Part of the Job? Workplace Violence in Massachusetts Social Service Agencies

Jennifer R. Zelnick, Elspeth Slayter, Beth Flanzbaum, Nanci Ginty Butler, Beryl Domingo, Judith Perlstein, and Carol Trust

Workplace violence is a serious and surprisingly understudied occupational hazard in social service settings. The authors of this study conducted an anonymous, Internet-based survey of Massachusetts social service agencies to estimate the incidence of physical assault and verbal threat of violence in social service agencies, understand how social service agencies collect data on workplace violence, and identify disparities in who is at risk in terms of staff education and training level and the work setting. The study gathered general descriptions of each agency and compiled incidence data on workplace violence that were collected by agencies in fiscal year 2009. The key findings of this descriptive study showed high rates of workplace violence against social services providers and a pattern of risk disparity, with significantly more risk for direct care versus clinical staff. These results are based on data routinely collected by social service agencies that typically remain unexamined. A research agenda that is sensitive to potential occupational health disparities and focuses on maximizing workplace safety in social services is needed.

KEY WORDS: *occupational health; occupational health disparities; risk; workforce; workplace violence*

Workplace violence is a serious and surprisingly understudied occupational hazard in social service settings (Jayaratne, Croxton, & Mattison, 2004). In relation to other employment sectors in the United States, health care and social assistance (HCSA) is among the most dangerous. For example, according to the most recent Bureau of Labor Statistics (BLS) report on workplace violence, the median number of days lost as a result of assault for private sector workers employed in HCSA was twice that of the private sector as a whole (9.7 compared with 4.9 per 10,000), and for state HCSA employees the median was more than four times that of all state employees (136 compared with 30 per 10,000) (BLS, 2010). Studies conducted since the 1990s, many in response to deteriorating working conditions and service quality resulting from underfunding and program cuts, have consistently found high rates of physical assault (3 percent to 30 percent) and verbal threat of assault (42 percent to 82 percent) (Ringstad, 2009). In Massachusetts, where our study was conducted, three members of the social service workforce have lost their lives as a result of workplace violence since 2008.

Yet the topic of workplace violence in social services has received scant attention within social work and the public health and occupational health literature. For example, a search for the terms "social work" and "workplace violence" on EBSCO Academic Search Complete (which includes most social work– and occupational health–focused journals) between 2001 and 2011 turned up only nine empirical studies; considering the range of populations served by various social services and practitioners, this means that many settings where workplace violence is a risk have not been studied at all.

Therefore, there is a need to better understand workplace violence in social services to create policies and initiatives that make social services safer for the workforce and the people they serve. Building on previous literature, this descriptive study has three aims: (1) to estimate the fiscal year (FY) 2009 reported incidence of physical assault and verbal threat of assault in participating Massachusetts social service agencies; (2) to understand how different social service agencies collect data related to workplace violence; and (3) to identify disparities in risk for workplace violence in staff education and training level and the settings of workplace violence.

doi: 10.1093/hsw/hlt007 © 2013 National Association of Social Workers

BACKGROUND

What Counts as Workplace Violence?

Studies of workplace violence among social workers typically include physical assault, verbal threat of assault, verbal abuse, and property damage (Newhill, 1996; Rey, 1996; Shields & Kiser, 2003; Spencer & Munch, 2003; Winstanley & Hales, 2008). Some studies include sexual and racial or ethnic harassment in their definition of workplace violence (Guterman, Jayaratne, & Bargal, 1996; Hoobler & Swanberg, 2006; Jayaratne, Croxton, & Mattison, 2004; Koritsas, Coles, & Boyle, 2010; McDonald & Sirotich, 2005; Pollack, 2010; Ringstad, 2005). Few studies have used conceptually framed, validated tools to measure workplace violence (Ringstad, 2005; Winstanley & Hales, 2008); most rely on the individual worker's subjective definition of "workplace violence" to account for the variation in perceptions of what is "violent" (Guterman et al., 1996; Jayaratne et al., 2004; Koritsas et al., 2010; McDonald & Sirotich, 2005; Newhill, 1996; Pollack, 2010; Rey, 1996; Shields & Kiser, 2003). In our study, workplace violence is operationalized as incidents of physical violence or verbal threat of violence by clients directed at social service staff and captured by an agency's reporting system.

The most frequently used study design to estimate prevalence of workplace violence is a survey of NASW members (Jayaratne et al., 2004; Newhill, 1996), though this design could underrepresent minorities and those who work in agencies and overrepresent social workers in private practice (NASW, 2008). Of the few studies that took place at agency level or analyzed routinely collected injury data, one examined national BLS data on time lost as a result of physical assault (Respass & Payne, 2008), another gathered national data through local unions (American Federation of State, County and Municipal Employees, 1999), and a third was a case study of an agency in an urban setting with high crime and violence rates (Bell, Mock, & Slutkin, 2002). Our study adds to the knowledge base by reporting on incident data routinely collected by social service agencies in a geographic region.

Who Is Most at Risk for Workplace Violence?

