, E. M. (ed.) *Qualitative Research in IS: Issues and Trends.* Hershey, PA: Idea Group Publishing, 2001.

TRENOWETH, S. Perceiving risk in dangerous situations: risks of violence among mental health inpatients. *Journal of Advanced Nursing*, 2003, 42, (3), 278 – 287.

TOLSON, D., SCHOFIELD, I., BOOTH, J., KELLY, T. B. and JAMES, L. Construction a new approach to developing evidence based practice with nurses and older people. *Worldviews on Evidence Based Nursing*, 2006, *3*, (2), 62-72.

TYLER, R. W. *Perceptions on American Education: reflections on the past, challenges for the future.* Chicago: Science Research Associates, 1976.

US DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS). *Workplace Violence Prevention Strategies and Research Needs.* National Institute for Occupational Safety and Health (NIOSH) Publication No. 2006-144, 2006.

VAN SOEREN, M., DEVLIN-COP, S., MacMILLAN, L. B., EGAN-LEE, E., and SCOTT, R. Simulated Interprofessional education: An analysis of teaching and learning processes. *Journal of Interprofessional Care*, 2011, 25, (6), 434 – 440.

VERDUN-JONES, S., BRINK, J., LUSSIER, P., & NICHOLLS, T. L. *Aggression and violence at the B.C. Forensic Psychiatric Hospital: Description, prediction, management and legal issue.* Report prepared for the Forensic Psychiatric Services Commission, Vancouver, BC, 2006.

VIITASARA, E. *Violence in Caring. Risk Factors, Outcomes and Support. Dissertation*, Department of Public Health Sciences, Division of Social Medicine, Karolinska Institute and National Institute for Working Life, Department for Work and Health, Stockholm, Sweden, 2004.

VILLALON, L. R., MORISSEAU, C., YOO, H. J., FU, S. H., HAMMOCK, B. D. and TRAINOR, B. C. Stress responses and the mesolimbic dopamine system: social contexts and sex differences. *Endocrinology*, 2012, 153, 949-953.

VOLAVKA, J. *Neurobiology of violence* (2nd ed.) Washington, DC: American Psychiatric Publishing, 2002.

WADE, D. T. Ethics, audit and research: All shades of grey. *British Medical Journal,* 2005, 330, 468–471

WALSH, D. M. *The prediction of violent behavior.* Dissertation Abstracts International: Section B: The Sciences and Engineering, 2001.

WEISS, C. H. *Evaluation: Methods for Studying Programs and Policies (2nd ed.).* Upper Saddle River, NJ: Prentice Hall, 1998.

WELLS, J. and BOWERS, L. How prevalent is violence towards nurses working in general hospitals in the UK? *Journal of Advanced Nursing*, 2002, 30, (3), 230 – 40.

WELSH ADUIT OFFICE. *Protecting NHS Trust Staff form violence and aggression*. Cardiff: Welsh Assembly Government, 2005.

WELSH ADUIT OFFICE. *Protecting NHS Staff from Violence and Aggression - An Update.* Cardiff: Wales Audit Office, 2009.

WELSH, I. and SWANN, C. *Partners in Learning: A Guide to Support and Assessment in Nurse Education*. Abingdon: Radcliffe Medical Press, 2002.

WHITLEY, B. and KITE, M. *The Psychology of Prejudice and Discrimination.* Wadsworth: Cengage Learning, 2010.

WHITTINGTON, R. Violence to nurses: prevalence and risk factors. *Nursing Standard*, 1997, 12, (5), 49 – 56.

WHITTINGTON, R. and WYKES, T. A. Aversive stimulation by staff and violence by psychiatric patients. *The British Journal of Clinical Psychology*, 1996, 35, 11-20.

WORLD HEALTH ORGANISATION (WHO). *World report on violence and health Summary*. Geneva: World Health Organisation, 2002.

WHO GLOBAL CONSULTATION ON VIOLENCE AND HEALTH. Violence: A public health priority (document WHO/EHA/SPI.POA.2). Geneva: World Health Organization, 1996.

