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# Client Violence toward Social Workers: The Role of Management in Community Mental Health Programs

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*With the shift in mental health treatment from psychiatric hospitals to community agencies, mental health workers provide outreach interventions to clientele with increasingly acute psychiatric disorders in their neighborhoods and residences. This article examines job-related, client-perpetrated threats or physical violence against social workers in general, and community outreach mental health professionals in particular. The article highlights the critical role of supervisors and administrators in community mental health programs in developing proactive prevention and postincident response policies and procedures that create an organizational climate of safety awareness, training, and psychological support to traumatized worker-victims. Recommendations for macro-level intervention are proposed, and implications for social work education and the profession are addressed.*

**Key words:** *client violence; community mental health; management; safety; supervisors*

Fear gripped me. This routine psychotropic medication delivery and in-home assessment visit had gone terribly wrong. The look I saw in my client's eyes indicated to me that he had lost control of himself and that he was intent on killing me. We were alone in his house. While in the kitchen I listened to him describe in great detail how he was going to slowly kill me by dismembering me piece by painful piece, shoot me in the stomach, decapitate me and bury me in the backyard. What were probably only minutes felt like hours. It was clear to me that the client I had worked with for one year was not his usual self and was decompensating. I tried to remain calm as I scanned the room, looking for a way to escape. Somehow I came to the decision to slowly back out of the house towards the front door,

while continuing to talk calmly to my client as he described his murderous plans. In my mind as I was halfway to the front door, I thought I was on my way to safety. Suddenly, he grabbed my arm and swung me into the living room, effectively cutting me off from my exit. Out of the blue, my captor became distracted with the collection of videos on the other side of the room, while continuing to describe deadly scenes from each movie. Seizing the moment I turned and ran out, sprinting to the car. Safely I got in my car, locked the doors, and sped off back to my office.

My life was significantly disrupted for months after this incident. Nightmares interrupted my sleep. I was overwhelmed with feelings of shame and doubt. I began to question my judgment at every turn. Should I quit?

Maybe I'm not cut out for social work? My reactions altered the work patterns of my coworkers. Because I no longer felt comfortable going alone to a client's home, I requested a coworker accompany me on my outreach visits. The responses amongst my colleagues were mixed—some acknowledged the event as traumatic, others overtly and covertly expressed sentiments such as, "This is part of the job so just deal with it" and "If you are too afraid to deal with clients' needs, you do not belong in this type of work."

I didn't quit. In fact, since this incident I was promoted to a supervisory position and continue to work diligently with clinicians and agency administration to develop a comprehensive staff safety policy that goes beyond current policies dealing primarily with facility issues. My ability to cope with this traumatic incident was certainly impacted by my enjoyment of the challenge of the work and core belief that I am a conscientious and competent mental health professional. However, it was the knowledge and supportive presence of my supervisor that was key in helping me return to my previous levels of professional and personal sense of confidence.

**C**lient violence toward social workers is not a rare occurrence. In a study of licensed social workers in a western state, Rey (1996) found that violence against social workers occurs across settings. Griffin (1995) reported that social work cases have become more complex (for example, substance abuse and mental illness and homelessness) and that treatment is provided in a societal context fraught with greater violence. Community-based social workers face greater peril than their office-based counterparts because they often provide services in unsafe neighborhoods and have limited to no immediate support available if something should go wrong. Key indicators of potential violence include positive symptoms of schizophrenia, medication noncompliance, active drug or alcohol use, mandated clients, and a history of violence (Shergill & Szmukler, 1998; Weinger, 2001). Even in the midst of writing our final drafts of this article, we sadly read that Nicole Castro, a 23-year-old social worker in Maryland was murdered while serving a mentally ill client during a "routine visit" (O'Neill, 2002).

The introductory vignette is an actual account of the first author's experience of a serious threat to her physical safety at the hands of her client. Unfortunately, it is merely one among the many scenarios that social workers face daily in providing services to clients.

