

Background and Introduction

Occupational violence is an issue with significant legal, economic, and emotional impacts on employers and individuals. There is only limited Australian data on incidence and minimal prevention strategy advice is available. The Australian Institute of Criminology is committed to the production of prevention advice to reduce occupational violence.

A useful typology is to separate occupational violence into three categories:

- Client-initiated violence which may be systemic in some human services, justice, and health and welfare occupations, as well as in some commercial settings.
- Internal violence, such as between supervisor/employee or employee/employee.
- Random public violence that impacts on employers and employees, for example during robberies and armed hold-ups (Mullen 1997).

This handbook focuses specifically on the prevention of client-initiated violence. It excludes activity that could be described as sexual harassment, which is extensively dealt with elsewhere. Following an overview of prevention approaches, a series of possible policy/strategy/checklist documents are provided as appendices. It is hoped that organisations will find these documents useful in assisting the development of their own violence prevention strategies and documents. Further reports will be produced to assist with the prevention of other forms of violence (see Perrone (1999) for an overview, and Mayhew (2000) for the prevention of internal organisational violence, for example between employers/employees or employees/apprentices.)

Definition and Characteristics of Client-initiated Violent Incidents

Occupational violence is the attempted or actual exercise by a person of any force so as to cause injury to a worker, including any threatening statement or behaviour which gives a worker reasonable cause to believe he or she is at risk (NOHSC 1999, p. 1).

Client-initiated violence is committed by an individual who has, or has had, a service relationship with the victim or the victim's organisation. The incident may involve (a) a "one-off" physical act of violence that results in a fatal or non-fatal injury or no obvious injury; or (b) some form of threat or verbal abuse. In this latter case, sometimes there may be multiple victims and the events may be repeated over time (for example, clients with dementia may abuse every worker who attempts to wash them). Some commentators delineate between two basic types of perpetrators: clients with a violent history who can be expected to be aggressive such as prison inmates, and clients who are "situationally" violent, for example when they are frustrated by delays in service or refusal of benefits (Long Island Coalition for Workplace Violence Awareness and Prevention 1996, p. 14). Appropriate prevention strategies will vary between these two groups.

Occupational violence can include verbal abuse, threats, physical violence, "behaviours that create an environment of fear", stalking, and behaviours that lead to stress or avoidance behaviour in the victim. For night and shiftworkers, those who work alone, or those providing services off-site, the risks may be exacerbated. Jobs and workplaces in which there is a high risk of client-initiated violence include:

... jobs that require workers to handle money or valuables; carry drugs or have access to them; provide care and services to people who are distressed, fearful, ill or incarcerated; relate to people who have a great deal of anger, resentment, and feelings of failure, or who have unreasonable expectations of what the organization and the worker can provide; carry out inspection or enforcement procedures; or work alone (Warshaw and Messite 1996, p. 999; see also Wynne et al. 1996, p. 4).

The situations within which client-initiated violence arises also vary markedly from one job task to another within an industry sector. For example, health care workers operate within hospital, home-care and first-aid environments, and the incidence and severity of violent incidents

varies. In one health care study, the frequency of violent threats varied between clients in maternity (8.7%), children (13.8%), community (18.7%), and mental health (30.7%) work (Turnbull and Paterson 1999, p. 10; Wykes 1994, pp. 18–19). Police, juvenile justice and other law enforcement staff guard prisoners in jail, en-route to court, or in hospital, and the types and severity of risks vary accordingly. Even public service workers who generally perform their tasks in large offices have highly variable levels of risk when they perform different tasks, for example taxation advice compared with collection of revenue. Risks can also vary because of different regulatory provisions, for example prostitutes are at high risk of violence from clients—a problem exacerbated in states where activities are illegal and where standard workers’ compensation insurance cover is not available (see Sex Workers Outreach Project (SWOP) 1999). Because of these highly variable situations and specific risk factors, client-initiated violence prevention strategies adopted have to be customised.

What the Law Requires

Statutory law in Australia states that employers have a primary duty to ensure, so far as is practicable, the health and safety of all people on a worksite or performing work. This requirement is detailed under the OHS legislation in each Australian State and Territory. The OHS duty of care provisions include protecting people from violence. The preventive thrust of the OHS legislation requires the prevention of “foreseeable risk”. The process of risk identification, risk assessment, and risk control is explicit under the OHS Acts or subsidiary legislation in most Australian States and Territories. This process requires identification of the extent and nature of risks, the factors that contribute to risks, the changes necessary to eliminate or control the risks, and the monitoring and evaluation of the risk control process. Violence should be treated in a similar way to other OHS risks. Where an employer is aware of the potential for occupational violence, a court could interpret the risks as foreseeable, and it would be expected that a prevention program had been implemented. In such a case where an employer fails to take preventive action, the offence/breach of the OHS legislation occurs in a time frame prior to an actual incident. All employees also have a duty to comply with organisational policy and procedures, to report incidents, and to support arrangements to control risks (the website address of each Australian State and Territory OHS authority is listed at the end of this handbook). To date, Sweden and The Netherlands are the only

countries to have introduced specific legislation dealing with violence at work. However, WorkSafe Western Australia has introduced a *Code of Practice Workplace Violence* (1999)—which is a first for Australia.

In addition to the OHS Acts, other forms of legislation can apply to violent incidents. If there is a physical assault, the violent incident becomes a police matter and criminal codes apply. If people are dismissed as a consequence of client-initiated occupational violence (for example, if they are unable to perform previous duties), and due process has not been followed, federal or state unfair dismissal legislation may be used for re-instatement and/or compensation (Spry 1998, p. 241).

