Journal of Workplace Behavioral Health

ISSN: 1555-5240 (Print) 1555-5259 (Online) Journal homepage: https://www.tandfonline.com/loi/wjwb20

Workplace Safety Policies in Mental Health Settings

Tony B. Lowe PhD & Wynne S. Korr PhD

To cite this article: Tony B. Lowe PhD & Wynne S. Korr PhD (2008) Workplace Safety Policies in Mental Health Settings, Journal of Workplace Behavioral Health, 22:4, 29-47, DOI: 10.1080/15555240802157130

To link to this article: https://doi.org/10.1080/15555240802157130

Workplace Safety Policies in Mental Health Settings

Tony B. Lowe
Wynne S. Korr

SUMMARY. Social workers have repeatedly called for increased safety practices as a means of preventing and reducing client-related violence in the field. The present article investigated mental health service agencies' adherence to the National Institute of Occupational Safety and Health Administration's (NIOSHA) administrative and work practice policy guidelines to prevent workplace violence for health care and social service workers. A random sample of National Association of Social Workers members (N = 181) who were current or former supervisors in mental health settings were surveyed. The findings suggest that there are variations in compliance with recommended policy/protocols for worker safety. Implications for practice, policy, and research are discussed.

KEYWORDS. Workplace violence, social workers, supervisors, mental health and policy practices

---

Tony B. Lowe, PhD, is Assistant Professor, School of Social Work, University of Georgia.

Wynne S. Korr, PhD, is Dean and Professor, School of Social Work, University of Illinois at Urbana Champaign.

Address correspondence to: Tony B. Lowe, PhD, School Of Social Work, University Of Georgia, Athens, GA 30602-7016 (E-mail: tblowe@uga.edu).

The authors would like to express their special thank to Dr. June G. Hopps for her critical feedback and insight. An early version of this article was given as a paper presentation at the 24th National Symposium for Psychiatric Practitioners in Athens, GA. February 2-5, 2004. This study was funded by a grant from the Centers for Disease Control and Prevention, National Institute of Occupational Health and Safety Administration (Grant No. 1 R03 0H07374-01).

Journal of Workplace Behavioral Health, Vol. 22(4) 2007
Available online at http://jwbh.haworthpress.com

doi:10.1080/15555240802157130

INTRODUCTION

Client-related violence is all too often a common experience in the workplace for human service professionals. Research studies have recognized for about three decades that human service professionals, such as psychiatrists, psychologists, social workers, and nurses report significant experiences with client-related violence in the workplace (Beck & Schouten, 2000; Black et al., 1994; Flannery et al., 2001; Gates, 2004; Guy et al., 1990; Jayaratne et al., 1996; Spencer & Munch, 2003; Newhill, 1996; Rey, 1996). Therefore, it is no surprise that investigators also documented psychological and physiological trauma, as well as fatalities among workers targeted by such violence (Love et al., 2003; Spencer & Munch, 2003). Professional social workers, for example, report high annual (25%) and career (almost 50%) rates of this form of occupational health hazard that often contribute to significant levels of anxiety, burnout, depression, and irritability in comparison to their colleagues who experience low levels of such violence (Beaver, 1999; Jayaratne et al., 1996; Newhill, 1996). In fact, they also report delivering poor quality of services and having low interest in working with potentially violent clients. Similarly, significant rates of client-related workplace violence are widely documented among professional nurses (Love et al., 2003). Since most client assaults in human service work are not fatal and, therefore, remain unreported, there is limited public awareness and/or media attention (Department of Health and Human Service [DHHS], 1998; Spencer & Munch, 2003). Due to this reality, federal recognition of workplace violence in human services in 1996 led to the National Institute of Occupational Safety and Health Administration (NIOSHA) issuing voluntary guidelines for preventing and reducing violence toward health care and social service workers (DHHS, 1998).

Since professional social workers are among the nation's largest providers of mental health services (Substance Abuse and Mental Health Service Administration [SAMHSA], 1998), it seems prudent to recognize that they can provide both critical and valuable insights for safe policy practices in mental health service settings. The purpose of this study is to examine the mental health service industry's level of compliance with the NIOSHA recommended safety policies, and also to explore associated factors contributing to this compliance.

CLIENT-RELATED VIOLENCE IN MENTAL HEALTH SETTINGS

Risks of client-related violence toward professionals in mental health services are associated with a number of risk factors. Certain client characteristics have been identified as contributory to the phenomenon of increased risk of violence in these settings (Mulvey, 1994), which heightens the vulnerability of those delivering service. The demographic of those who demonstrate violence-prone behavior include young, male, unmarried, unemployed, and low socioeconomic status (Guy et al., 1990). Similarly, in terms of behavior, these clients have been found to have a prior history of violence and non-compliance with medication (Mulvey, 1994; Swartz et al., 1998). Diagnostically, they have been identified as having schizophrenia, bi-polar disorder, personality disorders, substance abuse, and other co-occurring disorders (Torrey, 1994; Swanson, 1994). The convergence of any combination of these risk-associated characteristics serves only to magnify the vulnerability of practitioners. The single most important predictive factor, however, is a prior history of violent behavior.