## Overview

During the middle of the 20th century, the focus of mental health treatment shifted from large psychiatric hospitals to community programs (Okin, 1995; Witkin, Atay, & Manderscheid, 1996). Since the advent of psychotropic medications in the 1950s (Kelly, 2000) and subsequent deinstitutionalization, the number and types of community mental health programs has grown substantially. The focus of treatment has expanded to include outpatient counseling and case management services provided at clinics, group homes, vocational programs, and in clients' homes (Fisher et al., 1996). Not only is community treatment the current trend for mental health professionals, patients, and their families, the 1999 U.S. Supreme Court decision *Olmstead v. L.C.* (1999) ruled that states must provide appropriate community mental health treatment.

Although community mental health treatment has become more prevalent, the consequences for social services workers have become increasingly dangerous. One state program that exemplifies national trends is the New Jersey Redirection Plans (State of New Jersey Department of Human Services, 2000, 2001), designed to shift treatment from psychiatric hospitals to home-based mental health treatment. In 1998 one New Jersey state psychiatric hospital was closed; currently another is designated for closure. Comprehensive outreach mental health treatment programs that serve clients in vivo (for example, within the general community such as client's home, vocational setting, homeless shelters, streets) have been created. Changes in laws requiring more stringent civil commitment criteria (Occupational Safety and Health Administration [OSHA], 1998) have also contributed to an increase in the psychiatric acuity levels of clients. Although the majority of individuals with severe and persistent mental illness are not inherently dangerous, the potential for danger exists because of the pervasive and unpredictable nature of the condition. Patients who were previously considered too ill and or violent to be released from the hospital now live outside

of hospitals, and tasks that were previously under the auspices of state psychiatric hospitals are now frequently carried out in the community. Although 53 percent of people with a mental illness in prison are incarcerated for a violent offense, mental health professionals in the community often serve those individuals before and after incarceration (Ditton, 1999). Despite the many advantages of community-based care for clients (for example, least restrictive environment) and workers (for example, intervening with clients *in vivo*), community-based social workers perform functions at an elevated risk of danger—clients are sicker and communities are more dangerous.

Unfortunately, client violence against social workers has received little attention by our profession. Despite social work's history of home visits with society's most vulnerable clients who are often at risk of dangerous and unpredictable voluntary and involuntary episodes of violence, the shift from hospital to community psychiatric care, and the increase in home visitation programs, few agencies have appropriate safety policies in place. Because it is in the client's own environment that social workers may be most vulnerable (Breakwell & Rowett, 1989), staff safety is a crucial concern particularly for agency social workers and administrators providing in-home psychiatric intervention services. Regrettably, it appears that safety is not a priority in agency program trainings (Newhill, 1995). When staff safety is addressed, the primary focus tends to be U.S. federal workplace safety standards (Griffin, 1995).

## Scope of the Problem

### Definition and Prevalence

There is no consensus on what constitutes a threat or act of violence (Macdonald & Sirotych, 2001; Nolan, Dallender, Soares, Thomasen, & Arnetz, 1999; Norris, 1990). However, the literature generally characterizes client-enacted violence against mental health professionals as actual physical assault, threats, or any other event the individual worker may deem as violent. The violent incident is defined by the worker's perceptions and the context in which the incident occurred (Breakwell & Rowett, 1989; Macdonald & Sirotych). What one worker finds violent or threatening, another worker may not. And, violent or threatening behavior in one situation may not be perceived as violent or threatening by the same person in a dif-

ferent context. Worker perceptions may also depend, for example, on the perceived intention underlying the action and the judgment regarding the meaning and social value of that act.

Although absence of standardized operational definitions and uniform reporting procedures have hindered the research on client violence, evidence suggests that violence against mental health professionals is common and that it is highly likely that published figures underestimate the extent of the problem (Nolan et al., 1999). Bureau of Labor Statistics (BLS) data for 1993 showed health care and social services workers having a higher incidence of assault injuries than any other field (OSHA, 1998). As early as 1972, Whitman, Armao, and Dent (1976) found that 79 percent of a sample of 101 mental health therapists in Ohio had been assaulted at least once in their professional career. The authors also reported that 81 percent of the social workers surveyed had been threatened or assaulted at least one time in their career. In a study of 500 clinical psychologists surveyed in the United States, 81 percent reported at least one incident of verbal abuse, harassment, or physical attack; two-thirds of the incidents occurred in the course of agency work and one-third in private practice (Tryon, 1986). Historically, staff employed at inpatient psychiatric units have experienced violence enacted by patients (Lanza, 1985). Recent studies in the United States and the United Kingdom suggest that psychiatrists, nurses, and other clinicians who work in state hospital emergency rooms and in private practice are increasingly subject to verbal threats and physical assaults by patients (Maier, 1996; Nolan et al.).

