


International Labour Office **ILO** International Council of Nurses **ICN**
World Health Organisation **WHO** Public Services International **PSI**

Joint Programme on
Workplace Violence in the Health Sector

Guidelines on Workplace Violence in the Health Sector

Comparison of major known national guidelines and strategies:
United Kingdom, Australia, Sweden, USA (OSHA and California)

Christiane Wiskow

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1. Introduction

Background of the study

This study has been carried out as an integral part of the research activities within the project "Workplace Violence in the Health Sector". The project has been launched jointly by International Labour Office (ILO), International Council of Nurses (ICN), World Health Organisation (WHO) and Public Services International (PSI). It aims to reduce violence in the health sector workplace and to minimize its negative impact on victims and health services.

Though health care professionals are known to be particularly at risk of exposure to workplace violence, attention is given to the phenomenon only in recent years. [1] Therefore a major element of the ILO/ICN/WHO/PSI project is to gain a better understanding of the nature and magnitude of workplace violence targeting health sector personnel. Included in the research activities are various case studies of countries of different regions of the world to obtain baseline data to fill major information gaps. Additionally three cross – cutting theme studies will compliment the results of the field work in the countries.
The project aims to develop guidelines and tools to support actions and interventions addressing workplace violence in the health sector at international, national and local level.

Objective of the study
The present study reviews and analyses major known national guidelines and strategies for prevention and management of workplace violence. The purpose is to get a detailed picture of strategies recommended, a better knowledge on existing guidance for employers and employees. Another objective is to obtain information on the implementation processes and the impact of the reviewed guidelines.
Identification of good practices as well as gaps shall serve as a basis for lessons learnt for the development of future guidance materials.

The comparison of the guidelines will cover different aspects which can be summarized as background of the guidelines, strategies which are recommended, implementation and impact of guidelines and strategies.

Methodology

The study focuses on four nations and states which are recognized as those who produced major known guidelines for prevention and management of workplace violence: USA with California, United Kingdom, Sweden and Australia. Specific guidelines for the health industry were available from USA (OSHA), California and United Kingdom. Further research was necessary to get guidelines and information from Sweden and Australia.

The study is a desk study, based on literature review including internet research. Additionally relevant institutions in the targeted countries were contacted to obtain information on unpublished guidelines and evaluation of implemented guidelines. All in all 34 contact-addresses within 27 organisations, institutions and authorities have been contacted in the four nations and states, of which 18 responded (55%). [2]

Literature and guidelines on workplace violence in general are represented in a broad range of publications. Several, parallel existing guidelines and strategies have been identified within the targeted countries.

The guidelines which are reviewed in this study have been selected under the following criteria:

1. addressing specifically workplace violence in the health sector or related industries like community services (social work)
2. published or referred to by governmental authorities on national or state level
3. addressing violence aspects in a broader organisational context (as opposed to clinical guidance for treatment of aggressive patients, which may be a part of workplace violence policies and strategies[3]).

Where specific and comprehensive guidelines for the health sector currently do not exist, available guidelines on workplace violence in general in these countries were added for comparison. These are the Swedish recommendations and the guidelines from Australian Centre Territories and from Victoria.
Following these criteria, the study includes a **sample** of 12 guidelines and strategies:

Published by:	Title	Acronym in the study text
Sweden		
Swedish National Board of Occupational Safety and Health (1993)	General Recommendations of the Swedish National Board of Occupational Safety and Health on the implementation of the provisions on measures for the prevention of violence and menaces in the working environment, including: Ordinance of the Swedish National Board of Occupational Safety and Health on Measures for the prevention of violence and menaces in the working environment	SWE Rec
United Kingdom (UK)		
Health & Safety Commission, Health Services Advisory Committee (1997)	Violence and Aggression to staff in health services – Guidance on Assessment and Management	HSC / UK
Health Education Authority (2000)	Violence and Aggression to staff in General Practice – Guidance on Assessment and Management	HEA / UK
Royal College of Nursing / NHS Executive (1998)	Safer Working in the Community: A guide for NHS managers and staff on reducing the risks from violence and aggression	RCN / UK
Department Of Health (2000)	NHS Zero Tolerance Zone Campaign	NHS ZT / UK
USA		
U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) (1998)	Guidelines for Prevention Workplace Violence for Health Care and Social Service Workers	OSHA / USA
Department of Occupational Safety and Health California (1998)	Guidelines For Security and Safety Of Health Care and Community Service Workers	CAL / OSHA
AUSTRALIA		
WorkCover NSW & Department of Community Services NSW (1996)	Preventing violence in the accommodation services of the social and community services industry	NSW / AU
WorkCover South Australia (1998)	Managing the risk of Violence at Work in aged care facilities –brochure	SA aged / AU
	Managing the risk of Violence at Work in home and community based care – brochure	SA home / AU
Australia Capital Territory (ACT) WorkCover (2000)	Guidance on Workplace Violence	ACT/ AU
Job Watch & Victorian WorkCover Authority (2000)	Workplace violence: Your rights, what to do, and where to go for help!	VIC/ AU

The documents have been reviewed using the technique of qualitative content analysis. [4]

Limitations of the study

The sample of guidelines is selective rather than exhaustive.
The same has to be considered for the sample of target countries. They all represent industrialised societies with an elaborated infrastructure in health care system. It has to be considered with caution to which extent guidelines and strategies developed in industrialised countries can be transferred to developing or transitional countries.

Brief overview on workplace violence guidance in the targeted countries

The scope of guidelines on prevention and management of workplace violence varies significantly in the targeted countries.

In **United Kingdom (UK)** National Health Service (NHS) the commitment to reducing the risk of violence for health workforce is most elaborated compared to the other countries. In addition to several guidelines published, governmental authorities and stakeholders are cooperating in the 1998 launched campaign "Zero Tolerance Zone". This is a comprehensive intervention series, not only providing multi- facetted materials and information, but stressing on cooperation with other relevant sectors as police and justice system and the unions. Within the campaign several short resource sheets are provided, which direct the user to more detailed guidelines. Included are two guidelines which appear as independent guidelines in the sample (HSC; RCN).

Because of the prevalence of the materials focusing on the health sector, general guidelines on workplace violence, such as the one developed by UNISON were not included in the guideline sample.

In **USA** violence at work is mainly addressed by the National Occupational Health and Safety Administration (OSHA), which developed specific guidelines for the Health and Community Services. Another major known governmental guideline on preventing workplace violence in the health and community services has been published by **California** Department of Occupational Safety and Health (CAL/DOSH).

In **Sweden**, an ordinance on workplace violence has been enforced in 1993. This has been accompanied by official recommendations on the implementation of the requirements set up by law. Additionally the organisation Prevent (formerly: Arbetarskyddsnämnden) produced information materials on the risk of violence, covering public service workplaces. According to information from Swedish Work Environment Authority (AV, Arbetsmiljö Verket) currently no special guidelines for the health sector have been developed.

In **Australia** various official, governmental initiatives concerning occupational violence exist, covering the Commonwealth as well as individual states and territories. Not less than 8 out of 10 states and territories have launched such initiatives and published materials and guidance for prevention and management of workplace violence[5].
Guidelines for the health sector workplaces do not exist on national level as stated by National Occupational Health and Safety Commission (NOHSC). However, a number of initiatives relating to the subject are presently taking place or have been recently completed. For example, at national level a working group, funded by the National Health and Medical Research Council (NHMRC), is developing a manual for primary health care workers in rural and remote communities (NOHSC).

At state level, New South Wales (NSW) has to be mentioned, where the Department of Health established the Taskforce on Prevention and Management of Violence in the Health Workplace in July 2001. The establishment of the Taskforce has prompted a major review of some of the key guidelines. For this reason the "Policy and Guidelines for the Minimisation

and Management of Aggression in NSW Public Health Care Establishments" (NSW Health Department, 1992) is no longer current and not available. A "Framework for the Prevention and Management of Adverse Incidents in the Health Workplace" is currently under development.

Within their initiatives and materials most of the states and territories are addressing violence covering all workplaces. However, South Australia has produced two short brochures on the risk of violence in home and community based care industry[6] and for aged care facilities[7], which were extracted from their general "Guidelines for reducing the risk of Violence at Work". [8]

It has to be pointed out that compared to the other target countries, the Australian occupational violence initiatives are focusing more often on internal workplace violence, referred to as bullying. This may indicate a greater concern about the phenomenon of co-worker initiated violence at Australian workplaces. Most of the guidelines in the other countries are focussing on violence initiated by clients or the public, which will be shown later.

2. Background of the guidelines

This section will take a close look on the context in which the guidelines have been developed (rationale) , which underlying conceptions of workplace violence are used, which sectors and target groups are covered and which objectives the guidelines pursue.

2.1. Definitions of workplace violence

The international literature describes a lack of consistency in understanding of workplace violence not only across countries but also on national and local level as well as across the various industries. More than that, the terms violence and workplace are not handled with an agreed definition [9]. RCN however argues that no single definition would be universally applicable to all workplaces and circumstances as it has to be modified when transferred from one to another sector [10].

Having traditionally given more attention to physical violence, the scope of violence addressed in recent years changed to a broader concept including to more or less extent the various forms of psychological violence.[11] This is also reflected in the scope of definitions existing. Leather emphasizes, a broad more than a restricted definition is needed to cover the full range of circumstances in which violence related to work may occur [12].

The need for definitions in general arises from the fact that interventions are only effective if they are based on a valid explanatory model of workplace violence. To define violence is a necessary first step , for "only then can incidents be recognised, reported, recorded and dealt with systematically" [13].

Most of the reviewed guidelines provide a definition of workplace violence. Those definitions are presented in the beginning of the text and indicate the underlying understanding of violence regarding the following recommendations.

In three of the guidelines no explicitly stated definition was found:

- The national USA Guideline (OSHA / **USA**)
- The Californian Guideline (**CAL**/ DOSH) ; Cal/ OSHA presents a glossary in the end of the document, explaining violence related terms as: injury, assault, threat, abusive behaviour and others.

- The **Swedish** recommendations (SWE Rec) refer , according to the underlying ordinance, to *"violence or the threat of violence"*, followed by examples of different types of violence, which will be described in the next section.

The definitions of workplace violence provided in the reviewed guidelines vary across the targeted sectors but also within those which focus on health sector workplaces. The variation consists in broadness of definitions and in clarity and explanations accompanying.

UK:

- In the guidelines published by HSC and HEA the definitions are the same and based on the definition of work-related violence by Health and Safety Executive (HSE):

  "Any incident in which a person working in the health care sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment"
- The definitions used in the RCN Community and ZT Campaign materials are adopted from the European Commission DG-V, as it is also used in the ILO/ICN/WHO/PSI project:

  "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."

