Help-seeking and use of Workplace Services for Emotional Needs among Community Residential Staff who support Adults with Intellectual Disabilities and Aggressive Behaviour

by

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A thesis submitted in conformity with the requirements for the degree of Master of Science
Institute of Health Policy, Management and Evaluation
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Abstract

Community workers supporting adults with intellectual disability get a lot of positive impact from their work. However, staff are also required to deal with challenges such as aggressive behaviours which can be associated with burnout. This thesis used a cross-sectional mixed methods design consisting of survey data analysis and qualitative interviews. The study aims were to examine staff report of emotional difficulties related to working with aggressive behaviours and use of available workplace resources. Staff frequently reported experiencing emotional difficulties; however use of workplace resources was low. Findings fit within existing models of general health service utilization with workplace resource use affected by: preventing and coping, severity threshold, enabling factors and cost versus benefit appraisal. Some unique factors included o-worker relationships, finding relief, lacking or inflexible rules and organizational focus on the service recipients. Multi-faceted interventions are likely to be the most successful in improving staff and related organizational outcomes.
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Chapter 1: Introduction

1.1 Thesis Overview

The front-line support staff who work in the community residential settings that accommodate the children and adults living with intellectual and developmental disabilities, provide the daily support and care for this vulnerable group of people who often are not otherwise able to live independently. The more recent priority of service organization within this domain has been on integrating people with intellectual disabilities (ID) into mainstream society including housing them in communities, supporting them to achieve employment, building social interactions and find quality of life (Developmental Services Ontario, 2013). As a result, community programs, including residential homes, provide a large component of these necessary services. With resettlement into communities and a focus on providing compassionate and inclusive care, there is a risk that staff may experience increased challenges given the organization of services and recipient characteristics.

As human services workers, staff working in this field are inherently at risk for high levels of work stress and job burnout due to the nature and demands of their work (Felton, 1998; Maslach, Schaufeli, & Leiter, 2001). There may also be additional challenges that further contribute to emotional and psychological difficulties they experience at work. For example, exposure to recipient aggression is a unique factor experienced by this staff group and a handful of others, including those who work with severe mental illness and the elderly affected by dementia. Exposure to aggression has been identified as a workplace stressor and has been linked to stress and burnout (Hastings, 2002).

In Ontario, legislative changes to the Occupational Health and Safety Act, known as Bill 168, were implemented in mid-2010. This Bill outlined the role that organizations must play with respect to assessing and managing the risk of workplace violence that employees may encounter. In addition, the Bill mandated that organizations have policy and resources to deal with the consequences of violence. This was an issue that was of particular relevance and

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1 The term recipient refers to the individual receiving care by the staff workers. In the literature various terms are used to refer to individuals with ID in this capacity. For example, ‘people supported,’ ‘service recipients,’ or ‘clients.’ Several of these terms are used interchangeably throughout this document.
interest to the ID sector given the awareness that service recipients can act aggressively or violently at times and therefore staff are susceptible to the negative effects that may occur.

While Bill 168 mandates that organizations provide resources for staff, we still do not have a good understanding of who is most at risk and what predicts actual staff utilization of resources. This study sought to answer some of these questions. First a survey of Ontario’s support staff was conducted to gather data on self-reported experiences of recipient aggression at work and the negative consequences staff experience. In addition staff were asked to answer questions about their use of workplace resources. A follow-up study consisting of individual interviews was carried out to explore staff help-seeking behaviour in more detail and determine what services were perceived to be needed. This information was sought with the aim of identifying barriers and enablers of resource use thus informing the resources that would be most utilized and useful to enable organizations to best support their staff. Trying to elucidate and understand the local and contextual factors that contribute to a phenomenon prior to implementing a solution is consistent with a systems approach that is widely advocated in intervention research and tends to lead to more fully adopted and sustained change (Rycroft-Malone, et al., 2002).

### 1.2 Study Aims and Research Questions

The first aim of this study was to examine the relationship between demographic variables, occupational variables, exposure to aggression, staff report of emotional difficulties related to aggression, burnout and utilization of resources for emotional problems related to aggression using survey data from a sample of community residential ID staff.

**Research Questions:**

- What proportion of staff exposed to aggression experience subjective emotional problems?
- What factors are associated with emotional problems?
- What proportion of staff who report experiencing emotional problems related to working with aggression seek workplace support?
- What factors are associated with utilization of workplace services?
The second aim of this study was to assess the help-seeking behaviours and utilization of resources as well as perceived service need of community staff supporting adults with ID and aggressive challenging behaviour using qualitative interview data.

**Research Questions:**

What are the barriers and facilitators of workplace service use?

What services do staff perceive to need?

The third and final aim of this study was to conduct a mixed or integrated interpretation of the quantitative and qualitative findings in consideration of existing theory and literature to delineate a framework to serve as a guide for further work in this population. Based on the findings and staff reports, some preliminary suggestions for interventions were also proposed.
Chapter 2: Literature Review

2.1 Human Service Workers in the Intellectual Disability Sector

2.1.1 Description of Services and Recipients

An intellectual disability (ID) is defined as the presence of permanent and lifelong limitations in intellectual functioning, conceptual and practical skills which become noticeable before the age of 18 (Sullivan, et al., 2011). The disability can be associated with a range of conditions, including genetic (eg. Down’s syndrome, Prader Willi syndrome), congenital (eg. structural brain defects) and acquired (eg. traumatic brain injury). The needs of people with ID are variable and range from very minimal to maximal supportive care depending on the severity of their disability. They often require more help to learn, understand and use information, have impaired language and social skills and many require assistance with daily life activities (Developmental Services Ontario, 2013). Despite these limitations, however, with adequate support many people with ID can achieve success and contribute to society in meaningful ways.

Because the level of assistance required varies, there are a wide range of supports available to people with ID. Traditionally, many individuals with more severe ID were held in institutions but since the latter half of the twentieth century there have been growing movements to transition them into the community to provide a better quality of life. Much like other parts of the country and the world, the province of Ontario has been undergoing a transformation whereby continuous efforts are being made to improve the services provided to people with ID (Developmental Services Ontario, 2013). The staff who provide community-based services play a key role in this transformation.

With the movement of people with ID into communities, a range of accommodations and programs of support have been developed. In Ontario, these range from community participation supports (akin to ‘coaches’ or ‘teachers’), home services, day program services, semi-independent living, respite services and residential group home services (Developmental Services Ontario, 2013). Residential group homes often accommodate individuals with higher
support needs and offer 24 hour care. The staff who work in these homes provide support with activities of daily living, including hygiene, toileting, nutrition and medical care, accompany people to health and dental appointments, provide entertainment and recreation and attend to the housing chores such as cooking and cleaning. Ontario’s developmental services agencies are funded by the Ministry of Community and Social Services (MCSS) and are available to all individuals who have a developmental disability as confirmed by psychological testing (Developmental Services Ontario, 2013). Families can also obtain some services through private payment. In addition, the Ontario government is presently introducing a direct funding model where resources will be allocated to individuals in need to use for services as they choose (Developmental Services Ontario, 2013).

2.1.2 Description of the Workforce

The developmental services workforce is characterized by a high number of casual and part-time employees due to several factors including a relatively low number of available full-time positions for new employees, low wages compared to similar work in other sectors, sector underfunding, and high turnover (Canadian Union of Public Employees (CUPE), 2008; Community Living Ontario, 2014). This has increased substantially in the last decade and part-time, casual or relief staff may account for 2/3 of staff in some agencies (CUPE, 2008). Staff entering the sector may have completed specialized post-secondary training in developmental services work (DSW) or may enter the field from a related profession (e.g. nursing). Many staff, however, have no formalized training in providing services to people with ID or support services in general, as it has not historically been a pre-requisite for employment in the sector. Despite high demand for support services, the pool from which to draw new workers has been declining (Hewitt & Larson, 2007). The sector has historically been dominated by women (CUPE, 2008; Hewitt & Larson, 2007), and this continues to be reflected in DSW college enrollment patterns as between 80 and 85% of Ontario’s graduates in 2012 were female (Ministry of Training, Colleges and Universities, 2014).

