

Étude exploratoire sur les mesures de sécurité obligatoires imposées aux gestionnaires de cas qui font des visites à domicile

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Cette étude qualitative avait pour but d'évaluer les perceptions des gestionnaires de cas à l'égard de la mise en œuvre et de l'efficacité de mesures de sécurité obligatoires destinées à ceux et celles qui font des visites à domicile. Les chercheurs se sont appuyés sur un cadre de recherche-action pour mener cinq groupes de discussion formés de gestionnaires de cas employés au sein d'un programme de services en santé mentale d'un État américain — ces gestionnaires intervenant auprès de personnes souffrant de maladie mentale grave et persistante. Les mesures de sécurité adoptées à la suite de l'homicide d'un gestionnaire de cas en visite sont jugées efficaces par certaines agences, mais pas par d'autres. La rigueur avec laquelle on met en œuvre ces différentes mesures, dont les protocoles de sécurité, méthodes de reddition des comptes, visites accompagnées dans les situations à risque élevé et programmes de formation, varie d'un établissement à l'autre. Par ailleurs, certains facteurs contextuels pourraient influencer sur la perception quant à la sécurité. Imposer des mesures de sécurité à tous les prestataires de soins à domicile est une solution envisageable, mais il faudra entreprendre d'autres recherches pour analyser les risques et les facteurs en jeu.

Mots clés : visites à domicile, gestionnaires de cas, personnes souffrant de maladie mentale

An Exploratory Study of Mandated Safety Measures for Home Visiting Case Managers

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The purpose of this qualitative focus group study was to assess staff perceptions of the implementation and effectiveness of safety measures mandated for home visiting case managers. A participatory action research framework was used to conduct 5 focus groups of case managers employed by a state mental health system in the United States. The participants were employed by a program to provide case management for the severely and persistently mentally ill in the community. Safety measures instituted after the homicide of a visiting case manager were found to be effective in some agencies but not in others. There was variability between agencies in the strictness with which safety protocols, accountability procedures, accompanied visits for high-risk situations, and training were implemented. Contextual factors influenced perceptions of safety. Mandatory safety measures for home visiting health workers may be feasible but further research is necessary to explore risks and contextual factors.

Keywords: Workplace violence, home visiting, community health nursing, case management, mentally ill persons

Background

Visiting human service workers are at risk for injury and death while in clients' homes (Barling, Rogers, & Kelloway, 2001; Bussing & Hoge, 2004; Department of Labor Statistics, 1997; Fazzone, Barloon, McConnell, & Chitty, 2000; Fitzwater & Gates, 2000; Schulte, Nolt, Williams, Spinks, & Hellsten, 1998). The home visiting workplace presents many of the same care-related risks as institutional settings, such as clients with a history of violence or with cognitive impairments, clients with mentally ill illness and a co-occurring substance abuse disorder, working alone, and exposure to weapons (Fazzone et al.; Fitzwater & Gates; Murphy, 2004; Powell & Lloyd, 2001). Home visiting workers are also exposed to risk factors associated with violent outcomes among workers in other occupations such as taxi drivers and late-night retail workers. These factors include working alone in the community, travel into crime-ridden areas, and working late at night (Fitzwater & Gates; Kendra & George, 2001;

Kendra, Weiker, Simon, Grant, & Shullick, 1996; Schulte et al.; US Department of Labor & Occupational Safety and Health Administration, 1996).

There has been no rigorous research on the risks of violence towards home visiting human service workers. However, case reports of homicide and the results of limited studies specific to home visiting suggest broad patterns of risk compatible with the literature on workplace homicide and violence (Kendra, 1996; Schulte, 1998). Even though home visiting human service workers are not identified in the literature as high risk for homicide, they exhibit several risk factors for homicide, namely travel into high-crime areas, working at night, exposure to firearms, and working alone (National Institute for Occupational Safety and Health, 1996a, 1996b). Homicides of home visiting human service workers have been reported in a number of US states, including Texas, Maryland, Michigan, Kansas, New York, and Washington (Gillespie, 2001; Killing in Texas, 2006; Ly, 2002; Martin, 2005; Newhill, 2003; Public Employee Safety and Health, 1999; Sedensky, 2004). In response, at least three states have introduced legislation to strengthen and/or require specific safety measures for these at-risk workers (Lipscomb, Silverstein, Slavin, Cody, & Jenkins, 2002). According to the Canadian Centre for Occupational Safety and Health (2007), several Canadian provinces have also adopted specific regulations or guidelines concerning workplace violence. In the United States, however, regulatory agency investigations and citations for workplace violence are rare, in spite of mounting evidence of violence as an occupational hazard in such industry sectors as health care, law enforcement, transportation, retail sales, and education (Bureau of Labor Statistics, 2001, 2002; Duhart, 2001; Jenkins, 1996a, 1996b; McCall & Horwitz, 2004; Moracco et al., 2000; Toscano, 1996; Toscano & Weber, 1995). An investigation *was* carried out in 1998 following the murder of a community mental health nurse in a northeastern state. In this case, the employer was cited by the state's occupational safety agency for failure to provide a "safe and healthy workplace." The citation required the employer (a state mental health agency) to institute five safety measures as remediation for all visiting mental health workers employed throughout the state:

- regular training in the handling of potentially assaultive patients
- a system to account for the whereabouts of all employees assigned to the field
- formal safety protocols to be followed by visiting mental health case managers, and adequately communicated to all employees
- accompanied visiting when the patient's history indicates assaultive behaviour

- a means to summon assistance when necessary (Public Employee Safety and Health, 1999)

This qualitative study was designed to assess whether the mandated safety measures implemented in the wake of the homicide improve the safety of home visiting case managers (HVCMs). In lieu of specific instruments to assess home visiting risk, a qualitative approach was taken in anticipation of developing measures for use in a future mixed-method study of this population of workers. This article reports the findings of a focus group study to assess the implementation and effectiveness of mandated safety measures for HVCMs several years after their implementation.

Conceptual Framework

A participatory action research (PAR) framework was employed in the design and conduct of the study (Keith et al., 2001; Leung, Yen, & Minkler, 2004; Schurman, 1996). In the aftermath of the visiting nurse's murder, her labour union played a pivotal role in crafting safety measures. The PAR framework allowed for the workers and their union to be equal partners and for the investigators to be "co-learners" in gathering information on the effectiveness of the safety measures. University-based occupational health researchers collaborated with the health and safety department of the union that had represented the murdered nurse. The union identified the primary research question: *Are the required safety measures in place and working?* The union also advocated for the use of focus groups as the data-collection method, in order to engage frontline staff in this safety issue. Focus groups are an accepted method for PAR (Morgan, 2006) and have been used in other exploratory occupational health studies (Goldenhar et al., 1999; Keith et al.). The university-based investigator secured funding for the project and collaborated with the union to develop a plan for recruiting visiting mental health case managers for the study.

Methods

Sample and Recruitment

The union represented approximately 250 visiting mental health case managers throughout 12 geographic regions of a northeastern state. In 2003, five focus groups, representing urban, rural, and suburban settings, were conducted in 4 of the 12 regions. The union's health and safety staff publicized the project in their newsletter (circulation: 55,000). They described the purpose of the focus groups, listed dates and locations, and encouraged visiting case mental health case managers to register to participate. One month prior to each scheduled focus group session, a

memo was mailed to every visiting case manager listed in the union's database who lived in the targeted region. Additional efforts to reach out to case managers were made through the union's network of local union leaders (council leaders and stewards). Focus group participants were not compensated but were provided with food and reimbursed for travel expenses.

The focus groups were conducted either in a regional union office (3 groups), in a hotel conference room (1 group), or at the worksite (1 group, with the consent of management). All groups with the exception of the worksite group were conducted in the evening after work. The worksite group was conducted at midday. Each focus group was conducted by a trained moderator (the PI) and a trained co-moderator. Three of the five groups were also attended by a representative from the union's health and safety department. The focus groups consisted of between 4 and 12 persons currently working as visiting mental health case managers for the state mental health system. The sessions lasted approximately 2 hours. A total of 42 visiting mental health workers participated in the focus groups. Urban and suburban work settings were represented, with half of the participants making visits in both urban and suburban settings.

Focus Group Questions

The focus group questioning route was as follows: (1) Is a system in place and working to ensure accounting of employees? (2) Are there established safety and communication protocols? (3) Are accompanied visits available upon need? (4) Is adequate training provided to deal with potentially violent patients? (5) Are intensive case managers provided with a cell phone or some other means to summon assistance? The sessions were audiotaped and the tapes were transcribed by a professional medical transcription service.

