Staff Perceptions of Risk of Assault in Psychiatric Settings

by

Katherine Jackowski
BAppSci (Psych), GDip (Psych)

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Deakin University

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Full Name: Katherine Jackowski

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Abstract

Assault against staff in psychiatric settings is commonplace. The way staff experience and interpret these incidents can have a dramatic impact on perceptions of their risk of future assault and sense of safety in the workplace. These assaultive experiences can instill negative perceptions of the workplace climate and impact on staff wellbeing, as well as the level of care afforded to service consumers and overall treatment outcomes. The added complexity of patients with forensic histories further increases risk of assault and may perpetuate these negative perceptions. The flow-on effect of negative perceptions can be very costly for an organisation due to the financial pressure of high staff turnover, reduced productivity and the amount of sick leave taken, hence the importance of conducting research about current staff perceptions and views on the workplace climate. The overall aim for this dissertation was to examine staff perceptions of risk of assault and the influence of workplace climate in psychiatric settings. Study One was largely exploratory and qualitative, utilising one-on-one interviews to develop an understanding of current staff experiences in psychiatric settings in relation to risk of assault and the workplace climate. The qualitative analyses indicated that the way staff process assaultive incidents and their ability to effectively deal with potentially violent and aggressive consumers is dependent on the type and level of training they have received (whether leading to actual or perceived ability), their experience in the setting, as well as their overall confidence. Study Two explored the themes extracted from Study One in greater detail with a larger sample from the same metropolitan health service. This was done adopting a quantitative research methodology utilising a questionnaire (N = 55). In support of previous research, the results indicated that assaultive experiences increased a staff member’s vigilance and fear that they will be assaulted in the future.
Fear of assault also differed depending on the number of years of experience that staff had working in a particular setting, and the type of setting. Inpatient settings were considered to be more ‘high risk’ than community services and outpatient settings. Utilising the same methodology as Study Two, Study Three explored the implications on staff perceptions when working in a forensic setting (N = 50). The findings were that staff in this setting had a positive perception in relation to their fear of future assault and of the workplace climate. A major unexpected finding was that increased fear did not equate to a more negative workplace perception post-assault. Further, neither years of experience working with psychiatric patients or the type of unit appeared to influence fear or perceptions of risk of assault. In sum, whilst some differences were found, staff held similar perceptions across the two settings and held more positive perceptions than expected. Interestingly, perceptions of the workplace climate were largely unrelated to staff experiences of assault and more to do with interpersonal factors and the supportiveness of the working environment. Participants from both organisations identified that workplace pressure and the demands placed on staff could be improved. A key implication from this research was the importance and emphasis that should be placed on organisational and interpersonal support. This support was seen to influence fear of future assault, particularly post-incident. Staff (particularly those in a forensic setting) should be encouraged to utilise the available organisational and supervisory support, especially post-incident. Further research into the link between staff experiencing assault and reporting increased fear, as well as the proposed function of patient aggression, is indicated.
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Chapter One

Staff Perceptions of Risk of Assault in Psychiatric Settings

Prior research has shown that staff practices are influenced by individual understanding and knowledge (termed ‘perceptions’) of risk in the workplace (Murphy, 2004). Research has also demonstrated that experiencing assault can influence both staff practice and perceptions, as well as feelings of personal safety, risk appraisals, overall job satisfaction and, ultimately, productivity (Gormley, 2011; Howard & Hegarty, 2003; Nijman, Bowers, Oud & Jansen, 2005; Snowden, Gray, Taylor & Fitzgerald, 2009; Weyman & Kelly, 1999). These perceptions, in the context of the continued occurrence of staff assault by consumers of psychiatric services (for example, Jones & Lyneham, 2000), highlight the importance of continued research in the area.

Furthermore, the new Community Correction Orders introduced under the Victorian Sentencing Amendment (Community Correction Reform) Act (2011) place a greater emphasis on the provision of access to treatment services for offenders “with an emphasis on alcohol, drug and mental health treatment” (Victorian Department of Justice, 2012, p. 10) to reduce reoffending. This change in legislative approach is likely to increase the number of consumers presenting to an area mental health service with a forensic history or prior forensic contact, and thus an increase in the number of people who pose a higher level of risk of assault. This has prompted a need for further research into the impact of workplace risk on staff perceptions.

The aim of this chapter is to gain further insight into the impact staff perceptions of risk of assault and the workplace climate have on key stakeholders in psychiatric settings; i.e. individual staff, patients and the organisation. It also
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aims to explore the factors driving or influencing these perceptions. Finally, this chapter aims to better understand the function of and factors contributing to patient aggression, as well as management strategies and current risk assessment practices.

Much of the previous literature has focused on the actual incidence of violence in the workplace and of patients’ propensity for violence, rather than how staff respond to and perceive these incidents of violence and aggression, and how workplace factors and training can either contribute to or reduce the likelihood of its occurrence.

The purpose of conducting research into the area of staff perceptions of risk and the workplace climate is that these perceptions, either positive or negative, can not only have a considerable effect on the staff themselves but also on the patients they are treating and the organisation as a whole (Barrett, Riggar & Flowers, 1997; Gormley, 2011; Harenstam, Palm & Theorell, 1988; Hatch-Maillette & Scalora, 2002; McKinnon & Cross, 2008; Weyman & Kelly, 1999).

A pivotal study in support of the impact of staff perceptions was that of Rogers and Kelloway (1997), who found that fear mediated the consequences of violence. Evaluating a model of the consequences of workplace violence with a large cohort of bank staff, Rogers and Kelloway found that fear of workplace violence contributed to psychological and physical health issues and impacted negatively on organisational outcomes such as intent to leave and staff turnover. Whilst not pertaining to a sample of healthcare staff, this study is important as it highlights the importance of focusing on perceptions and the potential consequences of high levels of fear within the workplace.
Impact on Individual Staff

Physically, a staff member who holds more negative perceptions may suffer from high blood pressure due to stress and undue pressure or anxiety; they may also suffer from fatigue due to being in a constant state of arousal brought about by fear (Hatch-Maillette & Scalora, 2002). They may also have trouble sleeping, suffer from cardiopulmonary problems and/or have an increased susceptibility to illness post witnessing or experiencing a workplace assault (Hatch-Maillette & Scalora).

Emotional costs (often co-existing with the physical effects of negative perceptions) include: the potential onset of depression as a result of workplace unhappiness and dissatisfaction, loss of self-esteem due to a lack of confidence, conflict in personal relationships, feelings of anger or resentment, or an impaired ability to cope with mundane stressors (Hatch-Maillette & Scalora, 2002). The results of a study by Flannery, Fisher, Walker, Kolodziej and Spillane (2000) between 1991 and 1992 indicated that 69.2% of assaulted staff reported acute stress disorder symptoms, and 48.7% had problems with sleep, frequent intrusive recollections of the incident, and had become more hypervigilant. However, it is possible that the staff involved may have been more susceptible to negative emotional responses.

A staff member may also internalise assaults as personal attacks. Evidencing this, Omerov, Edman and Wistedt (2002) reported that 43% of staff felt insulted that a patient had acted violently towards them. A belief such as this could lead to a staff member feeling de-valued or dissatisfied.

Patient self-harm has also been reported to have profound effects on the stress levels of staff and on their ability to manage their own emotional
devastation, particularly in instances where suicide has resulted (Bowers & Simpson, 2007; Thompson, Powis & Carradice, 2008).

Comparatively, there is a much lower rate of reported physical injuries resulting from assaults than emotional consequences. The findings of Omerov et al. (2002) acknowledged this disparity, reporting that 95% of incidents on the ward, which resulted in physical injury, were minor, being painful for less than 10 minutes, and did not require complicated treatment.

Regardless of the injury sustained, the physical and emotional costs that can arise from assault and negative perceptions due to exposure to workplace assault may ultimately lead to personal financial cost. This is due to the need for private therapeutic intervention, loss of income due to frequent absenteeism, or in extreme cases it may lead to staff terminating their employment (Dowden & Tellier, 2004; Garrett & McDaniel, 2001; Gormley, 2011). Nijman et al. (2005) reported that staff stayed home on average 3.7 days a year when they were experiencing or had experienced symptoms due to a severe form of physical violence inflicted at work. In comparison, nursing staff who did not report experiencing a severe form of physical violence stayed home an average of 1.2 days (Nijman et al.).

On the contrary, positive perceptions can have a profound positive impact on the overall physical and emotional wellbeing of staff. For example, Harenstam et al. (1988) found links to better health and a significant decrease in absenteeism and rates of sick leave.

**Impact on Patients**

Staff perceptions can also influence the relationship and therapeutic outcomes with a patient (Arnetz & Arnetz, 2001; Carlsson, Dahlberg, Lutzen &
Nystrom, 2004; Gormley, 2011; Hurlebaus & Link, 1997; Poster, 1996; Thackrey, 1987). For example, a high level of job dissatisfaction and anger or cynicism can dramatically decrease a staff member’s willingness to engage with patients and affect their ability to provide adequate clinical care and support (Aiken, Clarke, Sloane, Sochalski & Silber, 2002; Berry, Barrowclough & Wearden, 2009; Gormley; Hatch-Maillette & Scalora, 2002; Parker et al., 2003). Staff who perceive the workplace climate as more negative may also engage in overly cautious behaviour towards patients, for example, only seeing a patient when another member of staff is present (Garofalo, 1981; Simonet & Wilde, 1997; Weyman & Kelly, 1999).

Often the social networks of patients are dramatically diminished and, as a result, the patient relies on their relationship with staff as a type of social connection and support. This can have a profound effect on a patient’s potential for engaging in therapy, as well as their motivation to achieve a positive therapeutic outcome (Aiken et al., 2002; Randolph, 1998). This was emphasised by Howard and Holmshaw (2010) who concluded that if a staff member’s willingness to engage with a patient decreases, then the effectiveness of the treatment and therapeutic outcomes may be compromised. Importantly, previous research also suggests that patients are aware of negative feelings held by staff towards both themselves as a patient and the service as a whole (Barrowclough et al., 2001). This negativity towards patients can also be counter-intuitive to the prevention of future violence, with Lion and Pasternak (1973) and Whittington and Wykes (1994) reporting that the probability of future assaultive acts actually increases when staff hold negative attitudes towards patients. Not surprisingly, the quality of the staff-patient relationship has also been linked to the potential for
relapse and recovery (Berry et al., 2009), with patients more likely to act out or become non-compliant if they believe staff hold negative attitudes towards them.

**Organisational Impact**

Workplace assault and associated negative perceptions have a negative impact on organisations by prompting a decrease in staff productivity and morale, with studies reporting significant distress for staff, high staff turnover and financial strain on the organisations (Nijman et al, 2005; Snowden et al., 2009).

The costs incurred at an organisational level as a result of workplace assault and negative perceptions of perceived risk are more so of a financial nature. The Victorian Government estimated that in 2003 violence in the workplace cost organisations $57 million per annum (Victorian Government, 2003). This was due to: high staff turnover and the financial costs involved in the rehiring process; high rates of staff absenteeism resulting in important tasks not being completed on time; the cost of staff taking more sick leave; compensation claims including potential medical expenses; the allocation of resources to retain staff; the decrease in staff morale and motivation which results in decreased productivity; and the outlay associated with educational programs and other preventative strategies to address these concerns (Alderman, 1997; Barrett et al., 1997; Dowden & Tellier, 2004; Hatch-Maillette & Scalora, 2002; Hunter & Carmel, 1992; Lanza, 1983; Lanza & Milner, 1989; McKinnon & Cross, 2008; National Audit Office, 2003; Nijman et al., 2005; Poster & Ryan, 1994; Rossberg, Eiring & Friis, 2004; Sullivan, 1993; Ulrich et al., 2007).

Conversely, fewer workplace assaults and more positive perceptions of risk and the workplace climate typically yield better organisational outcomes such as: shared goals among staff, better work performance and a decrease in the
amount of sick leave taken (Harenstam et al., 1988; Martin & Daffern, 2006). The flow on effect can lead to financial gain or, at the very least, a reduction in financial strain for the organisation.

**Current Perceptions**

On the whole it appears from the literature that many staff of psychiatric inpatient settings hold a more negative perception of the workplace climate than they do positive (for example, Bernstein, 1981; Department of Health, 2006; Howard & Holmshaw, 2010; Martin & Daffern, 2006; Ryan & Poster, 1989; Wykes & Whittington, 1998). A study conducted by McKinnon and Cross (2008) reported that high rates of violence in the workplace complicated by the issue of underreporting, and an overall high level of fear amongst staff, were likely to be responsible for this.

**Factors Affecting Perceptions**

**Experience and roles.** Personal experience is said to play a key role in ultimately determining a person’s level of fear and apprehension, as well as their feelings of vulnerability in the workplace (Arnetz, Arnetz & Petterson, 1996; Carmel & Hunter, 1991; Poster & Ryan, 1994). Each clinician tends to use a different set of cues to assess risk of violence and assault (Werner, Rose & Yesavage, 1990). Specifically, the level of control staff feel they had over an assaultive incident and the extent to which staff consider that the acts of violence were a personal attack have been shown to collectively influence their perceptions of risk and of the workplace climate, and level of fear post-incident (Howard & Hegarty, 2003). Similarly, younger staff have reported generally being more fearful and, as a result, hold more negative perceptions than their older and more experienced colleagues (Rose & Cleary, 2007).
Nurses, followed by other healthcare workers, appear to be the most common victims of patient assault (Chou, Lu & Mao, 2002; Lanza, 1992; Morrison, 1998; Nijman et al., 2005; Quintal, 2002; Rippon, 2000). Benjaminsen, Gotzsche-Larsen, Norrie, Harder and Luxhoi (1996) reported that nursing staff were the victims of violent behaviour in 82.8% of cases, followed by physicians (6.4%) and other patients (6.4%). This may be somewhat expected due to the nature of their roles, as nursing staff typically have the most frequent and direct contact with the patients at risk of initiating an incident. Regardless of the type of healthcare worker, from 1994 to 1998 staff were reportedly the target of 66.6% of documented assaults by patients (Flannery et al., 2000).

**Physical environment.** Interestingly, the research indicates that staff who work in environments deemed to be of higher risk of patient assault, such as inpatient and forensic psychiatric settings, appear to possess less negative perceptions than staff working in lower risk environments (Rose & Cleary, 2007). In support of this, Bootsmiller et al. (1997) found that staff on specialised wards (wards providing more intensive service beyond stabilisation and short recovery) viewed their workplace in a more positive light than those wards who provided rehabilitative and longer term treatment (Bootsmiller et al.).

Perhaps those working in a high-risk environment develop an increasing tolerance to violence as they are frequently exposed to assaultive incidents (Thomas, Bartlett & Mezey, 1995). Over time these assaults may become somewhat accepted as the norm or viewed as an extension of a patient’s symptoms, and through this process of normalisation may become less feared (Secker et al., 2004; Thomas et al.). Further, workplace environments that regularly experience assaultive incidents are likely to have well developed and
effective policies and procedures in place to deal with these situations, more so than in workplaces where assault is infrequent (Rose & Cleary, 2007; Thomas et al.). Forensic settings are also likely to have higher staff ratios and staff who are provided with more specialist training on control and restraint. A staff member may feel safer and less vulnerable in an environment in which they have seen firsthand the ability to effectively deal with assaultive patients.

An alternative may be that staff who are more fearful of assault or who are less experienced may choose not to work in these high risk environments which increase their fear (Rose & Cleary, 2007). This would explain why those in lower risk environments perceive themselves to be more vulnerable to assault, as they are likely to be more fearful of assault generally, regardless of their actual level of risk. This is supported by the work of Rogers and Kelloway (1997) who found that rather than having a real desire to leave their workplace, staff turnover may be related to staff leaving their workplace out of perceived necessity in an attempt to cope with and reduce their fear of threatening workplace environments.

Workplace climate. Another important contributing factor to the formation of staff perceptions is the workplace climate. This refers to perceptions of the functioning of an organisation, how conducive it is to change and how supportive it is of innovation and new ideas (Taxman, Cropsey, Melnick & Perdoni, 2008). These perceptions are formed through the use of workplace cues (Garrett & McDaniel, 2001; Griffin, Hogan, Lambert, Tucker-Gail & Baker, 2010; Lambert, Hogan & Allen, 2006; Parker et al., 2003; Ulrich et al., 2007). These cues are typically contextual factors, meaning they are dependent upon the surrounding environment (Gadon, Johnston & Cooke, 2006; Steinke, 1991). Personal safety, psychological well-being, physical health, job satisfaction and
productivity are purported to influence a staff member’s perception of patients and their level of risk, and the broader workplace context (Arnetz & Arnetz, 2001; Garrett & McDaniel; Griffin et al.; Lambert et al.; Parker et al.; Ulrich et al.). In more secure environments such as prisons and Secure Extended Care Units (SECU), key factors in determining the workplace climate are: the perceived supportiveness of therapeutic intervention and positive therapeutic outcomes, the level of mutual support available and the perceived risk of aggression and violence (Schalast, Redies, Collins, Stacey & Howells, 2008). In support of this, Jonsson (2011) identified that support, the level of personal control staff had, how clearly roles were defined, task distribution and responsibility and the demands placed on staff were clear indicators of overall workplace satisfaction.

Workplace environments and organisational factors have been shown to both support and hinder a staff member’s perception of safety and comfort, which can impact on their level of confidence and performance, as well as their intention to continue working for an organisation or to terminate their employment (Arnetz & Arnetz, 2001; Cline, Reilly & Moore, 2003; Larrabee et al., 2003; Leveck & Jones, 1996). Expectedly, staff perceptions of the workplace climate have been significantly correlated with issues such as job satisfaction, job performance and stress (Melnick, Ulaszek, Lin & Wexler, 2009; Taxman et al., 2008). Amongst healthcare professionals in particular, a high workload and a lack of adequate resources have been identified as major stressors (Healy & McKay, 2000; Molloy et al., 2008). However, these perceptions of the workplace climate are not seemingly entrenched; instead, they are amenable to change, for example if the organisation was to undergo a significant overhaul or restructure (Day, Casey, Vess & Huisi, 2010).
**Forensic history.** A known risk factor for being assaultive is having a forensic history. This includes, but is not limited to, people who have had a charge brought against them, served time in a correctional facility and those who have been ordered by the courts to serve Community Correction Orders. Those with a forensic history in conjunction with a severe mental illness are at increased risk of acting violently when compared with either a person with a forensic history or psychotic symptomology alone (Butler et al., 2006; Douglas, Cox & Webster, 1999; Douglas, Ogloff & Hart, 2003; Hodgins, 1992). Thus, unsurprisingly, working with patients with forensic histories has been found to increase staff fear of personal victimisation (Australian Institute of Criminology, 2004; Chiricos, Padgett & Gertz, 2000; Ferraro, 1995; Sanderson, 2005; Warr, 2000). It has been suggested that fear is a motivator for attitude formation, whereby the more fear provoking a person (or their history) is, the greater the negative attitude will be towards them regardless of the actual risk of harm or victimisation (Chiricos et al., Ferraro; Sanderson; Warr).

**Current Violence Estimates**

Jones and Lyneham (2000) reported that patients suffering from psychiatric illness were one of the most likely collectives to act violently towards nursing staff. Official reporting measures from the last fifteen years have indicated that aggression and assault in psychiatric settings, particularly inpatient settings, is commonplace (Arnetz & Arnetz, 2000; Beech & Leather, 2006; Chappell & Di Martino, 2006; Dillner, 1994; Erikson & William-Evans, 2000; Gournay, Ward, Thomicroft & Wright, 1998; Howerton & Mentes, 2010; Leather, Brady, Lawrence, Beale & Cox, 1999; O’Connell, Young, Brooks, Hutchings & Lofthouse, 2000; Perrone, 1999; Poster & Ryan, 1994; Uzun, 2003; Vandenbos &
Bulatao, 1996; Whitehorn & Nowlan, 1997; Wynn & Bratlid, 1998). Most of the data has either been collected from inpatient units or health services as a whole rather than per team/unit. This is perhaps due to the heterogeneous nature of the patients or clients seen and the functions of the teams/units in community settings.

One study reported that between 18-25% of psychiatric inpatients show violent and aggressive behaviour during their hospitalisation (Raja & Azzoni, 2005). Grassi et al. (2006) reported a more conservative estimate of 11.6% of patients acting violently during an inpatient admission. A study by the American Nurses Association found that 17% of nurses were physically assaulted within a twelve-month period and 57% had been verbally abused and/or threatened (Houle, 2001).

According to Australian data, McKinnon and Cross (2008) reported 400 incidents of inappropriate behaviour and assault by patients each year between 2002-2008 in a Victorian mental health service (six incidents per week), whilst Mayhew and Chappell (2001a) reported that in Australia one healthcare worker will fall victim to patient homicide each year. Lam (2002) reported that 62.1% of a sample of Australian nurses had witnessed or experienced patient aggression in a one-month period. Alarmingly, according to another Victorian study conducted in 2003, the average rate of potential and actual patient aggression across four hospitals was 14.6 incidents per day (Gerdtz, Maude & Santamaria, 2005). In line with this, O’Connell et al. (2000) found that 95% of nurses reported having been verbally abused at work, and 80% reported having been repeatedly exposed to physical aggression over a twelve-month period.

Although varying widely in time period and methodology, the above studies indicate that assaults in psychiatric settings are typically occurring in
somewhere between 11.6% and 25% of patients. Of particular interest are the findings that the majority of patients who acted violently did so towards objects such as furniture, and a high proportion of reportedly aggressive patients resorted to verbal abuse rather than physical violence (Omerov et al., 2002). Where physical violence was present, severe physical injury rarely resulted (Omerov et al.). As expected, more secure environments such as SECUs, which typically care for more acutely unwell people and those who pose a higher risk of harm to themselves and/or others, were more likely to experience patient assault (Abderhalden et al., 2007; Adams & Whittington, 1995; Alexander & Bowers, 2004; Krakowski, Czobor & Chou, 1999; McKinnon & Cross, 2008; McNiel & Binder, 1994b; Mellesdal, 2003; Stanley et al., 2000).

In some cases, however, it has been suggested that the true rate of violence and aggression in psychiatric settings may be somewhat underestimated due to underreporting (Crowner, Peric, Stepcic & Vann Oss, 1994; Thomas et al., 1995). There may be a percentage of violent incidents and threats not formally reported for various reasons such as embarrassment, working in a culture of acceptance and excusing the behaviour of the patient due to their illness (Mayhew, 2000). According to an Australian study, respondents reported that 70% of violent incidents went unreported (Perrone, 1999). It is thought that less severe types of violence committed by patients who are known to be repeatedly aggressive are more likely to go unreported (Abderhalden et al., 2007; Ng, Kumar, Ranclaud & Robinson, 2001). It may also be the case that if violence and assault are seen as somewhat expected then they are less likely to be reported, with staff only addressing those more injurious assaults through formal channels (Thomas et al.). Also, staff may feel somewhat responsible for or fear being blamed and/or
reprimanded for the assault (Hatch-Maillette & Scalora, 2002; Poster & Ryan, 1994). Regardless of the reason for not reporting violent incidents, according to a taskforce established by the Victorian Government in 2004, the issue of underreporting continues to impede efforts to address occupational violence in psychiatric settings (Victorian Taskforce on Violence in Nursing, 2005). Thus, the current violence estimates are likely to be somewhat conservative.

**Functions of Patient Aggression**

Research has shown that patients who repeatedly act in an aggressive manner are doing so to fulfill a rational purpose rather than as a result of spontaneous psychopathology (Daffern, Howells & Ogloff, 2006). Understanding the function of aggressive behaviour helps determine what factors result in the occurrence and continuance of this aggression (Haynes, 1998; Sturmey, 1996) and thus, can be used to help contain and prevent future violent behaviour (Daffern, 2007).

Whilst there are many reasons for why a patient may react in an aggressive manner, previous research has depicted a model of aggression, which categorises the underlying function of aggressive incidents as either hostile or instrumental. In other words, aggressive behaviour is either driven by anger, threat and frustration with the intent to cause harm (Bushman & Anderson, 2001), or driven by another more tangible goal aside from harm (McEllistrem, 2004; Weinshenker & Siegel, 2002).

It has been proposed that whether the function of the aggression is hostile or instrumental is dependent on individual factors such as: a history of aggressive behaviour; recent substance use and antisocial behaviour; and the presence of positive psychotic symptoms such as hallucinations and thought disorder.
(Daffern, Howells, Ogloff & Lee, 2005). With this in mind, Daffern, Howells and Ogloff (2007) proposed an Assessment and Classification of Function system, which depicted nine key functions of patient aggression: avoiding demands placed on them; ensuring compliance from others; an expression of anger; an attempt to reduce internal conflict and tension; a means of gaining something tangible such as cigarettes; attention seeking; to enhance or gain social status and peer approval; and to inflict suffering on either themselves or others.

The diathesis-stress model also provides an explanation of the function of patient aggression. Emotion dysregulation has long been associated with aggression both in psychiatric patient populations and the general community (Cohn, Jakupcak, Seibert, Hildebrandt & Zeichner, 2010). The diathesis-stress model proposes that immediate stressors can trigger and mediate aggression (Ferguson et al., 2008). It is suggested that a person can be put under a certain level of psychological stress that exceeds their ability to cope; for some, this inability to cope will result in aggression. These stressors include: trauma, boredom, anxiety, peer pressure, fear of social isolation and feeling overwhelmed by demands placed on them. However, according to the design theory, certain environmental/situational features can decrease the likelihood that patients will be exposed to such stressors and subsequently act in an aggressive or violent manner. These factors include: having single rooms, smaller patient populations on wards, spacious day rooms/communal areas, reduced level of noise, windows that provide views of nature surroundings, a patient-accessible garden, art that reflects nature themes, exposure to daylight and staff stations with large observation windows close to communal areas such as recreational rooms (e.g. Depp, 1976; Dietz & Rada, 1982; Fottrell, 1980; Wong, Slama & Liberman, 1987). The
London Health Services Research Department (1999) reported that environmental considerations including the layout of the ward, a lack of structured activities and poor staff attitudes towards patients and their treatment all contributed to the risk of patients being assaultive.

In summary, research has shown that there are a myriad of factors that underlie patient aggression. However, it appears that the unique environment of an inpatient facility coupled with the acute stage of psychosis evident in patients admitted to these units proves to be a catalyst for patient aggression (Daffern et al., 2005). Patients have difficulty understanding and regulating their emotions and are forced to comply with restrictions and the requirements of these specialty units. This in turn increases the likelihood that patients will be exposed to stressors that extend them beyond their limited coping abilities (Daffern et al.). Further, the addition of the forensic element of a history of aggressive behaviour, antisocial attitudes and potential substance use has led researchers to conclude that aggression in these settings is inevitable (Daffern et al.).

**Factors Contributing to Patient Assault**

The literature is yet to establish a single standout precursor to assaultive behaviour by patients in psychiatric settings. This is perhaps in part due to the lack of a universally clear definition of what constitutes assaultive behaviour. For the purposes of this dissertation the term ‘assaultive behaviour’ refers to actions of either a verbal or physical nature that were intended to cause physical or emotional harm. In other words, the purpose of which was to intimidate, hurt or demean the person/people the actions were directed towards. This definition is intended to encompass the broad spectrum of behaviours that have been referred to in the literature under the umbrella term of ‘assaultive behaviour’. These
include verbal threats that instill a sense of fear that this threat will be carried out, as well as the use of language aimed at undermining a person’s dignity and causing distress.

With this in mind, several explanations have been suggested as potential precursors and contributors to assaultive behaviour by psychiatric patients. Firstly, some studies have reported an interaction between length of inpatient stay and risk of assault, with risk increasing the longer a patient is hospitalised (Abderhalden et al., 2007; Arango, Barba, Gonzalez-Salvador & Ordonez, 1999; Cheung, Schweitzer, Tuckwell & Crowley, 1996; Raja & Azzoni, 2005). Contradictory to this, Nijman, Merckelbach, Evers, Palmstierna and à Campo (2002) and Grassi et al. (2006) found that aggressive tendencies were more likely to be seen in the first few weeks post-admission. This risk is increased if the ward environment is overcrowded, does not have adequate temperature control and does not provide private bedroom or bathroom facilities (Nijman, 1999).

Aggression is also more likely to result through one-on-one contact and personal patient care (Lanza, Kayne, Hicks & Milner, 1991; Rasmussen & Levander, 1996). This is perhaps due to perceived coercion or provocation by staff; one study reported that provoking antecedents were present in 110 of the 157 violent acts (70.1%; Benjaminsen et al., 1996).

Another main contributing factor to assaultive behaviour in inpatient settings is being involuntarily admitted and held in a locked facility (Abderhalden et al., 2007; Arango et al., 1999; Duxbury, 2002; Kho, Sensky, Mortimer & Corcos, 1998; Nijman, Albertz, Merckelbach & Ravelli, 1997; Nijman et al., 2002; Owen, Tarantello, Jones & Tennant, 1998a, 1998b; Powell, Caan & Crowe, 1994). According to Abderhalden et al., being involuntarily admitted to a
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Psychiatric facility led to an increased odds ratio risk of 2.16, meaning a patient who was involuntarily admitted was 2.16 times more likely to be assaultive than a voluntary patient. A possible explanation for this finding is the authoritative role the staff may be seen to take, as well as the hostility and suspicion that is likely to come from a patient unwillingly having their freedom revoked (Alexander & Bowers, 2004; Allan & McGonagle, 2002; Arango et al., 1999; Braithwaite, 2001; Irwin, 2006; Krakowski et al., 1999; McKinnon & Cross, 2008; McNiel & Binder, 1994a; Mellesdal, 2003; Stanley et al., 2000).

Management and Best Practice

During the early 1980’s greater emphasis began to be placed on occupational health and safety standards and the risks faced by employees at work. Both violence and aggression, which had previously been viewed as expected and a hazard of working with those with mental disorders, was no longer viewed as the norm but as an issue that should be addressed in terms of harm minimisation and prevention.

One of the best harm minimisation and prevention strategies identified in the literature is that of staff training (Barlow, Grenyer & Ilkiw-Lavelle, 2000; Baxter, Hafner & Holme, 1992; Grainger & Whiteford, 1993; Mayhew & Chapell, 2001b). For example, in reviewing the implementation of a training program in the United Kingdom, Whittington and Wykes (1996) found a 31% reduction in violence overall in the sampled healthcare facilities. The training typically relates to de-escalation techniques (including giving positive messages, assisting in healthy ways to express emotions, providing calm or relaxation time, and limit-setting) and the correct, most humane way to physically restrain someone (United Kingdom Central Council for Nursing, Midwifery and Health...
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Visiting, 2002). Training may also relate to the recognition of early warning signs (Hatch-Mailette & Scalora, 2002).

As well as preventing harm, training programs and the confidence gained from completing such programs have also been shown to instill staff with more positive perceptions (Beech & Leather, 2003; Collins, 1994; Fowler, Bushardt & Jones, 1993; Gerace, Hughes & Spunt, 1995; Howard & Holmshaw, 2010). The use of effective training programs allows staff to build on their existing clinical knowledge and skill base, which can lead to increased confidence in ability, particularly in managing assaultive behaviour (Berry et al., 2009; Gerace et al.). It is thought that increasing staff awareness about the therapeutic environment creates a flow-on effect, which improves a staff member’s motivation and confidence in their ability, their perception of the workplace climate and potentially the treatment outcomes for patients (Day et al., 2010). Managing staff distress at work through training may also enhance the workplace climate by improving contributing factors such as the supportiveness of the workplace environment (Fowler et al.).