  As stated in the RCN Community Guideline, this definition is similar to the above mentioned, but wider in the sense that in addition to violence initiated by clients or the public it is also included violence by co-workers and other professionals.[14]

Australia

All guidelines of the Australian sample use definitions in a broader sense, which means that psychological and physical forms of violence are covered. Differences in the wordings indicate differences in the underlying models of workplace violence. These, however only get clearer in the contextual explanations:

- NSW guidance for community services defines violence in general, not explicitly related to work. This may be due to the fact that violence against clients is included in the guideline. In difference to all other definitions, violence against property is also mentioned.
- ACT definition targets the impact of violence as criteria in a very broad sense:

  "Workplace Violence is any action or incident which causes physical or psychological harm to another person"

  As will be shown in the next section, this guideline addresses all types of aggressors which may explain the open wording.
- South Australia brochures definitions emphasize on "employee or employers" .
- Victoria guideline definition mentions as the only one of the sample "racial and sexual harassment". This guideline is focusing on bullying as type of violence.[15]

Concluding it can be noted that all definitions of the guidelines are covering the broader scope of violent behaviour, not being restricted to physical violence. Most of the definitions are focused on violence against persons in circumstances of their work, only one definition includes violence against clients and against property.

The full meaning of provided definitions can be understood only in the context of the explanations and examples given in the surrounding text. These allow an overview on the types of violence which are addressed.

2.2. Types of violence addressed

The types of violence addressed in relation to work can be categorised along three axes:

One axe describes the forms in which violence may appear. Violence in the workplace may include a wide range of behaviours, which often overlap[16]. Two major categories are those of physical and psychological violence. Under these categories the broad variety of violent behaviour can be subsumed.

As already mentioned all guidelines of the sample address physical violence as well as psychological violence.
The terms related to violence used in the guidelines are:

Terms used for **physical violence**	Terms used for **psychological violence**
▪ those incidents which cause major injury, require medical assistance, require first aid only ▪ assault, assaultive incident ▪ murder (SWE) ▪ fatalities (OSHA) ▪ physical or sexual assault ▪ attack ▪ abusive behaviour (CAL/OSHA)	▪ threat (verbal and non-verbal); threat of assaults; threat of sexual nature; threatening behaviour ▪ verbal abuse, verbal attack ▪ non-verbal abuse (stalking) ▪ bullying ▪ "ganging up" ▪ harassment (includes threatening letters, phone-calls (SWE, ACT)) ▪ health and safety hazards, including fear ▪ intimidation

On another axe, workplace violence can be separated into different types according to the aggressor and his/her relation to the affected work setting or worker. This typology has been introduced by Californian OSHA and is accepted and adopted commonly in the literature and some of the guidelines[17]. Three broad types of workplace violence have been identified:

TYPE I : The aggressor has no legitimate relationship to the workplace and the main objective is to commit a robbery (cash, drugs) or other criminal act. ("External" violence)
TYPE II : The aggressor is the recipient or the object of a service provided by the affected workplace or the victim, e. g. a client, patient. This may include also relatives or friends of the clients. ("Client initiated" violence)
TYPE III : The aggressor has an employment-related involvement in the work setting. Usually it is a another employee , a co-worker, a supervisor, a boss , a student ("internal" violence).

It is recognised by some authors that each of these types of violence need a specific response.[18] UNISON for example exclude co-worker violence in their workplace violence definition, because they believe it is crucial to separate violence between staff from violence to staff as the organisational responses required to deal with them vary markedly.[19] According to this policy, UNISON produces separate guidance for bullying and harassment.[20]

Though only one of the guidelines (RCN/UK) refers explicitly to this typology of workplace violence, the different types of violence addressed in the other guidelines can also be classified within this scheme.

Using this typology, differences between the guidelines of the sample have to be stated. For comparison, the sample is differentiated into Health and community sector related guidelines and general guidelines covering all workplaces:

Regarding the health and community services related guidelines, all of them focus on client initiated aggression. It is clearly the priority subject, followed by violence of type I, committed by members of the public. Whereas seven guidelines include explicitly or implicitly type I violence, two guidelines (OSHA/ USA, NSW / AU) exclusively address client initiated violence.
Only the RCN guideline addresses all three types of violence clearly, which means that internal workplace violence is included. Within the Zero- tolerance campaign materials, client

and public initiated violence are emphasized. Though the broader definition is used which may include co-worker violence, as mentioned above, in the text and the examples of good practices only violence of type I and II are addressed.

Of the three general guidelines, the Swedish recommendations focus on violence from the public and client aggression. Type I is more described compared to the health sector guidelines as workplaces handling with goods (banks, retail industry) are included.
The ACT/AU guideline represents the broadest approach, covering explicitly all types of violence.
An exception is the Victorian /AU guideline, as it addresses internal workplace violence exclusively.

RCN uses an additional type of categorization: the authors differentiate between instrumental and emotional violence, which is comparable to intentional and unintentional modes of violence. Instrumental violence is calculated to achieve a certain aim, as most often involved in type I violence. Emotional violence often arises out of interpersonal interaction, which may be influenced by the social settings and physical environment [21].

Looking at the definitions provided in the guidelines, none of them separate explicitly between intentional and non-intentional violence. This may be due to the fact that most of the sectors covered by the guidelines, such as health sector and community services are subject to a variety of different modes of violence, be it intentional or unintentional.[22] Care workers have to face situations and clients characterized by distress and tension on a daily basis. In these situations not all violence may be used intentionally to harm a person (e.g. by cognitively or behaviourally disturbed persons or in emergency situations), but nevertheless means a risk to the involved persons.

Two other guidelines, besides the one of RCN/ UK, mention this differentiation of violent behaviour explicitly. The Swedish recommendations especially name health and social welfare workplaces as settings where “unprovoked and sometimes quite unintentional” violence and threats may occur[23]. ACT / AU guideline explains in the case of harassment the possibility of “lack of awareness and understanding of various cultural, religious or other factors affecting an individual or a group” as opposed to being intentional.[24]

2.3. Rationale

The reasons why the guidelines have been developed are very similar within the sample. Two common major concerns can be remarked in the explanations:

- Increasing numbers of workplace violence incidents

The guidelines summarize evidence and conclusions from studies either on national or on international level.[25] Rising awareness on the severity of the problem is addressed as a consequence of increasing numbers of violence related injuries stress or trauma disorders. It is also mentioned that the problem is not new but has been ignored or neglected in the past. In most of the guidelines the high risk rate of health and community service sectors are mentioned, even if they do not focus on these sectors[26].
For the USA the reasons for the increasing violence is especially related to the high prevalence rate of handguns and other weapons in public. The other reason addressed is the change of care patterns for the mentally ill, emphasizing on community based care rather than on in-house treatment and leaving.

- negative impact of workplace violence: organisational and human costs

Most of the guidelines (except for one: Victorian) address costs as major negative impact of workplace violence. This is done under various aspects. Most commonly mentioned are organisational financial costs in terms of lost productivity, sickness absence, lost efficiency as direct costs. Indirect financial costs are addressed in some of the guidelines

in terms of loss of expertise, education costs and management time that investigation may include. In some guidelines qualitative aspects of organisational costs are mentioned such as effects on standards of care, damage to the confidence and morale of staff, bad image as employer (HSC/UK).
Human costs are described as impact on safety and welfare of staff and patients or as the personal costs of emotional trauma suffered by the victims and their families.

In addition, two of the publishing organisations state a mission which may be a part of the underlying rationale:

CAL / OSHA "recognizes its obligation to develop standards and guidelines to provide safe workplaces for health care and community service workers" (p.5)

The NHS/ Zero Tolerance Campaign / UK states: "The Government is determined to ensure that staff who spend their lives caring for others are not rewarded with intimidation and violence." [27]

The rising awareness of the problem may have led to an effect that the edge of tolerance is reached, as shown by the name of the UK NHS campaign as well as a note in CAL / OSHA: "Increasing numbers of health care and community workers, as well as OSHA Professionals have come to the conclusion that injuries related to workplace violence should no longer be tolerated".[28]

Few of the guidelines explicitly address as a rationale the fact that with anti-violence interventions costs can be saved and human suffering can be reduced.

2.4. Objectives

Majority of the sampled guidelines state to provide assistance on how to manage workplace violence. This assistance is emphasizing on employers and managers in eight of the guidelines, in four guidelines workers are also included in the assistance. The Victorian guideline provides information and advice on how to deal with workplace violence for employees.
In general the guidelines aim at giving information and practical help on how to develop and implement measures or policies to manage workplace violence according to the different approaches suggested. The South Australian brochures are more restricted, providing "information on risk factors of client aggression and opportunistic violence"[29]

The overall goal – if stated explicitly or being interpreted implicitly – is to reduce workplace violence in number and severity or, in other words, to provide a safe workplace and protect staff. As already mentioned, the NSW guideline includes protection of clients and property against violence.

Few of the sample differentiate clearly between long term and short term goals of their guidelines. The following examples have to be highlighted:

- Zero Tolerance Campaign/ UK is the only one which declares clear quantified goals within a timeframe:
  "In September 1998, Frank Dobson set the NHS a national target for reducing the incidence of violence against NHS staff by 20 per cent by 2001 and 30 per cent by 2003. By April 2000 , NHS Trusts are also required to have systems in place to record incidents of violence against staff and have published strategies in place to achieve a reduction of such incidents. "[30]
- OSHA / USA explains the guideline to be only a first step in accomplishing the goal to eliminate or reduce workplace violence:

"OSHA plans to conduct a coordinated effort consisting of research, information, training, cooperative programs and appropriate enforcement to accomplish this goal".[31]

- CAL/OSHA aims by developing their guidelines to motivate other states to follow: *"We anticipate more states and Federal OSHA will eventually follow suite."*[32]

The majority of the guidelines focus on the measures to develop in the direct context of the targeted workplaces with managers and employees as target groups.
It is only NHS Zero Tolerance campaign which clearly includes in their goals to address the attitude of public and staff:
"The NHS zero Tolerance zone campaign has two principle aims:

- *to get over to the public that violence against staff working in the NHS is unacceptable and the Government (and the NSH) is determined to stamp it out; and*
- *to get over to all staff that violence and intimidation is unacceptable and is being tackled"* [33]

2.5. Legal status

All guidelines are voluntary as stated explicitly in some of them. All are related to the Occupational Safety and Health legislation and provide relevant passages of them . All address the mandatory responsibilities and employers' general duties of care, but the guidelines are "advisory in nature"[34].
The Swedish guideline relates recommendations directly to the sections of the ordinance: the ordinance on workplace violence is disseminated together with the recommendations on the implementation of the provisions on measures for the prevention of violence incidents. Guidance is given to each section of the ordinance.

2.6. Responsible Stakeholders

On a first glance the question who is responsible for implementation of workplace violence reducing measures seems to be answered easily:
All guidelines refer to the relevant legislation on occupational safety and health and stress that responsibility for a safe workplace is **employer's** duty which includes the protection from violence hazards.

However differentiations are made within some guidelines which identify additional stakeholders with duties:
Not only employers or organisations are responsible, but also line **managers** supervising workplaces or , in other words, "persons in control of a workplace"[35].
Five of the publications include employees' duties as an additional aspect of responsibility. This covers the duty of care for their own health and safety and cooperation with the employer. One example:

"The NSW OHS Act 1983 requires (...):

- *Employees to take reasonable care of the health and safety of others and to cooperate with employers in their efforts to comply with occupational health and safety requirements"*[36]

RCN / UK proposes a systemic approach, mentioning not only employers and employees as responsible persons, but identifying responsibilities within the different system levels: **organisation** (management/ policies), **work team** and **individual**.

