VIOLENCE AND AGGRESSION IN MENTAL HEALTH INPATIENT UNITS: AN EVALUATION OF AGGRESSION MINIMISATION PROGRAMS

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Abstract

Violence and aggression in inpatient units constitute a major workplace hazard for mental health nurses, who must take account of many considerations when dealing with potentially aggressive or violent patients. This paper discusses some of the problems that arise in connection with violence and aggression in mental health facilities, including incidence and prevalence, risk management processes, under-reporting, causes of aggression, the link between aggression and mental illness, difficulties in defining and categorising aggressive incidents, and the effect of such behaviour on the therapeutic relationship. Research into the effectiveness of aggression minimisation programs is in its infancy and it is difficult to draw conclusions about the effectiveness of relevant training systems.

After a review of various national and international training courses, a description is given of methods of aggression minimisation conducted in The Hunter New England Health Service, NSW, Australia.

The aims of this paper are to explore aspects of violence and aggression in mental health inpatient units and to evaluate programs designed to prevent and manage violence and aggression in these settings.

INTRODUCTION

Each day throughout the world, caring professionals do their best to provide quality care for patients within their organisational and legislative frameworks. Despite their compassion and empathy, many health care workers are the target of acts of violence and aggression. Whether this is a reflection of society's attitudes towards health care professionals or a reflexive response by people physically or mentally ill, in pain, or not receiving the service they expect, it is vital that governments, communities, organisations and individuals understand that violence is not an acceptable workplace hazard.

Violence and aggression towards nurses working in mental health inpatient units is an everyday event, but they should not accept it as an inevitable aspect of their role. Nurses should consider the clinical implications of patient aggression and how they manage its effect on their therapeutic relationship with patients. According to Stone (2009), who conducted a study into the effects of swearing on nurses and the therapeutic relationship, only seven per cent of nurses surveyed believed aggressive and violent incidents could be prevented. However, measures and strategies can be implemented by organisations and clinicians to control and minimise the rate and severity of violent and aggressive incidents.

The term "patient" is used in this paper as a matter of convention however other terms such as consumer, client and service user are acknowledged.

DEFINITIONS AND CLASSIFICATION OF AGGRESSION AND VIOLENCE

Comments throughout the literature stress the difficulty regarding definition and categorisation of aggressive incidents in mental health inpatient units. Various studies draw attention to the numerous definitions of violence and aggression making it hard to compare results and draw conclusions about the degree of severity; for example, aggression is defined by Irwin (2006, p. 309-310) as "verbal and physical assaults . . . behaviour that is intended to inflict, and can actually cause, physical or psychological injury" Anderson and Bushman (2002, p. 27) define aggression as any behaviour directed towards another individual that is carried out with the immediate intent to cause harm, and violence as aggression intended to cause major harm that is goal or outcome driven: it can be best described as an extreme form of aggression in action (Anderson & Bushman, 2002). The numerous definitions, with no clear consensus, illustrate the problems involved in classification.

Additional complexities can arise due to the subjective nature of clinical reporting and documentation of violent and aggressive incidents. Descriptions of the severity and causation of an incident witnessed by several nurses may differ considerably. For example Morrison (1993) asked 69 mental health nurses to categorise aggressive and violent behaviours (verbal, violence to self, violence to others, or against property), and observed major disagreement in three of the four areas, agreement occurring only about violence to others. Factors that influence subjective interpretation of an incident include the nurses' tolerance levels and personal variables such as age, gender, experience, and attitudes towards aggression and violence (Whittington, 2002).

Distinguishing between type and severity presents further problems: some forms are overt, others more passive and subtle; each incident requires measurement and description of the broader context. The multiplicity of definitions complicate appraisal by mental health nurses of violent and aggressive acts by patients. Rippon (2000, p.457) listed the several different categories of aggression to be considered: hostile, violent, affective, angry, bullying, emotional and instrumental, impulsive and reactive.

