Preventing *Client-Initiated* Violence: A Practical Handbook

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Foreword

Violence at work takes many forms and ranges from armed robbery to threats from clients to degrading initiation rituals imposed by other employees. The severity of outcomes also varies from homicides to verbal abuse.

This handbook focuses on *client-initiated* violence. Client-initiated violent incidents can occur in a range of situations. For example, aggression by patients with dementia, or violence by an anxious customer or client who does not receive attention promptly.

The approach taken in this handbook is preventive rather than reactive.

In addition to the intrinsic value of a safe and happy workforce, the prevention of violence from clients can be profitable. In Australia and overseas, employers have been found liable for failing to prevent workplace violence and have had significant damage claims awarded against them. Diminished productivity in a violent workplace can further detract from the bottom line.

This handbook is written with violence prevention in medium to large sized organisations in mind. An abbreviated version will also be published which is more suitable for organisations with fewer than 20 employees.

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Director, Australian Institute of Criminology
July 2000

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Contents

Abbreviations

ATM	Automatic Teller Machines
CAL/OSHA	California Occupational Safety and Health Administration
CCH	Commerce Clearing House
CCTV	Closed Circuit Television
CEO	Chief Executive Officer
DETIR	Department of Employment, Training and Industrial Relations
EAP	Employee Assistance Program
EEO	Equal Employment Opportunity
HRM	Human Resource Management
HSAC	Health Services Advisory Committee
HSE	Health and Safety Executive
MSFU	Manufacturing, Science and Finance Union
NOHSC	National Occupational Health and Safety Commission
OHS	Occupational Health and Safety
OOS	Occupational Overuse Syndrome
PTSD	Post-Traumatic Stress Disorder
RSI	Repetitive Strain Injury
SWOP	Sex Workers Outreach Project
TUC	Trades Union Congress
UNISON	A large public sector union in the United Kingdom
USOPM	United States Office of Personnel Management
WCBBC	Workers' Compensation Board of British Columbia
WHC	Workers' Health Centre

Executive Summary

Occupational violence is a problem with significant legal, economic, and emotional consequences for employers and individual victims.

The Australian Institute of Criminology is producing a series of publications on occupational violence. The first was *Violence in the Workplace* by Santina Perrone. Subsequently, an annotated bibliography of the scientific literature on prevention strategies was compiled and placed on the Institute's website for general access (see www.aic.gov.au/directories). This database was developed in conjunction with the National Occupational Health and Safety Commission. In addition, a series of three handbooks were produced with practical advice on prevention. The first handbook is called *Preventing Violence Within Organisations: A Practical Handbook*. It is aimed at preventing violence between a supervisor and an employee, or one employee and another.

This second handbook *Preventing Client-Initiated Violence: A Practical Handbook* addresses the prevention of the forms of violence that can occur between social workers and their clients, or nurses and patients. The final handbook is focused on the prevention of violence during *armed hold-ups* and robberies. These handbooks are designed for medium to large-sized organisations.

Client-initiated violence is committed by individuals who have, or have had, some form of a service relationship with the 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 harassment that continues over time. Sometimes both workers and other clients can be victims of the violence (for example, a client in a social security office may threaten everyone present with a knife) or the events may be repeated over time to a number of victims (for example, all workers who try to wash a senile patient). The violent acts and behaviours can include:

- verbal abuse and intimidation;
- threatening phone calls or letters;
- stalking;
- threats of harm to the worker or his/her family and friends;

- destruction of property or possessions; and/or
- physical assault of some kind.

This handbook includes discussions on:

- the importance of Chief Executive Officer (CEO) commitment to zero-tolerance of violence;
- some of the economic and personal impacts from violence;
- an outline of risk identification, risk assessment, and risk control procedures applied to client-initiated violence;
- the statutory legal responsibilities of employers/managers to provide a safe and healthy worksite and work process under Occupational Health and Safety (OHS) legislation;
- other legislative instruments that apply to client-initiated violence;
- the need for written violence prevention policy and strategy documents, and implementation of these;
- some high-risk occupations where patterns of client-initiated violence and effective prevention strategies have been identified; and
- detailed draft violence prevention policy and strategy documents and checklists for employers to adopt & adapt to specific on-site conditions.

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 of 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 medicos 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 Easteal 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.

The Risk Identification, Risk Assessment and Control Process

The process of risk identification, risk assessment, and risk control is now standard practice to control OHS risks in Australian jurisdictions. Client-initiated violence is most readily controlled through the same process, although additional attention must be paid to the hidden nature of much violence, the need for organisational learning, and the fact that many violent clients are not responsible for their actions (Wynne et al. 1996, p. 43). To date, there is very little evaluation of the effectiveness of preventive interventions (Peek-Asa and Howard 1999, p. 648).

Risk Identification

A formal risk identification process must identify the extent and nature of the risk, the circumstances under which risks arise, causes, and potential contributing factors.

If abuse, threats, and assaults have occurred in the past, the frequency, severity, and characteristics of client/perpetrators and victim vulnerability need to be formally documented. Proper documentation of incidents is important for an organisation to learn by its experiences, and this documentation needs to be reviewed at the highest level. Those responsible for OHS need to identify what measures have been taken to stop the client-initiated violence, ascertain if the preventive strategies implemented have been adequate, and whether the outcomes have been objectively evaluated. A regular violence audit is an important part of the preventive strategy (Appendix 6).

Frequent turnover of staff in an area, particularly those who are distinctive in some way (for example, home-visit staff and care of dementia patients) may be a warning sign that violence is occurring. It is also important to note that victims of violence are likely to have at least twice the rate of stress-related conditions compared with non-victims (Speer 1997, p. 10). Other risk factors for stress are also well known, for example, work overload, lack of control, and burnout amongst “caring” professionals.

Numerous studies have suggested that violence rarely "comes out of the blue", but is commonly preceded by behaviour that indicates a potential for violence (Speer 1997, p. 8). While the best predictor of future aggression remains past aggressive behaviour, relying on profiles is a dangerous practice as violence has been committed by a range of people under a variety of circumstances.

Some warning signs for client-initiated violence have been identified (Tardiff 1998, p. 37; Vandenbos and Bulatao,1996, p. 104; Shepherd 1994). Violent behaviour can be scaled according to the intensity of the aggressive behaviour and the degree of threat, as seen below:

Warning Signs of Impending Client-initiated Violence

- *Early potential:* rapid breathing, clenched fists and teeth, flared nostrils, flushing, panic, loud talking or chanting, restless and repetitive movements, clinging to staff, pacing, violent gestures—for example pointing, swearing excessively and/or using sexually explicit language, veiled threats, verbal abuse, unprovoked outbursts of anger or emotion, or sexually harassing.
- *Escalated potential:* argues frequently and intensely, blatantly disregards "normal" behaviour, hyper-vigilant, obsessional thinking and behaviour, throws/sabotages/steals equipment or property, makes overt verbal threats to hurt workers, rage reactions to frustration, sends violent or sexual comments via email, voicemail or letter, and blames others for all difficulties.
- *Urgent signs:* fascination with weapons, substance abuse, severe stress, violent history, marked changes in psychological functioning, exotic claims (losing touch with reality), social isolation or poor peer relationships, poor personal hygiene, and drastic changes in personality.
- *Realised potential:* destruction of property, involved in physical confrontations or commits assaults, displays and/or uses weapons, commits sexual assaults, arson or suicide.

(See UPOSM 1998, p. 17; Davis 1997, pp. 11, 14, 21, 30, and 54; Randall 1997, pp. 53–54; Speer 1997, p. 8; Heskett 1996, p. 45; Kinney 1996, p. 307; Editor 1995, p. 29; Witkowski 1995, p. 216; Cembrowicz and Ritter 1994, p. 23; Murdach 1993, p. 308; Seger 1993, p. 141)

A more detailed checklist of possible warning signs appears as Appendix 7.

While there are no reliable indicators of dangerousness, there are certain characteristics that indicate a potential capacity for violence. As we have noted, the best predictor of future violence is past violence. Young single men, low socio-economic status, high residential mobility, and those with an existing mental illness may be higher risk (Bowie and Malcolm 1989). Other risk factors include: a history of abuse as a child, substance abuse, history of dangerous or impulsive acts, history of unstable relationships, paranoid delusions, pathological jealousy, rigid thinking style, low IQ, and some learning and reading difficulties (Cherry and Upston 1997, p. 12). Situational characteristics compound these risks, such as access to weapons, easy contact with intended victims, use of disinhibiting substances, and over- or under-stimulating environments (Cherry and Upston 1997).

A register of violence-prone clients may be an appropriate precaution as there have been a number of instances when warning signs were present, and threats were made, but no preventive action was taken—with fatal consequences.