The content of these training programs typically includes building on confidence levels and using educational material tailored to understanding and working with specific disorders/diagnoses and types of service users (for example, managing people with schizophrenia or drug and alcohol issues; Howard & Holmshaw, 2010).

One relevant study focused on staff perceptions regarding illicit substance users in an inpatient setting by considering how health professionals (nurses, doctors and psychologists) perceived and experienced interactions with patients with co-morbid substance abuse (Howard & Holmshaw, 2010). This study found
that staff who had attended the relevant training program possessed less negative attitudes towards patients with co-morbid substance abuse when compared with staff who had not completed training. Berry et al. (2009) provided evidence in support of this, with staff who had participated in an intervention program to modify their perceptions showing a reduction in patient blame and a decrease in negative attitudes.

Gerace et al. (1995) in the United Kingdom also confirmed that training had a positive impact on perceptions through the use of programs in an effort to improve the knowledge, confidence and overall clinical skills of the participants. An improvement was found pre- to post-program implementation, with an increase in nursing students’ confidence in working with patients with alcohol and drug problems (Gerace et al.). Beech and Leather (2003) researched a similar training program aimed at managing aggressive patients. Evaluation studies reported that in many instances there was a change in staff perceptions, particularly in relation to confidence, that was both positive and robust (Beech & Leather; Collins, 1994). A shortcoming of this research, however, is that whilst the program appeared to be effective in creating a positive change in perception, it remains unknown if that program ensured staff were afforded greater actual protection from patient assault (Morrison & Love, 2003).

In each of these studies it is the perception that changed rather than the actual level of risk. However, it could be argued that shifting a person’s negatively skewed perception and improving their skills to deal more effectively with at-risk patients may change the actual risk of assault. This would most likely be due to increased competence in recognising early warning signs and in managing potentially assaultive situations (e.g. through de-escalation).
Management strategies. A range of management and intervention strategies have been employed across the different mental health services for dealing with aggressive and assaultive patients. The current stance is that the least restrictive intervention needs to be applied, with other less intrusive interventions attempted prior to restraint and seclusion (Victorian Government Department of Health, 2011). Aside from complying with the Victorian Charter of Human Rights and Responsibilities Act (2006) this is likely to foster a better therapeutic relationship and potentially reduce the risk that a patient will act in an aggressive or assaultive manner towards staff.

Risk Assessment and Perceptions

The concept of risk assessment is not a new phenomenon. Assessments of risk are conducted daily in routine settings and are integral to mental health and forensic settings managing people with elevated levels of risk compared with the general community (Briant, 2003). At present, it is understood at both a policy and community level that risk assessment pertaining to future violence is a fundamental component of a mental health clinician’s role (Mullen, 2000). Risk assessment is not a static concept; it refers to estimating a probability or degree of risk, which does not simply divide people into discrete categories of either safe or dangerous (Munro & Rummgay, 2000). It involves fluid and ever changing appraisals shaped by factors such as socio-cultural influences, historical factors and clinical issues (Denzin & Lincoln, 2000; Scott & Resnick, 2006). By assessing a person’s risk it allows the individual to be compared to an established norm or population to ensure the safety and protection of not only the patient but also staff and the wider community (Crowe & Carlyle, 2003; Rose, 1990).
The MacArthur violence risk assessment study (see Monahan et al., 2001) is one of the largest and well-known studies of its kind and has provided much guidance in the area of risk assessment and clinical utility. The study consisted of many components with the aim of reviewing a large sample of adults from a range of acute psychiatric inpatient settings in order to ascertain which key factors contributed to a person being violent in the future. The study found empirical support for the following risk variables: a history of previous violence and a criminal history, a co-occurring diagnosis (particularly personality disorders), exposure to violence during childhood, psychopathy traits, anti-social peers with pro-criminal attitudes, command hallucinations and anger. This study provided support for the notion that those with both a serious mental illness and a forensic history are seen to be of higher risk of being assaultive. This evidences the need for and importance of accurate risk assessment in both clinical and forensic settings.

The current view on risk assessment approaches is that they should be evidence-based; in other words, they need to be guided by clinical observation, research and/or empirically sound theory (Sackett & Rosenberg, 1995). Broadly, there are two major classes of evidence-based risk assessment: non-discretionary approaches which yield actuarial data and discretionary approaches which are a form of “informal subjective and impressionistic” assessment (Grove & Meehl, 1996, p. 293).

In this respect, discretionary approaches to risk assessment rely on clinical and professional judgement to decide how information will be gathered, what information should be considered, how this information should be weighted and how the final decision of future risk will be reached.
Structured professional judgement is considered a discretionary approach. It is a method of guided clinical judgement that combines empirical research and professional standards (best practice principles) with clinical opinion in order to deduce a formulation regarding a person’s future risk.

Historically, actuarial (non-discretionary) risk assessment practices have been favoured. However, the acknowledgement that relying solely on actuarial assessments of risk is inadequate has led to the increasing reliance on structured professional judgement approaches. There has been a shift in recent times to strive for evidence-based risk assessments that lend themselves to more comprehensive and clinically useful formulations. Given that structured professional judgement adheres to best practice principles and is directed towards providing comprehensive risk assessments that take into account potential risk management needs, this approach is the preferred risk assessment method at present. A major benefit of this approach is that it enables clinicians to construct detailed management strategies with a view to modifying dynamic risk factors, and thus reducing the risk that a person will be violent in the future (Hart, 2009). It also dramatically decreases the reliance on non-evidence based practices of subjective personal experience and intuition.

The Historical-Clinical-Risk Management Scheme (HCR-20) is an example of a structured professional judgement approach and is one of the most frequently used risk assessment tools in clinical and forensic settings (Daffern & Howells, 2007; Khiroya, Weaver & Maden, 2009). This is a general violence risk assessment tool that allows clinicians to structure their clinical evaluation of a person’s likelihood of engaging in future violent behaviour (low, moderate or high). It is also used to inform ongoing treatment needs and management planning
to minimise the current risk level of patients and/or offenders, stipulating the scenarios to which this risk applies (such as if the person continues to associate with the same anti-social peers or does not address their anger management issues).

**Fear disproportionate to actual risk.** In the context of this paper, perception refers to the way that staff members understand and interpret both incidents in the workplace and the environment in which these incidents occur (Gerdtz et al., 2005). In this way, staff perceptions are subjective risk assessments. To staff members these perceptions of risk are real and their feelings of vulnerability and fear of future assault exist regardless of whether their perceived risk is proportionate to the likelihood of an imminent assault.

The literature presented throughout this chapter illustrates that, whilst there is a real risk of physical harm to staff that work with patients in psychiatric settings, there are different levels of risk depending on the type of staff member and the psychiatric setting in which they work. A key question asked when conducting standardised risk assessments is whether the risk is actual or perceived (Hatch-Maillette & Scalora, 2002). However, given the subjective and often internal nature of perceptions and personal risk, separating actual versus perceived risk is likely to be very difficult for a staff member. For example, Wykes and Whittington (1998) found that 25% of psychiatric intensive care nurses who had recently been assaulted reported feeling overly alert and hypervigilant even though their actual risk remained unchanged. Similarly, a Turkish study pertaining to the beliefs and attitudes of psychiatric nursing staff towards safety and assault in the workplace found that 92% (n = 149) of nursing staff agreed that staff could expect to be physically assaulted by a patient throughout their career.
despite only 54.9% \((n = 89)\) being actually physically assaulted and 38.9% \((n = 63)\) being subjected to verbal assault (Bilgin & Buzlu, 2006).

In this regard, perceptions have the potential to cloud staff objectivity and rational clinical judgement, particularly if a staff member has been adversely affected by patient assault. In some cases this could lead to a personal appraisal that certain patients are at higher risk than risk assessment measures predict. This is supported by the research of Rogers and Kelloway (1997) that fear is subjective and mediates the consequences of staff experiences of workplace violence.

**Measures of Perceptions**

The most common technique for gathering information regarding staff perceptions has been through the use of questionnaires distributed to various staff working in a range of settings. These typically incorporate a validated scale along with items specific to the research question (Martin & Daffern, 2006). Survey data also enables researchers to look for links between management practices and workplace outcomes such as productivity (Camp, 1994). Structured and semi-structured interviews with smaller focus groups are also frequently used for more in-depth responses regarding personal experiences (for example, Howard & Holmshaw, 2010).

There has also been much variation in the measurement scales used to assess perceptions of the workplace climate. Four commonly used measures which appear to encompass the various factors underlying workplace climate are: the Essen Climate Evaluation Schema (EssenCES), the Prison Social Climate Survey (PCS), the Organisational Climate Questionnaire (OCQ) and the Working Environment Scale (WES). All of these measures have been empirically validated.
The EssenCES is a 15-item instrument constructed by Schalast (2008). Scoring three factors associated with perceptions (Therapeutic hold, Patient’s cohesion and Mutual support, and Experienced safety), this tool was designed for use in forensic psychiatric wards. Each item is scored using a likert rating scale from zero (no agreement) to four (complete agreement), with higher scores indicating a more positive perception of the workplace climate (Schalast). Research has shown that the EssenCES has high internal consistency and there appears to be good convergent validity (Schalast et al., 2008; Tonkin et al., 2012). That being said, it is not yet known whether these results transcend forensic psychiatric facilities, and therefore caution must be taken when extending the use of this tool to a non-forensic psychiatric population.

The PSCS is another forensic-based assessment tool developed in the United States by Saylor (1984). It is used to assess staff perceptions of a prison organisation and the way it is structured, as well as personal job satisfaction. The survey measures perceptions using seven subscales and has shown excellent internal consistency (Saylor & Wright, 1992). However, like the EssenCES, this tool is limited in its use as it was designed for the forensic environment and its accuracy and reliability may not translate to a non-forensic facility.

The OCQ was developed by Koys and DeCotiis (1991) to measure what they refer to as the “psychological climate” (p. 265) within the workplace. It was originally constructed from research into over 80 individual dimensions purported to underlie perceptions of the workplace climate. These 80 dimensions were refined to form the current measure, which utilises 45 individual dimensions that are categorised into eight global concepts: Autonomy, Cohesion, Trust, Pressure, Support, Recognition, Fairness and Innovation. This measure can be used across
various work settings and with a range of staff. It has shown adequate reliability and good internal consistency (Koys & DeCotiis).

The fourth scale often referred to in the literature is the WES developed by Moos and Insel (1974). This scale aims to measure employees’ and managers’ perceptions of their current work environment and is applicable to a variety of work settings. There are 10 subscales that relate to three principal dimensions: Relationship, Personal growth/Goal orientation and System maintenance and Change. This measure can be used to “describe and compare work settings, examine the determinants of work climates, and focus on the connections between work climates and outcomes for groups and individuals” (Moos, 2008, p.10). There is a focus on perceived support, pressure, workload and job satisfaction. The WES is reported to have sound internal consistency varying from .68 to .86 and good reliability (.69 to .83; Moos). This tool has been normed on several work settings, including a Health Care Work Group. It was noted that those in the Health Care Work Group rated their workplace relationships, support, clarity of rules and policies and the appeal of the physical environment as poorer than those in the General Work Group (Moos). It was also acknowledged that work stressors were higher than the general work population in health settings. Health care staff also relied less on self-sufficiency and autonomous decision-making but reported greater work demands and more strict enforcement of rules and policies (Moos).

Both the EssenCES and PSCS measures appear to be reliable and valid tools, however, being specifically designed for use in forensic settings they are not as versatile as the OCQ or the WES. Therefore, for the purposes of the current study, both the OCQ and the WES seem to be the most useful for specifically
measuring staff perceptions of the workplace climate across different psychiatric settings.

**Current Study**

The aims and overall research topic of this dissertation have undergone many changes over the past three and a half years. The researchers have had to overcome many hurdles and difficulties in obtaining data and permission to recruit certain types of participants. During the inception of the project the researchers had planned, in collaboration with the targeted services, to focus on serious mental illness, namely schizophrenia, and patient experiences of their symptoms and illness management, as well as the care they received from psychiatric services in addition to examining the perceptions of staff. Study One was conceptualised and started while the necessary permissions were sought for access to patients and their information. However, after considerable work, the organisations would not consent to interviewing patients nor would they consent to conducting file audits. As a result the project was re-conceptualised to instead focus on risk assessment and the specific risk factors with which those with serious mental illness present, comparing the data and incident reports pertaining to patients who have acted aggressively with those who have not been violent. This would also have been contrasted with follow-up data on patients who, once discharged, came into contact with the criminal justice system whether through the police and/or courts. This focus was pursued with the understanding that access to certain agencies would be forthcoming. However, after initial verbal agreement, when formal written endorsement was sought, the researchers were again denied access to the relevant data from the participating organisations. While these other proposed arms of the research were being pursued, Study One
had been analysed and the questionnaire used in the further studies was developed and implemented. Given the consistent difficulties in obtaining access to both patients and patient data, the researchers decided to concentrate efforts on the staff perceptions of risk within the workplace arm of the research project.

The current study attempts to make an important contribution to the area by encompassing both theoretical and empirical approaches in examining staff perceptions of risk of assault and the influence of workplace climate in psychiatric settings. Chapter Two focuses on developing a clear picture of the current perceptions held by staff in a metropolitan psychiatric setting in relation to fear, safety, workplace satisfaction, and overall level of risk of assault. Chapters Three and Four introduce, describe and discuss two empirical studies that aim to further our understanding of staff perceptions of risk of assault and the influence of workplace climate across both a metropolitan psychiatric setting and a forensic psychiatric setting. Chapter Five discusses and integrates the major findings and concludes this dissertation.

The implications of this research are twofold. Firstly, this research will provide staff with insight into their own perceptions and will enable management teams to understand the key areas in which staff hold more positive and negative perceptions.

Secondly, there is the potential that identifying the specific perceptions and the factors that influence these perceptions will indicate to key managerial and financial stakeholders the areas of competence or specific healthcare teams/units that should be the focus of targeted training programs. This will allow for training programs to be tailored to each facility and group of staff, which creates the overall potential for improvement in staff job satisfaction, motivation,
absenteeism and staff turnover. The view is that promoting positive staff perceptions will allow organisations to optimise the level of patient care and staff wellbeing in psychiatric settings.
Chapter Two

Clinical Staff Experiences of Managing Threatening Behaviour from Mental Health Service Consumers: What is the Current View?

Staff health and productivity are important to any organisation, however they are even more pertinent to a psychiatric setting in which staff are engaging with severely unwell people with complex presentations and multiple diagnoses on a day to day basis. Studies have reported that violence and aggression are commonplace in psychiatric settings (Bimenyimana, Poggenpoel, Myburgh & van Niekerk, 2009; Bonner, Lowe, Rawcliffe & Wellman, 2002; Dillner, 1994; Gourney, Ward, Thornicroft & Wright, 1998; Livingston, Verdun-Jones, Brink, Lussier & Nicholls, 2010). Whilst there are a vast range of varying methodologies and methods of data collection, as discussed in Chapter One, past research has indicated that somewhere between 6.2% and 11.6% of consumers of psychiatric services display some form of violence during their contact with a mental health service (Benjaminsen, Gotzsche-Larsen, Norrie, Harder, & Luxhoi, 1996; Bowers et al., 2009; Kay, Wolkenfeld & Murrill, 1988; Nijman, 1999; Nijman, Albertz, Merckelbach & Ravelli, 1997; Nijman, Bowers, Oud & Jansen, 2005). Staff are frequently exposed to acts of patient self-harm, property damage, verbal aggression and varying degrees of physical violence (Bowers et al.; Foster, Bowers & Nijman, 2007; Omerov, Edman & Wistedt, 2002). Few studies have considered the personal risk appraisals of staff working in mental health settings and their views of their own safety, support and personal level of risk whilst at work, even though the perceptions held by staff have been shown to predict the

\[1\] Note that for the purposes of the study described in this chapter the terms ‘consumer’ and ‘client’ are used interchangeably in reference to a person receiving a psychiatric service. This is in keeping with the terminology adopted by the organisation sampled.
health and productivity of an organisation (for example, Day, Casey, Vess & Huisi, 2010).

For the purposes of this study, the term ‘perception’ refers to the way staff understand, interpret and ultimately experience assaultive incidents and threatening behaviour, such as swearing, biting and kicking, that occur in the workplace. It also encompasses how staff view the management of the risk that consumers pose, as well as the prevention methods adopted by the organisation. Perceptions are likened to attitudes and thoughts. They can be interpreted as a subjective personal risk assessment that encompasses feelings of safety, vulnerability, confidence in one’s own ability and level of trust one has in the organisation for which they work.

There are a myriad of factors, such as contextual issues or personal experience, that all contribute to a person’s perception. In regards to mental health settings, previous experience of assault and violence in the workplace is one factor that has shown to greatly impact a person’s perception of their safety, support and personal level of risk, and confidence in dealing with that risk within the workplace (Carmel & Hunter, 1991; McKinnon & Cross, 2008; Whittington, 2002). Another factor is the level of training and opportunity one has within their organisation to build on their existing knowledge and skills base (Berry, Barrowclough & Wearden, 2009; Gerace, Hughes & Spunt, 1995). Although organisations may provide certain mandatory training to staff, this does not necessarily translate into relevance and full competency in all aspects of working with aggressive and assaultive service consumers. Gathering a better understanding of someone’s personal experience of assault and violence in the workplace may help to facilitate an understanding of the type of training they see
as useful and as necessary in order to give them the confidence to manage threatening behaviour exhibited by service consumers.

As yet, no actuarial tool exists that specifically targets staff perceptions. Given the lack of a valid psychometric tool, the researchers decided to embark on a phenomenological qualitative research study to uncover the experiences of clinical staff working in a mental health setting and to establish key themes that might be present and could assist in meaning-making. As such, the primary aim of this study was to investigate the current attitudes and experiences (referred to as ‘perceptions’) of a range of clinical staff working in a psychiatric setting. We also aimed to understand these perceptions, which are subjective and may routinely and unconsciously be formed by staff. Our specific interest in perceptions was in relation to risk of assault, and preparedness in dealing with and managing threatening behaviour by service consumers. Preparedness, in this context, was thought to pertain to the training provided by a staff member’s organisation and the efficacy of such training.

**Methodological Approach**

This research was conducted based on a phenomenological perspective in order to explore the current opinions and experiences of staff working in mental health settings. The ontological and epistemological assumptions underlying the phenomenological approach taken in this study are that the research focuses on understanding each individual’s experience of a particular phenomenon. This is in keeping with the research of Palmer, Larkin, de Visser and Fadden (2010) on interpretative phenomenological analysis. The decision to focus on each individual staff’s perspective and experience allowed us to uncover each person’s
determinants or judgement system of risk and safety, and the value they place on workplace support and trust.

The method employed in order to ascertain these perceptions involved non-judgemental discourse with each individual participant. As such, the primary researcher was engaged in the research process in its entirety from conception to completion. Given this level of engagement it was possible that the primary researcher may have become immersed in the data to the extent that differentiation of meaning between individual responses may have been overlooked. In order to address this, the data was first analysed by the primary researcher and then independently analysed by an affiliate of the research project. Following this, the outcomes of the data and any variances between the two data analyses were conferred.

In order to verify the themes drawn from the data and their relevance to current known overarching clinical issues, the findings were also discussed with a senior member of staff from the participating organisation, who was an affiliate of the research project and who has worked within the organisation in various roles for over 20 years.

Participants

Participants were drawn from the Mental Health Services sector of Eastern Health, one of Melbourne’s largest metropolitan public health services. The participants were recruited from within the 15 teams that comprise the Eastern Health Mental Health Services sector, including:

- Inpatient Services (Upton House, Inpatient Unit 1 and Inpatient Unit 2 Ringwood East)
• Crisis Assessment and Treatment Team (Outer East OECATTT and Central East CECATT)
• Mobile Support and Treatment Service (MSTS; Box Hill and Maroondah)
• Continuing Care Team (CCT; Koonung, Waverley & Chandler)
• Prevention and Recovery Care (PARC; Linwood House & Maroondah)
• Outer East Continuing Care Services (Murnong Clinic & Chandler House)
• Maroondah Community Care Unit (MCCU)
• Continuing Care Unit (CRCCU; Canterbury)

These teams were purposefully sampled, meaning that participants were recruited based the researcher’s knowledge that the staff were clinicians currently working within Eastern Health Psychiatric Services and had worked in this environment for at least six months. Furthermore, to ensure responses were obtained from those in senior roles and non-managerial positions, the names of staff in management roles were made known to the researcher by an affiliate of the research project. This enabled the researcher to gather rich and diverse data that encompassed a range of staff, rather than being dependent on a specified subtype within the organisation (such as applying only to those in non-managerial positions).

The teams differed in size from three to 25 staff, and there was considerable variation in roles, job description, type of hours worked, risk level of the consumers and service offered to consumers (ranging from acute inpatient care to rehabilitation and community care). This variation is typical of the diversity within public mental health services across Australia. The researchers had planned on conducting the phone interviews until saturation had occurred. However, of the teams targeted, only six staff chose to participate (three team-
leaders and three non-team leaders), all from different teams within Eastern
Health Mental Health Services. Of the six participants, four were nurses (two
team leaders and two non-team leaders), and two were social workers (one team
leader and one non-team leader). In the interest of maintaining the anonymity of
each participant, the team for which each participant worked has not been
identified.

Procedure

Approval to conduct this study was obtained from both the Eastern Health
Human Research Ethics Committee and the Deakin University Human Research
Ethics Committee, and from the Acting Director of the Eastern Health Mental
Health Turning Point Alcohol and Drug Program (refer to Appendices A, B and
C). The Eastern Health research project affiliate provided email addresses for staff
from each of the teams within Eastern Health Psychiatric Services and assisted the
primary researcher to identify ineligible staff participants based on one exclusion
criteria: not having worked within the organisation for at least four months. It was
made known to the primary researcher which staff were team leaders. Potential
participants were then sent an email detailing what participation in the research
project would involve (refer to Appendix D for the Participant Information Form).
Staff nominated their interest and willingness to participate via reply email to the
primary researcher.

The one-on-one in-depth interviews took place via telephone, and lasted
between 20 and 40 minutes. The telephone interviews were conducted at a time
dee med convenient by the participant and pre-arranged via email correspondence.
The questions were provided to participants via email prior to the interview as the
open-ended questions being asked were deemed by the primary researcher to
require detailed and considered responses. These questions were developed in order to understand a range of staff experiences related to consumer presentations, the level of risk posed by these consumers, and participants’ overall preparedness to engage with aggressive and assaultive consumers. Examples of the questions asked included, “How well do you think the organisation manages threatening behaviour by patients/clients?” “What is your experience of assault by patients/clients at work?” and “What training have you received for managing assaultive behaviour and has this training been effective?”. The telephone interviews were recorded and transcribed for coding and analysis of the text.

**Data Analysis**

The data were examined using a phenomenological approach to uncover a range of key themes in line with the work of Giorgi (1985) and others since then (e.g. Palmer et al., 2010).

This data was coded and then analysed based on thematic analysis. This involved six stages: initial familiarisation with the data, documenting where and when patterns in responses occur, searching for themes based on these patterns, reviewing these themes, defining these themes, and providing a synthesis of this information. We commenced analysing the data by first re-engaging with the transcripts once all of the telephone interviews had been conducted. Following this, each transcript was scrutinised for excerpts related to the overall theme of staff perceptions of service consumer aggression and assault towards staff working in mental health settings. Themes were drawn out based on recurring views and experiences, which were then used to arrange the phenomena according to participant meaning encapsulated in the wider concepts of safety, behaviour/threat management and training/preparation. In order to remain as close
to the attributed meaning of each participant’s narrative, an independent researcher specialising in qualitative research was also employed to analyse the data and reach consensus.

Findings

The findings are presented as extracts of data pertaining to each of the key themes that were drawn out from the transcripts. Due to the common themes noted across both the team leader and non-leader transcripts, these have been presented collectively rather than separated by job title. There were several recurring themes noted in the analysis, which are summarised in Table 2.1.

Table 2.1

Recurring themes from transcripts

<table>
<thead>
<tr>
<th>Theme</th>
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<tbody>
<tr>
<td>A lack of early intervention and prevention across all services</td>
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<tr>
<td>A feeling of being supported and that a good level of support exists</td>
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<tr>
<td>Mixed responses in relation to the efficacy of training</td>
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<tr>
<td>Verbal assault is very common and appears to be expected/part and parcel of the job; Experiences are normalized</td>
</tr>
<tr>
<td>Personal safety is the responsibility of the individual</td>
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</tbody>
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Lack of Early Intervention

A key theme that consistently emerged from the interview transcripts was the lack of early intervention in each participant’s current team or setting. It was suggested that the organisation viewed incidents retrospectively rather than in a more proactive or preventative manner, with the organisational approach referred to by one participant as currently aimed at “damage control”. Typically
participants spoke of organisational responses to manage risk but not necessarily to prevent or potentially eliminate it. This view of a lack of early intervention was also regarded by some as a wider societal issue, with members of the community not seeking out or being able to access services early enough and hence presenting to mental health service providers in a much more unstable and unwell state. This perpetuated their risk of engaging in threatening behaviour towards staff.

Participants viewed the benefits of early intervention as reducing the risk of threatening behaviour from consumers and helping to better manage that risk. Two participants specifically spoke of their opinion that “things get missed like substance use” when early intervention is not the priority. Participants spoke of de-escalation as a skill that could help aid in prevention and reducing their risk of an assault.

That said, the difficulty and unpredictability of working with people who are predominately acutely or chronically mentally unwell, was also noted in the transcripts. This observation appeared to be in the context of acknowledging that no single preventative measure would be applicable to all individual service consumers, thus implying that early intervention was not the only solution to reducing the risk of assaultive consumers.

**Feeling Supported**

Feeling supported was an integral part of a participant’s overall assessment of their workplace. Most participants acknowledged that the organisation took risk “seriously” and had made clear that they had a “zero tolerance” stance on threatening and assaultive behaviour by consumers. The clear message from participants was that the more supported they felt, the safer they deemed the workplace to be. Participants also reflected that the organisation
recognised the importance of staff safety. Not only did participants feel that the organisation was supportive during the time period of an incident occurring, but that the organisation also had an understanding of the impact this type of work could have on staff. Regardless of whether they were victims of assaulting behaviour by consumers, “As an organisation they understand the toll dealing with these clients can take on staff”. This support from the organisation instilled confidence, a degree of trust, and gave participants a sense that they were in some way protected, with participants reporting that there was a “clear message that aggression is not tolerated and is dealt with accordingly” and that even though “I haven’t ever really had an occasion that I’ve needed support… the service is definitely offered”.

Regardless of whether they had actually required support from their organisation, most participants reported being satisfied with the support they were offered or had received, stating that the organisation was “supportive” and that there were “systems in place” to provide staff with the support they may need, such as being offered “time off” or a “taxi home” following an incident in the workplace. Participants also spoke of the “option to call for help” after such incidents and reported an appreciation of services provided within their teams, such as debriefs, team meetings, incident reports, case discussions and daily handovers. However, one participant was of the opinion that this level of peer support was dependent on which staff members responded and their level of experience. The more experience the clinician had the better their response was expected to be. This is indicative of experience as a measure of confidence and competence.
Some participants were of the belief that individual staff were responsible for their own wellbeing and for seeking support when needed. However, the issue of knowing what services were available to staff was also raised. Some participants felt that, whilst there may be good support services available, a staff member had to actively seek out these opportunities for support, as some services were seemingly “hidden” or unknown to staff. In these circumstances, participants felt that they were often left to fend for themselves. Another issue raised by several participants was that of “lone worker policies”, in that participants felt that they worked in an “isolated” environment and had a lack of leadership due to these policies. However, this relates more to a lack of support in general and lack of managerial support rather than a lack of support specifically in relation to the organisational response to a workplace incident/assaultive consumer.

**Efficacy of Training**

Much of participants’ discourse surrounded the effectiveness of the training they have received. Overall, it appears that participants did not believe that the organisation manages threatening behaviour by consumers particularly well. More specifically, whilst the mandatory training participants had completed was “good”, they unanimously reported that there were “gaps” in training and knowledge. An associated lack of confidence in responding and adapting to challenging and unexpected situations in the workplace appears to have ensued.

Words such as “outdated”, “basic”, “inadequate” and “unsatisfactory” were used to describe the current training that participants receive. Participants also spoke of how the mandatory training was often not suitable to their particular team or collective of consumers. Most participants suggested that the training they
receive should have an emphasis on making staff feel “comfortable”, “safe” and “confident”.

Several participants made reference to the role played by experience, in that the longer a staff member had occupied their role the more competent they were regardless of the training they had completed. Further, there was the belief that knowledge comes from experience, not necessarily from training. Experience in this regard was viewed as a measure of confidence. However, participants were not indicating a lack of desire for training, instead, they were suggesting that training has a role in conjunction with experience. In other words, training is not the sole determinant of competence and is not the only measure by which to gauge competence.

It was also noted by participants that much variance exists in the quality of staff and their responses to an incident, suggesting that even though each staff member may have completed comparable training, this does not lead to the same skill set or ability to deal with threatening consumers. Some participants went so far as to label other staff as “incompetent”, indicating that more access is needed to a range of training, not just that which is mandated. Identifying a lack of confidence in their current training, two participants spoke of their pursuit of training outside of work in the form of “self-defence” training in order to build their own confidence, and of how the onus is on the individual to equip themselves with the necessary skills. There is a real sense that they need to take measures to protect themselves. Participants took personal responsibility for this, and were of the mind that the onus was not solely on the organisation; to some degree it is their own personal responsibility to ensure that they are competent to fulfill their role (which includes dealing with assaultive consumer behaviours).
Preparedness was another issue that was consistently raised in relation to training. Many referred to a lack of preparedness and of experiencing a degree of “shock” when exposed to certain consumer behaviours in the workplace. Participants identified that preparation decreased risk and increased confidence in one’s own ability, yet participants seemed unsure if anything could actually prepare them for working in such an environment, regardless of the organisation or the organisational training methods employed and associated level of preparedness.

Several participants remarked on the lack of “relevant” training for their specific team, rather than the more general training they receive as part of the mandatory training offered by the organisation. In terms of improving the current training they receive, participants referred to being taught “restraint”, “de-escalation”, “conflict resolution” and techniques that would “promote problem solving”. They identified that the bulk of incidents occur because consumers are angry and frustrated, and that by improving their communication skills with these types of consumers staff may be able to avoid potentially threatening or aggressive situations. Participants also spoke of the importance of better understanding and being able to interpret early warning signs that a consumer would act aggressively or was relapsing. However, most of the training in their organisation was reported to occur “on the job”, with the suggestion that tasks such as undertaking consumer assessments were “a skill” that could be learned “on the job”. The term “on the job training” was frequently used by participants to describe skills obtained in addition to mandatory training. This “on the job” training did not include references to a mentor but instead referred to things that participants become familiar with in their everyday work. Again, participants
have made a link between exposure and experience and individual skill/competence levels.

Interdisciplinary communication was also raised as an issue by participants in the context of improvements to training and how, at present, the sharing of information rarely occurred between disciplines, particularly in relation to training and assessment tools. One participant provided an account of a conversation she had with another professional about the best way to assess a particular consumer and how that professional had spoken of using screening tools that she herself had never heard of. General consensus was that improvements in interdisciplinary communication would better align with best practice.