As of 2007, employees in the developmental services sector in Ontario were earning on average 25% less than employees doing similar work in other sectors with some recent funding increases acting to start to narrow this gap (Community Living Ontario, 2014). In 2012 the average entry
level salary for a full-time employee with a DSW degree was between $30,000 – $35,000 per year (Ministry of Training, Colleges and Universities, 2014). Only 40-45% of employed DSW graduates were working full-time in an occupation related to their field due predominantly to ‘labour market pressures’ (Ministry of Training, Colleges and Universities, 2014). Many of Ontario’s developmental services workers are unionized by the Canadian Union for Public Employees which represents over 8,000 members in this sector (CUPE, 2008), however part-time and casual staff are not necessarily included in this group in all agencies. In addition, many part-time staff are not eligible for insurance benefits through their employer (Hewitt & Larson, 2007).

Turnover in the sector is high and has been consistently for decades (Hewitt & Larson, 2007). There are jurisdictional differences in turnover with U.S. studies citing annual rates between 50 and 70% or more (Hewitt & Larson, 2007) and U.K. studies citing 10-30% annually (Hatton, et al., 2001). Although there are noted challenges with published turnover rates in Ontario (including measuring full-time equivalents versus actual number of staff), the annual rate is estimated to be around 22% (Community Living Ontario, 2014). Turnover is typically higher among part-time staff and staff working in the most challenging settings such as residential group homes. In one agency providing services in South Western Ontario, the 2012/2013 annual turnover rate for part-time staff was 30% whereas full-time staff turned over at a rate of less than 10% (Lambton County Developmental Services, 2013). The developmental services sector has been characterized as having a ‘leaver’ phenomenon whereby employees leave after a relatively short time (Hall & Hall, 2002). These leavers are typically younger, more educated and have limited tenure and it is hypothesized that they are more mobile and marketable than the ‘stayers’ (Hall & Hall, 2002). Ontario’s developmental services sector has recently launched a human resource strategy (Developmental Services Ontario, 2013) in an effort to respond to and improve current workforce pressures. This will include recruitment and retention strategies aimed at building a qualified and committed workforce. Fostering staff well-being and responding to staff challenges will certainly be an integral part of this.
2.1.3 The Positive Impact of the Work

While working as an ID staff has been associated with many challenges, some of which will be discussed below, the work has also been identified to make many positive contributions to the lives of the staff that do it. For example, in a preliminary survey of positive impact received from the work they do, Horne and Hastings (Horne & Hastings, 2004) surveyed staff in services for adults with ID about a range of possible experiences. The most commonly endorsed items that related to a more general positive impact (beyond just learning more about ID and the people affected) were: “I am more sensitive to wider professional issues” and “I have learned to adjust to things I cannot change.” An earlier study of residential support staff in Australia (Ford & Honnor, 2000) that examined sources of job satisfaction reported that staff held ‘moderately favourable’ views of their work. Sources of job satisfaction were noted to come from relationships with residents, families and co-workers as well as the nature of the work including job duties and goals of services. Hastings (2010) has suggested that the positive impact staff receive from their work may in fact be independent of any negative impact they may experience and may be embedded in the relationship that develops between them and their service recipients.

2.1.4 Stress and Burnout

The fact that staff experience such positive aspects from their work and deliver an important service to a highly vulnerable population means that understanding and responding to the potential challenges that arise is of ongoing importance. As human service workers, ID staff are susceptible to the development of job burnout, a psychological syndrome that develops in the setting of exposure to ongoing stressors associated with the workplace and one’s occupational role (Maslach, et al., 2001). Burnout is widely conceptualized as having three components: emotional exhaustion (EE), depersonalization (DP) and a lack of personal accomplishment (PA). Emotional exhaustion is often regarded as the core feature of burnout and reflects the stress aspect of burnout but on its own is not sufficient to suggest burnout (Maslach, et al., 2001). Rather it is the exhaustion a person experiences that leads to the other two components of burnout that occur as a coping strategy and consequence. Depersonalization refers to a process that involves distancing oneself, becoming detached or cynical with respect to one’s
service recipients and may develop as a reaction to counter and cope with emotional overload. The declining sense of personal accomplishment that is the third component of burnout can relate to a combination of EE and DP and the toll they take on a worker, often exacerbated by a lack of available resources (Maslach, et al., 2001).

One of the most popular instruments used to measure burnout is the Maslach Burnout Inventory (MBI) which contains 22 questions corresponding to the 3 subscales and has a version specifically adapted for human services workers (Maslach, et al., 2001). Although the conceptualization of burnout and correspondingly the ability of the MBI to accurately measure it has been debated in recent years (Cox, Tisserand, & Taris, 2005), Maslach’s three component model remains the most widely accepted and the MBI is still the most widely used instrument to assess the phenomenon.

Many factors have been discussed and studied with respect to their contributory roles in the development of burnout in ID staff. Some factors are individual and are not specific to the nature of the work they do, for example demographics, personality characteristics and coping style (Chung & Harding, 2009; Devereux, Hastings, Noone, Firth, & Totsika, 2009; Maslach, et al., 2001; Skirrow & Hatton, 2007). Organizational factors have also been implicated in burnout and stress in ID and other human service organizations (Banerjee, et al., 2012; Gray-Stanley, et al., 2010; Hatton, et al., 1999; Maslach, et al., 2001; Skirrow & Hatton, 2007). In addition there are some factors more unique and specific to working with people with ID that have been implicated. For example, dealing with aggressive behaviour has been investigated as a factor in the development of burnout in ID (Hastings, 2002; Skirrow & Hatton, 2007) and long-term care home staff (Evers, Tomic, & Brouwers, 2002) and will be discussed in detail in the next section.

2.2 The Challenge of Aggressive Behaviour and its Consequences

2.2.1 Prevalence and Risk

A range of challenging behaviours that people with ID can have, including aggression, is something that many staff do encounter in their daily work and has been studied as a source of stress and other negative outcomes (Hastings, 2002; Rose, 2011). Working with such behavioural issues is not necessarily unique to this staff population, as they are also seen in
other recipient populations including those with severe mental illness and elderly geriatric patients who have dementia (Evers, et al., 2002; Needham, et al., 2005; Richter & Berger, 2006; Whittington, 2002). The term ‘challenging behaviour’ is widely used to refer to the behaviours exhibited by individuals with ID which can range from non-compliance, tantrums, over-activity, sexual inappropriateness and overt aggression, both verbal and physical (Benson & Brooks, 2008). These behaviours are often in response to external or internal stimuli (such as pain, noise or smell) and secondary to the fact that communication is often impaired in ID (Tyrer, et al., 2006).

Such challenging behaviour is not uncommon and can create management and safety concerns for staff. It is estimated that about 50% of individuals with ID will engage in aggressive challenging behaviour at some time including verbal and physical aggression as well as property aggression and self-injury (Benson & Brooks, 2008; Crocker, et al., 2006). However, only a small percentage of individuals are responsible for repeated and severe incidents (Benson & Brooks, 2008; Crocker, et al., 2006; Tenneij & Koot, 2008). In particular, physical aggression has been more often observed among individuals with more severe ID, younger age, presence of psychopathology and residing in an institution (Tenneij & Koot, 2008; Tyrer, et al., 2006).