Victims of occupational violence may also pursue remedies under common law. Common Law breaches of the duty of care are usually founded on four basic principles: the foreseeability of the event, causation, preventability, and reasonableness. For example, United States lawyers generally have to prove: (a) warning signs preceded the violent act; (b) if the company had been listening it would have seen or heard the warning signs; and (c) the company could have minimised or prevented the act but chose not to become involved (McMurray 1995, p. 12). The more foreseeable the risk, the greater the duty to prevent. There have been a number of cases where violence between clients and employees resulted in court action, and the employer has been generally found to be liable, for example:

A taxation interviewing officer had to walk into a public waiting area to get to a cubicle to interview an irate taxpayer:

- *the irate taxpayer stabbed the taxation interviewing officer as he walked from behind the counter into an area open to the public*
- *evidence was produced in court to show that, for a modest sum, the office could have been rearranged so that officers would not be exposed to the same risk from members of the public*

Outcome: In court it was held that the failure of the Taxation Office to take these precautions to protect taxation interviewing officers from the foreseeable risk of attack from irate taxpayers was unreasonable (Brown v. the Commonwealth of Australia, 1982).

A “culture of denial” of lower-level violence may exist in some organisations. Similar denials have been documented in other areas of OHS when new diseases first emerged, for example, with Occupational Overuse Syndrome (OOS), previously known as repetitive strain injury (RSI) and stress. When the number of OOS and stress cases first began to increase rapidly in Australia, the disbelief was frequently greeted with scepticism and an attitude now known as “blame the victim” (see Quinlan and Bohle 1991). This lack of early recognition and preventive action resulted in significant workers’ compensation and legal costs for employers.

Medical, nursing, and involuntary detention acts provide important guidelines for some workers. Health care institutions are guided in their activities by a significant body of patient rights legislation, including consent, disclosure, public interest, right to access medical records, anti-discrimination provisions, as well as additional protections afforded to the aged and mentally ill (see Commerce Clearing House (CCH) 1992, pp. 347–74). The violence prevention policy in health care institutions will have to include the physical restraint techniques that are permissible within the specific state, and an outline of other procedures that must be followed if staff members are exposed to aggressive clients.

All the above regulations vary across the Australian States and Territories. However, the primary legal responsibility for prevention of client-initiated violence remains with the employer/CEO.

Typical Client-initiated Violent Incidents and Behaviours

Some client aggression escalates through inadequate design of the environment and poor service provision. Some arises through anxiety, inadequate coping skills, or illness in the client, and some through pure malicious intent. Client aggression can be scaled on a continuum of: abuse, covert threats, overt intimidation, and physical assaults. The inappropriate behaviour will most commonly be communicated face-to-face, but sometimes through telephone, email, via letters, or through stalking of some kind. Sometimes inappropriate behaviour has developed slowly over time and perpetrators may not even be aware of the impact of their conduct.

Verbal abuse and threats are the most common forms of client-initiated violence, but any of the following can occur:

- shouting, intimidation, and sarcasm;
- damaging the property of the victim and/or the employer;
- deliberate insults through offensive pictures and images;
- sexual harassment or offensive suggestions;
- scratching, pinching, and hair pulling;
- stalking, loitering or repeated following;
- threat of assault;
- groping or “accidentally” touching;
- slapping;
- cigarette burns;
- splashing with infected blood; and
- actual physical assault (police may need to be called at this stage).

(See Workers’ Health Centre (WHC) 1999, p. 1; Arnetz 1998, p. 23; Chappell and Di Martino 1998, p. 11; Sheehan et al. 1998, p. 32; Neales 1997; McCarthy et al. 1996; Spiers 1995, p. 381)

There are considerable impacts on victims that are not necessarily correlated with the severity of injury, and occur independently of motive.

Consequences of Client-initiated Violence

Any form of violence can have serious effects on the workforce, employer and victim, and negative productivity and profitability impacts can even threaten organisational survival. Potential consequences include: (a) high levels of anxiety, depression, stress-related illness, as well as absenteeism and turnover amongst victims; (b) diminished productivity, job satisfaction, morale, and employee involvement; and (c) difficulties in recruiting and retaining valued staff (See Randall 1997, p. 57; Wynne et al. 1996, p. 16; Reynolds 1994, pp. 35–36; Cardy 1992, p. 32).

The personal emotional trauma and costs from perceived or real threats may be considerable and cumulative. Depression amongst victims is likely to be significantly exacerbated by non-supportive colleagues who may wish to avoid involvement and protect their own jobs, and so they ignore the pain experienced by victims, exclude them, and may even “blame the victim”. The violence policy and strategies, and the CEO, should include sufficient precautions to ensure that victims are not further victimised.

If inappropriate behaviour from clients has been tolerated or ignored for some time, the client/perpetrator may have come to believe this behaviour is acceptable and normal, or that this is the only way to get immediate attention and action from staff providing the service. Firm support for the victim and enforcement of behavioural change for the client/perpetrator will be needed in such cases.

Patterns of Client-initiated Violence

It is difficult to identify unambiguous trends in *non-fatal* occupational violence incidents as routine reporting only began around 1990. The lack of a uniformly accepted definition for non-fatal violence prevents identification of clear trends: some databases/surveys include only physical attacks that result in an injury, while others include sexual harassment, abuse, intimidatory behaviours, and obscene phone calls (Wynne et al. 1996, p. 5).