Several studies have found increased risks for male compared with female social workers (Guterman et al., 1996; Jayaratne et al., 2004; Newhill, 2003; Ringstad, 2009), though others have found increased risk among women (Baines, 2005; Bell et al., 2002; Flannery, Fisher, & Walker, 2000). Other factors associated with increased risk have included younger age (Jayaratne et al., 2004; Koritsas et al., 2010) and urban setting (Bell et al., 2002; Shields & Kiser, 2003). The only study to look at staff educational and training level found no significant differences between risk of being the target of workplace violence and different levels of training and education (Winstanley & Hales, 2008). The use of physical restraint has been linked to workplace assault on staff in a residential psychiatric setting (Flannery et al., 2000) and an intellectual disability group home setting (Hawkins, Allen, & Jenkins, 2005).

Where Are Incidents of Workplace Violence Most Likely to Occur?

In a study of violence against social workers, Newhill (2003) identified a hierarchy of risk based on primary area of practice; criminal justice, drug and alcohol services, and child welfare were identified as "high risk" areas of practice, and health care services and services for older people were identified as "low risk." However, these categories do not reveal whether elevated risk is related to the environmental setting, client population, or nature of the services or intervention. In terms of risks associated with specific settings, Ringstad (2005) found increased risk of workplace violence in inpatient and correctional institutions and schools. Although the dangers of providing services in the client home are frequently discussed (Rey, 1996), no empirical study compares the likelihood of incidents in home-based services with other social service settings.

Why Do Social Workers Fail to Report?

Underreporting of workplace health and safety incidents is a common phenomenon (Azaroff, Levenstein, & Wegman, 2002). A recent study of U.S. workplaces estimated that 69 percent of work-related injuries are not reported (BLS, 2010). Within social services specifically, one study found that only 18 percent of assaults on staff at a state mental hospital were formally recorded during a 1-year period (Lion, Snyder, & Merrill, 1981). Among a random sample of clinical social workers, 25 percent experienced an incident of workplace violence that they did not report (McDonald &

Sirotich, 2001). Reasons for failure to report included not thinking that the incident was serious enough, a perception that violence is "part of the job," a belief that nothing would be done, fear of being blamed for the incident, and lack of institutional reporting policies (Lion et al., 1981; Lowe & Korr, 2008; McDonald & Sirotich, 2001; Nobel, 2007; Rey, 1996).

How Are Data on Workplace Violence Collected in Social Service Settings?

Several studies have reported on the adequacy of safety policies in social service settings (Lowe & Korr, 2008; Rey, 1996; Sarkisian & Portwood, 2003). The only study that evaluated compliance with Occupational Safety and Health Administration (OSHA) safety guidelines for workplace violence prevention found that, among mental health agencies, only half were in compliance (Lowe & Korr, 2008). There is little discussion in the literature of how agencies collect data on incidents of workplace violence beyond the requirement of reporting an incident to a supervisor. Public employees may not be covered by the Occupational Safety and Health Act of 1970 (P.L. 91-596) (in Massachusetts, the setting for this study, they are not); therefore, reporting requirements vary between those employed in the public sector and those in private or nonprofit settings (Massachusetts Coalition for Occupational Safety and Health, 2011).

This Study's Approach

Our aim was to describe workplace violence in Massachusetts social service agencies on the basis of routinely collected incident data so as to aggregate and examine baseline data and identify areas that need to be explored further. We took a literature- and field-informed approach to our inquiry that recognized existing variations in regulatory requirements for recording workplace violence–related incidents in different agencies. This study represents an attempt to develop a data collection strategy for gathering workplace violence incident data by using a uniform survey to capture data from different agency reporting and recording systems. As members of a statewide task force to maximize social worker safety, one of our goals was to make data, not typically publicized, publically available to spark dialogue and agency- and community-level focus on workplace violence in social services.

METHOD

Site of the Study

This study was conducted in the state of Massachusetts under the auspices of the Task Force for Maximizing Social Worker Safety, a statewide stakeholder task force supported by the NASW, Massachusetts Chapter.

Sample and Procedure

Eligible participant agencies were agencies delivering social services in Massachusetts. The sample population of agencies was identified through the membership lists of two statewide coalitions (the Human Services Coalition and the Child Welfare League), all public agencies serving the state of Massachusetts, and the attendance list for a summit on social work safety hosted by the Boston University School of Social Work in 2008. A committee of experienced professionals in the field concluded that this approach made the survey available to the vast majority of Massachusetts social service agencies. A letter describing the study was distributed electronically to the executive director or chief executive officer of 200 human service agencies. Agencies who received the letter also received a follow-up phone call to encourage participation. Data regarding social service staff were provided by participant agencies. Eligible social service staff were employed by participant agencies during FY 2009 in the capacity of clinical staff or direct care providers. Clinical staff were defined as employees holding a master's degree or higher. Direct care staff were defined as employees with a bachelor's degree or less. The data collected by the Internet-based survey relied on the data collection tools used in each agency. The study was conducted between May and August 2010.

Participating agencies were asked to designate an individual with access to human resource documents to complete an anonymous, Internet-based survey. Feedback from a pilot phase of the study indicated that, without anonymity, agency leaders were reluctant to make workplace violence data public. As a main goal of our study was to help make agency data public, we accepted that participation would be anonymous. A disclosure statement included in the Internet-based survey explained the rights of the participants and the procedures for protecting the anonymity of participating agencies. The study protocol was approved by

the institutional review boards of NASW and Salem State University (Salem, Massachusetts).