Aggressive behaviour seen in institutions may be more frequent and severe, however, given the emphasis on community services, significant levels of aggression are being seen in the community as well and it is often an indication for admission to hospital (Burge, et al., 2002; Cowley, Newton, Sturmy, Bouras, & Holt, 2005). The prevalence of staff exposure to aggression in community settings has been estimated in several studies and may be as high as 90% when all forms and targets of aggressive behaviour from verbal to physical are considered (Hensel, Lunsky, & Dewa, 2012; Lundstrom, Saveman, Eisemann, & Astrom, 2007; Strand, Benzein, & Saveman, 2004). Some settings are inherently higher risk depending on the severity of the disabilities served and the amount of contact between staff and service recipients. With the focus on accommodating people with ID in the community, the prevention and management of aggressive behaviour when present is an important goal. However, the fact remains that it is not an uncommon occurrence and so managing the impact it has on staff is also crucial.
2.2.2 Consequences for Staff

A negative association between challenging behaviour, more specifically aggression, and ID staff psychological well-being has been reported in several studies. In a large scale population study on the prevalence of physical aggression among adults with intellectual disabilities (Tyrer, et al., 2006), it was found that poor coping was reported by 42% of staff working with aggressive individuals versus 10% of staff working with non-aggressive individuals. Similarly, Howard et al. (2009) compared a sample of 45 staff in a private residential service who were exposed to a high level of violence and a sample of 41 community staff exposed to a low level of violence and found a significant positive correlation between both the level of physical and verbal aggression and emotional exhaustion (EE) as measured with the human services version of the MBI. Chung and Harding (2009) reported a significant relationship between challenging behaviour and EE and lack of personal accomplishment (PA), another dimension of burnout measured with the MBI. They did not observe a relationship with depersonalization (DP), the third dimension of burnout. More recently a study of 78 staff from residential homes reported a significant positive association between aggressive behaviours and all three dimensions of burnout on the MBI (Mills & Rose, 2011).

Hastings has previously reviewed the literature on this topic and concluded that although causality is difficult to determine, there appears to be strong evidence of an association between challenging behaviours and burnout (Hastings, 2002). One limitation is the use of cross-sectional data which provides evidence of association only. A second limitation is that most of the studies which have been done are small limiting the number of factors that can simultaneously be evaluated in statistical analyses and include staff from a range of occupational settings. In addition, many of the studies were done outside of North America which affects generalizability given that there may be important differences in the way services are structured compared to other countries including funding, provision of services and staff training.

In an effort to address this knowledge gap, a large scale study of direct support staff was conducted in Ontario, Canada between the months of January and April of 2010. A total of 926 community staff that support adults with ID completed a survey which included measures of
recipient aggression and the human services version of the MBI. The results of that study were that there was a significant positive association between frequency and severity of recipient aggression and staff burnout (Hensel, et al., 2012). Among other staff groups such as nurses, those working with the mentally ill or elderly with dementia, exposure to aggressive behaviour has also been associated with burnout (Evers, et al., 2002; Needham, Abderhalden, Halfens, Dassen, et al., 2005; Whittington, 2002).

Additional outcomes that may arise in the setting of working with aggressive behaviours, with or without the development of burnout, are physical injury, mild to severe psychological consequences ranging from increased fear (Rose, Mills, Silva, & Thompson, 2013) or reduced self-efficacy (Evers, Tomic, & Brouwers, 2001) to clinical mental disorders such as excessive anxiety or post-traumatic stress disorder following a particularly distressing incident (Needham, et al., 2005). A qualitative study of stress among a sample of 9 Ontario residential staff reported that working with aggression emerged as a source of stress that could contribute to the experience of burnout (Neben & Chen, 2010). In this study, some staff were specifically noted to transfer locations in order to avoid the stress caused by dealing with aggression.

Various authors have begun to propose some possible factors that may mediate or moderate the impact that being exposed to aggression has on their psychological well-being. A mediator is an explanatory mechanism through which a variable leads to another variable, whereas a moderator affects the relationship between two variables depending on its value. Howard et al. (2009), found that self-efficacy significantly moderated the effect of physical aggression on EE with higher self-efficacy buffering the negative impact. The role of aggression in increasing fear of assault has been studied as a mediator of EE (Mills & Rose, 2011). Similarly, negative emotional reactions including fear/anxiety and depression/anger have been proposed to mediate the impact of exposure on burnout (Hastings, 2002). Positive contributions gained from the work have been proposed to have a possible moderating effect although alternatively, these contributions may be more independent of negative outcomes and aggressive behaviour (Hastings, 2010; Lunsky, et al., under revision). Staff reactions may also be linked to how they attribute the behaviours, both causally as well as the extent to which they feel them to be under the offender’s control (Mills & Rose, 2011). Staff who have greater knowledge about behaviours and their precipitants may experience fewer negative outcomes (Noone, Jones, &
Hastings, 2006). Similarly, those behaviours felt to be more stable and less under the control of the individual may cause less emotional damage for staff (Mills & Rose, 2011). Staff psychological correlates such as their ability to practice acceptance and mindfulness has also been implicated (Noone & Hastings, 2011). Staff reactions, attributions, and self-efficacy may be modifiable factors that can provide some primary prevention of the potential negative impacts of dealing with aggressive behaviour.

### 2.2.3 Associated Costs and Consequences for Organizations

In addition to the negative consequences that staff experience directly, there are also consequences to the organization and service recipients with potentially significant associated costs. There are no studies to date that evaluate the actual economic impact of working with aggressive behaviour specifically in the ID sector, however comparisons can be made to cost analyses in the human service sector more broadly. Costs can be associated with the physical consequences of injury as well as the negative emotional impact that staff experience.

A study from Denmark (Rugulies, et al., 2007) followed 890 human service workers for 3 years and measured psychosocial work characteristics and sickness absence. After controlling for a wide range of potential confounders, the authors found that workers exposed to violence had 60% more sickness absence days and overall, exposure to violence accounted for 10% of all sickness absence days. With respect to cost, a study from the mid 1990’s in the United States estimated the cost due to work-related physical assaults across several industry groups (McGovern, et al., 2000). Social service and healthcare workers were the second and third highest risk occupational groups (after justice and safety) and the average cost per case was highest for social service workers ($24,210) reflecting higher severity of injury with more associated direct and indirect costs.

Other studies have evaluated outcomes related to burnout and stress regardless of the precipitant(s). In the same study mentioned above of 890 human service workers in Denmark, those with stable high levels of work-related burnout (measured with the work-related burnout scale of the Copenhagen Burnout Inventory) or large increases in burnout over the study period, had more sickness absence days (Borritz, Rugulies, Christensen, Villadsen, & Kristensen, 2006). Among nurses, higher burnout, particularly depersonalization, has been found to be
associated with turnover intention in a Canadian sample (Leiter & Maslach, 2009). Based on a small number of studies done in the United States, the average cost associated with replacing a developmental services employee has been estimated at $2,413US (Hewitt & Larson, 2007). In general, mental health related disability costs in Canada have been steadily climbing and are estimated to account for over 30% of disability claims totalling between $15 and $33 billion in annual costs (Dewa, Lesage, Goering, & Craveen, 2004).

An additional consequence that may be downstream of the impact on staff, is the resultant impact on service recipients. For example, negative staff outcomes have been linked to lower quality of care for recipients, subsequent escalations in aggressive behaviours and even abusive care relationships (Rose, 2011). These consequences may lead to additional organizational costs and healthcare costs as aggressive behaviour is a common indication for use of emergency room services and inpatient hospital admissions among individuals with ID (Lunsky, Bradley, Durbin, & Koegl, 2008; Lunsky, et al., 2012). Although the exact financial burden of staff experience of aggression in the ID sector in Ontario or Canada is not known, when all of staff, organizational and client costs are considered, it is likely to be considerable.