One widely accepted estimate is that, at best, 1 in 5 incidents are reported (see Turnbull and Paterson 1999, p. 9; Barling 1996, p. 29; Warshaw and Messite 1996, p. 995; Wynne et al. 1996, p. 10; Cox and Leather 1994, p. 214). The reasons for non-reporting vary and can include embarrassment, the influence of organisational culture, toleration of minor incidents with reporting only of major assaults, and staff may excuse the behaviours if clients are ill and not their “normal” selves. If their employment is insecure, victims may be unwilling to formally report lower-level violence because of job loss fears. However, some staff under-report because they experience so much aggression that they would never be able to do their jobs if they were continually filling in report forms (Turnbull and Paterson 1999, p. 9).

Mullen (1997, p. 29) has argued that a high unemployment level, and marginalisation of a disaffected and neglected underclass, provides the backdrop for violence directed at community, health care providers, and other service industry workers. When cuts in public spending and services

lead to a reduction in resources, the clients may respond violently believing they are being treated unjustly or unfairly (Mullen 1997, p. 29). In such a scenario, solutions based on increased penalties are unlikely to be effective.

The Incidence of Occupational Violence

One Australian poll assessed whether workers had ever experienced violence from members of the public while doing their job. It was found that 50 per cent had been verbally abused, 10 per cent physically attacked, 33 per cent had not been abused, and 17 per cent had never worked with the public (Roy Morgan Research Centre 1998, p. 1).

There appears to have been a rise in non-fatal violent incidents over the last decade. However this increase may reflect, to some extent, improved *reporting* as the issue has gained prominence (Long Island Coalition for Workplace Violence Awareness and Prevention 1996, p. 2; Reynolds 1994, p. 18; Leather et al. 1990, p. 3). For workers in public agencies (where reporting is likely to be more consistent), an increase has been seen across western countries (see Perrone 1999, p. 82; Standing and Nicolini 1997, p. 26; Heskett 1996, pp. 8, 17–18; Long Island Coalition for Workplace Violence Awareness and Prevention 1996, p. 5; Nelson and Kaufman 1996, pp. 441–44; CAL/OSHA (California Occupational Safety and Health Administration) 1994; Cardy 1992, pp. 25, 32; Leather et al. 1990). A range of sources of data have been used to assess the extent of work-related violence in public agencies, including workers' compensation insurance claims, internal organisational records, surveys of staff, insurance claims, and police records.

Industries/Occupations/Groups at Higher Risk of Occupational Violence

The high-risk occupations/industry sub-groups are similar across the industrialised world, and have remained relatively constant over time (although the incidence may have increased). *“Generally, any employees who come into contact with clients likely to be violent (such as mental health workers) are at risk”* (Standing and Nicolini 1997, pp. 9, 18–19; see also Wynne et al. 1996, p. 8; Reynolds 1994, p. 15; Wykes 1994, pp. 11–12).

Groups at risk of occupational violence in the United Kingdom have remained relatively constant. In 1986 Poyner and Warne listed 20 high-risk jobs in the United Kingdom, including police and prison officers, housing office staff, social workers, nurses, teachers, postal workers, bar staff, retail sales staff, bank workers, and those employed in transport. Over 10 years

later the high-risk jobs were police, security guards, fire service, teachers, welfare workers, nurses, staff in takeaway food outlets and other retail stores, bar and off-licence staff, social security, transport, milkmen, and taxi drivers (see Standing and Nicolini 1997, pp. 7–9; Trades Union Congress (TUC) 1999, pp. 6, 8–9, 18).

In the United States, law enforcement, security guards, taxi drivers, prison guards, and bartenders were at highest risk, followed by a range of “caring” client-focused jobs including health care workers (Department of Justice 1998, p. 2; Wilkinson 1998, pp. 3–9; NIOSH 1996, p. 2). Estimates of the proportion of United States traumatic work-related fatalities due to violence vary between 12 per cent to 20 per cent (Peek-Asa and Howard 1999, p. 647; Department of Justice 1998, p. 2; NIOSH 1997, p. 1; NIOSH 1996, pp. 6–8; Myers 1996, p. 1). Attention became focused on client-initiated violence in the United States after a New York man whose wages had been garnisheed for child support murdered four social service workers (Seger 1993, pp. 141, 145).

Workplace violence is not random in Australia. However, in contrast to the United States pattern, only 2.8 per cent of traumatic work fatalities in Australia are due to homicide, with taxi drivers, security guards, and police at highest risk (Driscoll et al. 1999, p. vii; NOHSC 1999). In the second Work-related Fatalities study which examined coronial records over the 4-year period 1989–1992, 38 per cent of all homicides were committed by clients, customers or patients of the murdered worker (Driscoll et al. 1999, p. 7). Over half were shot (Driscoll et al. 1999, p. 7). In New South Wales, 85 per cent of all violence-related workers’ compensation insurance claims were from the following industry sectors: health, welfare and community services; education; property and business services, retail trade, public administration, and road and rail transport (Estreich 1999, p. 4). By occupation, the most “at risk” jobs were: miscellaneous labourers, registered nurses, miscellaneous para-professionals (for example, welfare, community, and prison workers), personal services (refugee, home companion, enrolled nurse and family aid), police, road and rail transport, and school teachers (Estreich 1999, p. 4). In Australia, as elsewhere, prostitution is a very high-risk job.