The language used by participants to describe the efficacy of training in the workplace was suggestive of a need for improvement. Further, from the participants’ point of view it does not appear that training is solely for the purposes of improving skill, but also training to improve confidence and to learn to deal with and process the sorts of issues and incidents that they may encounter at work. Further, it seems that regardless of how effective the training is there was the perception that, if there is a lack of competent staff to apply that training then the training is virtually ineffective.

Normalising Assaultive Experiences

The discourse surrounding assaultive experiences related to participants’ experiences of both verbal and physical assault. Participants spoke in a very matter of fact manner when sharing their experiences. There was an overall tone of acceptance by participants of certain behaviours by consumers, particularly that of verbal abuse. Participants collectively described the occurrence of verbal abuse
as “very common”, reporting that they were subjected to verbal abuse from consumers on at least a weekly, but most often daily, basis. Participants described the verbal abuse as “expected in this sort of environment” but most commonly engaged in by “chronic treatment-resistant patients”.

Verbal assault was seen by participants as inevitable, unavoidable and unpreventable, as there was always going to be a population of “angry”, “drug-affected and highly aroused people” presenting to mental health services and there were “always going to be times when people need to be restrained”.

Participants reported that the rate of physical assault was much lower than that of verbal assault. Inpatient settings seemed to be the most common place for incidents of physical assault to occur. However, regardless of whether participants worked in an inpatient or community setting, they all normalised their experience of assault and their daily risk in the workplace. One participant remarked, “we are all potentially at risk any time we see a client”. Participants seemed to minimise incidents involving being pushed, kicked and/or bitten by consumers, with most participants describing themselves as “lucky” or “fortunate” not to have been a victim of or involved in a more serious physical assault by a consumer. One participant stated that they were “lucky” because they worked in a team that was “somewhat protected” from consumer assault. This discourse is suggestive that to the participants there is inevitably a high chance of being physically assaulted at work.

Some participants seemed to have an underlying understanding or expectation that assaultive behaviour was a given because of “the nature of the clients we see and unpredictability of patient’s behaviour”. Participants expressed the opinion that it was okay to expect assaultive behaviour in the workplace as
long as no lasting injuries resulted. This is perhaps part of a greater systemic practice as some participants disclosed that verbal assault was not typically dealt with through the formal channels, i.e. formally reported or made known to management. This was supported by the response of another participant that verbal abuse is not an issue or should not be taken personally unless it is “a threat”, in which case this is serious and should be formally dealt with. However, participants themselves are unsure about what constitutes a verbal threat; they continue through the day as best they can and adjust their view of what is ‘normal’ depending on current circumstances. In this regard, what constitutes ‘normal’ or ‘acceptable’ consumer behaviour is a fluid, ever-changing concept within the mental health setting. Participants have essentially reported that expecting the worst is a form of coping strategy that helps them to get through the day and rationalise continuing to work in this setting.

**Personal Safety and Fear**

Participants’ assessment of their personal safety and the level of fear or danger they felt in the workplace was an underlying theme throughout the discourse. This is closely related to issues raised previously regarding how supported participants feel, the training they have received, as well as their expectation or normative view of experiencing assaultive behaviours in the workplace. Participants stated that the term ‘risk’ was associated with personal safety and vulnerability (fear), with the underlying message being that they are responsible for their own safety.

All participants spoke of the personal importance of feeling like they work in a “safe environment”, associating the term ‘risk’ with personal safety and vulnerability/fear. They referred to having a sense or perception of safety rather
than actually necessarily being physically safe. In this regard, participants have
described the perception rather than the reality, which links with their views of the
lack of control they have over other people’s behaviour and the unpredictability of
consumers. For many participants, this notion of personal safety was linked with
“patient satisfaction”, with one participant suggesting that there was an increased
risk of violence or aggression if the patient felt trapped or unhappy, for example,
in a setting with locked doors or lacking open spaces. Another participant spoke
of how the level of fear they felt was not just mediated by the patient, as the risk
of assault (most commonly verbal) was also present in dealings with family
members and/or carers. The language used places the onus on the individual staff
member to ensure their own personal safety.

In conjunction with patient satisfaction, participants identified feeling
“isolated” as a threat to personal safety and were reluctant to work with people
who were potentially dangerous as they did not have any “back up”. This
isolation, referred to as the “lone worker policy”, was thought by some
participants to feed into and ultimately increase their level of fear regarding their
personal safety as they believed that there was “safety in numbers”.

Gender also played a role in the perception of safety with some female
participants believing that they were at “less risk” as they were seen as “non-
threatening”. Others felt less vulnerable as they saw themselves as “protected”
due to the “nature of the service we offer”, in that they were dealing with less
acutely unwell consumers who they deemed less likely to become violent.

The issue of preparedness was also raised by participants in relation to
being able to accept and deal with the occurrence of threatening behaviour. Some
participants noted that potential threats are usually known to staff as these
consumers act suspiciously and are particularly noticeable, which automatically
heightens staff awareness.

**Individual Impact of Incidents**

Participants also acknowledged the individual impact (i.e. level of
associated distress) incidents have on staff, for example, recognising that some
staff were affected by an incident more so than others. This was tied to a reliance
on personal/clinical judgement to gauge a staff member’s comfort in dealing with
a threatening service consumer. Some participants had either witnessed or had
been directly involved in quite severe or potentially dangerous situations, for
example, “code-grey”, which is called when an unarmed person who is a threat or
perceived threat (typically aggressive or violent behaviour) cannot be contained;
this can lead to physical, mechanical or chemical restraint being used. Other
participants who had not had these experiences felt that staff could become quite
lax or comfortable due to not having been faced with such incidents and might
therefore be less acutely alert and more trusting (less fearful) of potentially
threatening behaviour from service consumers. However, the majority of
participants agreed that their judgement of personal safety was based largely on
whether they felt that they were in immediate danger. Some participants were
comforted by the knowledge that there were duress alarms to help keep them safe.
The use of language by the participants reflected the illusion or perception of
safety rather than the actual utility and effectiveness of such devices.

**Environmental and Organisational Influences**

A small proportion of participant discourse was related to organisational
or environmental factors that were seen to contribute to participants’ perceptions
of their workplace. Several participants spoke of the issue of safety versus an
aesthetically pleasing work environment. It was noted by at least half of the
participants that the openness of certain buildings increased staff vulnerability to
assault. Another participant also suggested that the openness of the waiting area
and proximity of the staff car park to that of consumers placed staff at greater risk
of assault, or at least left that particular participant feeling more vulnerable.
However, there was an acceptance by some participants of the physical
parameters in which they work and the limits to what they can change
structurally.

Another organisational issue discussed was the way threatening behaviour
was managed by the organisation as a whole. Participants were quite ambiguous
and non-committal about this, using phrases like, “reasonably well” and “pretty
well” to describe the overall performance of the organisation, whilst one
participant felt that threatening behaviour was “not handled well” at an
organisational level. A contributing factor to this view appeared to be the
confusion or lack of clarity around the different roles of the various staff within
the team. Further, some participants were of the opinion that allowances were
made for consumers’ behaviour due to a lack of insight into their illness, but that
this was of little comfort to staff as it did not negate the risk of having to deal with
assaultive behaviours in the workplace.

**Comprehensive Understanding**

Overall, participants were more concerned with their experiences at a
team/mental health setting level rather than on a larger organisational level.
Whilst there were issues raised by participants that they felt needed to be
addressed, the discourse surrounding the organisational level response and
provision of services conveyed a seemingly positive overall collective experience.
Of particular interest is the interdependent nature of the themes that were raised by participants. Whilst five distinct themes emerged, the themes in many ways seem to incorporate various underlying constructs that are co-dependent, for example, it has become evident from the transcripts that the effectiveness of the training staff receive impacts on how supported a participant feels at work, which feeds into how safe and equally how fearful they are in the workplace. Further, the lack of early intervention coupled with the identified environmental and organisational influences may lead to participant perceptions or experiences of more assaultive behaviours by consumers, which can lead to the normalising of these experiences due to the expectation that they will continue to occur.

Participants also seemed to suggest that the normalising and expectation of assaultive behaviours by consumers plays a part in their level of fear. While this is particularly true of verbal assault, where participants described less fear for their own personal safety as a result of its frequent occurrence, the opposite is true of physical assault. Participants reported being more fearful of physical assault, particularly if they had previously been exposed to an incident resulting in physical injury, regardless of how frequently they were exposed to incidents or their expectations that incidents would occur.

Participants spoke of the efficacy of mandatory training as the area of most concern. In doing so, participants described how they felt that “gaps” existed in the current training they received and that no provisions were made for training outside of the mandated programs. This applied equally to the relevance of the training, with participants stating that they typically were not trained in techniques that they were not expected to use frequently but that participants thought would be of use. In this respect, it was remarked that techniques can be overlooked as
not necessary or important when in actual fact they are still of use to staff. However, from an organisational perspective it could be viewed that a skill needs to be practiced in order for a person to maintain proficiency in its use. As such, there may be a reason why staff are not trained in specific techniques that they are rarely required to perform. For example, this may be an active way of the organisation avoiding the misuse or overuse of certain techniques, particularly in the example of restraint training. It is important to note that participants were not communicating that the training they received was ineffectual; instead they were indicating a desire to receive more training and learn more varied techniques. This provides evidence in support of the importance of training both for staff perceptions of safety, comfort and preparedness, as well as skill acquisition and preservation.

There appear to be different mechanisms pulling participants’ thoughts in competing directions. On the one hand, they recognise that they need substantial training to be prepared for different circumstances that may arise in their work environment, however they also know that training alone will not suffice, referring to the experience they gain from “on the job” practical exposure. They believe that you have to experience these circumstances and learn through that experience, which is frightening for them. They also talk about the organisation having responsibility to keep them safe, but at the same time discuss themselves having to take responsibility for their own safety. This implies that whilst participants consider that the organisation should bear this responsibility, they feel the training they currently receive is inadequate and so they resort to their own personal measures to ensure their safety and preparedness.
Aside from the relevance of training, another issue noted by participants was that much of their training occurred “on the job”. However, it is not known what specific skills are obtained on the job and how participants are supported. Interestingly, participants did not appear to be concerned by the fact that they learnt in this manner and did not seem to be able to suggest how training could be improved to minimise the need to learn “on the job”. Regardless, participants did make a connection between knowledge/skills and increased confidence.

In terms of normalising their experiences, participants appear to have established defence or coping mechanisms to appease their own fears. It seems that the experience of assault (typically verbal) is common enough in a mental health setting that it does not concern participants as much as it might an employee in a lower risk work environment (such as a corporate worker who is not typically prone to being a constant target of verbal assault). However, there is the potential that participants are suppressing or denying their inner anxieties and finding a means to justify the occurrence of unpredictable behaviour in order to allay their fears. That being said, it may be that this is the unfortunate reality when working in a mental health setting with consumers who are acutely unwell. In this regard it would seem more an attitude of acceptance, which leads to a decrease in fear, rather than a denial. Further, it may be that the use of a defence mechanism is necessary in order for staff to be able to continue to work in a mental health setting given the frequency and risk of verbal and physical assault.

Although there appeared to be a norm or an expectation that assaultive behaviour (particularly that of a verbal nature) would occur in mental health settings, one participant was clear in their message that “staff should not expect this sort of behaviour working in the service”. However, not expecting this
behaviour does not equate to it not occurring. Instead, it appears to be more a reaction of acceptance of the inevitable. Interestingly, and perhaps an insight into the acceptance and/or expectation of assaultive behaviour, is that some participants externalised the inappropriate behaviour of consumers. Participants perceived the inappropriate behaviour as being related to the symptoms of their illness, such as hallucinations, paranoia and frustration, and that these symptoms are to some degree beyond the control of consumers, and as such explicable within reason.

Underlying this practice of normalising and justifying the occurrence of seemingly unacceptable behaviour is the experience of fear, and the need to rationalise and decrease that fear. Participants identified confidence as a factor that was associated with a decrease in fear whilst at the same time increasing their feeling of safety. One method that was described as leading to an increase in confidence was training. For example, if a participant believes that training in de-escalation is needed, they may feel less confident in that they are currently ill-equipped or potentially more at risk than a staff member who has received that training. Further, the participant discourse suggests that whether the participant actually uses the de-escalation technique after it has been taught is secondary to the gain or merit that may exist in the increase in confidence and safety, whether actual or perceived, that the de-escalation training itself has provided.

What has become apparent from this study is that the phenomena of staff experiences of threatening and assaultive consumer behaviour is unique and varies from setting to setting. However, there are common themes throughout, particularly relating to safety, confidence and training, that can impact on how staff perceive and experience working in a mental health setting. Further
interrogation surrounding the lived experiences of staff working in mental health settings with a larger sample would be useful in order to establish whether these themes are consistent across organisations or unique to this particular organisation and group of participants. Also, more in depth exploration of “on the job” training is needed as this theme was not canvassed in detail by this group of participants. However, it appears to be a very pertinent theme in this workplace setting.

**Discussion**

The purpose of this study was to seek to understand the current perceptions and experiences of staff relating to threatening and assaultive behaviours of consumers in a mental health setting. The researchers aimed to understand the meanings of these perceptions, in terms of staff feelings of safety and preparedness in dealing with service consumer aggression and assault within the workplace.

A major limitation of this study was the small sample size, which reduced the overall generalisability of the results from this study. However, it was not expected that more than 15 participants would be recruited due to the taxing nature of qualitative research. This study was designed to be largely exploratory, with the primary aim being to gain a better understanding of the themes and areas of concern amongst staff currently working in psychiatric settings, in supervisory roles and non-managerial positions. These findings were then used to help inform the items that were included within the quantitative questionnaire designed for a much larger sample. Whilst the findings from this study may not appear to be generalisable in the traditional sense due to a small sample size, it is arguable that this study was designed with this purpose in mind, with these findings being tested with a much larger sample in the form of the subsequent questionnaires.
utilised in Study Two and Three. These studies would confirm or disprove the findings of the first study and provide results that were generalisable to a wider population of health care workers in psychiatric settings.

This lower than expected response rate highlights the difficulties faced in sampling healthcare populations and also in recruiting participants for qualitative research purposes. It is speculated that the most likely reason for such a small sample size was more to do with the perceived time commitment rather than a lack of staff interest in the research. It is thought that being able to provide more of an incentive would have certainly encouraged greater participation. Furthermore, clearly articulating the personal gain staff could potentially receive from their participation and subsequent research findings would be of benefit. When presenting to each team it appeared as though staff were unsure as to how/if the service would implement any changes resulting from the research, which likely decreased their motivation to participate.

Despite the small sample size, the study uncovered the interrelated nature of staff experiences of assault in a mental health workplace and their associated level of fear and safety. The discourse suggests that staff are not necessarily discontent with the way their organisation manages threatening behaviour. In fact, detailed review of each transcript gave rise to the notion that the fears and concerns of participants regarding their personal safety in this work environment are somewhat normal or “expected” given that they are working with consumers who are mentally unwell and often acutely unwell. Further, the general consensus among participants would indicate that whilst some do not think that assault should be acceptable in the workplace, it does occur and is somewhat the “norm”. Assault in the workplace was also seen by some participants as inevitable given
the nature of the service population, being those with a mental illness, and the
type of symptomatology such as paranoia and hallucinations that can lead to an
increase in a person’s propensity for violence.

According to previous research, violence and aggression are commonplace
in psychiatric/mental health settings, with evidence that staff frequently
experience verbal aggression, and less commonly physical violence (Bowers et
al., 2009; Dillner, 1994; Foster et al., 2007; Gourney et al., 1998; Omerov et al.,
2002). The current study provides much evidence in support of this, with
participants reporting lived experiences of verbal assault on a daily or weekly
basis, and less commonly physical assault. However, participants who worked in
more rehabilitative arms of the mental health service reported less experience with
assault, particularly that of a physical nature. This may be indicative of a
population of more stable and less acutely unwell consumers or, as participants’
discourse suggested, it may be related to the less confined and more open treating
environment they provide.

In accordance with the findings of Carmel and Hunter (1991), McKinnon
and Cross (2008) and Whittington (2002), participants in the current study
demonstrated in their discourse the impact that experience and expectations of
assault in the workplace have on their level of fear and personal safety. In line
with this, a feeling of confidence was also named by participants as a key
determinant in their ability to cope with the demands of a potentially high-risk
work environment. The findings of the current study therefore indicate that staff
working in a mental health setting commonly witness and/or experience assaultive
behaviours from service consumers. However, the way that they process these
incidents and their ability to effectively deal with these types of potentially violent
and aggressive consumers is dependent on the type and level of training they have received (whether leading to actual or perceived ability), their experience in the setting, as well as their overall confidence.
Chapter Three

Staff Perceptions of Risk of Assault and Workplace Climate in a Mental Health Setting: A Comparison with Actuarial Data

The previous chapter identified a number of themes relating to personal safety in the workplace, staff experiences of assault and of the perceived level of organisational interaction and support. The purpose of the study in this chapter was to further examine these themes in conjunction with the existing literature. This was done adopting a quantitative research methodology with a significantly larger, more representative sample.

It has been established that there is a real risk of physical harm to individuals who work with mental health consumers\(^2\) in psychiatric settings (Dillner, 1994; Flannery, Fisher, Walker, Littlewood & Spillane, 2001; Gournay, Ward, Thornicroft & Wright, 1998; Raja & Azzoni, 2005). Workers are exposed to a range of aggressive and confronting behaviours on a regular basis. These actions include: verbal abuse, threats, property damage, self-harm and physical assault (Bowers et al., 2009; Omerov, Edman & Wistedt, 2002; Thompson, Powis, & Carradice, 2008), some of which occur when performing expected duties such as medication dispensing and restraint.

Such incidents in the workplace are subjectively appraised and staff form what is referred to as a ‘perception’. For the purposes of this study the term ‘perception’ has been defined as the way employees understand, interpret and ultimately experience assaultive incidents and threatening behaviour in the

\(^2\) Note that for the purposes of the study described in this chapter the terms ‘consumer’ and ‘client’ are used interchangeably in reference to a person receiving a psychiatric service. This is in keeping with the terminology adopted by the organisation sampled.
workplace, and their views on the risk management and prevention strategies that are utilised. This is an important area of research, as how a staff member perceives their level of risk, support and safety following workplace incidents can have a dramatic impact on their continued functioning within the workplace, as well as in their personal lives.

There has been substantial work in the area of actuarial risk assessment and risk management. However, few studies have considered the personal experiences and different perceptions of safety, confidence and support amongst clinical staff who work in mental health settings, particularly within Australia. Much of the available research has been conducted in the Netherlands, Denmark and the United Kingdom (for example, Benjaminsen, Gotzsche-Larsen, Norrie, Harder & Luxhoi, 1996; Foster, Bowers & Nijman, 2007; Nijman & à Campo, 2002).

Findings extracted from the qualitative study outlined in the previous chapter (Study One) indicated that there were several prominent themes related to the perceptions of staff working in mental health settings. These included themes of personal safety being the responsibility of the individual, and of assault (particularly of a verbal nature) being common and expected as part of the job. In keeping with this, participants also tended to normalise their experiences. Participants also expressed their belief that there was a lack of early intervention and prevention, but indicated that they felt supported, particularly when incidents occurred. Finally, there were mixed responses in relation to the effectiveness of the training they currently receive. However, all staff acknowledged the importance and benefits of sound training, particularly the increased confidence that they associated with feeling competent to effectively deal with difficult and
aggressive clients. These themes have illustrated that, regardless of whether the risk is real or perceived, to a staff member their feelings regarding their own competency (as well as their feelings of vulnerability and fear of client assault) are valid and warranted.

These perceptions of risk and the supportiveness of the workplace, particularly the feelings of anxiety or distress that may result from witnessing and/or experiencing assaultive incidents in the workplace are influenced by the ‘workplace climate’. The term ‘workplace climate’ refers to contextual cues in the work environment that are used to form perceptions about the functioning of an organisation, such as the extent to which it is conducive to change, the practicality and functionality of the physical environment, if staff are able to work autonomously and how supportive the organisation is of innovation.

Such workplace climate cues have been shown to both support and hinder an employee’s perception of their overall safety. This can impact on their confidence, workplace satisfaction, job performance and productivity (Arnetz & Arnetz, 2001; Barrett, Riggar & Flowers, 1997; Carlsson, Dahlberg, Lutzen & Nystrom, 2004; Harenstam, Palm & Theorell, 1988; Hatch-Maillette & Scalora, 2002; Howard & Holmshaw, 2010). Ultimately, the flow on effect of employees holding a more negative perception can be costly for an organisation (Barrett et al.; Dowden & Tellier, 2004; Hatch-Maillette & Scalora; Rossberg, Eiring & Friis, 2004; Sullivan, 1993; Ulrich et al., 2007), hence the importance of conducting research in the area of staff perceptions.

The findings from Study One provide support for the subjective nature of perceptions, and give rise to the notion that there are a range of underlying factors
that may play a role in forming perceptions about their risk of assault and the workplace climate.

Given that perceptions are a subjective judgement of one’s personal safety and level of risk, they are susceptible to personal biases. This means that they may in fact be skewed and/or disproportionate to the actual risk. In support of this, Wykes and Whittington (1998) found that 25% of psychiatric intensive care nurses in their study that had recently been assaulted reported feeling overly alert and hypervigilant of future violent incidents, even though their actual risk had remained stable. Another example is from the research of Benjaminsen et al. (1996), who reported that only a small percentage of patients were likely to act violently during their hospitalisation, and that the majority of incidents could be attributed to the same patients who repeatedly acted in this manner. This means that staff may perceive that they are at an increased likelihood of an imminent act of violence when in actual fact they are not.

Whilst it appears that staff may have the tendency to be hypervigilant relative to their actual risk post-assault, some of the literature suggests that this does not necessarily hold true in all mental health settings. This appears to be particularly pertinent to those working in inpatient settings, with research by Nijman, Bowers, Oud and Jansen (2005) revealing that approximately one in six participants (16%; nursing staff of an inpatient unit) had experienced a severe act of physical violence on the ward. In support of this, Raja and Azzoni (2005) reported that between 18-25% of inpatients acted in aggressive and violent ways during their inpatient admission. Given this level of risk, it would be expected that staff in such settings would hold a higher level of fear of assault and a decreased sense of personal safety at work. However, of the little prior research available,
studies have shown that those who work in ‘higher risk’ environments such as an inpatient setting appear to hold less negative perceptions than their colleagues who work in ‘lower risk’ settings such as outpatient services (Rose & Cleary, 2007).

There are several explanations for this anomaly, such as the fact that ‘higher risk’ settings having clearer, more effective and practiced policies to effectively deal with potentially volatile patients (Rose & Cleary, 2007). Another explanation for this finding provided by Rose and Cleary was that staff who are more fearful of assault or who are less experienced would likely choose to work in seemingly ‘lower risk’ work settings to alleviate their anxieties. These findings suggest that there may be a negative correlation between poorer perceptions/increased fear and the type of mental health setting. In other words, it seems that the more high risk the workplace setting is deemed to be, the less negative staff perceptions tend to be.

These findings could also be extrapolated to years of experience, given that the research has shown that a person’s personal experience of an assaultive incident can mediate their level of fear post-incident (Arnetz, Arnetz & Petterson, 1996; Carmel & Hunter, 1991; Howard & Hegarty, 2003; Poster & Ryan, 1994; Werner, Rose & Yesavage, 1990), and that those in ‘higher risk’ environments hold less fearful and negative perceptions than those working in ‘lower risk’ settings (Rose & Cleary, 2007; Thomas, Bartlett & Mezey, 1995). It would not be unexpected that with more experience comes greater confidence, which provides an alternate explanation as to why staff working in ‘higher risk’ settings hold less negative perceptions and are reportedly less fearful. The findings from Study One (refer to the previous chapter) provide evidence in support of this.
Based on this previous research, five hypotheses were made in order to test whether the findings from Study One hold true, and also to add to the growing body of literature surrounding staff perceptions of risk in a mental health setting.

It was hypothesised:

1. That staff who have personally experienced assault by a client will report a higher level of fear post-assault than they had prior to the assault.

2. That staff who have reported witnessing and/or experiencing assault by a client will have a more negative perception of the workplace climate compared with staff who have not reported witnessing and/or experiencing assault by a client.

3. That staff with more experience within the field of mental health will report being significantly less fearful than staff who have less experience.

4. That staff who work in inpatient settings will perceive their risk of client assault as significantly lower when compared with staff who work in community and outpatient settings.

5. That staff who work in inpatient settings will have a significantly more positive perception of the workplace climate compared with staff who work in community and outpatient settings.

Method

Participants

Respondents were recruited from the population of clinical staff currently employed within Eastern Health Psychiatric Services, one of Melbourne’s largest metropolitan public health services.
The respondents were drawn from sixteen clinical teams within Eastern Health Psychiatric Services located throughout various suburbs across south-east Melbourne, including:

- Inpatient Services (Upton House, Inpatient Unit 1 and Inpatient Unit 2 Maroondah)
- Crisis Assessment and Treatment Team (Outer East OECATT and Central East CECATT)
- Mobile Support and Treatment Service (MSTS; Box Hill and Maroondah)
- Continuing Care Team (CCT; Koonung, Waverley & Chandler)
- Prevention and Recovery Care (PARC; Linwood House & Maroondah)
- Outer East Continuing Care Services (Murnong Clinic & Chandler House)
- Maroondah Community Care Unit (MCCU)
- Continuing Care Unit (CRCCU; Canterbury)

Note. Although the Secure Extended Care Units (SECU) are located within Eastern Health they were excluded for the purposes of this study because they are primarily supported and operated by Austin Health.

**Participant demographics.**

Table 3.1

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17</td>
<td>30.9</td>
</tr>
<tr>
<td>Female</td>
<td>37</td>
<td>67.3</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Table 3.2

*Age of Respondents (Years)*

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>12</td>
<td>21.8</td>
</tr>
<tr>
<td>30-39</td>
<td>12</td>
<td>21.8</td>
</tr>
<tr>
<td>40-49</td>
<td>15</td>
<td>27.3</td>
</tr>
<tr>
<td>50-59</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>60-69</td>
<td>4</td>
<td>7.3</td>
</tr>
<tr>
<td>70+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 3.3

*Profession of Respondents*

<table>
<thead>
<tr>
<th>Profession</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>2</td>
<td>3.6</td>
</tr>
<tr>
<td>Nursing</td>
<td>38</td>
<td>69.1</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>8</td>
<td>14.6</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>Social worker</td>
<td>6</td>
<td>10.9</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 3.4

*Length of Time Working with Psychiatric Clients*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 – 12 months</td>
<td>5</td>
</tr>
<tr>
<td>1 - 2 years</td>
<td>3</td>
</tr>
<tr>
<td>3 - 5 years</td>
<td>7</td>
</tr>
<tr>
<td>6 – 10 years</td>
<td>14</td>
</tr>
<tr>
<td>11+ years</td>
<td>26</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
</tr>
</tbody>
</table>

Table 3.5

*Length of Time Working in Current Team*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-12 months</td>
<td>17</td>
</tr>
<tr>
<td>1-2 years</td>
<td>9</td>
</tr>
<tr>
<td>3-5 years</td>
<td>14</td>
</tr>
<tr>
<td>6-10 years</td>
<td>8</td>
</tr>
<tr>
<td>11+ years</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
</tr>
</tbody>
</table>
Table 3.6

Respondents by Inpatient and Community and Outpatient Teams

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Community and Outpatient</td>
<td>42</td>
<td>76.4</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>3.6</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 3.7

Length of Time Working in Organisation

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-12 months</td>
<td>9</td>
<td>16.4</td>
</tr>
<tr>
<td>1-2 years</td>
<td>8</td>
<td>14.5</td>
</tr>
<tr>
<td>3-5 years</td>
<td>12</td>
<td>21.8</td>
</tr>
<tr>
<td>6-10 years</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>11+ years</td>
<td>15</td>
<td>27.3</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Overall, there were 55 respondents across Eastern Health Psychiatric Services. Tables 3.1 to 3.7 presented above illustrate that the sample included a range of clinical disciplines, with the majority of respondents being nursing staff (69.1%). This is not unexpected given that the largest clinical staff population within these teams is nursing, namely, psychiatric nurses. Teams that provide community services were also over-represented in the sample population,
however this is expected given that the majority of the teams from which the sample was drawn provide community and outpatient services.

The majority of respondents were female (67.3%). The range of ages indicated slightly more people in the 40-49 years age bracket (27.3%), however only 7.3% of respondents were aged between 60-69 years. This smaller percentage of older participants is expected given the average retirement age in Australia (Australian Bureau of Statistics, 2011). Interestingly, the highest number of respondents had only been working in their current team for six to 12 months (30.9%) even though the highest percentage of respondents had been working both with psychiatric clients and for their current organisation for 11 or more years (47.3% and 27.3% respectively).

Also obtained as part of this study was the actuarial data pertaining to the number of assaults and assaultive related incidents that had been reported within each team across Eastern Health Psychiatric Services (refer to Table 3.8). This data was extracted from the service-wide Victorian Health Incident Management System (VHIMS), where all reported workplace incidents within Eastern Health are recorded. The data included in Table 3.8 pertains to assaultive related incidents that occurred over the course of the previous financial year (1 July 2011 to 30 June 2012).
### Table 3.8

**Number of Reported Incidents per Team/Location**

<table>
<thead>
<tr>
<th>Incident location</th>
<th>Code Grey</th>
<th>Code Black</th>
<th>Aggression</th>
<th>Self harm</th>
<th>Assault</th>
<th>Property damage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CE CCU</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>CE MSTS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Chandler House (Consulting Suites)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chandler House Community Team</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Koonung CCT</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Linwood House (PARC)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Triage (Maroondah)</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Murnong Clinic (community)</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OE + CE CATT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>OE CCU</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>IPU 1</td>
<td>26</td>
<td>1</td>
<td>9</td>
<td>20</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>IPU 2</td>
<td>13</td>
<td>1</td>
<td>23</td>
<td>29</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Upton House – Inpatient Adult</td>
<td>117</td>
<td>6</td>
<td>33</td>
<td>16</td>
<td>28</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>161</strong></td>
<td><strong>8</strong></td>
<td><strong>74</strong></td>
<td><strong>84</strong></td>
<td><strong>55</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

*Note.* Assault includes biting, punching, kicking, scratching and hitting  
Code Grey relates to threatening behaviour  
Code Black refers to serious personal threat

This data indicates that the highest official total was recorded for ‘Code Grey’ incidents, with a total of 161 incidents. Of those, 117 (73%) occurred within the adult inpatient unit at Upton House. The lowest official total was recorded for ‘Code Black’, with a total of eight reported incidents across all teams. There were no teams who did not report some form of incident for the previous financial year, however Chandler House Consulting Suites recorded the least number of incidents (one).
Materials

Participants were each given an A4 envelope containing: a Participant Information Form, a questionnaire, a prize draw consent form and two reply-paid envelopes.

The Participant Information Form (refer to Appendix E) contained information about the purpose of the research, what participation involved, the possible benefits and risks of participating, how results would be disseminated, the privacy of their information and who to contact if they had any queries or complaints.

Participants were asked to complete a thirteen-page anonymous paper questionnaire (refer to Appendix F). The questionnaire consisted of six sections: Section A – About you; Section B - Current views about work; Section C – Your experience of assault at work; Section D – Patient characteristics; Section E – Training and support; Section F – Workplace climate. This questionnaire was developed based on previous literature and was refined based on the themes elicited from the qualitative study outlined in the previous chapter (Study One), with some items reworded or omitted based on the findings of Study One.

