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FEATURE ARTICLE

Nurses under threat: A comparison of content of 28 aggression management programs

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ABSTRACT: *Staff who work in the health service are now recognized as a high-risk group for assault in the workplace. Recently, professional and industrial organizations have begun to suggest appropriate curricula for training staff in aggression management. However, there is currently a plethora of aggression management training programs (AMP) available, varying both in content and in duration. In this paper, 28 programs were evaluated against 13 major content areas derived from the recommendations made from key professional and industrial organizations, and what may be today considered appropriate/ideal content areas for AMP. Information on programs available in English was sought via standard databases, the Internet, program providers, and through networking with colleagues and professional organizations. The majority of the programs reviewed covered personal safety issues for staff and patients, together with legal issues. The use of restraint, pharmacological management of aggression and seclusion were features of programs specifically addressing the needs of health care staff in mental health settings. Most programs appeared not to address the psychological and organizational costs associated with aggression in the workplace. This is surprising since the literature suggests that the effects of violence are wide and varied, including increased absenteeism and sick leave, property damage, decreased productivity, security costs, litigation, workers' compensation, reduced job satisfaction together with recruitment and retention issues. Also, few programs were based on a systematic evaluation of their outcomes. Suggestions for program development and their teaching are discussed.*

KEY WORDS: *aggression management programs*, *aggression*, *nurses*, *violence*.

INTRODUCTION

State and Federal Occupational Health and Safety requirements dictate the role of employer and employee in relation to workplace safety. Recently, these requirements have been amended to include such things as a safe and harassment-free workplace. The Australian legislation is incorporated into several acts similar to United Kingdom legislation (Health Service Advisory Committee 1997). This legislation, combined with industry standards, outlines the responsibilities of all parties in the workplace, including the necessity to report injuries and accidents. Australian Industry Standards are now recommending that all mental health staff undertake compulsory training for dealing with potentially violent and aggressive situations (Victorian Department of Human Services *et al.* 2003). Similarly the Department of Health and Professional bodies in the UK recognize the need for staff training (United Kingdom Central Council for Nursing 2002).

Aggression management programs (AMP) for staff in the health care setting have mushroomed over the last few years. The earliest programs were derived from those used by the police force and because of this were more directed towards the management of domestic violence, focusing mainly on physical restraint and protection of self.

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A major focus for present AMP has centred on accident and emergency departments, psychiatric units and disability services. Programs range in length from 1 day to a four-term Post Graduate Diploma. Some programs recommend follow up every 12 months to 2 years. Also, some programs provide accreditation points or credits to further education.

However, course content varies across programs and there is little information available to assist health care providers in choosing one program over another. In this paper, 28 programs are evaluated against what may be today considered appropriate/ideal content areas for AMP.

LITERATURE REVIEW

Workplace violence in the health care sector

In a recent discussion paper it was noted that nurses along with the police, security and prison guards, fire service, teachers, welfare, and social security workers are most at risk of violence, both in the USA and in the UK (School of Industrial Relations and Organisational Behaviour 2001; p. 8). Staff who work in health services in Australia have been identified as a group at high risk of being assaulted in their workplace, with registered nurses high on the at-risk list (Mayhew 2000; pp. 19–20).

There is a developing body of literature evaluating the extent and impact of workplace violence in the health care sector (Farrell & Bobrowski 2003; International Labour Office *et al.* 2002; Wells & Bowers 2002; Whitley *et al*. 1996). Nevertheless, many incidents go unreported (Badger & Mullan 2004; Gates *et al*. 1999, 2003; Hurlebaus 1994; Lion *et al*. 1981; Rosenthal *et al*. 1992; School of Industrial Relations and Organizational Behaviour 2001; Sommargren 1994; Wilkinson 1999). It is suggested that perhaps only one in five violent incidents in the workplace are reported, possibly due to embarrassment, organizational culture, tolerance or excusing the behaviour of 'ill' clients (Mayhew 2000; p. 18).

Early program development

One of the first programs specifically designed to assist staff in managing disturbed behaviours was at St. Thomas Psychiatric Hospital, USA, in 1976 (Gertz 1980; Rice *et al*. 1989). Another of the early training programs established for health care workers was developed at the Audie L. Murphy Memorial Veterans Hospital in Texas, USA. The program was delivered as a single day, 5-h workshop focusing on the 'preventative identification of potentially violent situations and on methods of verbal and physical management of violent behaviour' (Lehmann *et al*. 1983; p. 40).