Some of the publications mention within employers' duties to consult with occupational health and safety representatives.

2.7. Target population and sectors covered by the selected guidelines

Half of the sample of guidelines is specialised on the health sector. Within these six, three are concerned with primary health care sector, including community based and home care, and one with aged care.

Health sector in general are addressed by two strategies:

- HSC/UK, which covers NHS and private healthcare providers and contractors in the health service. All work settings are covered: hospital, primary and community care, nursing homes, mental health and ambulance services. The target population mentioned is all people at work, including the self-employed and contractors, students, volunteers.
- NHS ZT /UK is concerned with all NHS staff in all NHS services

Three publications specifically address primary health care and community based care:

- RCN /UK targets NHS employees who are based in the community. Included are also staff who are based in hospitals but make visits into the community and ambulance staff. It is stated that independent contractors such as general practitioners (GP) are not specifically included.
- HEA / UK is focusing on primary care and covers employers and all those working in primary care such as general practices. HEA/ UK has been adapted from the HSC publication with changes addressing the specific needs of general practices.
- SA home / AU is a brochure designed for organisations involved in home and community based care. It has been extracted from current general workplace violence guidelines in South Australia as a specialised industry service.

SA aged / AU is also an extract of the general South Australian workplace violence guidelines, but specifically addresses the risks at aged care facilities.

The two American guidelines address health and community services together.

- OSHA / USA target population are health care and social service employers and providers in all work-settings. The guidelines cover a broad spectrum of workers, including qualified professionals as well as less qualified and ancillary personnel (maintenance, clerical, security).
- CAL / USA does not specify, but covers workers in health care and community service organisations in general.

NSW / AU guideline is focusing on community based accommodation and related services. It is designed for managers, supervisors and management committees, but target on all workers in the services.

Three guidelines (Swedish Recommendations, ACT / AU and Victoria/AU) cover all workplaces in general. Health and social services are included but not specifically addressed.

2.8. Tools provided

The scope and richness of tools provided for the users of the guidelines vary in number and quality.

Examples of **good practices**, or **case studies**, within this study are defined as tools, because they provide very practical examples of how different problems may be solved.

Very strong under this aspect are the materials of NHS ZT / UK. Within the first package of resource sheets one exclusively looks at case studies and good practices, the recently published updates also include further case studies. This collection of examples from the practice cover a broad scope of problems regarding workplace violence (from policy development over risk assessment to traceability of workers away from base and victim support) and how they have been tackled locally. The first case studies are presented in a structured way (risks, reducing risks, outcomes), which allows a good overview on the processes and benefits of actions taken. The second package of case studies provides contact addresses for each of the presented cases, which allows a direct communication of interested users.

Short case studies are also presented within the RCN /UK guideline, where they are included into the text directly.

Direct technical tools most often provided (6 guidelines) are workplace violence **checklists** to identify risks and to review safety procedures. HSC and HEA UK present not only the most common checklist for managers but also lists for staff going on home visits

Another category are **samples of forms**:

- risk assessment forms designed for workplaces with examples how to fill them in (ACT and NSW/AU)
- incident report forms (OSHA)
- Workplace Violence Prevention Policy (NSW)

Another tool is the presentation of the relevant **legislation**. Nearly all guidelines have included – either as Annex or within the text - relevant paragraphs of all relevant Acts concerning Occupational health and safety, some of them summarized and commented.

A common tool is the listing of useful **contact addresses**, covering all aspects of stakeholders: organisations for victim support, all relevant authorities, professional associations and unions, employer organisations, crime and justice services. Again NHS ZT provides a most comprehensive list regarding the scope of institutions, in addition a list of useful websites is presented.

The most comprehensive set of tools is provided by OSHA / USA. Indeed the Annexes are exceeding the guideline-text threefold.
The tools include:

- SHARP staff Assault Study (questionnaire for staff survey) (7 pp)
- Workplace Violence Checklist (employers)
- Assaulted and/or Battered Employee Policy
- Violence Incident Report Forms (2 Samples)
- Sources of OSHA Assistance
- Addresses: States with Approved Plans, OSHA Consultation Project Directory, all OSHA regional and Area Offices
- Suggested readings

A list of **suggested readings** is included in most of the guidelines.

Three guidelines present **models** or charts as a tool:
HSC/ UK and RCN /UK provide comprehensive explanatory models of a violent incident. The model presented by HSC illustrates factors relevant to violent incidents in the health services[37]. The model RCN refers to is emphasizing on the interactional process in the context of an incident. Both models are meant as a tool to help assessing risks.

NSW / AU presents an incidence response chart, which illustrates the immediate and further response processes regarding major and minor incidents.[38]

3. Strategies recommended

To tackle the complex problem of workplace violence, in the literature it is recommended to use a comprehensive multi- dimensional approach with a mix of risk control measures. It is meanwhile recognised that workplace violence arises from multi-factorial causes, not only determined by individual factors of offender and victim, but rather by situational , organisational, interactional and even structural respectively societal factors.[39]
Widely accepted as the most appropriate strategy is the risk-management approach, which consists in risk assessment, risk control measures and review of the strategies.

In all sampled guidelines, the recommended measures represent a multi-dimensional approach with a mix of components. All refer to the risk management approach in general. They can be described as problem-solving strategies, recommending a process cycle in more or less the same phases: identify the problem, assess the risks, reduce the risks and review the effectiveness of what has been done.

There are different ways of categorizing the strategies recommended:
Most common is the differentiation into pro-active and re-active interventions, and accordingly preventive and post-incident measures are described.
Another categorisation used separates into three approaches[40] :

- prevention approach, which aims to reduce the risk of violence
- protection approach, which deals with appropriate behaviour and procedures in handling a violent incident while it occurs
- treatment approach, or post-incident response which aims to reduce the negative impact of violence

According to Wynne et al[41], in many guidelines the balance between security, treatment, protective and preventive measures is often confused.

In this section, the different measures being recommended by the sampled guidelines are compared along the categorisation of preventive, protective and post-incident measures. It will also have a look at what kind of measures are recommended regarding the different types of violence.

3.1. Strategies according to types of violence

It has already been mentioned earlier (see chapter 2.2 Types of violence) that some authors stress the need to design anti-violence actions according to the type of violence because of the probable differences in risk factors, even if they may often overlap. Within the health sector, prevention measures are proposed to be separated into

- those recommended for patient or outside initiated violence (Type II and I) and
- those recommended in the case of co-worker violence (Type III) [42]

Within the sample majority of the guidelines focus on violence initiated by clients (Type II), with most of them including violence of external intruders (Type I). Only two guidelines clearly cover all three types of violence , and one exclusively addresses internal workplace violence (Type III).
This is reflected well in the scope of measures presented in the sample: the mass of the measures is addressing the risk of violence initiated by clients and the public, which will be described later in detail.

Two guidelines address internal workplace violence. However the attention given to violence initiated by co-workers is relatively neglected in terms of details and volume. But at least the

existence and some of the risk factors are mentioned and few general measures recommended.

RCN / UK addresses internal workplace violence on organisational and on work team level, stating that organisation has to be alert for any tensions between members of staff and must not tolerate any bullying or harassment. As a measure it is recommended to provide more than one communication channel for support or complaint.[43]

ACT/AU goes one step further , recommending as one of the key-principles of prevention measures to establish clear policies on co-worker violence :

> *" Workplace policies should make it clear that management will not tolerate any activity deliberately designed to humiliate, degrade or embarrass other workers. These policies should cover activities such as harassment, initiation ceremonies and practical jokes, which can cause physical injury as well as psychological harm." [44]*

Additionally the legal responsibilities of both, management and workers, in these situations are mentioned.
Co-worker violence is also addressed within the needs for training. Training of staff regarding the need for tolerance of others (cultural differences) and the development of good communication between workers are recommended as a means to promote a positive working environment. A good work climate is known as a prevention and reduction factor to co-worker violence.[45]

The Victorian guideline, written exclusively on co-worker violence, is an exception in the regard of the target group which has consequences on the measures proposed: as it addresses employees, the measures recommended are not that complex organisation-wide as the other ones. It rather gives very detailed information on the different forms of co-worker violence, how they may appear and what the legal judgements are in Victorian law. Further the employee is given advice what to do and whom to contact in the case of this form of violence. This means the Victorian guideline is focused on information and on advice related to post-incident measures to take by the victim or a witness.

3.2. Preventive measures

All guidelines (except for the Victorian example) stress the importance of prevention. This emphasis is visible in the volume given to preventive measures. The description of preventive action can be seen as the heart of all guidelines. Prevention is prioritised over post-incidence amelioration.
Two phases of prevention strategies are separated in this section, as they have been identified in most of the guidelines:
Risk assessment and risk control or risk reduction measures.

3.2.1. Risk assessment

With the exception of three guidelines[46] all declare the assessment of risks as the basis for the development of effective prevention measures. The methodology of risk assessment proposed is quite similar, differences are observed in the theoretical presentation: identification focused on risk factors or on a step-by-step process. There is a variety of assessment steps, between 2 and 5, but three main steps of assessment can be defined: the problem or hazard identification, the risk assessment and the evaluation of existing precautions.

For the identification of hazards different sources of information are considered: various records (incident, accident records, e.g.), discussions with employees, discussions with similar organisations, for example. Most of guidelines focus on environmental factors and work procedures to assess, but some , as HSC and HEA / UK , address also vulnerability of

staff groups according to qualification and task. OSHA /USA include situations and conditions in their "security analysis".

Only OSHA and CAL are referring to the instrument of staff survey for a risk assessment. They recommend to conduct surveys on a regular basis, at least yearly or when changes in operations have been made.

Those which differentiate between identification and assessment of risks, refer to assessment as the analysis of identified risks regarding their frequency or likelihood and the potential severety of consequences. The USA guidelines and NSW/ AU recommend to monitor the trends by analysing incidents using several years of data [47]

Some of the guidelines propose to analyse the effectiveness of existing safety precautions as a necessary part of the assessment.

Tools , such as checklists for worksite analysis, are provided in some of the guidelines.

The assessment has to result in action program, as formulated in Swedish recommendations. The guidelines agree on the fact that prevention measures have to be designed according to the results of the risk assessment.

