

The Risk of Violence in Mental Health Work

A Report on Workplace Violence in Washington State Community Mental Health Services

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This report is dedicated to Marty Smith, a Kitsap Mental Health Services CDMHP and SEIU 1199NW member who was murdered on November 4, 2005 while evaluating a client on a home visit, and to Judi Scanlon and Nicole Castro who suffered the same fate in New York (1998) and Maryland (2002), and to the mental health workforce who provide care to the nation's mentally ill against overwhelming odds.

III. EXECUTIVE SUMMARY

Researchers from the University of Maryland Work and Health Research Center present findings and recommendations from a field study of safety hazards to community mental health workers in Washington State. This field study was requested by the Service Employees International Union (SEIU) Local 1199 Northwest subsequent to the murder of Marty Smith, a County Designated Mental Health Professional (CDMHP). Mr. Smith was murdered in November 2005 and shortly thereafter SEIU conducted a survey of its members and began an effort to pass legislation that would improve safety for the mentally ill, the community-at-large, and ultimately, the mental health workforce.

Findings are based on discussions with mental health managers, state mental health and safety experts, labor leadership, consumer representatives, and four structured focus groups of community health workers representing four distinct regions in northwest Washington State. The following themes emerged from the staff focus groups:

- A respectful and effective therapeutic relationship is the foundation for caring for the mentally ill. The ability to form and sustain therapeutic relationships is compromised by high caseloads, burdensome paperwork, and highly stressful work environments.
- Caseloads have increased and many case managers believe the increased caseloads diminish the effectiveness of case management and other services by causing staff burnout, reduced ability to develop trusting and therapeutic relationships with patients, less knowledge of patient history, and pressure to cut corners or conduct home visits alone.
- Home visits are generally done alone (i.e. not in pairs), but visiting in pairs is considered much safer.
- Clients are more acutely ill, more often have co-occurring substance abuse disorders, and are much more likely to be violent.
- It is difficult and sometimes impossible to obtain relevant information pertaining to a client's past history of aggression, assault, and criminal behavior.
- Staff safety training is critical, but many staff report little or no safety training, and inconsistent safety policies.
- Knowledgeable and supportive supervisors and upper management are seen as extremely important to staff safety.

Recommendations are based on the findings from the visit as well as the experience of the researchers, national best practices, and the federal Occupational Safety and Health Administration (OSHA) Guidelines for the Prevention of Workplace Violence in Healthcare and Social Service Workers (1996/2003)

1. Continue legislative and policy efforts to **increase funding for community mental health** with the ultimate objective of improving the quality of patient services through **reduced caseload size**.
2. Continue legislative efforts to **mandate accompanied visits** for high risk visits in the

home. First visits, those where there is reason to believe the patient is in crisis, and those where child custody or institutionalization issues may exist, should always be conducted in pairs.

3. Create a tripartite Labor-Management-Consumer State-wide Health and Safety Committee with responsibility and authority over Division of Mental Health workplace safety matters.
4. Conduct a baseline comprehensive state-wide survey of community mental health workers and their employers.
5. Create a State-wide Violence Prevention Training task-force with responsibility for developing a training curriculum and certifying trainers.

In conclusion, this field study attempted to understand the context of the publicly funded system providing mental health services in Washington State. Discussions with consumers and advocates of the mentally ill in addition to the paid workforce and managers provided multiple perspectives. The authors wish to emphasize that mentally ill persons are not inherently dangerous or violent. In fact, those who are under competent and consistent care are at much less risk for behavioral manifestations of their disease. The conclusion of many providers and workers in this field is that more attention and resources must be devoted to the care of the mentally ill for the safety of the consumer, the public and the workforce alike.

I. Background

Experts in the fields of mental health and occupational safety contributed to the activities and effort described in this report. Given the varied perspectives and experiences of the authors, contributors, and readers it is essential to establish a common set of terms and their definitions. A team of occupational safety and health researchers from the University of Maryland Work and Health Research Center along with staff from SEIU Local 1199 Northwest, as well as mental health direct care staff, management and policy makers worked together to assess the safety issues of community mental health workers, focusing on the risks to workers in the field and home setting. In this section, we will:

- *Briefly define and summarize workplace violence in social services*
- *Summarize homicides in home visit services*
- *Describe the federal approach to workplace violence prevention (“OSHA Guidelines”)*
- *Conclude by emphasizing two unique challenges to worker safety in community mental health:*
 - *Unpredictable and changing home and community environments that cannot be controlled by traditional environmental approaches (i.e. security guards, electronic surveillance, door locks and architectural design)*
 - *Workers who provide services in the home enter unmonitored situations resulting in an element of surprise or unpredictability not encountered in the institutional setting*

Workplace violence in social service workplaces

Workplace violence is defined by the U.S. government as “violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty” (CDC/NIOSH Current Intelligence Bulletin, 1996). Employers and other organizations have also included uncivil behavior between staff and supervisors, bullying, hostility, sexual harassment, and verbal abuse in their organizational definition of workplace violence. Thus, workplace violence covers a broad spectrum of events ranging from harassment and/or bullying to homicide.

Workplace violence is widely recognized as a significant occupational hazard in the healthcare and social service sectors (CDC & NIOSH, 2001; Lipscomb & Love, 1992; Rippon, 2000; Toscano, 1995; Warchol, 1998). The Washington State Department of Labor and Industries issued a report entitled "Violence in Washington State Workplaces 1995-2000". The report is based on data from the BLS Survey of Occupational Injuries and Illnesses and on Washington State workers' compensation claims related to assaults and violence. For nonfatal violence-related injuries, workers' compensation data ranks Social Services (142.0 per 10,000 workers) as the highest risk industry followed by Health Services (74.6 per 10,000 workers). Residential Care was ranked second among specific industry codes (301 per 10,000 workers); Individual Family and Social Services was ranked tenth (79

per 10,000 workers). Notably, these two sectors reported the second and third greatest percent increase in assault rates over the period 1995-2000, 46% and 33%, respectively.

Among Washington State workers across all industry codes, assault rates (compensatable cases only) were substantially higher for state (30.4 per 10,000 workers) and local government (8.9 per 10,000 workers) workers compared with private sector workers (2.3 per 10,000 workers). Differences between public and private workers' risk is due in part to the high concentration of health and social services employment within the public sector, however the trend for the assault rate was sharply downward for private sector workers, both in Washington state and nationally. For public sector employees, however the trend is rising significantly (Foley, 2002).

Also in Washington State, Bensley et al. (1997) compared the number of formal incident reports and the workers' compensation claims from a state psychiatric hospital with the number of reported incidents of assault reported on a survey that measured attitudes and experiences related to assaults. She found that 73% of staff surveyed reported at least a minor injury related to an assault by a patient in the past year. Only 43% of those reporting moderate, severe, or disabling injuries related to assault filed for workers compensation. Staff reported an assault incidence rate of 437 per 100 employees per year via a self-administered survey (on average, each employee suffered more than four assaults per year), while hospital incident reports indicated a rate of 35.3 assaults per 100 employees. Having received assault management training within the prior year was associated with less severe injuries. Working in isolation, being a mental health technician, and working on the geriatric-medical hospital unit were each associated with more severe injuries.

Risk Factors from the Literature

NIOSH (2002) summarizes the risk factors for occupational violence to hospital workers, many of which are applicable to the social service sector, including community and residential settings. For example, working directly with volatile people, especially those with a history of prior assaultive behavior, is a known risk factor for hospital workers.

Understaffing, especially during times of increased activity such as meal times and visiting hours is also associated with a higher risk of assaults on hospital workers. Staff working alone or in isolation from other staff are vulnerable to assault. Moreover, meal times and times of increased activity on hospital wards appear to result in agitation and violence in some hospitalized individuals. In the social services, as in any setting, the presence of multiple staff is probably a deterrent to assault, but specific studies in this sector are absent.

Transporting patients, long waits for service, inadequate security, poor environmental design and unrestricted movement of the public are associated with increased risk of assault in hospitals and may be significant factors in social service workplaces as well. Often transportation is provided by social service agencies for clients who are disabled or not competent to drive or get themselves to appointments. This is yet another unexamined aspect of risk in social services.

Finally, lack of staff training and the absence of violence prevention programming are associated with elevated risk of assault in hospitals. This factor is particularly relevant in social services workplaces where it is potentially more challenging to provide training and where the problem of workplace violence is under recognized.

