A charter for trainers in the prevention and management of workplace violence in mental health settings

Brodie Paterson, Kevin McKenna and Vaughan Bowie

Abstract
Purpose – The purpose of this paper is to present the results of a Delphi study of trainers in the prevention and safer management of violence in mental health settings that sought to identify and clarify what represents best practice at a European level.

Design/methodology/approach – A Delphi method was used to garner the views of a sample of 54 trainers involved in the training of managing violence and aggression on a draft charter of best practice.

Findings – A high level of agreement was found with the suggested indicators of best practice but the levels of agreement varied in some key areas and respondents identified a series of omissions from the charter and a number of potential challenges to its implementation.

Research limitations/implications – The sample was restricted to Europe and further research is planned to seek the views of a wider sample.

Practical implications – The charter will provide a reference document for best practice in the interim.

Social implications – Its implementation will require trainers to consciously identify the ethical implications not just of the content of their training buts its overall approach.

Originality/value – The study is presently unique in its focus and context but further research in this area is underway designed to complement this study.

Keywords Violence, Training, Delphi, Mental, ENTMA, Restraint

Paper type Research paper

Introduction
The European Network for Training in the Management of Aggression (ENTMA 08) is a not for profit association, which aims to unite and support those involved in the design, delivery, commissioning, evaluation and regulation of training across Europe. Its ambition is to promote evidence-based best practice and share experience and expertise in order to achieve practice and organisational excellence in the design, delivery and evaluation of training in the prevention and safer management of aggression and violence.

ENTMA evolved from an informal European collaboration between trainers in the management of aggression, which had existed since 1998 and adopted the name ENTMA in 2004, which was changed to ENTMA 08 in 2008 to mark the formation of an international steering group to guide the future of the network. The collaboration has to date involved professionals across a broad range of health, care and related sectors who are engaged in, or associated with training in the management of aggression and violence. The collaboration has provided a forum within which perspectives on the nature, function and methods of training can be exchanged. This has facilitated an exploration of the core values that should underpin training, and sought to establish a shared understanding of best practice in the design, delivery and evaluation of training.
Despite the existence of sectoral guidance mandating training and specifying its content at a European level for staff in services for people with mental disorder (Council of Europe Steering Committee on Bioethics, 2000) it is clear that training and practice continue to vary significantly across Europe and sometimes within individual states (Whittington et al., 2006). It appeared to ENTMA 08 therefore that the development of a “charter” identifying the principles that should underlie the role and content of training offered an opportunity to establish a Europe wide vision of best practice. Such a charter is hoped will provide not just a statement of such principles but a document that may be used to identify and challenge examples of poor practice.

This paper will first discuss the contemporary background in order that the rationale behind the development of the charter is understood. It will then outline the development process and present the results of the first stage of a Delphi exercise undertaken to establish face and content validity. It will then discuss the implications of such results for the further development of the charter as well as wider practice and policy in this area.

Background

Training forms only one element of the multidimensional strategies that are invariably needed to realise the whole organisation, public health-based approaches that currently represent best practice in the prevention and safer management of workplace violence in mental health services (Bowen et al., 2011). Training in managing violent crisis may, however sometimes be misused as a stand alone intervention by organisations as a means to avoid the broader organisational changes whether in staff numbers, wider skills, the physical environment or the malign influence of corrupted cultures that are needed (Bowie, 2011). When such ill-informed initiatives fail, blame may then be attributed to the training content, the training provider, or to the participants who are invariably direct care staff. This may absolve the wider organisation and its management of their responsibilities and perpetuates denial of the need for the deeper improvements in governance and practice necessary (Bowie et al., 2005; Bowie, 2011).

Where the focus of training is primarily on improved crisis management and in particular on physical intervention, i.e. restraint, there is at least some research to suggest that such approaches with some training models appear to produce negative results with increases in violent incidents and staff and patient injuries recorded in a number of studies (Leadbetter and Paterson, 2010). Training in the prevention and management of violence and aggression is though not a homogenous intervention. There is huge variation in the frame of the problem used to inform training, how the training provider engages with the service provider and the content and duration of training. In addition who is trained varies between approaches, e.g. only direct care staff or all clinical staff or all direct care staff, all clinicians and all senior managers (McKenna, 2008).

Considerable caution must therefore be exercised in assuming that “training” in this area will produce a positive results, or even do no harm (McKenna, 2008; Stubbs et al., 2009). Unlike some other types of training that at their worst may have little impact, inappropriately conceived and/or poorly designed violence prevention and management training developed and conducted in an inappropriate manner in a dysfunctional and toxic service may result in considerable harm (Bowie, 2013).