Measures

The measure used in this study was an anonymous Internet-based survey developed collaboratively with a large research team. The survey gathered agency-level data for FY 2009 on agency characteristics (numbers of clients served, numbers of employees, populations served, services provided, and settings where services were provided), methods for collecting data on violent incidents, reported incidents of physical assault or violent threats among direct care and clinical workers in the context of the use of physical restraints, reported incidents of physical assault or violent threat among direct care and clinical workers in a non-restraint-related context, and setting of reported incidents and perceptions of risk in each setting. Participants were provided space to give comments on the topic of workplace violence at their agency at the end of the survey.

For the purpose of this study, *workplace violence* was defined as physical assault with or without injury and verbal threat of physical assault by a client directed at a staff member. The use of restraints was not specifically defined in the survey but was intended to capture the types of manual physical restraint of clients by staff in some social service settings (Haimowitz, Urff, & Huckshorn, 2006). Our decision to classify violent incidents as restraint- and non-restraint-related was based on feedback from a pilot phase of the study. Agency leaders indicated that physically restraining clients could escalate violence and lead to assaults or incidents that should be differentiated from physical assaults or verbal threats in contexts where restraints were not involved. The data collected by the Internet-based survey relied on the data collection tools used in each agency.

Two focus groups composed of purposive samples of social service workers were conducted to contextualize the survey findings to yield a range of attitudes and perspectives (Krueger & Casey, 2000). In addition to gathering group viewpoints, small groups are potentially effective in drawing out nuanced and unanticipated information.

Procedurally, after the research team provided detailed information about informed consent and developing an agreement to maintain each group's confidentiality, the focus groups commenced. The interview guide used by the facilitators (the first and second authors of this study) included open-ended questions addressing the central research questions related to workplace safety. Each question was written to encourage study participants to provide expansive responses. Polling techniques were also used to ensure that all study participants contributed to the discussion (Vaughn, Schumm, & Sinagub, 1996). Identical questions were posed to both focus groups, although individualized probes and clarifying questions were also used as necessary. The focus groups were audiotape-recorded and transcribed.

Method of Data Analysis

Survey data were analyzed using SPSS, version 19 (IBM Corp., 2010). Bivariate statistical associations were tested with chi-square tests. Odds ratios (*OR*s) and 95 percent confidence intervals (CIs) were calculated using standard methods. Means were determined and compared with *t* tests. For the focus group transcript analysis, an open coding approach was taken using the constant comparative method elucidated by Glaser and Strauss (1967).

RESULTS

Characteristics of Agencies and Workforce by Agency Type

In total, 40 agencies participated in this study (see Table 1). The number of clients served in these agencies ranged from 120 to 89,000 (*Mdn* = 4,407; interquartile range [IQR] = 2,500–10,000) and the number of employees ranged from 10 to 3,500 (*Mdn* = 117; IQR = 101–202). About half of the agencies who participated in this study primarily served older adults (57.5 percent), but the agencies serving nonolder adult populations employed far more staff. Results of this study represent the experiences of 2,627 (29 percent) clinical and 6,395 (71 percent) direct care staff, with 9 percent of clinical staff and 17 percent of the direct care staff working primarily with older adults.

There were a total of 1,049 incidents reported of physical assault or verbal threat of violence. The rates of incidents of physical assault or verbal threat among direct care or clinical staff were comparable (11 out of 100 per year in older adult–focused services, compared with 12 out of 100 per year in nonolder adult–focused). However, a significantly

Table 1: Agency Characteristics and Aggregate Incident Data, by Older and Nonolder Service Focus

	Older Adult–Focused Agencies (*n* = 21)			Nonolder Adult–Focused Agencies (*n* = 19)		
Agency Characteristic	***n***	**%**	***Mdn***	***n***	**%**	***Mdn***
Number of clients served FY 2009	138,801	36	4,000	245,655	64	5,927
Number of clinical staff	233	9	10	2,394	91	35
Number of direct care staff	1,071	17	53	5,323	83	126
Number of agencies using restraints	10	42		14	58	
Number of incidents	138	13		911	87	
Verbal threats	134			361		
Physical assault	4			550		
Incidence rate verbal, physical (total)	11			12		
Verbal threats	10			5		
Physical assault (incidents per 100 workers per year)	0.31			7		

Note: FY = fiscal year.

higher percentage of incidents among those working with older adults were verbal assaults (97 percent) compared with those working primarily with nonolder adults (40 percent; $p < .001$). Excluding verbal assaults, the rate of incidents or injuries among those serving nonolder adult populations was significantly higher (seven of 100 per year) than that of those working with older adults (0.31 of 100 per year; $p < .001$). Overall, a far greater percentage of incidents reported in our study occurred in nonolder adult–focused services (87 percent) than in older adult–focused services (13 percent). Also of note, there were no restraint-related injuries reported among staff employed by agencies that primarily served older adults.

