Workplace violence in the health care sector: A review of staff training and integration of training evaluation models

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Abstract

Internationally, workplace violence within the health care sector is acknowledged as a serious and increasing problem, and ‘management of aggression’ training is now firmly established as part of an organization’s health and safety response. This article considers the extent of the problem, the prominent role afforded to staff training in tackling the problem, indicative training content, and models of training evaluation. Several published evaluations of training will be reviewed in order to illustrate the development of training design and content, and highlight measures used to determine possible training effects. Finally, an enhanced, integrated hierarchy of training evaluation measures is offered that may prove useful to managers, trainers, and training departments as they struggle to determine the proper training and appropriate trainers for the particular needs of their staff.

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1. Introduction

Workplace violence is now widely recognized as a major occupational health hazard for many organizations and employees the world over (Chappell & Di Martino, 2000). Di Martino, Hoel, and Cooper (2003), for example, suggest that the issue of violence affects a substantial part of the workforce in many European countries. In the U.S., Fletcher, Brakel, and Cavanaugh (2000, p.339) cite studies that label workplace violence as a “national epidemic” and “an occupational health problem of significant proportions”.

It is difficult, however, to compare exact rates of incidence, whether between nations or individual organizations. As Leather, Beale, Lawrence, Brady, and Cox (1999, p. 4) point out, “the available research studies and statistical indices often utilize different criteria for (1) what constitutes violence, (2) who is to be involved, and (3) where an incident must take place for it to be considered ‘work-related’”. Di Martino et al. (2003) indicate the inherent subjectivity of the phenomenon as well as the influence of different cultures, contexts, and an expanding knowledge base as being responsible for the lack of a consistent definition of workplace violence. The UK Royal College of Nursing (RCN, 1998) also asserts that no single definition can capture this complexity of manifestations, workplaces, and occupational groups.

Despite the many difficulties in pinning down exactly what is meant by the concept, it is nevertheless important to work towards some agreed understanding of its content; otherwise, the phenomenon will remain forever unexplained and efforts to better manage it frustrated.

2. Workplace violence: an emerging epidemic, but what exactly is it?

Definitions of workplace violence usually contain mention of physical assault or verbal threats, but can also include bullying and sexual harassment. The balance of this distinction is important for a number of practical reasons. First, Budd (1999) suggested that victims of threats could be more seriously emotionally affected than victims of assaults. Second, drawing definitions of workplace violence too narrowly excludes all but the rarest, most serious offences and creates a concept that, thankfully, very few employees can associate with. Alternatively, creating too broad a definition blurs the distinction between workplace violence and ‘general’ violence in society (Perone, 1999).

Finally, with regard to violence versus bullying/harassment, many organizations, including health services, would treat these issues separately, having completely distinct and different policies for each.

The limits of the term ‘workplace’ are also debated. This has implications, for example, for those workers who ‘work from home’, or those who are attacked while traveling to, or from, or between work sites or in a client’s home (Bowie, 2000; Budd, 1999). In addition, some researchers are primarily interested in violence from ‘the public’ and exclude violence perpetrated by work colleagues.

Further, within the health care sector, most studies that examine patient dangerousness and its effects do not tend to use the phrase ‘workplace violence’, nor position themselves under this category. Instead, workplace violence is reserved for attacks by strangers or colleagues with a grudge. Hatch-Maillette and Scala (2002, p. 279) suggest that, “studies on staff assaults are often found in the nursing or risk assessment literatures pertaining to custodial care of patients and inmates, whereas workplace violence studies are found in literatures focusing on a broader scope of occupations and on staff-on-staff (or “coworker”) assault”.

Love and Hunter (1996) agree and highlight the major consequences of the recent shift in viewing violence as an occupational health issue rather than a clinical problem, especially in psychiatry, since it brings into play powerful legislative leverage in the form of Health and Safety legislation. Obviously, all of these issues are important since each will alter the calculation of number and type of incidents reported and recorded in various settings.

Perhaps the most widely used and accepted definition of work-related violence is that which has been accepted by the European Commission DG-V and adapted from Wynne, Clarkin, Cox, and Griffiths (1997), namely, “incidents where (staff) are abused, threatened or assaulted in circumstances related to their work, involving an explicit or
implicit challenge to their safety, well-being or health”. The value of this definition is to be found in both its comprehensiveness (it covers all forms of violence, whether physical or psychological) and its inclusiveness (it does not exclude ‘colleagues’ as a source of violence).

The importance of acknowledging colleagues, as well as service users, as possible sources of violence is demonstrated by Farrell (1997, 1999, 2001), who has shown that student nurses expect aggression from patients, relatives, and even doctors, but find aggression from other nurses to be least acceptable and most distressing.

 Differences in the reporting of violence are not just a matter of how the term is defined. There are also differences between nations in terms of what must be reported by law. Equally diverse at the organizational level is the variety of psychological pressures that militate against the reporting of incidents. These include a professional concern for the perpetrator in the case of client-initiated violence (Mayhew & Chappell, 2002), a willingness to accept low-level aggression as part of the job, the avoidance of form-filling as a way of managing the workload, and self-conscious awareness about the monitoring and interpretation of incident numbers by the employer (Beale, Fletcher, Leather, & Cox, 1998; Cox & Leather, 1994; Lion, Snyder, & Merrill, 1981; Rosenthal, Edwards, Rosenthal, & Ackerman, 1992).

 Thankfully, the comparability of data between organizations and nations is improving. Driven by the expansion of liability and legal responsibility for the maintenance of violence-free work environments, efforts to measure incidence, prevalence, and preventive measures will improve to the extent that, “the substantial gaps, which are at present commonplace, in the information on this subject are likely to be narrowed if not closed in the near future” (Chappell & Di Martino, 2000, p. 24). However, for now, the safest conclusion that can be drawn on the basis of officially reported incidents is that the numbers are a gross underestimate of the actual number of incidents (Dickson, Cox, Leather, Beale, & Farnsworth, 1993; Smith-Pittman & McKoy, 1999).

2.1. Incidence statistics: health care workers as an ‘at risk’ group

 There is general recognition that certain occupational groups have an increased risk of exposure to workplace violence. These include workers in public contact service industries (health, education, personnel), lone workers in community settings (night workers, taxi drivers) staff who handle cash or drugs (convenience stores, pharmacies, petrol stations), security staff and those involved with the legal system (police, lawyers, probation workers) (Bowie, 2000; Bulatao & Vanden Bos, 1996; Chappell & Di Martino, 2000; Flannery, 1996; Mayhew & Chappell, 2002).