Homicides of Home Visiting Social Service Workers

Visiting social service and healthcare workers are at risk for injury and death while in clients' homes (Schulte, 1996; Fitzwater, 2000; Fazzone, 2000; Barling, 2001; Bussing, 2004). Homicides of visiting social workers and nurses have been reported in Texas, Maryland, Michigan, Kansas, New York, and Washington. (Public Employee Safety and Health, 1999; Gillespie, 2001; Ly, 2002; Newhill, 2003; Sedensky, 2004; McCormick, 2005; Associated Press, 2006). In response to these deaths, at least four U.S. states have introduced legislation to strengthen and/or require specific safety measures for these at-risk workers. Important possible risk factors emerging from these homicides include 1) the client's perception (regardless of the reality) that the visit would result in removing children from the home (New York, Texas, and Michigan), 2) care provider unknown to the patient (Washington and Maryland), 3) client in mental health crisis requiring possible involuntary commitment (Washington, Kansas), 4) relevant criminal history not known to case worker (Washington, Kansas, New York) and 5) worker visiting alone (all).

Approaches to Prevention

In 1996, the U.S. Occupational Safety & Health Administration published "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers" (U. S. Department of Labor & OSHA, 1996). These federal guidelines provide a framework for addressing the problem of workplace violence and include the basic elements of any proactive health and safety program:

- *Management Commitment and Employee Involvement*
- *Worksite Analysis*
- *Hazard Prevention and Control*
- *Training and Education*
- *Recordkeeping and Evaluation*

The OSHA guidelines provide an outline for developing a violence prevention program, but since they are "performance-based," the challenge of developing a specific, effective process for implementing the guidelines is left to individual workplaces. It should be noted that a number of international professional and governmental agencies have also issued guidance on violence prevention in the health care setting (AACN, 2004; ANA, 1994; CFNU, 1994; CAN, 2002; ILO, 1998; WHO, 2005).

The Unique Challenge of Home Visiting

Protecting all mental health workers from violence has proved to be a significant challenge. Risk factors described above are exacerbated by public budgetary constraints on mental

health care. But protecting **home visiting** mental health workers from violence while in the field presents two additional substantive and complex challenges that must be recognized.

First, each home entered by the worker is a new and unpredictable work environment. Unlike institutional settings, there are no security guards screening for weapons and contraband, there are no alarm systems or panic buttons, there are no video monitors, mirrors, special lights, quick release locks, drop phones or secure rooms, and no additional staff to attend to an agitated patient. Typically, an environmental survey and architectural assessment are crucial elements to understanding and controlling violence risks in the institutional setting. Current safety paradigms include controlling workplace hazards by conducting an environmental assessment coupled with appropriate environmental interventions. Home visiting pushes the limits of traditional safety programming practice (OSHA, 2002; Lipscomb, et al., 2006).

Second, unlike outpatient services, caring for the mentally ill in an institution allows staff to witness client behaviors on a 24-hour basis. Patient behavior is observed and discussed by qualified clinicians around the clock. Monitoring and documenting patient behavior may not be perfect in inpatient settings, but the ability to develop a relationship and understand the patient's immediate needs are improved.

By contrast, home visitors obtain information by phone or other sources and conduct visits blind to the patient's immediate history (and often past criminal history) and behavior. Home visiting mental health workers routinely conduct visits without the benefit of either their own or their colleagues' professional assessment. Granted, the majority of mentally ill clients living at home do so because their condition is stable. Home visiting services contribute to keep clients stable in the community. Yet, clients decompensate and some are "high risk" to a home visiting worker. Identifying "high risk" visits based on the research evidence, clinical recommendations, and community input allows dedication of scarce resources to visit in pairs for the type of visit or client that increases the chance of harm to the worker.

Given the unique issues of home visiting and the recent tragic murder of Marty Smith, this project was undertaken to evaluate the "status quo" and provide substantive, evidence-based recommendations for improving the safety of community mental health workers. What follows is a brief description of our methods, our findings in detail, and finally, five substantial recommendations accompanied by a rationale.

II. Methods

During the period of July 11-15, 2006, University of Maryland researchers conducted four focus groups and held a series of meetings with mental health stakeholders in Washington State. The four focus groups were in Mount Vernon, Bremerton, Lacey, and Seattle. The groups were publicized by SEIU Local 1199NW. Groups had between 6 and 13 direct care workers and lasted two hours, on average. Participation was voluntary and not limited to union members. Consent forms were utilized, and an audio recorder and flip charts were used to capture the discussion. Participants were asked to describe their jobs, their perception of risk due to violence (risk factors and severity), and suggested mitigations.