Mental health practitioners know all too well about violence in the workplace. In fact, mental health professionals (psychiatrist/social workers) are four times more likely to experience non-fatal workplace assaults than employees in the general workforce (Department of Justice, 1998; Flannery, 2002). Although fatal assaults are rare in human services, non- fatal assaults in the form of verbal and physical assaults, attacks, and threats are common (Beck & Schouten, 2000) and contribute to elevated rates of trauma (Horwitz, 2006; Jayaratne et al., 1996). The risk of experiencing such violence is associated with the proximity to factors previously noted, providing services to violent clients or in potentially violent communities, increases service providers' risk of being a target (Findorff et al., 2004). These findings are widely documented in both the professional social work and nursing literature (Beaver, 1999; Flannery et al., 2001; Gerberich et al., 2004; Goodman et al., 1994; Rey, 1996). Therefore, this widespread risk of occupational health hazards has a rippling effect on client services, worker productivity, and institutional effectiveness (Toscano & Weber, 1995).

WORKPLACE SAFETY APPROACHES

Davis (1991) suggested workplace safety in mental health services must be addressed at both the individual and administrative levels. Individual efforts include workers' training on topics such as identifying service risks, developing de-escalation skills, and proper restraining methods–commonly called non-violent crisis intervention training. On the other hand, administrative efforts generally involve policy protocols designed to prevent, minimize, and reduce the effects of safety hazards in the workplace (Spencer & Munch, 2003). These methods include reporting and documenting incidents as well as post-incident interventions that involve mid-level managers (i.e., examining the event, providing support, developing a prevention plan). Similarly, NIOSHA called for behavioral (or individual), administrative and environmental design strategies to prevent workplace violence in 1996. The NIOSHA endorsement of environmental design strategies represented an extension of safety consideration to human services. Their strategies include a series of administrative and work practice control policies that address both the human service agencies policies and work practices. Agency policy recommendations, for example, included clearly prohibiting violence and establishing a liaison with local law enforcement. Despite these concerns, there has been no systematic investigation into practices across the health care industry (Lipscomb et al., 2002), like mental health.

RATIONALE AND PURPOSE OF THE STUDY

Despite three decades of recognition of client-related violence in mental health services, there remains no way of comparing safety policy practices across industries. To date, no study has systematically investigated the level at which mental health service agencies are responding to safety in the workplace from the social work supervisor's perspective. To address this gap, this project surveyed a sample of National Association of Social Workers (NASW) members, who identified supervision as their primary role and mental health settings as place of employment. Since professional social workers are often found in mid-level roles in mental health agencies across the nation, they are in a position to inform service planners on current safety practice trends.

Thus, this study solicited information about their mental health service settings compliance with the NIOSHA's administrative and work practice

guidelines to prevent workplace violence in mental health settings. The purpose of this descriptive and exploratory study is to document and understand current patterns in this industry. Thus, three questions are central to this investigative effort: (1) What are the levels of compliance with the NIOSHA recommended safety policy guidelines in mental health settings? (2) Are agencies current policy practice levels adequate? and (3) What factors are correlated with an agency's level of compliance?

RESEARCH METHODOLOGY

Design and Data Collection

This investigation used a cross-sectional mail survey design as a means of collecting data from professional social work supervisors. Active National Association of Social Workers (NASW) members who identified "mental health" as their primary practice domain and "supervision" as their primary practice function were solicited via mail for voluntary participation. Of the 1,246 NASW members who met the above criteria, 600 were randomly solicited. Nine solicited mailings were returned by the postal service marked "undeliverable." Of the 592 delivered surveys, 295 (50%) were returned by respondents. In an effort to increase the number of respondents, the researchers sent a reminder postcard one week after the original mailing, and a second wave mailing was sent to those who had not responded three weeks later.

Based on the original inclusion criterion of "currently supervising," 114 (38.6%) of the total returned surveys were excluded from the study. After further examination, the researchers found that 95 respondents were former supervisors in mental health settings. Therefore, a decision was made to include them in the sample to increase the final number of respondents. Thus, a total usable count of 181 current and former social work supervisors was achieved (a 30% response rate). Although lower than what the researchers anticipated, the response rate is within the national average for mail surveys (Dillman, 1991; Larson & Poist, 2004). Uni-variate and bi-variate analyses were used to examine the data.

Study instrument. The instrument included a survey of agency safety policy practices, supervisor perception and policy adequacy, and demographic information. The descriptive section included 10 items about respondents' demographic profile, supervisory characteristics, and service setting. The section on safety policy included 24 closed-ended questions concerning their agency's workplace organizational safety policy

practices, and the respondent's beliefs regarding safety and level of client-violence risk for social service staff.