LITERATURE REVIEW STRATEGY

A search of electronic databases was conducted using keywords, combinations of keywords and appropriate truncation. In order to find studies showing the historical progression of research into mental health inpatient aggression and aggression minimisation training, no date range limited the searches which were confined to peer-reviewed material. In the initial stages many articles cited several of the same authors, therefore reference lists of included articles were reviewed. The precise targeting produced a thorough, fruitful field of sources and provided the majority of articles for this review.

INCIDENCE/PREVALENCE

Although the risk for nurses of inpatient violence and aggression has been extensively researched, it is still a major organisational and professional concern. Eisenstark, Lam, McDermott, Quanbeck, Scott and Sokolov (2007) reported that each year twenty five per cent of mental health nurses in public sector hospitals are subject to a violent incident resulting in a serious injury: a prevalence rate, according to Del Bel (2003), three times that of any other vocational group. This has implications for nurses' emotional, physical and psychological health (Lanza, 1992). Data collected prospectively from five mental health inpatient units over a seven-month period

for a study by Jones, Owen, Tarantello, and Tennant (1998) indicated that seventy eight per cent of reported incidents of violence and aggression were directed at nurses. Aggressive incidents were recorded using the Violence and Aggression Checklist (Jones et al, 1998) and measured by means of an eight-point severity scale.

UNDER-REPORTING OF AGGRESSION AND VIOLENCE

The literature provides numerous reasons why it is difficult for mental health nurses to report violent and aggressive acts by patients: heavy workloads, time constraints, the lack of adequate education and resources and of standardised reporting tools have contributed to inaccurate reporting (Jones & Lyneham, 2000; Irwin, 2006). Duxbury (2002) viewed the absence of clear guidelines for classification and definition of violent and aggressive behaviours and incidents as hindrances to accurate reporting and data collection, and Binder and McNiel (1994) referred to methodological design flaws including under-reporting of violent incidents and omissions of comparative control groups. According to a study by Jones and Lyneham (2000), under-reporting in Australia of aggressive and violent incidents by nurses is as high as 25per cent, comparable with international estimates of 20per cent. Strategies to improve reporting to provide a more accurate representation of the levels of aggression and violence should include educating and training staff to recognise and categorise them (Duraiappah, Meehan, Fjeldsoe & Stedman, 2006).

AGGRESSION AND MENTAL ILLNESS

Research into the link between mental illness or mental disorder and violence has been extensive but the findings contradictory. Some have suggested demographic factors such as age and gender are better predictors of violence than the presence or absence of mental health problems (Mortimer, 1995), but Noffsinger and Resnick (1999) assert a direct relationship between mental illness and violence. They examined the different diagnoses and symptoms to get a clearer idea of the causal link between aggression and mental illness and disorder. There is evidence of a higher incidence of violence and aggression when major mental illness and disorder are coupled with substance abuse or dependence, the highest being attributed to people with a personality disorder and co-occurring substance use problems (Mullen, 2006; Noffsinger & Resnick, 1999; Browne et al, 1998). This contrasts with Stone's (2009) finding that patients with schizophrenia were over-represented in aggressive incidents. A high incidence was associated also with psychotic symptoms such as command hallucinations, severe thought disorder, and delusional ideation with violent themes (Irwin, 2006; Bebbington et al, 1998; Browne et al, 1998). Patients who scored low on the Global Assessment of Functioning (GAF) were found also to be at higher risk of violent behaviours (Irwin, 2006; Bebbington et al, 1998; Browne et al, 1998).

RISK MANAGEMENT

Risk management in assessing violence and aggression is a complex task having as yet no instruments of high reliability and validity. Interaction with unpredictable patients, with individual idiosyncrasies and preferences compounded by symptoms and behaviours associated with mental illness or disorder, presents evident difficulties in forming an accurate risk assessment and management plan. A'Campo, Evers, Nijman and Palmstierna (2002) concluded that the use of clinical judgment and decision-making in conjunction with actuarial methods gives the greatest chance of predicting and assessing the risk of violence. This method of risk assessment is feasible in a controlled and non-hostile environment, but for nurses working directly with acutely unwell mental health inpatients there are moments when only clinical decision-making and judgment are available.