A computer engineer had a history of disputes with government agencies. A former co-worker warned their supervisor that he had behaved so irrationally that he "might come in and shoot me". After losing his job the computer engineer:

- *entered an unemployment agency office and began shooting;*
- *killed 3 people;*
- *on leaving the office he was confronted by a police officer whom he killed; and*
- *he wounded three other people on the way to another unemployment agency.*

Outcome: At the next agency he was confronted by police and killed (Capozzoli and McVey 1996, p. 41).

Risk Assessment

Regular *systematic* occupational violence audits/risk assessments (Appendix 6) provide a baseline for violence prevention planning. The level of detail in risk assessments should be broadly proportional to the risk. That is, there should be objective assessment of the probability and likely severity of an incident and evaluation of existing violence control measures (see WorkSafe Western Australia 1999). Wishful thinking ("it can't happen with these clients") should be avoided.

It is important that *all* violent incidents be recorded (see Appendix 8). Past incident records need to be grouped, analysed, and the patterns identified. These can be separated into:

- severity categories (major, minor, and near miss events);
- incidence in particular unit/task categories;
- client characteristics (for example, medical condition, history of aggression, and type of service being provided);
- possible causes or contributing factors, for example delays in service provision;
- location categories, for example home visit, detention, and street; and
- other risk factors such as time of day or night.

Violence can often be predictable and preventable when the evidence is examined objectively (Warshaw and Messite 1996, p. 993). Sometimes aggression from otherwise rational clients results from cumulative stresses such as grief at whatever circumstance brought them to the service provider (for example, illness, loss of function, or loss of a loved one). Other serendipitous events, irritation through long waiting times, poor service provision, or lack of forthcoming information can be the "final straw". The warning signs (or "cues") of impending aggression listed on the previous two pages can alert staff to developing situations.

During risk assessment, all available information needs to be recorded with a separate incident form completed for each event (Appendix 8). Incidents of abuse, verbal attack, or aggressive behaviour that do not result in a physical injury should all be recorded. Any of these behaviours may indicate a potential for future tragedies. The timespan within which incidents must be formally reported should be specified as soon as possible, but no later than 3 working days. Facts are required on "who, what, when, where and why".

Incident Investigation Schedule

- Type of incident—for example, abuse, threat, or assault.
- Who was abused/threatened/assaulted, and their occupation.
- Type of client who committed the abuse/threat/assault.
- Description of the location where the incident took place.
- Activity underway at the time, including detailed description of any high-risk activities.
- Time of occurrence/day of week.
- Nature of injuries sustained.
- How the incident arose and progressed (narrative data).
- Access ability of client, for example uncontrolled area.
- Contributing causes.
- Lost time.
- Potential or actual costs.
- Corrective action recommended.
- Follow-up recommendations

(Long Island Coalition for Workplace Violence Awareness and Prevention 1996, p. 28)

Individuals who are the victim of client-initiated violence should also keep a record of the incident(s) and remedial actions (Appendix 9).

A *verbal* as well as a written violence audit should be conducted at regular intervals (see possible survey form in Appendix 10). The aim of a verbal audit is to find out if incidents are not being reported for fear of victimisation or because it may reflect badly on victims. It is important that independent and *trusted* people do this verbal stocktake, for example union representatives or OHS committee members. This process may identify what really happens, as opposed to instructions, official policies, or written records. Evidence suggests client-initiated violence may be repeated and may escalate in intensity over time. Maintenance of anonymity is essential.

Economic influences should also be considered during the violence audit/risk assessment. For example, if there are stringent funding restrictions, staff may have to see known high-risk clients alone, rather than 2 employees being present during delivery of services.

Feedback on the formal and informal risk assessment outcomes should then be provided to all staff. If no problems are found, suspicions may be allayed (WCBBC 1995, p. 4; Lamplugh 1994, pp. 4–5).

Risk Control

The risk control process should be introduced systematically based on objective evidence. The overt commitment of management/CEO is of core importance, as is the establishment of an ambience or culture that will not tolerate any form of aggression on-site. If the risks cannot be eliminated, then work environment arrangements should be reconfigured to minimise the risks (WCBBC 1995, p. 4). A mix of risk control measures, specifically tailored to each site, will usually be most effective (see Peek-Asa and Howard 1999; Schneid 1998, p. 24; Nalla et al. 1996, p. 95).

The OHS Committee Role in Violence Prevention

The OHS committee has a central role in any comprehensive client-initiated violence prevention or risk control strategy. Tasks and strategies overseen should include security arrangements, identification of high-risk clients, emergency or crisis response planning, off-site precautions, post-incident supports, training programs, the introduction of interventions, and the monitoring and evaluation process.

Management nominees, elected employee representatives, and all those with OHS responsibilities, should be members of the OHS committee. Ideally, an equal number of employer and employee members will be appointed or elected (see specified legislative requirements and duties for each Australian State and Territory). Employees are more likely to be committed to the violence policy and strategies if they or their representatives have input into the design of the risk assessment and risk control measures and are involved with putting them into action. All OHS committee members should take an active role to ensure that the violence prevention policy, strategy, and regular audits are comprehensive in coverage and adequately implemented.
A violence contact officer should be nominated who is acceptable to all sections of the workforce, and his or her name should be widely publicised.

Minutes of OHS committee meetings should be recorded and actions, interventions, and evaluations filed and dated, and retained for at least 10 years. Records of all violence audits, other inspections, and training conducted should be maintained (Appendices 6, 8, 10, 11, 12, 17, and 19;

and WorkSafe Western Australia 1999). Any marked variations by job task or site should be noted (microfiche records over the company lifetime are a useful precaution in case of long-latency conditions, for example PTSD). If records are kept up-to-date, any improvements resulting from interventions should be easy to track. Similarly, new or emerging risks will be clearly apparent. All staff should be aware of this process.

Finally, nightshift, unremitting intensive work, and unpredictable workloads can lead to fatigue, a diminished ability to recognise and identify early warning signs of impending violence, and a failure to competently cope with violent situations (HSAC 1987, p. 7). In high-risk jobs, comprehensive prevention strategies should be devised by the OHS committee to ensure that staff are alert and functioning to full capacity. Staff rotation may be appropriate.

Security Plan Role in Violence Prevention

The OHS Committee needs to consider and plan for potential emergencies on-site (for example, a depressed or anxious client threatening other clients/staff with a weapon or bomb threats). Engineering and administrative controls are often very effective in reducing such risks, for example name tags should be worn by all staff on-site.

A detailed client-initiated violence security measures checklist is provided in Appendix 11. This has been divided into two sections (a) security provisions; and (b) emergency/crisis response plan. A possible security plan audit form is provided as Appendix 12 (see United States Office of Personnel Management (USOPM) 1998, p. 22).

The OHS committee and security personnel should liaise with local police and develop appropriate response plans in case emergency calls need to be made by staff in a clinic, outpatient or detention centre, or other high-risk situation. Following any severe violent event, post-incident assessment, demobilisation, and evaluation of the effectiveness of security procedures should be routine.

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

Basically, the greater the contact with members of the public, the greater the risk. Strategies to reduce risks for workers in contact with the public include:

- reducing face-to-face contact;
- checking credentials of clients before face-to-face meetings;

- changing layout of waiting areas and making them more comfortable, using wider counters, and raising the height of floors on staff side;
- improving security through installing video cameras and alarms, inserting protective screens around high-risk working areas, and using coded security locks to restrict public access;
- reducing cash incentives for robbery by, for example, removing petty cash containers, installing ATMs (Automatic Teller Machines), using cheques, credit cards, electronic transfers, or tokens;
- the storage and issuing of medication should be subject to strict environmental controls and rigorous administrative procedures and record-keeping rules;
- training of staff to identify early warning signs;
- sharp knives should be removed from communal areas;
- employees wearing company uniforms "cover up" when travelling to and from work; and
- ensuring safe journeys to and from work for staff working at night.

(Chappell and Di Martino 1998, p. 114; Lamplugh 1994, pp. 6–7; Seger 1993)

High-risk Clients

High-risk clients will require additional security measures. Staff should be given the most comprehensive client information possible to assist with evaluation of the potential for violence. Aggressive clients should be interviewed in open areas where other staff can observe from a distance, but where privacy and confidentiality can still be provided, for example in a room with large (safety) glass windows (CAL/OSHA 1998, p. 13). Prior notification of security personnel is a wise precaution. Possible guidelines for interviewing or treating a high-risk client on-site have been provided in Appendix 13.

Other prevention strategies to consider when confronted by an aggressive client include:

- stand outside their personal space area and outside of the reach of their arms;
- stand on their non-dominant side (usually side wrist watch is worn);
- use a calm, quiet but determined manner;

- always be courteous to clients whatever their behaviour;
- avoid staring eye contact;
- avoid pointing at or touching angry people;
- if providing guidance on condition/treatment/service, do so in terms of suggestions rather than instructions;
- try to appear relaxed and non-aggressive; and
- recognise the causes of complaint by clients (for example, long waiting periods) and explain the formal complaints mechanism available

(Cembrowicz and Ritter 1994, pp. 23–37; Murdach 1993, p. 309).