The Study's Central Measures

Supervisor's gender. Respondents' self-report on a closed-item question established their gender.

Service settings. Settings were originally categorized as: outpatient mental health counseling centers, inpatient mental health, acute care, residential facilities, private practice, child welfare/foster care, veteran's affairs, health care, retired/unemployed and others. Responses were later collapsed for reporting purposes into three categories: Inpatient/acute care/residential settings = 1, outpatient/counseling centers = 2, and others = 3.

Supervisor's perception of risk. Respondents were asked to report their perception of staff risk to client-violence in their agency. Their response options ranged from low = 1, moderate = 2 or high = 3 to operational variable.

Supervisor's perception of policy adequacy. Respondents were asked to report their perception of their agency's safety policy adequacy. Their response options were dichotomized, agree = 1 or disagree = 2. One opened-ended question was presented which solicited the reason for their belief.

Level of safety policy practices. The Administrative and Work Practice Control Questionnaire (AWPCQ) measure, a 24-item instrument, was used to evaluate the implementation of OSHA's policy recommendations for preventing workplace violence in social service and healthcare settings. This measure was adapted from administrative and work practice recommendations proposed by NIOSHA to prevent workplace violence (DHHS, 1998). Respondents were asked to indicate whether current policy and/or procedures in their agency reflected specific work practice safety controls. A sample of items follows: "Our agency currently has policies and/or procedures that establish a system for identifying potentially volatile clients" and "Our social service employees are required to report all assaults or threats to a supervisor or manager." Their response options were yes = 1, no = 0, to not applicable = 0. Select items were re-coded to indicate where respondents had implemented select policies. A summative score range of 0-24 was created. Using a median split, the agencies were dichotomized into high and low implementation of OSHA's AWPC recommendations. As a result, 83 (49.4%) of agencies were recognized as having low safety policy levels and 85 (50.6%) of agencies were recognized as having high safety policy levels.

A Profile of the Study Sample

Demographics. The respondents' ages ranged from 36 to 75 years; the mean age of the respondents was 52.88 years (SD = 7.37) and the median age was 53 years. The majority of the participants (n = 125, 70.2%) were female. Regarding race and ethnicity, the majority of the respondents (n = 157, 87.2%) identified themselves as "European American/White." Respondents identifying themselves as African American/Black were the second largest group (n = 11, 6.1%). The remainder included respondents who identified themselves as either "Hispanic American/Latino," "Asian American/Pacific Islander," or "Other" (n = 3, 1.7%). Most (n = 167, 93%) of the respondents indicated having a master's degree in social work (e.g., MSW, MSSW, MSSA) as their highest level of professional education. A few (n = 5, 3%) reported holding doctoral degrees in social work, and the remainder (n = 5, 3%) reported holding graduate and/or postgraduate degrees (e.g., M.A., Ed.D., Ph.D.) in other disciplines. Respondents also reported their state of employment. For descriptive purposes, regional categories (e.g., Northeast, Midwest, South, West) as established by the United State Census Bureau were used. The largest segments of the respondents came from the Northeast (n = 65, 35.9%) and Midwest (n = 56, 31.5%) regions. The lowest numbers came from the South (n = 38, 21.3%) and West (n = 19, 10.7%). This pattern reflected the population distribution of NASW's members across the nation.

Supervisors' experiences, roles, and supervisees. Within this sample, over two-thirds (n = 124, 68.5%) were currently supervising and almost a third (n = 57, 31.5%) had supervised professional social workers in the past. Their length of supervisory experience ranged from 2 to 40 years. The mean length of supervisory experience was 15.23 years (SD = 6.55) and the median number of years was 14. Current service roles varied. Seventy (39.3%) of the respondents reported "frontline supervisor/manager" as their primary practice role. The second largest group of respondents reported "program manager/director" (n = 43, 24.2%) as their role. Respondents also reported a wide range of experience in their current agency (or setting). Their tenure with the current agency varied from 1 to 35 years. The mean number of years in their current agency was 12.3 years (SD = 8.64), and the median number was 11 years. Respondents supervised various groups of professionals and para-professionals. The largest segment (n = 52, 28.7%) reported that they only supervised professional social workers. However, 22 (12.2%) reported supervising professional social workers and counselors, 21 (11.6%)

reported supervising professional social workers and human service para-professionals, and 19 (10.5%) reported professional social workers and counselors, and human service para-professionals.