Utilising a questionnaire enabled the researchers to sample a large population of psychiatric staff in a non-confrontational manner. The decision to distribute the questionnaire in paper format was made based on discussions with the Eastern Health Turning Point Alcohol and Drugs Review Committee. From these discussions, it was decided that there would be greater opportunity for more participants if the questionnaire were in paper format rather than electronic format, as staff did not always have access to computer facilities throughout their work day.
Based on Cronbach’s alpha, the overall reliability of the entire questionnaire was .82. Using the arbitrary cut-off of .70 as a measure having good internal consistency (George & Mallery, 2003), this means that the reliability was sound. However, upon further analysis of the individual sections of the questionnaire, two sections were below .70: Section B: Current views about work (.67) and Section D: Patient characteristics (.62). Given that the information provided in Section D was not used in the current study this did not pose a problem. Further, the lower rating in Section B was due to the single item, ‘I feel very safe in my workplace’. Due to this item being somewhat unreliable, it was omitted from the analyses, which increased the reliability of the scale to an acceptable .72.

Note. Section F - Workplace climate incorporates two validated workplace climate measures: the ‘Work Environment Scale’ developed by Moos and Insel (1974) and the ‘Organisational Climate Questionnaire’ developed by Koys and DeCotiis (1991). These measures were chosen as, unlike the wider area of staff perceptions, literature exists on workplace climate and provides evidence-based measurement tools. The decision to include both of these workplace climate measures was made based on several factors such as: their reasonably sound psychometric properties and the fact that they could be self-administered. Another important consideration was that the measures chosen had to be applicable to a clinical and forensic setting; both the OCQ and WES fulfilled this criterion.

A diverse range of previous studies internationally have utilised these measures to assess university students, teachers, case managers, health care workers, nurses, managers and workers in correctional facilities (e.g. Chan & Huak, 2004; Day; Minichiello, & Madison, 2007; Dickens, Sugarman, & Rogers, 2005; Goddard, O’Brien & Goddard, 2006). Based on this, the use of these two measures in full was justified as they could enhance the validity of the questionnaire and allow for more in-depth interpretation. Due to copyright law, sample items from the Moos and Insel Work Environment Scale have been included in Appendix F rather than the full scale (refer to Appendix G for the Authors Permission to use this tool).
The prize draw consent form was a separate half-page form asking participants to tick a box if they wished to be entered into the prize draw and provide their name, signature and contact telephone number (refer to Appendix H).

**Procedures**

The study had institutional ethics approval from all participating agencies. (refer to Appendices I and J).

The recruitment process involved the primary researcher attending a pre-arranged team meeting at each location to briefly present the study to staff. The primary researcher explained what was involved in participation and illustrated the documents each participant would receive in their A4 envelope (Participant Information Form, questionnaire, prize draw consent form and two reply-paid envelopes). It was also explained to staff that consent for participation in this research project was implied.

Participants completed the anonymous questionnaire and returned it via the reply-paid envelope. Participants also completed and returned the prize draw consent form in the separate reply-paid envelope for the chance to win one of two $100 Coles/Myer vouchers.

A reminder email was sent to each team leader three weeks after the primary researcher distributed the questionnaire to staff of that team (refer to Appendix K). This was then followed by a reminder telephone call to each team leader.

Data return was closed approximately eight weeks after the last team presentation had occurred.
Data Analysis

The statistical analysis of the data from the questionnaire was performed using SPSS Version (20.0) for Windows. The analyses involved using non-parametric quantitative tests including the Wilcoxon Rank-Sum Test and the Kruskal Wallis Test.

Results

Of the 150 questionnaires distributed, 55 (36.67%) were returned within the researchers’ timeframe of eight weeks.

Prior to analysis the data were assessed for normality. As the data failed to fit the normal modal distribution, non-parametric tests were performed on the data. This was somewhat expected given the subjective nature of perceptions, as well as the fact that these perceptions were being measured in a highly specified population which yielded a relatively small sample. Outliers were inspected. All outliers were determined to be real responses and deemed important and were therefore included in the analyses. Table 3.9 summarises participant responses to each of the variables studied.
### Table 3.9

**Summary of Study Variables**

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Variable</th>
<th>Response</th>
<th>n (%)</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you been physically assaulted by a client at work in the past year?</td>
<td>Yes (1)</td>
<td>9 (16.4)</td>
<td>1.84</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (2)</td>
<td>46 (83.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Do you have a higher level of fear of assault as a result of being assaulted?</td>
<td>Yes (1)</td>
<td>17 (30.9)</td>
<td>1.68</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (2)</td>
<td>36 (65.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Are you more vigilant since witnessing/experiencing client assault?</td>
<td>Yes (1)</td>
<td>36 (65.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (2)</td>
<td>17 (30.9)</td>
<td>1.32</td>
<td>1.00</td>
</tr>
<tr>
<td>2</td>
<td>Have you witnessed and/or experienced verbal or physical assault at work?</td>
<td>Yes (1)</td>
<td>53 (96.4)</td>
<td>1.04</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (2)</td>
<td>2 (3.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 &amp; 5</td>
<td>I enjoy coming to work each day.</td>
<td>Strongly Agree (1)</td>
<td>10 (18.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agree (2)</td>
<td>39 (70.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uncertain (3)</td>
<td>3 (5.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree (4)</td>
<td>3 (5.5)</td>
<td>1.98</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strongly Disagree (5)</td>
<td>0 (0.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 &amp; 5</td>
<td>I have a positive view of my workplace.</td>
<td>Strongly Agree (1)</td>
<td>9 (16.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agree (2)</td>
<td>40 (72.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uncertain (3)</td>
<td>4 (7.3)</td>
<td>1.98</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree (4)</td>
<td>2 (3.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strongly Disagree (5)</td>
<td>0 (0.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I am very fearful of client assault at work.</td>
<td>Strongly Agree (1)</td>
<td>0 (0.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agree (2)</td>
<td>7 (12.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uncertain (3)</td>
<td>7 (12.7)</td>
<td>3.87</td>
<td>4.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree (4)</td>
<td>27 (49.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strongly Disagree (5)</td>
<td>14 (25.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am very vulnerable to client assault at work.</td>
<td>Strongly Agree (1)</td>
<td>3 (5.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------</td>
<td>-------------------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strongly Agree (1)</td>
<td>1 (1.8)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Agree (2)</td>
<td>10 (18.2)</td>
<td></td>
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<tr>
<td></td>
<td>Uncertain (3)</td>
<td>7 (12.7)</td>
<td></td>
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<tr>
<td></td>
<td>Disagree (4)</td>
<td>23 (41.8)</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Strongly Disagree (5)</td>
<td>11 (20.0)</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>I am very fearful that I will be threatened by a client at work.</th>
<th>Strongly Agree (1)</th>
<th>1 (1.8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Disagree (4)</td>
<td>32 (58.2)</td>
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<tr>
<td></td>
<td>Strongly Disagree (5)</td>
<td>9 (16.4)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>I am at a very high risk of client assault in my workplace.</th>
<th>Strongly Agree (1)</th>
<th>9 (16.4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree (1)</td>
<td>9 (16.4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agree (2)</td>
<td>11 (20.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uncertain (3)</td>
<td>6 (10.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disagree (4)</td>
<td>22 (40.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strongly Disagree (5)</td>
<td>7 (12.7)</td>
<td></td>
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</table>

Note. For a summary of the variables of length of time working with psychiatric clients and inpatient versus outpatient/community teams refer to Table 3.4 (p.66) and 3.6 (p.67) respectively.

In order to test hypothesis one, ‘That staff who have personally experienced assault by a client will report a higher level of fear post-assault than they had prior to the assault’, respondents’ scores on three items of the questionnaire were used. Scores on the item, “Have you been assaulted by a client at work in the past year” (Section C, Question 4) were compared with scores on the combined variable of ‘level of fear post-assault’. This ‘level of fear post-assault’ variable incorporated two items on the questionnaire, “Do you have a
higher level of fear of client assault as a result of having witnessed and/or experienced client assault”, and “Are you more vigilant at work since witnessing and/or experiencing client assault” (Section C, Questions 11 and 12). It was decided that combining these items provided a good collective gauge of a respondent’s level of fear following an assault/s rather than either of these items on their own.

The Wilcoxon Rank-Sum Test was conducted and found a statistically significant result with a moderate effect size, \( W_s = 123.50, Z = -2.45, p = .02, r = .34 \). In other words, it was found that those who reported having been assaulted by a client at work in the past year also reported a higher level of fear and vigilance as a result of the assault.

In order to test hypothesis two, ‘That staff who have reported witnessing and/or experiencing assault by a client will have a more negative perception of the workplace compared with staff who have not reported witnessing or experiencing assault by a client’, respondents’ scores on three items of the questionnaire were used. Their scores on the item, “Have you witnessed and/or experienced verbal or physical assault at work” were compared with their scores on the combined variable of ‘perception’. This ‘perception’ variable consisted of two items on the questionnaire, “I enjoy coming to work each day”, and “I have a positive view of my workplace” (Section B, Questions 1 and 3). The decision to use these two variables was made on the basis of the definition of a perception, which for the purposes of this study referred to the way staff experience their workplace. In other words, it refers to how they view, understand and interpret both interactions and incidents in the workplace, and the workplace environment itself.
The Wilcoxon Rank-Sum Test was conducted, however a non-significant result was found with a small effect size, $W_S = 37.00$, $Z = -.89$, $p = .37$, $r = .12$. This indicates that there is no significant difference in staff perceptions of the workplace (i.e. their view of their workplace and enjoyment at work) regardless of whether or not they have witnessed or experienced verbal or physical assault at work.

In order to test hypothesis three, ‘That staff with more experience (as measured by years of experience working with psychiatric clients) will report being significantly less fearful than staff who have less experience’, respondents’ scores on four items of the questionnaire were utilised. Scores on the item, “How long have you been working with psychiatric clients” (Section A, Question 10) were compared with scores on the combined variable of ‘fear’. This ‘fear’ variable incorporated three items on the questionnaire: “I am very fearful of client assault at work”, “I am very vulnerable to client assault at work”, and “I am very fearful that I will be threatened by a client at work” (Section B, Questions 8, 9 and 10).

A Kruskal-Wallis Test was conducted and a statistically significant effect was found with a large overall effect size, $H (3) = 12.70$, $p = .01$, $\eta^2 = .24$.

Post-hoc comparisons were made in order to ascertain the location of the significant difference. These differences were found using the Wilcoxon Rank-Sum Test with a Bonferroni correction. Two significant differences were found after the Bonferroni correction; between group one and group four with a large effect size ($W_S = 23.00$, $Z = -2.59$, $p = .004$, $r = .59$), and between group one and group five with a moderate effect size ($W_S = 32.00$, $Z = -2.56$, $p = .004$, $r = .47$). Thus, there was a significant difference between the years of experience held and
fear. People with less years of experience reported higher levels of fear but only when compared with those who have been working with psychiatric clients for six or more years. For those with six months to five years experience, they reported a relatively equal level of fear.

In order to test hypothesis four, ‘That staff who work in inpatient settings will perceive their risk of client assault as significantly lower when compared with staff who work in community settings’, respondents’ scores on the item, “I am at very high risk of client assault” (Section B, Question 6) were compared with whether they worked in an inpatient or community setting. The respondents were divided into the inpatient group or the community services and outpatient group depending on which team they worked in. Three teams (Inpatient Unit 1 and 2 and Upton House) were included in the ‘inpatient’ group, and the other 13 teams within Eastern Health Psychiatric Services (refer to the Method section, p.60 for specified teams) consisted of the ‘community services and outpatient’ group.

The Wilcoxon Rank-Sum Test was conducted and a statistically significant result was obtained with a small to medium effect size, $W_s = 206.50, Z = -2.06, p = .02, r = .28$. This demonstrates that more respondents in the inpatient group perceived that they were at very high risk of client assault compared with fewer respondents in the community services and outpatient group.

In order to test hypothesis five, ‘That staff who work in inpatient teams will have a significantly more positive perception of the workplace climate compared with staff who work in community services and outpatient settings’, the ‘inpatient’ and ‘community services and outpatient’ groups were compared on their scores on the combined variable of ‘perception’ (outlined in hypothesis two).

The Wilcoxon Rank-Sum Test was conducted, however a non-significant
result was found with a small effect size, $W_s = 249.00, Z = -1.09, p = .28, r = .15$. No significant difference exists in staff perceptions of the workplace (i.e. their view of their workplace and enjoyment at work) between those who work in an inpatient setting compared to those who work in a community services or outpatient setting.

To further assess staff perceptions of the workplace climate (hypothesis five), and to establish if there was a difference between the inpatient group and community and outpatient group, staff responses to the Work Environment Scale (Moos & Insel, 1974) were compared. The decision to use only the data from the Work Environment Scale was made as greater than 10% of the data from the Organisational Climate Questionnaire (Koys & DeCotiis, 1991) was missing at random, which prevented the accurate scoring of this tool.

Table 3.10 shows that as a cohort (overall) staff ratings of their workplace environment spanned the ‘Average’ to ‘Above average’ ranges. The overall highest score was within the Relationship dimension for Involvement and the overall lowest score corresponded to the subcategory of Innovation within the System maintenance and system change scale.

The items for the WES were scored using the scoring key template provided by the authors of the tool. This was then matched to the answers provided on the answer scoring key. The total number of matched responses was then tallied and converted to a standard score using Appendix A of the author’s manual. Each standard score was then matched to the corresponding interpretive statement for each subscale.

The psychometric properties of this scale were sound. The internal consistencies (Cronbach alphas) for each of the 10 WES were all in an acceptable
range and varied from moderate for Coworker cohesion (.69) to substantial for: Involvement (.84), Work pressure (.80), Innovation (.86) and Physical comfort (.81; Moos, 2008). The test-retest reliabilities were also in an acceptable range, varying from .69 (Clarity) to .83 (Involvement). In terms of validity, the intercorrelations indicate that the subscales measure distinct, though somewhat related, aspects of work environments (Moos). Involvement, Coworker cohesion, and Supervisor support were shown to positively relate to each other and to Autonomy and Task orientation. Innovation and Clarity also displayed moderately positive correlations with these subscales. However, it was noted that the intercorrelations were reported to account for less than 10% of the subscale variance (Moos).

These scores were also compared to the mean values for the norm group of 4,879 employees in health care and social services environments, including outpatient general medical and psychiatric services, patient care personnel, state mental hospitals, and long-term care units. It is acknowledged that the norm population was taken from the San Francisco Bay Area in the United States, which operates under a markedly different health care system to that of Australia. However, it is thought that these staff would share some similarities as Moos (2008) acknowledged that all health care workers typically work in environments that are more stressful and emotionally taxing compared with those who work in mainstream business corporations. The overall means were higher in comparison to the norm mean health care group except for scores on Work pressure and Control, which were slightly below that of the norm comparison.

In terms of the comparison between inpatient settings and community and outpatient settings, no statistically significant differences were found regarding
staff perceptions of the workplace climate. However, there were differences of interest in five of the ten subcategories. Inpatient settings scored higher on Work pressure and Physical comfort, whereas community and outpatient settings scored higher on Involvement, Peer cohesion and Task orientation.

Table 3.10

*Workplace Climate Data*

<table>
<thead>
<tr>
<th></th>
<th>Mean rating</th>
<th>Interpretive statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>6.98</td>
<td>Average</td>
</tr>
<tr>
<td>Community</td>
<td>7.71</td>
<td>Well above average</td>
</tr>
<tr>
<td><strong>Norm mean health care group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>5.80</td>
<td>Average</td>
</tr>
<tr>
<td>Peer cohesion</td>
<td>6.45</td>
<td>Above average</td>
</tr>
<tr>
<td></td>
<td>6.33</td>
<td>Above average</td>
</tr>
<tr>
<td></td>
<td>7.14</td>
<td>Considerably above average</td>
</tr>
<tr>
<td>Supervisor support</td>
<td>5.25</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>6.00</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>5.83</td>
<td>Average</td>
</tr>
<tr>
<td><strong>Relationship dimension (n = 50)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>6.98</td>
<td>Average</td>
</tr>
<tr>
<td>Peer cohesion</td>
<td>6.33</td>
<td>Above average</td>
</tr>
<tr>
<td></td>
<td>7.14</td>
<td>Average</td>
</tr>
<tr>
<td>Supervisor support</td>
<td>5.25</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>6.00</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>5.83</td>
<td>Average</td>
</tr>
<tr>
<td><strong>Personal growth or goal orientation (n = 50)</strong></td>
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<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td>5.73</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>6.22</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>6.34</td>
<td>Average</td>
</tr>
<tr>
<td>Task orientation</td>
<td>6.45</td>
<td>Above average</td>
</tr>
<tr>
<td></td>
<td>5.89</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>7.20</td>
<td>Well above average</td>
</tr>
<tr>
<td>Work pressure</td>
<td>5.25</td>
<td>Above average</td>
</tr>
<tr>
<td></td>
<td>6.44</td>
<td>Above average</td>
</tr>
<tr>
<td></td>
<td>5.46</td>
<td>Average</td>
</tr>
<tr>
<td><strong>System maintenance and system change (n = 50)</strong></td>
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<tr>
<td>Clarity</td>
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<td></td>
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<tr>
<td></td>
<td>5.60</td>
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<tr>
<td>Control</td>
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<td></td>
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<tr>
<td></td>
<td>5.51</td>
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<td>Innovation</td>
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<tr>
<td></td>
<td>5.56</td>
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</tr>
<tr>
<td></td>
<td>5.11</td>
<td>Average</td>
</tr>
<tr>
<td>Physical comfort</td>
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<td></td>
<td>6.44</td>
<td>Average</td>
</tr>
<tr>
<td></td>
<td>5.03</td>
<td>Average</td>
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In support of previous research, the results of this study indicate that assaultive experiences increase a clinical staff member’s level of fear that they will be assaulted and increases their vigilance within the workplace (Carmel & Hunter, 1991; Hatch-Maillette & Scalora, 2002; Poster & Ryan, 1994). However, the findings and subsequent conclusions of this study must be interpreted with some degree of caution due to the relatively low response rate (36.67%).

That being said, this study provides evidence in support of the notion that the level of fear of assault that clinical staff members experience differs depending on the number of years of experience they have working in a particular setting (for example, mental health; Arnetz et al., 1996; Carmel & Hunter, Poster & Ryan). The same was true of risk levels across different workplace environments, with inpatient settings considered by respondents to be more high risk than community services and outpatient workplace environments. In keeping with staff perceptions, objective data from incidents across settings also found the risk was higher in inpatient units.

**Fear and Experience**

As predicted, of those respondents who reported having been assaulted by a client at work in the past 18 months, the majority reported a higher level of fear as a result of this assault. They noted a difference in their own comfort and sense of personal safety from pre- to post-assault. This finding is consistent with the research of Arnetz et al. (1996), Carmel and Hunter (1991), and Poster and Ryan (1994) who collectively found that personal experience had a large influence on a person’s level of fear and vulnerability in the workplace.

However, surprisingly, this fear did not translate to a more negative
perception of the workplace overall and does not appear to feed into staff views on the workplace climate. Instead, this fear related directly to staff fears of future and potentially imminent client assault, their feelings of vulnerability and fear of being threatened. This suggests that while fear of assault is affected significantly by personal experience, perceptions are not. There are two reasons why this might be so; firstly, perceptions may be more robust than levels of fear and thus are harder to shift; secondly, these findings support the notion that there are multiple underlying factors that ultimately determine workplace perceptions, with personal experience being only one of these factors. This is in keeping with the research of Arnetz and Arnetz (2001), Garrett and McDaniel (2001), Griffin, Hogan, Lambert, Tucker-Gail and Baker (2010), Lambert, Hogan and Allen (2006), Parker et al. (2003), and Ulrich et al. (2007), who proposed that personal safety, fear, psychological wellbeing, physical health, current job satisfaction and overall productivity contributed to a person’s overall perception of their workplace.

It may be the case that, due to the assault time period being relatively recent, a staff member remains hyper-aroused and is potentially still processing their emotions around the incident, which may result in them remaining fearful and using emotional, rather than cognitive appraisals regarding their personal level of risk. Further, it could be argued that being hyper-aroused following an incident is an adaptive response with the aim of preventing future attacks. This is in keeping with the findings of Wykes and Whittington (1998) who found that 25% of nurses who had recently been assaulted felt hypervigilant and unnecessarily alert post-assault even though the actual level of risk remained unchanged.

Another possible explanation for this hyper-arousal is that recently
witnessing and/or experiencing assault reminds staff of their own risk. There is the potential for staff over time to become somewhat complacent regarding their risk of assault, particularly if they have not experienced client assault for an extended period. Therefore, when an incident does occur it reminds individuals that they are at risk and could potentially lead them to overcompensate for their complacency by becoming hypervigilant. This explanation would again support the findings of Wykes and Whittington (1998) that staff fear is disproportionate to and higher than their actual risk of assault, with Benjaminsen et al (1996) reporting that only a small proportion of patients (between 6.2% and 11.6%) act in a violent or aggressive manner during their hospitalisation.

Regardless of whether or not they had been assaulted in the past year, respondents’ level of fear of assault differed depending on the number of years they had been working with clients in psychiatric settings. This is consistent with the research of Rose and Cleary (2007), who found that younger staff reported being more fearful than their older and more experienced colleagues. This previous finding suggests that there is an age-related component to fear but also that experience plays a role in determining a person’s level of fear. Interestingly, the findings of the current study indicate that whilst experience (as measured by the number of years working with psychiatric clients) appears to impact on level of fear to some degree, this is only the case when comparing those who have six months experience in the field compared with staff who have six or more years of experience in the field. In other words, it was found that those who have between six months and five years of experience in a mental healthcare setting hold a relatively equal level of fear. This begs the question of what factors determine a person’s confidence and feelings of competency that appear to cement themselves
after approximately six years of working in psychiatric settings.

Prior research has identified the role of confidence and training (themes also arising in Study One) in bolstering positive staff perceptions and reducing fear (for example, Howard & Holmshaw, 2010). It is unknown why six or more years is specifically important, but perhaps in this timeframe staff become familiar with this type of workplace environment and of the demands that come from working with people who are suffering from mental illness. After such time staff may have received a level of training that they feel is adequate to provide the confidence they need to fulfill their roles with confidence. Conversely, it may be the case that the ‘on the job’ experience they have received has given them the self-confidence they need to effectively reduce their fear. Another explanation could be age-related maturity, with staff potentially reaching an age where a combination of life experience and work experience reduces their overall level of fear and instills them with a greater confidence.

**Perceived Risk and Reported Incidents of Assault**

The hypothesis that, overall, those in inpatient settings would rate their personal risk of client assault as lower compared with their community services and outpatient counterparts was not supported. In fact, it was found that more respondents from inpatient settings compared with those from community services and outpatient settings perceived that they were at “very high risk” of client assault.

The data pertaining to the number of reported incidents of assaultive and threatening behaviours (categorised as ‘codes’ within the service) supports the idea that inpatient staff perception of risk is accurate. Not only were the majority of actual incidents reported on inpatient units, they were also the incidents of the
highest severity. Furthermore, whilst it may be the case that respondents from inpatient settings hold the expectation that it is common to be assaulted at work, they do not appear to have normalised or de-emphasised their level of risk. It seems that fear of client assault is somewhat warranted in inpatient settings and contradicts the notion that perceptions of risk of client assault are disproportionate to a staff member’s actual risk of assault. However, this notion may still hold true for staff who have personally experienced client assault. These staff may perceive that they are at disproportionately increased risk of client assault, above that which would be expected of a staff member working in an inpatient setting. This finding is in line with Poster and Ryan (1994) that perception of risk can be disproportionate to actual risk, with a finding that 85% of staff who had been assaulted held the belief that they should expect to be assaulted again.

**Perceptions and Workplace Climate**

Interestingly, no significant differences were found in respondents’ perceptions of the workplace, regardless of whether or not they had been assaulted at work in the last year or worked in an inpatient compared with an outpatient or community setting. This suggests that perceptions of workplace climate may not be largely determined by exposure to assaulitive incidents. This result also provides support for the notion that the contextual cues that help form staff perceptions of the workplace climate also contribute to staff perceptions of overall safety and fear of assault (Garrett & McDaniel, 2001; Griffin et al., 2010; Lambert et al., 2006; Parker et al., 2003; Ulrich et al., 2007).

Further, the type of mental health setting is not necessarily seen to impart a more positive or negative perception of the workplace. This is unexpected and contradictory to prior literature (for example, Rose & Cleary, 2007; Thomas, et
al., 1995). However, there are two possible explanations for these findings. Firstly, it is important to note that these non-significant results are most likely primarily due to the small sample size coupled with the over-representation of respondents from community services and outpatient settings (76.4%). Given the subjective nature of perceptions, it may be the case that the small percentage of respondents from inpatient settings provided a negatively skewed sample. Of course, it is also plausible that this is a true finding and that those in inpatient settings currently hold less positive perceptions than expected, or alternatively, that those in community and outpatient settings currently hold a more positive perception of their workplace than expected.

Another explanation for these findings is that the items from the questionnaire used to measure perceptions of the work environment were insufficient to capture the domain appropriately. The combined measure on the questionnaire termed ‘perception’ was an overt and narrow measure of how staff are currently experiencing the workplace. It only incorporated two items from the questionnaire, “I enjoy coming to work each day” and “I have a positive view of my workplace”. This narrow measure does not take into consideration the different aspects that encompass the workplace climate and the range of factors that influence perceptions.

Another more in depth measure of staff perceptions of the workplace was obtained from the ‘Work Environment Scale’ (Form R; Moos & Insel, 1974). Results from this scale indicate that differences (albeit not statistically significant) were in fact found across the various areas encapsulating workplace climate. The overall cluster of scores around the ‘Average’ to ‘Above average’ range indicates that staff are quite satisfied with their current work environment. This finding was
unexpected and contradicts the previous research of Bernstein (1981), Department of Health (2006), Howard and Holmshaw (2010), Martin and Daffern (2006), and Rose and Cleary (2007) that on the whole staff perceptions in mental health settings appeared to be more negative.

Staff had notably positive perceptions of their colleagues, viewing them as friendly and supportive of each other (Peer cohesion). They were also pleased with the level of focus the organisation placed on good planning, efficacy and productivity (Task orientation). However, an area that performed slightly more poorly than all other aspects was Work pressure. Whilst still considered ‘Above average’, staff reported that the demands placed on them to get the job done and the timeframe by which to complete such tasks were higher than they would like. This does, however, need to be considered in the context of the field of healthcare.

It is noteworthy that, whilst staff rated this demand and pressure to be higher than their ideal, collectively this score was still lower in comparison to the norm health care group. This means that, although staff perceive a higher demand and time pressure in the workplace, in actual fact this perception is more positive than what is expected from working in a mental health setting.

Further, differences were found between the inpatient and community and outpatient groups on five of the ten subscales. Those from the community and outpatient group appeared to hold more positive perceptions than the inpatient group in relation to: the degree of concern and commitment employees have towards their job; the level of support and friendliness staff show towards each other; the level of focus the organisation placed on good planning, efficacy and productivity; and the demands and pressure placed on them. However, that is not to say that those from inpatient settings hold negative perceptions with regards to
these areas. In fact, staff of inpatient settings rated these aspects as ‘good’ but these ratings were closer to the health care work group norm, meaning that staff did not perceive them as standout attributes of their workplace.

One reason for this may relate to the perception of work demands and time pressures reported by those in community and outpatient settings. Feeling less pressured to get tasks completed than their inpatient colleagues, they may have greater capacity to conduct team meetings and planning sessions and more time to work on developing and strengthening peer relationships. Alternatively, it could also be the case that the managerial style differs between the two groups and that the managerial style exhibited in inpatient settings is not as good a fit as the style of management in community and outpatient settings.

Surprisingly, those from the inpatient group perceived the pleasantness of their physical surroundings (Physical comfort) as very good in comparison to other areas of workplace climate. Given the community and outpatient settings rated their physical surroundings as ‘Average’, it is of interest to consider what factors are contributing to this seemingly enhanced physical environment in inpatient settings. This is of particular interest as previous research indicated that inpatient settings were at higher risk of patient assault (Rose & Cleary, 2007; Thomas et al., 1995), and this element of increased risk was assumed to play a role in reducing positive perceptions of the physical environment. However, this is inconsistent with the findings of this study, which found that on the whole staff have reasonably positive perceptions of the workplace.

As its name suggests, the Physical comfort subscale relates to the extent to which the physical work environment provides an ideal work environment, referring to environmental factors such as lighting, appearance, colours and
heating and cooling. Perhaps more focus has been placed on the physical environment in these ‘higher risk’ settings for that reason, that they are high risk. It may be that the presence of visible safety mechanisms such as locked wards, closed-circuit security surveillance and duress alarms have positively influenced inpatient staff perceptions. They may feel physically safer or take more note of the physical environment due to these extra safety measures. This borrows from the notion of Newman (1972) that crime can be prevented (or perceived to be prevented) through environmental design. In other words, the physical work environment can be tailored to decrease both the perceived and actual risk of patient assault.

These results would suggest that perceptions of the workplace climate are perhaps based more heavily on supportiveness and positive working relationships rather than assumptions of level of risk and exposure. This sheds some light on the finding that staff that had experienced assault were no more likely to hold negative perceptions of their workplace climate than their non-assaulted counterparts. It may not necessarily be the assault per se that affects a staff member’s perception but rather their experience during and post-assault at an interpersonal level that truly influences their overall perception of the workplace climate.

**Limitations**

There were some limitations of note with regard to this study, which relate to the sample size, questionnaire and time restraints of respondents.

Firstly, whilst the response rate of 36.67% was sufficiently high to be a reasonable representation of the sample population, it could be argued that the results may have been different with a larger sample. However, given that some of
the analyses provided statistically significant results with a relatively small sample size, it is more likely that a larger sample size would simply serve to increase the effect size rather than dramatically change the results.

Several factors are likely to have contributed to 63.33% of staff choosing not to complete the questionnaire. Issues such as time constraints in the workplace and the lack of relative importance of the study to some staff are likely to have influenced the decision to participate. It may also have been the case that non-responders were content with their current workplace environment and did not have any issues to raise, therefore they did not see the practical utility of completing the questionnaire. The questionnaire only being available in print form may have also deterred those who predominantly utilise computers in the workplace and/or at home.

Future research with a larger sample size is warranted in order to determine whether the analyses which provided a non-significant result would return a significant result. The use of non-parametric tests for data analyses may also have affected the result, as the statistical power of these tests is known to be lower than the parametric equivalents (for example, Freidlin & Gastwirth, 2000; Hodges & Lehmann, 1956; Tanizaki, 1997).

Secondly, the study is limited in its overall generalisability as the sample population consisted of a single mental health service within the south-eastern metropolitan region of Victoria.

Thirdly, as there was no standardised measure available to capture the nature of the research questions being posed, the questionnaire used was developed for specific use in this study. Items were based on: the findings of previous research, data from qualitative analyses of telephone interviews from
within the population sample (Study One) and two standardised workplace climate measures. However, it would be useful if the measure were validated in other studies.

Fourthly, the questionnaire was quite detailed and therefore required a considerable time commitment from participants. This may have impeded the number of completed questionnaires returned. This is particularly pertinent to this sample given that time pressure was an issue raised by staff in this workplace. The primary researcher also had to follow-up with each team before closing data collection as an insufficient number of questionnaires had been returned. Given these issues, it is likely that selection bias was a significant confounding variable, with the majority of staff either currently being content in their perceptions of their workplace and not feeling the need to participate in the study, or holding more negative views and feeling uncomfortable in voicing these views for fear of being identified. It is also possible that staff simply did not think that they had the time to complete the questionnaire given their work demands meaning only those who felt less time pressured seemingly more likely to participate.