Separate structured discussions were held with union officials, staff from the Washington State Department of Labor and Industry's Safety and Health Assessment and Research for Prevention (SHARP) program, the director of the State Division of Mental Health, management of Kitsap Mental Health Services, and the Seattle chapter of the National Alliance for the Mentally Ill (NAMI).

III. Findings

Structured discussions with key informants in mental health management and policy positions, labor leaders, consumers, and community mental health workers confirmed that, indeed, community health work is dangerous and stressful. Each stakeholder's commitment to the care of the mentally ill was evident and compelling based on their comments and discussion. Unfortunately, significant obstacles to providing safe and effective mental health care exist. The death of Marty Smith, in the face of other warning signs, suggests that Marty's death was not an isolated, freak occurrence, but rather an indicator of system-level dysfunction that, if left untended, can be expected to cause more tragedy.

Our field study interviews and discussions found much agreement on the etiology of the unsafe working and patient care conditions. Common themes emerged from discussions with labor, management, consumers, and direct line staff across practice types (inpatient, outpatient, and community), geography (rural vs. urban), management (across several Regional Support Networks - RSNs), and across experience levels and job titles. Recurring themes that emerged:

- A respectful and effective therapeutic relationship is the foundation for caring for the mentally ill. The ability to form and sustain therapeutic relationships is compromised by high caseloads, burdensome paperwork, and highly stressful work environments.
- Caseloads have increased and many case managers believe the increased caseloads diminish the effectiveness of case management and other services by causing staff burnout, reduced ability to develop trusting and therapeutic relationships with patients, less knowledge of patient history, and pressure to cut corners or conduct home visits alone.
- Home visits are generally done alone (i.e. not in pairs), but visiting in pairs is considered much safer. Sub theme: as long as there is worker and supervisor discretion about paired visits (especially in the context of high caseloads and fiscal constraints), there will be pressure for staff to go out alone.
- Clients are more acutely ill, more often have co-occurring substance abuse disorders, and are much more likely to be violent. Sub theme: direct care workers experience a lot a violence including verbal hostility, threats, and physical assaults.
- It is difficult and sometimes impossible to obtain relevant information pertaining to a client's past history of aggression, assault, and criminal behavior. Sub theme: there

is no time to search for this information in the files and often databases are incomplete.

- Staff safety training is critical, but many staff report receiving little or no safety training, inconsistent safety policies, or no regularity in training. Sub theme: content of safety training is not standardized across the system.
- Knowledgeable and supportive supervisors and upper management are seen as extremely important to staff safety.

Description of the focus group participants

Focus group participants represented inpatient, outpatient, and home visiting direct care staff. Supervisors were excluded from focus groups to increase the comfort level and honesty of the participants. Four geographic regions representing four RSNs and multiple job titles and service settings. Both male and female workers participated.

Figure 1. Staff Focus Groups by Location and Type of Staff.

Date	Location	# of Community Staff	# of Inpatient Staff	Total Staff Participants
7/12/06	Lacey	4	2	6
7/13/06	Bremerton	5	8	13
7/14/06	Mount Vernon	8	2	10
7/15/06	Seattle	3	3	6
Total		20	15	35

Types of violence

Staff in the community mental health system experience the full spectrum of violence, from sexual harassment, verbal threats of harm, spitting, profane language, unwanted touching and physical contact, to major assaults with physical injuries (or even death). Violence, as defined by the participants, includes working with patients who masturbate publicly, destroy property, display and brandish weapons, threaten to kill, and suddenly attack.

The frequency of violent encounters depends on the setting. Emergency and Treatment Centers (E and T's) reported having, by far, the most frequent experience with combative and assaultive clients. The very purpose of these centers is short-term institutionalization for the acutely and dangerously mentally ill. County Designated Mental Health Professionals (CDMHPs) also encounter agitated clients frequently. They make the final judgment for involuntary commitment and often do so in emergency rooms, other community settings, and client homes. Other inpatient, residential and crisis settings report agitated and violent clients. Outpatient and home visiting settings report less overt violence, but more verbal aggression and fear associated with the potential for violence, as well as the lack of safety and security programs, particularly security alarms and training. Unpredictable behavior, a symptom of some mental illnesses, increases the risk of assault to workers.