Physical Assaults and Threats among Direct Care and Clinical Staff

Data were collected with respect to both restraint-related and non-restraint-related injuries (see Table 2). Participating agencies reported 173 restraint-related injuries for FY 2009; 143 (83 percent) of those injured were direct care staff, who were twice as likely as clinical staff to suffer a restraint-related injury (*OR* = 2.02, 95 percent CI [1.34, 3.06]). Direct care staff were 10 times more likely to experience a restraint-related injury requiring an emergency room (ER) visit compared with clinical staff (*OR* = 10.13, 95 percent CI [3.09, 40.18]) and nearly four times more likely to lose time due to their injuries (*OR* = 3.89, 95 percent CI [1.33, 12.81]).

Data on non-restraint-related incidents of physical assault and verbal threats were also explored. Agencies were surveyed about four types of non-restraint-related injuries: verbal threat, physical assault without injury, physical assault with injury, and death. Among direct care staff, 63 percent ($n = 456$) of non-restraint-related injuries were verbal threats, compared with 83 percent ($n = 92$) among clinical staff; physical assault without injury accounted for 35 percent ($n = 254$) of non-restraint-related injuries compared with 14 percent ($n = 16$) among clinical staff; and 2 percent ($n = 17$) of direct care staff sustained injuries from a physical assault, whereas 3 percent ($n = 3$) of clinical staff did. Overall, direct care staff were twice as likely to be threatened verbally at work (*OR* = 2.05, 95 percent CI [1.62, 2.60]) and nearly five times more likely to be the victim of a physical assault (*OR* = 4.91, 95 percent CI [3.15, 7.73]).

Settings Where Incidents Occurred

Data were collected on the setting where incidents took place for each agency. The vast majority of restraint-related incidents for direct care workers occurred in a group home setting (82 percent), whereas for clinical staff a majority occurred in the psych-inpatient hospital setting (68 percent). For non-restraint-related incidents among direct care staff, the settings where a majority of incidents occurred were either in psych-inpatient hospitals (35 percent) or day rehabilitation facilities (23 percent). The vast majority of non-restraint-related incidents among clinical staff occurred in the psych-inpatient hospital setting (80 percent).

We also collected data on where non-restraint-related incidents were perceived as most likely to occur; the client home was perceived to be the most risky setting for both direct care and clinical staff.

Table 2: Odds of Physical Assault and Verbal Threats in Restraint- and Non-Restraint-Related Incidents among Direct Care Compared with Clinical Workers

Incident	Direct Care (*n* = 6,394)	Clinical (*n* = 2,627)	Odds Ratio	95% Confidence Interval
Restraint-related injuries/first aid[a]	64	27	0.89	(0.55, 1.44)
Restraint-related injuries/ER visit	79	3	10.13**	(3.09, 40.18)
Restraint-related injuries/lost time	41	4	3.89**	(1.33, 12.81)
Restraint-related injuries/all	143	30	2.02*	(1.34, 3.06)
Verbal threats	443	92	2.05**	(1.62, 2.60)
Physical assaults	266	23	4.91**	(3.15, 7.73)
Physical assault with injury	17	4	1.75	(0.55, 6.14)
Non-restraint-related incidents/all	709	114	2.75*	(2.23, 3.39)

Note: ER = emergency room.

[a]Because not all agencies used physical restraints, the numbers at risk for such incidents differed: 3,301 direct care workers and 1,242 clinical workers were at risk for restraint-related incidents.

*p .05. **p .01.

Table 3: Most Likely Settings for Restraint-Related and Non-Restraint-Related Incidents, by Worker Type

Settings/Worker Type	Most Common Setting *n* (%)	Perceived Most Common
Restraint-related incidents, direct care workers	Group home/residential: 153 (82) School: 17 (9) Psych inpatient/hospital: 9 (5) Day rehabilitation: 5 (3)	
Restraint-related incidents, clinical workers	Psych inpatient/hospital: 23 (68) Group home/residential: 6 (18) Day rehabilitation: 5 (15)	
Non-restraint-related incidents, direct care workers	Psych inpatient/hospital: 347 (35) Day rehabilitation: 224 (23) Office/facility: 175 (18) Client home: 121 (12) Community outreach: 52 (5) Court: 32 (3) Group home/residential: 28 (3)	Client home Group home/residential Office/facility Vehicle
Non-restraint-related incidents, clinical workers	Psych inpatient/hospital: 251 (80) Client home: 23 (7) Office/facility: 21 (7) Group home/residential: 12 (4)	Client home Office/facility Community outreach Vehicle

Note: Data on perception gathered for non-restraint related incidents only.

This contrasts with the data on where incidents actually occurred; 12 percent of non-restraint-related incidents among direct care staff occurred in a client's home, and 7 percent of incidents involving clinical staff occurred in this setting (see Table 3).

Differences in Data Collection among Agencies

Agencies responding to the survey were asked to report on how they collected information on incidents of assault and threat. The most common methods were incident reports (18 of 40), workers compensation forms (15 of 40), and human resources (11 of 40) (see Table 4).

Environment for Reporting Incidents of Workplace Violence

Two focus groups discussed the environment for reporting workplace violence incidents at two agencies; one group was composed of licensed social workers and the other of program managers.