 According to Budd’s analysis of the British Crime Survey (Budd, 1999), nurses and other health professionals are second only to the police and security staff in terms of their likelihood of experiencing violence at work. These relative positions were confirmed by the National Audit Office (NAO) in their analysis of the British Crime Survey data for the year 2000 (NAO, 2003). In terms of quantifiable risk, Budd (1999) calculated that those in the most at-risk occupations are 153 more times likely to be a victim of workplace violence than those in the least at risk occupations. Nurses had the second highest risk of being physically assaulted, at four times the national average, while their exposure to verbal threat and intimidation was calculated to be twice the national average (Budd, 1999).

 Further, when other factors implicated in exposure are controlled for (e.g., age, gender, hours worked and occupational status), Budd (1999, p. 25) concluded that “there is something intrinsic in the nature of the work itself which results in high risks”. Among those intrinsic work features which put an occupational group ‘at risk’ is the need to interact with members of the public who are in pain, frustrated, receiving bad news that confirms their worst fears, or who may have poor impulse or anger control as part of their problem, or who are in hospital against their wishes.

 More detailed information on nurses’ risk of exposure to workplace violence is obtained from surveys conducted specifically within the health service sector. The survey of the Health Services Advisory Committee (HSAC) (1987) showed that violence was a feature of the work environment for all health care staff. The survey collected data on four sorts of violence — verbal threat, minor and major injuries and incidents involving a weapon — and found that, overall, 1 in 200 had suffered a major injury requiring medical assistance during the last year while 11% had received a minor injury, 4.6% had been threatened with a weapon, and 17.5% had received a verbal threat.

 Higher risk staff groups included ambulance staff and nurses in training. Student nurses were placed equal second in major injuries, first in minor injuries, second in incidents involving a weapon, and second in verbal threats. Other
staff with higher risks were those working in Accident and Emergency, Mental Health (1 in 4 minor injury), Learning Disability, and Elderly Care settings (1 in 5 minor injury).

More recently, HSAC (1997) cites figures by the National Audit Office (NAO) showing that 14% of recorded accidents in the NHS involved physical assault making it the third most common type of accident involving staff (NAO, 1996). A study of 105 NHS Trusts by Industrial Relations Services (IRS) revealed that the majority of NHS employers (52%) considered workplace violence a major problem and reported that health workers are four times more likely to suffer work-related violence than the general public with approximately 1 in 10 suffering a violent incident in the previous year (IRS, 1998).

This equates to an overall ratio of 850 incidents per 10,000 workers per year. However, in some settings, including community and mental health settings, a much higher incidence of violence was found, around 1 in 3 being victims of work-related violence. Incidents causing major injuries accounted for around 10% of cases overall and around 20% of community and mental health cases. Minor injuries accounted for approximately 2/3 of all incidents.

This incidence rate — 850 incidents per 10,000 workers per year— is almost identical to that reported by the Department of Health (DoH) —7 per 1000 staff per month (840 per 10,000 per year) for all NHS trusts — in the annual survey of sickness, absence, and violence by the NHS Executive over a contemporaneous period (DoH, 1999a). This survey of reported incidents of violence from 364 Trusts cited figures of 13 violent incidents per month per trust overall, with 64% of these being against nursing staff. Indeed, across all health care professions nurses are frequently found to face the highest levels of risk of assault. Whittington (1994) found that, in psychiatric settings, about 90% of assaults were against nurses who constituted less than 60% of the workforce.

In the NHS Executive study described above, the incidence rate also varied with the type of service, mental health/learning disability services having three times as many incidents as the average for all trusts (24 per 1000 staff per month versus 7 per 1000 staff per month). This overall figure equates to 65,000 reported violent incidents per year against NHS trust staff.

The very latest figures published by the National Audit Office (NAO, 2003) paint a similarly concerning picture:

- Violence and aggression accounted for 40% of the health and safety incidents in the NHS reported to the NAO.
- NAO 2001–2002 survey showing a further 13% increase to 95,501 reported incidents and significant variation across regions of the country.
- Only 20% of NHS Trusts meeting targets of 20% reduction by April, 2002, as required by the UK Government’s NHS Zero Tolerance Zone Campaign (DOH, 1999b).
- The rate of incidents for mental health and learning disability Trusts is almost two and a half times the average for all trusts.
- Estimated level of under-reporting at around 39%.

Varied reasons (both positive and negative) are offered by the report for rising levels include training resulting more complete reporting of incidents, more widespread use of a common definition which includes verbal abuse, but also increased levels of hospital activity, higher patient expectations and frustrations due to increased waiting times (NAO, 2003).

The problem of under-reporting is still clearly apparent. And, once again, the report includes previously cited reasons, for example, incident viewed as an indication of staff inability to manage, not wanting any resulting attention, forms too complicated or time-consuming.

What is abundantly clear from this brief review of the available evidence is that nurses are an especially at risk group (Leather, 2001). Further, it is generally accepted that the number of incidents of workplace violence, whether in health care or elsewhere, is increasing (Budd, 1999; Flannery, 1996; HSAC, 1997; RCN, 1998), or is at least perceived to be increasing (Cox & Leather, 1994). Other effects confound this conclusion, however, including the possible reduction in tolerance and growing readiness of staff to report incidents following training and awareness raising (Whittington, 1994), and concern over the perceived increase of violence in society more generally (Whittington, 1997).
2.2. The economic and social costs of workplace violence

Estimating the full costs of workplace violence is not easy. Many of these costs are intangible—such as loss of morale, problems with recruitment and retention, increased staff fear, and post traumatic stress disorder (Dickson et al., 1993). While the financial costs of other effects are more easily calculated—sickness absence, premature ill health, and early retirement (Di Martino et al., 2003), it is recognized that much estimation of costs is underestimated (Chappell & Di Martino, 2000).