Analysis

The transcriptions were analyzed and coded using Atlas.Ti, a qualitative data analysis program. The PI and two of her co-authors coded transcripts by searching for keywords reflecting any one of the five safety measures (visiting in pairs, cell phone, accountability system, etc.). Each of the five measures was analyzed and discussed in depth in order to elucidate every aspect of the staff's perceptions. Additionally, themes emerged that were not directly related to the safety measures but were, in the opinion of the case managers, significant risk factors for violence. These themes are discussed below. The study was approved by the university's human subjects committee and written informed consent was obtained from each participant.

Findings

The availability and effectiveness of each of the five safety measures are described. Contextual themes regarding the safety of HVCMs are also described.

Formal Safety Protocols

Most of the focus group participants were unable to describe formal safety protocols. In the focus group for the HVCM unit that had experienced the tragic murder, however, the case managers were able to consistently describe specific policies governing accompanied visits, weapons in the home, household and family members under the influence of alcohol or drugs, and use of police escorts:

If we were to send you our policy, you'd see that...calling in twice a day identifying that you are safe, and knowing [that] if you don't call in somebody is going to page you or call you to determine that you are safe — those things are in place and are working.

Case managers from other locations thought that formal safety policies existed, especially for accompanied visits when a staff person felt uneasy or when the client had a history of violence, but they were unable to provide much detail about these policies:

My understanding is, if you're not comfortable, don't [go]...take somebody with you...you have a right to ask.

Some described policies governing accountability or check-in systems:

There's a strict policy that actually the County developed as the result of...it's a policy... I'm not saying that we originated it, but if you're out in the community for more than 3 hours, you check in so that people know that you're safe.

Case managers generally agreed that safety protocols were in place but believed that contextual issues at the societal and agency levels undermined their effectiveness. These contextual issues are described in the following sections.

Accountability System

Each community case management program is required to have an accountability system in place for visiting field staff. A member of the office staff is supposed to know the location and itinerary of case managers at all times. The visiting case managers, for their part, are supposed to communicate their itineraries in advance, provide current contact information, and periodically check in to the office, especially if

their itinerary changes. Staff itineraries change frequently throughout the day due to emergencies and the changing needs of clients. Case managers reported that some offices did not have adequate staff to effectively monitor field workers and their constantly changing itineraries. Furthermore, some offices would call the field worker if a check-in call had been missed. Some visiting case managers disliked being interrupted by a call from the office when they had failed to check in. Variations among programs emerged:

I don't know how well it's adhered to... I know the main phone at [our program], you call for hours there and won't be able to get through...it's an automated system and it'll just ring and ring and ring.

You're supposed to call in...and schedules...things happen...the minute you walk out the door you're getting calls from the police, the hospitals, this client, that client, and, you know, you're always reassessing who you're going to see, what the priority is...and you can't always convey back to other people...

The comments of participants from units with efficient accountability systems contrasted with those of participants who reported problems that revealed inconsistencies in the structure, implementation, and effectiveness of this abatement measure. Some units appeared to have an effective accountability system, some to have no functional accountability system at all, and others to have a system characterized by apathy and anger. For some visiting case managers, the accountability system was a hot-button issue, while for others it was an accepted part of their work life:

We have a system...where we all have to call in every day between 2:00 and 2:30...and the secretary, she takes the message or she takes your call and she checks off who has called in... That's one accountability system... We also have a schedule that we read before we go out every day...in terms of the client, the location, telephone number, what car we are driving...daily...

When case managers viewed the accountability system as ineffective or as unnecessary for their own safety, they were less likely to adhere to policies:

But the actual execution is problematic either for organizational reasons or, in some cases, because the individual[s] themselves don't view it as helping with their safety.

Training

Case managers had almost nothing positive to say about their training experiences. When they were asked if safety training was required, they gave conflicting responses:

They cancelled it due to lack of interest.

We do have a mandatory training every year.

I know we don't have it every year...that's not mandated.

The larger issue appeared to be that it is difficult to engage experienced case managers in meaningful training. Some case managers recalled a training series at a local college with well-intended instructors and ample opportunity for discussion:

It had a very good value...just the opportunity to ventilate and to brainstorm among us.

According to the participants, this series of training sessions, which covered more than just safety, was suspended.

The involvement of local law enforcement bodies in safety training received mixed reviews:

There's a local police officer that comes here and tells us to lock our car and keep our purse in the trunk...that's not cutting it.

We had brought in the police department, and that was effective...and parole people who literally did what we did but in a different system.