Despite difficulties in documenting prevalence rates, most social workers experience client-initiated violence while on the job. The percentage of social workers experiencing violence varies greatly in the literature, ranging in estimates from 50 percent to 88 percent (Weinger, 2001). The most prevalent form of violence is verbal threat (Kadushin, 1992). Physical assaults, although not as prevalent, were reported by 25 percent of the 175 licensed social workers and 98 agency directors surveyed in a western state (Rey, 1996). Other notable types of violence include being threatened with a weapon, property damage, harassing phone calls, and stolen property. Cross-culturally, violence toward social workers has been noted as a significant issue in the United Kingdom (Norris,

1990). Although research addressing community-based workers is scarce, field social workers have been found to be more at risk of assault in the client's primary physical environment, usually the client's home, than in other locations (Breakwell & Rowett, 1989).

Although all social workers are at risk, research shows that younger and less experienced staff are at greatest risk of client assault in community residential mental health programs (Flannery, Fisher, & Walker, 2000; Flannery, Lizotte, Laudani, Staffieri & Walker, 2001). However, the definitions of "young" and "inexperienced" are lacking. The scholarly literature is contradictory regarding whether female or male social workers are at greater risk of violence and threats. The NASW (2000b) publication *Social Work Speaks* notes, "Women social workers are especially vulnerable to physical violence by clients." (p. 315) Tryon (1986) reported that women are physically attacked as frequently as their male counterparts. Conversely, Newhill (1996) found that male social workers were significantly more likely to be targets of client violence because men traditionally work with more volatile populations and female counterparts tend to ask for male assistance when clients become increasingly agitated. Rey (1996) found that 80 percent of social worker and director respondents believed that safety issues in social work had become a growing concern over the past 10 years.

### **The Problem of Underreporting**

Mental health practitioners (Brasic & Fogelman, 1999; Flannery, Anderson, Marks, & Uzoma, 2000; Lanza, 1985), and social workers in particular (Kadushin, 1992; Macdonald & Sirotych, 2001; Norris 1990; Rey, 1996; Weinger, 2001), appear to underreport incidents of client violence. A variety of factors contribute to workers' underreporting violent incidents, including the perception that violent incidents are an inevitable part of their work and that social workers should be able to take care of themselves. In addition, many agencies lack reporting requirements or subtly discourage reporting because it leads to additional time-consuming paperwork. Finally, social workers may underreport because they believe management is not supportive or fear being judged or criticized by supervisors and coworkers. Evidence suggests that workers' perceptions of inappropriate or inadequate managerial responses to reports

of assault contributes to a lack of confidence in their immediate managers to do something about the problem, resulting in workers who are less likely to report future violent incidents (Macdonald & Sirotych, 2001). This parallels research indicating that in addition to the low priority management gives to the subject of violence against social workers, management partially neglects social workers who are victims of assault (Norris, 1990).

Social workers tend to have difficulty addressing their own safety and may prioritize their clients' needs at the expense of their own (Macdonald & Sirotych, 2001). Social workers often deny that they can become victims at the hands of their clients, thereby overlooking the potential for danger (Maier, 1996). Coworkers avoid the topic of staff safety even after an act of violence to a fellow worker has occurred (Shulman, 1993; Weinger, 2001); acknowledging the event forces coworkers to admit that they, too, are vulnerable—dismantling a sense of perceived safety. This culture of silence may contribute to feelings of isolation and exacerbation of the negative effects of the incident. Ignoring safety concerns may place staff at greater risk of future violence. Supervisors who are not informed about incidents of threats or actual violence cannot act on the needs of their employees. Furthermore, it is no wonder that few agency administrators report knowing about violent incidents against their employees (Rey, 1996). Without accurate reporting of client violence, administrators operate in a world of ignorance (Norris, 1990). They cannot act on what they do not know.