Rudimentary evaluations were conducted on these programs, with findings suggesting a reduced level of injury to staff, and an increased staff confidence when dealing with aggressive and violent patients following training (Infantino & Musingo 1985; Lehmann *et al*. 1983; Thackrey 1987). Other early programs were implemented in residential aged care, with similar outcome results (Mentes & Ferrario 1989). A more rigorous evaluation was conducted by Quinsey (1977, 1979) on a program offered to staff at an all-male maximum security psychiatric unit, and data from this evaluation 'suggested that . . . it had its intended effect' (Rice *et al*. 1989; p. 30). However, during this time assaults on patients in that facility increased!

Rice *et al*. (1989; p. 32) suggests that there is considerable support for staff training to significantly reduce institutional violence, especially where training programs are aimed at 'teaching non-restrictive, nonauthoritarian, and non-provocative ways of acting with residents; behavioural cues and situational characteristics associated with assaultiveness; and effective verbal strategies for use with highly upset individuals'. The implication being that staff can be trained to be able to intervene safely in a crisis situation; to diffuse such situations when they arise; and also to act proactively to reduce the frequency of aggressive behaviours (Rice *et al*. 1989; p. 29).

Aggression management programs have since been developed to suit the particular needs of individual institutions. While many have not been systematically evaluated they nevertheless claim that such programs help to promote 'positive and significant changes' in staff knowledge and management of violence (Paterson *et al*. 1992; p. 373); increases in staff awareness of aggression management, improved staff safety, improved documentation (Martin 1995; pp. 214–215); decreased 'behavioural expression of fear' of staff (Phillips & Rudestram 1995; p. 168); and decreased 'levels of burnout manifested by high rates of turnover, negative attitudes, and lack of concern for patient care' (Goodykoontz & Herrick 1990; p. 133). Yet, according to recent authors who reviewed the research around 'appropriate staff training' to aid in the prevention of violence against staff, they noted that it has 'mushroomed' and become a 'highly lucrative, yet poorly regulated business' (Beech & Leather 2003; p. 604). They point out that few AMP have been properly evaluated.

A standard for aggression management programs

Rice *et al.* reviewed AMP of the 1970s and 1980s and concluded that the curricula of the early programs addressed five key areas: (i) verbal preventative skills teaching; (ii) self defence training; (iii) training in patient

restraint; (iv) discussion of policy and legal issues; and (v) administrative changes (Rice *et al*. 1989; p. 31).

Since then a United Kingdom publication, developed to provide guidance for employers on violence and aggression in the health-care sector, suggests that 'good training programs' are 'appropriate for all groups of employees at risk from violence' and these programs should include: (i) theory – understanding aggression and violence in the workplace; (ii) prevention – assessing the danger and taking precautions; (iii) interaction – with aggressive people; and (iv) post-incident action – reporting, investigation, counselling and other follow up (Health Service Advisory Committee 1997; p. 19).

More recently, a joint publication addressing workplace violence in the health sector recommended 'interventions should be developed to reinforce the capacity of individuals to contribute to the prevention of workplace violence' (International Labour Office *et al.* 2002; p. 24). Recommendations included: (i) orientation to the workplace environment, management policies and grievance procedures; (ii) information on the different types of workplace violence, physical and psychological, and the best practices for its reduction; (iii) information on gender, multicultural diversity and discrimination to develop sensitivity to such issues; (iv) improving the ability to identify potentially violent situations; (v) instilling interpersonal and communication skills which could prevent and defuse a situation of potential workplace violence; (vi) developing competence in the particular functions to be performed; (vii) preparing a 'core group' of mature and specially competent staff and workers' representatives who can take responsibility for more complicated interactions; (viii) assertiveness training or empowerment, especially for women; (ix) self-defence, as required according to risk assessment; and (x) assistance and counselling together with well-being promotion (International Labour Office *et al.* 2002; p. 24).