3.2.2. Risk control measures

The recommended measures for controlling risks are in a broad sense similar in all of the guidelines. Those measures presented by all of the guidelines can be grouped into main areas considered:

- Physical environment of work- site , including security equipment
- Work – practices
- Training
- Staffing

According to Mayhew and Chappell [48] the occupational health and safety (OHS) preventive approach is based on a hierarchy of preferred actions. The preferred option is elimination of hazards through re-design of the work site. This should be complimented with a change of work processes to less hazardous options. Installing barriers and administrative controls such as training and warning signs are lowest on the list of priorities. The authors recommend to keep this prioritisation in mind with the planning of interventions. They further point out that there are many similarities between the OHS hierarchy approach and a body of knowledge developed by criminologists, known as "crime prevention through environmental design" (CPTED). This approach includes strategies as "target hardening" consisting in measures to make violence more difficult to execute, "improved surveillance" which allows a better identification of perpetrators and better control of valuables and drugs. The underlying assumption of CPTED is that "opportunities to commit violence can be reduced, and the 'costs' of violence to the perpetrator can be increased to the point where they exceed any possible 'benefits'".[49] According to Hoel et al CPTED technique has shown effectiveness especially in retail industry in reduction of robberies.[50] Regarding the health sector this would correspond to risks of violence committed by public (type I).

ACT/ AU guideline refers to a hierarchy of control measures which differs from the described one. The control measures are prioritised according to the effectiveness of eliminating the hazard. *"The best way to control a hazard is to remove it. If this is not practicable, the risk should be reduced as much as possible (...)."*[51] Control approaches are presented within a list which rates measures near to the top as more effective than those at the bottom. Control measures near the bottom of the hierarchy are more difficult to maintain , and should be regarded only as interim measures. A combination of different actions may be required to reduce the risk to an acceptable level.

The hierarchy list includes following approaches:

(a) Eliminate the hazard: Always try to get rid of the hazard completely
(b) Use a safer alternative: Try to replace the work process with something less hazardous.
(c) Use engineering solutions: Where appropriate, make changes to the workplace or to equipment to reduce the risk of injury or harm
(d) Reorganise work and provide training: Make changes to the way work is organised to reduce the risk of injury or harm
(e) Provide personal protection : personal protective equipment should not be the only control, as it is the least effective way of dealing with hazards.

Each level of hierarchy is explained with examples in the following text of the guideline. It has to be considered that ACT/ AU is a guidelines covering all work places. If the proposed hierarchy of measures is applicable to health industries, especially mobile services, has to be discussed further.

In the majority of sampled guidelines no prioritisation of control measures is indicated. All refer to the process of risk assessment as the determinant of priority setting. Taking sequence, volume and scope of details described as an indicator for priorities of the guidelines, however, differences in priority setting may be described, as for example changes in physical environment mostly are listed first, followed by work practices. In this sense most of guidelines seem to follow a hierarchy of measures as described by Mayhew and Chappell.

Physical environment

Much attention is given to physical aspects as **layout and design of premises**. These are described as influencing the occurrence of aggression and violence by the atmosphere created. The purpose is to create an environment that does not trigger or exacerbate a stressful situation. [52]

General aspects considered are design of building regarding positioning of departments and entrances to control public access, lighting, decoration and furniture. NHS ZT / UK points out that buildings and areas should always be kept clean and hospitable. In criminology sciences the image of a “well-cared-for” building is known as a factor to reduce aggressive or criminal acts.[53]

The removal of hazardous furniture or instruments which could be used as weapons is proposed in most of the guidelines. Good lighting inside and outside is mentioned as an important factor for risk reduction.

Special attention is given in some guidelines to reception and waiting areas, as the first and main interface of public and health workforce. HSC/ UK, for example, describes this area most detailed on two pages. Aspects considered are the provision of enough space to avoid overcrowding, accommodation of patients with sufficient and comfortable seats and provision of facilities like pay-telephones. The reduction of boredom and anxiety can be achieved by up-to-date reading materials or play opportunities for children. Two guidelines even propose TV or radio in waiting areas, but this may – to the researchers opinion – on the other hand create tension because of irritating noise. Noise reduction is also an issue to consider which can be achieved, e.g. by positioning of waiting areas (not on thoroughfares) or by noise absorbing surfaces and materials.

A very important aspect is addressed with facilitation of information between patients and staff: an easily identifiable reception desk and clear signs for direction of patients as well as visual displays to inform on waiting times help to avoid irritation and impatience.[54]

As **security measures** most of the guidelines propose secure lockable doors for restricted areas, some add CCTV (Closed Circuit Television) surveillance, which is known to demotivate criminal or unsocial behaviour. The use of CCTV should be clearly indicated in the premises. Several Alarm systems are discussed, such as stationary or mobile alarms, panic buttons, silent phones, advantages and disadvantages of audible and visual alarms,

those being linked with police or other organisations to summon help or those just to surprise the offender.
Very strong appear the security measures described in the two US guidelines. OSHA and CAL/ OSHA separate their violence control measures into engineering controls, administrative controls, including working practices. Under engineering controls not only the general aspects are listed as in most of the guidelines, but also extra-ordinary security measures such as bullet-resistant glass for reception areas where appropriate, security guards, metal detection at entrances and even armed guards in high volume emergency rooms. These measures may be relevant in the USA considering the high level of violence in the society and the high prevalence rate of guns and handguns due to the different gun laws. In guidelines of other regions such as Europe recommendations for security measures appear more moderate at present.

Physical changes of environment however are more relevant to stationary services as hospitals, small clinics, practices. Those institutions providing outreach services, such as home and community based care and ambulances, have to focus on administrative measures and work procedures when designing risk control interventions. This is reflected in the RCN/ UK guidelines for community based care, where a broad range of suggestions regarding work practices are listed whereas technical aspects are only few, such as personal security equipment and the safety aspects of vehicles to be considered.

Work practices
Broad commonalities exist across the guidelines regarding the suggestions of working practices to control the risks of violence initiated from patients or clients and public. In general the suggestions concern general daily work practices on one hand and procedures for a potential violent incident on the other hand.

Written work procedures for daily work, such as patient and treatment protocols are recommended by two guidelines (HSC / UK and CAL/ OSHA), ACT/ AU recommends written work procedures for special tasks. Most often addressed is the issue of information and communication. Sufficient and up-to-date **information on clients** is the first concern in order to be aware of potential risks. This information should include previous history of aggressive behaviour and violent episodes. Regarding outreach services additional information on family or other bystanders and location of home is mentioned to be useful. The flow of information should be ensured between all relevant colleagues and departments and it should be available and accessible at all times including out of hours. New colleagues and temporary staff should be instructed carefully. RCN/ UK and OSHA/ USA recommend to install a system within the client records to mark risk patients (flagging system). Some guidelines point out the importance to collect patient data and give information to staff (to staff? To patients?) with respect to confidentiality of data.

A minority of guidelines (4) address the necessity to provide **information for clients:** Information on the service and what they have to expect , about the role and task of staff member, and about their rights in cases of complaints. Further it is recommended to inform patients and customers about delays, to reduce impatience and irritation. For this especially the community services should be equipped with adequate communication means (mobiles, e.g.).

Regarding **outreach services,** some special practices are described. The most detailed list of useful practices for safer work in the community is provided by RCN/UK. Here, and in other guidelines addressing this work setting, communication is crucial for risk control. Procedures which ensure the **traceability** of workers away from base have to be agreed on. This includes detailed check out and check in procedures with agreed times to report back, also after hours. For services which cannot ensure out of hours back up the use of hospital services or other local services for check procedures is recommended. It is pointed out that all failures of checks have to be followed up within an agreed time frame.

Health workers going on visits should assess the risk of violent situations every time (RCN / UK , CAL/ OSHA). At an initial visit, a risk assessment on client and locality has to be routine and this information should be made available to all relevant colleagues. If no information is available it is recommended to arrange the initial contact at a clinic or other facility instead of going to the home of the client.
If a potential risk cannot be avoided, some common measures for preparation are suggested: so called **emergency procedures** should be agreed on and all personnel should be aware of and comply with them. Some guidelines recommend to cooperate with local police in the development of such procedures, to ensure the compatibility with police procedures. The roles of everyone, staff and management, in case of an incident have to be clear. This is most crucial as workers have to be confident that in case of emergency help will be organised. RCN/ UK additionally mentions that roles have to be clarified also between the different agencies.
Assistance should be available at all times which includes access to senior staff and management.
A common practice recommended is the agreement of **emergency codes**, which allow staff in a critical situation to summon help without alerting the potential assailant and not being forced to explain the circumstances.

Staffing is an issue commonly addressed in the guidelines. Especially in cases of potential violent incidents adequate staffing patterns are necessary, not only in terms of quantity but also in terms of qualification. Only experienced staff should conduct a contact with a patient in situations where a potential risk for aggression has to be considered. In this sense a good match between staff competencies and client need is required. New or inexperienced workers should be paired with more established staff members.
Most common is the recommendation to **avoid working alone** or isolated. Wherever a potential risk is expected, working in pairs should be made possible. Some guidelines also recommend escort services such as drivers or colleagues who wait outside in the car when a visit with two persons is not appropriate but the worker does not feel safe alone. A so – called buddy system, where colleagues are assigned to each other is recommended in several guidelines. Where solitary work is unavoidable, an effective communication system should be in place or – in stationary institutions- surveillance of the situation should be possible.

Sufficient staffing levels are not only recommended to cope with risky situations. Several guidelines point out that a good staff-patient ratio helps to reduce the risk of violence by lowering work stress. Continuous stressful work situations may not only result in short tempers and frayed nerves, but mostly in fatigue. Both can contribute to the inability to deal with a violent situation.[55] Job rotation may be a means to reduce time in stressful working situations as recommended by ACT/ AU but also flexibilisation of working times to cover peak times sufficiently. These means however require agreement by workers to be efficient interventions for stress reduction.

Training

A key measure to prevent and control violence is training of staff. According to HSC/UK, training can contribute to the reduction of frequency and seriousness of incidents their impact and improves the response to incidents and morale of staff in general [56]. Adequate and regular training of staff is addressed in all guidelines, with more or less details. A good summary of all aspects of training is provided by HSC / UK, covering the broad consensus of training requirements in all guidelines:[57]
Participants of such training are not only all staff members who may be at risk, but also superiors and managers to ensure continuity. Additionally management may need training in management of violent incidents and support measures for victims.

Typically a training program covers

- Theory , to understand aggression and violence at work
- Prevention , how to assess and take precautions

- Interaction, to enable staff to deal with aggressive persons
- Post-incident action, as reporting, investigation , counselling and follow-up

Training should be provided according to the risk assessment for different levels of risks. This covers basic training on procedures, recognition of warning signs, interactional skills, etc. Staff groups working in areas with higher rates of potential violence need additional training in defusing and de-escalation methods and breakaway-techniques. Courses on control and restraint, as well as physical self-defence training should be provided most specifically to those staff working in high risk areas.

A few guidelines explicitly point out the importance of appropriate professional competencies of trainer or training institutes. Training should be up-to-date, relevant, purposeful, backed by evidence, given by experts and include scope for feedback. [58]
OSHA / USA and CAL/OSHA are giving recommendations regarding time frames: training should be provided annually. For large institutions refresher programs are suggested to be offered quarterly or monthly to effectively reach all employees.[59]

Special recommendations
In addition to these commonly described control measures, some guidelines address aspects, which are relevant for risk reduction process but are not considered in the majority of guidelines.