Licensed clinicians expressed a great deal of concern over safety despite few actual incidents at their agency. They complained that a lack of safety planning left them feeling unsupported and entirely responsible for their own safety. This lack of support was underscored by the perception that there was a "gendered" response from management, where a mostly male administration discounted the

Table 4: Agency Safety Data Collection Tools and Methods		
Key Collection Techniques	**Number/ Total**	**Implications**
Incident reports	18/40	What data are different agencies collecting?
Workers compensation	15/40	How are these claims used at the agency level?
Human resources	11/40	Does human resources implement safety training?
Reports from the field to supervisor	3/40	How can these informal reports be used?
Safety committee	4/40	Who is on the committee, and how does it function?
OSHA log	4/40	Under current rules, not all agencies are required to keep an OSHA log.
CQI committee or other evaluation committee	4/40	What is the relation between CQI and other quality evaluations and worker safety?

Note: OSHA = Occupational Safety and Health Administration; CQI = continuous quality improvement.

concerns of a predominantly female clinical staff. In addition, participants in this focus group indicated that, whereas some of the settings they worked in had safety protocols, others did not. Even where protocols were in place, they were sometimes "forgotten" or "not implemented" because of people "being too busy with their work."

Program managers from a different agency discussed barriers to reporting incidents of workplace violence among the staff they supervised and identified factors that encouraged reporting. Being seen as a "bad" social worker and feeling as if the incident was one's "fault" was seen as a huge barrier to reporting, particularly among newer social workers. Being stressed for time was also seen as making a difference, in terms of both the limits on time as a result of high caseloads and the amount of time required to complete reporting paperwork. Exacerbating these problems was a shift in how services were billed, which left staff with no way to bill for time that was not directly related to service delivery.

Program managers also reflected on the role they played as supervisors, both in creating an environment where reporting and debriefing on incidents and threats were encouraged and in not minimizing their staff's perceptions of threats. There was broad consensus among this group of managers that peer debriefing sessions were an effective and underused forum for evaluating workplace violence hazards.

DISCUSSION

The five key results of this study are as follows: (1) high rates of workplace violence against social service providers, (2) a pattern of risk disparity showing significantly more risk for direct care versus clinical staff, (3) perspectives on why staff in social service agencies might fail to report incidents of workplace violence, (4) more incidents of workplace violence in inpatient and institutional versus other types of settings, and (5) insight on the inconsistent approaches to collecting data on workplace violence.

Our most striking result is the risk disparity between direct care staff and clinical staff that is evidenced by their statistically significant increased odds of nearly every type of assault or threat surveyed. Because direct care staff have more contact hours with clients, their increased risk is logical. This logic is reflected in health service sector data that show higher injury rates for health support staff compared with health practitioners (20.4 compared with 6.1 per 10,000; BLS, 2010). However, this inequality in risk between staff within the same work environment needs further attention.

The study of "occupational health disparities" examines how population-level differences in health outcomes are rooted in the work experiences of different groups, including access to employer-based health insurance (Krieger, 2010). "Two-tiered" employment in social services that divides licensed from unlicensed personnel has been criticized for creating inequities in job quality (Baines, 2004). Being a lower paid, lower status worker in social services appears, by the data in this study, to be associated with increased risk of exposure to workplace violence. If direct care workers are also more likely to have poor access to health care, adverse health outcomes of exposure to workplace violence could be exacerbated. We did not collect demographic data that would allow us to evaluate patterns of risk inequity according to race–ethnicity, sexual orientation, socioeconomic status, or community background, but this topic should be taken up in future research. For example, if socially disadvantaged

groups are overrepresented among those in lower status social service jobs, this raises a social justice issue that social workers are compelled to examine.

Risk disparity was also apparent in the distribution of restraint-related incidents; direct care staff members were significantly more likely to be injured, visit the ER, or lose work time as a result of a workplace violence incident in the context of physical restraint. Manual physical restraint may be defined as pressure applied by one or more staff to restrict the movement of an individual during an episode of challenging behavior (Hawkins et al., 2005). Although our study design does not allow us to make detailed assessment of why injuries occurred in the incidents recorded in our study, our findings do suggest that use of restraints might be a component of the increased risk of physical assault and injury borne by direct care staff. This finding is supported by reports that staff injuries and workers compensation claims have dropped significantly in agencies where use of physical restraints has been eliminated following advocacy efforts by the Child Welfare League of America (Caldwell & LeBel, 2010).

Our study also identified risk of workplace violence among clinical staff, including the death of a clinician during a home visit. This underscores the shared interest of the social service team in making the work environment safer. Indeed, a larger lens for analysis reveals occupational health disparities for those employed in the social service sector compared with other industries in regards to prevalence of violent incidents (BLS, 2010) and lower pay and benefits (Barth, 2003; Hudson, 2007).

Our qualitative results indicate that there are good reasons to expect that assaults and threats are underreported, and they echo what has been reported in previous literature in terms of fear of being blamed for an incident, being seen as a "bad" social worker, ignoring violence as "part of the job," or working in an environment inhospitable to reporting incidents. Given this, it is very likely that our study underestimated the number of actual incidents of workplace violence in the agencies studied. Focus group participants worried that there was no requirement for reporting "near misses," noting that these incidents could contribute to stress in the workforce but fail to be reported or addressed in the agency.