Within some organisations the dominant frame of the problem of workplace violence stems from concern over staff being potentially injured during assaults and/or their attempts to restrain and the interpretation of this as a technical problem capable of resolution by training staff to restrain more effectively. Implicit to this frame may, however be the belief not only that improved staff competency will reduce injuries during restraint but that service users will be dissuaded from assault in future (Paterson et al., 2011). Both of these premise may be false but convincing such an organisation of the need to embrace what may be a profound change in their fundamental values, core working practices and hierarchies may be perilous for a trainer employed by such an organisation. For an external commercial training provider convincing such an organisation that their framing of the problem is wrong and that their training needs are more extensive than those perceived may result in the organisation choosing to find an alternative training provider who will meet their original demands at the lowest cost.
Much training in the prevention and management of aggression continues to be delivered via standardised scripts, via trainers who have themselves undertaken short “train the trainer” programmes. The content of such programmes is typically not informed by the detailed consultation and training needs analysis necessary to develop a programme that will actually respond to the needs of a particular service, its staff, and its potentially diverse range of service users (Paterson et al., 2008). There are two intrinsic flaws in such approaches. The first is the perpetuation of the perception of physical interventions as a “skill taught to staff” rather than as an “intervention done to patients”. Physical interventions need to be understood as a patient focused intervention purposefully employed within a professional care context, which effectively shifts the focus from one of managing aggression and violence to one of professional patient care (McKenna, 2008, p. 60). The second flaw is the application of a “product” solution, i.e. standardised training packages to a “process” problem, which almost invariably has service specific dimensions. This requires an integrated solution in which training is nested within a broader violence prevention strategy designed specifically to reflect the context of that organisation and whose senior management team are committed to its implementation (McKenna and Paterson, 2006).

The pressures of an unregulated marketplace in training in the prevention and management of violence that continues to exist in most settings and countries in Europe are, however substantial. This may create ethical dilemmas for trainers whose awareness that ethical issues are present in their overall approach and not just the content of their training appears to vary (Ward and Syversen, 2009). Trainers may be aware of the dilemmas involved in physical intervention training, e.g. around pain compliance but lack the broader awareness that the framing of the problem, the demands placed on training and the decisions regarding who needs trained in what also have significant ethical ramifications (Ianinska and Garcia-Zamor, 2006).

The recognition of the potential dangers of an unregulated marketplace have led to the development of a number of “accreditation” schemes for training in the prevention and safer management of violence most notably in the UK. These include a scheme developed by the British Institute of Learning Disabilities specifically for physical intervention training providers in the care sector and a number of qualifications endorsed by UK Government recognised educational accrediting bodies including City and Guilds and Edexcel. Such schemes can be criticised, however, the BILD scheme whilst endorsed in English government guidance is not mandatory and actually explicitly eschews any judgments on the physical intervention procedures a given accredited training provider may use. Hence accreditation may offer little real assurance regarding the content of training, its appropriateness in relation to meeting the relevant sectoral or occupational standards or ultimately even its safety (Steckley and Kendrick, 2008).

There is presently no European regulatory mechanism and in many countries no guidance on the suggested philosophy or content of training. In the absence of such guidance there is little to differentiate the more unscrupulous elements of the training industry from those who espouse best practice. A charter developed by ENTMA08 and endorsed as representing best practice by trainers could therefore fill at least in part the current regulatory gap. It could also inform potential customers of training providers of what currently represents best practice.

Method
The approach taken in the development of the charter involved a modified Delphi approach that to date has involved the initial development of the charter by the ENTMA steering group and piloting the draft charter to establish face and content validity with a sample of trainers. The results of this first round are reported here with subsequent rounds planned.

Face validity in this context describes the extent to which trainers agree that the charter appears to represent what it purports to i.e. best practice in the provision of training in the prevention and safer management of workplace violence (Bowling, 2002; Greenwood, 2004). While ultimately based on subjective judgments it is important for the charter to enjoy reasonable face validity with the community of trainers involved in the delivery of the training in this area if it is to have any impact (Greenwood, 2004). Content validity in this context seeks to establish more
specifically whether the multiple dimensions of what best practice in this area may involve are adequately represented within the charter, i.e. has anything been missed and to exclude any themes considered irrelevant (Greenwood, 2004).

The Delphi technique has been used for some decades and is regarded as an effective means of ascertaining group consensus (Black et al., 1999). Utilising a structured process, the method typically involves a number of structured rounds of consultation with identified experts to arrive at group agreement. An implicit challenge to the validity of the process is, however the means by which expertise in a given area is determined (Hasson and Keeney, 2011). Expertise may variously be determined by seniority, years of experience, qualifications or research undertaken and published (Hasson and Keeney, 2011). In this instance given the lack of evidence correlating such criteria with the adoption of best practice a pragmatic and inclusive approach was adopted such that the sample used in the first round were those attending a workshop at the ENTMA 08 trainers conference in Amsterdam in 2010. The aims of the study and how completed data would be used were presented at the workshop. Implied consent by participants was presumed by their voluntary completion and return of the survey.