If the threats are made by phone, notes should be recorded of

- time of call;
- the phone extension number the call was received on;
- sex of caller;
- estimated age of caller;
- details of accent, background noise or other features; and
- if the number is displayed on the receiver's phone, this should be recorded (WorkCover New South Wales 1996, p. 14).

Staff members should not have to confront continually threatening clients, nor should non-acceptable behaviour be allowed to continue. Other more restrictive settings, exclusion of the client, or more intense treatment options or rehabilitation may have to be considered (CAL/OSHA 1998, p. 12). Assaultive clients may need to be placed in the care of the police or in a high-security unit.

Those who work alone on-site will need enhanced security protections, for example, periodic checking of their well-being, personal alarms and mobile phones could be issued, or they can be visually checked at regular intervals by workers in adjacent premises. If a particular individual is a known risk (for example, a dementia client) the identity of the individual and the nature of the risk should be provided to all relevant staff, including cleaners (WCBBC 1995, p. 5).

Off-site Workers

Workers making home visits cannot control all the risk factors and may have limited influence over people they work with. It is important to remember that employers can be held liable for violent incidents if the risks are known and appropriate preventive interventions are not taken. Thus, additional violence prevention measures need to be implemented for those who work off-site and in mobile work places. Levels of risk escalate for those who take members of the public in their cars with them, for example real estate agents.

There is a range of risk control provisions that should be taken if workers are with clients off-site. For example, there should be careful recording of each address to be visited, pre-recording of times of visits (with checks made after each one), predetermined interval phone-ins, and the issuing of hand-held personal alarms or sprays can be considered. The clothing worn by the staff member should also be appropriate, for example low heeled and non-slip shoes should be worn in case a quick escape is needed.

Detailed guidelines to prevent client-initiated violence when working off-site have been provided in Appendix 14. Because those who conduct off-site visits with clients often have to collect the clients from their homes and transport them in a car, prevention strategies for off-site visits with clients are combined with the guidelines for those who visit the homes of clients.

Home-based Workers

Home-based workers at risk of client-initiated violence should take a number of steps to reduce the risks. A detailed possible "working from home" violence prevention checklist has been provided as Appendix 15.

Stalking

While stalking has rarely been documented as a problem for Australian workers, the incidence may increase in the future. Because stalking has been identified as a problem in the United States for some time, some useful preventive advice has been documented. Possible "tips" for victims of stalking have been listed in Appendix 16 (USOPM 1998, pp. 40–42; Schneid 1998, pp. 394–96; Heskett 1996, p. 40).

Training for Violence Prevention

Training for client-initiated violence prevention should be included in all induction and re-training courses, and more frequently for "at risk" staff. Records of this training should be kept. Topics covered should include the policy and strategies in place; risk identification, risk assessment and risk control procedures; off-site procedures; warning signs of potential violence and appropriate responses; security provisions and emergency plans; procedures for working with high-risk clients and situations; interpersonal/ diffusing aggression skills; and incident reporting procedures. It should be impressed on participants that the failure to report one incident may put others at risk later. However using training as the sole violence prevention strategy is unlikely to be successful. Further, if violence prevention skill-enhancement training is allocated to specific sections of the workforce, untrained workers in other sections may be exposed to a heightened risk of violence. Training in personal protective measures, communication devices, administrative procedures, and back-up protection are also needed (CAL/OSHA 1998, p. 3). A possible outline of a client-initiated violence prevention training course appears as Appendix 17 and the resources needed are listed in Appendix 18.

Some possible guidelines to reduce the risks to staff involved in discussions, mediation meetings, or confrontation with aggressive clients are shown in the box on page 38.

Possible Procedures to be Followed During Meeting with Violent Client/Perpetrator

- All clients must be treated with objectivity, respect, and dignity.
- The client/perpetrator should be allowed to have a support person present.
- A structured interview should be conducted in *private*.
- Mediators should use positive language.
- Appropriate appeal and complaint procedures must be explained.
- The specific reasons why a meeting is being held must be explained, but rational responses cannot be expected.
- Security and reception officers may need to be alerted prior to the meeting.
- All literature and required forms must be prepared beforehand.
- If the client/perpetrator is to be removed from his or her residence/group home/hospital ward/detention centre, all belongings should be collected from the premises (perhaps accompanied by security) so there will be no excuse to return.
- The client/perpetrator should be issued with any required medication.
- Future arrangements for service provision should be clearly explained with written confirmation provided.
- If the meeting is perceived to be "high risk", appropriate support or security persons must be present.
- Any threats made should be reported immediately to security and, if necessary, the police.
- In rare cases, restraining orders may be needed.

(Adapted from Capozzoli and McVey 1996, p. 103; Mantell and Albrecht 1994, pp. 166–76; Seger 1993)

Evaluation

Finally, the existing risk control measures should be evaluated. That is, do they work in controlling the identified risk factors? If not, the search for new or additional interventions and preventive measures should begin—which should also be subsequently evaluated.

The full costs of violence should be calculated. For example, violence-induced leave, workers' compensation claims, stress-related illness, downtime, and replacement staff (Speer 1997, p. 10). During costing calculations, allowance has to be made for the "normal" under-reporting of violent incidents. Another important consideration is that incident recording procedures tend to be poor at recording sensitive emotional and psychological sequelae of violent incidents (Wynne et al. 1996, p. 45). These emotional sequelae have significant detrimental effects on productivity and must be included in calculations. The dialectical relationship between occupational violence and stress should be recognised (Tidwell 1998, p. 591).

A possible client-initiated violence prevention policy and strategy evaluation checklist is provided as Appendix 19. The design and implementation of appropriate interventions may be challenging and involve difficult decisions. Shortcomings in management commitment, resources, and training/re-training should be clearly and courageously (where necessary) identified.

The risk control strategies adopted in some specific industry sectors are described below. These examples are illustrative of how tailored site-specific approaches are more effective.

Health Care Sector Client-initiated Violence Risk Control Strategies

Reich and Dear (1996, pp. 399–415), CAL/OSHA (1998, 1994) and OSHA (1996, 1995) in the United States have developed comprehensive violence prevention guidelines and strategies for health care and community service workers. These guidelines include suggestions on how to conduct violence audits, risk control, training, and record keeping. CAL/OSHA (1998: 11) argues on-site controls must include a "Universal Precautions for Violence" program which must be integrated into all settings, with administrative methods developed to ensure "float" staff, new personnel, and changeover shifts are warned of potentially violent activities and behaviours amongst clients and/or their visitors.

Some prevention strategies for client-initiated violence in the health care industry have been evaluated. Analysis of data trends underpinned the design of the most effective preventive interventions:

- In the casualty section of a hospital in The Netherlands, staff identified a number of factors associated with aggressive behaviour by patients: annoyance at being kept waiting, dissatisfaction with treatment, intoxication with alcohol and/or illicit drugs, understaffing, no smoking rules, impersonal waiting areas, and small treatment rooms. Aggression was found to be worst in the evenings, weekends, and on public holidays and late-shopping nights. The most effective prevention measures introduced were found to be an extra nurse on night shift, a silent alarm, and security surveillance (Chappell and Di Martino 1998, p. 90; Birman 1999; Shepherd 1994).
- Another major study found that Wednesday (the day claimants collected unemployment benefits) was a particularly dangerous night for United Kingdom ambulance and hospital staff, so staff were warned and prepared for increased risks on that evening (TUC 1999, p. 24).

In Australia, a number of the OHS authorities have developed advice to reduce the risks of client-initiated violence in the health-care industry. One recommendation from WorkCover New South Wales is that on admission, a code of behaviour should be made clear to all patients. This code should include curfew, visitors, drug and alcohol use, security and general conduct expectations (WorkCover New South Wales 1996, p. 7). That is, clear messages must be given to clients about non-violence and any warning about the possibility of charges being laid may need to be repeated. WorkCover South Australia (1998b) has developed brief guidelines to manage the risk of aggression in aged care facilities. Another preventive New South Wales project is underway which aims to develop guidelines for the prevention and management of workplace aggression, based on case studies from the New South Wales health industry. A report is expected during 2000.

An important aspect in a comprehensive prevention strategy is close liaison with local police officers, including reviews of premises by crime prevention officers. The reporting of incidents internally, and to the police if there is an assault or serious risk, may be crucial in any subsequent investigation or as evidence in court. As PTSD has increasingly been recognised in "caring" jobs, it has also been found that the symptoms often do not emerge for months after the event (Cembrowicz and Ritter 1994, p. 40). Hence it is very important that these events, with or without physical injuries, are fully recorded.