A female prostitute worked nights, often starting work at 11:00 p.m. or midnight:

- *around 12:30 a.m on a Sunday she was kidnapped by a man in a car as she walked the street;*
- *she was seen to be struggling to get out of the car, but was subdued by the man; and*
- *she was taken to a sporting oval where she was assaulted with blows from an implement like a woodcutter.*

Outcome: The prostitute was killed. Toxicology revealed evidence of the use of narcotics and benzodiazepines. The assailant was never found (extracted from Driscoll et al. 1999, unpublished data).

There are gender variations in vulnerability to client-initiated violence. While the international evidence is patchy, it appears consistent—females tend to experience higher levels of verbal abuse and males more overt threats and physical assaults (Chappell and Di Martino 1998, p. 44; Mayhew and Quinlan 1999). This variation in risk can be partially explained by the gender division of labour with women concentrated in low paid, low status jobs with greater face-to-face contact. The Victorian community-based legal centre Job Watch (1999) found that over two-thirds of violence complaints were reported by women (cited in Dale et al. 1997, p. 6). Interestingly, aggression against women may be more restrained if she is perceived to be attractive (Cox and Leather 1994, p. 226). While one study found younger workers may be at particular high risk (Fitzgerald 1998, p. 10), others have identified an increased risk for older females who may be perceived to be “easy targets” in hold-ups (see also Nelson and Kaufman 1996).

The consistent pattern evident in data from the United Kingdom, the United States, and Australia is that client-focused jobs that involve a lot of face-to-face contact are high risk. The probability and severity of violence will vary markedly between job tasks. Groups at specific risk of being harmed need to be identified. Identification of characteristics of the workforce may help in this process. For example, if females are concentrated in counselling tasks and males in arrest duties in the police force, different patterns of occupational violence are likely. Close examination of data patterns is necessary to identify risk patterns and hence appropriate prevention strategies. For example, the potential for violence may increase at particular times of the day or night, on specific days of the week, at venues where

there is excessive alcohol intake, or if there are client waiting periods in excess of 20 minutes. Once correlated variables have been identified, intervention strategies can be designed, implemented, and monitored. Some high-risk job and task examples are provided below, although this is not intended to be an exhaustive list.

Off-site Visits to/with Clients

Off-site or isolated work environments are higher risk. One United Kingdom study of 800 women and 200 men found that 1 in 3 professionals who went out to meet their clients had been threatened, and 1 in 7 male professionals working away from their office had been physically attacked (Phillips et al. 1989, p. 11; see also Vandenbos and Bulatao 1996, p. 104). There are a number of jobs that require off-site visits, many with clients in their car. A frequently overlooked high-risk activity—transporting a stranger in their car—is undertaken by estate agents on a daily basis.

A United Kingdom real estate agent disappeared in July 1986 while doing her normal day's work:

- *no trace of her body was ever found; and*
- *she was declared dead presumed murdered in 1993.*

Outcome: The Suzy Lamplugh Trust was established under the directorship of her mother Diana Lamplugh. In collaboration with other organisations, this trust has produced a series of substantive documents to prevent work-related violence (Gates 1995, p. 42).

There are a number of simple precautions that can reduce the risk of off-site client-initiated violence significantly (discussed later).

Visits to the Home of Clients

There is a range of jobs where staff must visit the home of clients. While these clients usually welcome the service, sometimes they may become violent because of their condition, for example senile patients living at home. At other times, visits can be quite unwelcome, for example when children have to be taken into care.

A worker visited an elderly man to discuss the provision of home help:

- *the man became agitated and chased the worker with his walking stick;*
- *the worker found that the battery in her mobile phone was flat;*
- *the worker took refuge in the toilet with her feet up against the door; and*
- *the client pounded on the door with his fists and stick.*

Outcome: The worker was aware that the elderly man slept every afternoon between 3 p.m. and 5 p.m. She waited in the toilet for 2 hours and then cautiously looked out. As the house was quiet, she left quickly by the nearest door (Cherry and Upston 1997, p. 9).

Attacks on Staff on the Way to or from Work

Some jobs require staff to do shiftwork, which almost inevitably means they arrive or leave work at unusual hours when there are few other people around and/or during hours of darkness. Under the workers' compensation insurance provisions in Australian States and Territories, journeys to and from work are usually covered. The legal responsibilities of employers to provide a safe place and process of work under OHS legislation clearly includes ensuring that on-site car parks are designed and maintained in a way that protects shiftworkers from violence when leaving or returning to their vehicles or to public transport stops.

Nurses working at large public hospital regularly caught trains to and from work. One night at the end of the evening shift, a 19-year-old man was waiting:

- *at 10.45 p.m. a 22-year-old nurse was attacked while waiting for a train;*
- *the perpetrator threatened her with a knife and punched her in the head, face and body;*
- *he cut her face before fleeing;*
- *soon after he threatened another nurse with the knife and forced her to walk along the rail tracks;*
- *he forced her into a disused railway shed where he raped her and attacked her with the knife; and*
- *the nurse fought back and escaped.*

Outcome: The hospital provided a security guard to accompany nurses to the railway station for a time.

Workers in Contact with the Public in Offices or Other Client Service Outlets

A balance needs to be maintained between creating a welcoming, calming, and a non-threatening environment and process of delivering the service while ensuring the safety of staff and other clients. The balance will need to be worked out for each specific site and according to the degree of risk (Cardy 1992, p. 106). For example, environmental controls are of central importance in psychiatric facilities (Murdach 1993, p. 309).