RCN/UK and NHS ZT/ UK state the importance of a good relationship between the health services and the community in which they provide their services. This may be related to the fact that this guideline specially is concerned with community based services as opposed to hospitals which may consider less interdependency with the surrounding community. However the view on the wider system in which a health service works, should be relevant to all kinds of health care establishments.
"The trust is by no means an isolated sub-system but is an integral part of the community which it serves, and its overall policies and procedures determine what happens at the interface between health care staff and patients. It is important for the trust as a whole to forge good working relationships with the community and to use such relationships to minimise the risks to health care staff." [60]

The aspect of client orientation is explicitly addressed only in NSW/AU guideline. Remarks on general daily staff behaviour and attitudes towards clients , which is a major influencing factor on potential emerging of risks, were only found in three of the guidelines. An explanation why this important aspect is missing in the majority of the sample may arise from the fact that health professionals in general have ethical standards and codes of conducts as a basis, so addressing this aspect may be felt to be unnecessary. Nevertheless it remains an important influencing factor in daily work which can reduce aggression and thus violent incidents.

> *"(...) the quality of service given to the client may contribute to violent behaviour. A lack of sensitivity and an indifference to clients by staff can develop over time (...). Poor service can be due to poor training and communication skills and irritability from overwork and overtaxed facilities (...)."* [61]
>
> *"I firmly believe that people learn by example, that if you speak to people properly and treat them with respect, then you are a lot of the way down the road to stopping violence and aggression. (...) It's a culture of reacting to aggression rather than being proactive, putting too much emphasis upon control and restraint training and panic buttons and not enough upon getting and retaining good quality staff, in treating people with respect(...)."* [62]

Staff behaviour is addressed indirectly however in most of guidelines in the context of dealing with an incident mostly under the subject of training.

In addition, appropriate, comfortable clothing for field workers and the discouragement to wear jewellery is mentioned in three guidelines.

The Swedish recommendations name comradeship and social support as a means to cope with stressful work , especially in service oriented workplaces. The regular supervision and advice on cases in meetings is recommended in three guidelines (SWE, CAL , OSHA). RCN / UK suggests regular discussion of work practices with occupational health and safety representatives on work team level.

A publication of a clear organisation's statement about the right of staff to be treated with respect and that violent behaviour will not be tolerated is recommended by RCN / UK and OSHA/ USA. NHS Zero tolerance zone campaign has not only chosen this as its name (the name is the program), but is the only to state repeatedly that violence to staff is a crime.

3.3. Protective measures

The attention given to measures which describe what to do while an incident occurs is, compared to preventive measures, relatively small. This is astonishing but may be related to the fact that most of the guidelines are targeted on managers and organisational level as users. On the other hand it indicates that priority is given to preventive strategies.

Where protective measures are described they refer to the suggested emergency procedures which should be applied:
Communication among staff is mentioned as crucial, the use of coded requests for help, assistance by senior staff and managers, follow up of failed checking procedures, as described earlier.
Practical tips to the individual, how to behave, what to do when an incident occurs, are only found in two of the guidelines. RCN/ UK opens this section with the request to staff to put their own safety first and to leave a situation which is perceived as dangerous. To recognise own limits to deal with the situation is mentioned as important. Some options how to handle an aggressive person are given and the advice to avoid physical contact where ever possible.
The most detailed section with practical recommendations how to behave during violent incidents is provided by NSW/AU. It begins with examples of verbal and non-verbal signs of potential for violence, such as raised voice or agitated movements. This is followed by suggestions regarding different types of violence. The recommendations cover physical violence, armed hold-up procedures, verbal threats and procedures to follow in case of phone-threats including bomb threat.

Most guidelines however subsume the requirement of staff who is capable to recognise signs of potential violence under the subject of training.

3.4. Post-incident measures

Post – incident response and evaluation are essential to an effective violence prevention program. [63] One reason is given within the model of violent incident in the RCN / UK guideline: experiences with violent incidences will shape future attitudes and behaviour and increase the likelihood of future violence.[64] Post-incident responses aim to reduce the negative effects of incidents on victims, other persons involved and the workplace. ACT / AU, for example, differentiates into immediate responses, which focus on victim assistance and safety procedures, followed by the recovery phase, which covers the reorganisation of the workplace to normal operations.

The importance given to this element of violence intervention appears to be more than the protection measures in the sampled guidelines. Again there are more commonalities than

differences in the approaches. Generally the suggested post-incident responses cover following aspects:

- Assistance and support for victims

Main concern within most of the guidelines is the immediate support for the victims. The measures vary according to the kind of incident. Medical treatment and psychological support are mentioned most often. There are several types of assistance that can be incorporated into the post-incident response. OSHA / USA mentions for example trauma-crisis counselling, critical incident stress debriefing. Crucial is the professional competence of assistance providers. Time frames are not explicitly named, but some guidelines mention that immediate response has to be followed by more attention at a later point of time to ensure complete recovery of employee and avoid longterm consequences. A very detailed model of response procedures , differentiated into major and minor incidents, with a firm time frame is provided by NSW/ AU. The model is presented as a chart which is a useful tool for implementation.
Some guidelines include the need of care for the families of victims in case of major incidents as well as the responsibility of management to protect victims from media.
Regarding internal workplace violence RCN / UK recommends to offer several communication channels. It should be possible for victims to get access to support without reporting to their superiors.

- Information and communication at the workplace

In order to reduce long-term problems at workplace some guidelines, such as ACT/ AU recommend to provide all staff with information on the incident. Swedish recommendations argue that information for all employees avoids rumouring and anxiety. A joint debriefing shortly after incident should be considered.

- Reporting procedures

The reporting of incidents is addressed as an important part of intervention. NHS ZT/ UK recommends to establish a robust and uncomplicated reporting system in order to encourage staff to report details of all incidents, including verbal abuse. Such a system should be easy to use and not too time consuming. Most of the guidelines stress on legal responsibilities , either of employer or of employee, to report at least major violent incidents. This is in most cases restricted to incidents causing injuries, but some include also minor incidents. NHS ZT / UK states that all incidents have to be reported and managers are requested to provide support. CAL/ OSHA recommend to record incidents of verbal abuse and threats and evaluate the record on a monthly basis by department safety committee.
Reporting systems should be user friendly: easy to understand, not too time consuming and accessible.[65] The implementation of less formal ways to report less serious incidents could help to overcome the problem of underreporting. This should be complimented by the clear encouragement and support of management to report every incident.

The Victorian guideline addresses employees with recommendations what to do in case of internal workplace violent incidents. The advice is categorised according to the kind of violence. They are written in form of memory aids (mnemonic). For example the advices what to do in case of verbal abuse:
"Remember, always tell the employer what happened! Also:

1. *Keep a diary about the abuse, be specific about what was said and who said it and keep any evidence like notes, pictures and hard copies of emails.*
2. *Get advice from Job Watch, your union or a solicitor.*
3. *If nothing is done after you have told the employer, supervisor or manager about the verbal abuse, write a memo to the employer outlining what is going on and asking them to do something about it.*

Note: all contact numbers are at the back of this guide." [66]

- Evaluation of incident , review of interventions

The reports on incidents are crucial for the evaluation of the event. Record keeping is according to CAL/ OSHA the heart of the program, as it provides information for analysis, evaluation of methods of control, severity determinations, identifying training needs and overall program evaluation. [67]
Some guidelines include recommendations which specify minimum information required for reporting incidents:

- details of victim and perpetrator,
- location, date, time of incident
- circumstances of incident
- details of outcome (injuries, time off, etc)
- information about action taken

Investigation of incidents are recommended in most guidelines, some requiring action in the sense of improvement of control measures to reduce reoccurrence.

3.5. Assessment of the recommended strategies

Time frame
Very few of the guidelines give time frame suggestions with their recommendations. Mainly the USA guidelines mention time frames, for example with risk assessment to be conducted annually or record systems to be evaluated on a monthly base. One exception is also the post-incidence response model presented by NSW/ AU, describing procedures to be carried out within 1 hour, 24 hours and 36 hours following an incident [68]. Most of guidelines, if at all, use general formulation such as “regularly” when addressing time aspects.

The relevance of the recommended strategies has to be seen in the context for which the respective guidance has been developed. The variety of work settings being addressed by the guidelines, inside and outside the health sector, requires differentiation of the strategies. This is obvious for example in the question of environmental changes, which may be relevant for stationary institutions but less relevant for community based services. Few of the guidelines, like CAL/ OSHA and HSC/ UK include separate sections for different work settings, which would increase the relevance of measures.
Another aspect is the societal background: The USA with their different gun laws face a higher rate of violence with weapons. This is reflected in the OSHA and CAL/ OSHA recommendations on security measures, such as bullet resistant glass and armed security guards, which are not found in health sector guidelines of other countries. It also has to be considered that all presented strategies are designed for industrialised countries. For developing countries other emphases may be necessary due to weaknesses in the overall infrastructure of health systems. The provision with panic buttons and mobile phones appears not very realistic for a rural clinic or health post in a remote area.

The credibility of measures is difficult to assess. It may be related not only to the measure itself but also to the kind of implementation and how it will be addressed at organisational level. One good practice of credibility is UK Zero Tolerance, launching anti-violence initiative at high profile level in cooperation with other relevant sectors, showing that a lot of effort has been made. Credibility may also be related to resources available to implement the strategies. For example, the recommendation of working in pairs is ideal, but if it is practicable for some organisations in times of staff shortages in the health sector has to be doubted.

Sustainability of the recommended measures depends on the degree to which they are integrated in daily work on a regular basis. Most of the environmental changes for example are long-term measures, but they have to be maintained. Same has to be considered regarding work practices. A single induction of a policy does not guarantee that it will become lived work practice. Robertson stated that after the series of initiatives of Zero Tolerance

Campaign at national level, the program now has to be delivered locally and more efforts are needed in this respect. [69]

4. Implementation

This section will have a look (1) if and how methods and process for implementation of interventions are recommended within the guidelines and (2) summarise external information available on experiences with implementation of the sampled guidelines.

4.1. Approaches for implementation of violence control measures

4.1.1. Methodology

According to Perrone and others [70], an "Off-the- shelf" solution will not be effective to prevent violence at work due to the multiple differences of organisations. A suitable tailored organisation-wide strategy, developed and implemented in cooperation of employers and employees and involving important stakeholders, such as unions and occupational health and safety representatives and experts will be most successful.

Not all of the guidelines include the question of how a violence prevention program can be implemented as an extra subject. Some guidelines just mention two or three phrases, others address it as an important issue on a prominent place – in the beginning.

There are different levels to be considered when speaking about implementation:
The overall approach of a suggested program is one level. Those guidelines addressing this theoretical level, show broad commonalities. The approach has to be seen as an ongoing process, they agree, which some describe as a cycle of control. The major phases considered are – only in different wordings- the same:
(1) identify the problem , (2) assess the risks , (3) reduce the risks, (4) review the results which leads to a re-assessment of the situation. Ideally this will be designed within an ongoing system of monitoring.
RCN / UK presents with the integrated organisational approach a comprehensive view, which states that the risk management approach requires action at all levels and in all areas of the organisation. However, other guidelines agree in terms of programs to be organisation-wide and comply with overall policies and strategies in place.