Many case managers who had worked for the state mental health system reported having received the same training as the inpatient mental health staff. They found many of the same principles to be applicable, though not the “takedown” and seclusion and restraint procedures, which they could not and did not use in the community.

Table 1 *Frequently Cited Conditions Impacting on Safety of Staff*

<p>Ability to choose accompanied visiting</p> <p>Quality of violence-prevention training</p> <p>Effectiveness of accountability system</p> <p>Assisted Outpatient Treatment Program requirement (involuntary treatment)</p> <p>Community environment</p> <p>Safety and communication procedures</p> <p>Role of representative payee</p> <p>Ability to summon help</p> <p>Erosion of resources for mental health care</p>
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Some case managers reported viewing training videos that were almost entirely without merit — dated, redundant, and even offensive:

Yeah, but those are tapes...that's inpatient.

It's tapes from 1960 that they have you sit and watch.

Same training for the past 5 years.

Some HVCMs thought that they should be involved in the training design, or at least in the needs assessment:

They develop this training without any kind of involvement from the case managers themselves.

One HVCM felt that case managers could give the safety training themselves:

It's the same training and, honest to God, it's generic and we could teach safety training.

A Means to Summon Assistance

Cell phones are now universally issued or available to case managers who are state employees and union members. All participating case managers reported having a cell phone for their professional use: "Everybody has cell phones *now*." Staff in one program reported having to give up beepers now that cell phones are available. Other staff reported that cell phone service was inconsistent in rural areas. In New York State it is illegal to make or receive a call on a cell phone while driving. In general, a means to summon assistance from the field appeared to be widely available to case managers. Although one HVCM said, "Technology is probably not going to save us," a communications device of some kind was considered essential.

Cell phones allow HVCMs to report their whereabouts and alert the office to any changes in their schedules. Most HVCMs agreed that cell phones enhanced their therapeutic role by facilitating communication with providers, social services, police, and others. Cell phones appear to be a permanent addition to the safety armamentarium for case managers, but this safety measure must be viewed in the context of overall risk and hazard. A cell phone is a communications device, not an assault deterrent or a substitute for the presence of another person in the event of an assault.

Accompanied Visiting

The requirement that HVCMs visit high-risk clients in pairs is perhaps the most challenging of the abatement measures. This safety measure

forces case management programs to define a high-risk visit (usually, a first visit or a visit to a client with a history of violent behaviour) and to stretch already tight staff resources to accommodate pairing. Staff were often conflicted about whether and when to request accompaniment. HVCMs are aware of the risks but are also experienced mental health providers who develop a therapeutic bond with their clients. They do not want to jeopardize this therapeutic relationship by bringing in a stranger, nor do they want to be injured by a client or to be the victim of violence in a crime-ridden community. They are further conflicted by the knowledge that other HVCMs have a full caseload with no time to visit someone else's clients:

I'm quite sure the supervisor would have accompanied me... I know that, but I also know that for her to come with me it's an hour out, it's an hour there, and it's an hour back, and then if she has a meeting and she can't come when I come, that's a hassle, you know.

Some staff did not believe that accompanied visits were any safer:

Two is not safer.

I don't always think going with someone else is necessarily any safer.

Two targets instead of one.

Most, however, felt that it had a “deterrent” and “assistive” effect — “you can pull the other individual [out].”

The accompanied visit policy, though known and understood, is not always easy to implement:

It's kind of easier to go there even though you know maybe you shouldn't, so that piece of the safety policy is difficult, and...really, I wrestled with this since [the murdered nurse] died, on how to cover that, and there is no way to cover it other than [my colleague] and I, we try to...we have between us, you know, 27 people, 26, 27 people between us. If we did double visits we'd need 80 hours a week to get all our work done and we only have 40 hours a week to get it done, so you have to make a decision at some point. But geographically it's easier in the city and in the surrounding suburbs to get a second person to go with you, much easier than [for] somebody to drive 35 miles for a 20-minute visit. That's a difficult thing.

Accompaniment is more difficult to arrange for rural visits, yet isolation from neighbours is common and in some areas cell phone service is not available. One HVCM described the efforts of a new colleague to visit a client in an isolated area. The client was considered

high risk due to substance abuse problems. He lived without electricity, telephone service, or running water:

He lives in a little hut that has no running water and no electricity...this was where he was put...he was a known drug user, and the case manager was instructed by the supervisor to go out and visit this client by herself... The first time she went to visit the client she took somebody with her. The second time she arranged to take somebody with her and then the HVCM coordinator pulled her aside and said, "You've got to learn to do this on your own," leaving her to go out to...visit this client in the middle of nowhere.