The majority of incidents of reported workplace violence in this study occurred in inpatient or institutional settings rather than in a client home or community setting. This contrasts with the perception that the client home presents greater risk. It would be important to understand whether this is a true difference or whether this phenomenon is the result of reporting differences, as reporting protocols may be more developed or better regulated in inpatient and institutional settings.

Our results on how agencies collect data suggest that there is a difference between collecting data for the purpose of compensation versus using it for hazard assessment and violence prevention. Few agencies seemed to be using their data for assessment and prevention purposes. A rare exception among our participants was the following, reported in the Comments section of the survey:

> After an incident of a violent or threatening nature the employee files an incident report describing the incident, setting, and who was involved. The report is reviewed by the supervisor and manager, a safety plan is developed with the employee and is recorded in the incident report. In some instances a debriefing meeting is convened with the employee, supervisor, and other staff to assess the impact and for support. The report is submitted to the central office for review, and to be recorded in a worker safety database.

At the other extreme, another participant observed the following:

> I learned that our workers' compensation claims for fiscal year' 09 were just under $400,000. In reviewing these incidents I was struck by the violent nature of them. I am unsure whether the agency addresses the psychological trauma that may result from these attacks by clients. Most of these assaults occur in our residential programs; it seems as if the direct care workers should be receiving combat pay.

This study has several limitations. The 40 agencies that participated in our study were self-selected; the effects of bias limit the generalizability of the results. For example, more than half of the agencies that responded to our survey served older adults, employed fewer staff, and experienced comparatively

fewer incidents of physical assault; given this, our description might underestimate the incidence of physical assault. However, the responding agencies did represent a range of services, populations, sectors, and size and varied between those with few or no incidents and those with many and between those who used restraints and those who did not. Because of the need to protect the anonymity of the participating agencies, we are unable to characterize aspects of the services, catchment area, and organizational setting. For instance, it would be helpful to know what region of the state was served by each agency, because risk of workplace violence in social services has been shown to differ among geographical regions (Green, Gregory, & Mason, 2003). For the purpose of our statistical analysis, we assumed that each incident of reported workplace violence occurred to a different individual, which could have led to an overestimate of incidence rates. Because our sample population of agencies included a vast range of sizes and services offered, it reflects complex differences in working conditions related to workplace violence risk that we are unable to consider given our study design. Although a strength of our study is that it gathers agency-level data that explore the environments where workplace violence might occur and individual-level data on reported incidents, because of anonymity requirements for study participation, our sample lacks the capacity to typify workplaces or sufficiently describe individual characteristics. Because we did not gather rich data on each incident, we were not able to analyze incidents of physical assault or verbal threat to inform prevention efforts. Future research should capture agency, individual, and incident data that can fully characterize workplace violence hazards to individuals in the environmental context. Doing this will require a commitment of agencies to promote safe working conditions above concerns over negative publicity and trust among the workforce that they can disclose honestly without fear of negative repercussions.

Given the number of incidents of workplace violence that our study identified and the profound implications of these types of incidents, we were left wondering why this topic has been so seldom studied. Within social work research, failure to examine workplace violence may reflect a larger phenomenon of social work's failure to study itself. Some suggest that the "client-centered" approach that is the hallmark of the social work mission hinders examination of the workplace by practitioners, academics, and researchers (Abramovitz, 2005; Barth, 2003; Kosny & Eakin, 2010). Social service workers perceive that measures to improve workplace safety might reduce their ability to work in solidarity with clients, and violence is often accepted as "part of the job."

From the perspective of public health, the somewhat insular nature of social work as a discipline has limited social work's participation in occupational health research. Social service workplaces are covered under the general duty clause of the Occupational Safety and Health Act of 1970, and in 2004 the U.S. Department of Labor Occupational Safety and Health Administration (OSHA) issued guidelines for violence prevention in health care and social services . However, with notable exceptions (Lowe & Korr, 2008; McPhaul et al., 2008; Sarkisian & Portwood, 2003), studies of workplace violence in social service settings have not been placed within the framework of wider efforts to protect workplace health and safety. At the same time, government agencies such as OSHA and the National Institute of Occupational Safety and Health (the agency under the Centers for Disease Control and Prevention [CDC] that is charged with generating knowledge about workplace safety and disease risks and methods to prevent them) typically combine social services and health care into a single category (CDC, 2012). Within this framework, the study of workplace violence in health care settings dwarfs attention to social service settings, and research on the social service workforce is often limited to their presence in health care institutions. The higher rates of unionization among nurses compared with social workers may, in part, be responsible for more nurse-led studies of workplace health and safety (Barth, 2003; McPhaul & Lipscomb, 2004).

Restructuring and retrenchment in social services, in response to the political "attack on the welfare state" and the recent economic crisis, also play a role in neglect of working conditions in social services. As services are cut, needs increase. Paradoxically, working conditions suffer, but attention to improving them is superseded by more basic job security concerns. These concerns have intensified since the 2008 economic crisis. Cuts in the federal and state budgets have fallen disproportionately on social services, and this has led to growing caseloads, shrinking workforces, and negative impacts on conditions of work and service quality (Johnson et al., 2011; Social Work Policy Institute, 2010).

