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MANAGEMENT OF WORKPLACE VIOLENCE VICTIMS

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ILO/ICN/WHO/PSI Workplace Violence in the Health Sector

CROSS-CUTTING THEME STUDY

MANAGEMENT OF WORKPLACE VIOLENCE VICTIMS

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MANAGEMENT OF WORKPLACE VIOLENCE VICTIMS

1. INTRODUCTION

This study aims to summarise information, research and practice relating to the management of workplace violence victims under a set outline. The objectives are to confirm the importance of victim management to minimise the consequences of workplace violence in the health sector; to present the range of measures being used to meet the needs of victims, management and policy-makers; and where possible, provide data suggesting effectiveness and sustainability of the various measures.

Whilst there are many documents which look at aspects of violence and preventive measures, authoritative studies covering the management of workplace violence victims in the healthcare sector are less common. This study is based on relevant literature and practice in the United Kingdom, with additional information from other countries where complementary or additional policy and practice has been documented. Consequently, readers should assume that statements and legislation quoted, refer to the UK unless otherwise specified. This paper has been subject to restrictions, in time, to reports in the English language and in access to materials from other systems and countries.

Whilst this report is primarily concerned with incident and post incident victim management, it also inevitably covers preventive measures aimed at thwarting repeat incidents to the victim or colleagues. As well as an analysis of published materials the study is based on day to day practice using employers' written policies and discussions with health workers, researchers and specialists.

1.1. Definition

The definition of workplace violence being used by all studies in the series is: "Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well being or health".

Workplace violence has been categorised into three types by the Californian Occupational Safety and Health Administration (Cal/OSHA) and this has become accepted internationally (11, 43, 69).

Type I: The aggressor has no legitimate employment relationship to the worker or the workplace and, usually, the main object of the violence is obtaining cash or valuable property, or demonstrating power. Examples are robbery, mugging and road rage.

Type II: the aggressor is someone who is the recipient of a service provided by the affected workplace or by the worker. Examples are assault or verbal threats by patients, carers or relatives of the patient.

Type III: The aggressor is another employee, a supervisor, or a manager. Examples are bullying and harassment.

In this study Type I is referred to as “external” violence, Type II as “client initiated” violence and Type III as “internal” violence (43).

Some working definitions of violence do not include internal violence (29). This is because of the different management mechanisms which employers’ use to address internal violence compared to client initiated and external violence. For instance, it is possible to use internal disciplinary measures to tackle bullying and harassment by colleagues that are not an option for dealing with violence generated by the general public.

1.2. Target population

Healthcare staff covered by this study include all those employed by health care employers, working in all parts of hospitals, in the community including health centres, outreach services, General Practitioners (family doctors – GPs) and their staff, nursing home workers and ambulance staff. Most will have a contractual relationship as an employee, however some will be temporary, students, self-employed or work for a sub-contractor or agency. The range of employers, number of employees and resources available, means that the range of responses to violence will vary in type and quality by employer.

Statistics show that large numbers of health workers have been or will be subjected to violence at some stage of their working life. Valid sources of statistics from around the world are few but increasing (11, 14, 36, 43). Longitudinal term surveys are rare, however Box 1 shows the results of an annual survey on violence to health care staff from the public, with responses from over 3,000 workers using a random sample each year. The examples given show the increase in reported incidents between 1995 and 2000 and the variation between selected staff groups.

Box 1. Percentage of staff reporting that they had been subjected to (external and client initiated) violence in the previous year.

Staff group	1995 %	1998 %	2000 %
All	34	39	39
Nurses	42	48	63
Ambulance Workers	63	70	69

UNISON (73)

High levels of violence are also recorded by other health workers, for instance a recent study of violence amongst 697 GPs showed that around 70% had been subject to verbal abuse and 10% assaulted between 1997 and 1999 (25).

There are some studies which show comparisons between violence, for instance an Australian survey of nurses reported 86% had experienced aggression from patients, 42% from visitors and 31% verbal abuse by co-workers (43). A small Canadian study of nurses and physicians

looking purely at verbal abuse found the highest perpetrators were physicians at 38%, followed by patients' relatives at 28%, and then patients at 24%. Just over two thirds of the respondents reported that the circumstances surrounding the abuse were stress related and the primary abuser was male. The article notes that gender might be an issue, or that because physicians were mainly male and nurses mainly female that this was a reflection of a professional power struggle and unequal physician – nurse relationships (13).

A number of studies provide useful data on bullying. For instance a study of 1100 staff in one health service employer showed 38% of workers had experienced bullying in the previous year, two thirds of whom tried to take action but a third of these were unhappy with the results (62). A larger survey of over 4,000 nurses showed that whilst 17% had been bullied in the previous year this rose to 30% for those from an ethnic minority and 41% for workers with a disability (68).

A report looking at racial harassment in nursing in the UK National Health Service (NHS) showed that around two thirds of ethnic minority nurses had been racially harassed or abused by patients, whilst one third had been racially harassed by colleagues (58). A detailed study looking at racism in a rural area of the UK where there are few ethnic minority staff showed up to 9% had experienced direct racism during the previous year and 19% indirect racism (21).

The International Council of Nurses (ICN) reviewing a number of surveys, showed significant incidence of sexual harassment amongst nurses, 48% in Ireland, 69% in the UK and 76% in the United States (38). Another study showed it as an important factor associated with psychological disturbance amongst junior doctors (24). A survey of NHS workers of which two-thirds were nurses, showed that for 29% when harassment occurred it happened weekly, whilst for a further 29% it happened every few months (12).

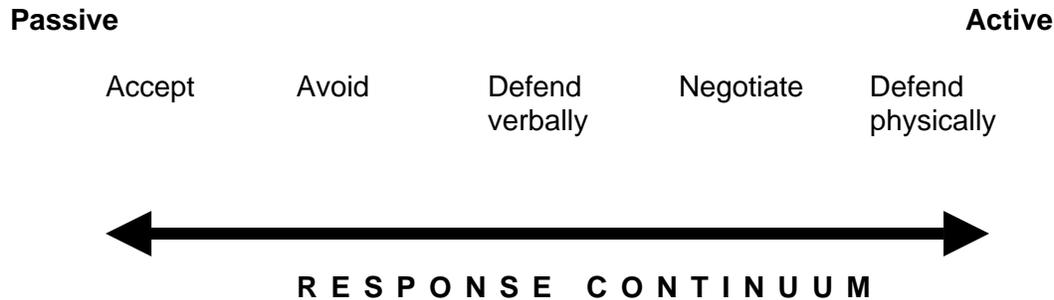
The changing world of work and the growing number of people being offered work on a temporary or part-time basis and sub-contracting or outsourcing and the resultant perception of job-insecurity may affect the presence of violence. This process is not limited to the industrialised world as for many working in precarious employment in developing and industrialising countries mistreatment and sexual harassment is commonplace. Similarly students may also be particularly vulnerable to violence within the healthcare sector (31).

1.3 Range of personal responses

Individuals vary in their reaction to violence. They may utilise their experience and training to defuse, control or physically react to a conflict. Alternatively they may not have had training, or be overcome by fear or panic and forget their training, reacting in a manner that inflames the situation. Individuals' innate personality plus the situation, context and environment act as influential factors in establishing a person's response. The ICN has produced a "response continuum" which sums up workers' immediate responses to violence (Fig. 1).

An individual's physical response during an incident is governed by a rush of adrenaline through the body. This triggers a number of physical responses such as the speeding up of metabolic functions, suppression of other systems such as digestion and the immune system, increased levels of sugars that tense up muscles and an increasing heart rate preparing the body for urgent action. Whilst this 'alarm' reaction is an important reaction and useful in the short term it may also be generated from other daily emergency situations common in the health service. Continued exposure to adrenaline bursts and continued suppression of the immune system has long term consequences for physical illness (40).

Fig 1. Immediate responses to violence



ICN (38)

Box 2 shows the consequences of abuse and violence (38).

Box 2: Consequences of abuse and violence:

- * shock, disbelief, guilt, anger, depressions, overwhelming fear;
- * physical injury;
- * increased stress levels;
- * physical disorders (e.g migraine, vomiting);
- * loss of self-esteem and belief in their professional competence;
- * paralysing self-blame;
- * feelings of powerlessness and of being exploited;
- * sexual disturbances;
- * avoidance behaviour that may negatively affect the performance of duties and thereby reduce the quality of care provided;
- * negative effect on interpersonal relationships;
- * loss of job satisfaction;
- * absenteeism;
- * loss of morale and efficiency;
- * increased rate of nurse turnover;
- * anxiety of patients, staff and loved ones.

ICN (38)

The ICN state that the impact of verbal abuse should not be minimised. This is confirmed by a Canadian study on verbal abuse, where 66% responded with anger, 42% anxiety, 36% disbelief, 34% helplessness, and 30% powerlessness (13). Another Canadian guide (8) provides specific guidance for staff responding to an abusive telephone call Box 3.

Box 3: Responding to an abusive telephone call.

Interrupt the conversation firmly, but politely.

Advise the caller that you will end the call if the caller does not stop using abusive language.

Advise your manager or supervisor of the incident

If the caller calls back, interrupt the conversation firmly, but politely. Advise the caller that you will transfer the call to your manager or supervisor.

If necessary:

- Remind the caller that you will not accept abusive language or treatment

- Put the caller on hold and contact your manager or supervisor

- Advise your manager or supervisor that the caller is on hold

- Transfer the caller to your supervisor.

Canadian Centre for Occupational Health and Safety (8)

The ICN guidelines also suggest that nursing personnel choose to respond to violence from a number of options: avoidance, denial, discussion, reporting, counselling and prosecution. This is backed up by a study in the UK NHS that asked victims what action they took when sexually harassed. Around one third of the respondents tried to avoid the harassor with mixed results, with equal numbers reporting improvement, no change or worsening behaviour. Those who chose to ignore the harassment or make a joke of it, reported equally that this either made the situation worse or made no difference. Mixed results were also reported by those who chose to ask the harassor to stop (just under half of the respondents tried this). Those who threatened to tell or did tell others mostly found it improved matters. Half of those who reported it to the management or union reported an improvement although a third still reported no change. One third did not report the harassment as they felt nothing would be done or were scared to do so. Students and young workers in particular reported that they did not know what to do or were scared to report. Whilst the survey did not ask about counselling it did note that only a small number pursued their case through the courts (12).

Unsurprisingly in the healthcare field there is usually a quick medical response to physical injuries, especially where the victim is in a treatment setting, such as a hospital. However in cases of sexual assaults there is an acute need to address additional effects. Whilst the victims' initial reactions may be similar to other assaults, they may also have particular feelings of shame, embarrassment, humiliation, anger, rage, revenge and helplessness. They may also feel unloved or soiled. Victims' physical reactions to sexual assault can include everything from general or vague complaints to specific symptoms related to the area of the body that was attacked (4, 57).