Practice settings and populations. Almost half of the respondents (n = 87, 48.9%) indicated that they worked primarily in an "outpatient mental health/counseling center" setting. The second largest segment of respondents (n = 40, 22.5%) were found in "acute psychiatric/residential care" settings. Others reported private practice (n = 12, 6.7%), veterans facilities (n = 5, 2.8%), child welfare (n = 5, 2.8%), health care (n = 3, 1.7%), and retired/unemployed (n = 7, 3.9%) and other (n = 16, 9%). The respondents' service populations varied by age and diagnosis. While over half (52.4%) served adult clients exclusively, a third (33.5%) served both adults and children. In addition, a smaller group (n = 16, 9.4%) reported serving children and adolescents. The respondents reported serving clients with psychiatric disorders, developmental disorders, substance abuse disorders, or some combination. Almost half (n = 82, 48%) reported that their agency primarily served clients with psychiatric and substance abuse disorders. Over a third (n = 67, 39.2%) indicated that their agency primarily served clients with psychiatric and developmental disorders. Of the remainder, 20 (11.7%) reported serving other populations.

MAJOR FINDINGS

Safety Policy Implementation (or Compliance)

Respondents were asked to identify whether their agency had existing administrative and work practice safety policy and/or procedures. Given the varying types of mental health service agencies (i.e., inpatient, outpatient, residential), they were provided the options of yes, no, or not applicable. Thus, each item had different response rates. The item's response (or applicable) rates ranged from a high of 170 to a low of 77. The compliance level for the item ranged from a high of 95% (n = 169) for having a policy "requiring all social service workers to report all assaults (or threats) to supervisors" and a low of 24% (n = 148) reporting having a policy that "discouraged workers from carrying sharp items." For presentation (see Table 1), the items were listed in descending order of most compliance to least compliance and then divided into three levels of implementation (i.e., high, moderate and low). High rates were 85 to 95%, moderate rates were 66 to 82%, and low rates were 24 to 60%.

TABLE 1. Mental Health Service Agency's Compliance with NIOSH's Administrative and Work Practice Workplace Safety Policy/Procedures Recommendations

Policy/Procedures Items	n	Compliance Level
High level of implementation		
Requiring all social service workers to report *all* assaults (or threats)	169	95%
Clearly stating that violence is not permitted	170	92%
Ascertaining behavioral history of new clients	164	92%
Restricting access to pharmacy area	90	90%
Conducting post-incident interviews on assaulted workers (or clients)	158	88%
Contingency to treat acting out (or threatening) clients	163	88%
Assisting workers in filing formal criminal charges	157	86%
Transfer aggressive clients to acute units (or facilities)	124	85%
Moderate level of implementation		
Supervisors keep log (or reports) of incidents of violence	158	82%
Advising the establishment of daily work plans for those in the field	128	82%
Advising worker to have a contact person, if working in field	117	81%
Monitoring violent clients at night	77	78%
Establishing a liaison with local law enforcement	153	77%
Establishing a list of restricted visitors	96	72%
Restrict access to facilitates other than waiting room	146	67%
Establishing a system of identifying potentially violent clients	156	66%
Low level of implementation		
Requiring a sign-in for all visitors	146	60%
Workers are not permitted to work alone in emergency clinic(s)	115	60%
Provided adequate training for de-escalating and/or restraining clients	159	58%
Requiring supervised client movement in facility	132	55%
Treat and/or interview aggressive clients in restricted areas	142	54%
Provide staff escorts to parking areas (i.e., evening, late)	146	41%
Discouraging workers from wearing jewelry	147	41%
Discouraging workers from carrying sharp items	148	24%

*Note: The n's vary because the number of applicable items varied.

Supervisor's Perception of Risk and Policy Adequacy

Respondents were asked to rate the level of risk of client violence toward social service staff in their agency. Among this sample, 72 (41.9%) report believing the risk of client violence is low, 77 (44.8%) report believing the risk is moderate, and 23 (12.7%) reported that risk is high. Therefore, over half (57.5%) rated their staff's risk exposure level as moderate to high. This finding supports the moderate to high level of risk reported by Newhill (1996). Regarding their views relative to their agency's existing safety policy practices, 121 (71.5%) reported positive agreement, while the remaining 48 (28.4%) noted disagreement. Thus, over a quarter disagreed with the existing state of workplace safety policies. When asked to explain their agreement or disagreement, respondents provided a number of reactions (see Table 2). Supervisors in agreement cited sufficient training, links with law enforcement agencies, the use of mechanical devices (i.e., panic buttons) and serving low risk client populations. Those in disagreement reported insufficient training, lack of mechanical devices (i.e., panic buttons) and limited post-incident follow-up. Female social work supervisors were significantly more likely in comparison to male supervisors to disagree about the adequacy of their existing current agency's approach to safety policy practices ($\chi^2 = 3.89$; $p < .05$).

Other Factors Associated with Compliance

We also examined factors associated with an agency's level of administrative and work policy implementation and its level of policy compliance (high vs. low) with settings (inpatient, outpatient, and other), level agreement with existing policy practices (agree vs. disagree) and perceived level of risk (low, moderate, and high). This relationship between agency level of compliance and type of setting was found to be significant ($\chi^2 = 13.51$; $p < .001$). That is, those in inpatient settings were more likely to have higher levels of policy compliance than those in outpatient or other settings. Agreement with an agency's existing safety policy practice was also associated with level of policy compliance ($\chi^2 = 8.31$; $p < .004$). Supervisors in agencies with high levels of safety policy implementation rates were more likely to agree that their agency's safety policy was adequate than those affiliated with agencies with low safety policy implementation. However, perceived level of risk of client violence toward staff was not associated with the level of implementation ($\chi^2 = 4.95$; ns).