Many readers may assume that *physical assaults* are the primary cause of concern because they result in lost work time, injuries with medical costs, workers compensation costs, permanent disability, and in the case of individuals such as Marty Smith, death. Yet, staff describe a broad range of violence including verbal and sexual aggression and minor assaults, much of which is not reported and, thus, not officially recognized. The possible relationship between *lower level violence* to job satisfaction, patient safety, quality of care, absenteeism and staff retention is not well understood but merits additional investigation.

"...in the parking lot [I was] trying to separate two men that wanted to take a child home after a group. Myself, another colleague and an intern directed them to stay apart for about 20-30 minutes until the police arrived...the child, a little girl, was terrified. So basically, it was just kind of being a lion tamer for 20 minutes."

"We currently have a situation...it's been going on for at least a month...a client got very angry and displayed a gun and was asked to leave...but this client continues to threaten his case manager even with a protective order."

Many outpatient case managers and mental health workers are responsible for transporting clients, frequently without a co-worker present. Workers describe instances of unpredictable behavior on the part of their passenger/client such as downshifting the gears without warning or trying to exit the vehicle. Obviously this presents an extremely serious risk.

The following quotes illustrate some of the stressful, often overlooked, violence reported by staff. In some cases, escalation to tragedy was averted but just barely.

"I work in a residential facility...there have been fights between clients, so there's a potential for danger."

"The most recent incident was 5-6 weeks ago, I was involved in a serious assault by a client [whose] meds were (seemingly) stable, thought processes stable...he had developed a pattern of acting out and then going to his room and going to bed. This particular night he did not respond the same way...he attacked the chief of staff. We ended up with one nurse with a shattered knee and concussion, one female staff ended up with concussion, sprained neck, sprained wrists, bruised ribs and having some PTSD (Post-Traumatic Stress Disorder). Myself, I had concussions, sprained neck...three patients helped us before we could call 911...three staff went out for injury leave, one will likely be permanently disabled."

Mental health workers are trained to work with clients who display behavioral symptoms, but when are the symptoms "part of the job" and when are they "workplace violence"? Put another way, mental health workers should not have to die or risk disabling injury taking care of clients, but many are unclear how and whether to protect themselves from clients that they want to help and cure. Most mental health workers feel responsible when clients become violent, believing that they could have done something differently. Many

supervisors support that notion rather than considering the possibility that system-level factors may be at play.

“Once or twice a week we get a dangerous client alert [via email]...but it’s not clear what we are supposed to do about it...dial 911 if we see them on premises?”

Factors associated with violence:

High caseloads (low staffing) and sicker clients

Mental health workers fault the organization and funding of the mental health system as the root cause of violence. Not surprisingly, system deficits that erode the patient safety and quality of care are often the same root deficits that result in unsafe working conditions. Workers, patients, and managers alike agree that cutbacks and cost shifting in mental health care funding have resulted in higher caseloads and sicker clients. Budget cuts to mental health care mean more clients per worker. Furthermore, staff, consumers, and managers agree that reduced funding forces the system into prioritizing services for the acutely ill, leaving care for the chronically mentally ill and preventive and early intervention care largely unfunded.

“When someone gets hurt, it’s really the system’s fault that that happens.”

“...safety is a critical issue to me...when I started almost 15 years ago, I worked for 15 patients and worked five days per week. I work four days per week now, and I have 45 patients...the resources are down and the clients are more desperate... I can’t possibly track all these people”

According to workers, higher caseloads translate directly into reduced time for case management and therapy for clients. Reduced time for each client means less time to read their history (if there is one) or search databases for information about a previous history of violence. Higher caseloads mean shorter (or less frequent) appointments, reducing the likelihood that the client will develop a trusting relationship with the caregiver. Shorter initial appointments are especially problematic. The first visit may be the client’s first encounter in the community post hospitalization. This visit represents a crucial time for the case manager and the client to develop their relationship, begin therapeutic processes, and for the case manager to obtain valuable information. Community mental health workers report shortening appointments from one hour to a half hour in the face of radically increased caseloads (up from 15 to 45-60 in some cases).

“I’ve got too many clients to take care of”

“...they gave me a huge client load and I was only working three days per week and had 42 clients and was doing home visits on all of them.”

Sicker Clients

“It’s the high acuity people who are now receiving services and therefore that increases the risk. “

Currently, services focus on the acutely ill rather than on the chronic needs of the mentally ill. This means that, in many cases, a person’s mental illness has been allowed to progress without care until their condition is acute and life-threatening. Thus, patients are sicker by the time they receive care in the current system. Even community care clients are often dangerously ill by the time they are eligible for services.