Reaction to violence also causes under-reporting, because of damaged morale, staff not wanting to damage their professional reputation, or being seen as unable to cope. Some staff have also traditionally had a view that violence is "part of the job", or that managers would not take action. They also recognised and sympathised with the stresses that cause violence (69). This can be illustrated using an example from a large UK community health employer who, having introduced preventive and control measures, reduced violent incidents significantly. Nearly all the remaining violent incidents originated from a small number of patients. One in particular caused over 100 incidents a month. Initially the staff were reluctant to tackle the issue

as they interpreted it as being a characteristic of the patient. However the employer and local union persuaded the staff to pursue action in the courts and the patient received a criminal conviction. The patient did not subsequently commit an offence against police officers or prison staff. This shows the violence was not inevitable as staff had assumed but situational.

Studies have confirmed that a relationship exists between the experience of bullying and impaired health. A Swedish study reported that the strongest differences between bullied and non-bullied were found in 'cognitive effects' such as concentration problems, lack of initiative and irritability and psychosomatic symptoms such as stomach upset, nausea, and muscle aches (65). This is confirmed by a study in a health employer which found that those who had been exposed persistently to bullying were more likely to suffer from stress, anxiety and depression than those who had not (62). Similarly sexual harassment affects job satisfaction and commitment (36).

The management of stress related illness is less well developed and more inconsistent than that for physical treatment (see section 2.2). This is despite international recognition that physical hazards are a common stressor at work. The third European study on working conditions stated that violence at work clearly leads to an increase in health complaints, in particular stress. The survey showed that stress was experienced by 40% of workers exposed to violence, 47% of workers exposed to bullying and 46% exposed to sexual harassment (23).

The UK Health and Safety authorities accept that workers may be traumatised by a violent incident (29). Longer term psychological reaction and in particular Post Traumatic Stress Disorder (PTSD), is an area of dispute amongst academics and medical specialists. A study into organisational responses to traumatic incidents (66) recognised two working definitions of PTSD based on different diagnostic tools DSM-IV (APA1994) and ACD-10. The study summarised them as: PTSD is the name given to a cluster of symptoms still being experienced by some individuals at least one month after threat of death or personal injury to an individual or loved one, or learning of such an incident, and experiencing a horrified or helpless response to the incident. The cluster of symptoms can be divided into three: persistent re-experiencing of the traumatic event; avoidance of reminders of the event and feeling numb; and hyper-arousal or increased startle response. It has also been suggested that PTSD can be divided into 'acute' PTSD where symptoms have manifested themselves for less than three months, and chronic PTSD where the duration of symptoms is three months or longer. In delayed onset, symptoms appear at least six months after the event (10).

Further categorisation suggests other diagnoses such as Acute Stress Disorder, where symptoms last at least two days and cause clinical distress or impairment to social, occupational or other necessary functions. Essentially symptoms mirror PTSD but over a shorter period and may be considered a 'normal' reaction. Adjustment disorder offers a catch-all diagnosis where the response to a traumatic event is longer than two days but does not fulfil criteria for Acute stress disorder or PTSD symptoms or symptoms that are observed in response to a less extreme stressor (66).

Ultimately violence costs – the victim and the perpetrator plus the state, the private companies or insurance systems and the people who fund it. In the short term costs include time off, temporary staff cover, fees for legal action, medical treatment, counselling and occupational health services. One survey has shown sickness absence to be 26% higher amongst bullied hospital workers (39).

In the long term many staff will leave their employer as a result of violence. Studies have shown that over a quarter of bullied staff leave work (64) and in the US at least 18% of nursing turnover related to verbal abuse, with many nurses choosing to leave nursing as a result (38). This turnover leads to a loss of knowledge, skills and training invested, as well as the consequent costs of hiring new staff. It can also lead to loss of productivity due to general depreciation in morale as others see colleagues leave. This can give an employer a poor reputation leading to image problems and recruitment & retention difficulties as staff with transferable skills may not be attracted to work in an environment with a poor record. Similarly sexual harassment has been quoted by one in ten employees as the reason why they left their job. The same study gives the most comprehensive attempt to quantify the total cost of both stress and violence estimating that losses may account for between 0.5-3.5% of a country's GDP per year (36).

2. VICTIM MANAGEMENT MEASURES.

Government guidance from around the world recommends that all employers should have response strategies in place in case of a violent incident (18, 29, 33, 46, 51, 53, 58). Box 4 gives an example of suggested procedures for responding to incidents.

Box 4: Procedures for responding to incidents need to:

Describe the circumstances in which they should be followed;
Describe the role of the individual members of staff;
Nominate an individual to co-ordinate response action;
Set out any circumstances in which physical restraint is necessary;
Include arrangements for ensuring a control & restraint team is identified and available
Include criteria for calling the police
Give clear guidance on reporting procedures
Indicate follow up actions, including staff debriefing and counselling as appropriate.

Health and Safety Commission, (29)

Responses to an incident will be dictated by the nature of the employer, and the resources they have available, with larger employers able to utilise a wider range of interventions. Others may find it more difficult, for instance in a study of professionals in the community, GPs worried about dealing with patients with severe forms of mental illness. This was compounded by a perception of ever diminishing resources. Consequently GPs felt that violent behaviour from such patients was less amenable to their professional intervention and it was more difficult for them to protect themselves (16).

Responses and management strategies will also need to reflect the type of violence that is being inflicted on the victim. For instance measures such as debriefing (see section 2.2) will be appropriate for a response to a traumatic incident but not necessarily for subtle harassment. Other responses such as counselling can be used to respond to all types of violence, but will need competent assessment to ensure that referral is appropriate.

There may be other specific organisational responses necessary to address particular types of violence. For instance a US union (2) has produced specific guidance on domestic violence in the workplace in response to statistics that showed that during a one year period three quarters

of battered women were harassed by their abusive partners in person or by telephone at work. The guide encourages workplace representatives to address the issue by seeking to establish or expand Employee Assistance Programmes to provide services for victims. It recommends negotiating paid leave for victims to attend legal proceedings, to tend to family emergencies and attend counselling, plus paid legal assistance and help for victims with legal action. It also suggests that employers should enhance security to prohibit victims' abusers, such as providing photographs to security guards and other workers. Employers are also encouraged to sponsor workshops on domestic violence and make information, such as help-lines and shelters readily available. Guidance for managers on dealing with domestic violence suggests they seek early interventions by law enforcement officials in clear cut cases. In less clear cases it suggests that managers should not assume that it wasn't happening nor ignore the situation. The guidance suggests employers focus on their employees' behaviour at work, showing concern and support. Recognising the potential for employees' unpredictable behaviour it advises that professional support is sought via the employers Employee Assistance Programme (55).

In 1993 the UK health service employers and unions reached an agreement on harassment that proposed that health service employers provide a clear statement of what is considered to be inappropriate behaviour at work. It urged employers to make clear that policies apply to all grades and levels of employees, declare that harassment will be treated as a disciplinary offence, explain that such behaviour may in certain circumstance be unlawful, and inform staff how to get help and where necessary complain about the harassment (27). This agreement however applies only to staff employed directly by the NHS, so does not apply to GPs or their staff, contractors or employees of agencies.

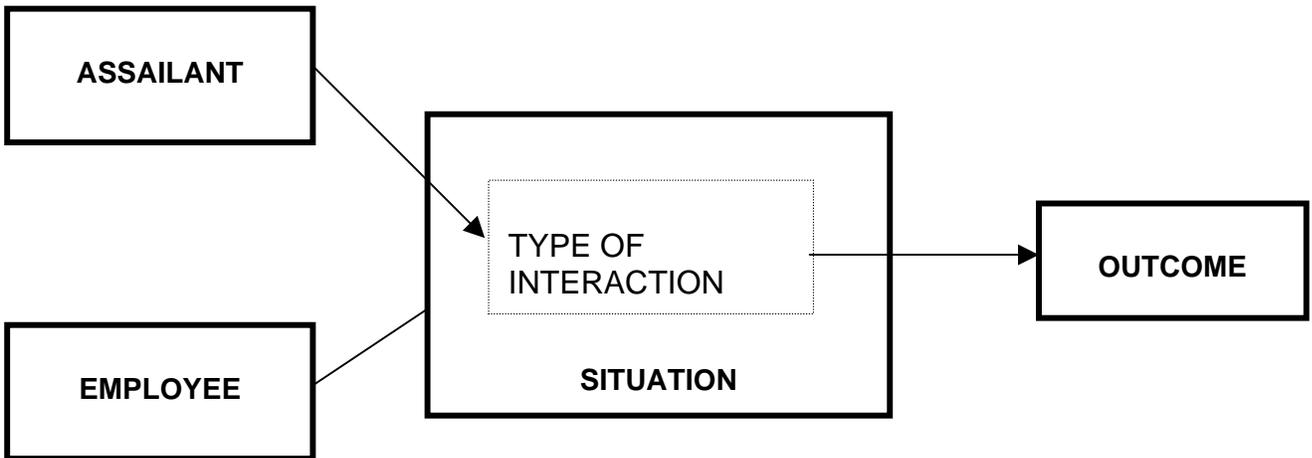
Responding to problems of racial harassment the UK Department of Health has issued a plan for action. This aims to inform service users that racial harassment will not be tolerated and that this message is widely disseminated to deter perpetrators. The guide also aims to ensure that staff have the knowledge, structures and skills to fulfil the commitments, and to give black and ethnic staff the confidence to challenge harassment effectively. This involves improving reporting and recording procedures, effective leadership, and education and training programmes. (50).

Health and safety legislation has changed from being punishment based i.e. focussing on fines and retribution after an accident, to focussing on prevention management. For instance the cornerstone of modern European health and safety legislation is the Directive on the Safety and Health of Workers 1989. This compels employers to deal with health and safety issues avoiding risks, evaluating those that cannot be avoided, combating risks at source, adapting work to the individual, adapting to technical progress, replacing the dangerous by the non-dangerous or less dangerous, developing a prevention policy, prioritising collective protective measures over individual ones and giving appropriate instructions to employers (22). This risk based model is the basis of similar legislation in other countries and is well documented in a book on violence published by the ILO (10). This book also describes a small study aimed at monitoring the impact of anti-violence legislation in the Netherlands, which found that the most successful measures according to staff were extra staff, silent alarms and surveillance schemes.

Statistics and media reporting are often focussed on particular groups of workers such as doctors and nurses. However the basis for most modern approaches to assessment prevention in the UK, which describes the process of incidents is a situational analysis (61). This looked at the interaction within a situation that an assailant and employee find themselves in and the resulting outcome (Fig.2). So, whilst nurses may be one of the main victim groups, this is because of the situation they are in rather than because they are nurses. Similarly whilst

administrative and clerical health staff generally face lower levels of violence, medical receptionists in Accident and Emergency Departments face much higher risks. This interactive model is widely accepted as a useful base model by policy makers in the UK (9) and has been expanded on by others (11).