Community Services Sector Client-initiated Violence Risk Control Strategies

Events that may precipitate violence typically include some form of deprivation of personal liberty, social control (for example, taking children into care), withholding of information or service, giving advice or disciplining a client in a residential home or day centre, or intervening to protect a third party (Bute in Wykes 1994, p. 49). Since many community service workers travel off-site while undertaking their duties, the strategies to reduce risks listed in Appendix 14 may also be useful for these workers. WorkCover South Australia (1998c) has also produced some brief prevention guidelines.

Education Sector Client-initiated Violence Risk Control Strategies

School violence prevention guidance has been produced and used in many United States schools (Dwyer et al. 1998). WorkCover South Australia (1998d) has also developed brief guidelines for assisting with managing aggression in the education sector, as has the Division of Workplace Health and Safety in Queensland (1999). A consistent message is that each school has different security needs and prevention programs need to be tailored to local circumstances.

Similarly, custodial workers in juvenile offender centres are at risk and prevention advice has been developed in the United States (Howell 1995).

Transport Sector Client-initiated Violence Risk Control Strategies

Violence in the transport sector may be reduced through limiting cash availability. Clarke and McGrath (1990, p. 161) noted that the introduction of safes on buses combined with a system of flat fares almost completely eliminated robberies of bus drivers in the 19 areas of the United States where the system was introduced. Similarly minimal amounts of cash decreased thefts, and fare systems based on zones reduced disputes over fares.

Environmental controls substantially reduce the incidence of violence for most transport workers. Assaults on bus drivers have been reduced through improved bus design and procedures. For example, exit doors in the centre reduce assaults by departing passengers, coordinating the supply of buses with the number of passengers reduces aggression from lengthy waits, and driver training that is geared to diffusion of aggressive interactions reduces risks (Hesselink et al. 1999, pp. 37–39; Easteal and Wilson 1991). Similar prevention measures were introduced on London Transport Buses and led to decreased assaults (Standing and Nicolini 1997, p. 20). Video cameras and screens, improved lighting and security, emergency communication systems, and controlled access can further reduce risk factors. The introduction of on-board cameras in United Kingdom buses have not only protected staff; vandalism and graffiti have also been reduced (Lamplugh 1994, p. 7). Prominently displayed signs stating that monitoring of the site is on-going may further reduce risks.

One high-risk factor remains difficult to control: transport workers frequently work alone, and they are often on-the-job in the evenings, night, or very early morning hours when they are particularly vulnerable (NIOSH 1996).

Taxi drivers are at particular risk and have one of the highest work-related homicide rates in all industrialised countries studied (see Driscoll et al. 1999; Mayhew 1999). In New York, widespread modification of cabs has significantly reduced the incidence of homicides. These measures include a bullet-proof screen between driver and passengers, a bullet-proof plate in the back of the driver's seat, external distress light and other provisions (Warshaw and Messite 1996, p. 1003). Similar modifications have been taken up in some Australian taxis since the factors contributing to the risks were identified. However, the installation of screens remain a topic of hot debate, with cameras and electronic positioning systems apparently more popular.

Law/Prison/Security Sector Client-initiated Violence Risk Control Strategies

Knowledge of high-risk situations and clients enables officers and guards to increase preventive interventions. Hostage survival skills training for correctional officers may not only increase survival chances if such situations arise, but also decrease stress levels for "at risk" officers. Some hostage survival skills which can be included in training programs have been listed

in Appendix 20 (Anfuso, cited in Standing and Nicolini 1997, p. 50; Dignam and Fagan 1996, p. 373; Long Island Coalition for Workplace Violence Awareness and Prevention 1996).

Conclusion

Client-initiated violence has significant physical and emotional impacts on victims as well as potentially large legal and economic risks for employers. There are few examples of "best practice" prevention in Australia to date, but as recognition of the problem grows, improved policies and strategies will emerge. The first step in prevention is the development of an organisational policy and strategy to control the risks. As with other OHS problems, the risk identification, risk assessment, and risk control process has been found to be an effective preventive strategy, as well as being a legal requirement.

Comprehensive violence risk control procedures include:

(a) explicit management commitment, a written zero-tolerance policy, risk control incorporated in standard operating procedures, violence reporting systems, and tripartite committees;

(b) regular occupational violence risk audits need to be conducted which include security provisions, formal identification of high-risk clients and situations, post-incident response plans, and introduction of appropriate interventions with formal evaluation of these; and

(c) adequate staffing, reduction of stress levels, modification of staffing procedures, and training programs are also important.

(Anfuso, cited in Standing and Nicolini 1997, p. 50; Dignam and Fagan 1996, p. 373; Long Island Coalition for Workplace Violence Awareness and Prevention 1996)

The possible policy, strategy, and checklist documents provided in this handbook may form the foundation step, but these have to be modified to the particular circumstances and risks in specific organisations or off-site work tasks. Regular objective reviews of performance are essential. However, violence prevention does not exist separately to other parts of effective organisational planning. Each CEO needs to ensure that all workplace policies complement each other and that the violence prevention policy and strategies are integrated with the strategic plan and complement

Equal Employment Opportunity (EEO) and anti-discrimination policies. Probably the most important step is unequivocal top management commitment to an organisational culture where violence in any form is not tolerated.

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Website Addresses for Further Occupational Health and Safety Information and Specific Legislation in Each Australian State and Territory

Comcare: www.comcare.gov.au

The Division of Workplace Health and Safety (Department of Employment, Training and Industrial Relations, DETIR, Qld): www.detir.qld.gov.au

The National Occupational Health and Safety Commission: www.nohsc.gov.au

The Northern Territory Work Health Authority: www.nt.gov.au/wha

The Victorian WorkCover Authority: www.workcover.vic.gov.au

The WorkCover Corporation of South Australia: www.workcover.sa.gov.au

WorkCover New South Wales: www.workcover.nsw.gov.au

Workplace Standards Tasmania: www.wsa.tas.gov.au

WorkSafe Western Australia: www.safetyline.wa.gov.au

See also the Australian Institute of Criminology, *Occupational Violence Database* on www.aic.gov.au/directories

Appendices: Possible Prevention Policy, Strategy Documents and Checklists

Appendix 1

Possible Mission Statement on Client-initiated Violence

This organisation aims to provide a working environment that promotes courtesy, trust, equity, and mutual respect across the workforce and to clients of our services. Our mission is to achieve "best practice" in the prevention of violence. All acts of threatening behaviour, harassment, intimidation, threats, and physical violence are expressly prohibited. In order to ensure widespread adoption of our zero-tolerance policy, a consultative framework involving management, employees, others on-site, and representatives of clients who use our services, will be maintained.

Appendix 2

Possible Client-initiated Violence Prevention Policy

It is the policy of (named organisation) to provide a safe work environment. We:

(a) recognise the potential for violence arising during work and undertake to do all that is reasonably practicable to eliminate or reduce the risks to everyone on-site;
(b) will develop a violence prevention policy, strategies, and guidelines tailored to this worksite and work process in consultation with the OHS committee;
(c) undertake to assess the potential for violence associated with the worksite and work processes, to identify groups of workers especially at risk, take all practical steps to eliminate/reduce the risks, and to provide adequate budgetary resources;
(d) undertake to conduct regular occupational violence audits/risk assessments;
(e) require clients to abide by the violence prevention policy;
(f) will address the special risks for those working alone, off-site and after hours;
(g) require full reporting of all violent incidents, including threatening behaviours, abuse, harassment, and intimidation;
(h) will take seriously, and investigate, all reports from employees about the potential for occupational violence;
(i) will investigate all incidents through the tripartite OHS committee;
(j) agree that corporate response to all forms of violence will be consistent with the zero-tolerance policy and without favour. The policy *requires* investigation of each alleged incident, and mediation procedures with clients after significant aggressive behaviour—which may result in restriction of access to future services;
(k) agree that the CEO, all managers/supervisors and the OHS committee are responsible for implementing and maintaining the violence prevention program;
(l) will identify/name the contact person responsible for the implementation of the violence prevention policy and strategies;
(m) require contractors on-site to abide by the violence prevention policy, and to adopt comparable security procedures *as part of normal contract conditions*;
(n) will, in consultation with the OHS committee and employee representatives, provide full training and regular re-training to workers who may be at risk of violence to enable them to recognise potentially violent persons or situations;
(o) affirm that employees are instructed not to take risks on behalf of the employer to protect the employer's property;
(p) will provide support and care, including counselling and professional care where appropriate, to those who have experienced a violent incident;
(q) will agree wherever possible to a change of duties/location for a person who is unable to perform their former duties as a result of violence, without prejudice to future prospects;
(r) will regularly monitor and evaluate the violence prevention policy and strategies in consultation with the OHS committee and employee representatives. Consultation will also occur prior to the design of any new worksite, or major change in work procedures; and
(s) will adopt legal counsel recommendations.