Staff who had experienced a threatening situation appeared to be more confident when visiting in pairs:

After the knife incident, where I found the guy with the knife, I didn't make single visits any more.

Contextual Factors

Reduced resources for mental health care. Case managers described and emphatically lamented the erosion of resources for intensive case management programs. The original mission of the program was to provide multiple supports, coordinated by the case manager, to enable the high-risk mentally ill to thrive in the community. Staff were saddened and demoralized by the inadequacy of the program. Case managers saw the deterioration in services as contributing to the risk of violence against staff. In their view, when the high-risk mentally ill have unmet needs in the areas of housing, social support, employment, safety, medication, and treatment, they are more likely to become aggressive towards case managers or others. The case managers across the state consistently described feeling like a "last resort" or "safety net" for a society that does not want to deal with the high-risk mentally ill while at the same time wishing to be protected from the dangers they represent.

Involuntary treatment issues. Related to this theme was another contextual finding specific to a state law providing for mandated treatment of the mentally ill who present a security risk to the community. The law was intended to reduce the risk to society when high-risk mentally ill persons become dangerous because they refuse treatment. The HCVMs reported that these "mandated" clients became their responsibility, and most felt that they represented a higher risk for violence because the mandatory nature of the provider-client relationship is a barrier to the establishment of trust and to an optimal therapeutic relationship. The HCVMs felt that an optimal therapeutic relationship is protective (i.e., reduces the risk of violence towards the case

manager) but that “mandated” relationships are less likely to achieve the level of trust necessary for the therapeutic relationship to thrive. A minority of the HVCMS, however, approved of one feature of the new law: the ability to call in the sheriff when a client fails to comply with treatment. They felt that, in general, it is better to force non-compliant patients to take their medications than to watch them decompensate and become violent.

Conflict of interest. In addition to the risks of dealing with mandated clients, HVCMS reported that, in the absence of a suitable relative, the case manager is often appointed “representative payee” for a client (managing the client’s finances). Many case managers said that this responsibility creates the potential for tension and conflict over money and increases the risk of violence towards the provider. Sometimes the risk of violence comes from individuals in the community who prey on the mentally ill and attempt to siphon their resources. This recurring theme bears further exploration by the mental health system. The case managers were practically unanimous in their view that representative payee and therapeutic case manager are conflicting roles that increase the risk of violence towards home visiting staff.

Discussion

Home visiting human service workers and their employers use a variety of safety strategies, none of which are supported specifically by clear evidence. We evaluated staff perceptions of the effectiveness of required safety measures in one state case management program. The results add to our understanding of the factors associated with the effectiveness of occupational safety measures for home visiting mental health programs.

The study found that the five required safety measures are generally in place across the state but are inconsistently implemented. Notably, the participants from the unit where the murdered nurse had been employed did report strict compliance with all safety measures. This finding indicates the feasibility of the measures. The reason for variable implementation of the safety protocols in other agencies is not clear; it could be a training deficit, a communications breakdown, or inadequate management commitment to safety issues.

HVCMS across the state were satisfied that they had a means to summon assistance. Most participants reported having a cell phone and many said they had a beeper provided by the employer. Some rural areas do not have cell phone service. A review of possible technological solutions in such areas is beyond the scope of this article; however, in the absence of standard cell phone service, other technologies such as radios or satellite phones may be available.

Most staff reported some type of telephone check-in system and most said it was their practice to leave a written itinerary in their field office. Many HVCMS, however, were dissatisfied with the accountability procedures in place in their home office/unit. These procedures were often described as ineffective and many staff members were suspicious of the accountability system. The reasons for the variability in accountability systems throughout the system are not clear.

Most participants indicated that they felt they could request that a colleague or supervisor accompany them on home visits, although some case managers seemed to believe that doing so frequently was discouraged. In one unit it was the policy for a supervisor to accompany the case manager on all new client visits and for 1 month thereafter, as well as any time the case manager believed there was a risk. It appears that the other jurisdictions allow HVCMS to visit in pairs when there is a specific high-risk situation but do not provide the resources for frequent accompanied visits, nor, apparently, do they have an explicit definition for "high-risk visit."