Fig 2. A Model of Violent Assaults at Work



Poyner and Warne (61)

However, this model only describes violent assaults. Wider solutions for dealing with staff who are victims of violence should be inextricably linked into general management systems based on risk management. In particular bullying and harassment are likely to need a wider organisational analysis.

2.1. Reporting

Government initiatives have stressed the value of reporting for employers (29, 51, 58). In addition some Governments have limited mandatory national reporting schemes. In the UK there is a statutory duty (under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)) to report to the enforcing authority (the Health and Safety Executive (HSE) in the healthcare sector) any accident resulting in death, major injury or incapacity for normal work of three days or more (29). The definition of accident includes 'non-consensual' physical violence done to a person at work. Reports are used to alert the regulatory authorities who can intervene at a workplace and to compile comparative data across industries. Similarly in New South Wales, Australia, death or serious personal injury, to an employee, subcontractor or visitor to the workplace must be reported to their enforcing authority, Workcover. A serious personal injury is defined as when a person is unable to carry out his/her usual duties for a continuous period of more than seven calendar days.

Unfortunately, statutory reporting systems such as those described above do not reflect the true picture, as incidents that result in short periods of time off are not recorded. Consequently the

results are partial and limited in their use. Additionally the UK HSE acknowledge that there is substantial under-reporting using RIDDOR (30).

Under-reporting is a recurring theme throughout the literature. As suggested before this may be because of staff accepting the patient's illness as explanation for an event, for example in aged care staff may see clients as 'not themselves' (43), or as 'part of the job' when looking after patients with learning disabilities (29). Another reason for under-reporting is work pressures that do not allow time for staff to report. Ambulance road crews may quickly receive another call after a violent incident, do not have time to report and may quickly lose sight of the violence. Later they may not be able to remember details and after a long shift want to rest. The next morning they may be unwilling to bother making a report. Staff may also feel that reporting may be of no use, for example nothing happens as a result of their report and assailants are not punished or their capability is questioned (75).

Employers should re-assure staff that reporting is of value, by showing concern, acting on statements, putting measures into place and publishing statistics. Reporting systems must be robust but they must also be simple to encourage staff to complete them. For instance some ambulance services have sought to answer problems of under reporting amongst road crews by asking staff in emergency despatch centres (control rooms) to begin report form if they are informed of an incident. The form is then passed on to the victims for subsequent completion and there is a requirement that crews fill it in.

Encouraging reporting enables employers to understand the full extent of violence, learn from the incident, ensure that risks can properly be assessed and, if possible, avoided in the future. For an employee reporting acts as an access point to support mechanisms and can be used for subsequent police investigations and compensation claims. To be able to measure violence an employer must have baseline figures to be able to compare subsequent data. Therefore competent reporting systems use victim reports to map problems, this data being the cornerstone of assessing risk, a fundamental building block of any management strategy.

Whilst systems must be robust this does not necessarily mean that forms should be over complicated. The suggested basics of a reporting form are given in Box 5, and a similar list is provided in Swedish guidance (56).

Box 5: Basics of a reporting form

- details of employee for example name, occupational group;
- location of incident – department, environment;
- date day and time;
- details of the assailant: for example name, if known, status for example patient, relative, other visitor;
- what the employee was doing at the time of the incident;
- the circumstances of the assault or abuse;
- details of the outcome: such injuries received, time off work, property damage;
- information about any remedial action.

Health and Safety Commission (29)

Forms should also state clearly to whom they should be submitted. There are a number of examples of incident report forms given in literature (58, 75). One UK employer has redesigned

their incident report form so it acts as both a health and safety incident form and as a criminal justice statement for use if necessary in court (32).

In addition to standard violent report forms professional staff can use their codes of conduct to report violence to employers and the statutory bodies that register them. In the UK the Code of Professional Conduct for nursing staff forms part of their statutory registration under the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC soon to be replaced by the Nursing and Midwifery Council). Whilst primarily focussed on patient welfare the Code includes a statement that staff “must report to an appropriate person or authority where it appears that the health or safety of colleagues is at risk, as such circumstances may compromise standards of practice of care.” Staff have been encouraged to report such risks to their employer and to copy in their union and the UKCC to ensure that they are not subsequently harassed for ‘whistleblowing’ (77).

Standard report forms are not used in the UK for employees reporting internal violence. In the case of bullying, 83% are carried out by managers (64), who might normally expect to see report forms for violent incidents. Therefore policies recommend that victims personally report incidents to others such as a manager with whom the victim has a rapport, the line manager’s immediate manager, a peer of the line manager, or a Contact Officer (see section 2.2).

2.2 Medical Treatment

Physical

The first noticeable feature after an incident of physical violence is usually physical damage – be it cuts bruises, minor wounds which need minor first aid to more serious wound needing full medical treatment or fatality. Whilst there is general material available, little has been published analysing the physical effects of assault and treatment of staff working in the healthcare sector. However, one survey does show the levels of physical damage that staff face. Comparable questions asked in 1998 and 2000 showed little statistical variation in the number of staff who required medical treatment after a violent incident. In 1998 of all staff who responded 4% needed medical treatment, which decreased slightly to 3% in 2000. For nurses there was a slight increase from 5% in 1998 to 6% in 2000 and for ambulance workers a change from 7% in 1998 to 8% in 2000 (73).

Types of injury for all workers are shown in the 1997 British Crime Survey where 46 % of all assaults at work resulted in some type of injury, primarily bruising and black eyes. However, one percent of the injuries resulted in broken bones (14).

As previously noted some health workers react to violence by feeling that they were in some way to blame or that they were not professional enough. They may also seek to cover up their injuries. These feelings may be heightened if their own colleagues are likely to provide treatment. ‘Macho’ or ‘coping’ culture amongst some groups, such as ambulance workers, also means that some staff may seek to play down their suffering rather than seek help (35).

Some guidance provides advice on procedures for immediately dealing with victims (58). This includes an example of a structured hospital employers’ memorandum that ties in medical treatment as part of a management process and establishes a formal procedure to ensure resources are available to provide support to hospital employees who have been assaulted or battered. Here assaulted is defined as an employee who has been put in fear by a menacing gesture, movement or threat. Battered is defined as actual physical contact. Procedures differ

for each type of violence but start with reporting the incident to a supervisor and completion of a report form. Assaulted employees are referred to an Employee Assistance Programme where advice is given on counselling, legal services, workers compensation or insurance. Battered employees have an additional reference to employee health for evaluation and medical treatment of injuries (or straight to admissions if the assault happens during non-administrative duty hours). Finally with assault victims a community meeting is set up to process the incident as soon as possible. Battered employees are given additional advice around compensation and criminal prosecution with support from relevant hospital staff.

There is a need to be particularly sensitive when injuries are related to medical treatment for victims of sexual assault. It is recommended that the victim should not be left alone during emergency treatment, they should be offered assistance in notifying significant others and deciding who to contact and how to disclose the assault. A calm caring and humane environment should be maintained and reassurance that their physical condition is stable, they are safe that their responses are typical and a full recovery can be expected. The situation can be particularly distressing when an examination is taken as part of the legal process as this can be reminiscent of the assault itself (42). There is also potential for victims to become pregnant or acquire sexually transmitted diseases, so provision should be made for testing. Specialist counselling should be made available to deal with any consequent mental health problems.

Mental Health - debriefing

There are a wide range of practices called debriefing. They can be broadly split under two headings: management debriefing and psychological debriefing. It is suggested 'technical' and 'emotional' debriefings are separated to ensure that people can contribute to the factual investigation of an incident whilst receiving emotional help (29).

Debriefing sessions differ significantly in what triggers an intervention, when they occur, their formality, content and their length. Triggers can be automatic, for instance after a particular incident (such as violence or death of a patient), or after a particular shift, in a difficult ward or by self referral. Debriefing mostly occur shortly after the event although some processes allow recovery time for the victim.

Formality depends on the employer and the incident itself, for instance a near miss in a high risk area might mean a relatively short informal discussion with a supervisor, manager or specially trained worker, whereas a serious event almost invariably means a more pro-active intervention by a specialist. Informal periods can be subject to unexpected delay or time limited because of emergencies or pressure of work.

Management systems tend to be more informal, are sometimes called defusing sessions (some use the term diffusing) and are based on interventions from a management perspective rather than full psychological debriefing (although they may be run by trained professionals). Such informal sessions vary in length and content and are provided for both individuals and groups. They tend to follow a general pattern of allowing the victim and others the chance to express their feelings and discuss the incident fully. However, depending on context and who is delivering the session they may then move onto management issues. This could include identification of courses of action taken, how the incident occurred, an initial gathering of information for a further investigation and on how to deal with the assailant. They can also look at how the victim responded, to analyse whether they could have had more support, whether the victim needs to modify their behaviour should a similar incident occur in the future, if they need additional training and what information should be passed to others in the team and management system. Session length varies or may be split with a first session aiming to defuse

the incident followed by a second more formal meeting a few days later. Sessions should be confidential and are sometimes done away from the workplace. The session can also be used to remind staff of the need to fill in incident report forms and the range of services and support mechanisms that can be utilised.

In the US workers may be initially referred to Employee Assistance Programmes which are structured ways of providing help to staff and might cover stress management, counselling for emotional problems, debt legal affairs and practical advice. Employees who need more in-depth psychological counselling are likely to be referred on.

Psychological debriefing originally derives from military debriefing which was then adapted for the emergency services before further adaptation for wider use. This process involves formal clinical methods of debriefing usually known as Critical Incident Stress Debriefing (CISD). These were originally formulated to involve groups and are normally held at least a day after an incident occurs, although they are often delayed. If the content of the session is in line with the original group session methodology then they should follow a seven point plan: starting with individuals introducing themselves; each describing the event from their perspective; then describing their cognitive reactions and moving through to their emotional reactions. Next they will describe the most traumatic aspect of the event to allow catharsis; identify personal symptoms of distress and move back to cognitive. This will be followed by education about normal relations, coping mechanisms and provide a cognitive anchor; and finally clarification of ambiguities and preparation for termination (45). The methods used for CISD have been adapted to provide debriefing sessions for individuals.

In one report on PTSD all organisations who used debriefing had only two points in common: the view that in some way debriefing would lessen the likelihood of subsequent traumatic experience and that the debriefing process itself would involve intense re-exposure to the incident (66). The report also looked at whether there was evidence to show that debriefing worked. Although the authors found a number of evaluations only six had credible randomised, controlled studies. These studies reported mixed findings but on the whole showed no differences between those who did not receive debriefing and those that did. There was even some evidence, albeit flawed that debriefing might have a detrimental effect. Other studies which suggested that debriefing worked, concentrated on improvements within a few weeks after the event. However as the majority of people would recover during this period anyway these studies were not accepted as valid. The reasons suggested why such approaches may not work are because the original intention of debriefing was focussed on group debriefing of emergency service personnel rather than individual debriefing which now predominates.