### **Effects of Violence on Worker and Agency**

In addition to worst-case scenarios of physical injury or death, clinicians who have experienced violence report that it contributes to stress, role conflict, and demoralization (Arnetz & Arnetz, 2001; Beaton & Murphy, 1995). Scholars in psychotraumatology suggest other common effects, including constricted thinking, restricted coping; states of fear, anxiety, depression; and symptoms associated with psychological trauma, especially hypervigilance, sleep disturbance, and recurring intrusive memories (Flannery, 1999). Even the anticipation or possibility of a traumatic incident can lead to stress (Kadushin, 1992). Workers involved in home visits may be less effective if they are afraid or find themselves in dangerous situations with little or no knowledge

of what to do (Wasik, Bryant, & Lyons, 2001), and in these situations mental health clinicians may veer from their routine psychiatric assessment protocols (Tardiff, 1992). Social workers may experience compassion fatigue, also known as secondary or vicarious trauma (Figley, 1995). *Compassion fatigue* is the potential psychological result of workers experiencing the signs and symptoms of their clients, disruption of self-protective beliefs about safety, control, and predictability; sometimes being a helpless witness to clients' repetitive self-destructiveness, manifesting itself in cynicism, despair, and loss of hope by the worker (Sexton, 1999). It may also manifest itself in colleagues who witness client violence against a fellow worker or listen to horrendous details about threats or incidents of violence.

Furthermore, the fiscal repercussions of primary and vicarious trauma on agencies are also significant because staff violence is associated with higher incidence of staff burnout, sick leave, medical and legal expenses, and turnover (Flannery, 1999). Agencies may also be liable for injuries or death suffered by the victims of violence in the workplace (Long Island Coalition for Workplace Violence Awareness and Prevention [LICWVAP], 1996).

### State of Safety Awareness and Training

NASW publications have recently recognized the need for safety awareness. *Security Risk: Preventing Client Violence against Social Workers* (Weinger, 2001) and the chapter titled "Social Worker and Agency Safety" in the *Encyclopedia of Social Work* (Griffin, 1995) are two such examples. Careful dissemination and access to these writings by practicing social workers and their supervisors may alter pre-existing low rates of safety training and education. For example, in a survey of NASW members in two states, Newhill (1996) found that 59 percent of the respondents received training on working with violent and potentially violent clients. Of those that received training, 59 percent received the training at their agencies, 4 percent in their BSW and MSW courses, and 6 percent at field placement. Six-percent independently sought training. Although the majority of respondents received training, it is important to note that 41 percent of the respondents received no safety training at all. Some argue that it is not surprising that as a profession we have been reluctant to address and implement safety procedures because

of our commitment to, and feelings about, clients; it is difficult for social workers to consider that our clients might harm us. This perspective may be instilled and perpetuated in part because of social workers' training and professional socialization (Macdonald & Sirotich, 2001). Norms within the profession such as an exclusively client-centered perspective may contribute to workers' belief that client service supersedes worker safety (Leadbetter, 1993).

The Council on Social Work Education's (CSWE) Educational Policy and Accreditation Standards (CSWE, 2001) emphasizes that one of the purposes of social work education is to prepare effective professionals. Therefore, it is reasonable to expect that knowledge about what to do if safety is compromised is an integral component of effective social work practice. Out of curiosity we read the field placement manuals of three prominent schools of social work. One school's manual mentioned safety in a policy titled "Student Insurance and Safety Preparation," which required students to be trained in infection control procedures. Not unlike agency safety policies that tend to emphasize facilities issues, there was no mention about worker safety considerations when working with potentially volatile clients and situations. The manuals of the other two schools did not discuss safety. We also contacted one of these schools and ascertained that no content about student safety was incorporated into the course curriculum offered to new field placement supervisors. We learned that discussion with students about safety is left to the discretion of individual field instructors based on their agency policies. At first glance this seems appropriate, yet given what we know about underreporting of violence, agency focus on facility safety precautions, and that most agencies are ill-equipped in their development of policies and procedures regarding violence against workers, we should be cautious in assuming that agencies include safety content in their agency orientation of social work interns. Similarly, although we located a newly published field work manual (Rothman, 2000) that includes a chapter titled "Personal Safety and Security," many social work practice textbooks discuss safety only in terms of client safety and protection (for example, suicidal clients).