Finally, a potentially important omission was that the questionnaire did not ask participants to estimate the number of clients who had assaulted staff in their team in the past year. This has prevented the researchers from making a comparison between staff perceptions of the number of incidents and the actuarial data. This was an area the researchers were interested in exploring as the previous literature had established a difference between a staff member’s perception and the actual number of reported incidents of assault, with perception of assault seemingly disproportionately high when compared with actuarial data (for example, Benjaminsen et al., 1996; Wykes & Whittington, 1998).
Conclusions and Recommendations

The findings of this study are relevant to clinical staff, particularly nurses who work in the various teams within a mental health service. The purpose of this study was to utilise a quantitative research methodology with a reasonably large sample in order to add to the growing body of literature regarding staff perceptions of risk of client assault and workplace climate within psychiatric settings. The study was also conducted in order to test the relevance of the themes extracted from Study One (refer to Chapter Two).

It is evident that the themes from Study One are of relevance to the wider population within the sampled mental health service. Some support was found in relation to previous research. However, overall it was found that clinical staff in this particular mental health service held a more positive perception of their workplace than expected, with those respondents from community and outpatient settings holding the most positive perceptions of their workplace climate. Previous literature has indicated that violence in mental health settings is commonplace. Results from the current study provide partial support for this finding in that reported incidents are much higher (more common) in inpatient settings. However, results did not support the same occurrence in community and outpatient settings. That being said, under-reporting may be an issue that is impeding an accurate reflection of the current situation.

Regardless of the commonality of aggressive and assaultive behaviour, from the current study it has become apparent that previous assaultive experiences are an important factor in determining the resultant level of fear and hypervigilance a staff member has. Further, this appeared to be influenced to some degree by the level of organisational and interpersonal support they received.
following the incident and on an ongoing basis. This is an important finding and provides evidence for the continued provision of funds and services that allow for an adequate level of support for staff who experience physical assault in the workplace. Investing in this area of clinical need would also ultimately serve to benefit the wider organisation as this could lead to reduced absenteeism as a result of workplace incidents and lower staff turnover rates. Furthermore, ensuring the wellbeing of staff is likely to lead to increased productivity.

One pertinent area that could be addressed for all staff is the time pressure and work demands placed on them. While these settings tend to be demanding purely due to the nature of the presenting problems of the client base and often limited funding, more could be done to reduce the pressure staff feel with regard to working harder, the perceived increased urgency in all matters and the inability to relax. Mechanisms for developing staff self-care and time management skills are indicated. Whilst it may not be feasible to reduce workloads, giving staff the tools to better manage and prioritise their workload could prove very effective in reducing their negative perceptions regarding work pressure. Further, given this study found that those with six or more years of experience perceived a decreased level of fear of client assault, it may be useful to introduce a mentor program that utilises the knowledge and confidence of these experienced staff. This may help to alleviate the level of fear in those staff with less years of experience in the field of mental health and also provide another avenue for the integral interpersonal support following workplace incidents.
Chapter Four

The Impact of Assault on Staff Perceptions of Risk and Workplace Climate: A Forensic Perspective

The purpose of this study was to add to the growing body of literature on staff perceptions and extend the results from Study Two in the previous chapter. The aim of this study was to adopt the same methodology from Study Two but with a forensic mental health organisation. This was done in order to investigate whether previous research holds true that the added complexity of working in a secure environment with people who have known violent and/or criminal histories (i.e. a forensic setting) does not lead to more negative staff perceptions of both risk of assault and workplace climate.

The previous chapters have illustrated a number of key points in relation to the incidence of violence in the workplace, the influence of staff perceptions on subjective appraisals of risk, the influence of the workplace climate on perceptions and the importance of research in the area of perceptions in terms of organisational functioning. Importantly, it is known that violence by service consumers does indeed occur in mental health settings and that staff typically bear the brunt of these incidents (Dillner, 1994; Flannery, Fisher, Walker, Kolodziej & Spillane, 2000; Gournay, Ward, Thornicroft & Wright, 1998; Raja & Azzoni, 2005). This is due to the nature of their role and constant contact with consumers (Chou, Lu & Mao, 2002; Lanza, 1992; Morrison, 1998; Nijman, Bowers, Oud & Jansen, 2005; Quintal, 2002; Rippon, 2000). It is also widely accepted that violence is commonplace and staff more often than not expect to be subjected to physical or verbal assault at work (Bernstein, 1981; Bilgin & Buzlu, 2006;
Chappell & Di Martino, 2006; Leather, Brady, Lawrence, Beale & Cox, 1999; Vandenbos & Bulatao, 1996). Further, research has also shown that inpatient settings have higher rates of assault than community settings, which is hypothesised to be primarily due to the range of acute presentations in those who have been admitted (for example, Abderhalden et al., 2007; Alexander & Bowers, 2004; Kay, Wolkenfeld & Murrill, 1988; Krakowski, Czobor & Chou, 1999; McNiel & Binder, 1994b; Mellesdal, 2003; Stanley et al., 2000). However, staff in inpatient settings appear to hold less fear of assault, which is purported to relate to their direct and frequent experience in managing these incidents (Rose & Cleary, 2007; Thomas, Bartlett & Mezey, 1995). It has been suggested that people become less fearful over time as their experience becomes the norm (Thomas et al.).

The fact that staff in higher risk settings reportedly hold less fear about potential assault supports the notion that perceptions are subjective appraisals of one’s personal level of risk (Benjaminsen et al., 1996; Wykes & Whittington, 1998). Thus, due to their subjective nature, perceptions are prone to bias and may not necessarily be an accurate representation of actual risk. The research of Bilgin and Buzlu (2006) provided evidence in support of this, reporting that the majority of staff have an expectation that they will be assaulted despite only 54.9% of staff having actually been assaulted. Findings from the work of Benjaminsen et al., Bernstein (1981) and Wykes and Whittington also support this notion.

The idea that perceptions of risk and level of associated fear are not always true reflections of a staff member’s actual risk implies that it is not necessarily the assaultive incidents themselves that determine one’s perceptions. Instead, it is more about the way staff understand, interpret and make sense of
these incidents that is most likely to influence their perceptions (Gerdtz, Maude & Santamaria, 2005; Rogers & Kelloway, 1997). Workplace climate factors such as safety, support and aesthetics also contribute to this overall perception of risk and satisfaction with their current workplace, be it positive or negative (Arnetz & Arnetz, 2001; Barret, Riggar & Flowers, 1997; Carlsson, Dahlberg, Lutzen & Nystrom, 2004; Harenstam, Palm & Theorell, 1988; Hatch-Maillette & Scalora, 2002; Howard & Holmshaw, 2010). It is the impact of these workplace climate factors that can affect an employee’s psychological wellbeing, job satisfaction and productivity in the workplace (Nijman et al., 2005; Snowden, Gray, Taylor & Fitzgerald, 2009; Weyman & Kelly, 1999). At an organisational level, the flow on effect of negative perceptions can be very costly to an organisation due to issues such as absenteeism, decreased productivity and high staff turnover rates (Dowden & Tellier, 2004; Garrett & McDaniel, 2001). Of course the opposite is true if staff hold more positive perceptions, with reduced recruitment costs as a result of lower staff turnover rates, reduced funds needed for temporary replacements in the case of extended absenteeism and increased productivity. The potential impact perceptions can have on both the individual and the entire organisation substantiates the importance of continued research in the area of staff perceptions from both an individual and organisational perspective.

In addition to these factors, a forensic setting adds a further element of a criminal nature. There have been several studies that have shown that not only is there a high incidence of mental illness within prison settings, but also that those with criminal histories are more likely to act violently (Butler et al., 2006; Douglas, Cox & Webster, 1999; Douglas, Ogloff & Hart, 2003). As a forensic
setting, the Forensicare - Thomas Embling Hospital treats patients\(^3\) who have both serious mental illness and have committed a criminal offence (typically violent, such as murder or rape) but who have been found not guilty by reason of mental impairment. One study found that those with a history of serious mental illness (such as schizophrenia) coupled with a history of criminal conviction/s for violent crimes were much more likely to act violently than those with a violent criminal conviction who did not have a serious mental illness (males were 4.16 times more likely to be violent while females were 27.45 times more likely; Hodgins, 1992). This research would seem to indicate that those offenders with a diagnosed mental illness are at high risk/very likely to be violent, more so than the average criminal offender or person suffering from a mental illness in isolation.

It has been purported that fear is a motivator for attitude formation, where the more fear provoking a person (or their history) is, the greater the negative attitude will be towards them regardless of the patient’s actual risk of inflicting harm (Chiricos, Padgett & Gertz, 2000; Ferraro, 1995; Rogers & Kelloway, 1997; Sanderson, 2005; Warr, 2000). In other words, the greater the perceived risk of assault, the higher staff fear becomes and the more negative their associated perceptions are likely to be (Rogers & Kelloway). Evidencing this, Warr found that both the potential threat of assault patients pose and the increased risk of personal harm due to physical contact/proximity with these patients evoked a greater level of fear. Research by the Australian Institute of Criminology (2004) supported these findings, reporting that being in the presence of an offender was

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\(^3\) Note that for the purposes of the study described in this chapter the term ‘patient’ is used in reference to a person receiving a psychiatric service. This is in keeping with the terminology adopted by the organisation sampled.
associated with staff fearing that they were at increased risk of personal victimisation.

However, this does not appear to be the case for staff in forensic settings. Previous research has indicated that this increased risk of violence in a forensic setting does not lead to more negative staff perceptions. Interestingly, those working in (what has been deemed as) ‘higher risk’ settings such as inpatient and/or forensic facilities have a positive view of their ability to manage risk in the workplace, perceiving that they are not necessarily at high risk of patient assault. Thus, staff of forensic settings appear to have lower levels of fear of future assault compared with their community counterparts (Rose & Cleary, 2007). This would seem to imply that fear is more of an influential factor in community settings. Given this, it is predicted that those who work in a forensic mental hospital facility will hold a lower level of fear in relation to their risk of future assault.

Furthermore, it is also predicted that a difference will be seen between staff perceptions across the different units within the forensic facility, with those in medium to lower secure units (which hold more stable and longer-stay patients) reporting more negative perceptions than those working in the higher security units, which hold more acutely unwell and short-stay patients. However, due to the seemingly subjective nature of perceptions it is expected that, overall, staff will hold a higher level of fear of future assault and perceive that they are at greater risk than the actuarial data would suggest given the reported number of incidents.
In addition to these predictions, five hypotheses are made in order to test the perceptions of risk of assault and workplace climate held by staff of a forensic mental health service.

It is hypothesised:

1. That staff who have personally experienced assault by a patient will report a higher level of fear post-assault than they had prior to the assault.

2. That staff who have reported witnessing and/or experiencing assault by a patient will have a more negative perception of the workplace compared with staff who have not reported witnessing or experiencing assault by a patient.

3. That staff with more experience (as measured by years of experience working with psychiatric patients) will report being significantly less fearful than staff who have less experience.

4. That staff who work on high secure units will perceive their risk of patient assault as significantly lower when compared with staff who work on medium or low secure units.

5. That staff who work on high secure units will have a significantly more positive perception of the workplace compared with staff who work on medium to low secure units.
Method

Participants

Respondents were recruited from the population of clinical staff currently employed within the Forensicare – Thomas Embling Hospital in Fairfield, the only forensic mental health hospital currently operating in Melbourne.

There are seven units operating within the 116-bed facility of Thomas Embling Hospital; they range from acute through to community rehabilitation.

The respondents were drawn from all seven units, including:

- Acute units (high secure): Argyle and Atherton
- Sub-acute unit (high secure): Bass
- Female unit (high secure): Barossa
- Extended and sub-acute care unit (high-medium secure): Canning
- Rehabilitation unit (low-medium secure): Daintree
- Community rehabilitation unit (low secure): Jardine

Participant demographics.

Table 4.1

<table>
<thead>
<tr>
<th>Participant Gender</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>20</td>
<td>40.0</td>
</tr>
<tr>
<td>Females</td>
<td>30</td>
<td>60.0</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 4.2

*Age of Respondents*

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>14</td>
<td>28.0</td>
</tr>
<tr>
<td>30-39</td>
<td>8</td>
<td>16.0</td>
</tr>
<tr>
<td>40-49</td>
<td>10</td>
<td>20.0</td>
</tr>
<tr>
<td>50-59</td>
<td>18</td>
<td>36.0</td>
</tr>
<tr>
<td>60-69</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>70+</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.3

*Profession of Respondents*

<table>
<thead>
<tr>
<th>Profession</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>3</td>
<td>6.0</td>
</tr>
<tr>
<td>Nursing</td>
<td>40</td>
<td>80.0</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>2</td>
<td>4.0</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>Social worker</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>47</strong></td>
<td><strong>94</strong></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td><strong>3</strong></td>
<td><strong>6.0</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Table 4.4

*Length of Time Working with Psychiatric Patients*

<table>
<thead>
<tr>
<th>Length of Time</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 – 12 Months</td>
<td>2</td>
<td>4.0</td>
</tr>
<tr>
<td>1 - 2 Years</td>
<td>5</td>
<td>10.0</td>
</tr>
<tr>
<td>3 – 5 Years</td>
<td>6</td>
<td>12.0</td>
</tr>
<tr>
<td>6 – 10 Years</td>
<td>8</td>
<td>16.0</td>
</tr>
<tr>
<td>11+ Years</td>
<td>28</td>
<td>56.0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>49</strong></td>
<td><strong>98.0</strong></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td><strong>1</strong></td>
<td><strong>2.0</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.5

*Length of Time Working in Current Team*

<table>
<thead>
<tr>
<th>Length of Time</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 – 12 Months</td>
<td>21</td>
<td>42.0</td>
</tr>
<tr>
<td>1 – 2 Years</td>
<td>13</td>
<td>26.0</td>
</tr>
<tr>
<td>3 – 5 Years</td>
<td>10</td>
<td>20.0</td>
</tr>
<tr>
<td>6 – 10 Years</td>
<td>3</td>
<td>6.0</td>
</tr>
<tr>
<td>11+ Years</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>48</strong></td>
<td><strong>96.0</strong></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td><strong>2</strong></td>
<td><strong>4.0</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Table 4.6

*Length of Time Working in Organisation*

<table>
<thead>
<tr>
<th>Length of Time Working</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 – 12 Months</td>
<td>7</td>
<td>14.0</td>
</tr>
<tr>
<td>1 – 2 Years</td>
<td>9</td>
<td>18.0</td>
</tr>
<tr>
<td>3 – 5 Years</td>
<td>12</td>
<td>24.0</td>
</tr>
<tr>
<td>6 – 10 Years</td>
<td>6</td>
<td>12.0</td>
</tr>
<tr>
<td>11+ Years</td>
<td>15</td>
<td>30.0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>49</strong></td>
<td><strong>98.0</strong></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 4.7

*Team by Classification Type*

<table>
<thead>
<tr>
<th>Classification Type</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>8</td>
<td>16.0</td>
</tr>
<tr>
<td>Sub-acute</td>
<td>5</td>
<td>10.0</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td>18.0</td>
</tr>
<tr>
<td>Extended care</td>
<td>9</td>
<td>18.0</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>11</td>
<td>22.0</td>
</tr>
<tr>
<td>Community rehabilitation</td>
<td>7</td>
<td>14.0</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>49</strong></td>
<td><strong>98.0</strong></td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>50</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Table 4.8

*Security Levels*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>31</td>
<td>62.0</td>
</tr>
<tr>
<td>Medium – low</td>
<td>18</td>
<td>36.0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>49</td>
<td>98.0</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Overall, there were 50 respondents across Thomas Embling Hospital. Tables 4.1 to 4.8 presented above illustrate that the sample included a range of clinical disciplines, with the vast majority of respondents being nursing staff (80%). This is not unexpected given that the largest clinical staff population within these teams is nursing, specifically psychiatric nurses. As predicted, the majority of respondents were female (60%), however this percentage was lower than expected.

In relation to age, the highest percentage of respondents was in the 50-59 years category (36%). There were no respondents in the 60-69 years or 70+ age brackets. Given that Thomas Embling Hospital provides graduate training programs and student placements, the skew of ages towards the lower end of the spectrum is somewhat expected.

Interestingly, the highest number of respondents had only been working in their current teams for six to 12 months (42%), even though the highest percentage of respondents had been working for the organisation for 11 or more years (30%). This would suggest that although there is a tendency for staff to
move between the units, they continue to work for the organisation for an extended period of time.

As part of this study the researchers also obtained actuarial data pertaining to the number of assaults and assaultive related incidents that have been reported within each unit of Thomas Embling Hospital (refer to Table 4.9). This data was extracted from the RiskMan (Risk Management) database where all formally reported workplace incidents within Thomas Embling Hospital are recorded. The data included in Table 4.9 pertains to assaultive related incidents that occurred over the course of the previous financial year (1 July 2011 to 30 June 2012). This data identifies that the highest official total was recorded for ‘Mild’ incidents, with a total of 291 incidents, with the vast majority (86.25%) occurring in the acute (high security) units. No ‘Severe’ incidents were recorded for any units. Of those severity categories that did contain data, the lowest official total was recorded for ‘Moderate’ incidents, with a total of only eight reported incidents across all teams. There were no teams that did not report some form of incident for the last financial year, however, the sub-acute unit recorded the least number of incidents ($n = 1$).
Table 4.9

*Number of Reported Incidents Per Team/Location*

<table>
<thead>
<tr>
<th>Incident location (unit)</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>No harm/near miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyle</td>
<td>0</td>
<td>3</td>
<td>84</td>
<td>42</td>
</tr>
<tr>
<td>Atherton</td>
<td>0</td>
<td>1</td>
<td>80</td>
<td>22</td>
</tr>
<tr>
<td>Barossa</td>
<td>0</td>
<td>4</td>
<td>87</td>
<td>7</td>
</tr>
<tr>
<td>Bass</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Canning</td>
<td>0</td>
<td>0</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>Daintree</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Jardine</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>8</td>
<td>291</td>
<td>109</td>
</tr>
</tbody>
</table>

*Note.* Severity examples: Severe = death
Moderate = staff injury following restraint
Mild = threatening violence and property damage
No harm/near miss = verbal abuse

**Materials**

Participants were each given an A4 envelope containing: a Participant Information Form, a questionnaire, a prize draw consent form and two reply-paid envelopes.

The Participant Information Form (refer to Appendix L) contained important information about the purpose of the research, what participation involved, the possible benefits and risks of participating, how results would be disseminated, the privacy of their information and who to contact if they had any queries or complaints.

Participants were asked to complete a thirteen-page anonymous paper questionnaire (refer to Appendix M). The majority of the questionnaire was the
same as that used in Study Two (refer to previous chapter). However, given that Thomas Embling Hospital houses patients who have had contact with the criminal justice system, either transferred from a mainstream prison or ordered by the courts to be detained for psychiatric assessment and/or care and treatment, the question asking participants to “Estimate the number of clients with forensic histories seen by your team in the past year” was omitted. Further, the reference to ‘clients’ was replaced with the term ‘patients’, which is in keeping with the terminology of the organisation.

Based on Cronbach’s alpha, the overall reliability of the entire questionnaire was slightly lower than that of the previous study (.74), however was above the accepted .70. Thus, the reliability of the contents of the questionnaire was sound. However, upon further analysis of the individual sections of the questionnaire, two sections were below .70: Section B: Current views about work (.62) and Section D: Patient characteristics (.40). As per the previous study, the items from Section D were not utilised in the current study. However, even when omitting the problem item in Section B, ‘I feel very safe in my workplace’, this only marginally improved the reliability of the individual section to .64. Past research has indicated that an alpha level of between .60 -.69 does not necessarily mean the items should be discarded (George & Mallery, 2003). It is not uncommon for the reliability to be underestimated in instances where there are variations in normality and violations of this assumption (Wilcox, 1992), as was the case with the data pertaining to this questionnaire. Thus, whilst a limitation, this did not preclude the analysis of data obtained from Section B of the questionnaire.
As per the previous study, the purpose of developing a questionnaire to obtain the data was to enable the researchers to reach a large population of psychiatric service staff in the least confronting and time restricting manner. The decision to distribute the questionnaire in paper format was also made for Thomas Embling Hospital clinical staff, as staff did not always have access to computer facilities throughout their work day.

The prize draw consent form was a separate half-page form asking participants to tick a box if they wished to be entered into the prize draw and provide their name, signature and contact telephone number (refer to Appendix N).

**Procedures**

The study had institutional ethics approval from all participating agencies (refer to Appendices O and P).

The recruitment process involved the primary researcher attending a pre-arranged team meeting at each location to briefly present the study to staff. The primary researcher explained what was involved in participation and illustrated the documents each participant would receive in their A4 envelope (Participant Information Form, questionnaire, prize draw consent form and two reply-paid envelopes). It was also explained to staff that consent for participation in this research project was implied.

Staff completed the anonymous questionnaire and returned it to the primary researcher via the reply-paid envelope. Staff also completed and returned the prize draw consent form in the separate reply-paid envelope for the chance to win one of seven $50 Coles/Myer vouchers (one per hospital unit).
A reminder email was sent to each unit manager two weeks after the primary researcher distributed the questionnaire to staff on that unit (refer to Appendix K).

Data return was closed approximately eight weeks after the presentation to the last unit.

**Data Analysis**

The statistical analysis of the data from the questionnaire was performed using SPSS Version (20.0) for Windows. The analyses involved using non-parametric quantitative tests including the Wilcoxon Rank-Sum Test and the Kruskal Wallis Test.

**Results**

Of the 140 questionnaires distributed, 50 (35.71%) were returned within the researchers’ timeframe of approximately eight weeks.

Similarly to Study Two, prior to analysis the data were assessed for normality. As the data failed to fit the normal modal distribution, non-parametric tests were performed on the data. This was somewhat expected given the subjective nature of perceptions, as well as the fact that these perceptions were being measured in a highly specified population which yielded a relatively small sample. Outliers were inspected. All outliers were determined to be real responses and deemed important and were therefore included in the analyses. Table 4.10 summarises participant responses to the variables studied.
### Table 4.10

**Summary of Study Variables**

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Variable Description</th>
<th>Response</th>
<th>n (%)</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you been physically assaulted by a patient at work in the past year?</td>
<td>Yes (1)</td>
<td>11 (22.0)</td>
<td>1.78</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (2)</td>
<td>39 (78.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Do you have a higher level of fear of assault as a result of being assaulted?</td>
<td>Yes (1)</td>
<td>16 (32.0)</td>
<td>1.68</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (2)</td>
<td>34 (68.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Are you more vigilant since witnessing/experiencing patient assault?</td>
<td>Yes (1)</td>
<td>31 (62.0)</td>
<td>1.38</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (2)</td>
<td>19 (38.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you witnessed and/or experienced verbal or physical assault at work?</td>
<td>Yes (1)</td>
<td>46 (92.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (2)</td>
<td>4 (8.0)</td>
<td>1.08</td>
<td>1.00</td>
</tr>
<tr>
<td>2 &amp; 5</td>
<td>I enjoy coming to work each day.</td>
<td>Strongly Agree (5)</td>
<td>7 (14.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agree (4)</td>
<td>25 (50.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uncertain (3)</td>
<td>12 (24.0)</td>
<td>3.64</td>
<td>4.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree (2)</td>
<td>5 (10.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strongly Disagree (1)</td>
<td>1 (2.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 &amp; 5</td>
<td>I have a positive view of my workplace.</td>
<td>Strongly Agree (5)</td>
<td>4 (8.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agree (4)</td>
<td>27 (54.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uncertain (3)</td>
<td>9 (18.0)</td>
<td>3.46</td>
<td>4.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree (2)</td>
<td>8 (16.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strongly Disagree (1)</td>
<td>2 (4.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I am very fearful of patient assault at work.</td>
<td>Strongly Agree (5)</td>
<td>5 (10.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Agree (4)</td>
<td>10 (20.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uncertain (3)</td>
<td>6 (12.0)</td>
<td>2.64</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disagree (2)</td>
<td>20 (40.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strongly Disagree (1)</td>
<td>9 (18.0)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Note. For a summary of the variables of length of time working with psychiatric clients and inpatient versus outpatient/community teams refer to Table 4.4 (p.102) and 4.8 (p.104) respectively.

In order to test hypothesis one, ‘That staff who have personally experienced assault by a patient will report a higher level of fear post-assault then they had prior to the assault’, respondents’ scores on the item, “Have you been assaulted by a client at work in the past year” (Section C, Question 4) were compared with their scores on the combined variable of ‘level of fear post-assault’. This ‘level of fear post-assault’ variable incorporated two items on the questionnaire, “Do you have a higher level of fear of client assault as a result of having witnessed and/or experienced client assault”, and “Are you more vigilant at work since witnessing and/or experiencing client assault” (Section C, Questions
11 and 12). It was decided that combining these items provided a good collective
gauge of a respondent’s level of fear following either witnessing or experiencing
an assault/s rather than either of these items on their own.

The Wilcoxon Rank-Sum Test was conducted and found a statistically
significant result with a moderate effect size, \( W_s = 205.00, Z = -1.88, p = .04, r = .27 \). Those individuals who reported having been assaulted by a client at work in
the past year also reported a higher level of fear from pre- to post-assault.

In order to test hypothesis two, ‘That staff who have reported witnessing
and/or experiencing assault by a patient will have a more negative perception of
the workplace compared with staff who have not reported witnessing or
experiencing assault by a patient’, respondents’ scores on three items were
compared. Similarly to Study Two in the previous chapter, the item: “Have you
witnessed and/or experienced verbal or physical assault at work” was compared
with scores on the combined variable of ‘perception’. This ‘perception’ variable
consisted of two items on the questionnaire, “I enjoy coming to work each day”,
and “I have a positive view of my workplace” (Section B, Questions 1 and 3). The
decision to use these two variables was made on the basis of the definition of a
perception, which for the purpose of this study referred to the way staff
experience their workplace; in other words, how they view, understand and
interpret both interactions and incidents in the workplace, and the workplace
environment itself.

The Wilcoxon Rank-Sum Test was conducted, however a non-significant
result was found with a small effect size, \( W_s = 1155.55, Z = -.64, p = .26, r = .09 \).
There was no significant difference in staff perceptions of the workplace (i.e. their
view of their workplace and enjoyment at work) regardless of whether they had witnessed or experienced verbal or physical assault at work.

In order to test hypothesis three, ‘That staff with more experience (as measured by years of experience working with psychiatric patients) will report being significantly less fearful than staff who have less experience’, respondents’ scores on four items were considered. As was the case in Study Two, the item: “How long have you been working with psychiatric clients” (Section A, Question 10) was compared with scores on the combined variable of ‘fear’. This ‘fear’ variable incorporated three items on the questionnaire: “I am very fearful of client assault at work”, “I am very vulnerable to client assault at work”, and “I am very fearful that I will be threatened by a client at work” (Section B, Questions 8, 9 and 10). It was decided that these items sufficiently captured the level of fear felt by respondents.

A Kruskal-Wallis Test was conducted and a non-significant effect was found with a medium overall effect size, $H(3) = 4.06, p = .40, \eta^2 = .09$. Thus, there was no difference in the level of fear felt by a staff member irrespective of the number of years of experience they have working with a psychiatric population. Further, the median level of fear held across all groups was two and a half out of five. This indicates that, as a collective, respondents’ level of fear tends to be towards the lower to mid-range of the scale (1= very little fear, 5 = high level of fear).

In slight contrast to Study Two, hypothesis four predicted ‘That staff who work on high secure units will perceive their risk of patient assault as significantly lower when compared with staff who work on medium or low secure
units’. In order to test this hypothesis, respondents’ scores on the item, “I am at very high risk of client assault” (Section B, Question 6) were compared against whether they worked on a high secure unit or medium to low secure unit. Note that, for the purposes of this study, the medium and low secure units were combined to form one grouping to compare against the high secure units. The respondents were divided into the high secure or medium to low secure group, which was dependent on the unit they primarily worked on. As per the categorisation by the organisation itself, five units (Argyle, Atherton, Barossa, Bass and Canning) were included in the high secure group, and the other two units (Daintree and Jardine) formed the medium to low secure group.

The Wilcoxon Rank-Sum Test was conducted and a non-significant result was obtained with a moderate effect size, $W_s = 378.500$, $Z = -1.54$, $p = .07$, $r = .16$. This demonstrates that perception of risk is considered equal irrespective of whether or not staff work on a unit deemed to be a high secure setting or a unit that is medium to low secure. Interestingly, the overall median of all respondents was four out of five, which indicates that the entire sample held the belief that they were at a reasonably high risk of patient assault at work.

In order to test hypothesis five, ‘That staff who work on high secure units will have a significantly more positive perception of the workplace compared with staff who work on medium to low secure units’, respondents were divided into two groups (high secure and medium to low secure) depending on the unit in which they worked. As per hypothesis two, the high secure setting group consisted of five teams (Argyle, Atherton, Barossa, Bass, Canning) and the other two units (Daintree and Jardine) were included in the medium to low secure setting group.
These groups were then compared based on their scores on the combined variable of ‘perception’. This ‘perception’ variable consisted of two items on the questionnaire, “I enjoy coming to work each day”, and “I have a positive view of my workplace” (Section B, Questions 1 and 3). Similarly to the testing of hypothesis two, the decision to use these two variables was made on the basis of the definition of a perception.

The Wilcoxon Rank-Sum Test was conducted, however a non-significant result was found with a small effect size, \( W_S = 382.50, Z = -1.44, p = .08, r = .21 \). In other words, there is no significant difference in staff perceptions (i.e. their view of their workplace and enjoyment at work) between those who work in high secure settings and those who work in medium to low secure settings. Interestingly, the median rank for respondents’ overall scores on the perception variable was four out of five. This suggests that the majority of staff do in fact enjoy coming to work each day and hold a more positive rather than negative view of their workplace.

To further assess staff perceptions of the workplace climate (hypothesis five), and to establish if there was a difference between the high secure units and medium to low secure units, staff responses to the Work Environment Scale were compared. These scores were also compared to the mean values for the norm group of 4,879 employees in health care and social services environments, including outpatient general medical and psychiatric services, patient care personnel, state mental hospitals, and long-term care units. It is acknowledged that the norm population was taken from the San Francisco Bay Area in the United States, which operates under a markedly different health care system to
that of Australia. However, it is thought that these staff would share some similarities as Moos (2008) acknowledged that all health care workers typically work in environments that are more stressful and emotionally taxing compared with those who work in mainstream business corporations.

As per the description provided in the previous chapter (refer to pp.79-80) the items for the WES were scored using the scoring key provided by the authors of the tool and converted to a standard score for comparison.