In 2003, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (now called the Nursing and Midwifery Council) published the first standards for the education of managing assaultive behaviour in the mental health sector. This publication recommends that training programs should include, at minimum: (i) the use of the overall treatment program and the therapeutic relationship as the overall context; (ii) behavioural theories and functional assessment; (iii) the necessity for staff to maintain control; (iv) legal concepts and issues of patient abuse; (v) pharmacologic treatment of violence; (vi) review of alternative interventions; (vii) team physical techniques (evasive techniques, breaking free, immobilizing and transporting patients; (viii) restraining patients with certain medical conditions; (ix) restraining children and elderly; (x) movement in and out of seclusion; (xi) risk of restraints; and (xii) medicating a non-cooperative patient (United Kingdom Central Council for Nursing 2002).

As the United Kingdom Central Council (UKCC) for Nursing recommendations are specifically for the providers of mental health care, there is a greater focus on restraint, seclusion and pharmacological management of clients.

Similarly, in Australia, an Industry Standard was produced for staff working in the Victorian mental health services which stated that 'training in the prevention and management of violence and aggression should be provided to all staff' (Victorian Department of Human Services *et al.* 2003). In keeping with the intent of the Australian Industry Standard, key components of such training are said to include: (i) the policies and procedures of the workplace; (ii) legal issues and legislative framework; (iii) predicting, preventing and managing aggression and potentially assaultive situations; (iv) system of emergency response processes; (v) post-incident processes including access to support systems; (vi) induction systems for all staff, including permanent casuals, part-time staff, and students, on commencement of work and regularly thereafter; (vii) competency-based skills for all staff for the roles undertaken by them; (viii) local practice issues that impact on response such as access to support from others, sufficient staff available to respond to an incident, availability of emergency services and acceptable response times; (ix) management personnel at all levels should be trained in the emergency response; and (x) training should be compulsory for all staff, and be provided in paid time (Victorian Department of Human Services *et al.* 2003; p. 26).

Interestingly, there is no specific focus on restraint, seclusion and pharmacological management in the Victorian recommendations for key training components. A sample policy included with the document does, however, note that 'the Shift Leader is responsible for deciding on the least restrictive intervention such as de-escalation, restraint and seclusion' (Victorian Department of Human Services *et al.* 2003; p. 21). Appendix A of the document also addresses training guidelines and here it is suggested that 'effective secure and escort techniques' should be included in AMP. Also, recommended is the inclusion of 'knowledge or reporting systems and their rationale'.

Seemingly, little has changed since the late 1970s. It would appear that for the most part, the content of the original programs discussed by Rice *et al*. (1989) has been adopted into the above recommendations from the

Victorian Department of Human Services *et al.*, the ILO *et al*. (2002) and the UKCC. The exception to this is the apparent exclusion of 'discussion of policy and legal issues' and 'administrative changes'. It would appear that the Australian Industry Standard (Victorian Department of Human Services *et al.* 2003) has included all the key areas highlighted by Rice *et al*. (1989). Table 1 illustrates the content areas suggested by each of the three bodies.

To capture a contents list that included all of the content areas recommended in Table 1, the authors independently looked at each set of recommendations and devised content categories. The authors considered the three sets of recommendations together even though two of them target mental health workers and the third appears to be more generic. It is now recognized that aggressive incidents occur across all health care settings, and that staff need to have a comprehensive awareness of the issues and be able to draw on a wide variety of response options.

The final list of content categories was determined by mutual agreement between the two authors. Altogether, 12 content areas for AMP were determined, that is, at least one of the bodies recommended its inclusion.

We omitted 'review of alternative interventions' because this could be included under a number of the categories above in Table 1, for example, 5, 6 and 7. Nor was 'the necessity for staff to maintain control' included, as this too could be included in a number of categories, for example, 1, 10 and 11. Some of the recommendations refer to program outcomes, such as 'developing competence in the particular functions to be performed' and so were omitted from the above category. While it is likely that several of the categories above have the potential to overlap, for example, the use of self-defence techniques might incorporate information on the risks of applying restraints to patients/residents/clients, for the purposes of program comparison, a pragmatic approach was adopted in determining overall evaluation criteria of AMP.

An additional category, 'Costs' of violence to staff, community etc.' was included to alert staff to the psychological, physical, organizational, and dollar costs associated with aggression in the workplace. The final list of content categories included: (i) orientation to the workplace environment, management policies and grievance procedures; (ii) causes of aggression, behavioural theories, disease processes; (iii) types of aggression (physical, psychological, verbal abuse); (iv) identification of potentially violent situations/risk assessment; (v) communication, therapeutic relationships, defusion techniques; (vi) pharmacological management; (vii) assertiveness training, self defence, physical restraint; (viii) risks of applying restraints; (ix) seclusion; (x) legal and ethical concepts; (xi) leadership and management – a core group; (xii) Debriefing and counselling post a violent incident; and (xiii) 'Costs' of violence.