As essential elements of an anti-violence program most often are named management commitment (5 guidelines) and employee involvement (7 guidelines). It is agreed that a program will only work effectively if it is developed, implemented and evaluated in cooperation between management and employees. **Management commitment** is necessary as a motivating force and crucial in creating an organisational culture where violence at work is taken seriously. NHS ZT/UK and both US guidelines stress the importance of visible involvement of top-management to engage the confidence of staff. NHS ZT / UK is its own best practice example:
The campaign has been launched at a high political level in cooperation of three government departments and in consultation with unions and other workers representatives.

How can management commitment become visible?
A first step is the development and endorsement of a **written policy**. Issues which should be included can be summarized from the different guidelines [71]as follows:

- recognition of the risk and a pledge to protect staff at work
- employers' legal obligations
- employers' goals and objectives with the program
- details on responsibilities of managers and employees
- details on the local prevention and reduction plan

There are only two guidelines mentioning the need to include a workplace violence definition in the policy paper.
Written policy documents should use a language easy to understand by non-specialist staff.

To further demonstrate commitment, NHS ZT /UK recommends to provide staff with regular updates and progress reports. This is common with RCN/UK guideline, which also mentions the instruments to be used, such as in-house newsletters and annual reports on actions taken in terms of case studies, improvements and measures introduced.

Swedish guideline recommends to put a person in charge of the program whereas OSHA suggests to assign responsibility for the various aspects of the program to individuals or teams to ensure that all managers, supervisors and employees understand their obligations.
The allocation of resources as well as the allocation of appropriate authority to the responsible parties is requested by management in three guidelines.

Employee involvement encourages the cooperation and commitment at workers' level and it helps gaining confidence. A program profits substantially from staff's experiences and feedback. Workers should be involved in the process of risk assessment and determining best ways of prevention measures, NSW / AU recommends consultation with staff on a regular basis. The participation of employees may take place in OSH teams or committees.

4.1.2. Dissemination

The written program should be communicated to all employees regardless of number of staff or work shift is stated by CAL/ OSHA and this is agreed by other guidelines though only few address this subject. RCN / UK adds that the policy should be disseminated also to other people working with the organisation. It recommends to provide relevant sections of the policy in readily accessible format such as card, booklets or posters. NHS ZT/ UK includes a high profile poster campaign in the NHS.
Additionally some of the guidelines and all materials of NHS ZT/ UK have been published in the internet. This allows a dissemination of the guidelines and materials to a broad interested public and opens ways to learn from each other.

4.1.3. Application

Policies do not implement themselves, HSC / UK states in its guideline [72], and recommends to plan carefully the implementation of strategies. Crucial is the formulation and setting of specific, measurable, achievable objectives within realistic timescales. Priority setting according to risk assessment is required as it will not be possible to do everything at once.

For translation of policies into practice RCN /UK suggests to provide practical working documents to all those with particular responsibilities. The materials could include[73]:

- detailed checklists to guide risk assessment
- timetables for risk assessments to be carried out
- systems to check that risk assessments had been carried out
- timetables for the required staff training according to identified training needs
- flowcharts of systems and procedures

The way how policies can be applied is demonstrated by few guidelines by providing examples of good practices or case studies (see tools).

4.1.4. Support measures

Support measures are seldom mentioned in the guidelines. Only OSHA/ USA stress on the practical advice and assistance provided by their organisation. Within NHS ZT / UK one time support is mentioned regarding funds for installing a CCTV surveillance at hospitals.

4.1.5. Monitoring and evaluation

Monitoring and evaluation are essential elements of an effective violence prevention and management program, on this the guidelines agree. The reporting procedures and systems, record keeping and analysis are "at the heart of the program" (OSHA), as described earlier.
Two monitoring systems may complement each other: active systems monitor the achievements of plans, re-active systems evaluate incidents. [74] Most of the guidelines include both types of systems within their recommendations in combination

Regarding the evaluation of programs, CAL/ OSHA recommends semi-annual reviews. [75]
The techniques for evaluation include:

- Establishment of a uniform reporting system and regular review of reports
- review of reports and minutes of safety and security committee
- Analyses of trends and rates in illness/injury or incident reports
- Survey of employees
- Evaluation of changes or new systems
- Records of implemented programs and job improvements

HSC/UK recommends to include the following issues in a program review:

- Compliance with the violence policy and procedures
- Achievement of objectives and goals
- levels of staffing required
- training of staff
- analysis of records
- maintenance and performance of security systems.

Regular review of policies, procedures and performance is also recommended by other guidelines stressing on the involvement of all responsible stakeholders and employees' representatives. Effective review also ensures that necessary changes are implemented. Changes in program should be discussed with groups of employees at risk. Results of the review should be written as a progress report which should be communicated to all members of the organisation.

The responsibility for monitoring and evaluation should be assigned to top management, as recommended by CAL / OSHA, including administrative and medical sections. In the other guidelines responsibilities are not explicitly named but one can conclude it from the responsibility for the overall program – from a legal point of view mostly the employer or the person responsible for a workplace.

4.2. Experiences with implementation of guidelines and strategies

Information on experiences with the implementation of the sampled guidelines was hardly available. Australian organisations responding to the request had no materials on this aspect. From USA no responses were received.
Organisations in Sweden and UK provided information on implementation of violence management programs, which will be summarized in this section.

Sweden

The Swedish Work Environment Authority conducted two supervisory campaigns about workplace violence in Sweden. According to Akerlind and Hultin [76] the purpose of the supervisory campaigns was to achieve effects on the problem of workplace violence by focusing attention to this problem during a limited period of time. Methods used are usually concentrated inspection efforts by the Labour Inspectorate, distribution of information material to the workplaces concerned and to the media.

The first campaign focused on the retail sale sector. 34 000 workplaces received written information material and 10% of these workplaces were inspected by Labour Inspectorate during the campaign week. Most common weaknesses identified concerned working routines such as safe money keeping, information and education of employees and the care for employees after an injury.

The second campaign, in 1999, concerned violence and menaces in schools and part of the health care sector. 18 000 employers received written information, and 1500 workplaces were inspected. The most common weak points, stipulated in 2400 inspection notices were:

- lack of security routines (19 %)
- insufficient education, training and information on violence (16%)
- insufficient reporting of occupational injuries and follow-up routines (12%)
- lack of prompt assistance and support connected with injuries (11%)

United Kingdom

The most detailed and comprehensive information on the experiences with implementation of violence management guidelines were obtained from United Kingdom. [77]
Information on implementation and evaluation are described for the two guidelines of HSC and HEA and for the Zero Tolerance campaign.

Dissemination

HSC guideline has been advertised widely throughout the NHS, employers had to buy a copy. Additionally dissemination was advertised and fostered by UNISON through their representatives at local level to ensure that all employers received enough exemplars. The HEA guideline, targeting on primary health care services, was disseminated by HEA to all general practices listed on their database and was made available to others for free. The Zero Tolerance campaign was mainly advertised through a series of high profile launches. The resource packages (5 resource sheets in the initial package) have been widely distributed to all appropriate employers. Additionally a website for the campaign has been established, where all materials are online accessible.

Application

The HSC guidance was seen as the basis for development of violence management policies throughout the NHS and was used to draw up new policies. Since the Zero tolerance campaign has been launched in 1998, many policies have been re-written, so it is hard to separate which of the guidelines have been applied.

Against the background of Zero tolerance campaign a recent survey gives an overview on the implementation of violence management strategies in NHS trusts. [78] 45 NHS trusts have been surveyed to get an impression on the present status. The survey results show the viewpoint of NHS employers, as respondents were employer representatives.
Of the 45 trusts sampled, 43 have policies in place addressing workplace violence and one is in development. In the majority of the cases, policy documents cover the following key issues:

- identification of potential violence (in 91% of the policies)
- deciding on preventive measures (87%)
- dealing with violent incidents (87%)
- follow – up action (80%)
- evaluating potential risks (77%)

- recording assessments (60%)
- compensation for victims (22%)

Support and advice concerning the implementation is offered by the Health and Safety Executive. This Government Agency however is at the same time the authority which ensures compliance with the legislation.
In terms of resources, Zero Tolerance initiative has been supported with a governmental budget. Measures to implement Zero Tolerance should be funded out of local employers budgets – however the Government did announce an additional £3 million pounds from central funding which has to be matched by similar amounts from Local Trusts. It is expected that this will be increased in future years.

Nearly all employers with written policies have taken measures to communicate these to their employees. Most commonly this is done with information and training , either directly at induction or using a cascade system or team briefings for more established staff. In one trust the elected safety representative is responsible for communicating the violence policies. Other methods used are leaflets, internal newsletters, written policy manuals as well as e-mail and internal computer networks, posters or a letter from chief executive to all staff.

Prevention measures, as advised by HSC and Department of Health (DoH), have priority. Within the three major categories of preventive measures, as environment, training and communication, all surveyed employers have made changes according to the risks identified.
Most of the changes regarding *environment* were:
installed CCTV (77%), controlled access to certain areas (73%), employ security guards (73%), better lighting (68%), improve signage (68%), improvements in space and layout (62%), and in decoration of public areas (47%), provision of smoking areas (42%) and private rooms (33%), improvements in cleanliness (31%), regulation of excessive noise (28%) and temperature (15%).
However, as stated in the survey, many of the changes have not been made specifically in relation to reduction of workplace violence, but as overall improvements in the institutions.

Training, as a key prevention measure, is provided by nearly all the sampled trusts (93%). Most employers provide three levels of training, which is in line with the Zero Tolerance recommendations : general awareness, management of violence and, for certain employees, where appropriate, instruction in control and restraint, based on Home Office- approved techniques. The first level of training is offered to all staff, further training is provided according to the needs identified with risk assessment. The training provided in the trusts contains as major elements:
assessment of danger and the taking of precautions (97%), interaction with aggressive people (95%), understanding of violence and aggression at work (95%), reporting and investigation of incidents (88%), counselling and other follow-action (82%)

Regarding *communication,* the third major category of prevention measures, 91% of employers surveyed state to have improved the flow of information between employees and their workplace. However, almost a third (32%) have not yet introduced protocols to track staff away from base. As technical communication means for security, most often panic buttons are installed (75%) and personal alarms are provided for certain workers. 68% of employers supply at least some of their employees with mobile phones and the distribution of pagers is current in 60% of the surveyed trusts. One third of respondents supply staff with a combination of communication means.

Zero Tolerance stresses on the advantages of cooperation with local police in the communities in developing anti-violence strategies. This possibility is presently only taken by 40% of the surveyed employers.

Victim support is provided most commonly by access to counselling services. A variation of methods is described within the survey sample, such as peer support, combinations of debriefing and counselling, telephone help-lines and 24-hour confidential counselling services. In several trusts, the in-house occupational health department is responsible for support of victims, where as some have contracted external agencies or are referring to clinical psychological services. A combination of self-referral and referral through line-management is described and in one case the exclusive referral through management.