Table 4.11 shows that as a cohort (overall) staff ratings of their workplace environment spanned the ‘Well below average’ to ‘Above average’ ranges. The overall highest score was within the Relationship dimension for Peer cohesion (6.00) and the overall lowest score corresponded to the subcategory of Physical comfort within the System maintenance and system change scale (3.20). The overall means were lower in comparison to the norm mean health care work group (refer to Table 4.11) except for scores on Peer cohesion and Supervisor support, which were slightly above that of the norm comparison. In terms of the comparison between high secure and medium to low secure units, there were differences in five of the ten subcategories. High secure units scored higher on Peer cohesion, Supervisor support, Autonomy and Clarity, whereas the medium to low secure units scored higher on Work pressure. However, these differences were not found to be statistically significant.
### Table 4.11

**Workplace Climate Data**

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Mean rating</th>
<th>Interpretive statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High secure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium − low secure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norm mean health care group</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>5.40</td>
<td></td>
</tr>
<tr>
<td><strong>High secure</strong></td>
<td>5.75</td>
<td></td>
</tr>
<tr>
<td><strong>Medium − low secure</strong></td>
<td>5.93</td>
<td></td>
</tr>
<tr>
<td><strong>Norm mean health care group</strong></td>
<td>5.80</td>
<td>Average</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High secure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medium − low secure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Norm mean health care group</strong></td>
<td></td>
<td>Average</td>
</tr>
<tr>
<td>Relationship dimension (<em>n</em> = 50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Involvement</strong></td>
<td>5.54</td>
<td>Average</td>
</tr>
<tr>
<td><strong>Peer cohesion</strong></td>
<td>6.00</td>
<td>Average</td>
</tr>
<tr>
<td><strong>Supervisor support</strong></td>
<td>5.06</td>
<td>Below average</td>
</tr>
<tr>
<td>Personal growth or goal orientation (<em>n</em> = 50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td>5.02</td>
<td>Average</td>
</tr>
<tr>
<td><strong>Task orientation</strong></td>
<td>4.86</td>
<td>Well below average</td>
</tr>
<tr>
<td><strong>Work pressure</strong></td>
<td>4.74</td>
<td>Above average</td>
</tr>
<tr>
<td>System maintenance and system change (<em>n</em> = 50)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clarity</strong></td>
<td>4.70</td>
<td>Below average</td>
</tr>
<tr>
<td><strong>Control</strong></td>
<td>5.26</td>
<td>Above average</td>
</tr>
<tr>
<td><strong>Innovation</strong></td>
<td>3.32</td>
<td>Below average</td>
</tr>
<tr>
<td><strong>Physical comfort</strong></td>
<td>3.20</td>
<td>Well below average</td>
</tr>
</tbody>
</table>
Discussion

Overall, the findings appear to indicate that staff in the forensic setting currently have a positive perception of their risk of assault and of the workplace climate. However, similarly to the previous study described in Chapter Three, the findings and subsequent conclusions of this study must be interpreted with some degree of caution due to the relatively low response rate (35.71%).

Whilst most of the hypotheses were not found to be significant, much of the previous literature is supported, particularly in relation to increased fear and hypervigilance following an assaultive incident. However, a major finding, contradictory to that of both the previous research and the hypotheses posed, was that increased fear did not equate to a more negative workplace perception post-assault. Further, neither years of experience working with psychiatric patients or the type of unit appeared to influence fear or perceptions of risk of assault.

In terms of workplace climate, the findings indicated that staff were generally satisfied with the organisation’s response to patient assaults. However, areas of concern were raised regarding individual elements of the workplace climate, particularly by staff working on medium to low secure units.

Effect of Assault on Fear and Perceptions of Risk of Future Assault

In keeping with the results of Study Two, this study indicated that fear of assault is influenced by whether or not a staff member has witnessed or experienced assault. If a staff member had witnessed or experienced assault, then they were more likely to report an increased level of fear from pre- to post-assault compared with the level of fear reported by those who had not been assaulted.
This fear incorporated an element of increased vigilance and sympathetic nervous system arousal. The increased fear has been characterised as hypervigilance, as there is no evidence to suggest that a staff member’s actual risk of future assault has in fact increased as a direct result of their most recent assault. This finding supports the research of Carmel and Hunter (1991) and Flannery et al. (2000) that hypervigilance typically occurs post-assault. Given that staff reported being more vigilant post-assault, they are likely to be more acutely aware of changes in patients and their immediate environment and potentially on edge, which would account for their increased fear.

One possible explanation for this finding could be the relative recency of the assaultive incidents. Given that this study asked respondents about assaults that had occurred within the last year, it may be that they are still processing the incident or that there is a time-limiting element to their increased hypervigilance that has not yet expired. Due to the relative recency of the incidents, it is not known whether this increased fear post-assault is ongoing or whether it reduces with the passage of time. This could be tied to potential symptoms of anxiety or post-traumatic stress. These symptoms may have heightened staff arousal and caused them to be more alert post-assault. Furthermore, asking staff about their experiences of assault may serve as a prompt that arouses otherwise dormant processing of emotion-laden thought content. Thus, the study lends importance to perceptions of fear that may not have a ready voice within the daily routine.

There is also a possibility that staff may have become complacent or have lulled themselves into a false sense of security if they have not recently been exposed to an assault. Consequently, their level of fear would seemingly increase.
STAFF PERCEPTIONS

pre- to post-assault. As such, their increased fear post-assault would likely be due to this assaultive incident acting as a reminder that they work in an unpredictable and ‘at risk’ environment in which assault can readily occur.

Another explanation for the increased level of fear is that staff may feel increasingly out of control in their work environment, in that it serves as a reminder of the unpredictable nature of clients with a mental illness. This may have increased their level of fear and arousal as they may now consider themselves a known target of patients, or feel that other patients will see them as an easy target. In their minds, this may signify that they are more likely to be victimised again by other patients (Howard & Hegarty, 2003). Given this perceived lack of control, staff fear may also have increased as they believe that having previously been assaulted has increased the likelihood of being assaulted in the future (Flannery, Fulton, Tausch & DeLoffi, 1991; Howard & Hegarty; Walsh & Clarke, 2003). Whilst not specifically addressed in the current study, the perceived humiliation or embarrassment of being assaulted at work may also contribute to this increased fear (Needham, Abderhalden, Halfens, Fischer & Dassen, 2005; Rowe & Sherlock, 2005; Walsh & Clarke; Whittington & Wykes, 1992) and could be an avenue for further research.

Actual Risk Compared with Perceptions of Risk and Associated Fear

In contrast to the results of Study Two, experience working with psychiatric patients did not play a role in a staff member’s level of fear of future assault. Whilst increasing post-assault, a staff member’s level of fear was not influenced by years of experience working with psychiatric populations. All staff (regardless of their years of experience in the field) held a collectively moderate
level of fear. Perhaps this speaks to the unpredictability of working with patients with psychiatric disorders, specifically those who have psychiatric disorders and a known forensic history.

A further explanation for this regression towards the mean may be that those with more years of experience have learnt to regulate their fear and not be overly fearful in their work environment, but at the same time be alert enough to intervene to prevent patients from escalating to assaultive behaviour. By the same school of thought, those with less experience may be more naive and may not have experienced many assaultive incidents, if any. Thus, they may not consider that they themselves are personally at high risk. The lack of experience in dealing with assaultive incidents may mean such staff do not know what to expect, which is in keeping with the research of Rose and Cleary (2007). In other words, they are not aware of the potentially confronting nature of the incident, which would potentially limit their level of fear.

Regardless of whether this explanation holds true, it would not seem sustainable in the longer term for staff to hold much higher levels of fear than the reported moderate level. Prolonged high levels of fear would indicate that staff may not be able to function effectively in their current work environment (i.e. with an offending psychiatric population; DeLongis, Folkman & Lazarus, 1988; Janis, 1993; Johnson & Sherman, 1997; Mandler, 1993; Seta, Seta & McElroy, 2002). If they held an ongoing high level of fear, it may be reasonable to question whether the chosen field, patient population and workplace are appropriate for the particular staff member. This notion provides support for the ‘healthy worker effect’ in that those staff with less positive perceptions and persistently high levels
of fear are likely to self-select out of these environments (Eisen & Robins, 2002; Li & Sung, 1999; McMichael, Spirtas & Kupper, 1974). Thus, only those with relatively positive perceptions of their work environment and intact coping skills remain and are able to function effectively.

Interestingly, the type of unit (i.e. higher or lower in risk) was not shown to be associated with the level of fear held or the type of perceptions held. Contrary to the prediction, those working in higher risk units were no less fearful than those working in lower risk units. Further, those in higher risk (acute) units did not hold lower perceptions of risk than those in lower risk (long-stay) units. These results would seem inconsistent with the previous literature of Rose and Cleary (2007) that, more staff on inpatient/high risk units have lower perceptions of their risk of assault than their lower risk counterparts. However, these results provide evidence in support of the notion described by Gerdtz et al. (2005) and also by Hatch-Maillette and Scalora (2002) that perceptions are not an accurate reflection of actuarial risk and are subjective in nature.

There are several explanations for these findings; firstly, the result may be due to the forensic nature of the facility and its patients, bearing in mind that previous offenders (who constitute a vast majority of the patient population at the hospital) are more likely to commit future criminal acts than their non-offending counterparts (Douglas et al., 1999, 2003). It is difficult to differentiate the risk levels between the units of this specialist facility as all of the units house patients with offending histories and serious mental illness, albeit at varying stages of their treatment. Whilst contradictory to the prediction, the result is somewhat explained by the fact that the entire hospital is a secure facility surrounded by high walls,
detection sensors, locked wards and entry/exit security clearances. In this respect patients are all seen as ‘at risk’ regardless of their stage of treatment or level of mental illness.

These findings also give rise to the notion that fear and perceptions do not differ a great deal when all patients treated at the hospital are considered to be at risk of assaultive behaviour. It could be argued that staff do not identify a great deal of difference between the two risk levels and view all patients as collectively at greater risk of being assaultive. As such, the level of fear they hold is similar across the units.

Further, whilst those patients in acute units are inherently unpredictable as they are typically more acutely unwell, these patients generally have less freedom, decision-making powers and instances of trust, and are arguably more closely monitored than those in less acute units. This is because those in less acute units have demonstrated increased stability in their mental health, proven ability to abide by the rules, and have shown appropriate behaviour and a degree of emotion regulation. An example of this is the progressive leave scheme operating within the hospital which works on a rewards system whereby patients are given time either off the unit (on-campus) or off-campus outside the grounds of the hospital. There are also variations within the leave system in which staff can escort patients or they may be unescorted and leave the facility independently. Thus, although there are different units that differentiate the types of patients (which is somewhat dependent on their risk) all patients within the hospital are necessarily assessed on an individual basis. Therefore, risk in this instance is not relative to each unit per se but rather to the facility as a whole.
Perceptions of Workplace Climate

In contrast to the predictions, unlike the effect on level of fear, witnessing or experiencing an assault did not lead to staff holding a more negative perception of their workplace overall. This provides support for the notion that increased fear is a time-limited response. Perceptions of the workplace, on the other hand, would appear to be more ingrained and less likely to shift with sporadic external influences such as patient assault.

Further, the increased fear may not have led to a negative change in overall perception of the workplace because of the level of support provided by the organisation and the policies in place for dealing with assaultive incidents. This would suggest that the experience of assault alone does not solely influence a staff member’s perception of their workplace. Matters such as the effectiveness of the debriefing and the organisation’s handling of the assault and post-assault reactions may be more influential on perceptions of the workplace than the assaultive incident itself. Although staff may have an increased level of fear post-assault, they are still reportedly content with their overall workplace and the policies and resultant level of personal support they receive.

A possible explanation for this is that the hospital has policies that apply to each unit and a standardised method of incident management and response. This streamlined process means that the same level of response is provided no matter which unit of the hospital staff work on or which unit is the scene of an assaultive incident. This could potentially explain why employees tend to hold a similar perception of the workplace regardless of the acuity of patient mental illness and actuarial level of risk. All staff, to a degree, are afforded the same protection.
Similarly, the hospital is also a purpose built facility with all units having a very similar if not identical structure and design. Therefore, although it is expected that staff may hold different perceptions as a result of interacting with a different patient population (i.e. acute or long-stay and high risk or lower risk), this difference is likely to be somewhat offset by the organisational and environmental consistencies.

Specifically looking at the workplace climate data from the WES, it appears that staff who work on both the high secure units and those who work on medium to low secure units hold similar perceptions of the workplace climate in relation to: Involvement, Task orientation, Managerial control, Innovation and Physical comfort. Overall, positive perceptions appear to exist surrounding the extent to which employees are concerned about and committed to their jobs and the emphasis on good planning, efficiency and getting the job done. However, both groups held similar more negative perceptions of the emphasis on variety, change and new approaches; management’s use of rules and procedures to keep employees under control; and the extent to which the physical surroundings contribute to a pleasant work environment. In other words, staff thought that the organisation did not place enough emphasis on change, they were also critical of management’s method of controlling employees, and they did not think highly of the physical environment.

Given that all of the units are very similar in design, it is not surprising that staff hold similar perceptions about the physical environment. However, the fact that staff are not particularly fond of the physical environment is unexpected as Thomas Embling Hospital is a purpose built facility, and having been
constructed in 2000, is relatively new and more updated than many other hospital facilities in the wider Melbourne metropolitan area. It is possible that the seemingly negative perceptions about the physical environment are in part due to the forensic nature of the setting, with locked doors, windows that do not open, the need for duress alarms and the use of scramble pin pads to exit each unit. It may also be that the forensic patient population negatively affects staff perceptions of the physical environment, with staff perceiving the unit as more of a prison-like setting rather than a hospital facility and permitting their fear and perceptions of risk of assault to cloud their view of the physical environment. This is in keeping with the research of Briere (2012), who found that the harsher the conditions of the physical environment of a prison, the greater the negative affect it had on staff wellbeing. Woodall (2013) also recognised the uniqueness of a prison setting, identifying a need for better health promotion in prisons. He reported that staff needs are often neglected and that prison settings are significantly behind other more mainstream workplaces in terms of addressing staff wellbeing (Woodall). Being a quasi-prison environment (albeit more therapeutic), these findings may also be applicable to the current setting.

Providing evidence in support of previous research (for example, Rose & Cleary, 2007), those staff who worked on high secure units held more positive perceptions than their medium to low secure unit colleagues regarding: the extent to which employees are friendly and supportive of each other; the extent to which management is supportive of employees and encourages employees to be supportive of one another; how much employees are encouraged to be self-sufficient and to make their own decisions; whether employees know what to expect in their daily routine and how explicitly rules and policies are
communicated. Perhaps due to the nature of the patient population, the acute units have a more highly structured day, which could account for the lack of clarity experienced in the medium to low secure units surrounding daily routine/rules and policies. As patients in the medium to low secure units are arguably given more freedom and choice than the high secure units, potentially staff feel that they need more guidance surrounding patient leave policies and other similar matters.

The comraderie on the medium to low secure units, whilst not as positively perceived as the high secure units, was still rated as adequate. However, employees on the medium to low secure units believed that the support they received from management and other employees could be improved, as could the support and encouragement they received to be more autonomous in their day-to-day tasks. This perhaps provides an explanation as to why medium to low secure units rated their worked demands as more pressured than did the high secure units.

If these units perceive a lack of support and supervision and do not believe that they are thought to be competent enough to work autonomously, then it follows that they may experience stress, particularly in relation to work tasks. Further, the perceived lack of clarity around roles would also likely be contributing to this perceived pressure. However, this perception of above average work demands is somewhat unexpected, as it was assumed that those on acute units would have higher work demands due to the increased patient demands, acute symptomology, monitoring and escorted leaves. This result does not necessarily mean that those on medium to low secure units have objectively greater work demands placed on them; instead, it may be that high secure units
have adopted superior coping mechanisms to manage the stress of time pressure and work demands, for example through better teamwork or supervision.

**Limitations**

The limitations identified in Study Two of sample size, generalisability, the use of a tool without validated psychometric properties and the length of time required to complete the questionnaire also apply to the current study.

There was a slightly lower response rate of 35.71% for the current study. Whilst this could be deemed a reasonable response rate, it is of interest that 64.29% of the sampled population chose not to participate. As such, selection bias is likely a significant confounding variable. One reason for this could be time constraints, whereby staff did not believe they could afford to take the required time out of their day to respond. However, this would seem to be more true of staff working on medium to low secure units as they perceived greater workplace pressure compared with both the healthcare norm and those working on high secure units. This was reflected in the response rate, with fewer respondents from medium to low secure units (36%) compared with those from high secure units (62%).

Another possible explanation is that staff were relatively content with their current workplace and did not feel the need to complete the questionnaire. Alternatively, staff may have had more negative views of their workplace but were not convinced of their anonymity. As such they may not have wished to put themselves at risk of being identified and having their opinions of their workplace made public. Another issue could have been that of insufficient incentive, in that
employees did not consider that the prize draw was adequate compensation for the time required to participate.

Another consideration is that the relatively poorer reliability of Section B of the questionnaire may have contributed to a non-significant result for some hypotheses. Reviewing the items and improving the reliability of this section of the questionnaire may have led to a significant result. However, given that four out of the five hypotheses produced a non-significant result, it is a possibility that a larger sample may have yielded statistically significant results. If this were the case, future studies replicating these results would be useful in order to determine that the effect is real and not attributed to a small sample size.

**Conclusions and Recommendations**

The purpose of this study was to ascertain the current perceptions of risk of assault and of the workplace climate for staff working in a forensic mental health setting. The study also aimed to assess whether the forensic nature of the facility and patient population played a role in the formation of these perceptions.

Indeed, it was concluded that the forensic nature of the patient population and particular aspects of the facility itself were likely to have impacted negatively on some staff perceptions of both risk of assault and workplace climate. However, overall the findings seemed to suggest that staff perceive that the organisation currently handles assaultive behaviour by patients well. Staff appear to be content with their overall workplace and the policies and personal support that they receive, particularly in relation to the management of assaultive incidents.

Interestingly, employees reported higher levels of fear post-assault, but
this was not mirrored in their overall perceptions of the workplace climate. Therefore, it was deduced that violent and assaultive behaviours are not the sole determinant of staff perceptions of the workplace climate. Further, experience was not shown to influence a staff member’s fear or perceptions of risk of future assault, nor did the type of unit impact on a person’s fear or overall perceptions of the workplace. These findings lend themselves to the idea that fear is time-limited, whereas perceptions are more ingrained and difficult to alter.

Overall, staff reported similar perceptions of the workplace climate and identified three main areas for improvement: emphasis on change and new approaches; the enforcement of rules and procedures by management; and the aesthetic appeal of the physical environment. The medium to low secure units also noted a lack of supervision, unclear expectations of duties and pressured work demands as areas of poorer performance by the organisation. A possible targeted intervention could be to incorporate workshops and practical strategies to promote effective coping mechanisms, together with psychoeducation about the effects of prolonged stress, into professional development plans and/or staff training days.

The results of this study are pleasing in that staff of this organisation appear to hold reasonable and seemingly functional levels of fear and relatively positive perceptions of the workplace climate. This study also demonstrated that staff appear to be very in tune with how they perceive their environment and what factors contribute to their reactions to events. This will place them in good stead for dealing with future assaultive behaviour from patients. However, all staff should be encouraged to utilise the available organisational and supervisory support, particularly following an incident in the workplace.
Chapter Five

Overall Discussion

Major Findings

Contrary to prior research and predictions, it appears that staff of the two psychiatric services evaluated have a relatively positive outlook in relation to their fear of future assault, and positive perceptions of the workplace climate. Further, staff across both organisations reported feeling that a good level of support was available to them post-incident should they be assaulted by a client/patient at work. These findings provide evidence in support of the qualitative data obtained in Study One that the more supported staff felt, the safer they deemed their workplace to be.

As expected, prior assault influenced the level of fear and vigilance that staff reported experiencing. In other words, staff who had previously been assaulted reported an increased fear of future assault (personal risk) and an increase in their overall vigilance compared with prior to their assault. This is consistent with the findings of Wkyes and Whittington (1998). It is likely that time plays a role in this heightened sense of fear, with the relative recency of the reported assaults (within the past twelve months) giving rise to this temporary increase in fear and alertness. This heightened sense of fear would likely decrease as the recency of the assault dissipates and the individual’s adaptive response and stress system is no longer overactive (Johnson, Kamilaris, Chrousos & Gold, 1992). This is supported by the fact that the vast majority of staff continue to work in psychiatric services and the organisations have not reported increasingly
high and alarming rates of post-traumatic stress disorder, major depression or generalised anxiety disorder in staff.

Interestingly, whilst workplace assaults impacted on fear, the same could not be said for perceptions of the workplace climate. Instead, perceptions of the workplace climate did not differ significantly between those who had experienced assault by patients/clients at work and those who had not. In contrast to the findings of McKinnon and Cross (2008), it is suggested that, assaultive experiences are not a major predictor of overall workplace satisfaction. Given this, it appears likely that perceptions of workplace climate are more related to factors such as available support and management of incidents, whereas perceptions of personal risk and safety are more directly related to the occurrence of the assaultive incidents themselves. Thus, it would seem that perceptions of workplace climate are harder to shift and potentially more ingrained than perceptions of personal risk and safety. That being said, there are also a myriad of factors that encompass workplace climate, meaning that one aspect alone (i.e. safety/vulnerability) may not be sufficient to shift overall workplace attitudes. Further, depending on how staff view and interpret patient/client assault, organisations are less likely to be seen to have played a main causative role in the occurrence of assaultive incidents, therefore staff would not necessarily view the workplace in a more negative light following such an experience.

As expected, another major finding was that assault is more commonplace in inpatient and acute (high secure) units, which is consistent with much of the previous research (e.g. Abderhalden et al., 2007; Alexander, 2005; Mellesdal, 2003; and Stanley et al., 2000). This provides some support for the notion that the presence and severity of psychotic symptomology likely plays a role in an
individual’s propensity for violence (Daffern, Howells, Ogloff & Lee, 2005). However, given the findings of previous research, it is more likely that the physical environment and the restrictions placed on patient liberty during an inpatient stay directly contribute to an increase in the probability that an individual will act violently.

While the current studies did not directly measure these restrictions, design theory (e.g. Depp, 1976; Dietz & Rada, 1982; Fottrell, 1980; Wong, Slama & Liberman, 1987) and the theory of the function of patient aggression as either hostile or instrumental (Bushman & Anderson, 2001; McEllistrem, 2004; Weinshenker & Siegel, 2002) may help to explain the increased prevalence of violence in inpatient settings. Further explanation can be found in the diathesis-stress model and the findings of Daffern et al. that patients are more likely to be exposed to environmental stressors outside of their control in acute settings, which extends them beyond their limited coping abilities and potentially leads to assaultive behaviour.

**Comparison between Metropolitan and Forensic Psychiatric Services**

One of the aims of this dissertation was to compare staff perceptions across a metropolitan (area mental health) and a forensic psychiatric setting. The metropolitan health setting utilised is one of Victoria’s largest public health services and the forensic setting is the only forensic psychiatric hospital operating in Victoria. Previous research suggests that there are clear differences in the perceptions of staff working in ‘high risk’ environments; these include inpatient settings and secure forensic settings like Thomas Embling Hospital. Furthermore, the researchers were keen to investigate the impact, if any, on staff perceptions in
a setting where staff are treating those with the added complexity of a forensic history and arguably are at higher risk of assault.

Of primary interest was the expected contrast between these environments and the expectations/perceptions of staff working in these different environments rather than the similarities, and the comparisons between the organisations as a whole rather than at a team level. The qualitative differences allow for assumptions to be made as to what underlies the observed differences between the settings.

However, whilst it is acknowledged that both settings can be viewed as qualitatively different in some respects, there are some key similarities that allow for comparison, such as the structure of the wards/units, the mental health issues with which patients/clients present and the multidisciplinary teams that work within each team. Eastern Health psychiatric staff also come into contact with clients who have had forensic contact or possess criminal histories, albeit less frequently than in a purely forensic setting.

Regardless of whether they have a criminal history, the patients/clients across both locations are all being treated for psychiatric concerns. Similarly to the various teams that encompass Eastern Health Psychiatric Services, the units of Thomas Embling Hospital range from acute and sub-acute to rehabilitation and independent living. The security also ranges from high (acute) to low (rehabilitation). Furthermore, Thomas Embling Hospital is run as a hospital facility rather than a prison environment. Even though a secure outer wall surrounds Thomas Embling Hospital, all units are run as shared accommodation, with open plan living, individual bedrooms and group programs. As such,
parallels can be drawn, for example, between the acute units of Thomas Embling Hospital and the Eastern Health inpatient units at Maroondah Hospital. In terms of security, beyond the initial entry point, security guards do not patrol the forensic facility itself. Similarly to teams within an area mental health service, incidents in which a duress alarm is activated are responded to by the psychiatric staff on a rotating roster, with all permanent staff at the forensic service trained in de-escalation and M4 (mechanical) restraint.

However, a key difference in perceptions between these two settings was the interplay between years of experience and reported level of fear. For those working in the metropolitan health setting, there was a significant difference in level of fear between those who had been working with psychiatric clients for six months and those who had been working with psychiatric clients for six years. This supported prior research that fear was somewhat dependant on experience (Arnetz, Arnetz & Petterson, 1996; Carmel & Hunter, 1991; Poster & Ryan, 1994; Rose & Cleary, 2007); however, no differences in fear were seen regardless of whether staff had been working with psychiatric clients for a year, three years or five years. On the contrary, those in the forensic setting held a consistent moderate level of fear regardless of experience. This supports the research of the Australian Institute of Criminology (2004), Chiricos, Padgett and Gertz (2000), Ferraro (1995), Sanderson (2005) and Warr (2000) that staff hold an increased level of fear of personal victimisation when treating psychiatric patients with forensic histories than they do treating patients without a forensic history.

Alternatively, the forensic setting may provide more comprehensive or frequent training to all staff rather than specific units, as staff on all units are regularly at higher risk than those in an outpatient/community metropolitan team
purely due to the volume of patients with forensic histories and the added complexity of working in a secure facility. Forensicare tend to provide all staff with the same training opportunities regardless of unit/team, therefore in line with the research of Berry, Barrowclough and Wearden (2009) and Gerace, Hughes and Spunt (1995) all staff are able to build on their existing clinical knowledge and skill base, which is likely to positively impact staff confidence. This could explain why years of experience were not seen to play a role in this setting. Thus, the increased risk associated with patients with a forensic history is not necessarily driving the consistently moderate level of fear within a forensic setting. Instead, all staff in the forensic setting could be seen to be on more of a level playing field when it comes to training and confidence than staff in the metropolitan health setting. In other words, to a degree the role of experience in terms of years of practice is important in a metropolitan health setting but does not hold true in a forensic setting. Furthermore, working with patients with a forensic history coupled with consistent training across all teams may reduce or negate the effect of increased fear in those with fewer years of experience.

There was also a difference within the metropolitan setting in perceived risk and level of fear depending on the type of team/unit. Those working on inpatient units rated their overall level of risk and associated fear as higher compared with those in community/outpatients teams, which was consistent with the actual data on reported incidents. This suggested that, contrary to the prior research of Bilgin and Buzlu (2006), fear was seemingly proportionate to the actual risk in the absence of any previous personal experience of assault (which increased fear). However, this difference between higher risk and lower risk teams/units was not supported in the forensic setting. It appears that the type of
unit did not impact on fear, with the staff members in the high secure units (deemed comparable to the inpatient units dealing with acute psychiatric illness in the metropolitan setting) being no more or less fearful than their medium to low secure counterparts. This was contradictory to the actual data of reported incidents, which illustrated that the high secure units were the only hospital units to report ‘severe’ incidents. These findings would seem to suggest that, contrary to the findings of Thomas, Bartlett and Mezey (1995), those working in higher risk environments do not develop a tolerance to these assaultive incidents even when they frequently occur. Perhaps this is influenced by the forensic nature of the patient population in that staff are more aware of their continued risk, and thus remain somewhat fearful. This supports the occurrence of normalisation of workplace violence as suggested by Secker et al. (2004) and Thomas et al. in that violence is expected as the norm, and heightened vigilance and fear are therefore warranted, perhaps as a coping or survival strategy. In other words, it may be that, the frequent occurrence of incidents across the facility (regardless of severity) has instead instilled a constant level of vigilance amongst all staff.

Interestingly, it appears that metropolitan setting staff differentiate their risk depending on the type of patients they are treating (acute or rehabilitation) and possibly the environment in which they work. This reflects the vast majority of prior research that level of risk is impacted by whether a patient is admitted involuntarily and environmental factors such as overcrowding, room sharing and locked wards (Abderhalden et al., 2007; Arango, Barba, Gonzalez-Salvador & Ordonez, 1999; Duxbury, 2002; Kho, Sensky, Mortimer & Corcos, 1998; Nijman, 1999; Nijman, Albertz, Merckelbach & Ravelli, 1997; Nijman, Merckelbach,
In contrast, staff of the forensic setting did not tend to differentiate their risk based on the stage of illness and respective treatment a patient is undergoing (acute versus rehabilitative). There are a number of reasons why this may be the case, namely, this may be indicative of the overall increased risk perceived when working with a psychiatric population with known forensic histories. This is consistent with the research of Butler et al. (2006), Douglas, Ogloff and Hart (2003) and Hodgins (1992). Further, the teams comprising the metropolitan setting operate throughout various suburbs and different physical environments compared with the forensic setting, which operates within one large facility. Thus, the perception of risk held by various staff members is likely to be qualitatively different for each of these organisations because of the diversity in the workplace environment. Also, it is possible that the potential risk posed by less supervised patients on the various units during on-campus leave to a degree may mitigate the perception that staff of rehabilitation units are at lower risk of future assault.

Whilst not a focus of the current research, the observed differences between the metropolitan and forensic settings may also be due to the difference in policies and management procedures. For example, there are clear differences in relation to both the aims and mission of these organisations. According to the Eastern Health Strategic Plan 2010–2015, the organisation’s mission is: “to provide positive health experiences for people and communities in the east” (p.3). On the other hand, the Victorian Institute of Forensic Mental Health (Forensicare) Strategic Plan 2010-2014 states that the organisation aims to: “provide leadership at an international, national and local level in the understanding and treatment of
mental disorders associated with criminal behaviour” (p.2). From this, one can see that the organisations, whilst both dealing with severe mental illness, differ on their clinical care focus and treat qualitatively different patient populations.

Overall, there was not a great deal of difference in relation to perceptions of the workplace climate across the two settings. It appears that for staff of both organisations, perceptions of the workplace climate are largely unrelated to staff experiences of assault and more to do with interpersonal factors and the supportiveness of the working environment. Individuals working for both organisations identified that workplace pressure and the demands placed on them could be improved. Interestingly, this was more so the case for the inpatient (high risk) teams in the metropolitan setting and, contradictory to this, for the medium to low secure units in the forensic setting.

Further, there were some variations in the perceptions of the support provided by peers and management, the level of encouragement to be autonomous, and the expectations and communication between the inpatient and outpatient/community teams of the metropolitan setting. The inpatient unit held more positive perceptions in these areas. The opposite was true of the forensic setting, with high secure units holding more positive perceptions of these elements than the medium to low secure units. The lack of substantial difference in overall perceptions of the workplace climate suggests that these particular nuances between the two settings cannot be explained by the forensic element alone. Instead, these differences perhaps speak to the qualitative differences between the teams and difference in management style and team structures rather than systemic organisational functioning or underlying patient characteristics such as a forensic history.
However, one key difference noted between the two settings that could be attributed to the forensic nature of one of the settings was the perception of the pleasantness of the physical environment. The staff from the forensic setting rated their workplace more poorly than the metropolitan setting in relation to this criterion. Regardless of the type of unit, staff of the forensic setting collectively viewed the physical work environment as needing improvement (‘Well below average’) compared with the teams of the metropolitan setting being quite satisfied (‘Average’ to ‘Well above average’) with the physical environment of their workplace. This is surprising given that the forensic facility is purpose built and is considered relatively modern (constructed in 2000) compared with some of the metropolitan setting sites (for example, Maroondah Hospital which houses IPU1 and IPU2 originated in 1976). Given this, it is assumed this result is more symptomatic of the physical characteristics of the setting (in terms of the facility being a secure complex with locked wards, detection sensors and entry/exit security clearances) and, ultimately, the forensic nature of the setting and its occupants. In this regard, perceptions of some aspects of the workplace climate, namely those relating to physical features, appear to be influenced by whether or not the facility provides services to a forensic population. However, this does not take into account any renovations that may have occurred in recent years to improve the physical environment of the inpatient units at Eastern Health.