Finally, programs for helping individuals cope with the psychological aftereffects of a traumatic event have typically targeted non-mental health

professionals (for example, police and fire fighters), but increasingly include mental health professionals as victim-clients. For example, Critical Incident Stress Management (CISM) and the Assaulted Staff Action Program (ASAP) are examples of crisis intervention programs for coping with the effects of traumatic events that occur at work (Flannery, 1999; Flannery, Anderson et al., 2000; Mitchell & Everly, 2000). These programs are designed to mitigate the psychological effects and prevent the onset of posttraumatic stress disorder (PTSD). With the apparent widespread underreporting of client violence, it is logical to assume that these programs are not being used to their fullest potential if at all.

### **Recommendations for Agency Administrative and Supervisory Intervention**

It is well within the scope of the role of supervisors to reduce the risk of violence to their staff. Training on safety is an important area of skill development. If schools of social work are not providing sufficient training, and only 59 percent of surveyed social workers reported that they had the training (Newhill, 1996), then a large percentage of social workers are without valuable information. The argument could be made that agency administrators are ethically bound to educate their employees on this subject. Some argue that supervisors have moral, legal, and ethical obligations to provide a safe work environment (LICWVAP, 1996). Although safety is not explicitly addressed, the *NASW Code of Ethics* (2000a) requires social workers to “provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experiences” (p. 8, Sect. 104(a)). Similarly, the *NASW Standards for Social Work Personnel Practices* (NASW, 1990) addresses administrators’ responsibility to provide competent workers such that staff hired meet the criteria for their position. Standard 11 addresses the topic of employee skills and ability development.

We developed a model of key considerations for agencies in developing prevention and postincident policies and procedures about staff safety for outreach psychiatric workers (Table 1). Because all contingencies cannot be anticipated, the model is offered as a template that can easily be modified. For example, decision trees that in-

corporate agency programmatic needs could be created. The model targets field considerations, but many aspects are relevant to office operations and applicable across other fields of outreach social work (for example, child welfare).

### **Prevention: Safety Training**

Agency supervisors and administrators must ensure that all personnel—direct care staff, support staff, and administrative staff receive safety training (Brasic & Fogelman, 1999; Weinger, 2001). Training during the initial orientation, periodic in-service programs, and ongoing staff meetings should address risk factors for client violence, including client and environmental assessments and worker-related issues. Client assessment is important in anticipating and identifying foreseeable risks before and during the outreach visit and instituting appropriate precautions. Clients should be assessed for acute symptomatology, noticeable behavioral changes, alterations or discontinuance of medication, known or suspected use of drugs or alcohol, mandated treatment, and known history of violence. Staff meetings might afford workers and supervisors the opportunity to discuss collateral contact information that is available before an outreach visit.

An environmental assessment is necessary to evaluate conditions workers might encounter during outreach interventions. The environment includes workers’ vehicles, the community at large, and clients’ residences. The worker’s vehicle is an environmental concern because it is used for transport of worker and clients and may be used as an “office” in which interviews occur. Therefore, installation of alarm or theft deterrence systems ought to be considered, and the vehicle should be free of potential weapons. For example, outreach workers often keep a can of Lysol in their vehicle to disinfect the enclosed area after contact with clients who have poor hygiene. Yet, aerosol cans are highly flammable, can be sprayed in one’s eyes, and can be used as a blunt object. Common sense vehicle issues such as sufficient gas, proper maintenance, and easy access to one’s keys are often overlooked or forgotten by new and experienced workers in stressful outreach interventions and should be emphasized in training. Workers have been known to lock their keys in the car and leave transparent bags of the day’s supply of psychotropic medication in plain view. At first glance these scenarios may