Reviewing aggression management programs' content/curricula

We compared the content of 28 AMP (available in English) to the above content list. Programs were sought via Cumulative Index to Nursing and Allied Health Literature using search terms 'aggression management', 'aggression and violence in nursing', 'aggression management programs', aggression management training'; the Internet using the search engine GOOGLE using the same terms as above; reference lists from published papers addressing aggression and violence in nursing; nursing professional organizations in Australia; and from speaking with researchers and program providers in the field.

The inclusion criteria was as follows: (i) availability to others to use; (ii) delivered free or for a $ cost; (iii) targeted to nurses (and/or others); (iv) targeted to aged care personal care assistants (PCAs) and extended care assistants (ECAs); and (v) face-to-face delivery and/or training manual/distance education (Table 2).

Programs were excluded if they were developed solely for research purposes or were not available for others to use/avail themselves of the training.

Table 3 indicates that the major content areas appear to be: causes ($n = 23$), communication ($n = 22$), and 20 programs included physical techniques, risk assessment and legal issues.

Information on the types of aggression (e.g. physical, verbal), dementia, mental health, disabilities etc. was included in fewer programs ($n = 15$), as was leadership, team work ($n = 14$) and debriefing ($n = 14$).

Very few courses appeared to cover orientation such as policies, protocols, and environment ($n = 9$), pharmacological management of aggression ($n = 7$), issues around the use of restraint ($n = 7$), 'costs' associated with aggression ($n = 4$) or seclusion ($n = 4$).

DISCUSSION

First, it should be acknowledged that we might not have captured the full extent of the content areas for each program due to the limited amount of specific information obtainable for some programs. We also do not claim to have included all of the available relevant AMP.

Of the programs reviewed, the majority included information on personal safety for staff and patients through

TABLE 1: *Summary of aggression management programs' recommendations*

VDHS *et al.* (2003)	UKCC for Nursing (2002)	ILO *et al.* (2002)
	Behavioural theories and functional assessment	Information on gender, multicultural diversity and discrimination to develop sensitivity to such issues
Managing aggression and potentially assaultive situations	Team physical techniques (evasive techniques, breaking free, immobilizing and transporting patients	Self-defence, as required according to risk assessment
	Restraining patients with certain medical conditions	
	Restraining children and elderly	
		Assertiveness training or empowerment, especially for women
	Risk of restraints	
Legal issues & legislative framework	Legal concepts and issues of patient abuse	
Managing aggression and potentially assaultive situations	The use of the overall treatment program and the therapeutic relationship as the overall context	Instilling interpersonal and communication skills which could prevent and defuse a situation of potential workplace violence
	Review of alternative interventions	
Predicting		Improving the ability to identify potentially violent situations
Post-incident processes including access to support systems		'assistance & counselling' plus 'well being promotion' should also be included
		Information on the different types of workplace violence, physical and psychological, and the best practices for its reduction
Local practice issues that impact on response such as access to support from others, sufficient staff available . . .		Preparing a 'core group' of mature and specially competent staff and workers' representatives who can take responsibility for more complicated interactions
Management personnel at all levels should be trained in the emergency response.		
	The necessity for staff to maintain control	
Competency based skills for all staff for the roles undertaken by them		Developing competence in the particular functions to be performed
	Pharmacologic treatment of violence	
	Medicating a non-cooperative patient	
The policies and procedures of the workplace.Induction system for all staff		Orientation to the workplace environment, management policies and grievance procedures
Training should be compulsory for all staff, and be provided in paid time.	Movement in and out of seclusion	

ILO *et al.* (2002); UKCC, United Kingdom Central Council; VDHS *et al.* (2003).