Limitations

One of the main limitations of this dissertation was the restricted scope of the project due to an inability to obtain the necessary patient data from the participating organisations. This meant that elements of the original project
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aiming to gain information from patients as well as staff could not be pursued. This limitation does, however, provide an avenue for future research.

Another consideration is the reduced generalisability of the findings, with the majority of participants being nursing staff. The sampled population comprised of a subset of psychiatric staff working in metropolitan Victoria.

Furthermore, the response rate across all three studies was also less than anticipated and could been seen as a limitation. It was somewhat expected to have a low response rate for Study One as this was an exploratory, in depth and time-consuming exercise. However, given the size of each of the organisations and the volume of questionnaires distributed, it was expected that at least 40% of staff would participate in Study Two and Study Three. It is likely that there are a myriad of reasons for this, some of which relate directly to the questionnaire such as: the questionnaire only being available in paper format; a perceived lack of adequate incentive to compensate participants for the time it took to complete the questionnaire; and potential concerns over the anonymity of responses and unsubstantiated fear of reprisal from management within their organisation. Given that the majority of staff reported issues with time pressure, whether perceived or actual, this may have also dissuaded staff who thought they simply did not have the time to complete tasks beyond what was already expected of them in their role.

This relatively low response rate suggests that the results of each of the studies must be interpreted with caution. These results provide limited insight and preliminary guidance as to the impact of assaultive incidents and the general workplace climate on staff perceptions within the framework of the Victorian mental health care system. Whilst the majority of the findings support that of the
previous research, it would be important to conduct future studies with larger sample sizes to distinguish whether this is a true reflection of the current state of affairs in psychiatric and forensic mental health settings, or whether in fact the non-significant results obtained in this study hold true.

Finally, it is pertinent to discuss the measure itself. The content of both versions of the questionnaire was developed primarily based on common themes and findings elicited from previous research, specifically relating to staff experiences of risk, safety and patient care in mental health settings. These items were then refined based on the findings of Study One. However, the majority of the questionnaire remained unchanged as the results of Study One supported the themes addressed in the questionnaire. Overall, Study Two showed reasonably sound reliability. This was confirmed by the reliability values for the second version of the questionnaire utilised in Study Three. Given the higher than expected and sound reliability of both versions of the questionnaire, it appears that the measure created was quite useful. Whilst there is no direct comparison, this measure also fared well in comparison to other climate measures such as the OCQ and the WES. In fact it fared slightly better in comparison to some aspects of the WES, although the reliability was not as high as that of the EssenCES. This was, however, expected as the questionnaire utilised two previously validated workplace climate measures.

Regardless of its sound reliability, it would be premature to adopt this measure in its entirety in future studies. This measure appears to be a work in progress, with Study Two and Study Three considered as somewhat of a pilot program for the use of such a tool. There were certain items that would need revision and entire sections that could be omitted in future as they did not appear
to add value. For example, ‘Section D: Patient characteristics’ had poor reliability. In retrospect, much of the content in this section was unnecessarily wordy and likely confused participants. If obtaining information on patient characteristics is deemed an important area by future researchers then it is suggested that this material be reworked for better readability and understanding, thus likely leading to improved reliability. Alternatively, given that this section was not utilised in the analyses of each study, this section could be omitted in its entirety to resolve the reliability issue in future studies.

Another major issue pertaining to the questionnaire, as previously mentioned in both Study Two and Study Three, was the length and time taken to complete. Omitting Section D would reduce completion time, however it may also be useful to omit one of the workplace climate measures, especially as neither study could provide accurate data from the second workplace climate measure due to a large amount of missing data. It is hypothesised that the vast majority of this missing data was due to the fact that participants had not had time to complete the remainder of the questionnaire or had lost interest at this stage.

**Recommendations and Clinical Implications**

The overall findings of this dissertation are applicable to clinical staff working in metropolitan and forensic psychiatric health services in Victoria. However, given that the majority of the sample were nurses, the results are most pertinent to this particular population. Given that nurses are the frontline staff that assume the most risk in these work settings, it is crucial to understand both their perceptions of risk, and their relationship with their workplace. It is important to note that few recommendations are necessary for these organisations, as they currently appear to manage assaultive incidents quite well and, unexpectedly, staff
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report holding positive views of both their personal level of risk and perceptions of the workplace climate overall.

As identified in Study One, confidence was depicted as a key determinant in staff ability to cope with the demands of a potentially high-risk work environment. Training was also seen as imperative in responding to and dealing with client assault. Should psychiatric services continue to invest in and provide the opportunity for clinically relevant training then staff are likely to further build on their confidence and ability to manage assaultive behaviour effectively. Consequently, staff are likely to cope well with their own experience of these incidents.

One of the major findings from all three studies was the importance and emphasis that should be placed on organisational and interpersonal support. This support was seen to influence fear of future assault, particularly post-incident. This is in line with the findings of Roman and Blum (1995; 2002) that providing staff with ongoing support through access to an Employee Assistance Program led to more contented, productive and committed staff. There was a 21% reduction in absenteeism, a 17% reduction in workplace injuries and a 14% increase in productivity (Roman & Blum). Furthermore, this research also provides support for the findings of Flannery (2000) in relation to the provision of support services following workplace incidents. Flannery found that the implementation of the Assaulted Staff Action Program, which provides staff with support following crisis intervention in the workplace, reduced assault rates and resultant injuries, reduced staff turnover, maintained productivity and improved staff morale; as well as saving state hospitals in the United States approximately US$268,000 (after the cost of the program had been deducted).
The findings of the current research in conjunction with this prior research indicates that the continued provision of accessible avenues of support, both internally and external to the organisation, is imperative. Staff (particularly those in a forensic setting) should be encouraged to utilise the available organisational and supervisory support, especially post-incident. It has been established (e.g. Flannery, 2000; Roman & Blum, 1995; 2002) that investing in this area of clinical need will lead to a reduction in the financial costs to an organisation following an incident, potentially leading to a reduction in absenteeism as a result of patient assault and lower staff turnover rates, as well as continued job productivity.

Another pertinent area that could be addressed is that of time pressure and work demands placed on staff. Regardless of the type of health setting, it appears that time pressure has a negative impact on the clinical judgement and decision-making of healthcare staff, particularly nurses (Retsas, 2000; Thompson, McCaughan, Cullum, Sheldon, & Raynor, 2005). Thompson et al. (2008) looked at the effect of time pressure on nurses’ decisions to provide medical intervention to patients at risk of a critical event, such as a heart attack or respiratory distress. They found that time pressure negatively impacted the value of clinical experience and led to an increase in the number of patients who were not identified as needing to be seen (i.e. were missed) from 14% to 32%. Although this study pertained to nurses of intensive care and admissions units, mental health nurses are also required to use clinical judgement and decision-making processes regarding patient health and care (particularly in identifying the early warning signs that a patient will act violently). They often do so under time constraints, as reported by participants in the current research. Thus, it appears that the effect of time pressure (albeit lessened due to the absence of life-threatening illness) could
be extrapolated to caring for psychiatric patients. In other words, the effectiveness of this decision-making ability is likely to be reduced when staff are presented with unrealistic time constraints in a psychiatric setting.

Given the potential effect time pressure could have on clinical decision-making and risk, both the metropolitan and forensic organisations should continue to work to reduce the pressure felt by staff to work harder and faster. This could include developing staff self-care and time management skills. Whilst it may not be feasible to reduce workloads, giving staff the tools to better manage this and prioritise their workload could prove very effective in reducing their negative perceptions regarding work pressure.

Future Direction

The link between staff experiencing assault and an increased level of fear as a result requires further investigation. Whilst there has been prior research which focused on critical incident management and reducing fear and chronic distress symptoms, much of this research pertains to mass disaster incidents rather than single incidents of violence or trauma instigated by patients (e.g. Marmar et al., 1999; Watson, 2007). Future studies will help researchers to potentially extend the findings relating to incidents of mass trauma to include staff exposed to incidents of patient assault. In doing so, researchers may be able to better understand the specific factors underpinning this increase in fear and determine whether this increased fear is indeed time-limited, and if so, whether certain factors can reduce this timeframe.

The results of this dissertation also suggest the need for further research into the proposed function of patient aggression. Future research exploring psychiatric patient/client experiences and perceptions would serve to provide a
comparison for the current research between staff and consumer perspectives. This would provide a more holistic representation of the overall experience of psychiatric settings and potentially enable organisations to enact change to further enhance staff perceptions and patient wellbeing, and by doing so potentially reduce the risk of future patient/client assault.

Furthermore, future research utilising a modified version of the questionnaire created for the purposes of this dissertation could enable researchers to determine whether this measure is a viable resource in a wider context. Future considerations should include: simplifying the workplace climate section by only including one measure; incorporating more content regarding risk and how often staff report on risk; and incorporating more information regarding the training techniques staff have access to, as well as questions pertaining to staff needs rather than areas of good or poor performance. If it is determined that the questionnaire is generalisable to staff from other health organisations, then it may prove to be quite a useful tool in measuring staff perceptions and assisting health organisations to identify key areas of need in terms of staff fear and job satisfaction.
References


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Appendix A

23 September 2011
Miss Kate Jackowski
School of Psychology
Deakin University
221 Burwood Highway
Burwood Victoria 3125

Dear Miss Jackowski,

**E05/1112 Staff perceptions of risk of assault in psychiatric settings**

*Principal Investigators:* Miss Kate Jackowski

*Associate Investigators:* Dr Lynda Byrne and Dr Karen Bird

*Other Approved Personnel:* Nil

*Eastern Health Sites:* Box Hill & Maroondah Hospitals

The above study was considered by the Eastern Health Research and Ethics Committee at its meeting on 21 July 2011 and 15 September 2011 and was approved subject to amendments and clarifications. Following receipt of amended documents and additional information (received on 24 August and 23 September 2011), final approval can now be given for **PART A (Telephone Interviews)** to proceed.

List of documents approved:
- NEAF Application
- Site Specific Assessment Form
- Victorian Specific Module dated 27 June 2011
- Participant Information and Consent Form version 4 dated 23 September 2011
- Phone Interview Questions version 2 dated 22 August 2011

**Conditions of approval:**

1. The Questionnaire and Participant Information and Consent Form for **PART B** must be submitted and approved by the Research and Ethics Committee before Part B can commence.

Please note, an annual progress report is due September 2012 – continuing approval is subject to the timely submission of a satisfactory progress report. Progress report template can be downloaded from our web-page:

The Eastern Health Research and Ethics Committee is constituted and functions in accordance with the National Health and Medical Research Council Guidelines (National Statement on Ethical Conduct in Human Research 2007). No member of the Committee adjudicates on research in which that member has any conflict of interest including any personal involvement or participation in the research, any financial interest in the outcome or any involvement in competing research.

Please refer to the National Statement on Ethical Conduct in Human Research (2007) http://www.nhmrc.gov.au/publications/synopses/e35syn.htm and Declarations by Investigators in the NEAF for researchers’ obligations. Continuing approval is subject to the adherence of these guidelines and the fulfilment of researchers’ obligations.

Please quote our reference number EOS/1011 in all future correspondence.

Yours sincerely

Ms Lai Wan Reid
Manager
Eastern Health Research and Ethics
Encl: Committee Composition letter
Cc: Dr Linda Byrne, Dr Karen Bird

Confidentiality, Privacy & Research

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients’ names or UR numbers must be stored on these devices.

Electronic storage devices must be password protected or encrypted.

The conduct of research must be compliant with the conditions of ethics approval and Eastern Health policies.

Publications

Whilst the Eastern Health Research and Ethics Committee is an independent committee, the committee and Eastern Health management encourage the publication of the results of research in a discipline appropriate manner. Publications should provide evidence of the contribution that participants, researchers and funding sources make.

It is very important that the role of Eastern Health is acknowledged in publications.
Appendix B

Memorandum

To: Dr Linda Byrne
    School of Psychology

From: Deakin University Human Research Ethics Committee (DUHREC)

Subject: Staff perceptions of risk of assault in psychiatric settings

Date: 29 May, 2012

B

cc: Miss Katherine Jackowski

The application for this project was considered at the DUHREC meeting held on 28/05/2012.

Approval has been given for Miss Katherine Jackowski, under the supervision of Dr Linda Byrne, School of Psychology, to undertake this project from 29/05/2012 to 29/05/2016.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Appendix C

Mental Health, Turning Point
Alcohol and Drugs

Turning Point Alcohol and Drug Centre
54-62 Gertrude Street
Fitroy, Victoria 3065
Australia

T: 03 8413 8413
F: 03 9416 3420
info@turningpoint.org.au
ABN 08 223 839 137
www.turningpoint.org.au

2nd June 2011

Eastern Health Ethics Committee

As Chair of the Mental Health Turning Point Clinical Program Research Committee, we support the below research submission for consideration by the Eastern Health Ethics Committee.

Project: "Staff Perceptions of Risk of Assault In Psychiatric Settings"
Principal Researcher: Miss Kate Jackowski
School of Psychology
Deakin University
221 Burwood Hwy
Burwood VIC 3125

Yours sincerely

Signature Redacted by Library

Professor Dan Lubman
Chair
Mental Health Turning Point Clinical Program Research Committee
Appendix D

Participant Information and Consent Form

Eastern Health

Full Project Title: Staff Perceptions of Risk of Assault in Psychiatric Settings
Principal Researcher: Kate Jackowski
Associate Researchers: Dr Linda Byrne (Deakin University) Dr Karen Bird (Eastern Health)

1. Introduction

You are invited to take part in this research project this is because you work in a psychiatric setting within Eastern Health. The research project aims to explore the interaction between the perceptions held by staff of their risk of assault by clients in the workplace, their perceptions of the workplace climate, their relative years of experience and the actual rate of physical assault reported in the previous year for the team.

This Participant Information and Consent Form tells you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully. Ask questions about anything that you don’t understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your local health worker.

Participation in this research is voluntary. If you don’t wish to take part, you don’t have to.

If you decide you want to take part in the research project, you may be asked to sign the consent section. By signing it you are telling us that you:

- understand what you have read;
- consent to take part in the research project;
- consent to be involved in the procedures described;
- consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2. What is the purpose of this research project?

- The overall aim of the project is to address the lack of knowledge about staff perceptions with regard to risk of assault when working in both psychiatric inpatient and outpatient environments. This research is important because it aims to identify key areas, if any, in which staff hold positive and/or negative perceptions. Previous literature provides evidence
to suggest that staff perceptions are important to the health and productivity of an organisation. This study may usefully inform participating organisations of possible areas of focus for any future staff training and/or professional development programs.

- The term perception used in this study refers to perception of risk which is the subjective appraisal of the likelihood and imminence of the occurrence of assault to oneself or other by another individual. Assault refers to any form of physical violence except for sexual assault.

- Another term used in this study is ‘workplace climate’ which refers to how staff perceive the support they receive, the cohesion of the team of professionals they work with and the policies of the organisation they work for.

- Previous literature has focused almost exclusively on the risk assessment of patients/clients and their risk to others. Few studies have considered the personal risk appraisals of staff and their perception of their own safety, support and personal level of risk in their work environment.

- There are two sites across Victoria that are involved in this project: a metropolitan health setting and a forensic health setting. The teams at Eastern Health that are being asked to participate are: Community Care Units, Mobile Support and Treatment Services, Central East Crisis Assessment and Treatment Team, Upton House, Waverley Continuing Care Team, Koonung Continuing Care Team, Central East Prevention and Recovery Care, Outer East Crisis Assessment and Treatment Team, Maroondah Inpatient Unit 1, Maroondah Inpatient Unit 2, Outer East Prevention and Recovery Care, Murnong Continuing Care Team and Chandler Continuing Care Team.

- This study is Part A of a two-part study. Part A will be conducted as telephone interviews with a small subset of staff from Eastern Health. These telephone interviews will act as a form of focus group. The information gathered will then be used to generate questions that are relevant to staff working in psychiatric settings for Part B of the study, a questionnaire for the wider population of psychiatric staff.

- It is expected that approximately 10 psychiatric staff from Eastern Health (5 team leaders and 5 non-team leaders) will participate in Part A (telephone interviews) of the study. It is expected that approximately 60 people from Eastern Health will take part in Part B (questionnaire) of this project.

- The results of this research will be used by the primary researcher, Kate Jackowski, to obtain a Doctor of Psychology degree. This research has been funded by Deakin University.

3. **What does participation in this research project involve?**

  - **Procedures**

    Participation in this project will involve committing to one 25 minute telephone interview. You will be asked a series of open-ended questions. We are interested in your opinions and ideas about your experiences in the psychiatric workplace.

    The information you provide will be anonymous, it will be assigned a research case number and it will not be possible to identify you
as the source of any information.

No access to personal records is required for this project. The only personal information, if any, we will obtain will come directly from you in the telephone interview.

It is expected that a brief summary of the results of Part A (telephone interviews) will be available in December 2012. You will be able to obtain a brief non-identifiable summary of these aggregated results from your team leader. The results for Part B of the project will also be available in December 2012. Again, you will be able to obtain a summary of the results from your team leader.

- Reimbursement

You will not be paid for your participation in this research, but you will be entered into a draw to win a $50 Coles/Myer voucher upon completion of the telephone interview. You will be asked at the conclusion of the phone interview if you want to be entered into the draw. Please note your details for the draw will be kept completely separate from any responses you provide during participation. After the draw has taken place and the winner is notified each participant’s contact details consenting to be entered in the draw will be shredded.

4. **What are the possible benefits?**

The results of this research will contribute to the growing body of literature surrounding staff perceptions of risk of assault in psychiatric settings, as well as, workplace influences on perceptions.

We cannot guarantee or promise that you will receive any benefits from this project.

5. **What are the possible risks?**

There is a risk that you may become distressed by your reflections and/or responses during or after the telephone interview. If you become upset or distressed during the telephone interviews, alert the researcher you are speaking with and the interview will be terminated. The researcher is able to arrange for appropriate support if required. If you become upset or distressed following your participation in the telephone interviews, please contact the researcher to discuss how you are feeling. It is then recommended that you contact your G.P. who will discuss a mental health plan and referral to an appropriate mental health professional. Medicare rebates are available for eligible people.

Due to the small number of staff in each team there is also a risk that you may be identified in the dissemination of results. To minimise this risk no site-specific individual data will be reported. Instead, only key themes/concerns/issues that were raised by more than one individual will be reported with no mention of the specific team you work for or any data that could identify you such as your position or occupation.

6. **Do I have to take part in this research project?**

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

If you do consent to participate, you may only withdraw prior to the conclusion
of the telephone interview. After the conclusion of the telephone interview your responses will be de-identified and the researchers will no longer be able to identify which responses you gave. If you decide to withdraw once the telephone interview has commenced the researchers would like to keep and use the information that has been collected up until the point of withdrawal. If you do not want them to do this, you must tell them before you withdraw from the research project.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your relationship with the researchers or Eastern Health.

7. **How will I be informed of the final results of this research project?**

It is expected that a brief summary of the results of Part A (telephone interviews) will be available in December 2012. You will be able to obtain a brief non-identifiable summary of these aggregated results from your team leader. The results for Part B of the project will also be available in December 2012. Again, you will be able to obtain a summary of the results from your team leader.

8. **What will happen to information about me?**

The data collected from this study will be in non-identifiable form. Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law. The de-identified data collected in this study may be used in future research, which relates to and extends this study for which separate ethical review and approval will be obtained.

The information collected will be stored in both the original paper copy and as an encrypted computer file. The paper copies will be kept in a locked filing cabinet and the encrypted computer files will be stored on a password secure computer. Both forms of information, paper and digital, will be kept in the primary researcher’s locked office in the Psychology building of Deakin University, Burwood. The information will be stored for seven years upon completion of the research project as recommended by the Australian Psychological Society Code of Ethics. After seven years has lapsed, the paper copies will be shredded and the computer files will be permanently deleted.

The primary researcher (Kate Jackowski) and the supervisor of the primary researcher (Dr Linda Byrne) will have access to the information solely for the purposes of this research project. The Eastern Health associate researcher (Dr Karen Bird) will also have continued access to the de-identified data generated from the study.

In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission. The data used will be de-identified and presented as aggregated group data. In order to maintain confidentiality, if less than 10 team members at a specific site participate, site-specific team data will not be reported, instead it will be aggregated across the three locations.

9. **Can I access research information kept about me?**

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and
stored by the researchers about you. Please contact one of the researchers named at the end of this document if you would like to access your information.

In addition, in accordance with regulatory guidelines, the information collected in this research project will be kept for at least seven years. You must be aware that the information collected about you may at some point not be able to be identified once the identifying information has been removed. The information will become non-identifiable once the telephone interview has concluded. Access to information about you after this point will not be possible.

10. **Is this research project approved?**

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Eastern Health and of Deakin University.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)* produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
11. **Who can I contact?**

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

**For further information:**

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project (for example, feelings of distress), you can contact either of the associate researchers:

Name: Dr Linda Byrne  
Role: Student supervisor/ Associate researcher – Deakin University  
Telephone: (03) 9244 6424

OR

Name: Dr Karen Bird  
Role: Associate Researcher – Eastern Health  
Telephone: (03) 9871 3988

**For complaints:**

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

The Executive Officer, Human Research Ethics Committee, Deakin University, 221 Burwood Hwy, Burwood Victoria 3125  
Telephone: (03) 9251 7123

OR

Chair person, Eastern Health Human Research and Ethics Committee  
Telephone: (03) 9895 3398
Appendix E

DEAKIN UNIVERSITY

**Participant Information and Consent Form**

*Eastern Health*

**Full Project Title:** Staff Perceptions of Risk of Assault in Psychiatric Settings

Principal Researcher:  Kate Jackowski

Associate Researchers: Dr Linda Byrne (Deakin University)

Dr Karen Bird (Eastern Health)

1. **Introduction**

You are invited to take part in this research project this is because you work in a psychiatric setting within Eastern Health. The research project aims to explore the interaction between the perceptions held by staff of their risk of assault by clients in the workplace, their perceptions of the workplace climate, their relative years of experience and the actual rate of physical assault reported in the previous year for the team.

This Participant Information and Consent Form tells you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully. Ask questions about anything that you don’t understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your local health worker.

Participation in this research is voluntary. If you don’t wish to take part, you don’t have to.

If you decide you want to take part in the research project, you may be asked to sign the consent section. By signing it you are telling us that you:

- understand what you have read;
- consent to take part in the research project;
- consent to be involved in the procedures described;
- consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2. **What is the purpose of this research project?**

- The aim of the project is to address the lack of knowledge about staff perceptions with regard to risk of assault when working in both psychiatric inpatient and outpatient environments. This research is important because it aims to identify key areas, if any, in which staff hold positive and/or negative perceptions. Previous
literature provides evidence to suggest that staff perceptions are important to the health and productivity of an organisation. This study may usefully inform participating organisations of possible areas of focus for any future staff training and/or professional development programs.

- The term perception used in this study refers to perception of risk which is the subjective appraisal of the likelihood and imminence of the occurrence of assault to oneself or other by another individual. Assault refers to any form of physical violence except for sexual assault.

- Another term used in this study is 'workplace climate' which refers to how staff perceive the support they receive, the cohesion of the team of professionals they work with and the policies of the organisation they work for, from the workplace in which these incidents occur.

- Previous literature has focused almost exclusively on the risk assessment of patients/clients and their risk to others. Few studies have considered the personal risk appraisals of staff and their perception of their own safety, support and personal level of risk in their work environment.

- It is expected that 100 people will take part in this project overall and approximately 30 of those will be from Eastern Health.

- There are two sites across Victoria that are involved in this project: a metropolitan health setting (Eastern Health) and a forensic health setting. The teams at Eastern Health that are being asked to participate are: Community Care Units, Mobile Support and Treatment Services, Central East Crisis Assessment and Treatment Team, Upton House, Waverley Continuing Care Team, Koonung Continuing Care Team, Central East Prevention and Recovery Care, Outer East Crisis Assessment and Treatment Team, Maroondah Inpatient Unit 1, Maroondah Inpatient Unit 2, Outer East Prevention and Recovery Care, Murnong Continuing Care Team and Chandler Continuing Care Team.

- This study is Part B of a two-part study. Part A involved brief telephone interviews with a small number of staff from each of the two locations. These interviews were conducted as a form of focus group to inform the sorts of questions that should be included in the questionnaire for Part B that are relevant to staff working in psychiatric settings.

- The results of this research will be used by the primary researcher, Kate Jackowski, to obtain a Doctor of Psychology degree. This research has been funded by Deakin University.

3. **What does participation in this research project involve?**

   - Procedures

   Participation in this Part B of this project will involve completing a paper questionnaire in your own time and sending it back to the researchers via the reply-paid envelope provided. The questionnaire will be handed out during a regular team meeting. The questionnaire is x pages and is expected to take approximately 20-30 minutes to complete. It consists of two types of questions: one type asks you to rate how much you agree or disagree with a statement and the second type is an open-ended question which gives you the opportunity to write a brief response.

   No access to personal records is required for this project. The only personal information, if any, we will obtain will come directly from you in the questionnaire.

   It is expected that the results will be available in December 2012. You will be able to obtain a summary of the results from your team leader.
• Reimbursement

You will not be paid for your participation in this research, but you will be entered into a draw to win a $100 Coles/Myer gift voucher upon completion of your questionnaire. There is a $100 Coles/Myer gift voucher to be won at each location. If you wish to be entered into the draw please fill out the form on Page 6 of this document. If you do not wish to be entered into the draw then simply do not fill out the form on page 6. Please note your details for the draw will be kept completely separate from your signed consent form and any responses you provide during participation. After the draw has taken place and the winner is notified all forms with each participant’s contact details consenting to be entered in the draw will be shredded.

4. What are the possible benefits?

The results of this research will contribute to the growing body of literature surrounding staff perceptions of risk of assault in psychiatric settings, as well as, workplace influences on perceptions.

We cannot guarantee or promise that you will receive any benefits from this project.

5. What are the possible risks?

There is a risk that you may become distressed by your reflections when completing the questionnaire. If you become upset or distressed following your participation in the research, please contact the researcher to discuss how you are feeling. It is then recommended that you contact your G.P. who will discuss a mental health plan and referral to an appropriate mental health professional. Medicare rebates are available for eligible people.

Due to the small number of staff in each team there is also a risk that you may be identified in the dissemination of results. To minimise this risk site-specific team data will not be directly reported if the number of participants from that team is less than 10. Instead, de-identified results will be aggregated across the three sites involved and reported by team type e.g. acute inpatient.

6. Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

If you do consent to participate, you may only withdraw prior to the questionnaire being submitted. After you have submitted your questionnaire the information you provided is de-identified and the researchers are no longer able to determine which questionnaire contains your responses.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your relationship with the researchers or Eastern Health.

7. How will I be informed of the final results of this research project?

A brief summary of the results of the study will be provided to each team leader of the participating teams at each location. Participants will have the opportunity to receive aggregate group results from their team leaders. The summary of results can be expected to become available in December 2012.
8. **What will happen to information about me?**

The data collected from this study will be in non-identifiable form. Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law. The de-identified data collected in this study may be used in future research, which relates to and extends this study for which separate ethical review and approval will be obtained.

The information collected will be stored in both the original paper copy and as an encrypted computer file. The paper copies will be kept in a locked filing cabinet and the encrypted computer files will be stored on a password secure computer. Both forms of information, paper and digital, will be kept in the primary researcher's locked office in the Psychology building of Deakin University, Burwood. The information will be stored for seven years upon completion of the project as recommended by the Australian Psychological Society Code of Ethics. After seven years has lapsed, the paper copies will be shredded and the computer files will be permanently deleted.

The primary researcher (Kate Jackowski) and the supervisor of the primary researcher (Dr Linda Byrne) will have access to the information solely for the purposes of this research project. The Eastern Health associate researcher (Dr Karen Bird) will also have continued access to the de-identified data generated from the study.

In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission. The data used will be de-identified and presented as aggregated group data. In order to maintain confidentiality, if less than 10 team members at a specific site participate, site-specific team data will not be reported, instead it will be aggregated across the three locations.

9. **Can I access research information kept about me?**

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. Please contact one of the researchers named at the end of this document if you would like to access your information.

In addition, in accordance with regulatory guidelines, the information collected in this research project will be kept for at least seven years. You must be aware that the information collected about you may at some point not be able to be identified once the identifying information has been removed. The information will become non-identifiable once the questionnaire has been submitted. Access to information about you after this point will not be possible.

10. **Is this research project approved?**

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Eastern Health and of Deakin University.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)* produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
11. Who can I contact?

The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

For further information:

If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project (for example, feelings of distress), you can contact either of the associate researchers:

Name: Dr Linda Byrne
Role: Student supervisor/Associate researcher – Deakin University
Telephone: (03) 9244 6424

OR

Name: Dr Karen Bird
Role: Associate Researcher – Eastern Health
Telephone: (03) 9871 3988

For complaints:

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

The Executive Officer, Human Research Ethics Committee, Deakin University, 221 Burwood Hwy, Burwood Victoria 3125
Telephone: (03) 9251 7123

OR

Chair person, Eastern Health Human Research and Ethics Committee
Telephone: (03) 9895 3398
Staff Perceptions of Risk of Assault in Psychiatric Settings

This research is important to help understand the impact of potential violence in the workplace.

This project is being undertaken as part of a Deakin University Doctor of Psychology degree in partnership with Eastern Health.

This questionnaire is designed to inform the researchers of the views and experiences of clinicians working in Adult Mental Health about client assault and workplace climate. For the purpose of this questionnaire the term ‘assault’ refers to verbal and physical assault with the exception of sexual assault.

We are interested in your thoughts, opinions and experiences. Do not spend too much time on any one question as we are more interested in your first response.

This questionnaire will take approximately 30 minutes to complete. Your participation is entirely voluntary and we have no way of identifying you from your responses. There are no right or wrong answers.

By completing the questionnaire you are providing your consent to participate in the research project. When you have completed this questionnaire, please return it in the reply postage paid envelope provided.

All participants will have the opportunity to enter the draw to win a $100 Coles/Myer voucher. If you wish to be entered into the draw please complete the separate consent form and return it in the separate reply postage paid envelope provided. Note: there will be no way of matching your prize draw consent form to your questionnaire, ensuring that all responses remain anonymous.

We thank you for taking the time to help us with this research by completing the questionnaire.

Sincerely,

[Signature Redacted by Library]

Kate Jackowski  Dr. Linda Byrne
SECTION A – About you

1. How old are you?
   20-29  30-39  40-49  50-59  60-69  70+

2. What is your gender?
   Female  Male

3. What is the highest level of education you have completed?
   Year 10 or below  Year 11 or 12  Certificate
   Diploma  Bachelor degree  Masters or above

4. What is your employment status?
   Fulltime  Part-time  Casual

5. What is your profession?

6. What adult mental health service organisation do you work for?

7. What healthcare team are you a part of within this organisation?

8. How long have you been working for this organisation?
   6-12 months  1-2 years  3-5 years  6-10 years  11+ years

9. How long have you been working in your current team?
   6-12 months  1-2 years  3-5 years  6-10 years  11+ years

10. How long have you been working with psychiatric clients?
    6-12 months  1-2 years  3-5 years  6-10 years  11+ years
11. Did you complete the online Forensic Clinical Specialist Evaluation survey in late 2010?