Date:..... signed by CEO:..... Policy last updated:.....
(Manufacturing, Science and Finance Union (MSFU) 1994, 1995 cited in Chappell and Di Martino 1998, p. 98; Davis 1997, p. 175; Long Island Coalition for Workplace Violence Awareness and Prevention 1996, p. 33)

Appendix 3

Possible Legal Vulnerability Checklist

	yes	*no*
• This organisation has a mission statement that defines client-initiated violence	☐	☐
• This organisation has a violence prevention policy that sets out strategies implemented in the organisation to eliminate/ reduce violence, mechanisms to involve the workforce in violence prevention planning and implementation of risk control strategies, and post-incident supports	☐	☐
• All personnel have been made aware of the violence prevention policy through induction procedures, an information campaign, and on-going monitoring by the occupational health and safety committee	☐	☐
• Adherence to zero-violence is obligatory for all clients	☐	☐
• As new information becomes available the policy and strategy will be updated	☐	☐

(adapted from Davis 1997, pp. 174–76)

Appendix 4

Possible CEO Statement of Commitment to Zero-tolerance of Violence

This organisation takes seriously our duty of care obligations and will work constructively with all members of the workforce and our client representative groups to encourage a participatory management style, foster teamwork, improve employer/employee communication, and adopt an "open door" policy to eliminate all instances of violence.

We have assigned specific responsibility for violence prevention to (*insert name*) who has the authority and responsibility for implementing the strategy, and for conducting regular occupational violence audits on-site. Nonetheless, under the regulatory framework in the Australian state of (*insert name*) this organisation recognises that primary responsibility for occupational health and safety—of which violence prevention is a part—rests with the employer/CEO. These responsibilities for a safe work site and process of conducting work are broadly known as the "Duties of Care". All workers are responsible for following the violence prevention policy, observing all directives, and for assisting in maintaining a workplace that is free from threats, harassment, intimidation or physical violence. All incidents of occupational violence will be investigated and offending clients may be forbidden future access to our services.

(developed from CAL/OSHA 1994, p. 3)

Appendix 5

Possible Communication Strategy for Client-initiated Violence Prevention

This organisation will:

- communicate the violence prevention policy to all clients as far as is possible, for example in waiting area noticeboards and through provider/client liaison group meetings;
- restrict access to the worksite of clients and members of the public with a history of violence. If violent clients require urgent assistance or treatment, appropriate security for staff will be provided;
- on admission, the code of behaviour expected will be made clear to all clients. This code includes curfew, visitors, drug and alcohol use, security and general conduct expectations;
- communicate the violence prevention policy to all supervisors and workers through bulletin board notices, with all employment contracts, in staff newsletters and through other appropriate means, for example changes notified with pay advice slips;
- develop and distribute violence prevention information through the OHS committee;
- include the zero-tolerance violence policy and strategies in new worker orientations;
- regularly re-train all "at risk" staff in violence prevention;
- periodically review the violence prevention policy and strategies;
- ensure that violence prevention is on the agenda of each meeting of the OHS committee;
- restrict access to the worksite of past and recently discharged violent clients;
- instigate and maintain a reporting system by which victims of violence can remain anonymous to protect them from fear of retribution (while retaining natural justice provisions for alleged client/perpetrators); and
- conduct post-incident support and counselling procedures in a manner which maintains personal confidentiality, and without prejudice.

(adapted from WorkCover New South Wales 1996, p. 7; CAL/OSHA 1994, pp. 3, 7)

Appendix 6

Possible Occupational Violence Audit/Risk Assessment Form

On *(insert date)* an on-site violence audit was carried out.
The audit was conducted by: .....
Employer representative: .....
Employee representative: .....
OHS committee representative: .....
Records reviewed:
Incident reports since last audit: .....
"Near miss/near assault" reports: .....
Off-site incidents: .....
Insurance reports: .....
Police reports: .....
Grievances/mediations: .....
Training records: .....
Other relevant records: .....
From these records, we have identified the following issues that need to be addressed:
.....
"Walk-through" audit:
Security/building access: .....
Reception: .....
Working alone/isolated/off-site: .....
Shiftwork/atypical hours: .....
Client/perpetrators: .....
Review of tasks and workloads: .....
From the "walk-through" violence audit, we have identified that the following issues need to be addressed: .....
.....
Semi-structured interviews with (anonymous) staff members:
Number of interviews conducted: .....
Areas of worksite/work process covered (only if does not identify individuals): .....
Gender/ethnicity/youth breakdown of interviews: .....
Client/perpetrators: .....
Working alone/isolated/atypical hours/off-site: .....
From the interviews with staff, we have identified that the following issues need to be addressed: .....
Overall risk controls recommended:
Engineering/security controls: .....
Work area and work process: .....
Off-site: .....
Working alone/isolated: .....
Training: .....
Client/perpetrators who may require early mediation, restriction or exclusion: .....
Adequacy of existing control measures: .....
.....
Other risk controls recommended (resources required, proposed implementation date, evaluation due date): .....
(adapted from Long Island Coalition for Workplace Violence Awareness and Prevention 1996. See alternative audits in WorkCover South Australia 1998a, p. 22; WorkCover New South Wales 1996, pp. 18–21)

Appendix 7

Possible Checklist: Warning Signs of Impending Client-initiated Violence

Does the client:	*yes*	*no*
• complain regularly about provision of services	☐	☐
• refuse to cooperate	☐	☐
• demonstrate "cries for help" in some way	☐	☐
• indicate a heightened level of anxiety or depression	☐	☐
• have rapid breathing, clenched fists/teeth, flared nostrils, flushing, loud talking or chanting, restless repetitive movements/ pacing, make semi-violent gestures for example pointing	☐	☐
• swear excessively and/or use sexually explicit language	☐	☐
• threaten or verbally abuse workers	☐	☐
• have noticeable mood swings and/or unprovoked outbursts	☐	☐
• have a condition that has been associated with an increased potential for violence, for example paranoid schizophrenia	☐	☐
• tend to be solitary with few social contacts; unstable family life	☐	☐
• sexually harass staff	☐	☐
• blame others for all difficulties	☐	☐
• cause anxiety or unrest through aggressive behaviour	☐	☐
• argue frequently and intensely	☐	☐
• blatantly disregard organisational policies and procedures	☐	☐
• throw, sabotage or steal equipment or property	☐	☐
• have a substance abuse problem	☐	☐
• send violent or sexual comments via phone, email, or letter	☐	☐
• make strange or exotic claims (losing touch with reality)	☐	☐
• have a fascination with weapons and/or military hardware	☐	☐
• have a history of violence	☐	☐
• make verbal threats to hurt workers or other clients	☐	☐
• tell other clients about their plans to initiate violence	☐	☐
• destroy property	☐	☐
• have physical confrontations	☐	☐
• display and/or use weapons	☐	☐
• commit sexual assaults or arson	☐	☐
• talk about self-harm or suicide?	☐	☐

Date:..... Client name:..... Staff member signature:.....

(See USOPM 1998, pp. 17, 46; Davis 1997, pp. 11, 14, 21, 30, and 54; Randall 1997, pp. 53–54; Heskett 1996, p. 445; Kinney 1996, p. 307; Editor, 1995, p. 29; Witkowski 1995, p. 216; Seger 1993, p. 141)

Appendix 8

Possible Client-initiated Violent Incident Report Form

Instructions:
All incidents must be reported as soon as possible, and not later than 3 days.
A separate incident form is to be completed for each event.
All incidents of abuse, verbal threat, or aggressive behaviour where no actual harm has occurred should be recorded as the pattern may indicate the need for strategies to prevent future tragedies.

Type of incident: ☐ abuse ☐ harassment ☐ threats ☐ assaults ☐ robbery
Mechanism used: ☐ face-to-face ☐ phone ☐ email ☐ letter ☐ other

Name of victim:.....

Position (job task):.....

Name of client/perpetrator (if known):.....

Address of client/perpetrator (if known):.....

Any known relationship between victim and perpetrator (for example, nurse caring for patient):.....

Time of occurrence: ☐ a.m. ☐ p.m.

Day of week: ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

Location/area where incident took place:.....

Activity underway at time of incident:.....

Other persons present at time:.....

Nature of injuries sustained:

Body part injured (for example, arm/head):.....

Type of injury (for example, laceration/emotional):.....

How the incident arose and progressed (narrative data):.....

.....

.....

Contributing causes:.....

.....

Total lost time: Victim:..... hours:..... minutes:.....
Replacement staff: ..... hours:..... minutes:.....
Investigator(s): ..... hours:..... minutes:.....

Costs: Lost time:..... Equipment/building damage:..... Other:.....
Estimated total costs:.....

Outcomes of incident (for example, treatment/charges by police):.....

.....

.....

.....

Date:..... Signature:..... (form last updated: .....).

(Long Island Coalition for Workplace Violence Awareness and Prevention 1996)

Appendix 9

Possible Record/File Kept By Victim of Client-initiated Violence

1. *Written record/diary of all incidents, threats, or physical attacks:*
- each incident should be recorded separately;
- date, time, place;
- name of client/perpetrator;
- details of what happened; and
- name(s) of witnesses.