### 2.3 Recent Legislation in Ontario regarding Workplace Violence

With increasing awareness of violence and harassment in the workplace, new legislation was introduced in Ontario that would address some of the growing concerns around workplace incidents, lost time, aggression and bullying (Industrial Accident Prevention Association (IAPA), 2011). This Workplace Violence Legislation, known as Bill 168, was put forth before parliament for a first reading April 9, 2009 and received Royal Assent on December 15, 2009. Official amendments to Ontario’s Occupational Health and Safety Act became effective June 15, 2010. The Bill addresses both workplace harassment and workplace violence (Fonesca, 2009). “Workplace harassment” was defined as ‘engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome’ and “workplace violence” has been defined to include:

(a) ‘the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker,
(b) an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker,

(c) a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.’

Under the legislation, an employer is responsible for preparing a policy and reviewing it at a minimum annually, and developing a program to implement the policy. This program shall include measures and procedures to control any risk identified, measures and procedures for summoning immediate assistance when violence occurs or is likely to occur, measures and procedures for incident reporting and a plan for how the employer will deal with incidents or complaints.

In a recent report published by the Ontario Public Service Employees Union (OPSEU, 2011), it was stated that 33% of violent incidents in the workplace are against staff who work in healthcare and social services. Furthermore, the report identified those who work with the developmentally disabled as an occupational group at a higher risk of violence at work. Additional highlighted risk factors that may uniquely affect ID staff were understaffing, working early or late hours, working with unstable recipients, the absence of violence prevention programs in community or home care settings and transporting people without effective violence prevention strategies (OPSEU, 2011). As a result developmental services agencies have necessarily had to pay more attention to the issue of workplace violence and have implemented required staff training and resources.

2.4 Help-seeking and Service Utilization

A literature review for studies on help-seeking behaviours did not yield any studies specific to staff in the ID sector, but did identify some studies on other groups of healthcare workers. For example, Putnik et al. (2011) conducted semi-structured interviews with 14 human service workers in the Netherlands (the majority were “teachers”) who had developed clinical burnout and were attending a health clinic. Using a grounded theory approach, they identified that the main hindrance to help-seeking was a strong sense of work responsibility and dedication. They
found that staff identified with the ideal work role, in an almost “heroic” way, and denial was a prominent mechanism of delayed help-seeking. Among the study participants, symptoms were present for a minimum of six months prior to help being sought. Similarly, Seibert and Seibert (Siebert & Siebert, 2007) used a survey design to study help-seeking behaviour in a large sample of social workers from North Carolina in the U.S. A measure of role identity the authors had developed previously was used in the study. This measure incorporated the key elements of role identity theory, namely one’s view of oneself as a carer/helper and perceptions of other’s views of oneself. The study included a logistic regression which identified that higher depressive symptoms and having a clinical license had a small positive effect on help-seeking behaviour, but role identity was a much stronger negative predictor. Scoring high on the measure of burnout was not associated with help-seeking. A survey of general practitioners and psychiatrists in the UK found that stigma was a major factor in decisions to seek help for depression (Adams, Lee, Pritchard, & White, 2010). In addition, physician respondents cited concerns over confidentiality, letting patients and coworkers down, lack of coverage and fearing an implication on their career trajectory.

In a review of the management of depression in the general workplace (Putnam & McKibbin, 2004), both organizational and individual factors were cited as barriers. Among the individual factors, stigma, concerns over confidentiality and privacy, job stability, and ability to recognize symptoms were highlighted. Barriers to the organization’s adoption of strategies included concerns about cost-effectiveness, lack of awareness of depression at the employer level and lack of initiative/ownership of the responsibility to offer interventions.

**2.4.1 Overview of Existing Theories of Health Service Utilization**

Many theories and models to explain and predict healthcare service utilization have been developed and studied. Three of the more prominent ones are discussed below. These models were chosen because they all come from slightly different disciplines, and while they all overlap in some ways, each also has unique elements. Although these models have been widely considered in the study of health behaviour, they have less often been applied to the study of mental health service use in general, and no applications to the study of service use for psychological problems in the workplace were identified in the literature. These considerations
may be relevant because decision making for mental as opposed to physical needs may differ, as could decisions for personal versus work-related problems. Furthermore, along with other developed theories and models, they have been criticized with respect to their applicability in some populations (eg. elderly immigrants (S. Choi, 2011)).

The Behavioural Model of Health Services Use

The Behavioural Model of Health Services Use (Andersen, 1995) was originally developed in the 1960’s to describe health service utilization. This model applies a socio-behavioural/socio-emotional approach and is rooted in medical sociology and public health. The core components of this model are predisposing characteristics, enabling factors and need. The model has been updated to incorporate the external environment, specific health behaviours and outcomes given the realization that these variables had considerable influence on future healthcare service use (Andersen, 1995). Predisposing characteristics refer to qualities such as demographic characteristics and health beliefs. Personal and family characteristics, availability of services and community context are considered enabling factors. Finally, need consists of both perceived and evaluated need. Perceived need being the subjective valuation of need by the individual considering whether or not to access care and evaluated need being that identified by a health professional, for example. At a threshold of need, both perceived and actual, these factors predict, to varying degrees, the likelihood of an individual using health services. Demographic and social factors are felt to be minimally mutable while health beliefs and enabling factors are moderately and highly mutable respectively (Andersen, 1995). In a recent study of a Canadian sample of individuals meeting criteria for having a mental disorder, the Behavioural Model was applied to assess factors associated with mental health service use (Fleury, et al., 2012). The authors found that service use was associated with older age, female gender, lower perception of mental and physical health, lower life satisfaction, and recent emotional problems.

The Health Belief Model

The Health Belief Model was also developed through the 1950’s and 1960’s to address a growing awareness of the problem of people not participating in preventative healthcare (Rosenstock, 1974). The model comes out of social psychology and takes a socio-cognitive
approach to explaining health services use. This model incorporates individual perceptions consisting of perceived susceptibility of illness and perceived seriousness of said illness, modifying factors including demographics, socio-psychological and structural variables, cues to action and perceived threat, and finally likelihood of taking action as determined by a cost versus benefit appraisal (Rosenstock, 1974). Individual perceptions are highly cognitive and subjective and depend on perceptions about how significant a disease can be both medically and personally, in terms of having a negative impact on relationships and function. To some extent these variables depend on previous experiences with disease and health knowledge. Socio-psychological variables in this model refer to personality, social class and culture while structural variables are related to knowledge about the disease and prior experience with the same disease process. Cues to action can come from the media, healthcare providers and friends or family and serve to motivate an individual to take action. A later revision to the model incorporated self-efficacy which refers to the individual’s belief in his or her ability to take the necessary action (Rosenstock, Strecher, & Becker, 1988). The Health Belief Model has been used to conceptualize use of mental health services in the general population with some limitations discussed (Henshaw & Freedman-Doan, 2009).