Table 1

## Key Considerations for Agency Policies and Procedures on Client Violence Toward Psychiatric Outreach Workers

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### Prevention: Safety Training

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- Client Assessment
    - Acute symptomatology
    - Behavioral change
    - Alteration/discontinuation of medication
    - Active illicit drug/alcohol use
    - Mandated treatment
    - History of violence
  - Environmental Assessment
    - Worker Vehicle
      - Common issues
        - sufficient gas
        - proper maintenance
        - access to keys
      - Alarm/theft deterrence system
      - Medications out of sight
      - Vehicle free of potential weapons
    - Community at Large
      - Known drug area
      - Known gang area
      - Recent community violence
      - Perception of social workers
      - Safe travel routes
    - Access to Neighborhood Exits
      - Park facing the way out
      - Avoid vehicle block-in
    - Client Residence
      - Appearance of external building
      - People entering and exiting building
      - Presence of animals
      - Observable illegal paraphernalia
      - Locations of exits
      - Security device on doors/windows
      - Location and types of potential weapons
      - Other people in residence
  - Worker-Related Issues
    - Imminent danger communication protocol
    - Cellular/GPS phone with police and emergency numbers preprogrammed
    - Double teaming
    - Communication and de-escalation skills
    - Nonviolent self-defense
    - Self-awareness of clinical and human instincts
    - Worker demeanor
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(continued)

Table 1

**Continued**

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**Postincident: Administrative Considerations**

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- Course of Action
    - For the Client
      - Is further assessment warranted?
      - Designate who will conduct follow-up assessment.
      - What are the outcomes? (no action, medication, increased outreach visits, hospitalization, incarceration, program termination)
    - For the Worker–Victim
      - Mediative Responses
        - Medical treatment
        - Appointment cancellation
        - Shift coverage
        - Caseload reconfiguration
        - Double teaming
        - Leave of absence
        - Workers' compensation
        - Legal action: none, file police report, press charges, secure attorney
      - Restorative Response
        - Internal or external designated critical incident stress management (CISM) program
        - Employee assistance program
        - Psychological support from team members
        - Psychological support from supervisor
        - Review and analysis of incident
        - Accompany worker to court proceedings
    - Potential Secondary Victims: Communication Mechanism and CISM
      - Worker's family members
      - Client's family members
      - Other clients
      - Coworkers
  - Incident Reporting
    - Zero-Tolerance Statement
    - Worker–Victim Incident Report
      - Time frame for reporting
      - Method of reporting
      - Recipient of report
      - Nature of the incident
      - Parties involved
      - Date, time, and location of incident
      - Sustained injuries
      - Course of action
    - Incident Tracking System
    - Systematic Review of Incidents
    - Other Administrative Considerations
      - Involve agency attorney
      - Contact risk management
-



appear implausible and a result of carelessness. Yet, we contend that lack of training combined with human error can and does result in incorrect procedures and high-risk behaviors—even for the most conscientious workers.

Environmental assessment of the community at large, the local neighborhood, and the client's residence equips workers with pertinent questions to consider in preventive field assessments and in instances when rapid appraisal of the imminent potential of danger is warranted. The assessment should address the geographic area of the worker's assignment, such as: whether the neighborhood is a known drug or gang area, incidence of recent community violence, how social workers are viewed in the area, safe routes to and from a client's residence, access to exits and secure parking of vehicles should the need arise to exit quickly, and which neighborhoods should be avoided at night. Local police departments are excellent resources for gathering some of this information and possibly providing training in these areas. Supervisors could maintain a database available to all staff to document and track changing environmental conditions and the deployment status of individual workers, ensuring that administration, office support staff, and fellow coworkers know where outreach workers are and when they are expected to return. On approach to a client's residence, workers should take note of the external appearance of the building (for example, general maintenance and lighting) and individuals other than the client whose presence in the client's home or vicinity poses a concern. Inside the home workers should scan for observable illegal paraphernalia, locations of exits, security devices on doors and windows, and location and types of potential weapons. Emphasizing the need to be alert in one's surroundings is especially important for seasoned practitioners in whom confidence and advanced clinical competence may lead to a false sense of security.