2. *Correspondence to client/perpetrator (or his/her formal representative) following any incidents:*
- all correspondence must be retained;
- statement(s) made by victim to deny or correct remarks, statements or claims by client/perpetrator;
- date all statement(s) and enter the dates mailed or delivered to client/perpetrator;
- if there has been a reply from client/perpetrator or his/her representative, attach to record and date; and
- if there is no reply or response from client/perpetrator, this should be recorded.

3. *Correspondence from client/perpetrator following any incidents:*
- all correspondence must be retained;
- statement(s) made by perpetrator to deny or correct remarks, statements or claims by victim; and
- date all statement(s) and record the dates correspondence mailed/delivered to victim.

4. *Records of correspondence between service provider/employer and perpetrator and client liaison group:*
- meeting(s) between service provider, client/perpetrator and/or client liaison group (record date, items discussed, names of those present);
- written correspondence (dated and copies filed);
- verbal discussion notes, including telephone discussions (date, time, people involved); and
- correspondence forwarded and received.

5. *HRM, Employee Assistance Program (EAP), or counsellors approached:*
- records should be kept of dates, items discussed, names of those (a) contacted and (b) present at meetings, and (c) copies of any written notes should be attached to the file; and
- If there is more than one victim, or more than one incident from the same client, a group complaint from victims may be appropriate.

6. *Correspondence and meetings with union delegate or officials:*
- confidential meeting(s) with Union delegate or official (date, names of those present, items discussed);
- copies of any notes taken during these verbal discussions should be attached to the file;
- written correspondence with Union delegate or official (date and file correspondence/photocopies);
- copies of correspondence forwarded by Union delegate or offical on behalf of victim filed;
- anonymous survey of member's experiences of violence and actions taken; a special union meeting to discuss violence; and encouragment of members to be well-informed/trained in violence prevention; and
- negotiations commenced with employer for improved anti-violence strategies.

7. *Guidance:* always stick with the facts and avoid statements that could be interpreted as ill-feeling, personality conflicts, or dislike of client/perpetrator or his/her condition. (developed from UNISON 1996)

Appendix 10

Possible *Anonymous* Client-initiated Violence Survey of Staff

The OHS committee requested this anonymous survey of staff to identify occupational violence risks and potentially useful prevention methods. A person independent of the organisation undertook the survey, and only grouped data was returned to the company. Date:.....

1. Violence policies and strategies:

Does your organisation have a client-initiated violence prevention *policy*? ☐ yes ☐ no ☐ don't know

The violence policy here is:

☐ excellent ☐ fairly good ☐ okay ☐ not very good ☐ terrible

Does your organisation have a client-initiated violence *strategy*? ☐ yes ☐ no ☐ don't know

The violence strategy is:

☐ excellent ☐ fairly good ☐ okay ☐ not very good ☐ terrible

Does the organisation hold regular meetings so everyone can discuss violence openly? ☐ yes ☐ no ☐ don't know

Is there a violence contact person? ☐ yes ☐ no ☐ don't know

Are there formal violence reporting procedures? ☐ yes ☐ no ☐ don't know

2. Occupational violence experiences:

Do you know what to do if you are having trouble with a client? ☐ yes ☐ no ☐ not sure

Have you experienced from clients: ☐ harassment ☐ abuse ☐ threats ☐ assaults ☐ robbery

Number of incidents in past 12 months (specify type): .....

If yes, did this violent incident come from: ☐ client/ex client ☐ stranger ☐ staff member(s)

Please describe: .....

If yes, did you report this to anyone here:

☐ yes, on the report form ☐ yes, but informally ☐ no (please explain why not)

.....

Have you missed work in the last 12 months because of something that a client did? ☐ yes ☐ no

If yes, please describe: .....

To your knowledge, has there been any other violence from clients here? ☐ yes ☐ no ☐ don't know

3. Violence prevention training:

The violence prevention training here was:

☐ excellent ☐ fairly good ☐ okay ☐ not very good ☐ terrible/useless

Violence prevention training was provided to me: ☐ during induction only ☐ re-training (date):.....

☐ at other organisation (name):..... (date):..... ☐ other (date):.....

4. Action taken by organisation post-incident:

☐ investigated and made changes to fix situation ☐ investigated and made no changes

☐ made life difficult for me ☐ did not report incident ☐ other

5. Recommended changes: .....

.....

(Long Island Coalition for Workplace Violence Awareness and Prevention 1996. See alternative possible survey in Vandenbos and Bulatao 1996, p. 285)

Appendix 11

Possible Client-initiated Violence Security Measures Checklist

In this organisation the security system is prevention oriented, but allows quick reaction to an emergency.

(a) Security provisions include:

- restrictive access devices for all staff, for example card keys with photo identification;
- a requirement for clients, maintenance workers and visitors who go into restricted areas to wear short-term access badges—these are issued at reception;
- physical barriers prevent access by clients to most working areas (and delivery bays are either locked except when in use or completely separate from other staff areas);
- there are security locks or bars on all public access doorways and windows;
- client waiting areas are comfortable, decorated in muted colours, and spacious;
- there is bright and effective lighting in all areas of the site;
- there is improved lighting in stairwells, car parks, and Closed Circuit Television (CCTV) where appropriate;
- curved mirrors have been placed at hall intersections or areas where a client could conceal his or her presence;
- security cameras are placed in high-risk areas, for example emergency treatment rooms;
- additional security measures are in place where drugs are stored or being distributed;
- staff are well trained or re-trained in appropriate responses to client-initiated violence;
- there are prominently displayed signs that the premises are monitored;
- glass in windows and doors near client access areas is shatter-proof;
- signs are posted that notify the public that limited cash or drugs are kept on-site;
- access of clients with a history of violence is restricted. When clients with a history of violence need to be seen, additional security measures will be adopted, for example security guards will be present;
- the emergency/crisis response plan requires: control of client/perpetrators (with restraining provisions where appropriate);
- security staff escort all high-risk clients on-site;
- additional security procedures are implemented for staff working late or unusual hours, travelling for work, and for those working with high-risk clients;
- there are detailed security provisions for staff who work off-site or visit clients in their home or on another site, including the provision of mobile phones, standardised phone-in check times, and recording of client details prior to the off-site meeting;
- all staff are required to report suspicious, violent or unusual behaviour to security;
- there are no obstacles to good visibility in the grounds, for example bushes near entrance;
- all weapons (including knives and screwdrivers) are banned and metal detectors are in place at the worksite;
- staff are escorted by security to parking areas after hours or in "high risk" situations; and
- maintenance, repair, testing and monitoring procedures are checked weekly.

Continued next page

Appendix 11 *(continued)*

Possible Client-initiated Violence Security Measures Checklist
(continued)

(b) Emergency/crisis response plan:

- on every phone is a sticker that states "in the event of an emergency, contact reception/security on (*insert number*)";
- an emergency alarm button is installed at reception and in all client-interview rooms;
- electronic as well as manual alarm systems are in place;
- an emergency/crisis response plan is in place;
- the emergency/crisis team meets regularly in conjunction with the OHS committee;
- the emergency/crisis team members have been trained in early threat recognition, and have liaised with relevant outside authorities;
- all personnel are aware of the emergency/crisis team;
- there is a floor/unit emergency warden system in place that is checked regularly;
- escape routes have been planned and are practiced regularly; and
- the emergency/crisis response plan includes: post-incident control of the immediate working environment; control of violent clients; provision of information to law enforcement agencies; guidelines for provision of media statements; post-incident investigation and analysis; and confidential debriefing of staff.

form last updated: .....

(Developed from USOPM 1998, p. 22; CAL/OSHA 1998, p. 9; Kinney 1996, p. 309; Long Island Coalition for Workplace Violence Awareness and Prevention 1996, p. 60; CAL/OSHA 1995, p. 10. See also Wynne et al. 1996, pp. 30–32)

Appendix 12

Possible Security Plan Audit Form

On (*insert date*) a security plan evaluation was carried out.

The security plan audit was conducted by:

Employer representative: .....

Employee representative: .....

OHS committee representative:.....

Security staff representative:.....

Client group representative:.....