*The Self-Regulation Model of Illness Behaviour*

This model arose from the discipline of psychology in the 1980’s and takes a cognitive-perceptual approach in parallel with learning theory to explain help-seeking (Leventhal, et al., 1998). The model incorporates illness representations (e.g. cause, consequence, control) and associated threat, coping procedures for risk management, outcome expectations and risks and benefits of procedures. With a qualitative study of a clinical sample meeting criteria for a depressive illness, Elwy et al. (2011) applied the Self-Regulation Model of Illness Behaviour to explain help-seeking in a qualitative study of depressed patients. The authors reported that help seeking among their sample was highly dependent on an individual’s illness perceptions and belief in treatment effects. Among those who did not seek help, the prominent themes emphasized were that the treatment would not be effective, that the depression would not last long and did not have an impact on their daily lives.
A recent review of the literature supported the applicability of the illness dimensions in the Self-Regulation Model as operationalized by the Illness Perception Questionnaire (IPQ) to mental health problems (Baines & Wittkowski, 2013). The authors alluded to, however did not comment in depth on how illness representations for mental health problems compare to illness representations for other physical health problems. They concluded that additional research is required to determine if there are additional themes of illness perceptions unique to mental health problems.

### 2.4.2 Unique Issues in ID Staff

Although many theories and models have been developed to explain and predict help-seeking behaviour and utilization of health related services, they have often been critiqued for their limitations in the application to specific population groups (S. Choi, 2011). In addition, these theories have not been applied to the study of use of workplace services and so it is unclear how many of these variables are operationalized in these settings. In contrast to health services which are focussed on the restoration of health, workplace services are likely to have a competing goal of maintaining or rapidly recovering an employee’s working status. As a result, help-seeking behaviours may differ with respect to where and by whom services are provided.

Many of the factors identified in these models and the previously described studies of help-seeking among health professionals, employees and clinical samples are likely to be applicable to the use of workplace services by staff in the ID sector. These factors were not specifically examined in the survey of Ontario staff (Hensel, et al., 2012) and there are also other issues that may be unique in this population. For example, the role of aggressive recipient behaviour as a precipitating factor has not been the focus of any help-seeking studies thus far and is an issue unique to a select number of professions. This is important, because the supports and interventions may be somewhat different (i.e. staff-centred versus recipient-centred), staff may be at risk of physical injury and there are psychological factors that impact how staff manage themselves in the workplace (i.e. fear of assault) (Mills & Rose, 2011). Staff causal attributions (i.e. why they believe the recipient is engaging in aggressive behaviours) and negative emotions (eg. fear, anger) have been identified as potential mediators of the stress response (Hastings,
2002; Mitchell & Hastings, 2001) and may be relevant factors in staff’s perceptions of what help is needed in these circumstances.

Studies which have examined attitudes and perceptions of challenging and aggressive behaviour in health professionals have frequently described a culture of tolerance which likely also impacts the willingness and motivation to seek help for related consequences. For example, a study of UK mental health nurses measured tolerance to aggressive behaviour using the Tolerance Scale, a subscale of the Perception of Aggression Scale which assesses aggression as a normal reaction (Whittington, 2002). The questionnaire contains items asserting that aggression is positive – for example, to ‘offer new possibilities in care’ or ‘to see the patient from another point of view,’ as well as natural – for example, ‘an expression of emotion just like laughing or crying’ or ‘a form of communication.’ Despite a “zero tolerance for violence” policy in their institution, there was a large degree of variation in the tolerance present among sampled nurses. One fifth of the sample endorsed some positive aspect to the aggressive behaviour. Higher tolerance was found to be positively associated with more experience in the field and negatively with burnout, suggesting that in some way a tolerant attitude may be protective. Similarly, a qualitative study of ID staff from a specialized UK residential school for children with severe intellectual disability and extreme challenging behaviour, used semi-structured interviews to assess the emotional reactions of staff to behaviour (Howard & Hegarty, 2003). The authors found what they felt was a surprisingly minimal response to severe incidents, and that staff generally had a high acceptance of violence as “part of the job” or “a choice.”

Therefore, staff help-seeking behaviour may depend on the level and severity of exposure, their beliefs and explanations for the behaviour and in turn their tolerance of it, as well as their individual reaction to it and their understanding and expectations of both the resultant impact and the treatment/support available. These factors may be important considerations in the development and implementation of interventions targeted at addressing staff emotional well-being in the context of working with aggression.
2.5 A Review of Interventions for ID Staff Working with Aggressive Behaviour

There is a growing literature on interventions for staff who work in the developmental services sector. Interventions have predominantly been targeted at training staff in behavioural interventions. The literature has also described some interventions focussed on addressing staff behavioural attributions, cognitions, emotions and self-efficacy (Allen, 1999; Grey, Hastings, & McClean, 2007; Singh, et al., 2009; Tierney, Quinlan, & Hastings, 2007; Williams, Dagnan, Rodgers, & McDowell, 2012). A systems approach which involves considering the local environment and unique contextual factors applicable to what is being implemented has been advocated within this field with respect to staff training (Allen, 1999). It has been demonstrated and emphasized that knowledge alone is inadequate and simply training staff in behavioural interventions is ineffective without a wider systems level of change including supportive management and front-line practice leaders (Allen, 1999; Grey, et al., 2007).

There have been few studies that focus on helping staff cope with burnout and other negative psychological outcomes, both preventively and after the onset of difficulties. An early study employing a comprehensive training program directed at addressing recipient behaviours (Allen, McDonald, Dunn, & Doyle, 1997) included a component of post-incident support focussed on “sensitizing” the caregiver to the emotional consequences. Little description of this component is provided in the article and no specific findings are reported; however the study did find an overall reduction in staff injury rates. The studies that have been published more recently have used various therapeutic strategies including cognitive behavioural (Gardner, Rose, Mason, Tyler, & Cushway, 2005), mindfulness (Singh, et al., 2009) and acceptance-based (Noone & Hastings, 2009) therapeutic models.

Innstrand et al. (2004) employed an interesting study design whereby the experimental group self-determined the interventions at both the individual and organizational levels. In this study, 43 staff responded to a questionnaire which included items intended to identify sources of occupational stress. All respondents then attended a meeting where priorities were set and interventions were assigned. Individual level interventions included an exercise program, a series of workshops organized by the staff and designed to offer education and social support
and incentive to attend the workshops (lottery ticket). At the organizational level, performance appraisals were carried out, work schedules were reorganized and routines for new employees were improved. After a ten month period the experimental group had significantly lower EE (measured with the General Burnout Questionnaire, which is equivalent to the general survey version of the MBI) compared to the control group who did not participate in the intervention. However, on inspection of data plots presented by the authors the difference appears to emerge as a result of a substantial increase in EE among the control group in contrast to little or no change in the experimental group. This may suggest that the intervention acted as a buffer against increasing levels of EE. Although the experimental group had higher job satisfaction at baseline, they experienced a further increase in this variable over the study period compared to a decline among the control group. However, study conclusions were limited by the fact that the two groups came from different municipalities although noted that they were quite similar in their service systems, had some marked pre-test differences in measure scores and there was a high level of attrition (approximately only 50% of participants in the pre-intervention group completed the post-intervention assessment).

Gardner et al. (2005) assigned administrative and clinical ID staff to cognitive therapy which focuses on modifying cognitive appraisals, behavioural coping skills therapy or control and measured general health status with the General Health Questionnaire (GHQ) and stress level with the Mental Health Professionals Stress Scale. Although no significant differences were observed across the groups as a whole, follow-up analysis supported a significant benefit of both interventions in those participants with high initial levels of ill health. The cognitive therapy intervention was noted to achieve the most substantial and lasting effect. Singh et al. (2009) studied a 12 session mindfulness intervention in 23 group home staff delivered over 12 weeks. The intervention involved education and guidance around using mindfulness techniques as well as encouragement of mindful practice and meditation. Over a 40 week observation period, the use of physical and chemical restraints declined, as did the number of injuries. Finally, Noone and Hastings (2009) studied an intervention based on acceptance theory among 28 community support staff. Their intervention, which they called Promotion of Acceptance in Carers and Teachers (PACT), involved a one day workshop and a follow-up half day session. For the 14 staff for whom follow-up data was collected, there was a significant reduction in scores on the
GHQ with a moderate effect size (Cohen’s $d=0.5$). The authors concluded that there was support for the positive impact of PACT on staff well-being.