The social and economic costs of workplace violence are substantial. The 1998 British Crime Survey estimated that, in England and Wales, 3.3 million working hours were lost due to workplace violence during 1997 (Budd, 1999). Fletcher et al. (2000) estimated its financial cost to be $55 million per year in lost wages alone. The latest NAO report (NAO, 2003) roughly determined the annual direct cost of violence to the NHS to be at least £69 million. However, this total took no account of staff replacement costs, treatment costs, and compensation claims. Internationally, the increase in workplace violence has been associated with crises in recruitment and retention of nursing staff (Jackson, Clare, & Mannix, 2002; NAO, 2003).

In addition to the death and physical injury that can sometimes result from physical assault, workplace violence of all kinds has a profound negative impact on psychological well-being. Di Martino et al. (2003) list this negative impact as including: stress reactions; poorer general health, anxiety, depression, psychosomatic symptoms, isolation, loneliness, deterioration of relationships, concentration problems, impaired problem-solving capacity, reduced self-confidence, diminished work satisfaction, fear reactions, and post-traumatic stress.

Whittington and Wykes (Whittington & Wykes, 1992; Wykes & Whittington, 1994) have demonstrated the full range of anxiety symptoms, up to and including those consistent with a diagnosis of post-traumatic stress disorder, that can follow a physical assault. Others have presented a growing body of evidence linking verbal abuse, threat, and even fear of violence, with many of these symptoms of impaired health and well-being (Leather, Beale, Lawrence, & Dixon, 1997; Leather, Lawrence, Beale, Cox, & Dixon, 1998).

Post-trauma reactions can occur without any actual physical injury being sustained (Flannery, 1996; Stockdale & Phillips, 1989). Indeed, the mere witnessing of a violent incident at one’s place of work may be enough to trigger a traumatic reaction (van der Kolk, 1987). Budd (1999) reported that in some circumstances, verbal threat can have a more serious impact than physical attack.

What is clear from this brief discussion of the costs of workplace violence is that it is damaging to both individual and organizational health (Di Martino et al., 2003; Leather et al., 1999). If the causes of violence are not tackled, or its effects ignored, then, as Chappell and Di Martino (2000, p. 48) conclude, stress symptoms “are likely to develop into physical illness, psychological disorders, tobacco and alcohol abuse, and so on; they can culminate in occupational accidents, invalidity and even suicide”. Yet, the recent NAO report (NAO, 2003) cited a survey of 1500 nurses in 2002 which revealed that of the 581 nurses who had been assaulted while on duty, only 11% were offered counseling following the incident.

Clearly much remains to be done, whether in terms of preventing incidents, empowering staff to better handle them, or supporting victims post-incident. Fundamental to effective intervention, however, is a valid understanding and analysis of the etiology of workplace violence and it is to this which we now turn.

2.3. Understanding and responding to workplace violence: the need for an integrated approach

Workplace violence now attracts significant academic, legal, managerial, and governmental attention and concern (Bulatao & Vanden Bos, 1996; Cox & Leather, 1994; Leather et al., 1999). As the corresponding research effort into the subject has grown, so too has the level of sophistication in our understanding of it. Bowie (2000) and Chappell and Di Martino (2000), for example, suggest that early studies of workplace violence were intent largely on defining the characteristics of the assailant or attacker and with generating lists of common factors thought to be responsible for incidents of workplace violence.

Examples of such trigger factors include perpetrators feeling aggrieved, irritated or frustrated, being in uncomfortable conditions, or suffering mental instability of some sort. More recent treatments of the subject (e.g., Di Martino et al., 2003; Leather et al., 1999; Paterson & Leadbetter, 2002) warn against over-emphasizing any single factor in the etiology of violence, arguing instead for the interplay of a host of factors at the individual, organizational and environmental levels. Examples of each might include individual propensity to
anger and to making hostile attributions of another’s intentions (Dodge, Price, Bachorowski, & Newman, 1990), the impact of organizational rules and procedures in generating reasons for perceived grievances (Cox & Leather, 1994), and the role of crowding, noise and a lack of privacy, respectively (Cox & Leather, 1994; Shepherd & Lavender, 1999).

In effect, these more recent multi-factorial treatments all emphasize the need to see violence as more than a simple matter of individual pathology. This is not to say that intra-personal factors do not play some part in the etiology of workplace violence, but that they are not necessarily the sole, or the most essential factor. Equally important, at least, are the social and organizational roles, procedures, and processes which frame and contextualize acts of individual aggression and violence.

Nowhere is this need to contextualize workplace violence more apparent than in studies investigating the prevalence of violence in inpatient psychiatric settings. Blumenthal and Lavender (2000, p. 25), for example, review much of the existing evidence of a link between violence and mental disorder and conclude that, “the patient’s state of mind is not the only factor in provoking violence”. Rather, it reflects in addition: ‘reactions to restrictions and provocations from other patients and visitors’ (Powell, Cann, & Crowe, 1994); ‘the enforcement of rules and denying patients’ requests’ (Sheridan, Henrion, Robinson, & Baxter, 1990); ‘situational factors’, such as overcrowding, provocation, staff inexperience and management practices, and ‘structural factors’, such as changes in mental health policy (Davis, 1991); ‘environmental and interpersonal factors’ (Whittington, 1994).

What is important about this shift to multi-factorial explanation is that it also alters the locus of intervention. Specifically, if workplace violence is a matter of individual pathology, then ‘policing’ and security measures become the most logical targets for intervention activity (i.e., ways and means of protecting the ‘at risk’ individual from another’s pathological behavior). The adoption of a multi-factorial model, on the other hand, carries with it many more avenues and possibilities for organizational action and intervention (e.g., a review of work and organizational policies, practices and procedures which perhaps either give rise to incidents in the first place or contribute towards their escalation and development once started).

In line with this multi-factorial perspective, it is now generally recognized that what is needed in tackling workplace violence is an ‘integrated organizational perspective’ (Cox & Leather, 1994; Leather et al., 1999). As with the management of any other occupational health hazard, it is a problem solving or control cycle that underpins this integrated organizational approach to workplace violence (Dickson, Leather, Beale, & Cox, 1994).

Essentially, this entails examining what might be done before incidents start, as they unfold, and afterwards, at the level of the individual employee, the work group or team and the organization as a whole. In this way, managing workplace violence entails a simultaneous focus on everything from security measures, through individual, team and organizational work practices, to organizational policies, codes of practice and arrangements for everything from job and work design to post incidence support and counseling.