Our study suggests several directions for future research: We need to understand how risk is distributed among the workforce and what agency characteristics best promote workplace safety. We were impressed that the agencies who participated in our study were willing to take the time to fill out the survey and to make public their data about workplace violence (albeit anonymously), even though they were not obliged to do so. It is critically important that researchers, agencies, and regulatory bodies develop ways to work together that focus on understanding hazards and developing prevention practices. Given the current environment of cuts to social service programs and the increased needs among many who use such programs, it is an important time to reignite a research agenda for workplace safety in social services. It is critically important that the social service sector provide decent working conditions as part of attracting and retaining staff and delivering quality services to those who need them. **HSW**

REFERENCES

Abramovitz, M. (2005). The largely untold story of welfare reform and the human services. *Social Work, 50*, 175–186.

American Federation of State, County and Municipal Employees. (1999). *Double jeopardy: Caseworkers at risk helping at-risk kids*. Retrieved from http://www.afscme.org/publications/1331.cfm

Azaroff, L. S., Levenstein, C., & Wegman, D. H. (2002). Occupational injury and illness surveillance: Conceptual filters explain underreporting. *American Journal of Public Health, 92*, 1421–1429.

Baines, D. (2004). Pro-market, non-market: The dual nature of organizational change in social services delivery. *Critical Social Policy, 24*, 5–29.

Baines, D. (2005). Criminalizing the care work zone? The gendered dynamics of using legal and administrative strategies to confront workplace violence. *Social Justice, 32*, 132–150.

Barth, M. C. (2003). Social work labor market: A first look. *Social Work, 48*, 9–19.

Bell, C. C., Mock, L., & Slutkin, G. (2002). The prevalence of victimization and perceptions of job neighborhood safety in a social service agency and the need for screening. *Journal of the National Medical Association, 94*, 602–608.

Bureau of Labor Statistics. (2010). *Nonfatal occupational injuries and illnesses requiring days away from work, 2010*. Retrieved from http://www.bls.gov/news.release/osh2.t01.htm

Caldwell, B., & LeBel, J. (2010). *Reducing restraint and seclusion: How to implement organizational change*. Retrieved from http://www.cwla.org/voice/MA10restraint.html

Centers for Disease Control and Prevention. (2012). *The National Occupational Research Agenda; NORA Healthcare and Social Assistance Sector Council*. Retrieved from http://www.cdc.gov/niosh/nora/councils/hcsa

Flannery, R. B., Fisher, W. H., & Walker, A. P. (2000). Characteristics of patient and staff victims of assaults in community residences by previously non-violent psychiatric inpatients. *Psychiatric Quarterly, 71*, 195–203.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine de Gruyter.

Green, R., Gregory, R., & Mason, R. (2003). It's no picnic: Personal and family safety for rural social workers. *Australian Social Work, 56*, 94–106.

Guterman, N. B., Jayaratne, S., & Bargal, D. (1996). Workplace violence and victimization experienced by social workers: A cross-national study of Americans and Israelis. In G. VandenBos & E. Bulatao (Eds.), *Violence on the job: Identifying risks and developing solutions* (pp. 175–188). Washington, DC: American Psychological Association.

Haimowitz, S., Urff, J., & Huckshorn, K. A. (2006). *Restraint and seclusion—A risk management guide*. Retrieved from http://www.nasmhpd.org/docs/publications/docs/2006/R-S%20RISK%20MGMT%2010-10-06.pdf

Hawkins, S., Allen, D., & Jenkins, R. (2005). The use of physical interventions with people with intellectual disabilities and challenging behaviour—The experiences of service users and staff members. *Journal of Applied Research in Intellectual Disabilities, 18*, 19–34.

Hoobler, J. M., & Swanberg, J. (2006). The enemy is not us: Unexpected workplace trends. *Public Personnel Management, 35*, 229–246.

Hudson, C. (2007). *Social work salary study. Social work in Massachusetts: A survey of employment, compensation & working conditions*. Available from the author at the National Association of Social Workers Massachusetts Chapter.

IBM Corp. (2010). IBM SPSS for Windows (Version 19) [Computer software]. Armonk, NY: Author.

Jayaratne, S., Croxton, T., & Mattison, D. (2004). A national survey of violence in the practice of social work. *Families in Society, 85*, 445–453.

Johnson, N., Oliff, P., & Williams, E. (2011). *An update on state budget cuts: At least 46 states have imposed cuts that hurt vulnerable residents and cause job loss*. Retrieved from http://www.cbpp.org/files/3-13-08sfp.pdf

Koritsas, S., Coles, J., & Boyle, M. (2010). Workplace violence towards social workers: The Australian experience. *British Journal of Social Work, 40*, 257–271.

Kosny, A. A., & Eakin, J. M. (2010). The hazards of helping: Work, mission and risk in non-profit social service organizations. *Health, Risk & Society, 10*, 149–166.

Krieger, N. (2010). Workers are people too: Societal aspects of occupational health disparities—An ecosocial perspective. *American Journal of Industrial Medicine, 53*, 104–115.

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Lion, J. R., Snyder, W., & Merrill, L. G. (1981). Underreporting of assaults in a state hospital. *Hospital and Community Psychiatry, 32*, 497–498.

Lowe, T. B., & Korr, W. S. (2008). Workplace safety policies in mental health settings. *Journal of Workplace Behavioral Health, 22*(4), 29–47.