Members of the public may have escalated anxiety levels if benefits are reduced, if there are long waiting times, staff attitudes are perceived to be unhelpful, or if bureaucratic red tape delays service provision (Warshaw and Messite 1996, p. 1000; Reynolds 1994, p. 53). Perceived invasion of privacy can add to these tensions and clients may become enraged if they believe officers are applying their own discretion—rather than regulations—to limit services (Gates 1995, p. 40).

Unfortunately, some clients have learnt over time that abuse and threats lead to improved or quicker service provision. Such clients may attempt to force the providers to meet their needs, this has sometimes been called “learned aggression”. This aggressive behaviour can be a *learned* response to frustration through behavioural reinforcement during childhood development (Reiss and Roth 1993, p. 7). Thus aggressive children tend to grow into aggressive adults, although the forms the violence takes may change. This pattern of aggression may be “acted out” in all spheres of a person’s life. For example, an informal study at Polaroid in the United States found that half of the people who had committed acts of violence at Polaroid over a 3-year period also battered their spouses or partners at home (cited in Speer 1997, p. 11).

Since extreme emotional arousal prevents calm thinking, prevention and/or reduction of arousal in the client has to be the primary aim of staff (Cembrowicz and Ritter 1994, p. 17). An aggressive response by the worker would be inappropriate as the level of overall violence might escalate, but a passive response could be interpreted as acceptance of the client’s right to behave inappropriately. Staff should, therefore, respond to client aggressiveness by being quietly assertive, expressing facts calmly and quietly, avoiding extreme discussions, and taking firm appropriate action.

A 25-year-old client was involuntarily admitted to a health care psychiatric institution for assessment after threatening his neighbour with a gun during a dispute over a parking space. Following admission he:

- *spoke in a threatening tone to staff;*
- *warned staff not to “mess” with him as he had an uncontrollable temper;*
- *refused to participate in therapeutic groups or activities; and*
- *when confronted with discharge refused to leave.*

Outcome: He was discharged administratively and escorted off hospital grounds by police (Murdach 1993, p. 310).

The risks in some industry sectors that involve significant contact with clients are described below.

Health Care Sector Client-initiated Violence

Health care professionals must deal with clients who are often in a vulnerable situation, anxious, and who are strangers to the service provider—but who may have to reveal very personal information about themselves (Cembrowicz and Ritter 1994, p. 18). Almost inevitably, high levels of anxiety characterise health care staff–client relationships, and aggressive behaviours are likely to be difficult to predict.

However, higher levels of risk do not necessarily result in formal reporting of incidents. The lack of a consistent definition of violence, the varied epidemiological methods adopted, the sensitivity and subjectivity of the issue, and the paperwork and time that formal reports require have all been given as reasons for under-reporting of occupational violence amongst health care workers (Arnetz 1998, p. 18). Further, Grainger (1997) has warned that the risks faced in health care, and *reporting/non-reporting* of incidents, can vary in different cultures.

In an evaluation conducted by the Health Services Advisory Committee (HSAC) of the Health and Safety Executive (HSE), variations in violent incidents by health care sub-sectors were collated: accident and emergency department and psychiatric hospital workers were at greatest risk, followed by those working with people with a mental handicap. Ambulance staff and

nurses were also at high risk (Cardwell cited in Standing and Nicolini 1997, pp. 13–14; Turnbull and Paterson 1999, pp. 14–15). The higher levels of risk in emergency admission units can be exacerbated by other problems—one United States study found that 25 per cent of major trauma patients treated in emergency rooms carried weapons (Reich and Dear 1996, pp. 401, 408). In addition, some conditions can be correlated with increased aggression, for example intoxication. A Swedish study of violence in health care workplaces found the perpetrators were mentally ill (44%), senile (37%), under the influence of alcohol or narcotics (12%), or the medical condition of the aggressive patient was unknown (6%) (Arnetz 1998, p. 24).

In the United Kingdom, health care workers had a 1 in 10 chance of a minor injury, and 1 in 6 were verbally abused (see HSE 1987 cited in Cox and Leather 1994, p. 215). Other United Kingdom studies have found that 1 in 200 health care workers suffer a major injury from violent clients each year, and 1 in 10 needed first aid (Wykes 1994, p. 1). One survey of general practitioners in the United Kingdom found 10 per cent had been assaulted and 5 per cent threatened with a weapon; another survey of general practitioners found 11 per cent had been assaulted and 91 per cent experienced verbal abuse (Cembrowicz and Ritter 1994, p. 13). A study in Ireland found 44.4 per cent of male and 32.5 per cent of female medics were the victim of some form of aggression or assault in the year studied (cited in Wynne et al. 1996, p. 13).

There has been little occupational violence research in the Australian health care sector. In one study amongst nurses conducted by the Royal Australian Nurses Federation, 85.8 per cent had experienced aggression by patients, 41.9 per cent from visitors, and 30.9 per cent reported verbal abuse by co-workers (cited in Bowie and Malcolm 1989, p. 162). It is, therefore, hardly surprising that many regarded client-initiated violence as “part of the job” (cited in Bowie and Malcolm 1989, p. 179). However, fatalities on-the-job remain low. In the second Work-related Fatalities study that examined coronial records over the 4-year period 1989–1992, 3 of 4 medical workers killed on-the-job were attacked by patients (Driscoll et al. 1999, p. 6).