TABLE 2. Supervisors' Explanation for Existing Safety Policy Agreement or Disagreement: Selected

Statements reflective of adequacy
• "As a CARF [accredited] agency with close ties with the police and sheriff [department], we are safety conscious."
• "Extensive annual formal training provided on 'diffusing violent situation'; [r]einforced at staff meetings and in individual supervision."
• "We have been refining our policies concerning risk and its management for years. We can always improve and will . . . Security [guard] is on [the] premises."
• "We have panic buttons. No one leaves staff alone in unit with patient. . . ."
• "Telephone screening usually prevents potentially violent clients from getting appointments."
• "Due to relatively low risk population."
Statements reflective of non-adequacy
• "Inadequate training of workers re: de-escalation of violent situations and self-protection tactics."
• "No system for therapist to signal for assistance from their office (except for a phone)."
• "Case managers many times cover [the case of] individuals (often risky ones) where they have little awareness of [the] degree of danger."
• "We really have not given much attention to these issues."
• "More debriefing of . . . violent/crisis incidents."

Note: CARF = Commission on Ambulatory and Rehabilitation Facilities.

DISCUSSION

Variations exist in the compliance with NIOSHA's safety recommendations. Specifically, policies that addressed generalized risk of violence in the agency, which included prohibiting violence, restricting pharmacy access, ascertaining the behavioral history of clients, mandating the report of violence, and procedures for treating aggressive clients, were the most likely to be reported (above 85%). However, policies that addressed work practice control policies including requiring all visitors to sign-in, not permitting practitioners to work alone in clinics, providing adequate safety training, interviewing aggressive clients in restrictive areas and the supervising of client movement in the facility were least likely to be reported (below 60%). Such variations seem to reflect strong views about the relative effectiveness of specific policies.

Still, over half of the supervisors report that their social service practitioners are exposed to moderate or high risk of client-related violence and almost a quarter are in disagreement regarding the adequacy of their agency's current efforts to curtail, reduce and/or prevent this type of occupational health hazard. These findings suggest that there are internal (i.e., practitioner, supervisory, agency) and external-related (i.e., federal, state and/or accreditation monitoring) actions that need to be brought to bear on this phenomenon.

Practitioners have concerns about roles in enhancing safety in the workplace. First, ascertaining a new client's behavioral history occurs frequently, generally during intake evaluations at the time of the admission's process. Practitioners (or intake workers) pose a series of questions to establish prior behavioral history. Given that select demographic and behavioral factors (i.e., gender, history of violence, substance abuse) are recognized as the best predictors of future violence, gathering such data is a logical means of assessing potential risk that a client might present. However, consideration must be given to the effect of bias in this process. For example, Coontz, Lidz, and Mulvey (1994) found that clinicians in the psychiatric emergency room were significantly less likely to ask female clients regarding previous violent behavior than male clients. This finding suggests not only that those clinicians were more concerned about violent male clients than female clients, but that gender bias may affect worker's judgments. After recognizing risk, steps must be taken to translate these concerns into precautionary practices (e.g., a systemic warning system and/or threat assessment). Second, reporting incidents of client-related violence is a means of receiving immediate assistance and guidance. Current research suggests underreporting in mental health is a major issue (Brastic & Fogeman, 1999; Flannery, Anderson, Marks, & Uzoma, 2000). In fact, earlier research suggested that less than a quarter of all incidents of actual client-related violence (i.e., abuse, threats, and assaults) in mental health are officially reported in inpatient settings (Lion, 1981). Although Beavers (1999) found that 80% of professional social workers admitted reporting an occurrence of client violence to supervisors, there is still ongoing concern of underreporting. Third, reports of policies prohibiting practitioners from working alone in emergency clinics are low. In mental health, practitioners at times work in emergency intake clinics that require them to assess incoming clients and help determine appropriateness of care. Such clients are at times actively confused, psychotic, and threatening, which increases their dangerousness to practitioners. Those providing service to these clients are at great risk. Thus, staffing patterns in such environments need to

reflect not only clients' service needs, but also concern for the service provider's safety.