Data collection

The draft charter was circulated with respondents asked to rate their agreement using a visual analogue scale to identify their agreement with the charter statements of principle. Qualitative data were also sought via the option for individuals to make comments in relation to any aspect of the proposed charter.

Response rate/sample demographics

As a pragmatic convenience sample the response rate was 100 per cent with a sample size of $n = 54$. The sample was 66 per cent male, 35 per cent female. In total, 92 per cent had trained as an instructor and 98 per cent of those trained were currently practicing as a trainer either part time or full time (sample mean 55 per cent time spent in a training role) suggesting the sample were overwhelmingly active trainers who spent the majority of their time training. More than 50 per cent of the sample had trained in more than one model (range of number of models trained in $1 = 10$) indicating most had some experience in different approaches to WPV training with respondents identifying a total of 19 different models they had trained in or were using. Their length of experience (not necessarily as a trainer with their current organisation) ranged from seven months to 33 years with the mean 12 years and two months. Their mean cumulative experience in a training role was eight years six months (not just their current post or training model). The range was from two months – 25 years. In total, 35 per cent ($n = 19$) worked in general psychiatry, 25.9 per cent worked with children (child and adolescent mental health and social care; $n = 14$). In total, 22 per cent worked in Forensic mental health/secure settings ($n = 12$). In total, 9.3 per cent worked in general hospital settings ($n = 5$) and 5.6 per cent worked in services for people with a learning disability ($n = 3$). However, 63 per cent respondents ($n = 31$) trained in more than one clinical setting compared to 27.8 per cent ($n = 15$) who trained in only one. Training outside the trainers original or continuing area of practice was it appeared therefore commonplace. This practice may be questionable as the trainer may lack knowledge of key issues affecting that patient population and sector.

Data analysis

Quantitative analysis was undertaken using SPSS 16. The approach used in the qualitative data analysis was thematic and theoretical rather than inductive as it was informed by the focus on improving the validity of the charter (Braun and Clarke, 2006).

Results

Respondents were asked to rate their agreement/disagreement using a VAS scale (which provided an analogue ranking of 1-100 with a series of statements covering three broad areas. The VAS ranking used meant that a score of 100.00 represented complete disagreement with the statement and a score of 0.00 complete agreement (Table I).
Although broad agreement with most principles was extremely high some variation was evident both in the range of scores and the mean rating. Only two items achieved >90 per cent agreement, which is in some respects unsurprising. The two statements that failed to reach this level of agreement were; “Trainers should strive to integrate training into a broader organisational agenda” (mean rating 12.7) and “training should be located in the context of a professional relationship” (mean rating 13.05).

Given the emergent emphasis on the need for whole organisation approaches any lack of agreement is somewhat disquieting but may reflect for at least some trainers their inability to realise such an objective. As one respondent noted, “what does a trainer do with a ‘bad’ organisation, which has a different agenda” suggesting that “ENTMA provide a model for Management infiltration in order to accomplish integration”.

The suggestion that training should be located in the context of a professional relationship attracted what is in some respects still a high level of agreement but this was notably less than in other areas. This may however reflect a context where some trainers may not in fact hold any relevant professional qualification, e.g. nursing, psychology or psychotherapy (Zarola and Leather, 2006). They may therefore ultimately hold no professional obligation in terms of professional conduct to the end user, i.e. the patient/service user.

The suggestion that the training provided should be needs assessed, service specific and fit for purpose (mean rating 9.8) only just reached 90 per cent agreement, which is again surprising. Delivering training which was not based on needs assessment, was not service specific and was not fit for purpose’ would clearly be of concern. It appears, however, that such practice may still continue or at least that such practice is endorsed by an albeit small minority of training professionals.

The suggestion that trainers should not practice outside their sphere of competence generated a number of written comments. Participants noted that “working outside sphere of competence” would involve “dangerous practice” and could “compromise people”. Another respondent however suggested “conflict handling its relational so its everywhere”. What was interpreted by respondents as indicating competence in response to this statement is potentially interesting given earlier observations that the majority of trainers delivered training outside their own practice area.

A number of participants questioned what was meant in relation to one or several of the statements in the charter. A few made specific reference to the charter statement that the trainer should act in a professional and ethical manner suggesting that further clarification of what this meant in practice was required:

What is competent, professional, ethical?