Does the Security control plan include:

mission statement	☐ yes	☐ no	☐ yes, but inadequate
policy statement	☐ yes	☐ no	☐ yes, but inadequate
violence incident report form	☐ yes	☐ no	☐ yes, but inadequate
violence audit checklist	☐ yes	☐ no	☐ yes, but inadequate
emergency/crisis plan	☐ yes	☐ no	☐ yes, but inadequate
off-site work with clients	☐ yes	☐ no	☐ yes, but inadequate
floor plans posted with emergency exits/equipment	☐ yes	☐ no	☐ yes, but inadequate

Methods of control:

reception/access control	☐ yes	☐ no	☐ yes, but inadequate
emergency response plans	☐ yes	☐ no	☐ yes, but inadequate
reporting procedures	☐ yes	☐ no	☐ yes, but inadequate
work processes	☐ yes	☐ no	☐ yes, but inadequate
training program	☐ yes	☐ no	☐ yes, but inadequate
computer/records security	☐ yes	☐ no	☐ yes, but inadequate
after hours security	☐ yes	☐ no	☐ yes, but inadequate
vulnerable employee protection	☐ yes	☐ no	☐ yes, but inadequate
off-site workers	☐ yes	☐ no	☐ yes, but inadequate

Reviews undertaken by OHS committee:

past incidents by type	☐ yes	☐ no	☐ yes, but inadequate
past incidents by area	☐ yes	☐ no	☐ yes, but inadequate
past incidents by gender	☐ yes	☐ no	☐ yes, but inadequate
past incidents by position/task	☐ yes	☐ no	☐ yes, but inadequate
anonymous survey of staff	☐ yes	☐ no	☐ yes, but inadequate

Plan last audited on: ..... (date)

Plan last updated on: .....

(adapted from Long Island Coalition for Workplace Violence Awareness and Prevention 1996, p. 60)

Appendix 13

Possible Guidelines for Interviewing/Treating a High-risk Client On-site

- Make sure the interview or treatment is not conducted in isolation and others know where you are and who you are interviewing.
- Do not arrange to meet anyone when you know you will be alone in the building.
- Make sure the client knows their presence has been recorded.
- Use a room in which you are visible to others, for example glass (security) windows, but where confidential discussions cannot be overheard.
- If a room where you can be seen is not available, ensure someone else drops in to check on you frequently, for example bring cup of tea (but keep disruptions to a minimum).
- Ensure there is a duress alarm system of some sort (phones can disrupt interviews).
- Stay near the door—preferably have a room with two doors.
- Keep equipment in room to a minimum as many things can be used as a weapon.
- Ensure furniture is comfortable but robust enough not to be thrown.
- Make sure room is well lit.
- At the first sign you are in distress staff should know who will respond and what immediate action to take.
- Keep waiting time to a minimum. If the interview is delayed, ensure client is informed.
- Shake hands and introduce yourself by name and explain your job task.
- Use language the client will understand.
- If escorting a client to a room walk beside them on the same level, in front going upstairs, and behind them going downstairs.
- If the client is reacting badly to you because of your age, sex, and class, try to match the client with a more appropriate staff member (if client agrees).
- If the client has a history of aggression, find out about prior incidents to aid your interview process.
- Dress appropriately, including low-heeled shoes with good grip (in case you need to move quickly) and no jewellery (necklaces can be used to strangle).
- Attempt to have equal height seating with the client, at an angle, and leave greater inter-personal space with aggressive people.
- Maintain eye contact and adopt a relaxed posture rather than a closed arms posture.
- Maintain empathy/sympathy and paraphrase client comments.
- Try to solve some problems immediately to demonstrate that you are trying to find solutions.
- If you are governed by rules of some kind try to explain them.
- Avoid provocative expressions such as “calm down”.
- Never get drawn into aggression.
- Listen, and show you are listening by nodding and using words such as “I see”.
- Avoid tapping pens, fiddling or doodling.
- Don’t set deadlines in case you cannot keep them, or time limits irritate client.
- If the situation is escalating take a break to diffuse aggression (Cardy 1992, p. 110).

Appendix 14

Possible Guidelines to Prevent Client-initiated Violence When Working Off-site

- Where possible, arrangements are made to bring clients to the worksite.
- The days and situations when violence is more common are identified and patterns are monitored.
- Staff are aware of the limits of their physical mobility and strength.
- Records are kept of names, contact numbers and home address of off-site staff.
- Detailed timetables are kept of where staff are, whom they are with, how long they should be, and when they are expected back.
- If a stranger rings for an appointment, it is routine to call back to check details of client.
- Clients are assessed for violence potential before staff visit them off-site.
- Diaries are kept at the central site of: client name, car registration, medicare, and driver's licence numbers and the reason that the worker is visiting the client/accompanying the client to another destination.
- Procedures are in place for staff who feel at risk, change plans, or are delayed.
- Procedures are in place *and followed* if staff cannot be contacted or do not return/check in when expected.
- Additional precautions are made, and records kept if staff are likely to be unwelcome at site to be visited, or if the client has some history of aggression; for example staff go in pairs and alert police prior to the visit taking place.
- Before any off-site visit, a code word, phrase or sentence is agreed that can be incorporated in a telephone conversation to indicate danger.
- Off-site clients are visited in daylight only if possible.
- Off-site staff are issued with personal alarms, mobile phones and public phone change/card.
- Vehicles used for off-site visits have sufficient fuel, with spare in case staff are lost.
- Staff do not go out for meals or to other sites with clients they are uncertain about.
- When staff arrive at destination, parking location is assessed for nearest exit route.
- Staff always park cars in well-lit areas.
- Lock-up procedures are followed for cars, car keys, alarms, and safety equipment.
- Staff take only what is essential with them to visit a client. Staff do not carry information that clients should not read. Staff never carry their diary with them because a missing diary can help in tracing. Also, if a client is violent, a diary provides private information about the staff member and his/her friends.
- Staff carry a mobile phone with a charged battery with them into the house.
- Staff carry a personal alarm with them into the house.
- When staff knock on the door, they stand to one side and not in a position where the opening of a screen door can trap them.
- On arrival staff ensure the clients know who they are and why they are there.
- Staff wait to be asked inside, and let the client lead the way.
- Inside the house, staff try to ensure they have a clear exit line.
- If staff receive an aggressive reception, they leave immediately if possible.
- Staff try to avoid reacting to house, for example smell, surroundings, and untidiness.

Continued next page

Appendix 14 *(continued)*

Possible Guidelines to Prevent Client-initiated Violence When Working Off-site *(continued)*

- At all times staff remain alert to sudden changes in client mood.
- In the client's home, staff are respectful to the client as they may be perceived to be invading the client's personal space.
- Staff do not spread their belongings around so that if they need to leave quickly they have time to collect belongings.
- If staff feel at risk—they leave immediately—or make a very big fuss if they can't.
- When staff are helping someone escape a domestic violence situation, they choose the time of day to visit the home and collect belongings carefully. If large belongings have to be removed, the help of police or security guards is enlisted if possible. If large belongings are being loaded, a second car is parked where exit cannot be blocked—in case a quick departure is necessary.
- If staff are working in a shelter or a public place where clients may be sleeping, caution is exercised when waking them. If possible clients are woken via voice rather than touch.
- On leaving the client or site, staff approach their car with keys in hand.
- The back seat of the car is checked before staff climb into the driving seat.
- If there are people hanging around the car as staff approach, they do not go and ask them what they are doing as this will identify staff as the driver/owner. Staff are instructed to cross over, walk away and call the police.
- When transporting a client, there are sufficient personnel, the lighter and mirror on the passenger side are removed as these may be used as weapons, and staff drive in the left hand lane in case they have to stop quickly and get out.
- If staff are travelling by public transport, they plan to leave base just before the bus/train arrives; they always sit where they can see their upcoming stop; when stepping off ensure that they are not being followed; and if possible have someone meeting them afterwards at their destination bus stop.
- Staff are instructed to do whatever is necessary to protect themselves, and not to worry about failure of task.
- Procedures for staff working in other people's homes are fully understood and well practised.
- Staff are forewarned that the potential for violence depends on why the worker is there, for example estate agents may be more welcome than a building inspector

If staff believe that they are at special risk, additional measures include:

- routes to and from work are varied (particularly if valuables or drugs are carried);
- a work car is used for off-site visits; and
- a work colleague accompanies "at risk" staff to the car park or public transport stop, or a work colleague drives "at risk" staff home.