After social work supervisors are made aware of an incident of client-related violence, the question remains, what do supervisors do about the situation? Concerns continue regarding how supervisors respond to such reports. Specifically, some supervisors fear that they will be *blamed* (Littlechild, 1997), while others believe management will not take action (MacDonald & Sirotich, 2001). Such findings raise concerns relative to trust. If practitioners' reports of client-related violence are not adequately addressed, practitioners may not only underreport incidents, but grow to distrust both their supervisors and employers. In spite of this situation, reports are high of supervisors conducting post-incident interviews with workers relative to assault procedures. Post-incident follow-ups are designed to address the nature of the incident, safety and assurance for the worker (or victim), and development of a plan to prevent future occurrences. Because practitioners underreport, the critical follow-up after incidents does not always occur. Also, since there is no additional method of confirming supervisors' reports, caution must be given to the risk of social desirability bias. Nonetheless, supervisors in settings with a high level of policy compliance were significantly more likely to agree with the adequacy of the agency's safety policies. Conversely, supervisors in settings with low safety policy levels are in disagreement. This finding suggests that supervisors are not only aware of how their mental health agency is responding to workplace violence concerns, but some may feel powerless to improve these conditions. This opportunity to *advocate* for frontline service providers *must become a priority*.

Mental health service agencies and other service organizations not only have a *duty*, but a *responsibility* in addressing the safety of workers providing care. Although these findings suggest that client behavioral histories are obtained at a high level, protocols that establish a system of identifying potential violent clients are implemented at a moderately low level. The data suggest that slightly over a fourth (26%) of mental health agencies do not use such information to warn practitioners of potential risk. What this means is that despite collecting invaluable data that may be used to develop violence prevention strategies toward practitioners, few implement plans for utilization of such information. Client-related violence risk factors may not be translated into meaningful strategies to reduce or prevent violence for practitioners.

What should agencies/organizations do to address these concerns? First, they must establish and enforce a zero-tolerance policy on all forms of workplace violence. If properly developed, this approach would lay

the ground work for establishing a culture of respect and safety. This step toward enhancement of the quality of service environment is a fundamental building block to providing quality services. This is not to imply that all risk would be eliminated. Educating personnel is essential to achievement of workplace safety goals. Reports of adequate techniques and information sessions on de-escalating and/or restraining clients are low. Non-violent intervention techniques (i.e., recognition of risk, de-escalating and restraining skills) are an effective means of reducing client-related assaults experienced by staff in mental health (Infantino & Musingo, 1985; Tardiff, 1996). Safety prevention requires commitment from the agency's top administrators. Since agency directors are less likely to be aware of incidents of client-related violence (Rey, 1996), mid-level managers, supervisers and others, must advocate for adequate levels of safety education and preparation. Agencies cannot *totally* remove this risk, but they can improve the ways in which they address and prevent risks to reduce negative outcomes.

Compliance was associated with a number of factors. Specifically, inpatient service settings were significantly more likely to have a high safety policy level. Since these settings serve patients who are much more likely to be in the active phase of their illness, it is reasonable that they would have safety policies (or protocols) in place. This possibility, however, does not give other settings justification to ignore the risk of violence. Other settings must tailor their safety policy protocols to address the unique forms of service-related violence that they experience.

Reports of requiring visitors to sign-in are low. On the surface, visitor sign-in is a fairly benign procedure whereby a receptionist or other support staff engages potential visitors before they gain access to the service area of the agency. This procedure can be used to establish the purpose of the visit, person with whom they are meeting, and provide a means of determining whether the person is allowed access, and finally, require documentation of their presence. This procedure often serves as a deterrent to those who may have violent intentions.

Opportunities exist for external bodies to assume functions of stronger monitoring and enforcement. First, the Commission of Ambulatory and Rehabilitation Facilities (CARF) and Joint Commission of Hospital Accreditation, as leading national accreditation agencies in human services, may incorporate measures to monitor an agency safety policy protocol in their review processes. Thereby, they would provide ongoing oversight to this facet of the service environment. Second, OSHA might consider establishing a link with NASW to help facilitate providing

necessary guidance for the profession and the federal agency operating in this environmental domain.

The current study is challenged by a number of limitations and strengths. First, the fact that all mental health agencies do not have professional social workers in a supervisory capacity is reason for caution. The sampling framing of these supervisors is limited to only those who met the criteria. The NASW membership roster that includes over 150,000 members is one of the nation's largest databases of human service professionals. This fact supports the use of this database and provides a critical means to assess this condition. Then again, NASW geographic profile is heavily skewed toward the Northeast and Midwest. Still, the current sample represents one out of every six professional social workers who met the inclusion criteria.