Whilst debriefing may not ultimately have a noticeable effect on trauma it is well received by the staff who have undergone the process (44). It is suggested that this is because people are reassured that the symptoms they show are normal, it helps reduce isolation, helps victims understanding, and deals with survivor guilt. Most large UK healthcare employers have some form of debriefing system as they recognise there is a need to provide immediate support. Reports from staff suggest those that use it appreciate the provision of such a service, especially if paid time off is provided. Others may be reluctant to utilise debriefing particularly some staff in places with a 'macho' culture such as forensic mental health units and amongst ambulance emergency crews. In some workplaces managers can be unsupportive, lacking understanding, time or face contradictions around disciplinary issues. Victims who work for employers who do not have such a service complain that they felt unsupported after an incident and would have liked to talk through the issue with someone.

Progressive employers actively advertise their debriefing services and provide information on trauma in leaflets, posters, newsletters and through seminars and induction. Information is given on the nature of trauma, range of feelings, recovery periods and procedures to follow after incident. An important role that debriefing can play is in identifying victims who need further medical help or psychological counselling and refer them on appropriately.

Mental health - Counselling

There is a large amount of literature available on counselling, much of which is theoretical, unfocussed and unevaluated.

In a survey of over half the total of UK NHS trusts 95% said that they provided 'counselling services' with 82% specifically including reference to them in their policies (34). Respondents to the survey counted any form of post-incident psychological support as 'counselling' including general telephone helplines and post incident support packages. Services were mostly in house usually as part of occupational health or their own clinical psychology service, although some had options to refer to external services whilst others were wholly bought in. One Trust included reference to its chaplaincy, another to its 'stress spotters' (staff trained to identify colleagues with potential stress problems), whilst some utilise professional association and trade union support systems. The majority were open to self referral however a minority were restricted and subject to management approval. Another document (51) gives details of an employer that set up a 24 hour 'violence hotline'. This service offers immediate day time support and follow up, out of hours a recorded message offers support and commitment to follow up the next day. However evidence of its success is not presented. A study looking at GPs in the community asked what courses of action they took following violence, interestingly none of the respondents used counselling services. Unfortunately the study did not ask the reasons why (25).

Most local employer policies are sketchy in their reference to counselling. Many refer to it as part of a post-incident package and usually detail who can access it (such as victims of violence or stress) and how (usually via self referral, by a manager or by Occupational Health). However beyond that it would seem that services provide on behalf of employers are self determined by the providers. Some also allow for referral due to a problem or incident that had occurred outside of work. All policies have one thing in common, there appears to be little critical evaluation of their success locally.

The UK Government has set a target to ensure that all NHS staff had access to counselling services by April 2000. To provide support the NHS Executive (now re-integrated into the Department of Health) produced a useful guide for managers on Counselling services (52).

The guide proposes that "The overall aim of counselling is to provide an opportunity for the client to work towards living in a way he or she experiences as a more satisfying and resourceful one. Counselling denotes a professional relationship between a trained counsellor and an individual. The term counselling includes work with individuals, pairs or groups of people. The objectives of counselling will vary according to the clients' needs. Counselling may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insight and knowledge, working through feelings of inner conflict or improving relationships." The guide notes that a distinction needs to be made between counselling and counselling skills. There is recognition that many health service workers routinely use counselling skills as part of their work. However this should be distinguished from formal counselling which is a clearly defined professional relationship.

Box 6: Five essential functions of a counselling service

1. Face to face contact, which is preferably short term of between 5-8 sessions.
2. Telephone counselling. This is useful for self-referral, is easily accessible and allows initial contact but must not be seen as an alternative to face to face contact.
3. Response to traumatic incidents
 - i. Defusing – the practice of which varies but broad aims include:
 - helping staff to come to terms with what has happened
 - offering re-assurance and support
 - getting people to focus on the facts and give information
 - explain the subsequent help an available.
 - ii. Debriefing (as above).
 - iii. Post Trauma counselling
 - For staff who need more intensive support or when symptoms persist over a long period counselling or other therapeutic help may be required, if necessary with appropriate support. Such counselling must be delivered by an appropriately qualified and experienced practitioner.
4. Integration into the decision making process. This encourages closer links and greater consistency between departments whose function is staff health, such as Occupational Health, Health and Safety, personnel/Human Resources and Health Promotion.
5. Links to outside services. Arrangements need to be made for staff to have access to external advice where the full range of services is not available in-house. Written protocols for these services should cover accessibility.

NHS Executive (52)

The guide provides further information for managers on setting up a scheme, looking at delivery, key activities, staffing levels/competence/professional qualifications, stigma associated with counselling, confidentiality, education, accessibility/location and feedback. The guide also suggests high level support from senior managers and the involvement of unions. There is a section on audit/monitoring/evaluation which urges that these processes occur but does not give a lot of information on the processes that could be used.

There are differing views as to whether counselling services should be provided in-house or externally. The NHS Executive guide comes out in favour of in-house services as does a paper aimed specifically at ambulance services (63). This paper argues that there are few external counselling services with the specific skills of managing traumatic stress reaction in emergency personnel. It suggests that in-house services allow employers to build up knowledge of the specific needs of employees, it provides for easier evaluation and, if the onus is on the victim is to seek outside help, they may be less likely to do so. Another guide is less concerned with who delivers the service than the level of service provided (69). It recommends that employers ensure outside agencies have suitably qualified and supervised staff, who maintain confidentiality. It also reminds employers not to assume that in-house expertise will be accessed

informally or that mental health practitioners are accessed by other staff. Analysis of employers' policies and practices show that they use a mix of in-house and external counselling. The latter services are more likely to be provided for victims needing specialist help or if the violence involved bullying or harassment.

Credible evaluations are hard to find, for example the NHS Executive guide (52) focuses mainly on cost savings to employers, most of which are estimated. For example the Lothian and Regional Council Education Department estimated savings of £2,000 per employee counselled over a three month period rising to £4,000 over six months. The examples given are mainly studies outside of the health service but include a study in stress in the NHS (5). However the sample is small, is not restricted to victims of violence and is only measured in the short-term i.e. less than six months after counselling began. As with debriefing victims seem to find counselling services beneficial, for instance one survey showed that the majority of those who had used counselling services found them helpful (44).

2.3 Peer and manager support

US guidelines recommend a management commitment to a worker supportive environment that places as much importance on employee safety and health as on serving the patient or client (57). It also recommends a strong follow up programme for employees. Buddy systems are also proposed, which ensure that workers are accompanied by law enforcement officers or doubled up with colleagues when called out into a potentially high risk situation (2, 57). Clearly such systems are entirely appropriate for victims returning to work. Box 9 shows a section of UK guidance on staffing which recommends that there should always be enough suitably trained staff to cope with any foreseeable violence (29).

Box 7: Decisions about staff levels and competence should take account of:

- the acceptance of lone working in isolated premises or in the community and the possibility of pairing staff;
- limiting the length of time staff work alone;
- cover for breaks, nights, weekends and handover periods;
- the need to cater for unpredictable workloads;
- the need to respond effectively to a violent incident while maintaining care for other patients.

Health and Safety Commission (28)

Further suggestions are made on the need for managers to provide post incident planning with a focus on victims. This can be divided into three main areas. Firstly, action immediately taken by available managers, such as taking control of the situation, informing others and dealing with victims and other staff. Secondly, producing organisational and administrative policies aimed at minimising the impact of traumatic events which cover areas such as post incident support, provision of leave, costs and legal issues. Thirdly, matters of communication such as provision of information to families and the media, expressions of gratitude to staff and investigatory procedures (11a).

Swedish guidance recommends 'comradeship and support, including opportunities for experience interchange and personal and social contact, are important in all client-centred work,

but also in other jobs where violence and threats are liable to occur. It may be appropriate to hold workplace gatherings where employees can meet regularly for purposes of information, consultation and training (56). In practice some departments have regular informal “wash ups”, similar to debriefing sessions after gruelling shifts or in high risk areas, these sessions allow staff to offload information on minor incident and share learning experiences with colleagues. They are normally conducted by supervisors or managers and help build team work.

Most peer support mechanisms exist on an informal basis. One guide mentions that whilst treatment procedures may be clear other support is not and someone, usually a manager or colleague, may need to alert and care for relatives, pick up children from school, retrieve cars and arrange cover for work (68). Managers may also need to protect victims from the media and the Swedish guidance suggests that an appropriate procedure is to invite the media to interview a person (press officer or department spokesperson) previously appointed for that purpose (56).

A US guide for managers on dealing with traumatic incidents in the workplace has a section that deals specifically with helping an employee recover from an assault at work (55). It recommends that if a worker is hospitalised, managers should visit, send cards and convey other expressions of concern, so that the victim should not feel abandoned. Co-workers should be encouraged to show support as the victim may need to tell their story and colleagues need to be prepared to listen and be caring. Victims family may also need help such as caring for children whilst relatives visit the hospital or screening phone calls and mail. The guide also suggests planning a return to work (see section 2.5), offering counselling through an employee assistance plan and making career counselling and other assistance available if the victim decides to change jobs. When the victim returns to work colleagues should be aware of the need to allow for uncharacteristic behaviour from the victim as they may have to work in the environment in which their incident occurred. Colleagues should not be expected to fully comprehend the effect that an incident has on a victim. Managers have a role in supporting victims in allowing flexibility in workload and hours and there may also be a need for closer supervision to build up a victim's confidence. This should be offered as help in readjusting rather than being seen as a concern about competence.

Teams, and not just managers, should keep in contact with any colleagues who take time off. Rehabilitation back to work at the earliest opportunity, subject to an appropriate assessment will prevent them becoming isolated and to allow for early re-integration. However, there may be a fine line between what is viewed as support and what may be considered further harassment.

It has been suggested that peer pressure can be used during verbal abuse. This is referred to as a ‘Code 13’, where peers and managers go to the abuse site and stand around the victim (13). Whilst this may work for some forms of violence, such action should be strictly managed as there is potential to provoke an increase in the conflict in other situations. It is also questionable whether this is possible if the incident is bullying by a manager.

The exchange of information between professionals on violent clients is important in ensuring multi-disciplinary and inter-agency working. However, information relating to patient history passed on verbally or marked on their records should not be an exchange of vague worries, but examples of clear incidents and near misses where the patient was perceived as a risk to a health worker. There has been concern that keeping or exchanging such information might not be legal under data protection legislation. However in countries such as the UK the Crime and Disorder Act 1998 allows exchange of information if the patient is considered a risk.