Managing risks associated with aggression and violence is the responsibility of all staff in mental health inpatient units. It is important for nurses to understand the process involved in minimising chances of aggression and violence. Procedures for identifying possible risks, assessing their probability, seeking to control the risk through implementation of proactive interventions and reviewing measures are essential to risk minimisation (Daffern, Howells & Ogloff, 2007).

CAUSES OF INPATIENT AGGRESSION

Mental health nurses need to consider a number of clinical, professional, legal and ethical issues in their work. An understanding of the causes of inpatient aggression is essential in providing quality nursing care and maintaining a safe work environment. Historically research has concentrated on the views of mental health clinicians, but recent research has examined reasons for and causes of aggression from the perspective of both patients and nursing staff. A Campo, Merckelbach, Nijman and Ravelli (1999) found that inpatient aggression could be separated into three variables: patient, staff and ward or environment. Duxbury and Whittington (2005) refined this framework into the internal, external and situational/interactional model of inpatient aggression:

1. Internal factors leading to aggression and violence are those directly linked to the patient. They include, age, gender, pain, psychopathology, medical co-morbidities and other psychosocial variables (e.g. substance use/intoxication).

2. External causes of aggression are those related to the patients' environment: physical aspects of wards, such as layout and design, privacy levels, lighting, sound, lines of sight and temperature levels can affect aggression, in a positive or negative direction. Ward environment can also be contextualised according to the number and type of patients on the ward at any one time (Jones, et al, 1998; Noble, 1997).

3. Situational/interactional precursors to violence and aggression are variables directly related to nurse-patient interactions. The interactional causes of aggression account for a large proportion of aggressive incidents (Duxbury, 2002; Jones, Owen, Tarantello & Tennant, 1998).

These factors, together with staff skill mix and adequate staff rostering to provide reasonable workloads can affect the type, severity and incidence of aggression and violence. These matters need to be considered as part of the Occupational Health and Safety (OH&S) obligations of the organisation as a whole, and individually by managers of the respective units (A Campo, Merckelbach, Nijman & Ravelli, 1999; Jones, et al, 1998; Hills, 2008; Noble, 1997). From an organisational and systemic viewpoint there are moments when patients accessing services interact with the "system": involuntary admissions, organisational policies and procedures, ward routines and regulations all have an impact on the patient and at times may be the root cause of an aggressive outburst (Irwin, 2008, Noble, 1997).

Nurses and patients view differently the causes of aggression in mental health inpatient units (Grenyer & Ilkiw-Lavalle, 2003). Nurses predominantly cite internal causes, those directly related to the patient characteristics, as causative whereas patients cite

interactional and external factors. From a patient's point of view several factors can combine to create frustration resulting in an aggressive incident. For example, a patient diagnosed with paranoid schizophrenia hospitalised involuntarily, in a strange environment with total strangers and being "poisoned with pills", becomes argumentative and refuses medication. How the nurse interacts and communicates with the patient will impact on the outcome.

Interactions between nurses and patients are a major factor in prevention and management of aggression. Education and training designed to teach nurses the necessary interpersonal communication skills, coupled with the nurse's attitudes of empathy can greatly influence the incidence and outcome of aggression (Duxbury & Whittington, 2004).

THERAPEUTIC RELATIONSHIPS

The therapeutic relationship is widely discussed in the literature. Gergolas, McConnell, Scott, Tait and Virani define the therapeutic relationship as "an interpersonal process that occurs between the nurse and the client(s) [it] is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client" (Gergolas, et al, 2002, p. 12). From a clinical perspective mental health nurses seek to obtain a positive working relationship to minimise conflict and improve health outcomes for their patients.