Worker-related issues are also potential risk factors for client violence. Training ought to include effective communication during violent situations, planning for "what if" situations and what is expected of workers during violent situations (Kadushin, 1992; Munson, 1993; Norris 1990; Weinger, 2001), and nonviolent self-defense (Flannery, Fisher, & Walker, 2000). For example, policies and procedures specifying the use of double teaming and a protocol for whom to call

in circumstances in which imminent danger is perceived (for example, when to call 911, the police department, or one's supervisor first) can help to avert violence. The social work team might periodically review general warning signs of impending danger, volatile situations, and contingency plans. The use of role play in anticipating realistic situations that may arise can equip staff with verbal and physical scripts, thereby instilling some sense of empowerment and confidence. Rehearsing plausible scenarios for violence in the field and in the office is necessary. Training that addresses aspects of workers' demeanor, such as respect for client and others and awareness of one's physical location in relation to others and exits is crucial in preventing or at least reducing unfavorable outcomes of violence. Trusting personal instincts is also essential, yet training can heighten workers' common sense and gut instincts as well as enhance clinically based, perceptual skills. Human instinctual responses such as the psychophysiology of fight-flight, combined with a "clinical gut" should be acknowledged as a powerful resource for knowing. Workers should be instructed to trust their intuition and immediately leave the environment if something feels amiss—even when concrete, observable data are not available.

### **Postincident: Administrative Considerations**

Policies and procedures outlining aspects relevant to the course of action for the client, worker-victim and potential secondary victims, as well as an incident-reporting mechanism need to be established. It is necessary to determine whether additional assessment of the client is warranted and who will conduct the interview. Multiple outcomes for the client who enacted the violent threat or act exist, including no action, medication re-evaluation, increased outreach visits, hospitalization, incarceration, and termination from the program as a last resort. In addition to legal considerations, the outcome is determined on the basis of the agency's policies, protocols, values, and mission statement. With regard to the worker-victim, supervisors need to ensure staff access to a full range of agency support, including their direct coworkers and agency administrators (OSHA, 1998). Support is important to employees' views of their agency; employees who perceive the agency as supportive may be less likely to leave the agency and will therefore improve the

continuity and quality of services (Nolan et al. 1999; Rey, 1996). It is vital to emphasize that individuals need support after psychological trauma from physical and verbally threatening situations (Arnetz & Arnetz, 2001).

Brown and Bourne (1996) noted the mediative and restorative roles of supervisors. Mediative responses include mobilization of medical treatment for the worker-victim, appointment cancellation, shift coverage, caseload reconfiguration, establishment of partner-teams, legal options, and leave of absence if warranted. Restorative responses, such as the ventilation of emotions and mobilization of personal coping strategies and social support, can occur in the clinical supervisory session and through formal debriefing programs. For example, it would behoove agencies to budget for structured programs that address the psychological responses of traumatized workers. Ensuring that procedures are in place to activate responses in an expeditious manner to programs such as CISM can be helpful in ameliorating the negative mental, emotional, and psychological effects on victimized workers. Evidence suggests that implementation of structured programs contributes to a decrease in employee turnover, sick leave, and accident claims and legal expenses, and sustained employee productivity (Flannery, 1999; Flannery, Anderson et al., 2000). For example, when the ASAP was used with direct care staff at various mental health settings, there was a reduction in assaultive behavior toward staff (Flannery, Everly, & Eyler, 2000). Although formal programs can be costly, the financial ramifications of job-related violence seem to outweigh programmatic costs. There are feasible solutions despite the reality of financial constraints for mental health agencies. For example, agencies can hire staff with previous CISM training or provide training for a few key staff.

A holistic social work perspective would encompass communication mechanisms for informing appropriate others about incidents and potentially violent clients and the provision of support services to secondary victims in addition to the primary victim. Secondary individuals affected include the worker-victim's family members, coworkers, and supervisors (Beaton & Murphy, 1995; Shulman, 1993). Families may experience increased anxiety and fear for their loved one's well-being. Coworkers may need help because the incident can bring the reality of the dangers inher-

ent in the work to the forefront and to their conscious attention (Beaton & Murphy). Supervisors may need support and assistance because they may experience feelings of guilt about deploying workers in dangerous situations without adequate training. Secondary victims may also include other clients who witness or hear about the incident and family members of the client responsible for the violence.