WORLD HEALTH ORGANISATION (WHO). *Workplace violence in the health sector: Country case studies, research instruments. Survey Questionnaire English*. Geneva: World Health Organization, 2003.

WKYES, T. (ed). *Violence and Health Care Professionals*. Chapman & Hall, London, 1994.

WYNN, R. Psychiatric inpatients experiences with restraint. Journal of Forensic Psychiatry and Psychology. 2004, 15, (1), 124-144.

APPENDIX A

NHS

National Research Ethics Service

Derbyshire Research Ethics Committee
3rd Floor
Laurie House
Colyear Street
Derby
DE1 1LJ

Telephone: 01332 868765
Facsimile: 01332 868785

19 March 2008

Mr Paul Linsley
Senior Lecturer
The University of Lincoln
Faculty of Health, Life and Social Sciences
Bridge House
Lincoln
LN6 7TS

Dear Mr Linsley

Full title of study:	**Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes**
REC reference number:	**08/H0401/16**

Thank you for your letter of 14 March 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for Stage 1 of the above research, on the basis described in the application form, protocol and supporting documentation as revised. Documents relating specifically to Stage 2 of the study to be submitted as a substantial amendment as soon as they are available for review as confirmed in your response.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA.) There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Continued/

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	V 5.5	19 February 2008
Investigator CV		06 February 2008
Protocol	V 5.5	
Covering Letter		06 February 2008
Summary/Synopsis	V 5.5	
Letter from Sponsor		19 January 2008
Interview Schedules/Topic Guides	5.5	
Participant Information Sheet	5.6	13 March 2008
Participant Consent Form	5.6	13 March 2008
Response to Request for Further Information		14 March 2008
Academic Supervisor's CV		05 September 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

Here you will find links to the following

a) Providing feedback. You are invited to give your view of the service that you have received from the National Research Ethics Service on the application procedure. If you wish to make your views known please use the feedback form available on the website.
b) Progress Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
c) Safety Reports. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
d) Amendments. Please refer to the attached Standard conditions of approval by Research Ethics Committees.
e) End of Study/Project. Please refer to the attached Standard conditions of approval by Research Ethics Committees.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nationalres.org.uk .

08/H0401/16	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Phil Hopkinson
Vice Chair

Email: jenny.hancock@derwentsharedservices.nhs.uk

Enclosures: *Standard approval conditions SLAC-2*

Copy to: Professor Sara Owen, University of Lincoln
R&D Office for Lincolnshire Partnership NHS Trust

Appendix B

Questionnaire 3
Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes.

Introduction

The delivery of workplace violence management training constitutes a central part of the Healthcare sectors strategy for combating work-related violence and aggression. The purpose of the study is to evaluate how effective aggression management programmes are at preparing staff to manage violence and aggression in clinical practice.

The research is being undertaken towards an academic qualification, that of Doctor of Health Science.

Why have I been invited?

You have been invited to take part in the study because of the aggression management training you are about to undertake.

Invitation to take part in the study

It would be very helpful to me if you could complete the attached questionnaire. You can return your completed form directly to the address below;

Paul Linsley
Senior Lecturer
University of Lincoln (Brayford Pool Campus)
School of Health and Social Care
Bridge House
Lincoln

If you would prefer to complete an electronic copy of this form, please email plinsley@lincoln.ac.uk to request this. The form can them be completed and returned electronically.

Please note:
This research has not been commissioned by any organisation or agency. Your participation is voluntary, no expenses or fees can be paid for contributions to the research. Confidentiality is of the highest priority; with the exception of the researcher and his supervisor, no-one in the University, no organisations, institutions, managers or tutors will be given access to any of the raw data, or information on any research contributors or contributions. Your rights and the responsibilities of the researcher will be met as covered by the Data Protection Act 1998.

If you have any queries or concerns about this research work, please contact Paul Linsley directly by email on plinsley@lincoln.ac.uk

UNIVERSITY OF LINCOLN

Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes.

Name:

Job Title:

Area of work (e.g. Ward):

Please tick the box you most agree with.