IMPLICATIONS

Service delivery. Service delivery occurs in a challenging and dynamic environment. One such challenge is the growing possibility of client- and community-based violence (Hopps, 2000). Given the frequency of reports of client violence toward mental health professionals, thoughts must be given to how this form of violence affects delivery of effective treatment, as well as the development of treatment approaches that take into account safety considerations. Safety policy has significant meaning for direct service practitioners who are in pursuit of effective client outcomes, and at the same time are expected to provide solo delivered care in a variety of settings (i.e., client's homes, clinics, institutions, communities) and neighborhoods, which can be challenging. Facilities that develop the necessary administrative safety policies and staff educational sessions (i.e., crisis prevention, de-escalation skills) will more than likely be perceived as valuing the employee. On the other hand, those that fail to adequately provide such policies and education might well be perceived as devaluing employees. There is even anecdotal evidence that some practitioners change fields of practice and/or organizations out of personal safety concerns (Newhill, 1995). The loss of experienced practitioners in mental health settings impacts the quality and effectiveness of service delivery. What this suggests is that agencies have a responsibility to ensure that reasonable and prudent steps are taken to reduce unsafe workplace conditions. Although some situations in the community are beyond the control of an agency, what occurs within the confines

of the facility is well within the enterprise's range of responsibilities. Thus, to reduce institutional liability and promote the well-being and respect of staff, agencies/organization should take the necessary action to put in place policies, protocols, and procedures designed to address and reduce elements of risks to employees.

Employee Assistance Program. What does it mean for employee assistance programs (EAP)? They are likely to be called to assist staff who have been victims of workplace violence. They should also be proactive in implementing policies to reduce the likelihood of workplace violence. In an effort to control the rising cost of service operations, agencies/organizations must look under every stone to maximize the return on their major investment, personnel. Reducing the loss of productivity and healthcare cost to their employees are two such ways. Developing meaningful safety policy protocols that address the many occupational health hazards in these settings is critical for both. Staff turnover rates, personnel costs, and the loss of productivity often serve as a systemic drag on the agency operation. Such cost takes away from the meager funds allocated to provide clients service. By reducing the level of client-related violence, controlling the work environment, and preventing workplace violence agencies can expect an increase in productivity and a reduction in personnel costs owing to lower staff anxiety and turnover (Horwitz, 2006). Employee assistance programs and professionals that target mental health settings must be cognizant and skilled in addressing the unique workplace health risk from violence confronting practitioners from these settings (Glicken, 2007).

CONCLUSION

Few studies have addressed this phenomenon from the perspective of mid-level management. Recognition of this gap was one of the forces that drove this investigation. Preventing and reducing client-related violence toward practitioners should be a central concern for supervisors. Since many professionals, especially social work supervisors ascend from the ranks of direct practitioners, they are intimately aware of these concerns and the workplace conditions that give rise to them (or perpetuate them). Supervisors as middle managers are uniquely positioned to set the tone for improving the workplace for all mental health professionals. Difficulties identified in this discussion should not be viewed only as potential or real barriers to developing safety strategies but rather, as one of

the many challenges confronting the mental health and helping professions. In fact, all should advance the idea of greater professionalism via improving workplace safety concerns. This is an opportunity to also improve service effectiveness and delivery and improve the service environment for both clients and employees.

REFERENCES

Beaver, H. W. (1999*). Client violence against professional social work: Frequency, worker characteristics, and impact on worker job satisfaction, burnout, and health*. Unpublished doctoral dissertation. University of Arkansas at Fayetteville, AR.

Beck, J. C. & Schouten, R. (2000). Workplace violence and psychiatric practice. *Bulletin of the Menninger Clinic, 64*(1), 36-48.

Black, K. J., Comption, W. M., Wetzel, M., Minchin, S., Farber, N. B., & Rastoqui-Cruz, D. (1994). Assaults by patients on psychiatric residents at the three sites. *Hospital and Community Psychiatry, 45*(7), 706-710.

Coontz, P. D., Lidz, C. W., & Mulvey, E. P. (1994). Gender and the assessment of dangerous in psychiatric emergency room. *International Journal of Law and Psychiatry, 77*(4), 369-376.

Davis, S. (1991). Violence by psychiatric inpatients: A review. *Hospital and Community Psychiatry, 42*, 585-590.

Department of Health and Human Services (1998). *Guidelines for preventing workplace violence for health dare and social service workers* (NIOSHA Publication No. 3148). Washington, D.C.:U.S. Government Printing Office.

Department of Justice (1998). *National Crime Victimization Survey: Workplace Violence, 1992-96.* U.S. Government Printing Office: Washington, D.C., Bureau of Justice Statistics, Publication No. 168634.

Dillman, D. A. (1991). The design and administration of mail surveys. *Annual of Review of Sociology, 17*, 225-249.

Engel, F. & March, S. (1986). Helping the employee victim of violence in hospitals. *Hospital and Community Psychiatry, 37* (2), 159-162.

Findorff, M. J., McGovern, P. M., Wall, M., Gerberich, S. G., Alexander, B. (2004). Risk factors for work related violence in a health care organization. *Injury Prevention*, 10, 296-302.

Flannery, R. B., Jr., Fisher, W., & Walker, A. P. (2000). Characteristics of patients and staff victims of assaults in community residences by previously nonviolent inpatients. *Psychiatric Quarterly, 71*, 195-203.

Flannery, R. J., Jr. (2002). Characteristics of assaultive psychiatric patients: Review of published findings, 1978-2001. *Psychiatric Quarterly, 73*, 229-237.