A doctor in private consulting rooms attached to a private hospital employed a medical secretary:

- *a client had been writing abusive letters to this medical practice for some time;*
- *during phone calls, the client had threatened that he would “get the girls” who worked at the medical office;*
- *the police had been notified of these threats, however*
- *one day a male offender entered the hospital and confronted the secretary with a firearm.*

Outcome: After a brief conversation the offender shot the secretary in the head, and then left the office. The offender returned a short time later and fired further shots to her head (extracted from Driscoll et al. 1999, unpublished data).

It appears that workers having contact with *some* people with psychiatric disorders are at increased risk (Flannery et al. 1994). Younger male patients suffering psychosis with active impaired thinking or neurological abnormality and with a history of violence are most likely to assault staff (Flannery et al. 1994, p. 25). Thus patients with psychosis may present a far higher risk to staff than those with schizophrenia (Turnbull and Paterson 1999, p. 17). Nevertheless, clients with paranoid schizophrenia may be quite dysfunctional. These clients may have delusions of persecution, unrealistic perceptions of events and relationships, live in both real and fantasy worlds at the same time, have delusions of grandeur, and when they strike out they may do so in “righteous” self-defence (Capozzoli and McVey 1996, p. 66). Specific events may also trigger unprovoked assaults, including too much ward activity at one time, denial of services, overcrowding or inadequate facilities, or negative staff attitudes (Flannery et al. 1994, p. 25). Between 46 per cent and 100 per cent of nurses, psychiatrists, and therapists in psychiatric facilities in the United States have experienced at least one assault during their career; many in outpatient departments (cited in CAL/OSHA 1998, pp. 1–2). Following a death in a United States forensic hospital and of an outpatient psychiatric worker by a homeless client, more research on causes and prevention was funded.

Similarly, there may be increased risks in *some* environments with people with a learning disability (Turnbull and Paterson 1999, p. 16).

The house manager of a State home for people with developmental disabilities was working alone:

- *a resident had demonstrated mood swings earlier in the day;*
- *there had been difficulties in getting him to take his anti-psychosis medication;*
- *this client had a history of violence;*
- *the house manager was attacked by the resident when she tried to reach a phone;*
- *the resident was placed by police in an institution; and*
- *the house manager had 3 months off work for post-traumatic stress.*

Outcome: The community services department was prosecuted under the OHS Act for failure to provide adequate emergency plans. The employer pleaded guilty and was fined \$95,000 (Tuckley v. New South Wales Department of Community Services) (Editor 2000).

Other risk factors correlated with client-initiated violence in health care include:

- the de-institutionalisation of the mentally ill without sufficient community resources;
- the right of clients to refuse psychotropic treatment;
- restrictions on institutionalisation of the mentally ill without their consent unless they pose an immediate threat;
- the use of hospitalisation in lieu of incarceration of mentally ill criminals;
- insufficient staff resources, particularly at high activity times, for example meal and visiting hours;
- over-crowding and lack of privacy in facilities;
- low staffing numbers at night;
- increased frequency of exposure to, and interaction with, clients;
- activities that arouse fear or anger in clients;
- long waits for services, for example in emergency departments;
- unrestricted client access to staff areas;

- gang members or distraught relatives visiting clients; and
- clients who are drug users, social deviants or threatened individuals (CAL/OSHA 1998, pp. 2–3; Shepherd 1994; Bowie and Malcolm 1989).

The families of patients may also present a risk of violence. Many times the relatives are upset, anxious, are uninformed about medical procedures, and/or have a range of emotions to confront.

A middle-aged man was distraught and angry after his father died of a coronary thrombosis in an ambulance on the way to hospital. He believed that health care staff members were at fault. Stress and anger indicators included:

- *confusing upsetting emotions;*
- *anxiety;*
- *preoccupation with physical symptoms and conditions;*
- *feelings of helplessness and frustration;*
- *anger displaced inwards causing depression; and*
- *anger displaced outwards manifesting as aggression and hostility.*

Outcomes: Remedial interventions included conciliation to ease emotional pain and reduction in stress through calm firm help. Health care staff also held discussions with other family members, friends, a priest, and a social worker (Cembrowicz and Ritter 1994, p. 15).

Community Services Sector Client-initiated Violence

Community service workers are at increased risk when they visit clients in their homes, especially at night. Welfare workers taking children into care, parking enforcement officers, and housekeepers in hotels are all at increased risk. For example, a case worker who removed a 7-year-old child from a violent home in New York was beaten to death (CAL/OSHA 1998, p. 3). The substantial risks faced by social workers are rarely acknowledged. Some examples of client-initiated violence on United Kingdom social workers that resulted in fatalities or permanent disabilities include:

- male social worker stabbed to death when visiting a client;
- killed by former client in her office at psychiatric hospital;

- female died while visiting a youth who had tried to commit suicide;
- murdered while visiting a client at home;
- residential social worker fatally stabbed at hostel for homeless;
- probation officer received brain damage after attack in his office;
- probation officer blinded following assault by man who threw hydrochloric acid into his face;
- female probation officer stabbed by drug-abusing client during a home visit;
- unlawfully imprisoned and threatened by client whose 2 children had been taken into care; and
- car crash while escorting patient to psychiatric hospital resulted in a social worker receiving severe injuries—the crash was caused by client grabbing wheel of car being driven by police officer (Bute, cited in Wykes 1994, pp. 45–47).

An important risk factor, particularly in the United States, is the availability and carrying of weapons by either clients or their family/friends. For example, many homeless people carry weapons to protect themselves on the street, for example screwdrivers (CAL/OSHA 1998, p. 10). Thus clients who have been on leave from accommodation/psychiatric support units/community hostels should be screened for weapons on their return (CAL/OSHA 1998, p. 10).