### 2.6 Summary

Staff who support people with ID in the community are inevitably exposed to some challenges including aggression perpetrated by their service recipients, although the frequency and severity depends on many factors. Although staff receive training in behavioural interventions directed at managing aggression, they are also at risk of experiencing negative psychological consequences which can further affect their function at work and the nature of their relationships with recipients. Considering staff experience many positive benefits from the work they do and the important role they play in their recipients’ lives, ensuring their own well-being at work is an important consideration and is likely to contribute to retention and the quality of care provided. The literature suggests that staff are at risk of job burnout and that exposure to aggressive behaviour may be a contributory factor. With recent legislative changes in Ontario requiring that organizations have policy and resources relating to workplace violence, this has become a priority for this sector. However, little is known about staff utilization of services and what they perceive to need.

The literature describes several barriers to help-seeking for health services in general and more specific to emotional needs in the general population and human service workers. In addition, general theories and models of health service utilization highlight categorical factors affecting use of services. Many of these barriers are likely to be present in ID staff, however there may be unique ways in which they are operationalized. In addition, there may be other unique barriers related to utilization of workplace services for emotional health as opposed to general health services, and specifically to this field of work and supporting aggressive behaviour. Although several interventions aimed at addressing negative staff outcomes have been studied, these studies have been conducted primarily outside of North America and have not explicitly considered the local context into which they were being introduced. A better understanding of the barriers and enablers of help-seeking as well as staff perceived needs and desired resources, would inform further interventions in this sector. There has a been growing awareness that a systems approach to implementing change whereby an understanding of barriers is sought a
priori and the intervention is adapted and facilitated, is more highly successful both in terms of establishing the change and sustaining it (Allen, 1999; Baker, et al., 2010; Rycroft-Malone, et al., 2002). Based on this approach, my study aimed to identify potential targets for intervention as well as gathering the context with respect to the existing culture and associated barriers and facilitators that would assist or impede the implementation of interventions.
Chapter 3: Study Methods

3.1 Study Design

This study utilized a sequential cross-sectional design with mixed methods to address its aims. The use of mixed methods allows multiple data collection strategies that can inform each other and be interpreted together to gain a better understanding of the phenomenon under investigation (Johnson, Onwuegbuzie, & Turner, 2007). In this study the design was sequential and explanatory primarily, with a smaller complimentary component in that the different methods also explore additional aspects of the same phenomenon (see Figure 1). The first part of the study was predominantly quantitative and involved the analysis of data collected as part of a previously administered survey. The findings of the survey informed the research question for qualitative inquiry as well as some areas for exploration in the interview study. The second part of the study included some quantitative data collected in a telephone interview with potential participants, but was largely qualitative through the collection of interview data which was thematically analyzed. Data from the quantitative and qualitative methods were analyzed independently and considered together during interpretation. Research ethics approval for all components of this study was granted from the Centre for Addiction and Mental Health and the University of Toronto, both located in Toronto, Ontario, Canada.

![Figure 1. Schematic of Data Collection and Analysis.](image)

Quantitative and qualitative data collection methods were sequential, explanatory and complimentary with combined interpretation taking place at the end.
3.2 Survey Design and Target Population

The survey was developed by the study authors with input from relevant stakeholders, unions and support staff. It was administered to community direct support staff who support adults with ID in Ontario, Canada over four months in 2010. Agencies providing ID services in Ontario were informed of the survey by a variety of means: emails sent by the study investigators and/or personal visits, presentation at the Ontario Association of Developmental Disabilities annual conference, notification from unions and word of mouth. When an agency expressed interest in participating, they were given additional information including a link to the on-line survey or access to a hardcopy either as a printable document or delivered in paper form. Agencies were asked to disseminate the survey to their staff by whatever means they could. Staff participation was entirely voluntary and anonymous. Hardcopies were returned in aggregate by the agencies or mailed to the study investigators directly by respondents.

The survey questionnaire contained demographic items (including geographical region categorized according to the Ministry of Community and Social Services regions (see Figure 2)), occupational items, measures of exposure to recipient aggression, the 22-item MBI, positive contributions and difficult behaviour self-efficacy (measures described in detail below). Data for the subgroup of survey respondents who identified as working in the South West region of Ontario were selected out of the overall sample and used as the sample for the purposes of this study. This region was chosen because of an existing relationship with agency executives who had expressed interest in a follow-up project as well as the largest proportion of survey respondents coming from this region (n=258, 28% of total sample) representing the highest region-specific response rate. Survey respondents included staff from a variety of service types, including residential and respite programs, day programs and supported employment. Given that the service characteristics (and recipient profiles) across these settings may be quite variable, this population was narrowed to those staff who identified as working at least some of the time in residential group homes. This represented the majority of the South West sample (n=224, 87%). A main advantage of selecting this more homogeneous group is that the culture with respect to organizational policies, work setting and job responsibilities were similar. However, it means that findings may have limited generalizability to other settings within the ID sector, such as day program and recreational services or agencies outside of the South West.
which may differ in internal and environmental factors. For example, the South West is likely to have more services in more rural settings compared to more highly populated areas of the province.

### 3.3 Description of Survey Variables and Measures

#### 3.3.1 Demographics

Demographic variables captured in the survey included age (continuous), gender (male, female, other), Canadian born (yes, no), marital status (single/never married, married/common-law, divorced/separated/widowed), years of experience (<2, 2-5, 5-10, 10-20, >20), specialized degree for working in developmental disabilities (yes=degree in nursing, direct service work or child and youth work), region of work (according to the Ontario Ministry of Community and Social Services regions (see Figure 2)).

![Ontario's Ministry of Community and Social Services (MCSS) Geographical Service Regions](http://www.accesson.ca/NR/rdonlyres/D^%FF%CE-38E9-46C8-8BFF-717019BE959F/366/ontario_en.pdf)
3.3.2 Occupational Variables

Occupational variables included work setting (respondents could indicate multiple settings including residential settings, day programs, semi-independent living, supported employment and other), recipients serviced (again respondents could indicate as many categories that applied including dual diagnosis, autism spectrum disorder, medically complex, etc.), hours worked/week (fewer than 10 hrs/wk, 10-20 hrs/wk, 20-30 hrs/wk, 30-40 hrs/wk, more than 40hrs/wk), sick leave benefits (yes, no or unsure), and net income (less than $20,000/year, $20,000-$40,000/year, $40,000-$60,000/year, $60,000-$80,000/year, over $80,000/year).