Many employers use Contact Officers (COs) or Dignity at Work officers as part of their package of measures to deal with internal violence. Both employers and unions recognise that harassed staff as well as being wary of using formal management structures may not want to approach a completely independent party. This is borne out by results in one study (Box 8) that compared the proposed actions of employees who were not being bullied to the actions staff currently being bullied took.

Box 8		
Action	Not currently bullied	Currently bullied
See the union rep	73%	26%
Consult the personnel officer (or equivalent)	55%	24%
Go to occupational health	23%	5%
Rayner (64)		

This reluctance to use formal structures by bullied staff has led to independent peers being appointed as COs. These are 'ordinary' trained members of staff who can provide sympathetic assistance, explain procedures, establish details of complaints, channel it to the employer if requested, discuss cases in confidence, provide assistance and advice to colleagues of a person being bullied and approach a victim if appropriate, provide evidence in investigations. Other employers provide mediation services. These are staffed by peers trained in mediation skills who are available to employees who feel they are being harassed. After receiving a complaint, mediators approach the perceived harassor and seek agreement to participate in the process. The mediator will then meet separately with the individuals, on more than one occasion if necessary before a joint meeting. If the mediator judges a joint meeting inappropriate or the mediation breaks down the process is referred on to relevant managers for further action (67).

Some employers also utilise witness support groups for those caught up in violent incidents. Depending on the nature of the incident groups may be established by personnel and involve facilitators, occupational health practitioners and/or psychologists. The groups may undergo some debriefing, but mainly provide support empathy and education for the witness on further procedures.

Guidance on racial harassment states that everyone has responsibility for action. Employers need to provide clear, workable and relevant policies. Senior managers need to give strong leadership. Supervisors and team leaders need the awareness and skills to challenge harassment effectively. Staff and members of the public who witness events should report them. Staff need to work together to reinforce dignity at work and challenge harassment (50).

2.4 Representation, legal aid and union/professional association initiatives

Representation can consist of advocacy or written representations. Most employers' policies allow colleagues or union representatives to attend meetings, investigations and hearings. Others also allow accompaniment on any journey, visit or interview connected with the violent incident. There is also a reference for particular recognition of the need to involve unions in the

process of counselling for ambulance staff (63). In many countries professional associations also play a major role in supporting victims.

Most unions have policies and procedures designed to deal with violence and representation of members (2, 75). Stewards, particularly from larger unions will have access to training in the particular type of violence and how to respond. Training will also include how to interview victims, how to proceed with cases and details of the law. Unions will also provide back up from full-time officials, national specialists in violence and specific guidance.

Larger unions who have the resources may also be able to provide specific representation. For instance if a member from an ethnic minority is being harassed then, if possible, and if the victim wants, they may be represented by a steward from a similar background. If this is not possible then regional or ethnic minority national committees may be able to provide local representatives and the victim with specialist advice and support (74). Similar support should be offered for other groups such as Lesbians and Gay men or members with disability.

In case of harassment and bullying unions can find themselves in difficult situations. Union rules vary and some do not provide an absolute right to representation for members in each and every case. For instance some large unions believe that it should seek to represent members provided the member has not breached the union's policies and rules and provided that there is merit in the case. Members accused of harassment are entitled in accordance with natural justice to be dealt with fairly through the complaints procedure. (74)

Unions are also often the main providers of legal assistance to victims. Generally such advice is provided as part of the package of membership benefits. Elsewhere professional organisations, specialist mutual 'defence' schemes and private insurance companies provide cover. Local community schemes and Citizens Advice Bureau also provide limited free legal advice. The UK Government has a legal aid scheme for victims who are not members of a union or do not have their own insurance. However this is means tested which excludes most workers. Other alternatives are 'no win no fee' services provided by independent lawyers, where there is no charge up front but a percentage is taken of any compensation award.

Unions also propose initiatives to raise awareness on the plight of victims (2, 75). These include surveys, the use of joint committees, contacting health and safety inspectors, the use of the media, grievances, protests and coalitions. For instance in response to an attempted abduction in Northern Ireland, which was part of continuing sectarian violence, the union organised a lunchtime protest, which united the staff. The Branch Secretary recalled "when we called the protest people felt awkward about appearing but they got confidence from being together" (60).

Foreign health care workers often face additional opportunities for exploitation, harassment and abuse. They may have paid significant amounts of money to agencies in their home country to get work abroad, but once in their new place of work can face the threat of being deported by employers or agencies. Unions in the UK have come across examples of 'overseas' workers living in fear and subject to harassment. In one case 35 Filipino nurses were found work with new employers by a union after they had signed exploitative contracts with a nursing home. The workers' contracts prevented them from engaging in trade union activities and warned they could be sacked 'in cases where the employee is found to have violated the customs, traditions and laws of England' (54).

2.5 Time off and return to work

In the short term most employers are sympathetic to periods of time off for recovery from incidents, recognising the affects on staff. Many large employers also pay workers' wages for short periods of time off for counselling. However specific guidance on re-integration of victims of violence in the health sector is hard to find.

A US guide to dealing with traumatic incidents has a short section advising managers on planning a victims return to work (55). This recommends that supervisors, victim employee/labour relations specialist and health care providers work together to plan a return. The sooner an employee can return the easier it will be to rejoin the group and the employee will have missed out on less of the current information needed for effective job performance. However employees should not be subjected to too much stress at first and flexibility such as part time work, a different assignment or support of a co-worker can allow the victim to recover self-confidence. The victim's physical needs must be clarified with health care providers, such as what does "light work" mean. If the worker wears a cast or is scarred then other employees should be aware. Environmental changes such as access for wheelchair or place to lie down may also be needed. The guide notes that whilst such measures may take time in the short run efforts will be rewarded by retaining experienced staff as an integral part of the work group.

Statutory legislation exists in many countries, which provide for cover to allow recovery, rehabilitation and return to work. Measures to re-integrate victims of physical violence back into work are generally covered under work related injuries, but violence such as verbal abuse or harassment is not so well covered.

In Australia rehabilitation provisions vary between States, although most require jobs to be held open for an employee to return. Additionally in New South Wales employers must have a workplace rehabilitation programme including a written return to work plan for workers incapacitated for more than 12 weeks. Tasmania requires employers to prepare a return to work plan where incapacity exceeds 14 days and a rehabilitation plan for employers with more than 20 staff. In return in states with rehabilitation programmes employees can lose benefits if they fail to comply with plans or do not make efforts to return to work (28).

The Australian National Audit Office has published a useful guide to workers compensation case management (3). This starts from a premise of senior management commitment to ensure that incidents of workplace injury are kept to a minimum, with stakeholder consultation key. It gives good advice on case management systems with trained case managers ensuring early interventions. It also recognises the potential for isolation and rejection and encourages the involvement of co-workers. The guide also stresses the need for case workers to address employee capability; work adaptation; phased returns; realistic outcomes; continued dialogue between case managers, employees and managers and supervisors; and monitoring and evaluation systems.

In Europe many countries have limited legislation which ensures employers provide adaptations, or adapt work for employees injured at work. However whilst physical injury from assault is usually covered psychosocial conditions may not be. In Germany large accident insurance institutions, which are governed by the social partners, have statutory duties for the provision of medical vocational and social rehabilitation of victims. In the Netherlands employers have to submit a report on an injured employee and a work resumption plan to the social security agency within 13 weeks. Sweden's Work Environment Act requires employers to provide suitable organised activities for work adaptation and rehabilitation including targets, regular checks, early intervention, clear responsibilities, consultation, annual reviews and individual capacity.

The weakness in UK provision is the lack of a coherent rehabilitation policy, leading to inconsistent approaches by employers and a focus on worker compensation claims which leads to a drain on public funds. UK Disability discrimination law provides some help ensuring that workplaces have to be adapted to workers but is not detailed enough to provide consistency. A TUC working party set up to investigate rehabilitation looked at examples from other countries recommending a model based on the systems used in some Australian States (72).

In the US systems vary between States, although most require employers to provide full medical benefits, including medical rehabilitation. Under the Americans with Disabilities Act employers are required to provide “reasonable accommodations” to disabled workers. Resistance to implementing early return to work programmes, similar to those in the UK, have been well documented (20).

Whilst rehabilitation systems deal with the victim there may also be a need to address the perpetrators in internal violence situations. A systematic risk analysis should focus on the wider situation and the organisation as a whole, rather than just the conflict between two persons. Nonetheless relocation may be one of the consequences and employer policies generally state that one or other parties may need to be moved after incidents have occurred. If harassors are found to be guilty then it is they who should be removed. This gives the chance for a new start for staff and encourages them that it will not happen again. It also gives the harassor a chance to amend their behaviour in a different environment, as their standing and authority may well be undermined in their current position. In some cases the complainant might want to move and this ought to be considered sympathetically. It may be possible to move both in a large organisation. If separation is appropriate then others such as COs, staff side representatives and personnel should be taken into account. A badly handled relocation can send out the wrong message to staff and undermine their belief in the policy and ultimately the organisation (67).

As with many strategies evidence that they are successful is inadequate. A comparative study which looked at return to work strategies across six countries gives an idea of their success. However it should be noted that this is not limited to health or violence. This looked at work resumption with current or new employers, work adaptations, job re-designs, changes in working hours and therapeutic work resumption. Generally the Netherlands had the highest resumption rate with their current employer and whilst Denmark had high levels of job re-design they also had low levels of work resumption. The US and Israel had relatively high levels of dismissals and dismissal warnings. It is suggested that the Dutch system seems to work best because return to work is embedded in the social system, it employs a wide range of interventions and is backed up by a benefit system which allows a gradual return (15).

2.6 Training

For many years in the UK initiatives have identified training as a key area for addressing violence. Unfortunately reports still show gaps in staff training. For example only 47% of UK nurses say they have received any formal training relating to violence as part of their job (6). Even in high risk areas appropriate training is not universal. A recent survey of mental health practitioners (37), noted only 84.5% had received breakaway training, only 32% of these received it during their pre-registration training, whilst only 76.7% had received restraint training. Large numbers had not received any training by employers since they started work, a tiny minority had not received refresher training and courses were deficient in content e.g. theoretical aspects and de-escalation only briefly mentioned.

A 'training needs analysis' should be based on risk assessments and the information obtained from incident reports. Standard training packages that do not take into account the difference between health employers and the different risks that staff face will be inadequate. For instance frontline ambulance staff who respond to emergencies may face pushes, punches and kicks but are less likely to face close up holding. Therefore training will need to focus on defusion, positioning and the psychological aspects of ambulance workers' culture. This approach is different from that needed for staff working in mental health institutions where there is a need for closer interactions with patients. Here staff will need additional training in breakaway techniques and management of violent clients to cause minimum injury to themselves and patients. They will also need to practise team based approaches for emergencies situations such as when colleagues may be being held or threatened by a patient (37).