Although, from a multi-factorial perspective, there is no single solution to preventing workplace violence and aggression, training is often held to be a primary element of an organization’s strategy for combating work-related violence. This is especially true in human service organizations where Type II violence (CalOSHA 1995) predominates (i.e., where incidents involve assault by someone who is either the recipient or the object of a service provided by the affected workplace or the victim). In this context, conflict and aggression management skills training can, at least in theory, be used to empower employees to be better able to manage relationships with service users, whether customers, clients, patients, or whoever.

Several key questions remain to be answered, however, with regards to the role of training in violence management. First, what staff training is required? Second, how can training effectiveness be measured and why is training evaluation performed so rarely? Third, can an enhanced framework be applied to the evaluation of management of violence training?

2.4. The advocacy of training as a cornerstone in attempts to manage workplace violence in health care

Virtually all the published guidance on violence asserts the importance of training as a preventative measure (Brewer, 1999). Numerous bodies and agencies have advocated training of different types to meet the different needs of staff groups. The HSAC study previously referred to asserted, for example, that “training in the prevention and management of violence should be available to all staff groups who come into contact with patients and relatives and not only those working in high risk areas” (HSAC, 1987, p. 7). Ten years later this advice was further developed
(HSAC, 1997) by suggesting that staff managers also need training (to learn how to manage incidents and perhaps in order to gain a better appreciation of the training), and by specifying content for different levels of training.

The English National Board for Nursing Midwifery and Health Visiting (ENB) responded to the increased risk of student nurses identified earlier and instructed that all pre-registration training programs must include study relating to violence and aggression (ENB, 1993) and indicated appropriate curriculum content along with guidance for trainers courses and specifications for ‘control and restraint instructors’. Unfortunately, Wells and Bowers (2002) concluded that this is still not the case.

Elliott (1997, p. 40), writing from a U.S. perspective, asserted, “all staff must be trained in basic violence behavior prevention and they must know the correct emergency response procedures”. Once again different levels are identified for different staff groups and settings and she added that recent Californian law had decreed “mandatory violence training in all work-places for all employees”, with many other U.S. states expected to follow (Elliott, 1997, p. 40).

The RCN (1998, p. 9) advised employers to provide “appropriate training and education for their staff …commensurate with the degree of risk they face”, as did Beale et al. (1998) who indicated it should start during the induction and orientation process and be repeated (refreshed) regularly. In their guidelines for mental health settings, the Royal College of Psychiatrists (1998) suggested that training for all staff should include self-awareness and knowledge of risk factors.

The zero tolerance campaign program (Department of Health, 1999b) advocated appropriate training, and, in its manager’s guide advised individual assessment of different staff member risks in order to determine their training needs.

Chappell and Di Martino (2000) endorsed regular, up-to-date training as part of a battery of ‘preventive strategies and measures’ that include selection and screening of staff, information and guidance-giving, work organization and job design, defusing incidents and post-incident de-briefing.

Indeed, many authorities now advocate appropriate staff training not as a ‘stand alone solution’ but as part of a comprehensive, coordinated health and safety response to the phenomenon of work-place violence (Beale et al., 1998; Bowie, 2000; Cembrowicz & Ritter, 1994; Cox & Leather, 1994; Dickson et al., 1994; Hoel, Sparks, & Cooper, 2001; HSAC, 1997; Royal College of Psychiatrists, 1998).

HSAC (1997, p. 5), for example, suggests a framework that requires three groups of activities to tackle violence in the workplace, namely, “researching the problem and assessing the risk, reducing the risk and checking what has been done”. Training is seen as a key aspect of the second activity, along with modifying the working environment, and working practices, increasing security and instituting policies and response strategies. It could be further argued that training pervades all three groups of activities since training could include aspects of risk assessment relevant to the first group and also monitoring and evaluation, part of the third group.

2.5. Prevalence of training

Despite the clear and emphatic endorsement of training offered by many researchers and authorities, appropriate staff training is still not offered universally or consistently. HSAC (1987) reported that only 12% of respondents had received any form of training, the majority of this occurring as part of a basic training program. The survey of Beale et al. (1998) on community health care practice, found a wide variation in the amount of training received, ranging from nothing at all to high-level restraint and/or self-defense training. Beale et al. (1998) linked this patchy provision to other studies, citing the RCN (1994) survey of clinical staff — which revealed only one quarter of staff receiving any training regarding violence and aggression — and a more recent study by Shacklady (1997), which reported that 51% of respondents had received training in managing violence in the previous five years.

A survey by IRS (2000) showed varying levels of training provision for different staff groups with 93% of responding trusts offering some form of training (82% providing awareness training, 80% breakaway training, 73% restraint training, and 25% self-defense techniques).

A recent British survey of over 800 staff working in acute mental health in-patients unit conducted as part of a review of the subject on behalf of the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC), found 88% of this high risk group had received breakaway training (32% reported receiving this during their initial training), and 76% had received restraint training (UKCC, 2002). “Very large numbers” had received no training from their Trust since they started work and only a “tiny minority” had received ‘refresher training’ (UKCC, 2002, p. 33).
Moreover, this survey was unable to discover much reliable information about the background and preparation of trainers or details of training that was offered, and concluded that there was “little systematically collected evidence regarding the detailed content or length of training courses” (UKCC, 2002, p. 35).

The latest NAO report (2003) found inconsistency between the levels and types of training offered and also the proportions of staff and grades with regard to compulsory or voluntary attendance on training courses. Ambulance and A and E staff were the most likely to have attended specialist training while only 50% of doctors have received induction training with even fewer junior doctors likely to have attended.

This report also rued the lack of research into the safety or effectiveness of training measures taught on training courses (NAO, 2003). This NAO study also found a reactive rather than preventative emphasis in mental health trusts where, despite these trusts having several times the rate of violence of all NHS trusts, a large number of trusts provided higher level diffusion (70%), breakaway (79%) and restraint training (73%) while failing to provide training in situation risk assessment (50%) and customer care (36%). Both these forms of training are vital since they are preventative and have the potential to reduce both the number and level of violent incidents that confront nursing staff.

2.6. Guidelines on training

While there are many sources of general advice about the structure, objectives, and content of aggression management training, there are surprisingly few published examples detailing particular courses.