Education Sector Client-initiated Violence

There have been several major violent incidents in United States schools, as well as a much-publicised multiple homicide in Scotland. Evidence suggests that violence in schools is greatest in geographical areas with higher crime rates and more street fighting gangs (Reiss and Roth 1993, p. 155). This pattern suggests that school populations and risks mirror the community in which they are situated—an inherently logical proposition. Highest rates are found in schools with lax discipline, lax or arbitrary enforcement of rules, a weak principal, and where students did not aspire to high grades (Reiss and Roth 1993, p. 156). Most assaults involve students attacking another student. However, many assailants are people without a good reason to be on school

grounds, and in a significant proportion of incidents a student attacks a teacher (Gill et al. 1998, pp. 429–33). Teachers in the United Kingdom were most likely to be attacked by ex-pupils and the parents of pupils, with around 10 per cent of secondary teachers abused by pupils each week (Gill et al. 1998, pp. 431–33; and also Redmond 2000, p. 12).

Australian students are also violent towards their teachers. For example, the New South Wales Education Department has taken out 38 apprehended violence orders on behalf of teachers after a teacher was stabbed in late 1996 (Patty 1998, p. 34). As elsewhere, accurate Australian incidence rates are not available. For example, one United Kingdom study found one-third of schools had no procedures for reporting or recording incidents, and very few events were reported to police (Gill et al. 1998, pp. 431–33). Sometimes staff have a responsibility to intervene and protect students when individuals are not being attacked:

Four youths came onto the site just at the end of lunch time ... deputy actually went out to engage them in conversation, because he'd taught some of them. They were only 17-year-olds. They started throwing rocks and bricks and things at the science block across the way ... glass was breaking and classrooms were being evacuated ... we were standing there, desperately hoping the police would come, and I suddenly saw this flash ... I realised that this one really did have a knife in his hand ... (Gill et al. 1998, p. 432).

Studies have found that there are significant impacts on victims and bystanders at schools in both the immediate and the long term. Feelings of anger, grief, anxiety, and the meaningless of violence were persistent over time, with those who had known the victim, or who had been a witness to the event, being most at risk of Post-Traumatic Stress Disorder (PTSD) (Flannery 1996, p. 61).

Law/Prison/Security Sector Client-initiated Violence

Law enforcement officers are at risk when making arrests, conducting drug raids, serving warrants or eviction notices, investigating suspicious vehicles or during random breath testing on highways (CAL/OSHA 1995, p. 7). Robberies and domestic disputes are particularly high-risk tasks. In the United States over 100 police officers are killed in the line of duty each year. This has significant costs on surviving officers and the public purse:

70 per cent of those involved in shootings leave the force within 5 years, and untreated PTSD is a serious health problem (Flannery 1996, p. 60).

Two under-cover Australian police officers were performing general surveillance in an unmarked police car when they noticed a suspicious person:

- *the police officers attempted to search the suspect; and*
- *the suspect hit both officers.*

Outcome: The suspect pulled out a gun and fatally shot one of the police officers (extracted from Driscoll et al. 1999, unpublished data).

Correctional and juvenile detention workers face similar risks. One Canadian study of penitentiaries found that most assaults and homicides occurred in high security cell blocks during the day shift, with officers with less than a year of experience at greatest risk (Flannery 1996, p. 60). Again, the incarcerated assailant was usually a young male with a history of violence and the incident usually occurred when few witnesses were around. Correctional and juvenile detention workers also face the potential risk of being taken as a hostage in institutional riots.

Transport Sector Client-initiated Violence

The transport sector workforce is at risk of violence from abusive passengers, during robberies, as well as “normal” traffic-related threats. Sometimes they are on-the-job in the evening/night/very early morning hours when they work alone and are quite vulnerable (NIOSH 1996).

Over the past 3 years, I have been out of work for 19 months as a result of 4 separate attacks. During one attack, I was assaulted mid-afternoon by 2 men who pushed syringes against my throat and demanded money. This time it really got to me. I just crawled out of the bus on my hands and knees and started crying (Irish bus driver cited in Wynne et al. 1996, p. 17).

Taxi drivers have one of the highest levels of work-related homicide in all industrialised countries examined (Driscoll et al. 1999; Mayhew 1999; Haines 1998, p. 65; Nelson and Kaufman 1996, p. 440; Weiser Eastal and Wilson 1991, p. 38). Other forms of occupational violence are common: taxi drivers may suffer fractures, bruises/contusions, and laceration injuries to the head,

as well as many assaults and threats that do not result in injury. Verbal abuse can be an everyday occurrence. However, few incidents are formally recorded. As a result, there is a significant understatement of the incidence in official data. One explanation for the higher levels of risk in taxi driving is that they are now seen as comparatively “easy” targets as banks, all-night chemists, service stations, and corner stores progressively increase security. Eight factors were associated with assaults in one Queensland survey of 100 taxi drivers, with passengers with more of the risk factors more likely to assault. In order of importance, the passenger risk factors were: male (83.3%), young (75.4% under age 30), evening/night work (72%), inebriated (59%, plus 4% “partly”), “hail” from a street (46.1%) or a rank (36.5%), inner-city pick-up (33%), disadvantaged socio-economic clients (15%), and the pursuit of fare evaders by drivers (Mayhew 1999).