UK guidance (29) on training (which focuses on external and client initiated violence) states: Training is appropriate for all groups of employees at risk from violence. Good training programmes typically cover:

- Theory: understanding aggression and violence in the workplace;
- Prevention: assessing danger and taking precautions;
- Interaction: with aggressive people;
- Post-incident action: reporting investigation, counselling and other follow up.

Basic training, appropriate for all staff, might cover: the causes of violence; recognition of warning signs; relevant interpersonal skills; details of working practices and control measures; and incident reporting procedures. In addition to basic training staff who work with violent or potentially violent people may require training in diffusing, de-escalating and avoiding incidents, and breakaway training. Those most at risk may require a course in control and restraint. (29) US guidance adds to this: information on multicultural diversity and the location and operation of safety devices (58). A longer and more detailed list focussing on training needs for mental health practitioners, has also been produced (37).

Theory

Employees need to recognise violence triggers. These include physical illness, mental condition (boredom, confusion, frustration, anxiety, fear, paranoia/altered perceptions) alcohol and drugs (prescribed or other) environment (e.g, heat, space, comfort, noise), denial of rights (lack of information, denial of treatment or opportunity for second opinion or appeal), involvement in groups /peer pressure (27). They should also cover cultural, language and gender issues.

Staff also need to be able to identify the many signs that angry people give off. These include almost indiscernible twitching, avoidance of eye contact, sullenness, repetitive behaviour, alteration of body posture and clenching of fists up to swearing, raised voice and close proximity (27). Trained and experienced staff will learn to discern different reactions from different patients and monitor how they behave during interactions.

Prevention: de-escalation or defusion training

Defusion training (referred to by some as diffusion) uses both verbal and non-verbal communication to reduce the anger of potential perpetrators (9). Methods of teaching vary between trainers however they usually include teaching staff to maintain a calm but authoritative tone and utilise personal space. There is also a need to convey reassurance, respect, and concern to the angry person. Additionally training courses focus on making the perpetrator understand the state of the worker and their status as a person who can be of help. Calm, slow and deliberate movements also signal to the angry person show that a worker is not going to

harm them. Other conflict avoidance skills include considering giving concessions to the patient, trying to engage them, and make them reason by giving them choices on how to end the confrontation or how a joint solution can be found.

Defusion techniques need to be adjusted for staff who work in the community and may be unfamiliar with their environment. Staff will need to analyse any potential dangers and approach situations cautiously, identifying people around the scene. They will need to recognise the difference between being in the open and confined places such as ambulances or patients homes and learn to position themselves to ensure they can escape. Staff should also understand the consequences of actions such as taking drugs/alcohol away from patients, who may see this as a challenging action.

Interaction: restraint techniques

Breakaway training starts with identifying the stages leading to violent incidents and utilising de-escalation skills. However it also teaches methods of breaking free from holds commonly used by aggressors and the need for self awareness (9). Other techniques involve deflecting blows or kicks and understanding ways of escorting people with a minimum of physical intervention. There is increasing focus on techniques that create as little pain to perpetrators as possible. This should only be taught to people who need it and are likely to use it. Teaching it to others can give them a false sense of security and might encourage inappropriate use.

Unfortunately too many health service staff are given self defence courses which focus inappropriately on physical conflict. Only those who are regularly faced by violent offenders, should be offered training courses that teach serious physical interventions (29). These should include security staff, or staff working in some areas of mental health. Restraint courses were originally developed for use in the prison services have been adapted and now concentrate more on breakaway techniques, psychological aspects and immobilisation of patients rather than those that cause pain. Techniques include restraining holds group holds, taking patients to ground, limb control moving patients and separation. There is considerable debate around the use of restraint and the use of holds that can inflict pain (37).

Post incident action and understanding policies and procedures

These tend to concentrate on employers' policies and procedures, and may form part of longer courses. Some focus on internal procedures, reporting systems and support mechanisms, whilst others have set up joint training with local police and prosecution services. These show staff procedures and the reasoning of the judicial process and give an idea of what is expected of staff who may be called as witnesses.

Internal violence

There has been less work done on the contents of training packages for internal violence. Unions have often taken the lead on this issue and have set training packages for their stewards. One package on bullying suggests course content should cover: definitions; potential work organisation and staffing issues that may encourage bullying; work with personnel officers to ensure that bullying is addressed and managed; providing members with support, understanding how employment law and health and safety legislation applies to bullying and developing a workplace strategy to tackle bullying (71). Courses run by employers usually cover similar ground and will focus on local policies and procedures.

Competence of trainers and national standards

As well as qualifications and sufficient experience trainers need to be aware of their limitations. Their approach needs to be complementary to that of an employer and they need to be

knowledgeable of the healthcare sector its problems and the environment and constraints in which staff work in the community (69). This holds for other healthcare employers and environments. Employers need to decide whether they use internal trainers or whether they buy in external trainers. There is also a need to monitor and evaluate whether training works. Data in this area is lacking and it would be useful to analyse whether people were able to utilise the training they received and whether it was effective.

2.7 Involvement in policy making

Employer based policies

Guidance for policy makers is aimed at employers (7, 29, 58) or unions (2, 75). It is difficult to ascertain as to how much input is provided by victims. However the principle of staff involvement is enshrined within European law. The Health and Safety commission includes details of UK legislation, which specifically refers to the involvement of trade unions and employees not in groups covered by trade union representatives. It also states in practice employers have found that initiatives for reducing risk are only fully effective if they closely involve employees and their representatives (29). In practice most policies are drawn up either by employers and then consulted with staff or by joint committees involving staff representatives, which include or consult with victims as appropriate.

US guidance (7, 58) propose that an effective programme includes a commitment by the employer to provide for, and encourage employee involvement in the safety and security program and in the decisions that affect worker safety and health as well as client well being. The guidance suggests employee involvement via suggestion/complaints procedures, health and safety committees, reporting systems, case conference meetings and training initiatives.

Policies relating to internal violence include far more victim support measures. An analysis of the content of a number of health and local authority policies is included in Box 9.

Box 9: Local employers policies usually include:

- Statement of commitment
- Definition
- Duties of managers
- Trade union representation
- Contact officers
- Complaints procedures – informal and formal
- Training and information
- Support for bullied staff
- Monitoring - including review

Richards and Daley (67)

Box 10 gives a general list of what the UK Government considers should be included in a local violence policy, which covers external and client initiated violence. US guidance (7, 59) recommends local written programmes which complement those shown in boxes 9 and 10.

Box 10: What to include in a violence policy

pledge to protect staff
definition
details of employers legal obligations
consultation & communication with staff and union reps
details of managers and employees responsibilities
info on risk assessment
details of local prevention and reduction plans
explanation of staff training
explanation of emergency procedures and police involvement
recognition of different aspects of work – such as working alone, travelling home visits
reporting procedures – including critical incident review & near misses
support for staff in the event of an incident and post incident support
commitment to working with local police and Crown Prosecution Service
demonstration that policy has been implemented

NHS Executive (51)

There is a need to communicate trust policies not just to directly employed staff but to others such as agency staff, students, volunteers, employees of contractors or other employers on the site (69).

National policies

The UK Zero tolerance strategy included social partners in a cross Government initiative from the beginning. Early involvement in working groups created a broad base of support for the initiative when it began. Subsequent documentation on specialist areas was channelled through the social partners. These organisations took draft documents back to their members (including victims) and comments made by members were fed directly back to Government (51).

The results of not involving front-line staff can lead to errors. For instance in response to an increase in patient suicides the UK Department of Health issued advice that items such as curtains and hand rails, which could be used as ligature points by suicidal patients should be made collapsible. Unfortunately some of the products produced by manufacturers in response to the advice, such as rails attached by strong magnets, could be used as potential weapons. A wider involvement of front line staff might have identified this potential risk early on. Other UK Government initiatives which have raised patient expectations, such as set response times, have in some cases led to unachievable service demands which has lead to patient and staff frustration. Again involvement of front line staff would have been able to warn Government of the negative side effects of such policies.

A recent UK Government initiative on withholding treatment to violent patients was based on a pioneering scheme designed by staff. GPs have been able to remove patients who are violent or threaten violence from their practice since 1999. To ensure treatment is available the Government has provided resources to other GPs to see such patients in a secure environment. In 2001 NHS Trusts were given guidance on introducing similar procedures. The starting point is informing patients and visitors of what is unacceptable behaviour on the premises, including

excessive noise, general verbal abuse, racial and sexual abuse, malicious allegations, offensive gestures, drug and alcohol abuse, damage, theft, threats and violence. This is backed up by eye-catching posters which re-inforce the message. Offending visitors are warned and if they continue to display unacceptable behaviour, can be removed by security staff. Patients over 18 face ascending courses of action beginning with an informal warning, followed by a formal written warning - a so called "yellow card" (an analogy to football) followed by exclusion from the service for up to a year ("Red card"). There are of course necessary exceptions. If a person reports for emergency treatment then they will be treated but, where possible, they will be attended by security staff. The Department of Health's guidance which includes the Trust policy gives additional guidance relating to patients not competent to take responsibility for their action or are mentally ill (18).

The recognition of the variation in practice has led to UK Government agencies along with other stakeholders to begin drafting National Occupational Standards in managing work-related violence. The draft standards state that they can be used to aid the development of policies, form the basis of qualifications, guide the development of a syllabus for training courses and kite mark training providers. Most of the units are focussed on prevention, however one unit is aimed at supporting individuals involved in incidents of violence. This is divided into two areas: carrying out de-briefing (the unit focuses only on management debriefing) and ensuring the individual receives continuing support (general advice).

Only one relevant UK national guidance document refers to the need for sustainability. This guidance suggests that whilst good practice can be disseminated and pilots established, lasting improvement depends on long term sustainability of changes in behaviour. This sets target dates for implementation of racial harassment policies and proposes that performance management targets are agreed for reductions in incidents and progress measured (racial harassment guide).

In Australia there is a considerable amount of policy work taking place at State and Territory level. Initiatives include taskforces, such as that on the prevention and management of violence in the Health workplace in New South Wales (43) and one looking at bullying in Queensland. Other states are producing guidance and the Victorian Workcover Authority has produced an 'Issues paper on a code of practice for the prevention of workplace bullying'.

2.8 Re-creating a sense of security

Studies have shown a link between organisational issues and bullying. For instance a study of nurses, which asked about antecedents to bullying showed the main factors as organisational change 43%, change of manager 38%, change of responsibilities 31.5%, increase in responsibilities 28.5%, and change of job/department 26% (44). Another showed similar results but with additional factors of staff cutbacks 39.5% and funding cuts to the department 32.5% (64). Clearly bullying is linked to organisational situations and must be responded to in an organisational way. This is clearly shown in an article detailing organisational change in response to a health employer finding bullying in a particular section (70). After finding increased staff turnover followed by allegations of harassment an investigation discovered serious problems. Rather than responding by dismissing staff the employers sought to engage them and raise their awareness that behaviour in the section was unacceptable. They employed an external facilitator to work through the problems starting with the senior management team under whom the oppressive culture had been allowed to happen. This was followed by a programme for all staff, many of whom were shocked as they had not realised that their

behaviour had contributed to the problems. The employer's occupational health and counselling department were engaged for staff to access. After a year of the intervention the staff team had recognised the problems and welcomed the action. At the time of the article there had been no subsequent complaints. This organisational approach to the situation was being introduced to other sections within the workplace.