“Rather than intervene at a place where people can respond to treatment much better, it’s when they’re out of control or they’re completely decompensated, they’re a danger to themselves and others, that’s when the services go to them.”

Furthermore, acute hospitalizations, according to staff, are not long enough to return the patient to baseline or independent functioning in the community. Community supports are weak resulting in clients who are not quite ready for the community but are discharged nonetheless.

“So people are coming out of the hospital not quite compensated and they are not compliant with treatment, not getting medications, not following up with case managers, they may not even show up at the group home they’re assigned to, they might just go missing in action. I’ve got a gentleman who’s been missing for two months...no one knows where he is...this is not uncommon, people are falling through the cracks”

Paperwork Burdens Compete with Client Care

Case workers unanimously feel that their high caseloads prohibit them from providing the kind of care they were trained to provide. Some former case workers report switching to other jobs within the system, such as crisis team worker, where they do not take a caseload but handle only emergency decisions for involuntary commitment. One case worker fears termination by his supervisor because he neglects paper work in order to spend more time with his clients:

“I’m just letting paperwork go. They’re going to fire me because I’m taking care of my clients”

He has no plans to change his tactic. He feels that time with clients is more important than the paperwork.

The stress and job dissatisfaction arising from increased caseloads, as well as the related paperwork burdens, have resulted in high turnover and high vacancy rates according to some staff. Qualified workers are changing jobs within the field, and some are even leaving

mental health care altogether. Staff vacancies often result in an inexperienced, highly stressed workforce, and continue the vicious cycle.

Conversely, mental health workers report that when working conditions permit, the work is highly rewarding. Several focus group participants described leaving other occupational fields, including accounting and construction, to work in mental health because the personal rewards are greater. Mental health workers are dedicated to the care of society's most vulnerable and find great personal reward in this work. Unfortunately, when the system cannot support provision of decent, humane, effective mental health care, these workers may be less likely to stay in their jobs.

Management *emphasis on "Productivity"*

"...one of the problems with the mental health system right now is that it really follows the basic model of standard healthcare, in that you [patients] need to be very self-reliant and very active on your own in seeking out your own treatment...our clients don't have that ability."

A related issue concerns staff perception that *productivity* rather than *safety* or *quality* is the primary concern of management. The reduction of services for early intervention and treatment is combined with higher caseloads for both inpatient and community mental health workers. The current reimbursement scheme emphasizes "productivity" in terms of actual patient encounters but does not account for missed visits, clients who are not at home, travel time, and clients who require more intensive time and effort. Workers report that caseloads have tripled and paperwork requirements are unrealistic. No one disputes the fact that caseloads are enormous and that, as a result, clients "fall through the cracks".

"But our management tends to just turn a blind eye to all this that I just told you. It's more about 'well this is the budget and this is the contract and we have so much so just do it'... I've seen management turn over three times in 6-8 months, they are overwhelmed and don't know what to do."

"The treatment is budget-driven these days, that's all there is to it...money is the bottom line."

Staff would like more emphasis on patient care quality and safety for client, community and staff.

Incomplete access to client history of violence and criminal background

In the aftermath of Marty's tragic death, administrators at Kitsap Mental Services began to investigate the barriers to obtaining relevant information such as client past criminal history and evidence of past violent behavior. The problem is that some of this information goes beyond what is generally available in the clinical record, but may be relevant to both client and staff safety. In Marty Smith's case, relevant information about several past episodes of violent behavior involving law enforcement were not known to Mr. Smith when he decided to

visit alone. This type of information is critical for psychiatric care workers, but is of the utmost importance to community-based mental health workers. Substantive barriers to accessing this information continue to exist. Issues of confidentiality, civil liberties, and interagency cooperation (i.e. justice and social services) have been raised and will have to be methodically addressed in order to improve access to information so critical to worker and community safety.

Mental Health System Deficiencies: Client access to medications

“In the hospital, one of the most common reasons for admits off meds is they can’t afford them.”

Mental health workers lament that medication compliance is often a reason for decompensation and acute illness. Reasons for inadequate access to medications appear complex but related to cost, ease of access, eligibility for low cost drugs, entering the criminal justice system, and healthcare provider availability.

“You can get crack much cheaper than an anti-psychotic. I’ve been told crack is the best anti-depressant around...people withdrawing from crack probably have the highest incidence of violence in the hospital.”