Massachusetts Coalition for Occupational Safety and Health. (2011). *Safety protections for public employees*. Retrieved from http://www.masscosh.org/node/21

McDonald, G., & Sirotich, F. (2001). Reporting client violence. *Social Work, 46*, 107–114.

McDonald, G., & Sirotich, F. (2005). Violence in the social work workplace: The Canadian experience. *International Social Work, 48*, 772–781.

McPhaul, K. M., & Lipscomb, J. A. (2004). Workplace violence in health care: Recognized but not regulated. *Online Journal of Issues in Nursing, 9*(3), 7.

McPhaul, K. M., London, M., Murrett, K., Flannery, K., Rosen, J., & Lipscomb, J. (2008). Environmental evaluation for workplace violence in healthcare and social services. *Journal of Safety Research, 39*, 237–250.
National Association of Social Workers. (2008). *Fact sheet: Social work profession*. Retrieved from http://www.socialworkers.org/pressroom/features/general/profession.asp
Newhill, C. (1996). Prevalence and risk factors for client violence towards social workers. *Families in Society, 77*, 488–495.
Newhill, C. (2003). *Client violence in social work practice: Prevention, intervention and research*. New York: Guilford Press.
Nobel, S. (2007). Social services, Part XVII: Services and trade. Chapter 97: Health care facilities and services. In A. Yassi (Ed.), *Encyclopedia of occupational health*. Geneva: International Labor Organization. Retrieved from http://www.ilo.org/oshenc/part-xvii/health-care-facilities-and-services/item/435-social-services
Occupational Safety and Health Act of 1970, P.L. 91-596, 84 Stat. 1590 (1970).
Pollack, D. (2010). Social work and violent clients: An international perspective. *International Social Work, 53*, 277–282.
Respass, G., & Payne, B. (2008). Social services workers and workplace violence. *Journal of Aggression, Maltreatment & Trauma, 16*, 131–143.
Rey, L. D. (1996). What social workers need to know about client violence. *Families in Society, 77*, 33–39.
Ringstad, R. (2005). Conflict in the workplace: Social workers as victims and perpetrators. *Social Work, 50*, 305–313.
Ringstad, R. (2009). CPS: Client violence and client victims. *Child Welfare, 88*, 127–144.
Sarkisian, G., & Portwood, S. (2003). Client violence against social workers: From increased worker responsibility and administrative mishmash to effective prevention policy. *Administration in Social Work, 27*(4), 41–59.
Shields, G., & Kiser, J. (2003). Violence and aggression directed toward human service workers: An exploratory study. *Families in Society, 84*, 13–20.
Social Work Policy Institute. (2010). *High caseloads: How do they impact delivery of health and human services?* Retrieved from http:www.socialworkpolicy.org/2010/04
Spencer, P. C., & Munch, S. (2003). Client violence toward social workers: The role of management in community mental health programs. *Social Work, 48*, 532–544.
U.S. Department of Labor Occupational Safety and Health Administration. (2004). *Guidelines for preventing workplace violence for health care and social service workers* (OSHA Publication No. 3148-01R). Washington, DC: U.S. Government Printing Office.
Vaughn, S., Schumm, J. S., & Sinagub, J. (1996). *Focus group interviews in education and psychology*. Newbury Park, CA: Sage Publications.
Winstanley, S., & Hales, L. (2008). Prevalence of aggression towards residential social workers: Do qualifications and experience make a difference? *Child Youth Care Forum, 37*, 103–110.

Jennifer R. Zelnick, ScD, MSW, *is associate professor, Touro College Graduate School of Social Work, New York.* ***Elspeth Slayter, PhD,*** *is associate professor, School of Social Work, Salem State University, Salem, MA.* ***Beth Flanzbaum, MSW, LICSW,*** *is assistant director of family centers, Y.O.U. Inc., Worcester, MA.* ***Nanci Ginty Butler, MSW, LICSW,*** *is program coordinator, School and Community-based Services, Riverside Community Care, Needham, MA.* ***Beryl Domingo, MSW, LICSW,*** *is director of field support, Massachusetts Department of Children and Families, Boston.* ***Judith Perlstein, MSW,*** *is associate director of field education, School of Social Work, Boston University.* ***Carol Trust, MSW, LICSW,*** *is executive director, NASW Massachusetts Chapter, Boston. Address correspondence to Jennifer R. Zelnick, Touro College Graduate School of Social Work, 43 W. 23rd Street, New York, NY 10010; e- mail: jennifer.zelnick@touro.edu.*

Original manuscript received March 27, 2012
Final revision received June 19, 2012
Accepted July 9, 2012
Advance Access Publication May 8, 2013

PRACTICE FORUM

Have you worked with a practice innovation readers should know about? The Practice Forum editor can help you develop your insights into an article for this column. Describe your innovation in eight double-spaced pages or fewer and send as a Word document through the online portal at http://hsw.msubmit.net (initial, one-time registration is required).

READERS: WRITE TO US!

Submit your reactions to and comments about an article published in *Health & Social Work* or a contemporary issue in the field. Send your letter (three double-spaced pages or fewer) as a Word document through the online portal at http://hsw.msubmit.net (initial, one-time registration is required).