For victims of external and contact initiated violence it is important that all victims returning to work feel safe in their environment. An important part of this feeling of safety will be evidence that control measures (engineering controls) have been introduced as part of a preventive strategy. Lists of engineering and administrative controls and special measures for employees are given in a US union guide to preventing workplace violence (2). Similar lists are given in varying detail in other publications (29, 38, 58, 69). The Californian Occupational Safety and Health Administration in particular goes into detail about these measures and their application in different types of workplace (7). The following are general points taken from the guides and practice in workplaces.

Environment

A risk assessment should be completed before the victim's return that will seek to ensure the worker's immediate environment is safe. Often health care environments are not fully thought through. Clinical treatment rooms can be isolated and poorly designed, for instance placing patients by the door that might be the only exit point. Staff may also find themselves at risk when they are sent off on their own to remote parts of the hospital for records late at night. Car parks can be minimally policed, poorly lit and open to all, as can parts of hospitals. Areas such as landscaped gardens should be designed so as not to provide cover for assailants.

The risk assessment should address all aspect of the environment relating to both staff and the public. It will look at workplace layout and ask for instance is it too cramped and are people too close and invading other's space? Are there areas where individuals can conceal themselves? Is the light too harsh, startling patients – or too dim, making it hard for staff to identify warning signs? Is it too hot or cold? Are the seats uncomfortable or are they (and other furniture) loose so that they can be thrown around? Is it noisy? Are refreshments available for those who have to wait a long time? Are there phones to allow patients to let friends know where they are or if they are delayed? Are there areas where children can play so they do not get in the way of others? These points are dealt with in more depth by UK guidance (48).

Potential triggers for violence can occur around waiting times. An analysis of patient throughput could do much to relieve tensions. Some appointment systems are poorly designed giving general times that are not adhered to. The difference between family doctor appointment times in particular can vary enormously. In circumstances where patients have to wait for days to get an appointment and then face further delays at the healthcare provider there will inevitably be frustration. Throughput is especially difficult in hospitals where patients may need to visit a number of different departments. Systems are now available that will plan the route of a patient through a hospital. Where patients have an option of visiting different departments the system will allow staff to analyse potential waiting time and identify the shortest queue. Poor communication of waiting times and possible delays can also be a trigger. Not knowing how long a person has to wait can be annoying, but being given partial or incorrect information, can be just as bad. Up to date information relayed personally can diffuse anger.

Security

Security has traditionally been an ad hoc affair in many hospitals, for example in the UK it has been expected that porters and others would be called to intervene in situations. However they

may have had no training in either physical or interpersonal skills, so their intervention could inflame the situation. Trained security guards are now present in many hospitals and in some particularly difficult environments Police Offices have been opened (32). In Accident and Emergency Units security staff are now being used to restrict the number of friends of patients allowed in. Security staff, access pads and door locks can also be used to restrict access to other areas so that only those who need to be in a particular work environment are there.

Security guards themselves have been linked with potential incidents. A guide on security in Accident and Emergency (A&E) departments (48) noted that security can present a 'hard' image and recommended that employers considered a softer approach with less police like uniforms and that training focus on diffusion and a generally less aggressive response.

Whilst Identity cards are useful in ensuring that security staff know their colleagues, they should not have too much information, as an aggressor could use them to track staff down. Uniforms are also an issue especially in the community. Whilst some workers believe it gives them extra authority others believe that it sets them out as a target. Procedures on badges and uniforms should be subject to risk assessment and agreement.

CCTV and Alarms

Close Circuit Television (CCTV) and alarm systems are useful devices. Unfortunately far too often they are viewed as the main answer, to the detriment of other measures. They are useful but only as part of a package of measures, as on their own they are reactive protective devices utilised during or after an incident. So whilst CCTV can be good for providing subsequent evidence it does not necessarily stop an incident occurring, although some suggest the presence of CCTV alone acts as a deterrent (51). CCTV and alarms also need to be correctly managed and correctly sited in the first place. Alarms vary between so called "panic buttons" which are placed in parts of the room and "personal alarms" carried by the staff. Personal alarms come in two sorts "shriek alarms" which produce a loud noise or more complex systems which use infra red or radio waves to allow victims to be detected quickly (29). The choice of an alarm must depend on the risk analysis (56), and it is important that recent victims have a say in the choice to ensure their feelings of safety.

To be fully effective CCTV needs to be constantly viewed and tapes changed. There should be a procedure which identifies who and how to respond, that makes new staff aware of their use, and that cameras and alarms are moved, adjusted or numbers increased when changes to the building are made. Employers need ensure that there are correct procedures around disclosure of recordings. Systems such as CCTV, alarms and the hiring of Security Staff can be costly and the options open to hospitals and larger employers may not so easily utilised by smaller employers or those working in the community.

Mobile phones

Mobile phones can play an important part in the process of the safety of health workers in the community. They can be used to report in as staff make their rounds or for colleagues to check on workers who may have concerns on a visit to a patient. In difficult times communications systems can also be used to send coded messages to warn others of staff in difficulty, this is common practice amongst ambulance staff. With all communication systems and phones there is a need to be aware of areas where radio reception is inhibited.

Security screens

There has been much debate about the siting of security screens used in Accident and Emergency Departments. Many staff feel protected by them (2), whilst it has been suggested by

others that they act as a violence trigger to some aggressors, if they feel that staff are using them to avoid what they consider reasonable demands. There appears to have been minimal quality research into this area and so remains an area for debate. What is important is if staff are to feel comfortable moving from a screened to non-screened environment then they should be involved in the consultations from an early stage and their apprehensions discussed and allayed. There are compromises – which can involve partial screening, special screened areas for some staff or specially widened or raised desks that make it difficult for aggressors to reach staff (48).

Personal protective equipment

Another area of debate is around stab vests and personal protective equipment. There is a lack of evidence on the numbers of ambulance workers facing the risk of being stabbed in the UK. However some staff feel that they are necessary to protect themselves in hostile situations, whilst others are concerned that they may encourage employers to send them into situations which they should not be in (18). There is also potential physical interference whilst workers are handling patients and issues of comfort during hot weather. Again the determinant must be a risk assessment.

In mental health situations additional security measures such as the use of mechanical restraint (in the US) and shields by staff, seclusion, medication and the involvement of the police and CS gas are also subject to enormous debate (37). There are also suggestions that metal detection systems are used (7).

Staffing

Staffing levels play a crucial role in violence. Shortages can cause treatment delays, frustration amongst patients and fewer staff available to help colleagues out when an incident occurs (2, 7, 29, 75). US guidance recommends that safe staffing levels need to be ensured particularly during patient transfers, emergency responses, meal times, at night or when patients with a history of violence or gang activity are admitted (58). A&E departments in particular use shift planning to reduce violence during difficult periods, and ensuring a mix of experienced and junior colleagues. Shift patterns also take into account timing of public transport.

A suggestion for reducing violence amongst mental health staff is to include questions on the ability of staff to handle violent and aggressive patients at selection interviews (37). This would need to be handled sensitively so as not to be discriminatory. It also begins to look like 'victim profiling' where screening and selection procedures are used to weed out 'bad apples'. The effectiveness of such procedures has been questioned (2, 11).

Practice and funding for control measures

Many employers have drawn up detailed procedures, which include preventive and control measures outlined above. For example one employer has produced a Community Staff Safety Protocol. This sets out a list of mandatory standards to promote safe practice. Standards include: all client files to have updated risk information, case files for clients who are a known risk to be clearly labelled; care plans to include specific agreed safe practice; staff to personally report to managers before commencing visits; details of visits left in office log and high risk visits highlighted; on completion of last visit or high risk visits staff to report in (before a set time – or subject to a specified late reporting system); personal alarms and mobile phones available for high risk visits and safety check call during high risk visits available on request. (47).

The UK government has recognised the issue of the need to invest in "control" measures. In the Summer of 2001 it announced a £6 million initiative (£3 million direct from the Government and

£3 million from local employers) to be used on training, CCTV, buying personal alarms or spending on obtaining specialist advice on risk assessment. This was the first national ring fenced money ever spent on violence to health workers by the UK Government, as previous initiatives involved taking money from local employers' general budgets. Similarly in New South Wales, Australia in July 2001 the Minister for Health announced an immediate injection of A\$5 million to upgrade safety and security measures in hospitals and a further A\$5 million to deploy more security personnel. Continual funding from either Government to ensure sustainability was not detailed.

2.9 Involvement in the evaluation process

There are a lack of studies that give detailed evaluations of interventions to prevent violence. A study for the International Labour Organisation (ILO) noted that in a review of 41 studies only nine reported data on outcomes and evaluation, all of which were in the health service. Unfortunately, no conclusive evidence with regards to outcomes was put forward, although it was suggested that interventions that focussed on organisational rather than individual risks were more likely to succeed. (36a). Another study suggests improved outcomes for a strategy called the Assaulted Staff Action Programme, which is used in a number of US hospitals and includes a focus on the victim. The study looked at three hospitals and found a drop of 40% in assaults within six months of initiating the programme that led to a net saving per hospital of \$268,000. It was also reported that productivity was sustained and morale improved (36b). The study for the ILO study points out that as far as the authors are aware there have been no systematically evaluated anti-bullying interventions (36).

Guides agree that procedures and mechanisms should be developed to evaluate the implementation of the safety and security programmes and to monitor progress and accomplishments (7). UK guidance (29) divides the monitoring process into two parts:

1. Active monitoring, which involves checking that systems and procedures work without waiting until something goes wrong.
2. Reactive monitoring, which involves looking at incidents after the event and learning from the experience. This depends on an effective system of reporting and recording incidents.

Earlier in this paper it was noted that it is necessary to have baseline figures to be able to assess whether measures have been a success. However to ensure a competent analysis it is necessary for managers to know what is to be monitored, by whom and how often (Box 11) US guidance also recommends employee surveys and 'before and after' surveys of job or worksite changes/new systems (7).