“There is supposed to be a system where they get their drugs (meds) in jail...but for whatever reason they’re not getting their drugs”

“We have physicians three of the five days...if a client shows up on the wrong day, they don’t get a shot that day”

Suffice it to say, that without appropriate medications, many mentally ill persons will suffer relapses of their disease resulting in behavioral symptoms (i.e. violent acts).

Occupational Safety and Health Infrastructure

Focus group participants were not aware of comprehensive safety programs designed to keep staff safe. Some staff reported getting violence prevention training, others had vague recollections of a safety committee. Reporting systems for violence appear to be non-existent. Attention to the physical environment appeared to be equally non-existent. While some staff reported having access to security hardware, such as panic buttons and video cameras, all staff reported inconsistent or non-existing policies for their safety regarding the use of such hardware.

Violence Prevention Training

One of the primary purposes of this field study was to provide a needs assessment in order to develop a relevant training curriculum for community mental health workers. Violence prevention training is generally considered a standard practice and should be provided to community mental health employees (and all mental health workers) prior to beginning

employment, with refreshers provided at least annually (OSHA Guidelines, 2003). The training curriculum should provide a complete discussion of the following: workplace violence, a regular opportunity to review the violence prevention policies in the organization, its approach to reporting and follow-up, and the consequences for not functioning within the policies. Essential content also includes identifying potential risk factors for that workplace/job, and identifying preventive measures: personal (e.g. verbal de-escalation techniques), administrative, and environmental. Training should be provided by someone who understands the work done by the trainees, and should be lively and engaging.

Moreover, violence prevention training should be viewed in an even broader context. Legislators, communities, union members, mental health managers, and consumers must be educated about the devastating consequences of violence toward staff. SEIU Local 1199 Northwest has begun this larger educational outreach, but is strategizing a state-wide campaign to raise awareness amongst critical audiences. The New York State Public Employees Federation Violence Prevention Mobilization Campaign provides one example of a successful effort. Resources from this campaign as well as internal SEIU resources can assist with strategizing such an effort in Washington State.

IV. Recommendations

1. Continue legislative and policy efforts to **increase funding for community mental health** with the ultimate objective of improving the quality of patient services through **reduced caseload size**.
 - *Rationale: Excessively high caseloads appear to reduce the quality of case management services leading to frustration and, occasionally, loss-to-follow-up of community clients.*
2. Continue legislative efforts to **mandate accompanied visits** for high risk visits in the home. First visits, those where there is reason to believe the patient is in crisis, those where child custody or institutionalization issues may exist, should always be conducted in pairs.
 - *Rationale: All the homicides of home visiting human service workers of which we are aware have occurred to workers making a home visit **alone**. There is no security hardware, environmental design, or video surveillance technology available to increase the safety of a lone visiting worker. Visiting the high risk mentally ill in a home environment is associated with death by homicide, therefore this activity should require employers to provide state-of-the-art safety measures. Visiting in pairs together with appropriate training and information access represents the current state-of-the-art prevention techniques to homicide of visiting community mental health workers. **Mandating** that a second human service worker go along on high-risk visits takes the decision away from both supervisor and staff. Currently time and staffing pressures are too great in this system to allow this safety control to be discretionary.*
3. Create a **tripartite Labor-Management-Consumer State-wide Health and Safety Committee** with responsibility and authority over Division of Mental Health workplace safety matters

- a. *Rationale: There is an absence of a coordinated occupational safety and health infrastructure within the Division of Mental Health. In our view, this is best remedied by an approach balancing representation from the RSNs, management, labor and consumers. A successful model for such a committee exists in New York State and can be used as a blueprint to develop a similar committee in Washington State.*
4. Conduct a **baseline comprehensive statewide survey** of community mental health workers and their employers
- a. *Rationale: SEIU Local 1199NW with its initial staff survey and this subsequent field study has begun the work of establishing baseline information. However, in order to benchmark safety progress and evaluate the impact of safety interventions, it is essential to have credible, comprehensive data on outcomes of interest to workers and management. Staff and employer surveys are recommended in order to establish the baseline prevalence of verbal and physical violence, excessive caseloads, safety training, high risk home visiting, worker and management stress, and other risk factors.*
5. Create a **State-wide Violence Prevention Training taskforce** with responsibility for developing a training curriculum and certifying trainers.
- a. *Rationale: Violence prevention training is associated with improved safety in the context of a comprehensive occupational safety program. The stakeholders in Washington State are the “experts” for developing appropriate violence prevention training. The system has the expertise to develop the interpersonal communication aspects (i.e. de-escalation techniques) and the physical techniques (if deemed to be necessary). The Health and Safety Committee will formalize standards and policies that will also be taught in the training so that all staff understand the system’s policies. For example, staff need to know to what extent they can defend themselves from a patient assault and the appropriate methods for doing so. Such an activity requires a little more effort than “purchasing” a commercial violence prevention training, but we think that by taking responsibility for curriculum development the system will strengthen its capacity to protect workers.*