(Cherry and Upston 1997, pp. 6–10; WCBBC 1995, pp. 13–14; Cardy 1992, pp. 38, and 111–112)

Appendix 15

Possible Working From Home Violence Prevention Checklist

- Request a "silent" home telephone number.
- Do not have your name on doorbell. If not possible, use only initials and family name on doorbell and in the telephone book.
- Have name removed from Commonwealth, State and Local government electoral rolls.
- Work under former name if you have changed your name through marriage.
- Only divulge your given name to clients if possible.
- Contact the State Government department responsible for car registration to ensure your home address cannot be traced from your personal car registration number.
- Remove any stickers on your car that may identify the suburb in which you live.
- Fit a deadlock to each external door, and security bolts or screens to all accessible windows. Ensure the doorframe can withstand an attack on the locking points.
- Never leave keys in "safe" external places, for example under doormats.
- Never give keys to people working in or delivering to your home.
- Fit a spyhole to the door.
- Ensure any callers identify themselves and check their identity.
- Fit a door chain and use it.
- Draw curtains and blinds after sunset.
- Do not advertise that you are alone or live alone.
- If anyone comes to the door for help such as to use the phone, do not let them in but offer to make a call for them.
- If you hear strange noises outside do not investigate them; call the police.
- If you lose your keys, change the locks.
- Have a second phone line for work so that your private line remains confidential.
- Have a post office box for all work mail so your home address remains private.
- Only meet people at your home if you are completely sure that you are safe.
- Have someone check you periodically to ensure you are okay.
- If you are away from your normal base, arrange for a friend or neighbour to call when you are expected home to make sure you are safe.
- Do not carry your diary. If you went missing your diary could help in tracing movements. If a client attacks or robs you, a diary provides information about relatives and friends.
- If you must go to places you feel uneasy about, take someone with you.
- Avoid after hours meetings.
- If someone attacks you, scream; if your purse is grabbed do not resist and do not chase the attacker.
- Call the police after any incident and report appearance and mannerisms of perpetrator (see WCBBC 1995, pp. 13–15 and 26 for a suspect identification checklist; Cherry and Upston 1997, pp. 6–7, and 10; Cardy 1992, pp. 116–17).

Appendix 16

Possible "Tips" for Victims of Stalking

- Document every contact with the stalker, including telephone calls, messages, letters and deliveries. Also record all cases of being followed by car or on foot, or being watched. This documentation will provide evidence that you have been stalked.
- Contact the police every time the stalker makes any kind of contact. The police should also maintain documentation. Ask for copies of the police log. Request that the police crime prevention unit assess the security of your home.
- Use an answering machine on your home telephone, and have a telephone with a caller-identification screen. Log all calls from the stalker and clearly record the date, time and nature of the contact, for example "heavy" breathing. You could have a trace put on your phone, or record all messages and conversations yourself. Change your number to an unlisted one and only give it to people with a need to know. A mobile phone can provide emergency services access when you are in a car, away from home, or if your home number has been disconnected.
- Advise your co-workers, friends, family and neighbours of the situation. Ask co-workers and neighbours to watch for any unusual activities near your home, car or workplace.
- Keep the outside of your home well-lit and free of excessive bushes that might provide a stalker with a place to hide.
- Install extra locks, deadlocks, window security, flood lights, security screens and door alarms. Consider getting a large dog.
- Join "Neighbourhood Watch" or seek other outside assistance.
- File a restraining order against the stalker through your solicitor.
- Never enter into conversation with the stalker. Most stalkers are very personable and persuasive and are able to solicit a reply from the victim (often provoking anger).
- Consider enrolling in a self-defence class. Do not purchase a weapon as this may lead to other problems.
- Carry a personal security alarm.
- Keep another person with you as much as possible when running errands.
- Vary your routines. For example, go to different shops by different routes at different times and arrive at work at different times.
- If you are travelling by public transport, plan your arrival time just before the bus/train arrives; always sit where you can see your upcoming stop; when stepping off ensure that you are not being followed; and if possible have someone meet you at your home bus stop.
- Organisational support is crucial to success if the stalking occurs at, or near, work.

(adapted from USOPM 1998, pp. 40–42; Schneid 1998, pp. 394–96; Cherry and Upston 1997, pp. 6–7, and 10; Heskett 1996, p. 40; WCBBC 1995, pp. 13–14)

Appendix 17

Possible Client-initiated Violence Prevention Training Course Components

In this organisation:

- all workers have induction training that includes client-initiated violence prevention; and
- regular re-training is provided to "at-risk" staff.

Training components include:

- a definition of occupational violence;
- an explanation of the violence prevention policy and strategies in place;
- employer/CEO commitment and responsibilities;
- employee responsibilities;
- OHS legal requirements;
- the name of the violence contact officer;
- typical client-initiated violent behaviours and their impacts;
- off-site violence prevention strategies;
- warning signs of impending violence, including body language;
- mechanisms to report a violent incident;
- the aim of regular occupational violence audits/risk assessments;
- the process of risk identification, risk assessment, and risk control;
- risk factors specific to this organisation/work tasks, for example hostage survival skills;
- conflict and dispute resolution skills, and ways to help diffuse hostile situations;
- security and emergency response plans; and
- EAP contacts and other post-incident supports.

(see USOPM 1998, pp. 19–22). Date course last updated:.....

Appendix 18

Resource Needs for an Client-initiated Violence Prevention Training Program

Aim: to ensure employees can define the range of violent behaviours, are aware of the client-initiated violence prevention policy and strategies, can recognise warning signs of impending violence, understand the occupational violence audit process, and are aware of legal responsibilities.

Objectives: at the end of the program employees will be able to identify inappropriate client behaviours and warning signs, understand impacts on victims, complete an incident report, conduct an occupational violence audit, complete violence checklists, and recommend preventive actions.

Time required: 1.5 hours.

Target groups: all employees; representatives of client groups.

Resources:

- whiteboard;
- pens and paper;
- handouts on organisation violence prevention policy and strategies and checklists;
- handouts on typical client-initiated violent behaviours and risk factors;
- handouts on security guidelines, on-site procedures for interviewing high-risk clients, and off-site work guidelines;
- photocopies of recent legal case outcomes; and
- overview of OHS legislative framework for specific state.

Environment: large room with breakout space for small group role plays/discussions.

Timetable:

introduction	(10 minutes)
definition of occupational violence	(5 minutes)
employer/CEO duty of care	(10 minutes)
violence prevention policy	(5 minutes)
violence prevention strategies	(20 minutes)
off-site violence prevention strategies	(10 minutes)
occupational violence audits/risk assessment checklists	(10 minutes)
break-out role plays	(20 minutes)

(adapted from Cardy 1992, p. 168)

Appendix 19

Possible Client-initiated Violence Prevention Policy and Strategy Evaluation Checklist

In this organisation:	*yes*	*no*
• all workers and OHS committee members are trained in violence prevention, to recognise the warning signs of violence from clients, and in recording procedures	☐	☐
• all clients are required to fully comply with the organisational violence prevention policy and strategies	☐	☐
• violent incidents are tracked over time, and analysed by severity, work section, workload and workforce characteristics, for example gender, age, tasks, unit, and job security	☐	☐
• an anonymous survey of staff is conducted at least once a year to identify non-reported violence issues	☐	☐
• client group representatives have an input into the violence prevention strategies	☐	☐
• all contractors and outsourced staff who come on-site are required to fully comply with the organisational policy and strategies	☐	☐
• the pattern of violent incidents is reviewed by the tripartite OHS committee	☐	☐
• the risk control strategies are formally evaluated. Critical questions asked include:		
(a) do the strategies implemented successfully control the identified risk factors and situations?	☐	☐
(b) what is the cost of client-initiated violence (including diminished productivity estimates)?	☐	☐
(c) have new/additional preventive measures been evaluated?	☐	☐
• this evaluation process is documented, and grouped data is provided to all staff	☐	☐
• the violence data are included in annual reviews of supervisor and staff performance	☐	☐
• shortcomings in training and re-training are identified and corrected	☐	☐

date last formal evaluation completed:.....

date evaluation checklist last updated:.....

(adapted from Long Island Coalition for Workplace Violence Awareness and Prevention 1996)

Appendix 20

Possible Hostage Survival Behaviour

- The overall aim is to survive the hostage episode. The actions/words to achieve this may be against your nature or distasteful at times.
- Do not argue with hostage taker over any issue, particularly over his/her reasons or behaviour.
- If a person targeted for violence is not available, sometimes others can be taken in lieu.
- Try to establish a rapport with the hostage taker and try to relate to the plight of the hostage taker (if you are valued the chances of harm are lower).
- The more positive the emotional rapport the better. Do not appear to be unemotional or uninvolved.
- Encourage him/her to talk with you and be a sympathetic and sincere listener.
- Engage in conversation with the hostage taker as much as possible and talk about personal hopes, family and other matters that build on your identity as a "real" person. Ask his/her advice if possible.
- Focus on the future in conversations and your (modest) hopes with your family.
- Gently encourage the hostage taker to refer to you by your nickname.
- Do not try to reason with him or her, to defend the organisation or even yourself. He or she will be resentful of your authority, how you used it, and your insensitivity to his/her interests.
- Do not grovel, but be remorseful, empathetic and respectful. Do not tell him or her you know how they feel because they know that you cannot.
- Do not be condescending in any way.
- Do not be self-righteous in any way.
- Do not give the impression that you think he or she will fail or that you expect the situation to come out alright.
- Permit him or her to view him/herself as the master of your fate.
- Do not watch him or her all of the time. Make it appear you submit to his/her control and mercy.
- Side with the hostage taker in all matters and join with him or her against the authorities, but don't oversell it.
- Carefully test the permitted range of movement while engendering trust.
- Recognise that the authorities may need your assistance at some time to help you.

(Capozzoli and Mcvey 1996, pp. 117–19)