Legislation imposes an obligation on employers to report and record certain categories of violent assaults. In addition to this statutory duty, all surveyed employers have internal *reporting procedures* to monitor less serious incidents, as recommended by HSC guidance and the Zero tolerance campaign. All employers require staff to use internal accident/incident forms for reporting. 75% of the employers have guidelines for reporting procedures in place, including straight timeframes (24 hours – 3 days).

Responsible for reporting procedures of violent incidents are line managers in 90% of the sampled trusts. But in some trusts there are also other ways to report available, such as to contact a special management of aggression advisor, health and safety staff or colleagues and police officers.
The overall responsibility for dealing with violent incidents is assigned to senior staff , such as health and safety officers, personnel managers or heads of department. In 40% of the organisations responsibility is shared between two or more parties, in one case including the victim together with the line manager and support from whoever is felt necessary.

Monitoring and evaluation

Monitoring within the Zero Tolerance initiative will be done at local level as well as at regional and national level. Trusts have had to agree baseline statistics with their regional offices. This process however is behind schedule. [79]

The **review** intervals of the anti-violence programs in the surveyed trusts vary between quarterly , semi-annually, yearly up to every two years. The responsibility for the monitoring and review process is either assigned to human resources department or the joint health and safety committee or , in several trusts, shared between different departments or groups.

External control is conducted by Health and Safety Inspectors regularly. Tools and methods used to monitor the state of violence management are the reports of the inspectors. Where weaknesses are detected, “improvement notes”, which are statutory warnings are issued. This procedure is similar to those in Sweden and in other countries. The analysis of records on incidents reported to the Health and Safety Executive are another tool used to monitor trends. In UK the inspectors usually use the HSC guidance as a benchmark for their inspections, though legal status of the document is voluntary.

Health and Safety Executive (HSE), being concerned with overall occupational health and safety aspects, has set targets to achieve. Problems related to workplace violence are included in these targets:

- reduction of working days lost by 30 % by 2010
- reduction of fatal and major injuries by 10% by 2010
- reduction of incidents of work related health disorders by 20% by 2010

Half of the improvement targets shall be achieved by 2004, which has lead to a review of all strategies presently.

It has to be noted that the HSE targets are different from those set by DoH within the Zero Tolerance Campaign which aims a reduction of 20 % of workplace violence incidents by 2001 and 30% by 2003.

However, according to the survey cited, there is little confidence that these ambitious targets will be met. Only 22% of respondents state that they will meet the 2001 target and only one third is confident to attain the 2003 goal.
The main reason for not achieving the rates is the problem of underreporting. Most of the trusts have within their strategies encouraged staff to report violent incidents. The raising awareness led to an increased number of reported incidents. 81% of surveyed employers state an increase of incidents while one fifth report a decline within a one year period (1999-2000). In the overall sample the changes in violent incident levels range between 42% fall and 142 % increase. Some of the respondents pointed out that reliable basic data are missing to measure the changes and that it will also depend on the definition of violence used at local level how incidents are recorded.

Feedback on the guidelines is very scarce. One expert from UK stated that practitioners think the guidelines are helpful but very general[80]. This reflects the difficulty to create guidelines which are concrete on one hand but flexible enough for adaptation at local level on the other hand.

Regarding the HSC guideline UNISON's viewpoint is that it would be good to update the document and bring it in line with Zero tolerance. The fundamental elements are there, but more emphasis on management systems, organisational responses and partnership approach (government, trusts, unions) would improve the guidance.[81]

5. Impact

Information on impact and effects of implemented guidelines is hardly available. According to Hoel et al [82] evaluation is a weak point of many programs. As example the authors cite a review of 41 studies of violence interventions of which only 9 reported data on outcomes and evaluation.

Regarding the sampled countries in this country, again only from Sweden and United Kingdom information on the impact of violence management strategies could be obtained, which will be summarized in this section.

In **Sweden** the first supervisory campaign in the retail sale sector had been evaluated 3 ½ years later by interviewing 397 employers. It revealed an positive effect on safety measures of the campaign. The results of the evaluation showed that 62% of employers of workplaces which had been inspected, remembered the campaign, of whom 59% stated that the campaign had had an effect on their security measures. In workplaces not inspected 46% remembered the campaign, of whom 53% stated that the campaign had had an effect on their security measures. From these results it can be concluded that this kind of campaign has had effects on security measures in workplace. It has to be pointed out that this concerns a considerable part of workplaces which were not inspected but reached by means of written information and public relations work.
The second, recent campaign (1999) which included the health sector has not yet been evaluated.

Regarding the Zero tolerance campaign in **UK** IRS - survey[83] includes some data which give an impression of the impact Zero Tolerance campaign has had up to now:
Within the survey results, it is clearly stated that Zero Tolerance Initiative is making impact at trust management level. More than 90% of responding managers had heard of the campaign and 40% said that they have revised their policies and procedures specifically in response to the campaign. Accordingly, of the policies in place in the sampled trusts, one quarter have been introduced very recently (2000) and another 18% were implemented in 1999. 80% of the surveyed employers are planning future initiatives to tackle violence at work.

According to an UNISON expert media coverage has had a positive impact also on the awareness in general public, but it would be more difficult to get a picture of staff's response. They are certainly aware that there is talk of tackling things, he says, but in the end it depends on the local employer to which extent they feel the matter is actually being addressed.[84]

Looking at Swedish information as well as at those from UK, all in all there are effects observable in terms of rising awareness on organisational level. This lead to employers' activities in establishing or revising strategies against workplace violence. Another effect, reported from UK, are the increasing reporting rates , which shows that incidences are taken serious and the problem of underreporting is being addressed positively . This on the other hand has the paradox consequence that the set targets of incident reduction will not be met.

6. Conclusion

Commonalities and differences

More commonalities than differences have been observed in the 12 reviewed guidance documents. Regarding forms and types of violence, all guidelines include psychological as well as physical violence and majority of guidelines focus on violence initiated by clients including potential risks from members of public. Co-worker violence is only addressed clearly in three documents, one exclusively concerning this type. All bar three guidelines provide a definition of workplace violence. Common reasons for development of the guidelines are the increasing numbers of incidents, as well as concern of costs arising from violence at work. Two publishing organisations state a mission of responsibility additionally as rationale.

Majority of the guidelines address organisations and employers at management level with the purpose to give advice and guidance for development of violence management strategies. One of these (RCN /UK) includes explicitly employees, with the purpose to identify the roles and responsibilities at individual level. One of the guidelines (VIC/AU) is addressing exclusively employees with the purpose to give information and advice what to do if being subjected to co-worker violence.

Within health sector all work settings are covered, but an emphasis on stationary institutions is to be noted with exception of RCN/UK and one short brochure from South Australia which specifically address workplaces in community-based services. Additionally community and social services are addressed in three guidelines, three other documents cover all workplaces in general. Between latter and the health sector guidelines no significant differences are identified regarding the measures recommended.

All of the sampled guidelines identify and focus on employers as responsible stakeholders regarding violence management. Only few address duties of employees or differentiate between employer and management. From the legal point of view all guidelines are advisory of nature, but refer to the relevant occupational health and safety legislation. The HSC /UK document is used as benchmark at official inspections. The scope of tools provided with the documents differs significantly in terms of comprehensiveness and scope.

Regarding the strategies recommended commonalities in a broad sense can be stated, but with differences in presentation of approaches and measures.

Common sense is the recommendation of a multi-component , organisation-wide strategy, based on systematic risk management approach, including risk assessment, risk reduction and review of the strategy. RCN/ UK in difference to the others propose a systemic approach, not only addressing the tasks and roles at all organisational levels but also including a wider view on the organisation as integral part of the community.

Differences also are observed in presentation of measures. Though the majority of reviewed guidelines do not indicate clearly priorities they mostly appear to follow the occupational health and safety hierarchy of preferred actions. This is an impression arising from the fact that most of the measures start with a description of environmental changes to reduce violence. ACT /AU however follows a different hierarchy, with actions rated according to their potential effectiveness to eliminate hazards. It also has to be mentioned that environmental or engineering controls have more relevance for stationary services as for community based services.

The categories of measures recommended to control risks are very similar. They commonly include engineering solutions (physical environment and security equipment), working practices and procedures, training and staffing. Comprehensiveness and details of measures vary across the guidelines, for example regarding training, as one key area of preventive action, some guidelines present some phrases and listed issues while others describe training issues in a more systematic way. Within work practices, client orientation and staff behaviour are exceptional points addressed in minority of the documents.

Preventive measures mostly are the heart of guidelines, exceeding all other sections of the documents. This indicates the priority given to prevention. Opposed to this protection measures are relatively neglected and post – incident measures are not elaborated in comparable details.
Only NSW/AU presents detailed recommendation for individual responses during a violent incident according to different forms of violence. However majority of strategies seem to cover protective measures implicitly within training of personnel.
Post-incident actions are commonly described as victim support and incident reporting.

Reporting and record keeping are given a high importance within effective violence management strategies, as they are the basis to monitor trends and evaluate the effectiveness of action taken. Active and re-active monitoring aspects are combined in most of the reviewed documents. The description of how to report and record , however, varies between some phrases and –few - systematic approaches.

Regarding the recommendations how to implement the violence strategies, only minority of guidelines are addressing this on a systematic level.
It could be concluded all in all that recommendations are more focused on what to do rather than on how to bring it into practice.

<u>Gaps and weaknesses</u>

Guidance on internal workplace violence (co-worker violence) is hardly provided within the health sector specific guidelines. It may be necessary to address this type of violence with separate documents, as recommended by an expert. Several guidance publications on this specific type of violence have been developed, especially in Australia, but they cover workplaces in general. Within the frame of this study, no guidance on co-worker violence in the health workplace was found.

Information on implementation, feedback on guidelines, and thus evaluation of guidelines and strategies are hardly available.

Within the guideline documents weak points, considered with less attention in majority of guidelines, are:

- systematic program implementation
- guidance on reporting and record systems
- client orientation aspects (quality of service as influencing factor in terms of adequate staffing, match of services and community/patient needs, staff / organisational attitudes)

- guidance on individual level , and related to this:
- protection measures (what to do during a violent incident)
- specifications on where to get which kind of support for violence management strategies

Promising examples

There is no single guideline to name as best practice. Rather the different guidance materials reviewed provide promising examples regarding different elements. Out of these different elements a good guidance practice could be developed just like a kind of puzzle:

Though a campaign may not be compared with a single guidance document, it has to be pointed out that the resources packages provided within the Zero Tolerance Campaign in UK are most comprehensive. The module system allows the user to select materials according to interest and need. While more general information is presented in brief documents, easy and not too time consuming to read, references are made for more detailed information to other documents, such as HSC and RCN guidelines. The broad presentation of good practices and case studies helps to get a vivid illustration of how different strategies in different settings are realised.

HSC / UK provides the most systematic approach to risk assessment and a good overview on training issues.
RCN / UK is a good practice for guidance of community based health services. It is also a promising example for a systemic viewpoint, called the integrated organisational approach.