One example is the work of Chappell and Di Martino (2000) who advise:

Training involves instilling interpersonal and communication skills which defuse and prevent a potentially threatening situation; developing competence in the particular function to be performed; improving the ability to identify potentially violent situations and people and preparing a ‘core’ group of mature and specifically competent staff who can take responsibility for more complicated interactions (p. 114).

They add that “employees should have knowledge of the nature of client aggression, the motivations of aggressors, cues to impending aggression, how to conduct interviews properly and to adhere to prescribed procedures, and how to respond to emotional clients” along with guidance about when and how to curtail client contact (Chappell & Di Martino, 2000, p. 114).

In relation to healthcare workplace violence, the RCN (1998, p. 9) suggest the following principles for training: fit for purpose (i.e., reflects local need); clear and transparent purpose; expressed in learning outcomes; based on up-to-date content; evidence-based wherever possible; delivered by credible staff who value and respect human dignity; and to be responsive to feedback.

Further, they suggest a range of courses ranging from half study days on awareness and prevention through principles and practice of personal safety, to short courses on management that include breakaway and restraint techniques to courses to train trainers. The RCN list is similar to that included in the zero tolerance zone campaign literature (Department of Health, 1999b). Specifically, training should be up-to-date, relevant, and purposeful, backed by evidence, given by experts, invite feedback, and, ideally, be attended by managers.

Many authorities offer suggestions for appropriate content for staff with different roles and different degrees of patient contact. Many (Beale et al., 1998; Brewer, 1999; IRS, 1998, 2000; RCN, 1998; Royal College of Psychiatrists, 1998) suggest categories similar to the HSAC (1997) plan of three levels of training.

In its earlier guidelines, the HSAC (1987, p. 7) had advocated material on causes of violence, recognition of warning signs, relevant interpersonal skills, and details of management arrangements for “all staff working in areas where the risk of violence has been established”, with the type and depth of training depending on particular roles. Ten years later it advocated (HSAC, 1997) good training typically covers:

- theory: understanding aggression and violence in the work place
- prevention: assessing danger and taking precautions
- interaction: with aggressive people
- post-incident action: reporting, investigation, counseling and other follow-up.
This material was allocated under three levels of training with, for example, basic training for all staff covering the items identified in 1987 (causes etc.), additional training for staff working with violent or potentially violent people also requiring training in de-fusing, de-escalating and avoiding incidents, and breakaway skills and those staff most at risk also requiring restraint skills (HSAC, 1997).

In relation to this content list for good training programs, analysis of training content from the IRS survey of Trusts (IRS, 2000) revealed that 97% of employers included assessment of dangerousness and taking precautions, 95% included interaction with aggressive people, 95% included understanding violence and aggression at work, over 88% included reporting and investigation of incidents, and 82% included training on counseling and de-briefing. The survey also found that, for higher risk staff, more than 90% of employers provided training in defusing aggression and methods of restraint.

The previously-mentioned ENB guidelines suggested a number of topics for inclusion in pre-registration nurse training, including recognition and prevention of violence, communication skills in relation to impaired perception, assertiveness techniques, defusing, diversion and de-escalation techniques, support, de-briefing and post-incident management, ethical and legal aspects, self-awareness and conflict, understanding violence and aggression as a reaction to circumstances/conditions, promotion of a positive attitude towards individuals and physical responses, such as breakaway and escape techniques (ENB, 1993). The guidance also specified preparation for suitable instructors.

McDonnell, McEvoy, and Dearden (1994) bemoan the lack of a blueprint for training and suggest their own, which includes aspects of environmental design, and diffusion strategies. They also include prediction of violent incidents, social skills for defusing incidents, dealing with the physical consequences of violent acts and managing one’s own aggression.

The Royal College of Psychiatrists (1998) guidance offers a detailed list of content that includes methods of anticipating, de-escalating or coping with violent behavior, debriefing and restraint for staff working in mental health services. In relation to community working, Beale et al. (1998, p. 105) offer the following indicators of good practice:

- training emphasizes prevention, calming and negotiating skills rather than confrontation
- modular programs progressing from basic customer care and dealing with difficult clients “through to full control and restraint training”
- material on causes of aggression, reducing risks, anticipating violence occurring, resolving conflict and managing the aftermath of incidents
- teaching physical breakaway skills within the context of when they are and are not appropriate
- staff controlling their own feelings
- understanding of normal and abnormal post trauma reactions
- familiarity with local arrangements and policies.

3. How can training effectiveness be measured and why is training evaluation performed so rarely?

This section will review some of the key influential models of training evaluation devised over the last forty years or so. After doing so, damning findings from several published studies will illustrate how little evaluation of training is routinely performed within organizations.

3.1. Training evaluation models

Without doubt, the model of training evaluation by Kirkpatrick (1959, 1976) is still the most influential and commonly used (Kraiger, Ford, & Salas, 1993; Quinones, 1997). It is credited with revolutionizing the thinking on training course evaluation and remains the only model that many organizations and training departments are aware of (Thackwray, 1997). The model is structured around four levels, each measuring complementary aspects of a training course. The levels are entitled Reaction, Learning, Behavior, and Results.

The Reaction level considers the immediate subjective opinions of participants about a course, what they liked/disliked about a course and is equivalent to measuring their feelings. Crucially, it should be noted that this level does not measure any learning that has taken place. Reactions are comparatively easy to measure so tend to be the first (and too often only) resort.
The Learning level relates to the extent to which trainees achieved learning objectives and absorbed the knowledge and skills delivered in the course, although ‘learning’ is poorly defined (Kraiger & Jung, 1997). Kirkpatrick suggests that many aspects of experimental research design are useful at this level. For example, using a before-and-after approach, measuring each learner in an objective manner to produce quantitative results, using a control group where possible, using statistical analysis to identify correlation or levels of confidence. Behavioral tests are advocated for skills and multi choice tests for knowledge.

The Behavior level refers to ‘training transfer’ — the results of training in terms of on-the-job performance back at work. It is acknowledged that this level of evaluation is more demanding than the previous stages. There are difficulties in attempting measurement at this level, ranging from methodological issues to the necessity of certain personality characteristics in course attendees, for example, wanting to improve, recognizing one’s own weaknesses; working in a permissive environment; support from interested others.