Aggression and violence play a large part in the breakdown of the therapeutic relationship. Nurses' attitudes towards aggressive patients and levels of experience in dealing with them can either amplify a breakdown or conversely improve patient-nurse interactions and relationships (Abderhalden et al, 2006; Jones et al, 1998; Pryor, 2006).

Experience and skill in dealing with aggressive or potentially aggressive patients and their attitude to them furnish mental health nurses with the confidence and professionalism to maintain safety and provide care in challenging situations. Whittington (2002) found that nurses who have gained "professional wisdom" through experience are more competent and comfortable in dealing with aggression. Their attitudes determine the type of intervention and clinical planning used to manage the situation and will impact positively or negatively upon the patient's health (Irwin, 2006).

Positive attitudes and skills equipping nurses to provide a high level of care include empathy, tolerance and open-mindedness which can be well received by patients, improving the therapeutic relationship (Abderhalden et al, 2006). A high level of interpersonal communication skills is the cornerstone of a therapeutic relationship: even with an aggressive patient, nurses use communication skills such as active listening, summarising, paraphrasing, negotiating, questioning for clarification and body language to come to a mutually beneficial outcome. (Farrell et al, 2010; Irwin, 2006).

Transference and counter-transference both have an impact upon nurse-patient relationships and have been widely researched. Transference is the outward expression of patients' attitudes, emotional responses and expectations towards the nurse, based not in the present moment but from past personal experience and developmental occurrences. At times the transference of emotive responses is projected in the form of aggression and violence and can be the result of many years of repetitive behaviour. Counter-transference describes a process in which a nurse transfers feelings, emotions and actions onto the patient. As with

transference, counter-transference arises from past experiences in both the clinical and personal areas of the nurse's life. Both have a major impact on nurse-patient relationships, the most troubling aspect being that reactions displayed by both are predominantly unconscious and difficult to detect (Ens, 1999; O'Kelly, 1998; Pearson, 2001).

All the concepts discussed above – attitudes, experience levels, communication skills and the transference-counter-transference processes – will impact positively or negatively on the nurses-patient relationship. When aggression and violence are added, the ability of the patient and nurse to work together toward planned goals may be impaired.

TRAINING PROGRAMS

Given the importance of training, enhanced patient rights, increasing litigation and the use of evidenced-based practice in the prevention and management of aggressive incidents, health services both nationally and internationally have initiated training programs to educate nurses in prevention and management of violence and aggression in order to reduce their impact on organisations, staff and patients. Historically, interventions used to manage violent and aggressive patients in mental health inpatient units were haphazard and unstructured (Duxbury & Paterson, 2005). Appropriate training has reduced the need for coercive practices and reduced the rate, severity and negative outcomes due to the application of de-escalation strategies (Abderhalden et al, 2004).

Many training programs emerged from the prison system in the United States of America (USA) and United Kingdom (UK). Formerly known in the UK as "Control and Restraint" (CR), the programs were later modified and implemented in the health service but, despite efforts to adapt techniques to suit the needs of the health industry, early training programs concentrated only on physical skills relating to restraint (Wright, 1999).

Through research and with improvements to physical skill sets, aggression minimisation programs have expanded to include theoretical components allowing for a more complete knowledge base. The holistic approach has assisted clinicians to feel more confident in dealing with aggressive patients and safer in their work environments, and to improved health outcomes through a higher level of care (Abderhalden et al, 2006; Calabro, Mackey & Williams, 2002; Duraiappah, Fjeldsoe, Meehan & Stedman, 2006).

Several problems have been observed that affect aggression minimisation programs: those that have been evaluated are based on acquisition of skills, mostly of physical restraint. Farrell, Salmon and Shafiei (2010, p. 1645) suggest that a "smorgasbord of content" is delivered in these programs and emphasise the need for understanding the content, rather than merely reproducing the physical skills set; the combination of theoretical knowledge and the physical skills equips clinicians to apply the techniques effectively and competently.