1. The instructor was an able communicator

Strongly Agree	Agree	Disagree	Strongly disagree

2. The instructor retained my interest

Strongly Agree	Agree	Disagree	Strongly disagree

3. Sessions were paced appropriately

Strongly Agree	Agree	Disagree	Strongly disagree

4. Overall, the instructor(s) assisted my learning

Strongly Agree	Agree	Disagree	Strongly disagree

5. The aims and objectives of the course were clear

Strongly Agree	Agree	Disagree	Strongly disagree

6. The teaching methods employed were appropriate to the subject matter

Strongly Agree	Agree	Disagree	Strongly disagree

7. The course material was well structured and easy to understand

Strongly Agree	Agree	Disagree	Strongly disagree

8. The subject matter was developed logically

Strongly Agree	Agree	Disagree	Strongly disagree

9. The instructor related the subject matter to practice and current evidence

Strongly Agree	Agree	Disagree	Strongly disagree

10. The instructor stimulated my interest in the subject

Strongly Agree	Agree	Disagree	Strongly disagree

11. The instructor encouraged me to think about and question matters covered

Strongly Agree	Agree	Disagree	Strongly disagree

12. The explanations given by the Instructor were clear

Strongly Agree	Agree	Disagree	Strongly disagree

13. The Instructor emphasised key points

Strongly Agree	Agree	Disagree	Strongly disagree

14. The Instructor pointed out links to previous topics we had studied

Strongly Agree	Agree	Disagree	Strongly disagree

15. The visual aids used were clear and helped me understand the matter covered

Strongly Agree	Agree	Disagree	Strongly disagree

16. Open-ended comments

What was most effective about this staff member's teaching?

What might the instructor do, if anything, to improve the quality of teaching?

What skills/knowledge will you be able to use from the course in clinical practice?

What is the most important skill you have learnt during your time on the course?

Please use this space for any further comments you may wish to make about the teaching or course in general.

Thank you for completing the questionnaire

Version 1

Questionnaire 4

Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes.

Introduction

The delivery of workplace violence management training constitutes a central part of the Healthcare sectors strategy for combating work-related violence and aggression. The purpose of the study is to evaluate how effective aggression management programmes are at preparing staff to manage violence and aggression in clinical practice.

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You have been invited to take part in the study because of the aggression management training you are about to undertake.

Invitation to take part in the study

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Paul Linsley
Senior Lecturer
University of Lincoln (Brayford Pool Campus)
School of Health and Social Care
Bridge House
Lincoln

If you would prefer to complete an electronic copy of this form, please email plinsley@lincoln.ac.uk to request this. The form can them be completed and returned electronically.

Please note:
This research has not been commissioned by any organisation or agency. Your participation is voluntary, no expenses or fees can be paid for contributions to the research. Confidentiality is of the highest priority; with the exception of the researcher and his supervisor, no-one in the University, no organisations, institutions, managers or tutors will be given access to any of the raw data, or information on any research contributors or contributions. Your rights and the responsibilities of the researcher will be met as covered by the Data Protection Act 1998.

If you have any queries or concerns about this research work, please contact Paul Linsley directly by email on plinsley@lincoln.ac.uk

UNIVERSITY OF LINCOLN

Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes.

Name:

Job Title:

Area of work (e.g. Ward):

Please place a mark along each line indicating your response to the following statements.