Results, the final level, refers to the impact of training on the department or organization in terms of performance or profitability. Kirkpatrick (1959) acknowledged this to be the most difficult form of evaluation, given the many extraneous influences on organizations, and advocated a participative approach with the incorporation of peer and self-assessment.

The model encourages evaluators to progress through the levels in the specified order until unsatisfactory results are revealed. Apparently, the underlying intentions were to raise the aspirations of training managers, to increase their efforts, and to gradually encourage progression from subjective reaction sheets to more complex research designs (Kirkpatrick, 1976).

Critics of the model suggest that it is now decidedly dated. It has been useful in guiding thought about how to evaluate, and indeed, still remains a good starting point for evaluating training outcomes (Quinones, 1997). However it is restricted in helping make decisions about what to evaluate or how to convert evaluation results into decisions about future training (Kraiger & Jung, 1997). The suggestion of a hierarchy of levels with some levels displaying superiority over others has never fully been refuted.

Another identified limitation of the model (Kraiger et al., 1993; Kraiger & Jung, 1997) concerns its assumption that the levels are causally or sequentially linked, for example, learning being viewed both as a result of positive reactions to training, and as a cause of changes in trainee behavior (Kraiger et al., 1993). The belief that we have to ‘like’ a course or a presenter in order to learn the most from it/them is also unproven, seemingly suggesting that a slick, visual entertaining presentation of empty, unmeaning content can lead to learning.

The model also lacks clarity about operationalizing the different levels of measurement, that is to say, how objectives would be measured and fails really to suggest different methods for evaluating different levels (Kraiger et al., 1993).

Further, it is indicative of the behavioral stimulus–response type models of learning which were popular in the 1950s and 1960s and lacks modern ideas or psychological theories about how people learn or acquire skills (Kraiger & Jung, 1997), or take account of modern teaching methods, for example, computerized technologies. Notwithstanding the above criticisms and limitations, the model remains highly influential in organizations. And Thackwray (1997, p. 33) concludes that “if all organizations in the U.K. at least followed Kirkpatrick, billions of pounds would be saved each year”.

There have been several developments of Kirkpatrick’s model and two more will now be summarized. Warr, Bird, and Rackham (1970) also devised a model with four levels that incorporated the features evident in Kirkpatrick’s model, but extended the evaluation to include a consideration of the context of the evaluation and the inputs or resources available. Sanderson (1992) suggests that this model leads to a broader perspective which views evaluation as a continuous process commencing with a needs analysis and inter-related with the subsequent stages of course design and program delivery. Warr et al.’s model has the acronym CIRO, being the first letters of each of the levels.

The four levels are Context evaluation, Input evaluation, Reaction evaluation and Outcome evaluation. ‘Reaction’ has the same meaning as described in Kirkpatrick’s model, whilst ‘Outcome’ is subdivided into three sub-levels that correspond to Kirkpatrick’s other three levels but in this case labeled immediate (knowledge, skills and attitude development at the end of training), intermediate (changes in on-the-job performance) and ultimate (desired changes in the organization) (Sanderson, 1992). ‘Context’ refers to obtaining information on the operational situation in order to clearly identify needs and hence learning objectives. ‘Input’ concerns the best method of delivery taking in to account time scales, in-house resources, level and types of input, financial resources available (Thackwray, 1997).
Illustrating the hierarchical bias that is identified in the models of Kirkpatrick & Warr et al., Sanderson (1992, p. 129) concludes “both frameworks view the last level of evaluation (results or ultimate) as the most difficult, the least often done and the most valuable. Reaction evaluation is the easiest, the least useful and the most frequently used method”. Similarly, Reid and Barrington (1997) suggest that unless evaluation is completed at lower levels it will not be possible to identify the cause of failure identified by evaluation performed at a higher level.

Given the multitude of possible extraneous factors that impinge on departments and organizations and potentially confound any predicted change, Sanderson (1992) cites sensible advice from Warr et al. (1970). They conclude that it is prudent to concentrate on the lower levels (context, input, reaction, immediate outcome) and assume that if these have been completed properly then intermediate and ultimate level outcomes are likely to be successfully accomplished. A possible exception may be where most of, or an entire, department undergoes training development. In this case, evaluation of intermediate level outcomes may be practicable. Similarly, the importance and centrality of a training program in terms of likely costs, number of trainees, number of repetitions, length of training, support offered by line managers etc. may also make intermediate level evaluation of a training program desirable.

Hamblin (1974) further developed the ideas of Kirkpatrick and Warr et al. (reactions, immediate or learning, intermediate or job behavior, ultimate or results) creating a fifth level by effectively dividing the fourth level into two. This allows the evaluator to distinguish between the outcomes for the organization in terms of productivity, sales, absenteeism etc., and the effects on costs in terms of a cost–benefit or cost effectiveness analysis (Bee & Bee, 1994).

One further model will now be presented, that of Kraiger et al. (1993). This model is not viewed as a linear development of Kirkpatrick and all that has gone before. In this case its emphasis is rooted in the contemporary psychology of learning. The model offers “a theoretically-driven definition of learning along with a preliminary classification scheme for selecting evaluation measures given knowledge of learning outcomes” (Kraiger & Jung, 1997, p. 153).

The model criticizes the simple, ‘uni-dimensional’ approach of Kirkpatrick and others (Kraiger et al., 1993) and instead incorporates theoretical and research-based work from a number of diverse educational psychology sources in developing more expansive taxonomies of learning outcomes. This development extends the range of possible learning outcomes that can be evaluated by proposing three types or categories of learning outcomes (cognitive, skill-based and affective) and sub-dividing each of these in to a number of categories and constructs. For example, cognitive outcomes are sub-divided in to verbal knowledge, knowledge organization and cognitive strategies, while skill-based outcomes include compilation and automaticity. Affective learning outcomes are represented by attitudinal and motivational outcomes, which include aspects of self-efficacy and goal-setting.

These differing constructs reflect the complexity or stages of development of each category. The proposed model explores each of these categories and present a cogent review of relevant educational psychology theory. Further, it also identifies the likely foci for measurement and suggests appropriate training evaluation methods.

As an illustration, Kraiger et al. (1993) suggest that cognitive outcomes can be constructed around the recall of facts and declarative knowledge, around the internal structuring and organization of knowledge (as in the terms ‘mental models’ or ‘mental maps’) and cognitive strategies (the rapid, fluid use of knowledge by experts). This last category is obviously at the highest level and distinguishes ‘meta-cognition’, the ability to accurately monitor one’s own thinking and know when, say, problem solving is unlikely to work, or when we need to revise a particular way of working.