Quality assurance issues have also been identified. There is a lack of uniformity, scrutiny and oversight of health service training programs throughout the world (Duxbury & Paterson, 2005). Wright (1999) proposed that restraint practices be systematised and training programs to be conducted only by accredited trainers to ensure uniformity and implementation of quality assurance guidelines and to prevent incorporation of dangerous practices in mental health facilities' restraint procedures.

In an effort to streamline aggression minimisation training programs the Health and Safety Executive (HSE) in the UK conducted a study into the evaluation of violence and aggression management training to establish best practice guidelines in healthcare settings. The primary researchers, Leather and Zarola (2006) inquired into the health service's reasons for considering training, and how it was absorbed into an organisation's overall aggression minimisation policies and procedures; they also commented on the need for accreditation:

> *Accreditation of training programmes provides a sound benchmark against which training can be reviewed… an assessment of practical value, degree of learning and transfer has to be the final arbiter of training effectiveness and not accreditation in purely educational terms* (Leather & Zarola, 2006, p.10).

Leather and Zarola (2006) stressed the need for further research and for rigorous and systematic evaluation of aggression minimisation programs. They noted that previous research was limited by the methodology: poor research design, small sample sizes of participants, minimal variety of outcome measurements, and reliance on post-course evaluations, the so called "happy sheets". They proposed several clinical recommendations, a tool-kit to evaluate training programs, not in the form of an instrument for data collection but rather a set of tools for organisations and clinicians to develop policies and practice guidelines, foster discussion and enable strategic thinking, planning and decision making with regard to violence management training (Leather & Zarola, 2006, p. 57).

A research project by Allan, Bowers, Nijman, Simpson, Turner and Warren, (2006) in three UK hospitals with 14 acute mental health inpatient units included a retrospective analysis of Prevention and Management of Violence and Aggression (PMVA) programs and examined violence incidence rates and training course attendance. The results showed that during the two and a half year period 684 violent incidents took place for 5,384 admissions, and 312 attendances at PMVA training courses. Some findings surprised the researchers: a post-training increase in the number of violent incidents and the willingness of less experienced staff to engage aggressive patients. The authors suggested an explanation that reporting may have increased after training. Reporting mechanisms and reasons for reporting are discussed in the theoretical components of the course. A further possibility was that some of the wards over the period experienced staff shortages and high vacancy rates; this rather than the training course may have caused the increased incidence of violence. Also considered was the concept that participants feel more confident in engaging and confronting aggressive patients, so if de-escalation does not achieve a positive outcome a violent or aggressive incident ensues. In conclusion the authors advised further research to evaluate the PMVA training programs to determine the best course content to reduce violence and aggression.

Abderhalden et al (2006) conducted a study on the effect of a training course on mental health nurses' attitudes towards patient aggression, which are an important factor in the therapeutic relationship and can affect interactions between nurses and aggressive patients. A quasi-experimental method was used with 29 nurses in the intervention group and 34 in the control group. Participants were tested before and after implementation of the intervention group's training course. To measure nurses' attitudes the Management of Aggression and Violence Attitude Scale (MAVAS) was used. The MAVAS tool devised by the researchers consists of 27 statements, the questions distributed in four sections. Questions included items about the internal, external and situational/interactional model already discussed in this paper, and a few about general aggression management. Results showed minimal changes in the intervention group in attitudes towards aggression. The authors supplied several explanations: ineffectiveness of the content to change attitudes too ingrained to be influenced by training; that the MAVAS tool used to measure attitudinal changes was "too sensitive" to note any significant changes post-test. They proposed that to overcome the limitations of their research further studies of the effect of training on attitudes toward aggression be qualitative in nature (Abderhalden et al, 2006, p.201).