TABLE 2: *Agression management programs meeting the inclusion criteria*

Program	Provider	Location
1 A safer place to work: Preventing and managing violent behaviour in the health workplace	NSW Health Department	Australia
2 Aggression Management and Workplace Violence Prevention	Sorensen Wilder & Associates	USA
3 Anti-violence tool kit	International Council of Nurses	Switzerland
4 CALM – Crisis and Aggression Limitation Management	Royal Hobart Hospital	Australia
5 CIPO – Critical Incident Positive Outcome	The Rozelle Hospital	Australia
6 Clinical Risk Management and Assessment	Wolston Park Hospital	Australia
7 Code Black	DHHS	Australia
8 Dealing with aggressive & potentially violent behaviour	Achievement Awareness Training	Australia
9 INTACT	Illawarra Area Health Service	Australia
10 Management of Aggressive Behaviour	University of Dundee, certificate course	UK
11 Managing Care	South Bank Polytechnic	UK
12 MOVIAT program	Victorian Hospitals Industrial Association	Australia
13 Nonviolent Crisis Intervention	Crisis Intervention Institute	USA, UK, Japan, Aus, NZ, Ireland, Canada
14 P3	Department of Community and Health Services	Australia
15 PART	MTU training	Australia
16 Physically Aggressive Behaviour in Dementia	Rochester Community and Technical College	USA
17 Positive Approaches to Challenging Behaviour	Department of Psychological Medicine, University of Wales College of Medicine	UK
18 Preventing and Managing Aggression in the Health Workplace	Centre for Mental Health, NSW Health Department	Australia
19 Prevention and Management of Aggressive Behaviour (PMAB)	The Professional Development Centre	USA
20 Prevention and management of disturbed behaviour of patients program	St Thomas Psychiatric Hospital, Ontario	Canada
21 Professional and ethical responses to violence for health care and social care staff – Control & Restraint	Personal safety and training coordinator for the Isle of Wight NHS Trust	UK
22 Responding effectively to difficult or challenging behaviour	Nursing Australia – continuous learning centre 2004: Professional development education program	Australia
23 The De-escalation Kit	Liverpool Hospital	Australia
24 The Mandt System		USA
25 The Studio III Group	The Studio III Group	UK
25 Therapeutic Options	Therapeutic Options Inc.	USA
27 Violence and aggression to staff in health services: guidance on assessment and management	Health and Safety Commission	UK
28 When it's right in front of you: assisting health care workers to manage the effects of violence in rural and remote Australia	NHMRC	Australia

DHHS, Department of Health and Human Services; INTACT, Intervention Training for Aggression Control Techniques; MOVIAT, this is named after the developer whose surname is Moviat; MTU, MTU Training concepts (note MTU appears to be named after the developer Martin T Unger); NHMRC, National Health and Medical Research Council; NHS, National Health Service; PART, Professional Assault Response Training.

TABLE 3: *Re-evaluation of course content*

Program name	Orientation	People cost	Causes	Types	Risk	Communication	Pharmacology	Physical	Restraint	Seclusion	Legal	Leadership	Debriefing
A safer place to work: Preventing and managing violent behaviour in the health workplace			•	•	•	•		•			•	•	•
Aggression management and workplace violence prevention		•	•	•	•	•		•			•	•	•
Anti-violence tool kit		•	•	•	•				•				•
CALM – Crisis and Aggression Limitation Management	•				•	•	•				•		
CIPO – Critical Incident Positive Outcome			•	•	•	•	•	•	•	•	•	•	•
Clinical Risk Management and Assessment			•		•	•	•				•	•	
Code Black			•					•	•		•	•	
Dealing with aggressive & potentially violent behaviour			•		•	•		•			•	•	•
INTACT	•		•	•	•			•	•	•	•		•
Management of Aggressive Behaviour			•	•	•	•	•	•			•		•
Managing Care	•	•	•	•	•	•					•	•	
MOVIAT program	•		•		•	•					•	•	
Nonviolent Crisis Intervention			•	•	•	•		•				•	•
P3			•	•	•	•		•	•	•	•		•
PART			•	•	•	•					•	•	
Physically Aggressive Behaviour in Dementia			•	•		•	•	•					
Positive Approaches to Challenging Behaviour	•		•	•	•		•	•			•		•
Preventing and managing aggression in the health workplace					•	•		•				•	
PMAB – Prevention and Management of Aggressive Behaviour		•					•				•		
Control & Restraint – Professional and Ethical responses to violence for health care and social care staff						•		•					
Responding effectively to difficult or challenging behaviour	•		•	•		•		•			•		
Professional Crisis Management					•	•		•	•		•		•
The De-escalation Kit			•			•	•	•	•	•			
The Mandt System	•		•	•				•	•		•		•
The Studio III Group	•		•			•		•			•		•
Therapeutic Options Inc.			•		•	•		•				•	
Violence and aggression to staff in health services: guidance on assessment and management					•							•	
When it's right in front of you: assisting health care workers to manage the effects of violence in rural and remote Australia	•	•	•	•	•	•							