CAL/ OSHA provides specific recommendations according to different work settings in the health sector.
OSHA/ USA presents a comprehensive set of tools.

NSW/ AU addresses client orientation and protection measures, missing in other documents.
VIC /AU is a good example for specific and detailed information on internal workplace violence as well as how to present advice to employees in simple, clear wordings.

Recommendations

According to the results of the study some recommendations are concluded for the development of guidance on workplace violence management strategies.

Provide documents with a clear structure. The approaches may be different, but a good structure in the presentation of the complex dimensions are required to enable user friendliness.

A clear and comprehensive program description should include advice on the process of program planning, organisation and implementation.

Guidance on individual program elements could be more detailed, such as protection measures and description of reporting / record systems

Guidance on internal workplace violence is needed, existing general guidance has to be analysed regarding transferability to health sector workplaces.

Every guidance has to include a definition of workplace violence, which can be used as a model for definitions at local level. Description of the underlying concept of workplace violence helps to understand the scope of issues addressed.

Guidance for employees (individual level) could complement the recommendations for management level.

Guidelines should rather be specific than generalistic. Practical examples for different work-settings help better to get an idea of useful interventions than recommendations on a more abstract level.

The provision of tools is essential for vital guidance materials as well as advice where to get support at local level.

A cooperation with justice and criminology sector should be taken as opportunity to synthesise body of knowledge from all sectors involved.

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ANNEX **1**

List of contacts

Name / Address	**Organisation**
USA	
Naomi Swanson	NIOSH , USA
carriejl@home.com	Nurse Advocate
InfoCons@hq.dir.ca.gov	DOSH California
UK	
Cary Cooper	UMIST, Manchester
Helge Hoel	UMIST, Manchester
Jon Richards	UNISON, UK
Simon Bennett	Department of Health
Chris Taylor	Health and Safety Executive
Mike Collins	NHS, Human Resources
SWEDEN	
arbetsmiljoverket@av.se Elisabeth Delang elisabet.delang@av.se	Arbetsmiljoverket AV Swedish Work Environment Authority Focal Point, Eu-OSH SE
socialstyrelsen@sos.se	Socialstyrelsen (ministry of Welfare)
mailbox@vardforbundet.se Eva Szutkowska eva.szutkowska@vardforbundet.se Annica Magnusson annica.magnusson@vardforbundet.se	vardforbundet (Swedish Association of Health Professionals)
Anita Gallon anita.gallon@prevent.se	Prevent Sweden
Lotte Andersson	Arbetsmiljoforum
(kommunalinfo@kommunal.se)	Swedish Municipal Workers Union
Yvonne Ahlström y.ahlstrom@sktf.se	Swedish Union of Local Government Officers
kansli@akademssr.se	Akademikerförbundet (SSR)
AUSTRALIA	
Kristine Fisher, project officer working party Violence kristine.fisher@health.gov.au	National Health and Medical Research Council (NHMRC)
info@nohsc.gov.au neil.harris@nohsc.gov.au	National Occupational Health and Safety Commission (NOHSC)
Dr. Claire Mayhew, cmayh@doh.health.nsw.gov.au	Centre for Mental Health NSW Dept of Health Takforce Prevention &Management of Violence in Health Workplaces
gensec@nswnurses.asn.au	NSW Nurses Ass.
canberra@rcna.org.au	Royal College of Nursing
front.desk@aic.gov.au John.Myrtle@aic.gov.au	Australian Institute of Criminology John Myrtle, Principal Librarian
cpsu@cpsu.org	Community and Public Sector Union /Sidney
asunatm@asn.au	Australian Municipal, Adn., Cler. and Services Union (ASU)/ Sidney
workcover@act.gov.au	Work Cover Australian Centre Territories
info@workcover.vic.gov.au	WorkCover Victoria
territory.businesscentre@nt.gov.au	Department of Industries and Business Northern Territory Government
hsweb@detir.qld.gov.au	Health &Community Services Sector Standing Committee, Brisbane, Queensland
saftey@worksafe.wa.gov.au	Work Safe Western Australia

ANNEX 2

WORKPLACE VIOLENCE DEFINITIONS
used in the sampled guidelines

guideline/ source	*text*	*page*
HSC / UK	"Any incident in which a person working in the healthcare sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment" (based on HSE definition of work-related violence.	2
HEA / UK	same as HSC	2
RCN / UK	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. (adopted from European Commission DG-V)	6
NHS ZT/ UK Managers' guide	Any incident 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.	3
SWE Rec	no explicitly stated definition; referring to "violence or the threat of violence", description of Type I+II, client initiated or public	9-10
OSHA/ USA	no explicitly stated definition used terms: Assault (1), work-related injuries, fatalities(v); emotional and physical safety and health(2); workplace violence, verbal and nonverbal threats, and related actions (3)	
CAL / OSHa 1998	no explicitly stated definition; Glossary at end of document used terms: health and safety hazards, including fear and the threat of assaults(5)	
NSW / AU	Violence includes verbal and emotional threats, and physical attack to an individual's person or property by another individual or group.	3
Vic/ AU	Physical assault, threatening behaviour or verbal abuse, and reacial and secual harassment occurring in a work setting	3
SA age/ AU	Violence at Work is defined as any incident where an employee or employer is abused, threatened or assaulted in situation related to their work.	intro
Sa home/ AU	same as SA Age	intro
ACT/ AU	Workplace Violence is any action or incident which causes physical or psychological harm to another person.	3

[1] Leather (forthcoming), p.10
[2] see list of contacts, Annex
[3] Referring to : NSW Health Department (2001):
(a) Guidelines for the Management of Severe Behavioural Disturbance in Adults
(b) Mental Health for Emergency Departments. A Reference Guide
[4] methodology adopted from Mayring (1988): Qualitative Inhaltsanalyse. Grundlagen und Techniken. Weinheim: Deutscher Studien Verlag
[5] For an overview visit the Australian Institute of Criminology website at: www.aic.gov.au/research/cvp/occupational/index.html
[6] Work Cover South Australia (1998) : Managing the risk of Violence at Work in home and community based care . www.workcover.sa.gov.au
[7] Work Cover South Australia (1998) : Managing the risk of Violence at Work in aged care facilities. www.workcover.sa.gov.au
[8] The latter were not available due to technical problems on the website.
[9] Chappell , Di Martino (2000), p.23
[10] Royal College of Nursing(RCN) (n.d.):, p.3.
[11] Chappel/ di Martino (2000),p. 11
[12] Leather (forthcoming), p.9
[13] RCN: p.3.
[14] RCN, p. 6
[15] List of definitions see ANNEX
[16] Chappell/Di Martino/1998): Violence at Work, ILO, Geneva
[17] Perrone(1999); Chappell/ Di Martino (2000); Mayhew/ Chappell (2001); Hoel/ Sparks/Cooper (2001); Leather (forthcoming)
[18] ibid.
[19] Robertson: Violence in the NHS – the trade union viewpoint. In: Health Service Report, Issue 29, Winter 2000/01, p.21, Industrial Relations Services, London
[20] J. Richards, UNISON, information on request
[21] RCN Community/ UK, p.6-7
[22] Curbow: Origins of Violence at Work, in: Cooper/ Swanson: Violence in the Health Sector, ILO/ICN/WHO/PSI Workplace Violence in the Health Sector , forthcoming working paper.
[23] SWE/ Rec., p. 10
[24] ACT/ AU, p.3.
[25] for example: HSC/UK , p.3, quotes British Crime Surveys; RCN/UK, p.7-8, quotes British Crime Survey 1996, a HSAC Survey 1987 and UNISON statistics; OSHA/ USA, p. 1, quotes Bureau of Labor Statistics data 1993 and several studies and reports
[26] e.g. Sweden and ACT/ AU
[27] NHS ZT / UK, Resource sheet 1- Key messages
[28] CAL/ OSHA, p. 5
[29] SA age and SA home, introduction
[30] NHS ZT/ UK, Managers' guide, p.3
[31] OSHA / USA , p. 1
[32] CAL / OSHA, p. 6
[33] NHS ZT / UK, Managers' guide, p. 3
[34] OSHA/USA, p. V
[35] ACT/ AU, p.18
[36] NSW / AU, p. 2
[37] HSC / UK, p. 31
[38] NSW/ AU, p. 17
[39] e.g. Chappell / di Martino (2000), Leather (forthcoming), Mayhew/ Chappel (2001), Hoel et al (2001)
[40] Mayhew / Chappell (2001b) ; Chappel / di Martino (2000)
[41] cited in :Mayhew / Chappell (2001 b), p.2
[42] Swanson et al (forthcoming) ,p.65
[43] RCN/ UK, p. 13
[44] ACT/AU, p. 14
[45] Swanson et al (forthcoming), p.67
[46] Victorian guideline because it targets on employees; SA home and SA aged/ AU represent only extracted brochures from the general South Australian Workplace Violence Guidelines
[47] OSHA/ USA, p.4, NSW/ AU, p.4
[48] Mayhew/ Chappel (2001), p.3

[49] Mayhew/Chappel (2001), p.3
[50] Hoel et al (2001), p. 58
[51] ACT/AU, p.8f
[52] NHS ZT / UK, Manager's guide, p. 5
[53] Mayhew/ Chappel (2001), p.5
[54] HSC/ UK, p. 14
[55] ACT/AU, p. 12
[56] HSC/UK, p. 19
[57] HSC/UK, p.19 f
[58] NHS ZT / UK, Manager's guide, p. 5
[59] OSHA/USA, p. 7
[60] RCN / UK, p. 12
[61] NSW/AU, p. 7
[62] mental health nurse, quoted in RCN/ UK, p. 20
[63] OSHA/ USA, p.6
[64] RCN/UK, p. 10
[65] RCN / UK , NHS / UK
[66] VIC/AU, p. 12
[67] CAL/ OSHA, p. 18
[68] NSW/ AU, p. 17
[69] Robertson (2001), in Health Service Report, p. 23
[70] Perrone (1999),p.74 f, Mayhew/ Chappel (2001), p.2
[71] CAL/ OSHA and OSHA / USA, RCN , NHS ,HSC / UK
[72] HSC/UK, p. 12
[73] RCN/UK, p. 13
[74] Chappell/ di Martino (2000), p.125, HSC /UK, p.24
[75] CAL/ OSHA, p.22
[76] Akerlind / Hultin (2000): Basic rules and two supervisory campaigns in Sweden. In: EUROGIP Conference on workplace Violence in Europe, Paris, November 2000, p. 30-34
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[78] IRS (2001):Getting to grips with workplace violence – a snapshot survey; in: Health Service Report, Issue 29, Winter 2000/2001, Industrial Relations Services, London
[79] Robertson, in Health Service Report, p. 23
[80] Richards, UNISON, information on request
[81] Robertson, in Health Service Report, p. 24
[82] Hoel et al (2001), p. 57f
[83] IRS (2001)
[84] Robertson (2001), in Health Service Report, p. 23