Flannery, R. B., Jr., Lizotte, D., Laudani, L., Staffieria, A., & Walker, A. P. (2001). Violence against women and the assaulted staff action program. *Administration and Policy in Mental Health, 28(6),* 491-498.

Gates, D. M. (2004). The epidemic of violence against healthcare workers. *Occupational and Environmental Medicine, 61,* 649-650.

Gerberich, S. G., Church, T. R., McGovern, P. M. et al. (2004). An epidemiological study of the magnitude and consequences of work related violence: The Minnesota Nurses' Study. *Occupational and Environmental Medicine, 61*, 495-503.

Glicken, M.D. (2007). *Social work in the 21stcentury*. Thousand Oaks, CA: Sage Publication.

Goodman, R. A., Jenkins, E. L., & Mercy, J. A. (1994). Workplace-related homicide among health care workers in the United States, 1980 through 1990. *The Journal of American Medical Association,* 272,1686-1688.

Guy, J. D., Brown, C. K. & Poelstra, P. L. (1990). Who gets attacked? A national survey of patient violence directed at psychologist in clinical practice. *Professional Psychology: Research and Practices, 21*(6), 493-495.

Hopps, J. G. (2000). Social work a contextual profession. In J. G. Hopps & R. Morris (Eds.). *Social Work at the Millennium*. New York: Free Press.

Horwitz, M. J. (2006). Work-related trauma effects in child protection social workers. *Journal of Social Service Research, 32*(3), 1-18.

Jayaratne, S. Vinokur-Kaplan, D. Nagada, B. A., & Chess, W. A. (1996). A national study of violence and harassment of social workers by clients. *Journal of Applied Social Science, 20*(1), 1-14.

Kadushin, A. (1992*). Supervision in social work.* (3rd ed.). New York: Columbia University Press.

Lanza, M. (1983). The reaction of nursing staff to physical assault by a patients. *Hospital and Community Psychiatry, 34,* 44-47.

Larson, P. D. & Poist, R. F. (2004). Improving response rates to mail surveys: A research note. *Transportation Journal,* 43(4), 67-74.

Lipscomb, J., Silverstein, B., Slavin, T. J., Cody, E., & Jenkins, L. (2002). Perspectives on legal strategies to prevent workplace violence. *The Journal of Law, Medicine, & Ethics, 30*(3), 166-172.

Love, C. C., Morrison, E. and members of the AAN Expert Panel on Violence (2003). American academy of nursing expert panel on violence policy recommendations on workplace violence. *Issues in Mental Health Nursing, 24*, 599-604.

Lowe, T. B. (2006). Risk exposure to client violence: Case assignment, gender, and violence as factors. Unpublished paper. The University of Georgia.

Macdonald, G. & Sirotch, F. (2001). Reporting client violence. *Social Work, 46* (2), 107-114.

Mossman, D. (1994). Assessing predictions of violence: Being accurate about accuracy. *Journal of Consulting and Clinical Psychology. 62,* 783-792.

Mulvey, E. P. (1994). Assessing the evidence of a link between mental illness and violence. *Hospital and Community Psychiatry, 45*(7), 663-668.

Newhill, C. E. (1995). Client violence toward social workers: A practice and policy concern for the 1990's. *Social Work, 40*, 631-636.

Newhill, C. E. (1996). Prevalence and risk factors of clients' violence toward social workers. *Families in Society: The Journal of Contemporary Human Services*, 488-495.

Newhill, C. E. & Wexler, S. (1997). Client violence toward children and youth service social workers. *Children and Youth Service Review, 19*(3), 195-212.

Rey, L. (1996). What social workers need to know about client violence? *Families in Society: The Journal of Contemporary Human Services,* 33-39.

Spencer, P. C., & Munch, S. (2003). Client violence toward social workers: The role of management in community mental health programs. *Social Work, 48(*4), 532-544.

Substance Abuse and Mental Service Health Administration (1998). *Mental Health, United States, 1998.* Washington, D.C.: U.S. Department of Health and Human Services, Publication No. 99-3285.

Swanson, J. W. (1994). Mental disorder, substance abuse, and community violence: An epidemiological approach. In J. Monahan & H. J. Steadman (Eds.), *Violence and mental disorder: Development in risk assessment* (pp.101-136). Chicago: University of Chicago Press.

Swartz, M., Swanson, J., Hiday, J., Borum, R., & Burn, B. (1998). Violence and mental illness: The effects of substance abuse and non-adherence to medication. *American Journal of Psychiatry, 155*(2), 226-231.

Toscano, G., & Weber, W. (1995). *Violence in the Workplace: Compensation and Working Conditions*. Washington, DC: U.S. Department of Labor, Bureaus of Labor Statistics.

RECEIVED: 12/18/06
ACCEPTED: 03/12/07

doi:10.1080/15555240802157130