INTACT, Intervention Training for Aggression Control Techniques; MOVIAT, this is named after the developer whose surname is Moviat; PART, Professional Assault Response Training.

content areas such as communication, physical techniques and risk assessment. Many programs also covered legal issues. This perhaps could be attributed to Occupational Health and Safety policies and the increasing number of litigations arising from workplace hazards, including aggression.

Most programs appear not to address the psychological and organizational costs associated with aggression in the workplace. This is surprising since the literature suggests that the effects of aggression are wide and varied, including increased absenteeism and sick leave, property damage, decreased productivity, security costs, litigation, workers' compensation, reduced job satisfaction together with recruitment and retention issues (Gates *et al*. 1999; p. 14; Hoel *et al*. 2000).

The use of restraint, pharmacological management of aggression and seclusion were features of programs specifically addressing the needs of health care staff in mental health settings. Given that the literature is now focusing on the number of deaths that may be attributed to the use of restraint (Lewis 2002; Morrison *et al*. 2002; O'Halloran & Lewman 1993; Paterson *et al*. 2003; Rubin *et al*. 1993), it was surprising to find that only one of the recommending bodies explicitly included risk of restraint as a content area for AMP, and only seven of the programs appeared to include restraint as a major content area.

It is interesting to note the small number of programs addressing the need for staff orientation to their environment, including the relevant policies and protocols relating to aggression management in their work area. If staff are unaware of the local policies surrounding aggression it is likely that such incidents will go unrecorded and be poorly managed.

Many of the AMP recommend refresher courses to maintain accreditation or competency. Hurlebaus and Link (1997) suggest that we should not assume that one-off AMP training will equip staff with the ongoing necessary skills to manage aggression. They suggest that for adult learning to occur, new information needs to be regularly presented to participants. While this may appear to be a logical requirement, refresher courses can be a huge impost on organizations in terms of staff relief and course costs, however, these costs need to be equated with the personal and emotional costs, together with the financial and organizational costs of even one staff member being severely assaulted.

In summary, our review of AMP highlights that the Critical Incident Positive Outcome (CIPO) program covered 11 of the 13 content categories as suggested by key industrial and professional organizations. The INTACT program covered 10 of the categories with 'Aggression Management and Workplace Violence Prevention' and 'The Mandt System' and P3 programs covering nine out of the 13 categories. In the evaluation conducted by Morrison and Carney Love (2003), 'Therapeutic Options' and Profession Assault Response Training (PART) were considered the 'better' programs currently being offered – based on content, feasibility/level of training required, confidence following training, program effectiveness (e.g. decrease in assaults) and cost. While these authors acknowledge that although these programs appear to promote staff confidence in managing aggression, they ask the question 'do they work?' For instance, we currently do not have standardized techniques for managing physical assault or for diffusing incidents when they arise. Beech and Leather (2003) also acknowledge the lack of evidence surrounding AMP ability to change and maintain staff behaviour in the short, medium or long-term.

Whatever course is implemented, it should include a systematic evaluation, which moves beyond 'happy sheets', that is, the participants' subjective responses on completion of the program, which only measure staff's perceptions and may not be indicative of how they might cope in the real situation (Beech & Leather 2003). Also, where programs emphasize skill development at the expense of providing participants with a theoretical understanding of the overall treatment context, the nature of 'illness' and the determinants of a therapeutic relationship, the question could be asked, 'is emphasis on skill development more or less likely to promote stagnation?' (Campbell 2004; p. 53).

Regardless of the program chosen, it is imperative that there is a demonstrated commitment from senior management to reducing violence in the workplace (Mayhew 2000; p. 33). Managerial support is integral in moving the debate from an individual concern to that of the organization's. Without managerial support and promotion AMP are likely to offer a band-aid solution only. It should be noted that middle managers especially play a key role in the success or failure of an organization's enterprises (Industry Task Force 1995). Indeed, the UKCC recommends that violence be viewed as 'an occupational problem requiring a cohesive, multifaceted organizational approach' (United Kingdom Central Council for Nursing 2002).

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