In conclusion, the death of Marty Smith, a Kitsap CDMHP, has prompted a grass roots campaign to improve worker safety. Substantial system-level issues have been identified and described. This field study described the context of the publicly funded system providing mental health services in Washington State. The authors wish to emphasize that mentally ill persons are not inherently dangerous or violent. In fact, those who are under competent and consistent care are at much less risk for violent behavior. The conclusion of many providers and workers in this field are that more attention and resources must be devoted to the care of the mentally ill to promote the safety of the consumer, the public and the workforce.

We submit these five recommendations with the firm belief that their implementation will lead to improved worker and patient safety, and avert future tragedies.

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About the authors:

Kathleen M. McPhaul, PhD, MPH, RN

Assistant Professor
Work and Health Research Center
University of Maryland, School of Nursing

Dr. McPhaul has worked for the state of Maryland for fifteen years as an occupational health specialist, trainer and researcher. Previously, she worked in a mobile occupational health unit assessing workers and workplaces all over the state of Maryland. She has twenty years experience in occupational health and safety.

She has a Masters degree in Public Health from the Johns Hopkins University School of Hygiene and Public Health and completed her PhD at the University of Maryland. Her dissertation topic investigated the risk of violence toward home visiting healthcare and human service workers. Dr. McPhaul's areas of expertise include workplace violence, safety training, and occupational health and injury prevention through comprehensive safety programming.

Dr. McPhaul is currently a co-investigator on two federally funded workplace violence prevention intervention projects, as well as a study looking at the risk of blood exposure in home care. She is the author of several publications and has consulted with several state public mental health systems on issues of workplace violence and staff safety. In addition, she teaches leadership and nurse safety to both undergraduate and graduate nursing students.

Jane Lipscomb PhD, MS, BSN, FAAN, RN

Professor
Work and Health Research Center
University of Maryland, School of Nursing

Dr. Lipscomb received a PhD in Epidemiology at the University of California at Berkeley. She is a Professor and Director of the University of Maryland School of Nursing Center for Occupational and Environmental Health and Justice. She has an extensive research career in academia and the federal government. Dr. Lipscomb has conducted research on the health and safety of health care workers for over twenty years.

Dr. Lipscomb currently serves as PI on three NIOSH-funded intervention studies designed to investigate prevention strategies for health care worker exposure to workplace hazards. These studies focus on preventing workplace violence in the social service workplace, blood exposure in the home care work environment and

coworker violence in a state government workplace. All three of these studies include partnerships with SEIU affiliated local unions.

Prior to joining the University of Maryland, Dr. Lipscomb was a senior scientist in the Office of the Director of the National Institute of Occupational Safety and Health.

Matthew London, MS

Matt London has worked in occupational health and safety for 25 years. He earned an M.S. in industrial hygiene from the University of Cincinnati, received epidemiologic training as a member of the CDC's Epidemic Intelligence Service (EIS), and then worked from 1982-87 at the National Institute for Occupational Safety and Health (NIOSH) conducting Health Hazard Evaluations. Beginning in 1987, Matt worked at the NYS Department of Health (DOH), helping to develop New York's statewide Occupational Health Clinic Network and overseeing DOH's industrial hygiene activities. Throughout that time, Matt was active in his union (NYS Public Employees Federation – PEF) as a steward, chaired his workplace and council's health and safety committees, and served as a member of the PEF-NYS statewide health and safety committee. Since May 2004, Matt has worked as project coordinator for a NIOSH-funded workplace violence prevention project being conducted by the University of Maryland, PEF, and the Civil Service Employees Association at a NYS social service agency. He has also been an integral part of PEF's Stop Workplace Violence campaign, which has trained and mobilized hundreds of PEF members and resulted in the passage of key workplace violence prevention legislation.