One focus group included staff of a pilot project, Assertive Community Treatment (ACT), which reportedly *requires* home visiting in pairs or teams. According to the staff, the ACT model is newer than the intensive case management model and is being piloted in one county mental health department but is not widely used throughout the state. The mandatory nature of the visiting-in-teams requirement is significant because it eliminates possible tension between supervisor and case manager over staff resources. It also eliminates the need for the case manager or the supervisor to weigh staff resources against safety. This finding suggests that visiting in pairs is feasible, but details about the program and its resources are not available. Since only one of the focus groups included ACT staff members, this finding did not reach saturation. Models of care that provide community or home visitation by pairs or teams of providers should be explored from the standpoint of patient and staff safety outcomes.

Finally, violence-prevention training is an essential element of a comprehensive violence-prevention program (US Department of Labor & Occupational Safety and Health Administration, 1996). However, training must be considered in the context of "extra-training" factors (Cohen & Colligan, 1998), which include organizational attributes (such as adequate staffing) and quality parameters (such as trainer competency and a comfortable setting). It is useless to train staff for circumstances that require visiting in pairs without providing sufficient staff for visiting in pairs. Similarly, if staff are trained to check in at a set time during the day, this behaviour must be monitored or the training will not be optimally effective. A training method that insults the learner's intelligence not only

will be ineffective but will lower morale and foster resentment. Furthermore, training should be geared to the experience and skill level of the group. The training needs and requirements of seasoned mental health professionals are different from those of newly assigned HVCM staff. The murdered nurse was a veteran employee, which suggests that training for more experienced staff may need to address different issues, such as complacency or boundaries, and review data and risk factors. Furthermore, seasoned providers will simply dismiss irrelevant or meaningless training.

Strengths and Limitations

This project was a collaborative effort between the participants (HVCMs), their union, and the research team. The PAR framework is the most acceptable and appropriate means of studying an issue associated with severe trauma. The focus groups were well attended even though most were conducted after working hours and none of the participants was compensated beyond expenses. Contextual themes reached saturation and were raised repeatedly in each group. Other concerns were locally based or agency-based and reflected the broad theme of inconsistent application of safety measures. Furthermore, the project offered a unique opportunity to evaluate staff perception of mandated safety measures (which, to our knowledge, do not exist elsewhere).

The limitations of the project include the fact that it was carried out in only one state, thus possibly affecting the applicability of the findings to other states or other types of home visiting program. Also, information on the demographics, work experience, and assault/injury experience of the participants was not collected. Furthermore, the participants were self-selected, thereby increasing the likelihood of bias. Finally, the participants were all unionized HVCMs, restricting the applicability of the findings to non-union workplaces. The study might have been strengthened by the addition of a state-wide survey assessing the impact of the safety measures on the incidence of injury and violent assault since the introduction of the new measures.

Implications for Practice, Policy, and Research

The implications of the findings include the need to direct attention to the feasibility, effectiveness, and sustainability of five specific safety measures for visiting health and human service workers. To our knowledge, even in the few North American jurisdictions that have safety regulations regarding workplace violence and/or visiting human service and health-care workers, no evaluation of these measures has taken place. The findings of this study have direct implications for home visiting nurses and

other human service practitioners. First, safety of the community/home visiting workforce must be recognized as an essential element of operations. Workforce safety must be integrated into all aspects of patient care. Systems need to be developed to evaluate new clients for a history of violent behaviour and communicate this information to staff. Detailed protocols for specific high-risk situations must be developed and regularly reviewed with staff. Resources must be allocated to allow for visiting in pairs in high-risk situations. Finally, staff training must be evaluated for appropriateness and effectiveness.

The research implications of the findings include the need for exploration of the various types of home visiting programs, clients, services, and safety strategies, as well as the need for analytic research with respect to risk factors specific to home visiting. Given the paucity of evaluation data, a qualitative approach was considered the most appropriate for this study; however, surveys of current safety practices would also be helpful. Moreover, given the substantial risk even to experienced providers, more research attention should be focused on differentiating the training needs of novice and experienced home visiting staff. Ultimately, intervention effectiveness research must be undertaken to determine the effectiveness and sustainability of safety programs for home visiting health and human service workers.

The focus groups employed in this study have given voice to a workforce that is one of the chief supports for the mentally ill and other vulnerable individuals living in communities rather than institutions. This examination of mandated safety measures has implications for nurses, who, along with members of other professional groups, may be at risk for occupational homicide or “workplace violence” in the course of home visiting.

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