1. Patients are aggressive because of the environment they are in

Strongly Agree ——————————————————— Strongly Disagree

2. Other people make patients aggressive or violent

Strongly Agree ——————————————————— Strongly Disagree

3. Patients commonly become aggressive because staff do not listen to them

Strongly Agree ——————————————————— Strongly Disagree

4. It is difficult to prevent patients from becoming aggressive

Strongly Agree ——————————————————— Strongly Disagree

5. Patients are aggressive because they are ill

Strongly Agree ——————————————————— Strongly Disagree

6. Poor communication between staff and patients leads to patient aggression

Strongly Agree ——————————————————— Strongly Disagree

7. There are types of patients that are aggressive

Strongly Agree ——————————————————— Strongly Disagree

8. Different approaches are used on the ward to manage aggression

Strongly Agree ——————————————————— Strongly Disagree

9. Patients who are aggressive should try to control their feelings

Strongly Agree ———————————————— Strongly Disagree

10. When a patient is violent seclusion is one of the most effective approaches

Strongly Agree ———————————————— Strongly Disagree

11. Patients who are violent are restrained for their own safety

Strongly Agree ———————————————— Strongly Disagree

12. The practice of secluding patients should be discontinued

Strongly Agree ———————————————— Strongly Disagree

13. Medication is a valuable approach to treating aggressive and violent behaviour

Strongly Agree ———————————————— Strongly Disagree

14. Aggressive patients will calm down if left alone

Strongly Agree ———————————————— Strongly Disagree

15. Negotiation should be used more effectively when managing aggression and violence

Strongly Agree ———————————————— Strongly Disagree

16. Restrictive environments can contribute towards aggression

Strongly Agree ———————————————— Strongly Disagree

17. Expressions of anger do not always require staff intervention

Strongly Agree ———————————————— Strongly Disagree

18. Physical restraint is sometimes used more then is necessary

Strongly Agree ———————————————— Strongly Disagree

19. Alternatives to the use of containment and sedation to manage physical violence could be used more frequently

Strongly Agree ———————————————— Strongly Disagree

20. Improved one to one relationships between staff and patients can reduce the incidence of aggression

Strongly Agree ———————————————— Strongly Disagree

21. Patient aggression could be handled more effectively

Strongly Agree ———————————————— Strongly Disagree

22. Prescribed medication can sometimes lead to aggression

Strongly Agree ———————————————— Strongly Disagree

23. It is largely situations that can contribute toward the expression of aggression by patients

Strongly Agree ———————————————— Strongly Disagree

24. Seclusion is sometimes used more than necessary

Strongly Agree ———————————————— Strongly Disagree

25. Prescribed medication should be used more frequently for aggressive patients

Strongly Agree ———————————————— Strongly Disagree

26. The use of de-escalation is successful in preventing violence

Strongly Agree ———————————————— Strongly Disagree

27. If the physical environment were different, patients would be less aggressive

Strongly Agree ———————————————— Strongly Disagree

28. How confident are you in your capability to deal with verbal abuse originating from colleagues,

Very confident ———————————————— Not confident at all

Managers,

Very confident ———————————————— Not confident at all

Other staff (for example, other members of the multidisciplinary team)

Very confident ———————————————— Not confident at all

29. How confident are you in your capability to deal with verbal abuse from service users

Very confident ———————————————— Not confident at all

30. How confident are you in your colleagues capability to come to your assistance during an incident and to be sympathetic and supportive afterwards

Very confident ———————————————— Not confident at all

31. How confident are you in your Trust's capability to tackle violence and aggression

Very confident ———————————————— Not confident at all

32. How anxious are you about the possibility of personally experiencing some form of violence and aggression whilst at work

Very anxious ———————————————— Not at all anxious

33. The team in which I work is clear about what they are trying to achieve when managing an aggressive incident.

Strongly Agree ———————————————— Strongly Disagree

34. We know that we can rely on one another when managing an aggressive incident

Strongly Agree ———————————————— Strongly Disagree

35. We meet together sufficiently frequently to ensure effective communication and co-operation.

Strongly Agree ———————————————— Strongly Disagree

36. People in the team are quick to offer help to try out new ways of doing things.

Strongly Agree ———————————————— Strongly Disagree

37. There is a feeling of trust and safety within the team.

Strongly Agree ____ Strongly Disagree

38. We are enthusiastic about innovation within the team

Strongly Agree ____ Strongly Disagree

39. We can safely discuss errors and mistakes in the team

Strongly Agree ____ Strongly Disagree

40. We work supportively together to get the job done within my team

Strongly Agree ____ Strongly Disagree

41. Please state the techniques/skills you find most useful when managing an aggressive incident

Thank you for completing this questionnaire

Version 1

Appendix C

Questionnaire 1
Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes.

Introduction

The delivery of workplace violence management training constitutes a central part of the Healthcare sectors strategy for combating work-related violence and aggression. The purpose of the study is to evaluate how effective aggression management programmes are at preparing staff to manage violence and aggression in clinical practice.

The research is being undertaken towards an academic qualification, that of Doctor of Health Science.