With regard to skills-based learning, Kraiger et al. (1993) suggest that we need to pass through a number of developmental stages, including goal orientation and linking behaviors sequentially and hierarchically. Skilful performance is recognized by being smooth, rapid and error-free. In addition, the performer is able to maintain parallel activities (do other things) and detect appropriate situational circumstances for varying the skill.

The third category consists of aspects of attitude and motivation, an area of learning different to ‘reaction’ and completely ignored by Kirkpatrick (Kraiger et al., 1993). It includes elements of self-efficacy, a term originating from the social -learning work of Bandura (1977) and refers to one’s own perceived performance capabilities for a particular activity. Self-efficacy is theorized as determining whether an individual is likely to engage with and persist with a specific activity (Bandura, 1977).

Therefore, the model is supposed to overcome many of the deficits identified in the work of Kirkpatrick and followers. It certainly uses the published material derived by learning theorists and researchers, offers clear direction...
in terms of operationalizing change in different categories, and suggests methods by which this change can be measured. Further, the model’s emphasis on learning outcomes has helped in refocusing the attention of course managers and trainers on to learning outcomes at every stage of the course design process.

However, the model provides little guidance on how to identify training outcomes given a set of more specific learning objectives (Kraiger & Jung, 1997). It also offers no guidance on determining the financial value or cost effectiveness of training, as highlighted in some of the other models previously discussed. Further, it emphasizes the effects of training on the individual course attendee and rather neglects the effects of training on the organization. In addition, it underplays the possible delays between training and on-the-job performance improvement, and offers little opportunity to collect and incorporate the subjective views of trainees (or trainers) in to the evaluation.

Later, it will be suggested that, rather than view these models as competing alternatives, much can be gained from viewing them as complementary and amalgamating the strengths of each.

3.2. Why is training evaluation the exception rather than the rule?

Despite the availability of a range of models, evaluation in many areas of training remains a distant aspiration in the mind of training and personnel officers and a lowly priority for managers. Bee and Bee (1994) refer to a British survey which suggested that only 15% of organizations attempted an evaluation of training, with only 2.5% performing a cost–benefit analysis (Training Agency, 1989).

In a similar vein, Thackwray (1997) highlights a 1994 survey of a varied range of 467 companies by the Industrial Society that addressed a number of questions to their personnel/training professionals. The survey revealed that almost one fifth of companies did not attempt any systematic evaluation. Eighty percent of the ones that did used reaction sheets, while only 14% used a follow-up line-management questionnaire sometime later. The main problems identified by respondents were difficulty in establishing measurable results, lack of time, lack of knowledge of evaluation techniques, unclear training objectives, and lack of senior management support. These findings are consistent with many others that show that training is evaluated too infrequently, and that when it occurs, it tends to be confined to measuring trainee reactions.

Patrick (1992) suggests that there are a number of practical difficulties, but that evaluation methods are sufficiently well established to deal with them. Practical difficulties surround the dispersal of trainees to different settings immediately after completion of training; detecting subtle changes in skill level and job behavior; assessing the value of different attitudes involves many assumptions, as does calculating the costs of aspects of training.

Too often, evaluation is a belated after-thought rather than an integral part of developing the training. Finally, Patrick implies that evaluations may be performed by external people who could be unaware of the objectives of the training, that organizations may lack the political will to evaluate training, and view evaluation negatively so that it is possibly perceived “more as a weed-killer than a plant fertilizer” (Patrick, 1992, p. 514).

Adding to this rather depressing list, Sanderson (1992) suggests a number of other reasons commonly expressed to explain the reluctance to undertake evaluation. She identifies

- evaluation being unnecessary (since the benefits of training are obvious)
- evaluation being threatening to trainers, (possibly revealing inadequacies or ineffectiveness)
- only rigorous and scientific evaluation being worthwhile. Unfortunately, these methods are difficult or impossible in the real world so nothing is done
- trainers lacking the skills and incentives to evaluate
- end of training reaction sheets being sufficient
- evaluation using up scarce resources that could provide more training
- evaluation requiring coordination between trainers, managers and administrators (which is not possible in practice).

3.3. Review of training courses

This section will attempt to illustrate the essence of the two previous sections by summarizing details of several reports of training courses. While the call from the literature to provide training is virtually unanimous, there is a less compelling position with regard to the objective justification for training. The benefits of training might be apparently
obvious; however they become less clear and more difficult to establish on closer examination, not least because so few trainers have attempted to perform and publish objective evaluations.

Hoel et al. (2001) concluded from their international review of the literature that, generally, trainers did not perform proper evaluations of their courses. They also found few clear program descriptions. Similarly, Paterson and McComish (1998) found a great inconsistency in program content and duration in published accounts of training programs, an identical conclusion to that recently reached in the previously cited UKCC report (2002).

Broadly speaking the first studies tended to be reported by North American researchers. Later, investigations by British authors appeared and more recently studies by Australian researchers have been published. A brief selection of these will be summarized to illustrate the breadth of course design, in terms of time scale (five hours–ten days), content, and measures used by trainers/researchers to determine the effects of the training on attendees.

Gertz (1980) produced an early report on a two-day aggression management workshop in a U.S. mental health center for 317 staff. Content included prevention guidelines and plans, verbal de-escalation techniques, and physical breakaway and restraint skills. A descriptive comparison of year-before versus year-after patient incident figures showed a 33% reduction in incidents over two years.

Lehmann, Padilla, Clarck, and Loucks (1983) delivered a five-hour program to 144 staff in a U.S. veterans hospital. Course content included prevention measures, risk factors, verbal de-escalation, legal issues, and physical breakaway and restraint skills. Several measures of change were used, including attitude to violence, objective knowledge, confidence, comfort, and number of assaults. Pre-and immediate post course administration of a 10-item questionnaire (and an additional small sample of interviews) revealed improvements in knowledge, significantly increased confidence, and slowed acceleration of rate of incidents.