In a similar study based on nurses' attitudes toward aggression, Collins (1994, p.117) evaluated attitudinal changes for participants who completed the Prevention and Management of Aggressive Behaviour Programme (PMAB). The design included a pre and post-course questionnaire and another questionnaire six months later. The author developed the tool used to measure attitudinal change (Attitudes Toward Aggressive Behaviour Questionnaire), which comprised 12 statements where respondents selected a response on a five-point Likert scale. Participants were 22 students and nine Psychiatric Intensive Care Unit (PICU) nurses. The findings show a positive attitudinal change for the prediction of violence and aggression; patient motivation and responsibility for aggression; staff anxiety about assault; the need for skilled interventions in managing violence and aggression; and confidence in implementing new learning. Sample size and non-randomisation of subjects were limiting factors in this study.

Further research on the effectiveness of a de-escalation and physical intervention training course was conducted by Flach, Gray and Laker (2009) who aimed to examine the effectiveness and cost efficiency of the training course relating to incidence rates and severity of aggressive incidents in a PICU. Analysis of statistics showed no significant difference pre and post- training on these two outcome measures, but the authors suggested that under-reporting and difficulties associated with the subjective nature of classifying aggression and violence may have affected the results.

Calabro, Mackey and Williams (2002, p.3) studied a training program designed to prevent and manage violent and aggressive patients in the USA in an acute psychiatric hospital consisting of 12 inpatient units: the aim was to evaluate the course in the areas of "knowledge, attitudes, self-efficacy and behavioural intention". The Nonviolent Crisis Intervention (CPI) course teaches prevention and management of disruptive behaviours exhibited by patients, and the Handle with Care program is a mix of theoretical and physical skill interventions used to manage aggressive and violent patients. Hospital staff (n=180) completed an evaluation pre and post training to measure changes in knowledge and 66 per cent responded. A 5-point Likert scale was used to evaluate the areas of attitude, self-efficacy and behavioural intention and all outcomes showed a significant improvement immediately after the 1 ½ day course. The researchers suggested that participants were more likely to engage with aggressive patients and felt more confident and willing to utilise the skills taught and commented that the absence of a comparison group was a limitation. A further limitation was that there was no measurement of skills transfer to the clinical environment post intervention.

Research conducted in Australia by Biro et al (2004) developed and evaluated an aggression minimisation training program, of theoretical content only and consisting of three modules: first, general aggression and violence minimisation principles; the second, discussion relating to high-risk workplaces and their relevant special requirements; and the third directed towards

managers and supervisors. Two sample groups were selected, the first having 15 experienced aggression minimisation trainers to evaluate the two day "train the trainer course" by means of a 10-point scale for subjects such as appropriateness and relevance of the manual, course content, teaching strategies, and the ease with which the assessment could be conducted. The second group comprised 48 health service staff across a number of clinical and non-clinical disciplines. These participants did not attend all modules; only five completed the whole course content, a real limitation of the study. Post training participants were asked to complete a ten - question survey using a 10-point Likert scale relating to satisfaction with the program, also to provide comments about knowledge and skills acquired during training, attitudes toward violence and aggression, and perceived confidence in dealing with violence and aggression after training. The results for the first group of participants whose modules were evaluated by trainers indicated satisfaction with the course content and an increased skill and knowledge base. Attitudes to and confidence in dealing with aggressive patients also showed a significant improvement.

The researchers discussed the study limitations and suggested that further research look into the impact that aggression minimisation programs have on reducing workplace aggression rates in health services. The authors also suggested that less experienced clinicians be included in the sample groups with an increase in sample size required (Biro et al, 2004).