Whilst most evaluations are completed by internal managers it may well be useful to use independent auditors to provide a check on reliability, efficiency and effectiveness of performance measure. Investigation reports of health and safety representatives can contribute to an evaluation adding a different perspective. In the UK monitoring and evaluation have become even more important as the Government has set targets of reducing (external and client initiated) violence by 20% by the end of 2001 and 30% by the end of 2003. A survey of 45 employers suggested that only around 20% of them expected to reach the first target. (34)

Box 11: Forms can be used to collate:

Numbers of incidents
When they occur
Type of staff involved
Categories of patient visitor
Environment /locations
Level of injuries
Preventive measure used – immediately and proposed for the longer term.

In addition there should be continual review of:

Compliance with violence policy and procedures
Achievement of objectives set in plans
Levels of staffing
Training
Record analysis
Accommodation/environment correct
Maintenance and performance of security systems

Health and Safety Commission (29)

Additional measures for monitoring and evaluation of internal violence policies include analysing exit rates, absenteeism rates, and formal and informal complaints and grievances, the results from staff support programmes and counselling services using anonymised surveys, and monitoring the effectiveness of the policy making process itself (65). Using integrated personnel systems employers can build up profiles of victims and harassors. Further evaluation can involve regular reports for senior managers, compliance with training targets and time-scales for ensuring policies are met and the introduction of working groups to monitor. Evaluation of internal problems is often harder because of the hidden nature of bullying and harassment. However, just because there are no complaints does not mean there are no problems.

2.10 Compensation

Compensation systems vary significantly between countries and are often linked to rehabilitation programmes mentioned above. In Australia 85% of all violence related workers compensation insurance claims were from public services: health, welfare and community work services, education, property and business service, retail trade, public administration and road and rail transport (43). Most states have individual compensation and rehabilitation laws for injured workers on a no blame basis. Australian guidance gives a detailed comparison of such schemes which includes comparisons of legislation, funding, claims, cover, remuneration, definitions, limitations (28). All states have stressed specific exclusion factors but there is variance on whether journeys to and from work are included. In New South Wales victims whose injuries exceed particular thresholds can seek civil compensation instead of workers compensation.

In the US workers compensation systems provide state specific remedies for job related injuries on a no blame basis. Issues on what constitutes a claim and the rate of compensation paid, are decided by the State, their legislatures and their courts (58). Cover is provided by private insurance, state workers boards or by self-insurance. In some States psychological injuries are

not covered and this has led to a rise in claims to the Courts for damages from conditions not covered. Workers organisations have long complained that private companies do not release data on the number of claims nor on how much they pay out with the result that it is difficult to get reliable workers compensation data.

In the UK there is a statutory sick pay scheme which gives limited benefits for all healthcare staff. In the NHS there is also an occupational sick pay scheme which covers staff for medium term periods of absence which covers of ill health including victims of violence. Contractors, Agencies and smaller employers such as GPs usually have their own more limited occupational sick pay schemes. The NHS has an additional scheme called 'Injury Benefit' which has a temporary Injury allowance as additional protection against loss of earnings. Whilst a victim is on sick leave this guarantees 85% of normal earnings, to workers subject to accidents (including victims of violence). This scheme also provides permanent injury allowance and a death benefit both linked to accidents/incidents.

Other compensation comes from either civil claims against employers through the courts or via the criminal injuries compensation authority. Civil claims are based on breaches of employers' duties to provide a safe working environment. Victims need to prove that on the balance of probabilities their employer was negligent and did not provide a safe system of work, whilst an employer only has to prove that they took reasonable precautions to defend a claim. Case law in the UK is complex and depends purely on the incident and the situation that occurred. One clear area where employers are found at fault is when training is not given amongst workers where it would be expected such as the caring professions (76).

Claims for injury relating to psychological conditions such as PTSD are more difficult as there is no specific relevant legislation. Courts have been reluctant to allow claims for psychological injury and so only certain "categories" of case can succeed. This has made the law particularly complex and difficult to pursue. Bullying and harassment victims can claim constructive dismissal if forced out of work, but it is difficult to prove and compensation consists of a basic capped award plus compensation worked out on maximum weekly wage. In such situations the victim cannot get legal redress against the bully, but have to take it out on their former employer. Compensation can also be claimed under discrimination laws around gender, race and disability.

Compensation can also be submitted to the Criminal Injuries Compensation Authority (CICA). This is a state funded Government body covering England, Scotland and Wales that uses a tariff method of calculating awards for those who suffer a criminal injury. The levels of compensation paid by the CICA are lower than the courts as they are seen as "an expression of public sympathy and support for innocent victims". There is a chance to get compensation for psychological distress but this is difficult. Claims must be submitted within two years of an incident. If a case is proven there is a capped basic award with compensation for loss of earnings for the first 28 weeks and medical treatment for those unable to work after 28 weeks. Dependants and relatives can also claim. For minor injuries there must be at least three separate injuries – such as cuts, severe bruising, black eye etc. It is not possible to receive money from both the courts and the CICA, in such a case CICA money must be returned.

2.11 Prosecution procedures

Criminal law has long been used as a principal bulwark against the commission of acts of violence in all locations including those in the workplace (11). Legislation and prosecution procedures vary significantly between different States and Countries, although some have common themes such as anti-discrimination legislation.

Staff morale and confidence can be improved if they see that there is a genuine commitment from employers and the authorities to pursue criminal prosecution in cases of serious assault (29). In the UK employers are also encouraged to enlist the support of the police and support staff through a prosecution (51). These statements set the tone for issues around prosecution in the UK. This is further enhanced by a clause in the Crime and Disorder act, which sets a legal requirement for local authorities and police in co-operation with bodies such as health employers to formulate and implement crime and disorder strategies.

Many countries have case law or penal or labour statues referring to harassment (11). In the UK prosecutions against perpetrators can also be pursued under the Sex Discrimination Act 1975, Race Relations act 1976 and Disability Discrimination Act 1995 make unlawful any bullying or harassment that includes elements of discrimination. Certain types of harassment such as stalking are covered in the Protection from Harassment Act 1997 and the Criminal Justice and Public Disorder Act 1994 (1). In Northern Ireland there is also The Fair Employment (Northern Ireland) Acts 1976 and 1989, which define direct and indirect discrimination against individuals on the grounds of religious beliefs. The Protection from Harassment Act 1997, originally introduced to prevent the 'stalking' of victims by strangers could be used by workplace victims. This makes it an offence to pursue a course of conduct, on at least two occasions, which a person knows amounts to harassment of another person. Offenders can be subject to a restraining order, compensation claim or imprisonment.

The legal process is often bewildering for victims especially those who may still be suffering from an incident and may not relish having to relive the experience in court. UK Government guidance (51) gives a good readable account of what victims can expect from the legal system. This begins with a reminder of the need report incidents. Next there are details of the role of the Police and the prosecution services. This is followed by explanations of court procedures and then what to expect as a witness in court. Finally there are details on sentencing and possible compensation relating to the prosecution.

In the UK there is specific guidance for magistrates (lower courts) which make it clear that violence against public service workers make the case more serious and make it more likely that perpetrators could receive prison sentences.

There has been concern for a long time that the Police and prosecution authorities do not always prosecute perpetrators. Prosecutions of mental health patients are a particular case where police dismiss them and do not want to spend time investigating incidents such patients cause as the police doubt they will achieve a prosecution in the courts. This has a negative effect on staff who feel hard done by and unsupported by the authorities. Local employers often shirk away from helping out with private prosecutions, although some more progressive employers do assist. NHS managers and clinicians have a key role in ensuring that the police have all the facts so that the police use all the remedies available to them (51). There is also some resentment that assaults on Police officers are treated differently to those of other public servants under the Police Act 1996. In particular Ambulance staff who may be involved in the

same incident as a Police Officer may see their case being treated differently and the assailant receiving a lighter sentence.

Some employer policies, particularly covering ambulance workers, make it clear that they will support staff who become involved in violence whilst the staff act in good faith. This is meant to show that the employer values staff and that they will take the impact if any member of the public tries to sue their worker. Some unions and professional bodies also provide professional indemnity insurance as part of their support mechanisms.

The UK Health and Safety Executive also have the ability to prosecute employers for failing to adhere to legislation. Whilst they have not done so in regard to violence, they did serve 20 'improvement notices' on employers who they felt were not complying with the law between November 2000 and September 2001 (30). These notices usually give the employer six months to resolve the breach of the law. Failure to do so would result in an order to stop work in the area where a risk was identified and a possible prosecution.

3. CONCLUSIONS AND RECOMMENDATIONS

Much has been written and researched about violence. Understandably that which covers workplace violence tends to focus on prevention, reporting and training. Comprehensive work on victim management is less common and in some guidance the victims appear to have been sidelined. There are also few studies that discuss the sustainability of proposed interventions. This paper has been an attempt to pull together literature and knowledge around violence which particularly affect victims after an incident. The following are recommendations that arise from the study:

Whilst most national and international definitions cover internal, external and client initiated violence, a few do not include internal violence – notably in the UK. Organisations seeking to address violence should ensure that internal violence by work colleagues is given the same priority as other forms of violence.

Local and national employers, organisations and Governments should produce guidance, policies and procedures that fully address the management of victims of violence, as well as risk assessment and preventive measures. Victims, staff representatives and appropriate employees should be included in working parties that formulate such policies. Such work needs to address the problems faced by temporary, agency and sub-contracted workers. Guidance should also address the difficulties faced by migrant workers.

There is a lack of information on victim support strategies amongst small and medium health care employers. Limited documented and anecdotal evidence would suggest that victims working for such employers receive less support than those working for larger employers. Guidance, policies and procedures that particularly focus on victims in this area should be produced.

There is a need to do more research on the analysis of best practice and successes. Many documented examples appear to be successful are self selected and have not been subjected to testing.

Methods of evaluating the success of interventions should be agreed before interventions begin. The viability of achieving international baseline data should be agreed to ensure that changes can be monitored.

Evidence is clear of significant psychological reactions to incidents by victims, yet there is little evidence of widespread assessment for psychosocial harm. Again evidence of interventions is limited. There is a clear need for more research into the effectiveness of counselling and debriefing

Training should be conducted by trainers who know and understand the health sector and the specific environment in which staff work. Types and content of training course currently vary significantly, so Governments or national organisations should formulate standardised packages.

A particular gap in the literature reviewed is the sustainability of measures introduced. Interventions should be evaluated for their sustainability at all levels and long term funding should be identified.

This report should be seen as one contribution towards improving the situation of victims of violence. Future papers should seek to identify examples from other countries and in other languages which would develop this aim.

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APPENDIX 2: Employer policies analysed

East Midlands Ambulance Service
Greater Manchester Ambulance Service
Hammersmith Hospitals NHS Trust
Hillingdon Hospitals NHS Trust
Isle of Wight Healthcare NHS Trust
Local Partnerships NHS Trust,
Northern Ireland Ambulance Trust,
Severn NHS Trust,
South Devon Healthcare NHS Trust
St George's Healthcare NHS Trust
West Country Ambulance Service
Worthing Priority Care NHS Trust

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