Yes [ ] No [ ] Uncertain [ ]

**SECTION B – Current views about work**

*Circle the most appropriate responses to the statements below.*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I enjoy coming to work each day.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I would describe my current overall wellbeing as optimal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have a positive view of my workplace.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I think my workplace impacts on my wellbeing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel well supported by the organisation that I work for.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am at a very high risk of client assault in my workplace.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel very safe in my workplace.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am very fearful of client assault at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am very vulnerable to client assault at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am very fearful that I will be threatened by a client at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel very confident in dealing with an assaultive client.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Staff in psychiatric settings should expect to be assaulted by clients at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Incidents of client assault on staff are under-reported.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Repeat incidents of client assault on staff are often unreported.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I fear being blamed for a client being assaultive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
SECTION C – Your experiences of assault at work

All questions in this section refer to experiences in your current psychiatric setting.
The term 'assault' refers to both verbal and physical forms (except sexual assault) unless otherwise stated.

1. Have you witnessed and/or experienced verbal or physical assault at work?
   YES – answer questions below    NO – skip to Section D

For the remaining questions circle the most appropriate response below.

2. Have you been verbally assaulted by a client at work in the past year?
   YES   NO

3. Have you been verbally assaulted by the same client more than once in the past year?
   YES   NO

4. Have you been physically assaulted by a client at work in the past year?
   YES   NO

5. Have you been physically assaulted by the same client more than once in the past year?
   YES   NO

6. What was the severity of injury that resulted from the physical assault?
   N/A    no injury    minor injury    first aid required    medical treatment required

7. Have you witnessed other staff being verbally assaulted by a client at work in the past year?
   YES   NO

8. Have you witnessed other staff being physically assaulted in the past year?
   YES   NO

9. Have you witnessed client aggression towards objects in the past year?
   YES   NO
10. Have you witnessed attempts or incidents of *client self-harm* in the past year?
   
   YES  NO

11. Do you have a higher level of fear of client assault as a result of having witnessed and/or experienced client assault?
   
   YES  NO

12. Are you more vigilant at work since witnessing and/or experiencing client assault?
   
   YES  NO

**SECTION D: Patient Characteristics**

*Circle the most appropriate responses below.*

1. Length of client stay or client contact with a service increase the likelihood that the client will be assaultive towards staff.
   
   Strongly Agree   Agree   Uncertain   Disagree   Strongly Disagree

2. A prior history of assaultive behaviour dramatically increases the likelihood that a client will be violent towards staff.
   
   Strongly Agree   Agree   Uncertain   Disagree   Strongly Disagree

3. What is the most frequent diagnosis your clients have?
   
   Schizophrenia   Schizoaffective disorder   Bipolar affective disorder
   Depression   Anxiety   Other (specify):

4. What diagnosis/cluster of clients do you think is the most likely to assault staff?
   
   Schizophrenia   Schizoaffective disorder   Bipolar affective disorder
   Depression   Anxiety   Other (specify):

5. What diagnosis/cluster of clients do you think is the least likely to assault staff?
   
   Schizophrenia   Schizoaffective disorder   Bipolar affective disorder
   Depression   Anxiety   Other (specify):
6. Estimate the number of clients with forensic histories seen by your team in the past year.
   0-4  5-9  10-15  15-19  20-24  25-29  30+

7. Estimate the number of clients with forensic histories who have assaulted staff in your team in the past year.
   0-4  5-9  10-15  15-19  20-24  25-29  30+

8. List the most common signs or symptoms of a client you suspect will assault staff

   ........................................................................................................................................................................

   ........................................................................................................................................................................

SECTION E: Training and Support

Circle the most appropriate responses below.

1. I have received adequate training from my organisation to assess and manage assaultive clients.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree

2. The organisation I work for is very supportive of therapeutic intervention and positive therapeutic outcomes for clients.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree

3. I receive a lot of guidance from my organisation for specifically assessing assault risk and managing assaultive behaviour.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree

4. I last completed training around assessing and/or managing assaultive clients...
   Within the last month 6 months ago  12 months ago  18 months ago  2+ years ago

5. Do you have trust in the organisation that you work for to provide the necessary training and support to equip you to deal with assaultive clients?
   YES  NO
6. Think of a critical incident you have either witnessed or experienced in the past 12 months.

In terms of the response to your organisation what worked and what did not work?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

In terms of the response to your team what worked and what did not work?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

SECTION F: Workplace Climate

Below are statements about the place in which you work. You are to decide which statements are true of your work environment and which are false.

If you think a statement is true or mostly true of your work environment circle T in the true box.

If you think a statement is false or mostly false of your work environment circle F in the false box.

Note: this section of the questionnaire has been removed due to copyright. Please refer to Appendix G for the Authors permission to reproduce the Work Environment Scale by Moos and Insel (1974). As per the authors' permission five sample items from the scale are illustrated below.
### Staff Perceptions

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>The work is really challenging.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>People go out of their way to help new employees feel comfortable.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Supervisors tend to talk down to employees.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Few employees have any important responsibilities.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>People pay a lot of attention to getting work done.</td>
<td>T</td>
<td>F</td>
</tr>
</tbody>
</table>

*Circle the most appropriate responses to the statements below.*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I make most of the decisions that affect the way my job is performed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I determine my own work procedures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I schedule my own work activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I set the performance standards for my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I organise my work as I see best.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>People pitch in to help each other out.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>People tend to get along with each other.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>People take a personal interest in one another.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There is a lot of ‘team spirit’ among people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel like I have a lot in common with the people I know.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It is a relaxed place to work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can count on my boss to keep the things I tell him confidential.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Uncertain</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------</td>
<td>-----------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>My boss has a lot of personal integrity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss follows through on his/her commitments to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is not likely to give me bad advice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have too much work and too little time to do it in.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>At home, I sometimes dread hearing the telephone ring because it might be someone calling about a job-related problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel like I never have a day off.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is behind me 100%.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Too many employees at my level get “burned out” by the demands of their jobs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can count on my boss to help me when I need it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is interested in me getting ahead in the company.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is easy to talk to about job-related problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss backs me up and lets me learn from my mistakes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can count on a pat on the back when I perform well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The only time I hear about my performance is when I screw up.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss knows what my strengths are and lets me know it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss does not play favourites.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is quick to recognise good performance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss uses me as an example of</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
STAFF PERCEPTIONS

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can count on a fair go from my boss.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The objectives my boss sets for my job are reasonable.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My boss is not likely to give me a bad deal.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If my boss terminates someone, the person probably deserved it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My boss encourages me to improve on his/her methods.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My boss encourages me to find new ways around old problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My boss “talks up” new ways of doing things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

('Organisational Climate Questionnaire' by Koys & DeCotiis, 1991)

Finally...

Do you have any other comments about any issues included in this questionnaire or things you would like to raise but have not had the opportunity to do so in the questionnaire?

..............................................................................................................

..............................................................................................................

..............................................................................................................

..............................................................................................................
Thank you very much for taking the time to complete this questionnaire. Your views are very important to the study. Please return the questionnaire in the enclosed reply postage paid envelope. If you wish to be entered into the prize draw for a $100 Coles/Myer gift voucher please also complete and return the prize draw consent form in the separate reply postage paid envelope provided.
Appendix G

For use by Kale Jackowski only. Received from Mind Garden, Inc. on July 12, 2012

---

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material:

**Instrument:** Work Environment Scale

**Author:** Rudolf H. Moos and Paul N. Insel

Copyright: Copyright © 1974, 2008 by Rudolf H. Moos

for his/her thesis research.

Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

[Signature Redacted by Library]

Vicki Jaimez
Mind Garden, Inc.
www.mindgarden.com
Appendix H

Entry form for the prize draw

Please tick this box if you wish to be entered into the prize draw

Name:

Signature: Date:

Telephone:
Appendix I

Memorandum

To: Dr Linda Byrne
   School of Psychology
   B
   cc: Miss Katherine Jackowski

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 14 October, 2011

Subject: 2011-226
   Staff perceptions of risk of assault in psychiatric settings

Please quote this project number in all future communications

Approval granted by Eastern Health HREC for this project will be noted at the DUHREC meeting to be held on 12 December 2011.

It will be noted that approval has been granted for Dr Linda Byrne, School of Psychology, to undertake this project as stipulated in Eastern Health HREC approval documentation.

The approval noted by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the memo. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Human Research Ethics Committee - Scientific and Ethical Review

Ethical Approval – Granted

Commencement of Research at Eastern Health has been authorised

02 December 2011

Miss Kate Jackowski
School of Psychology
Deakin University
221 Burwood Highway
Burwood Victoria 3125

Dear Miss Jackowski

E05/1112 Staff perceptions of risk of assault in psychiatric settings

Principal Investigator: Miss Kate Jackowski

Associate Investigators: Dr Lynda Byrne & Dr Karen Bird

Other Approved Personnel: Nil

Eastern Health Sites: Box Hill & Maroondah Hospitals

The above study was considered by the Eastern Health Research and Ethics Committee at its meeting on 25 July 2011 and 15 September 2011 and was approved subject to amendments and clarifications. Following receipt of amended documents and additional information (received on 21 November 2011), final approval can now be given for PART B (Questionnaires) to proceed.

List of documents approved:

- Participant Information and Consent Form Part B version 6 dated 21 November 2011
- Questionnaire version 8 dated 21 November 2011
- Prize draw consent form – Part B version 1 dated 21 November 2011

Reporting Requirements:

Please note, an annual progress report is due September 2012 – continuing approval is subject to the timely submission of a satisfactory progress report. Progress report template can be downloaded from our web-page:

Please ensure you notify the Ethics Committee of all personnel changes and any serious adverse events that may affect study conduct. Any changes to the approved Protocol or other approved documents must be submitted for ethical review and approval prior to use.

**Eastern Health Research and Ethics Committee**

The Eastern Health Research and Ethics Committee is constituted and functions in accordance with the National Health and Medical Research Council Guidelines (National Statement on Ethical Conduct in Human Research 2007). No member of the Committee adjudicates on research in which that member has any conflict of interest including any personal involvement or participation in the research, any financial interest in the outcome or any involvement in competing research.

Please refer to the National Statement on Ethical Conduct in Human Research (2007) http://www.nhmrc.gov.au/publications/synopses/e35syn.htm and Declarations by Investigators in the NEAF for researchers’ obligations. **Continuing approval is subject to the adherence of these guidelines and the fulfilment of researchers’ obligations.**

Please quote our reference number E05/1112 in all future correspondence.

Yours sincerely

Ms Lai Wan Reid
Manager
Eastern Health Research and Ethics

Encl: Committee Composition letter
Cc: Associate Researchers as listed above

**Confidentiality, Privacy & Research**

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients’ names or UR numbers must be stored on these devices. Electronic storage devices must be password protected or encrypted. The conduct of research must be compliant with the conditions of ethics approval and Eastern Health policies.

**Publications**

Whilst the Eastern Health Research and Ethics Committee is an independent committee, the committee and Eastern Health management encourage the publication of the results of research in a discipline appropriate manner. Publications should provide evidence of the contribution that participants, researchers and funding sources make.

**It is very important that the role of Eastern Health is acknowledged in publications.**
Dear (insert name of team leader here),

Just a brief follow-up email with regards to the questionnaires recently distributed to your team for the 'Staff Perceptions' project. Thank you very much for your help in organising the distribution of these questionnaires, your time was greatly appreciated.

We have now reached a stage where we would like to close off data collection and we would greatly appreciate it if you could remind your team about the questionnaires and ask that anyone who has not yet completed their questionnaire but would like to, to do so over the next week.

Many thanks,

Kate Jackowski

Candidate Doctor of Psychology (Forensic)
School of Psychology
Deakin University, Melbourne Campus
E: kjack@deakin.edu.au
Participant Information and Consent Form
Forensicare - Thomas Embling Hospital

Full Project Title: Staff Perceptions of Risk of Assault in Psychiatric Settings
Principal Researcher: Kate Jackowski
Associate Researcher: Dr Linda Byrne (Deakin University)

1. Introduction
You are invited to take part in this research project because you work in a psychiatric setting within Forensicare (Thomas Embling Hospital). The research project aims to explore the interaction between the perceptions held by staff of their risk of assault by clients in the workplace, their perceptions of the workplace climate, their relative years of experience and the actual rate of physical assault reported in the previous year for each unit.

This Participant Information Form tells you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully. Ask questions about anything that you don’t understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your local health worker.

Participation in this research is voluntary. If you don’t wish to take part, you don’t have to.

If you decide you want to take part in the research project, you may complete the questionnaire. By completing the questionnaire you are telling us that you:

- understand what you have read;
- consent to take part in the research project;
- consent to be involved in the procedures described;
- consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information Form to keep.
2. **What is the purpose of this research project?**

- The aim of the project is to address the lack of knowledge about staff perceptions with regard to risk of assault when working in both psychiatric inpatient and outpatient environments. This research is important because it aims to identify key areas, if any, in which staff hold positive and/or negative perceptions. Previous literature provides evidence to suggest that staff perceptions are important to the health and productivity of an organisation. This study may usefully inform participating organisations of possible areas of focus for any future staff training and/or professional development programs.

- The term perception used in this study refers to perception of risk which is the subjective appraisal of the likelihood and imminence of the occurrence of assault to oneself or other by another individual. Assault refers to any form of physical violence except for sexual assault.

- Another term used in this study is ‘workplace climate’ which refers to how staff perceive the support they receive, the cohesion of the team of professionals they work with and the policies of the organisation they work for, from the workplace in which these incidents occur.

- Previous literature has focused almost exclusively on the risk assessment of patients/clients and their risk to others. Few studies have considered the personal risk appraisals of staff and their perception of their own safety, support and personal level of risk in their work environment.

- It is expected that 150 people will take part in this project overall and approximately 35-70 of those will be from Thomas Embling Hospital.

- There are two settings across Victoria that are involved in this project: a metropolitan health setting and a forensic health setting (Thomas Embling Hospital). All units/teams at Thomas Embling Hospital are being asked to participate (Argyle, Ahterton, Bass, Barossa, Canning, Daintree and Jardine).

- This study is Part B of a two-part study. Part A involved brief telephone interviews with a small number of staff from the metropolitan health setting. These interviews were conducted as a form of focus group to inform the sorts of questions that should be included in the questionnaire for Part B that are relevant to staff working in psychiatric settings.

- The results of this research will be used by the primary researcher, Kate Jackowski, to obtain a Doctor of Psychology degree. This research has been funded by Deakin University.

3. **What does participation in this research project involve?**

- Procedures

  Participation in this Part B of this project will involve completing a paper questionnaire in your own time and sending it back to the researchers via the reply-paid envelope provided. The questionnaire will be handed out during a regular team meeting. The questionnaire is 14 pages and is expected to take approximately 20-30 minutes to complete. It consists of two types of questions: one type asks you to rate how much you agree or disagree with a statement and the second type is an open-ended question which gives you the opportunity to write a brief response.

  No access to personal records is required for this project. The only personal information, if any, we will obtain will come directly from you in the questionnaire.
It is expected that the results will be available in December 2012. You will be able to obtain a summary of the results from your team leader/unit manager.

- **Reimbursement**
  You will not be paid for your participation in this research, but you may consent to being entered into a draw to win a $50 Coles/Myer gift voucher upon completion of your questionnaire. There is a $50 Coles/Myer gift voucher to be won on each unit of the Hospital. If you wish to be entered into the draw please fill out the form and return it to the researchers in the separate reply-paid envelope provided. If you do not wish to be entered into the draw then simply do not fill out the form. Please note after the draw has taken place and the winner is notified all forms with each participant’s contact details consenting to be entered in the draw will be shredded.

4. **What are the possible benefits?**

The results of this research will contribute to the growing body of literature surrounding staff perceptions of risk of assault in psychiatric settings, as well as, workplace influences on perceptions.

We cannot guarantee or promise that you will receive any benefits from this project.

5. **What are the possible risks?**

There is a risk that you may become distressed by your reflections when completing the questionnaire. If you become upset or distressed following your participation in the research, please contact the researcher to discuss how you are feeling. It is then recommended that you contact your G.P. who will discuss a mental health plan and referral to an appropriate mental health professional. Medicare rebates are available for eligible people.

Due to the small number of staff in each team there is also a risk that you may be identified in the dissemination of results. To minimise this risk site-specific team data will not be directly reported if the number of participants from that team is less than 5. Instead, de-identified results will be aggregated across the two sites involved and reported by team type e.g. acute inpatient.

6. **Do I have to take part in this research project?**

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

If you do consent to participate, you may only withdraw prior to the questionnaire being submitted. After you have submitted your questionnaire the information you provided is de-identified and the researchers are no longer able to determine which questionnaire contains your responses.

Your decision whether to take part or not, or to take part and then withdraw, will not affect your relationship with the researchers or Forensicare.

7. **How will I be informed of the final results of this research project?**

A brief summary of the results of the study will be provided to each team leader/unit manager of the participating teams at each location. Participants will have the opportunity to receive aggregate group results from their team leaders/unit managers. The summary of results can be expected to become available in December 2012.
8. What will happen to information about me?
The data collected from this study will be in non-identifiable form. Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. It will only be disclosed with your permission, except as required by law. The de-identified data collected in this study may be used in future research, which relates to and extends this study for which separate ethical review and approval will be obtained.

The information collected will be stored in both the original paper copy and as an encrypted computer file. The paper copies will be kept in a locked filing cabinet and the encrypted computer files will be stored on a password secure computer. Both forms of information, paper and digital, will be kept in the primary researcher’s locked office in the Psychology building of Deakin University, Burwood. The information will be stored for seven years upon completion of the project as recommended by the Australian Psychological Society Code of Ethics. After seven years has lapsed, the paper copies will be shredded and the computer files will be permanently deleted.

The primary researcher (Kate Jackowski) and the supervisor of the primary researcher (Dr Linda Byrne) will have access to the information solely for the purposes of this research project. The Forensicare associate researcher (Dr Cristina Cavezza) will also have continued access to the de-identified data generated from the study.

In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your permission. The data used will be de-identified and presented as aggregated group data. In order to maintain confidentiality, if less than 5 members of a particular team participate, site-specific team data will not be reported, instead it will be aggregated across the two locations.

9. Can I access research information kept about me?
In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. Please contact one of the researchers named at the end of this document if you would like to access your information.

In addition, in accordance with regulatory guidelines, the information collected in this research project will be kept for at least seven years. You must be aware that the information collected about you may at some point not be able to be identified once the identifying information has been removed. The information will become non-identifiable once the questionnaire has been submitted. Access to information about you after this point will not be possible.

10. Is this research project approved?
The ethical aspects of this research project have been approved by the Human Research Ethics Committees of Deakin University (Project reference number: 2012-133).

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.
11. **Who can I contact?**
The person you may need to contact will depend on the nature of your query. Therefore, please note the following:

**For further information:**
If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project (for example, feelings of distress), you can contact either of the associate researchers:

Name: Dr Linda Byrne
Role: Student supervisor/Associate researcher – Deakin University
Telephone: (03) 9244 6424

**For complaints:**
If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact:

The Executive Officer, Human Research Ethics Committee, Deakin University, 221 Burwood Hwy, Burwood Victoria 3125
Telephone: (03) 9251 7123
Project reference number: 2012-133
Staff Perceptions of Risk of Assault in Psychiatric Settings

This research is important to help understand the impact of potential violence in the workplace.

This project is being undertaken as part of a Deakin University Doctor of Psychology degree in partnership with Forensicare (Thomas Embling Hospital).

This questionnaire is designed to inform the researchers of the views and experiences of clinicians working in Adult Mental Health about patient assault and workplace climate. For the purpose of this questionnaire the term ‘assault’ refers to verbal and physical assault with the exception of sexual assault.

We are interested in your thoughts, opinions and experiences. Do not spend too much time on any one question as we are more interested in your first response.

This questionnaire will take approximately 30 minutes to complete. Your participation is entirely voluntary and we have no way of identifying you from your responses. There are no right or wrong answers.

By completing the questionnaire you are providing your consent to participate in the research project. When you have completed this questionnaire, please return it in the reply paid envelope provided.

All participants will have the opportunity to enter the draw to win a $50 Coles/Myer gift voucher (one voucher per unit). If you wish to be entered into the draw please complete the separate consent form and return in the separate reply paid envelope provided. Note: there will be no way of matching your prize draw consent form to your questionnaire, ensuring that all responses remain anonymous.

We thank you for taking the time to help us with this research by completing the questionnaire.

Sincerely,

Signature Redacted by Library

Kate Jackowski

Dr. Linda Byrne
SECTION A – About you

1. How old are you?
   20-29  30-39  40-49  50-59  60-69  70+

2. What is your gender? (please circle)
   Female  Male

3. What is the highest level of education you have completed? (please circle)
   Year 10 or below  Year 11 or 12  Certificate
   Diploma  Bachelor degree  Masters or above

4. What is your employment status? (please circle)
   Fulltime  Part-time  Casual

5. What is your profession? (optional)

6. What adult mental health service organisation do you work for?

7. What unit do you work on within this organisation?

8. How long have you been working for this organisation?
   6-12 months  1-2 years  3-5 years  6-10 years  11+ years

9. How long have you been working on your current unit?
   6 -12 months  1-2 years  3-5 years  6-10 years  11+ years

10. How long have you been working with psychiatric clients?
    6-12 months  1-2 years  3-5 years  6-10 years  11+ years

11. Did you complete the online Forensic Clinical Specialist Evaluation survey in late 2010?
   Yes  No  Unsure
### SECTION B - Current views about work

*Circle the most appropriate responses to the statements below.*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I enjoy coming to work each day.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I would describe my current overall wellbeing as optimal.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have a positive view of my workplace.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I think my workplace impacts on my wellbeing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel well supported by the organisation that I work for.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am at a very high risk of patient assault in my workplace.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel very safe in my workplace.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am very fearful of patient assault at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am very vulnerable to patient assault at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am very fearful that I will be threatened by a patient at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel very confident in dealing with an assaultive patient.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Staff in psychiatric settings should expect to be assaulted by patients at work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Incidents of patient assault on staff are under-reported.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Repeat incidents of patient assault on staff are often unreported.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I fear being blamed for a patient being assaultive.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
SECTION C – Your experiences of assault at work

All questions in this section refer to experiences in your current psychiatric setting.

The term ‘assault’ refers to both verbal and physical forms (except sexual assault) unless otherwise stated.

1. Have you witnessed and/or experienced verbal or physical assault at work?
   - YES – answer questions below
   - NO – skip to Section D

For the remaining questions circle the most appropriate response below.

2. Have you been verbally assaulted by a patient at work in the past year?
   - YES
   - NO

3. Have you ever been verbally assaulted by the same patient in the past year?
   - YES
   - NO

4. Have you been physically assaulted by a patient at work in the past year?
   - YES
   - NO

5. Have you ever been physically assaulted by the same patient in the past year?
   - YES
   - NO

6. What was the severity of injury that resulted from the physical assault?
   - N/A
   - no injury
   - minor injury
   - first aid required
   - medical treatment required

7. Have you witnessed other staff being verbally assaulted by a patient at work in the past year?
   - YES
   - NO

8. Have you witnessed other staff being physically assaulted in the past year?
   - YES
   - NO

9. Have you witnessed client aggression towards objects in the past year?
   - YES
   - NO
10. Have you witnessed attempts or incidents of patient self-harm in the past year?
   YES  NO

11. Do you have a higher level of fear of patient assault as a result of having witnessed and/or experienced patient assault?
   YES  NO

12. Are you more vigilant at work since witnessing and/or experiencing patient assault?
   YES  NO

**SECTION D: Patient Characteristics**

*Circle the most appropriate responses to the statements and/or questions below.*

1. Length of patient stay or patient contact with a service increases the likelihood that the client will be assaultive towards staff.
   - Strongly Agree
   - Agree
   - Uncertain
   - Disagree
   - Strongly Disagree

2. A prior history of assaultive behaviour dramatically increases the likelihood that a patient will be violent towards staff.
   - Strongly Agree
   - Agree
   - Uncertain
   - Disagree
   - Strongly Disagree

3. What is the most frequent diagnosis your patients have?
   - Schizophrenia
   - Schizoaffective disorder
   - Bipolar affective disorder
   - Depression
   - Anxiety
   - Other (specify):

4. What diagnosis/cluster of patients do you think is the most likely to assault staff?
   - Schizophrenia
   - Schizoaffective disorder
   - Bipolar affective disorder
   - Depression
   - Anxiety
   - Other (specify):

5. What diagnosis/cluster of patients do you think is the least likely to assault staff?
   - Schizophrenia
   - Schizoaffective disorder
   - Bipolar affective disorder
   - Depression
   - Anxiety
   - Other (specify):
7. Estimate the number of patients who have assaulted staff in your team in the past year.

0-4  5-9  10-15  15-19  20-24  25-29  30+

8. List the most common signs or symptoms of a patient you suspect will assault staff

........................................................................................................................................
........................................................................................................................................

SECTION E: Training and Support

Circle the most appropriate response to the statements and/or questions below.

1. I have received adequate training from my organisation to assess and manage assaultive patients.

   Strongly Disagree  Do not agree  Agree  Strongly Agree
   Disagree  or disagree

2. The organisation I work for is very supportive of therapeutic intervention and positive therapeutic outcomes for patients.

   Strongly Disagree  Do not agree  Agree  Strongly Agree
   Disagree  or disagree

3. I receive a lot of guidance from my organisation for specifically assessing assault risk and managing assaultive behaviour.

   Strongly Disagree  Do not agree  Agree  Strongly Agree
   Disagree  or disagree

4. I last completed training around assessing and/or managing assaultive patients...

   Within the last month  6 months ago  12 months ago  18 months ago  2+ years ago

5. Do you have trust in the organisation that you work for to provide the necessary training and support to equip you to deal with assaultive patients?

   YES  NO
6. Think of a critical incident you have either witnessed or experienced in the past 12 months.

In terms of the response by your *organisation* what worked and what did not work?

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In terms of the response by your *unit* what worked and what did not work?

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........................................................................................................................................

**SECTION F: Workplace Climate**

*Below are statements about the place in which you work. You are to decide which statements are true of your work environment and which are false.*

*If you think a statement is *true* or *mostly true* of your work environment circle *T* in the true box.*

*If you think a statement is *false* or *mostly false* of your work environment circle *F* in the false box.*

*Note: this section of the questionnaire has been removed due to copyright. Please refer to Appendix G for the Authors' permission to reproduce the Work Environment Scale by Moos and Insel (1974). As per the authors' permission five sample items from the scale are illustrated below.*

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>The work is really challenging.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>People go out of their way to help new employees feel comfortable.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Supervisors tend to talk down to employees.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>Few employees have any important responsibilities.</td>
<td>T</td>
<td>F</td>
</tr>
<tr>
<td>People pay a lot of attention to getting work done.</td>
<td>T</td>
<td>F</td>
</tr>
</tbody>
</table>

*Circle the most appropriate responses to the statements below.*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I make most of the decisions that effect the way my job is performed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I determine my own work procedures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I schedule my own work activities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I set the performance standards for my job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I organise my work as I see best.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>People pitch in to help each other out.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>People tend to get along with each other.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>People take a personal interest in one another.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It is a relaxed place to work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>There is a lot of 'team spirit' among people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel like I have a lot in common with the people I know.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can count on my boss to keep the things I tell him confidential.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss has a lot of personal integrity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss follows through on his/her</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
commitments to me.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My boss is not likely to give me bad advice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have too much work and too little time to do it in.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>At home, I sometimes dread hearing the telephone ring because it might be someone calling about a job-related problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>The only time I hear about my performance is when I screw up.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is behind me 100%.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Too many employees at my level get “burned out” by the demands of their jobs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can count on my boss to help me when I need it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is interested in me getting ahead in the company.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is easy to talk to about job-related problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss backs me up and lets me learn from my mistakes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can count on a pat on the back when I perform well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Uncertain</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>I feel like I never have a day off.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss knows what my strengths are and lets me know it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss does not play favourites.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss is quick to recognise good performance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My boss uses me as an example of what to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Statement</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>I can count on a fair go from my boss.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The objectives my boss sets for my job are reasonable.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My boss is not likely to give me a bad deal.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If my boss terminates someone, the person probably deserved it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My boss encourages me to improve on his/her methods.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My boss encourages me to find new ways around old problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My boss &quot;talks up&quot; new ways of doing things.</td>
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(‘Organisational Climate Questionnaire’ by Kays & DeCotis, 1991)

**Finally...**

Do you have any other comments about any issues included in this questionnaire or things you would like to raise but have not had the opportunity to do so in the questionnaire?

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Thank you very much for taking the time to complete this questionnaire. Your views are very important to the study. Please return the questionnaire in the enclosed reply postage paid envelope. If you wish to be entered into the prize draw for a $50 Coles/Myer voucher (one per unit) please also complete and return the prize draw consent form in the separate reply postage paid envelope provided.
Appendix N

Entry form for the prize draw

Please tick this box if you wish to be entered into the prize draw □

Name:

Signature: Date:

Telephone:

Hospital unit:
Appendix O

Memorandum

To: Dr Linda Byrne
    School of Psychology

B

cc: Miss Katherine Jackowski

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 29 May, 2012

Subject: 2012-133

Staff perceptions of risk of assault in psychiatric settings

Please quote this project number in all future communications

The application for this project was considered at the DUHREC meeting held on 28/05/2012.

Approval has been given for Miss Katherine Jackowski, under the supervision of Dr Linda Byrne, School of Psychology, to undertake this project from 29/05/2012 to 29/05/2019.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
21 March 2012

Dear Ms Jackowski

Re: Staff perceptions of risk of assault in psychiatric settings

The Forensicare Operational Research Committee has given operational approval for your research to be conducted at Forensicare. This approval is subject to approval by the Department of Health Human Research Ethics Committee.

You may not commence the research until you provide a letter of approval from the Deakin University Human Research Ethics Committee, and you receive a letter from the Forensicare Research Committee acknowledging receipt of the approval letter.

In addition you will find enclosed a Researcher Information Pack. Please familiarise yourself with this document and return the confirmation of receipt as indicated.

Approval is given for the period between the anticipated commencement and completion dates as set out in the documentation. If the study has not been completed by the nominated completion date, an application for extension will be required.

To enable the Committee to meet its obligations in relation to monitoring Forensicare’s research program, you are required to provide a report within 12 months or on completion of your project, whichever is earlier.

Forensicare must report ongoing research activities to the Minister of Mental Health quarterly. As such you may be asked to provide information on the progress of your research and will be required to input and maintain up to date your research information into the Forensicare Research Database on the Intranet. Failure to comply may lead to the withdrawal of consent for the research to be conducted at Forensicare.

Please ensure that the Operational Research Committee is notified of any matter that arises that may affect the conduct of the approved program.

Should you have any queries please don’t hesitate to contact Ms Mitali Gupta on 99472543 or email mitali.gupta@forensicare.vic.gov.au.

Yours sincerely

* Professor Mairead Dolan
Assistant Clinical Director (Research)
Forensicare

Signature Redacted by Library