Why have I been invited?

You have been invited to take part in the study because of the aggression management training you are about to undertake.

Invitation to take part in the study

It would be very helpful to me if you could complete the attached questionnaire. You can return your completed form directly to the address below;

Paul Linsley
Senior Lecturer
University of Lincoln (Brayford Pool Campus)
School of Health and Social Care
Bridge House
Lincoln LN6 7TS

If you would prefer to complete an electronic copy of this form, please email plinsley@lincoln.ac.uk to request this. The form can them be completed and returned electronically.

Please note:
This research has not been commissioned by any organisation or agency. Your participation is voluntary, no expenses or fees can be paid for contributions to the research. Confidentiality is of the highest priority; with the exception of the researcher and his supervisor, no-one in the University, no organisations, institutions, managers or tutors will be given access to any of the raw data, or information on any research contributors or contributions. Your rights and the responsibilities of the researcher will be met as covered by the Data Protection Act 1998.

If you have any queries or concerns about this research work, please contact Paul Linsley directly by email on plinsley@lincoln.ac.uk

Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes.

Name:

Job Title:

Area of work (e.g. Ward):

Please place a mark along each line indicating your response to the following statements.

1. Patients are aggressive because of the environment they are in

Strongly Agree ______________________________ Strongly Disagree

2. Other people make patients aggressive or violent

Strongly Agree ______________________________ Strongly Disagree

3. Patients commonly become aggressive because staff do not listen to them

Strongly Agree ______________________________ Strongly Disagree

4. It is difficult to prevent patients from becoming aggressive

Strongly Agree ______________________________ Strongly Disagree

5. Patients are aggressive because they are ill

Strongly Agree ______________________________ Strongly Disagree

6. Poor communication between staff and patients leads to patient aggression

Strongly Agree ______________________________ Strongly Disagree

7. There are types of patients that are aggressive

Strongly Agree ______________________________ Strongly Disagree

8. Different approaches are used on the ward to manage aggression

Strongly Agree ______________________________ Strongly Disagree

9. Patients who are aggressive should try to control their feelings

Strongly Agree ———————————————— Strongly Disagree

10. When a patient is violent seclusion is one of the most effective approaches

Strongly Agree ———————————————— Strongly Disagree

11. Patients who are violent are restrained for their own safety

Strongly Agree ———————————————— Strongly Disagree

12. The practice of secluding patients should be discontinued

Strongly Agree ———————————————— Strongly Disagree

13. Medication is a valuable approach to treating aggressive and violent behaviour

Strongly Agree ———————————————— Strongly Disagree

14. Aggressive patients will calm down if left alone

Strongly Agree ———————————————— Strongly Disagree

15. Negotiation should be used more effectively when managing aggression and violence

Strongly Agree ———————————————— Strongly Disagree

16. Restrictive environments can contribute towards aggression

Strongly Agree ———————————————— Strongly Disagree

17. Expressions of anger do not always require staff intervention

Strongly Agree ———————————————— Strongly Disagree

18. Physical restraint is sometimes used more than is necessary

Strongly Agree ———————————————— Strongly Disagree

19. Alternatives to the use of containment and sedation to manage physical violence could be used more frequently

Strongly Agree ———————————————— Strongly Disagree

20. Improved one to one relationships between staff and patients can reduce the incidence of aggression

Strongly Agree ———————————————— Strongly Disagree

21. Patient aggression could be handled more effectively

Strongly Agree ———————————————— Strongly Disagree

22. Prescribed medication can sometimes lead to aggression

Strongly Agree ———————————————— Strongly Disagree

23. It is largely situations that can contribute toward the expression of aggression by patients

Strongly Agree ———————————————— Strongly Disagree

24. Seclusion is sometimes used more than necessary

Strongly Agree ———————————————— Strongly Disagree

25. Prescribed medication should be used more frequently for aggressive patients

Strongly Agree ———————————————— Strongly Disagree

26. The use of de-escalation is successful in preventing violence

Strongly Agree ———————————————— Strongly Disagree

27. If the physical environment were different, patients would be less aggressive

Strongly Agree ———————————————— Strongly Disagree

28. How confident are you in your capability to deal with verbal abuse originating from colleagues,

Very confident ———————————————— Not confident at all

Managers,

Very confident ———————————————— Not confident at all

Other staff (for example, other members of the multidisciplinary team)