Duraiappah, Fjeldsoe, Meehan and Stedman (2006) evaluated the effectiveness of a multi-strategy approach to reduce the incidence of aggression and violence in a mental health inpatient facility, consisting of an aggression minimisation training course, employee support program, a risk assessment checklist, and a computer based incident reporting system. The results showed a decrease in the number of staff injuries and incident rates, even though the severity of patients' illness increased over the three-year study period. Aggressive incidents for the period reviewed decreased from 60.4 per month to 32.83 per month, with staff injuries also falling from 10.70 to 3.17 per month, however the decrease was not statistically significantly when adjusted for occupied bed days. The aggression minimisation program was based on the Professional Assault Response Training (PART) program. Participants in the three-day workshop were instructed in theoretical de-escalation and intervention strategies, and physical skills training in evasion and restraint practices. The authors believed the multi-strategy approach was the reason for the positive results but, as in other studies cited in this review, implied that the lack of a control group in the study limited the reliability of the results.

In an effort to evaluate a training program designed to teach how to use breakaway techniques in the clinical area Dickens, Doyle, McGuinness, Rogers, and Rooney (2009) simulated an assaultive incident and asked the 147 participants to put into effect the methods learnt in physical skills training. Their proficiency was assessed by two independent experts. Results showed that only 14 per cent used the correct techniques, but still the large majority of staff (80per cent) were able to break away from the assault. The authors proposed that breakaway techniques are too complex to remember in a real life situation and that "instinctual responses" are best. The major study limitation is the superficial context of the assault. A simulated assault could never reproduce the same degree of threat as a real life assault. Further research of breakaway techniques was recommended to establish best practice content to be taught in training programs.

THE LOCAL SCENE

In response to problems associated with violence and aggression Hunter New England workplace implemented a training program designed to educate staff to deal with violence and aggression. The Prevention and Management of Violence and Aggression (PMVA) training program was first introduced in February 2004 to the Mental Health Service. Since its inception the incidence of violence and aggression, staff injuries and lost time due to injury has reduced (PMVA Unit, 2005), although whether this is due to the implementation of the program is difficult to assess. A total of 975 staff have attended the four day PMVA training program between February 2004 to October 2010. In this same period 563 of these staff have attended a one-day refresher course with 245 of these people completing a second refresher.

The PMVA training program includes the mandatory training requirement of the NSW Health "Zero tolerance" policy (NSW Health, 2003), an initiative implemented by NSW Health to increase awareness of violence and aggression in NSW Health facilities. In line with international evidenced based practice the PMVA program teaches theoretical and physical skills training that is delivered in a modular design to enable all staff to receive training at the level required of their position within the organisation (PMVA Unit, 2005). Further skills in the areas of evading and disengaging from personal attack, manual handling techniques for escorting aggressive clients and the controlled restraint process utilised by a team response are taught in a progressive manner where skills and rationales are compounded to enhance competency (PMVA Unit, 2005).Throughout the training staff are encouraged and reminded to use reflective practices and maintain a consumer-oriented perspective. All of the training is geared toward promoting client safety when implementing the theoretical and physical PMVA skills.

Since its inception PMVA has continuously expanded and adjusted to meet the demands of the organisation it services. With changes to the Mental Health Act of NSW (2009), the NSW Health seclusion policy in 2007 and the introduction of the area PMVA procedure in March, 2009, education and training related to updated legislation and policy have been included in the training package to educate participants about their roles and responsibilities in these clinical areas.

CONCLUSION

Violence and aggression, the basis of much research in recent years, is a major professional issue for nurses who work in mental health inpatient facilities. Health service organisations everywhere have been introducing various strategies in an attempt to minimise the problem, a major innovation being the introduction of aggression minimisation programs.

Results and opinions both nationally and internationally have varied about the effectiveness of training programs designed to minimise violence and aggression in the mental health context. Not only are researchers evaluating very different programs, but the types of studies conducted, the limitations of study designs including small sample sizes and lack of control groups, and the many outcome variables make it difficult to draw tangible conclusions about the success of the training programs in reducing violence. As discussed by Leather and Zarola (2006) not until a set of guidelines is agreed will researchers and health care organisations be able to assess the value of aggression minimisation programs.

Further research on aggression minimisation programs is indicated to establish best practice guidelines to minimise patient violence,

which has such a profound impact on patients, nurses and the therapeutic relationship.

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