<table>
<thead>
<tr>
<th>Table I</th>
<th>VAS ranking</th>
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<tbody>
<tr>
<td><strong>Section 1: the role of the trainer as professional</strong></td>
<td><strong>Mean rating</strong></td>
</tr>
<tr>
<td>Trainers should only provide training within their scope of competence</td>
<td>9.2</td>
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<tr>
<td>Trainers should demonstrate their commitment to continuing professional development</td>
<td>9.5</td>
</tr>
<tr>
<td>Trainers should act in a professional and ethical manner</td>
<td>4.09</td>
</tr>
<tr>
<td><strong>Section 2: training content</strong></td>
<td><strong>Mean rating</strong></td>
</tr>
<tr>
<td>Training should be located in the context of a professional relationship</td>
<td>13.05</td>
</tr>
<tr>
<td>Training provided should be safe, evidence based and best practice</td>
<td>6.3</td>
</tr>
<tr>
<td>Training provided should be needs assessed service specific and fit for purpose</td>
<td>9.8</td>
</tr>
<tr>
<td>Training should be conducive with prevailing legal and ethical guidance</td>
<td>6.0</td>
</tr>
<tr>
<td>Training should emphasise the primacy of prevention at all levels</td>
<td>8.2</td>
</tr>
<tr>
<td><strong>Section 3: the provision of training</strong></td>
<td><strong>Mean rating</strong></td>
</tr>
<tr>
<td>Trainers should strive to integrate training into a broader organisational agenda</td>
<td>12.7</td>
</tr>
<tr>
<td>Training should be conducted with due care to the safety of participants</td>
<td>5.4</td>
</tr>
<tr>
<td>Training should be conducted in a manner that recognises diversity in all its forms</td>
<td>7.4</td>
</tr>
<tr>
<td>Training should be conducted in a manner that respects the dignity of participants</td>
<td>5.3</td>
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</table>
Professional and ethical needs explanation. Professional how do we define and standardise terms. Ethical which point of view/philosophy.

Professional, ethical’. Specify what is meant, what do we want specifically.

This suggests that clarification of what is meant by the ethics of the trainer is required.

The National Staff Development and Training Association in North America Code of Ethics identifies six core values and principles of a human service training and development professional irrespective of the specific focus of training (Curry et al., 2004):

1. beneficence and non-maleficence;
2. learning, development, self-awareness and self-actualisation;
3. human service leadership;
4. individual uniqueness, cultural diversity and competence;
5. self-determination; and
6. integrity.

A number of these themes are, however, already reflected in the charter headings under Continuing Professional Development, Diversity and some existing elements may be argued to represent behaviour which represents integrity in the trainer such as ensuring that training is needs assessed, embedded within an organisational strategy embedded within a professional relationship, etc.

Omissions

It was suggested that the charter should contain an obligation that “trainers evaluate their training”. Whilst how this was to be resourced or accomplished in terms of what would represent an acceptable quality of evaluation was not specified and best practice in research ethics would suggest that trainers should not evaluate their own training the principle seems laudable and will be added to the revised charter for the next round.

It was also noted that the charter makes no reference to the question of “pain compliance” and comments suggested that the question should be at least in “discussion at ENTMA” within a broader discussion regarding the “Safety of techniques”.

The charter makes no explicit reference to trauma and this on reflection appears a potential omission for a number of reasons. Respondents suggested that “Service user/survival involvement” must be addressed within the standards and this introduces the need to discuss trauma. Research (Sellers and Hunter, 2005) suggests histories of high levels of assault and abuse in service users but also in human services students and graduates particularly women who may form the majority of the workforce in many settings where training in the prevention and safer management of violence may be delivered. Evidence suggests (Zarola and Leather, 2006) and this research confirms, however that the majority of trainers in the industry especially where physical intervention, i.e. restraint is taught are male. Given the perpetrator of abuse against women is most often male the potential for re-traumatisation during training is evident and may be increased in training experiences such as requesting female course participants to role play a female service user being restrained (Tjeltveit and Gottlieb, 2010). The issue of trauma may thus need to be made more explicit.

Irrespective of content a number of respondents observed the fundamental question was “who would regulate”. A voluntary code of practice was welcomed “as a start” but a “code of conduct for trainers was needed” that could actually be enforced was suggested. This might answer the observation of one respondent of who “will certify that trainers are professional”.

Conclusion

Trainers who provide training in the prevention and safer management of workplace violence face a number of ethical dilemmas. They face challenges regarding their framing
of the problem and thus the nature of the solution they advocate where these do not resonate with the organisation concerned. Even if broad agreement on the philosophical approach is reached the financial and human resources necessary to realise that approach may be limited forcing compromises (Paterson, 2010). In responding to such challenges trainers need to seek “to understand their own worldviews and frameworks that consciously or unconsciously may influence their own approach to training” (Bowie, 2013). Informed by such an awareness they then need to make use of charters, guidelines and relevant professional codes of ethics as well as decision-making models to guide them in their practice and the choices that inform it (Bergenhenegouwenm, 1996; Bowie, 2013).

References


Further reading


Corresponding author

Dr Brodie Paterson can be contacted at: b.a.paterson@stir.ac.uk

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