Macdonald and Sirotich (2001) advocated policies that include a philosophy of zero-tolerance of client violence and thorough reporting procedures. Mechanisms, verbal and written, for reporting all incidents and a database that contains detailed information pertinent to violent incidents could be developed. The systematic review of each incident by agency administrators and staff can help ascertain systemic situations that may have led up to the event (Breakwell & Rowett, 1989), and solutions for the problem can be analyzed and implemented. Finally, expenditures for cellular phones with a built-in GPS (location tracking device) system should be the norm for every outreach worker.

## Conclusion

The increasing prevalence of community mental health treatment and societal violence warrants urgent and comprehensive education and training about client violence against social workers for all social workers, and outreach field workers in particular. Implications for agencies, schools of social work, and the profession itself are apparent: losing able workers through burnout, turnover, and in extreme cases, death, because of inadequate education and training hurts us all, including the clients we serve.

NASW and CSWE standards on safety would be useful. Including safety in social work curricula and social work textbooks is important, yet when worker safety is addressed in textbooks, the topic tends to have marginal pedagogical content or appears as the last chapter or a brief aside. Newhill (1995) proposed course content that includes information on working with involuntary, resistant, and angry clients; recognizing signs of impending danger and loss of control; intervening to prevent violence from escalating; and effectively advocating for practice conditions favorable to violence prevention.

Curricula and agency supervision should incorporate content on stress, burnout, and compassion

fatigue—important components of social workers' overall health and well-being. In the midst of the class discussion on compassion fatigue in a graduate generalist practice course taught by the second author, a student, echoing the feelings of her classmates, voiced much relief in hearing that it is normal for social workers to experience grief and pain and stress and fear. She explained that she presumed only incompetent social workers experienced these thoughts and emotions. Educators often assume that students understand that social workers are sensitive beings—real people with human emotions and responses—and that through education and training we are better equipped to identify, address, and correct our reactions that may be harmful to us and impede our interventions with the clients we serve. Experienced professionals tend to forget that the struggle to master clinical and administrative skills, and successfully perform in course examinations, papers, and field placements can inadvertently misplace student as well as faculty and supervisor attentions, for instance, on learning “the right way” and mastering “clinical competencies,” thereby evading the realities of our natural human responses.

Agency supervisors and administrators can significantly affect the way in which violence against social workers is viewed and potentially mitigate the frequency of violent incidents by instituting policies, training, and psychosocial support for clinical and agency support staff (Griffin, 1995). Sexton (1999) advocates an environment where the problem is owned as an organizational one, and where the focus is to seek solutions rather than attribute blame. Agency administrators and managers also set the tone by creating an organizational culture that deems safety a priority and is proactive in its stance. Certainly, mental health agencies are strapped for resources, and staff is often overworked. However, designing the annual budget to include miscellaneous funds that account for additional fiscal budgeting of staff resources (for example, temporary double teaming), emergencies (for example, vehicle repair), and realistic caseloads and performance expectations will save money in the long run. Research is needed to investigate the prevalence and programmatic consequences of violence against community-based outreach mental health practitioners. For example, knowledge regarding the relationship between rates of violence toward staff

and variables such as staff–client ratios, client characteristics, and the impact on services to clients would be beneficial. Finally, a broader discussion of the roots of client violence that includes systems factors may be useful in our consideration of altering the systems, functions, and roles in which social workers, in many fields (for example, psychiatric, child welfare, substance abuse, corrections), are enlisted as agents of coercive social control. One of the first principles a lifeguard in training learns is: don't try to save somebody if you are going to drown yourself. Unveiling the façade of perceived safety, erroneous underlying beliefs, and a blaming-the-victim mentality that presumes “competent social workers already know what to do” or “you knew what you were getting into when you took this job,” and equipping social workers with safety knowledge are essential in our efforts to protect invaluable members of our profession. ■

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Original manuscript received February 13, 2002  
Final revision received September 9, 2002  
Accepted December 16, 2002

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