Management Action Required

Demonstrated top management/CEO commitment to non-violence is of core importance. Some suggested baseline documents have been included in this report to assist employers and employees in meeting their legal obligations in the prevention of violence. These documents are generic tools and will need to be adapted and tailored to reduce the specific risk factors within each individual organisation. The commitment to violence prevention should be clearly stated in an organisational mission statement (see Appendix 1) and through a violence prevention policy (Appendix 2). Both should be publicly displayed and widely disseminated, and be made explicit in the stated goals of the strategic plan. The policy also has to be seen to be applied to all violent incidents from clients. The organisation can self-assess the extent to which it has met legal requirements through a legal vulnerability checklist test (Appendix 3). A clear CEO statement of commitment to zero-tolerance of client-initiated violence is needed, together with a statement to clients or client groups that non-compliance can lead to refusal to provide future services (Appendix 4). There has to be widespread communication of the violence prevention policy and strategies, and of the CEO’s statement (Appendix 5).

Post-incident Support

Workers who have experienced violence from a client can experience any or all of the following:

- loss of self-esteem, self-doubt, depression, and fear;
- irritability and insomnia;
- disturbed relationships with family and friends;
- physical illnesses;
- difficulties with performing tasks at home;
- decreased ability to function at work, absenteeism, “flight from caring work”, fear of criticism from managers, feelings of professional incompetence, and performance difficulties;
- increased use of caffeine, nicotine, alcohol, and medication;
- post-traumatic stress disorder; and
- many leave their jobs (CAL/OSHA 1998, pp. 4, 16; Findorff-Dennis et al. 1999, p. 461).

In addition, a delayed critical stress reaction can follow:

- situations that threaten the security of colleagues;
- serious injury or death of a colleague;
- work situations or events that attract undue media attention; and
- events or actions that remind workers of other unpleasant past events and cause significant distress (ACT Chief Minister’s Department 1993).

While all of the above bring significant secondary costs to the worker and his/her employer, these costs are missing from most cost accounting calculations (see Reynolds 1994, pp. 34–37). In particular, the victim’s acute and chronic pain, emotional sequelae, and productivity impacts usually remain unrecognised (Findorff-Dennis et al. 1999, pp. 456, 460).

The support of co-workers is very important, but is often not forthcoming:

At a time when social support needs are critical, victims may find themselves socially isolated, not only because they might be depressed and unhappy individuals, but also because their presence is often an unwanted reminder of the vulnerability of others. Blaming the helper-victim assists other staff members to distance themselves from the possibility of themselves also being violated (Bowie and Malcolm 1989, pp. 171, 174).

Sensitive and appropriate support can reduce suffering through proper care of a person who has been subjected to violence from a client. Victims are usually thrown off-balance by these abnormal events and are at risk of physical and emotional illness (Wykes 1994, p. 5). Any person with an injury or adverse symptom should be encouraged to consult a physician of his or her choice (Workers' Compensation Board of British Columbia (WCBBC) 1995, p. 6), referred to the Employee Assistance Program (EAP), or debriefed through appropriate personnel. The victim should be kept fully informed about procedures that will follow and what action will be taken. If the victim is unable to perform his/her former duties as a result of the incident(s), a change of duties/location should be arranged if possible, without prejudice to future prospects. The victim or the organisation may wish to initiate procedures against the client.

Establishment of Grievance/Mediation Meeting

Total CEO commitment to prevention and open acknowledgment of violence risks is essential, otherwise aggressive client behaviours may continue and escalate (immediate action to stop the behaviour may also reduce litigation). Criminal acts, such as assaults or serious property damage, should be immediately reported to the police. For less serious violent incidents, a complaint may initially be verbal and lodged with the specified contact person, union delegate, a nominated Human Resource Management (HRM) staff member, or the immediate supervisor. If there is more than one victim, a group complaint against the client/perpetrator may be appropriate.

The violent client may not be contactable, may be incapable of engaging in a discussion about the incident, or may be unwilling to discuss the matter. If the client/perpetrator agrees to a formal discussion about the violent incident, he or she should be interviewed after the victim(s) and when detailed documentation has been compiled. The need for confidentiality should be stressed. At the initial meeting between the appointed mediator

and the alleged client/perpetrator, firm management of the process will be necessary. The appointed adjudicator must be well versed in the violence prevention policy and strategies, fully understand potential impacts on victims, have detailed knowledge of appeal processes, and be aware of typical violent behaviours from clients in that industry sector.

Guidelines for Mediation Meeting with Violent Client

- *Detailed preparation:* careful documentation of the violent incident(s), witness statements, prior liaison with other relevant staff, for example EAP and security, and objective assessment of evidence.
- *Equity:* the alleged client/perpetrator is entitled to have a support person present (as is the victim in prior discussions).
- *Address all the issues.*
- *Address only the issues,* for example objective specific behaviours.
- *Offer options:* resources available, for example treatment or transfer.
- *Be flexible:* allow alleged client/perpetrator to express extenuating circumstances, but keep focused.
- *Avoid verbal one-upmanship* and digressive arguments that may be introduced (Davis 1997, pp. 117–66).

Natural justice and due process require that the alleged client/perpetrator be fully informed of the accusations, have a right to respond, and be entitled to an unbiased decision. The alleged client/perpetrator is also entitled to have a support person present. If the incident is severe or repeated, there will need to be immediate action, for example notification to police and/or refusal of future services. The major outcome for the organisation should be identification and control of the risks so similar future violent incidents do not occur.