3.3.3 Exposure to Aggression

Aggression was defined as “any verbal, non-verbal or physical behaviour displayed by the client that was threatening or caused harm to self, others or property,” a definition adapted from the Staff Observation Assessment Scale-revised (SOAS-R) which has been used to assess aggressive behaviour in inpatient populations (Nijman, et al., 1999). Measures of exposure to client aggression included: 6 month frequency (never, <1/month, 1-3/month, 1-2/week, almost every day), subjective 6 month severity (0-100), objective severity of exposure by type of aggression. This latter measure has been used previously (Hastings & Brown, 2002b) and includes items related to experiencing aggression against the staff worker himself, observing aggression towards others (other staff, co-clients, etc), aggression towards property and auto-aggression towards the client himself. Each item is rated on a scale from 0-3 (aggression to self or others, 0=no aggression, 1=verbal, 2=physical not resulting in injury, 3=physical resulting in injury) or 0-2 (aggression to property and auto-aggression, 0=no aggression, 1=aggression without injury, 2=aggression with injury). A standardized exposure score can be created from this measure by summing the z-transforms of each item. Finally, an overall objective severity measure was created by computing the product of frequency of exposure and the standardized exposure score (translated by the minimum score to create a corresponding positive integer score).
3.3.4 Maslach Burnout Inventory - Human Services Survey (MBI-HSS)

This is a 22-item survey composed of three subscales corresponding to the emotional exhaustion (EE), depersonalization (DP) and personal accomplishment (PA) dimensions of burnout. Each item is rated on a scale from 1 (never) to 7 (every day) and scores are summed to produce totals in each of the three subscales. There are also established cut-offs for high, moderate and low scores in each subscale across a variety of staff groups including social workers, mental health workers and others (Maslach, Jackson, & Leiter, 1996). This measure has been used in a variety of populations with good validity and reliability. Although it has also shown good psychometric properties in samples of ID staff (Hastings, Horne, & Mitchell, 2004), more recent data suggest that some components of the scale may not accurately capture the nature of the relationship that ID staff have with their recipients (Chao, McCallion, & Nickle, 2011; Lunsky, et al., under revision). This has been particularly evident in low reliability on the DP subscale which may reflect some language and terms used which are not as applicable to this sector (for example, the items “I don’t really care what happens to some recipients,” “I treat some recipients as impersonal objects” and “I feel that recipients blame me for their problems” may be particularly problematic). However, given that this scale is the most widely used instrument to assess burnout in this and other populations, it was used in its original form here to allow comparisons to previously published data. Continuous scores on all subscales were used in analyses. In addition, EE was categorized according to the established cut-offs (13 and under=low, 14 through 20=moderate and 21 and over=high) (Maslach, et al., 1996).

3.3.5 Staff Positive Contributions Questionnaire (SPCQ)

This scale was developed initially with 41 items and has been used to examine the positive contributions held by family members and professionals caring for individuals with ID (Hastings, Beck, & Hill, 2005; Horne & Hastings, 2004). Items are rated using a 4-point Likert scale ranging from ‘strongly disagree’ to ‘strongly agree.’ Items are answered from the respondent’s point of view and include statements such as: “I consider working with people with developmental disabilities to be responsible for my increased sensitivity to people” and “the presence of people with developmental disabilities is an inspiration to improve my job skills.” A shortened version of the scale was used in the survey, with 11 items chosen from the original
scale on the basis of the highest inter-item correlations found in a previously examined sample of staff (Horne & Hastings, 2004). This brief scale has since undergone factor analysis and two subscales have emerged which the authors feel represent theoretically distinct constructs (Lunsky, et al., under revision). These two subscales, Positive Work Motivation Scale (PWMS—3 items) and General Positive Contributions Scale (GPCS – 5 items), were used in all data analyses.

3.3.6 Difficult Behaviour Self-Efficacy Scale

This is a 5-item scale with each item scored from 1 (the corresponding extremely negative evaluation, i.e. not at all confident) to 7 (the corresponding extremely positive evaluation, i.e. very confident). The item scores are summed to produce a total score. This scale has been used to study self-efficacy in number of samples (Hastings & Brown, 2002a, 2002b) and therefore allows flexibility in modification of the wording to suit the population under study. For example, for this study the statement: “How satisfied are you in the way in which you deal with the aggressive behaviours of the individuals with intellectual disabilities that you care for?” was modified by substituting the underlined sections to reflect the population of interest and the aggressive nature of the behaviours being examined.

3.4 Survey Data Analysis

All data analyses were performed with SPSS statistical software (various compatible versions). Alpha<0.05 was considered to indicate significant findings in all statistical analyses.

3.4.1 Incorrect and Missing Data

Data were analyzed for incorrectly entered values (eg. outside of eligible range). Only two such values were found. One (gender) was outside the allowable range and could not be confirmed so was deleted. The other (perceived severity of aggression) was outside of the allowable range and was corrected. Cases with missing data were removed in a pairwise fashion from all bivariate analyses. Cases with missing data were removed listwise in regression analyses. For each of the regression analyses, a comparison of demographic variables between included and excluded cases was conducted. No significant differences were found.
### 3.4.2 Descriptive Statistics

Descriptive statistics were used to examine frequencies and associations between variables. Confirmatory factor analyses were conducted for the three subscales of the MBI-HSS. In addition, scale reliability was tested with Cronbach’s Alphas for each of the measures and/or subscales used. Independent t-tests were used to compare the present study results to other previously published results across the MBI-HSS measure. Outcome measures were checked for normality using Kolmogorov-Smirnov tests and visual data inspection. Spearman correlations, independent t-tests and Chi-squared were used to examine associations between measures when linear and categorical respectively.

### 3.4.3 Regression Analyses

Two hierarchical binary logistic regression analyses were performed with two outcome variables: 1) subjective report of emotional difficulties related to working with aggressive behaviours and 2) use of resources. Variables were added into the model based on significant relationships with the outcome as well as theoretical implications based on review of the literature. When the aim is to both achieve an overall good model fit as well as to examine the role of individual predictors the sample size should be the larger of 50 +8k or 104 + k, where k is the number of predictors in the model (Field, 2009). This rule was applied to both regression analyses. In the first model with the outcome emotional problems, demographic and occupational variables were entered first, and then the scale scores for positive contributions, EE and self-efficacy, followed by the aggression variables to examine the unique contribution of aggression after controlling for the other variables. Demographic and occupational variables including age, gender, marital status, hours worked and experience have been implicated in burnout research (Maslach, et al., 2001). Positive contributions have been hypothesized to have an impact on negative emotional outcomes in staff (Hastings, 2010) and some recent data supports this (Lunsky, et al., under revision). EE is related to more generalized workplace emotional difficulties and was felt to be important to control in examining emotional difficulties specific to dealing with aggression. Self-efficacy has been linked to aggression and burnout in ID staff (Howard, et al., 2009) and may be expected to be negatively associated with emotional difficulties related to aggression. The severity of aggression experienced has also been linked to
negative staff well-being (Hensel, Lunsky, & Dewa, 2013; Howard, et al., 2009). In a fourth step, an interaction term was entered to account for the highly correlated relationship between perceived and standard severity of aggression. The perception of the aggressive behaviour, rather than the actual severity, may be more important in predicting the emotional response (Hensel, et al., 2013). The contribution of each step of the model was assessed by the change in log-likelihood values and pseudo-$R^2$ values of Cox and Snell and Nagelkerke.

Similarly, in the second model with the outcome use of resources, demographic variables were entered first (sick leave benefits were entered instead of hours worked because they were highly related and sick leave benefits explained more of the outcome), followed by self-efficacy and EE. EE was categorized into low, moderate and high based on established cut-offs (Maslach, et al., 1996) and entered in the model with the reference category set as low EE. It was anticipated that self-efficacy may play a role through its relationship to role identity and perceived competence that could be associated with higher use of denial regarding need for help. The rationale for including EE with cut-off values was the hypothesis that the level of burnout experienced may affect likelihood to seek resources and that this may not be a linear relationship. In a study of help-seeking among social workers, scoring highest in burnout was not associated with resource use (Siebert & Siebert, 2007). A third step in the model added in the perceived severity of the aggression experienced and time off for physical injury. Because resource use was specific to problems arising due to aggression, the severity of aggression experienced was a possible confounder. Time off for physical injury was included because of the possibility that taking time off for physical injury may reduce the likelihood of needing resources for emotional problems because the time off may have served a dual purpose.