Very confident ———————————————————— Not confident at all

29. How confident are you in your capability to deal with verbal abuse from service users

Very confident ———————————————————— Not confident at all

30. How confident are you in your colleagues capability to come to your assistance during an incident and to be sympathetic and supportive afterwards

Very confident ———————————————————— Not confident at all

31. How confident are you in your Trust's capability to tackle violence and aggression

Very confident ———————————————————— Not confident at all

32. How anxious are you about the possibility of personally experiencing some form of violence and aggression whilst at work

Very anxious ———————————————————— Not at all anxious

Thank you for completing this questionnaire

Version 1

Appendix D

Questionnaire 2
Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes.

Introduction

The delivery of workplace violence management training constitutes a central part of the Healthcare sectors strategy for combating work-related violence and aggression. The purpose of the study is to evaluate how effective aggression management programmes are at preparing staff to manage violence and aggression in clinical practice.

The research is being undertaken towards an academic qualification, that of Doctor of Health Science.

Why have I been invited?

You have been invited to take part in the study because of the aggression management training you are about to undertake.

Invitation to take part in the study

It would be very helpful to me if you could complete the attached questionnaire. You can return your completed form directly to the address below;

Paul Linsley
Senior Lecturer
University of Lincoln (Brayford Pool Campus)
School of Health and Social Care
Bridge House
Lincoln

If you would prefer to complete an electronic copy of this form, please email plinsley@lincoln.ac.uk to request this. The form can them be completed and returned electronically.

Please note:
This research has not been commissioned by any organisation or agency. Your participation is voluntary, no expenses or fees can be paid for contributions to the research. Confidentiality is of the highest priority; with the exception of the researcher and his supervisor, no-one in the University, no organisations, institutions, managers or tutors will be given access to any of the raw data, or information on any research contributors or contributions. Your rights and the responsibilities of the researcher will be met as covered by the Data Protection Act 1998.

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If you have any queries or concerns about this research work, please contact Paul Linsley directly by email on plinsley@lincoln.ac.uk

Evaluating Programme Effectiveness: A Study of Three Health Care Aggression Management Programmes.

Name:

Job Title:

Area of work (e.g. Ward):

1. What are your expectations of the training you are about to undertake? What do you hope to gain in the way of skills/knowledge?

2. Were your training needs discussed with you prior to coming on the course? If so, who was this with (i.e. line manager) and what was discussed?

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3. Below are the topic areas that will be covered in this training course. Please indicate how relevant (i.e. useful or practical) you think these topics will be for your own personal work experiences.

Please only tick one rating for each topic.

Topics covered in this course	Very Relevant	Relevant	A Little Relevant	Not at all Relevant
Understanding the legal context (including, the right to protect yourself and the use of reasonable force).				

Comments:

Topics covered in this course	Very Relevant	Relevant	A Little Relevant	Not at all Relevant
Information and models about why and how violence occurs (including, defining violence).				

Comments:

Topics covered in this course	Very Relevant	Relevant	A Little Relevant	Not at all Relevant
Non-physical management of violence (including, customer care, diffusion/de-escalation, verbal communication skills, non-verbal skills, cultural diversity).				

Comments:

Topics covered in this course	Very Relevant	Relevant	A Little Relevant	Not at all Relevant
Physical intervention/management skills (including, breakaway and control & restraint Techniques).				

Comments:

Topics covered in this course	Very Relevant	Relevant	A Little Relevant	Not at all Relevant
Organisational policy, procedures and practices in relation to work-related violence (including, roles and responsibilities of management and staff, reporting and emergency action plans).				
Comments:				

Topics covered in this course	Very Relevant	Relevant	A Little Relevant	Not at all Relevant
Post-incident reactions and support (including, how you might feel after an incident, how to get help internally and externally).				
Comments:				

4. Any additional comments about the training that you are about to undertake

Thank you for completing this questionnaire

Version 1