Goddynkoontz and Herrick (1990) selected a different course design and delivered four workshops over four months to 27 registered staff and aides in a U.S. university psychiatric unit. Content included verbal de-escalation, early signs recognition, self-awareness, physical breakaway and restraint skills, and awareness of burnout and feelings. They measured burnout, confidence and control, number of incidents and number of staff injuries and compared scores immediately before training with four-months post training, concluding no overall impact on burnout measures, but a reduction in the number of incidents and anecdotal evidence of fewer injuries.

In the UK Paterson, Turnbull, and Aitken (1992) reported a ten-day course delivered to 25 staff working in Scottish mental health and learning disabilities settings. Content reviewed current practice, legal issues, safety, verbal and non-verbal means of preventing incidents, breakaways and restraint. A pre-and immediately post-training evaluation design incorporated a range of measures (questionnaires, factual questions, Likert scales, videoed role-play rated by ‘blind’ instructors) to determine changes in knowledge, stress and burnout, job satisfaction, role conflict, and...
skill competence. Results showed significant change in knowledge, stress level, reduced role conflict, improved role-play performance of physical de-escalation, breakaway and restraint skills, but no improvement in job satisfaction.

Also in Scotland, Collins (1994) reported on an established five-day course delivered to mixed groups of 31 mental health staff and student nurses. The program included prediction and assessment, verbal and non-verbal de-escalation, legal issues, breakaways and restraint. Measures were administered pre/post-course and at six months follow-up, and included staff attitudes towards violence prediction, patient responsibility for aggression, staff anxiety and fear, staff confidence. Results were positive in all areas except attitude towards expectation of assault and patient responsibility for violent behavior.

Finally, Ilkiw-Lavalle, Grenyer, and Graham (2002) report on a two-day training course delivered to 103 nurses, allied, medical and ancillary staff in Australia. Again, a recognized program was delivered that included content legal issues, characteristics of aggression, prediction, managing aggression, reporting and self-care. On this occasion a 14-item knowledge test was administered pre and immediately post course in a between and within group design along with a course evaluation form. Results showed that nurses scored highest on the tests, all groups improved significantly, and staff without prior training had greatest improvement, particularly in the prediction, management and reporting aspects of aggression.

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Subjective satisfaction sheets (enjoyable, relevant, interesting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning (immediate)</td>
<td>Knowledge tests, vignettes, scenarios (risk factors, statistics, interventions)</td>
</tr>
<tr>
<td></td>
<td>Problem solving (interventions, team approaches, management strategies, rationale, philosophy)</td>
</tr>
<tr>
<td>Skills</td>
<td>Role play exercises and individual skills demonstration (de-escalation skills, breakaways, violence management and restraint), Self-assessed competence relative to an earlier time</td>
</tr>
<tr>
<td></td>
<td>External assessors?</td>
</tr>
<tr>
<td>Affective</td>
<td>Attitude scales</td>
</tr>
<tr>
<td></td>
<td>Self assessment (confidence in managing escalating aggression, self and team morale, job satisfaction)</td>
</tr>
<tr>
<td>Behaviour (intermediate)</td>
<td>Manager review (annual individual performance review)</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Performance during incidents (feedback in post-incident de-briefing sessions and clinical reflection sessions)</td>
</tr>
<tr>
<td>Skills</td>
<td>Manager review (annual individual performance review)</td>
</tr>
<tr>
<td>Automaticity</td>
<td>Customer satisfaction (user group feedback, complaints)</td>
</tr>
<tr>
<td></td>
<td>Team morale, Staff recruitment and retention figures, Team work</td>
</tr>
<tr>
<td>Results (ultimate)</td>
<td>Work atmosphere assessment, Reported incident figures –number, type &amp; seriousness, Customer satisfaction (user group feedback, complaints)</td>
</tr>
<tr>
<td>Finance</td>
<td>Complaints and inquiries, Sickness and injury claims, First aid consumables Compensation claims</td>
</tr>
</tbody>
</table>

Fig. 2. Appropriate variables for outcomes measures in aggression and violence management training.
4. Can an enhanced framework be applied to the evaluation of management of violence training?

As can be seen from the examples of training evaluations reported above, there are many possible measures of change and these can be related to the training evaluation models described earlier. Broadly speaking, changes can be determined in the knowledge and practice of individual course attendees, the functioning of the department in which they work or more broadly in the organization. As an example of the latter categories, with regard to aggression management training, the HSAC (1997, p. 19) asserted that training can result in fewer incidents, less serious incidents, a reduction in the psychological sequelae following incidents, improved response to incidents, and better staff morale.

The review of training evaluation models concluded by suggesting that much could be gained by viewing the models as complimentary rather than competing, each with different strengths and foci. This article will conclude with an attempt to combine several of the models discussed earlier in order to produce an integrated framework. This framework is then applied to aggression management training to produce a more comprehensive, structured list of possible change measures. Such a list may well prove useful to managers, trainers, and training departments as they struggle to determine the proper training and appropriate trainers for the particular needs of their staff. It could help to structure any evaluation or appraisal needed to justify expenditure from hard-pressed training budgets.

By combining the mixed attendee and organizational aspects of Kirkpatrick’s, Warr et al.’s, and Hamblin’s models with the course-attendee focused, educational psychology aspects of Kraiger et al.’s model it is possible to create an integrated, more comprehensive, general framework or hierarchy for evaluating training courses (Fig. 1).

It is then possible to identify dependent variables associated with the different points that could be measured, with varying degrees of difficulty, as part of a course or program evaluation. Fig. 2 applies the general framework from Fig. 1 specifically to aggression management training and produces a wider range of possible training measures.

5. Conclusion

Workplace violence is increasingly recognized as a serious problem with implications for both managers and staff. Staff require training in a range of knowledge, skills and attitudinal areas, regularly updated, while managers need to discharge their responsibilities under Health and Safety legislation by organizing risk assessments, negotiating protocols, and organizing staff training based on particular identified needs. Therefore, a ‘total organization response’ is needed with duties and responsibilities for all members of an organization.

Although aggression management training is now widely available, it is often inappropriate for the needs of different staff groups within an organization and its effects are rarely evaluated. This article first reviewed the literature on workplace violence, aggression management training, and training evaluation before presenting an integrated framework that offers scope for use by trainers, managers or researchers. It concluded by applying the framework specifically to aggression management training courses and offered a broader range of possible measures that may prove helpful or appropriate for a particular aggression management course or organizational training department.

References