### 3.5 Qualitative Study

#### 3.5.1 Sampling and Recruitment

Purposive sampling strategies were used to yield a representative selection of staff who work in residential settings and deal with aggressive behaviour (Teddlie & Yu, 2007). The aim initially was to collect typical, representative cases with refined case sampling and maximal variation strategies employed as interviews progressed to achieve data saturation. Saturation occurs at the
point when no new data are collected with subsequent interviews (Teddlie & Yu, 2007). The
target sample was community staff with experience working in residential group home settings
for adults with ID in South Western Ontario to match the sample represented in the survey.
Additional requirements for participation were: over 18 years of age, exposed to or at risk of
exposure to aggressive behaviour in the workplace and ability to speak English and participate
in an interview lasting up to one hour. In addition, an attempt was made to capture staff across a
range of levels of experience and exposure histories to provide maximal variation. Initially, the
recruitment notice specified “full-time” staff only, however this term was later removed as it
was discovered that many staff work full-time hours (defined here as >20 hours/week), but do
not have the designation of full-time status. They may be permanent part-time for example, and
may not have volunteered if they thought that excluded them.

Recruitment strategies were discussed with the executive directors of developmental services
agencies in South Western Ontario and it was decided that agency executive directors would
opt-in to the study at their discretion and assist the researcher to inform staff. An email was
circulated to the executive directors of all agencies inviting them to participate in the study.
When an agency opted-in, they were sent additional study material and a recruitment notice to
circulate to their direct support staff. The notice invited interested staff to contact the researcher
by telephone or email. When staff indicated their interest, they were contacted by a follow-up
phone call by the researcher or assistant and their suitability for participation was assessed in a
brief telephone pre-interview (see Appendix B). In addition, any questions they had about the
study were answered and they were provided with the study information sheet. The pre-
interview collected demographic information (age, gender), occupational information
(experience, hours worked, setting, shifts) and experience with aggression and its consequences.
Based on completion of the pre-interview staff who met eligibility requirements were invited for
a one-on-one interview which was scheduled at a convenient location and time. The target
number of participants was 20-30 (Creswell, 2007), however data saturation was used to
determine the final sample size. Participating staff were given a small honorarium in the form
of a $15 gift certificate for a coffee shop. Agencies and regional managers were not made aware
of which staff responded to recruitment requests or participated in the study.
3.5.2 Data Collection

Data were collected through in depth semi-structured one-on-one interviews with the researcher. Interviews were held at a variety of convenient, mutually agreed upon locations including the agency office, staff home, coffee shop, or affiliated research office located in the community. A letter of information was provided and written informed consent was obtained from all participants prior to the start of the interview (see Appendix C). An interview guide with probing questions was developed by the researcher guided by the existing literature with additional input from experts in the field of ID and workplace health as well as agency directors. The interview guide was piloted with two staff working in two different settings in Toronto, one of whom had English as a second language to ensure accessibility of the interviewer and the questions asked. Minor modifications were made following the pilot interviews. In addition, the probes changed over the course of the interviews to allow for emerging themes and ideas to be further explored in subsequent interviews. Topics covered in the interview were: demographic and background information, occupational experience in the field, description of exposure to client aggression, personal consequences and in particular emotional consequences, help-seeking experience, barriers and facilitators to help-seeking, perceived and actual consequences of help-seeking or not and desired resources (see Appendix D). All interviews were audio-recorded and transcribed verbatim either by the researcher (JH) or a research assistant (TS). During the data collection phase, memos and researcher notes were collected to record reflections as well as forming hypotheses and questions. At the completion of the interview a list of available resources in the local community for dealing with psychological problems was provided to all participants. These resource lists were compiled from existing information available through the satellite offices of the Centre for Addiction and Mental Health.

3.5.3 Data Analysis

Interview data were analyzed thematically from inductive to deductive using the techniques of grounded theory (Creswell, 2007). Data analysis was conducted manually with hard copies of transcripts and the use of Microsoft Word for data organization. All transcripts were read in their entirety in depth and then segmented according to broad categories that emerged and
related to the areas of research interest. These categories were: 1) strategies for approaching/managing aggressive behaviours, 2) consequences of working with aggression, 3) how consequences are managed, 4) barriers to help-seeking for consequences, and 5) facilitators of help-seeking. Transcript excerpts could be present in more than one category. All segments were then inductively open coded for emergent themes followed by axial coding and thematic categorization. During open and axial coding, two additional coders (YL and CD) read and coded a sample of 4 transcripts. Coding was subsequently compared and discussed with elaboration on possible interpretations and relationships between emerging themes. This method was used to triangulate perspectives and enhance validity of results. Final thematic categories were also reviewed with the independent coders to confirm agreement.

3.5.4 Researcher’s Personal Statement

When conducting qualitative research, the need for the researcher to be reflexive and actively bracket her experience and assumptions is paramount (Creswell, 2007). In taking on the role of the interviewer in this study, I struggled with my other role as a mental health clinician and was unsure a) if that needed to be disclosed to participants and what the impact of that would be, and b) how I would be able to perform conducting a non-clinical research interview. After much consideration, I decided not to disclose my credentials and professional experience to participants and told them only that I was a researcher, although it was clear that I was affiliated with a psychiatric hospital and some participants did ask my opinion about particular experiences or symptoms they had. During interviews I was actively aware of when my mind and attention drifted from the research focus to thinking clinically about diagnoses or psychosocial formulations of participant’s problems because I have undergone such extensive training in this skill. In other ways, I think having that training was immensely helpful in that I felt easily able to develop rapport with participants using skills I have acquired through clinical training and I was able to recognize cognitive distortions and inconsistencies which then prompted me to follow up with additional questions. While I’m sure experienced qualitative interviewers have this skill, I don’t think I would have been as proficient at this level if I were not clinically trained.
An interesting struggle that occurred in me was not being able to focus on the research topic at times. My understanding of this is multi-factorial, starting with our experience in designing the survey. We found that although agencies were open and willing to participate in examining the issue of aggressive behaviour, they were very particular about the language used and the tone of the message. I also noticed this happening in the interview component of the study and it seemed to ripple across various levels of the study. For example, there was also some concern expressed by agency directors about the use of the word “aggression” in the interview questions with a preference for “challenging behaviour.” Moreover, I found that staff sometimes appeared uncomfortable directly talking about their experiences with aggression or tried to qualify things by prefacing statements with a minimizing or reassuring comment. This started to affect me, in that at times I even found myself deflecting the attention off of aggression to more general work issues to avoid the discomfort I perceived and then having to consciously return to the topic of interest. Or I would qualify my questions as well by stating first how important the work was or how unique their experiences were. Not that I think it majorly affected the data in the end, in fact it was an additional source of data that further highlighted to me the conflict with this issue within the field and some of the barriers that staff experience.

3.6 Approach to Combined Data Interpretation

A final step in the data analysis involved examining both the quantitative and qualitative findings to look for overlap, similarities and differences. Combined data interpretation is a minimum requirement to claim mixed methods as suggested by many authors (Johnson, et al., 2007). This analytic component also involved reviewing existing theory to determine how well the findings fit with established theories of help-seeking and resource utilization. Three main theories were used for this purpose: the Behavioural Model of Health Services Use (Andersen, 1995), the Health Belief Model (Rosenstock, 1974) and the Self-Regulation Model of Illness Behaviour (Leventhal, et al., 1998). The advantage of conducting this analysis with the application of theory after data analysis means that the findings were inductively generated from the data obtained without the bias of trying to fit an existing model. The contribution that this study adds is identifying those factors that are unique and operationalizing existing constructs within this population.
Chapter 4: Results

4.1 Survey Results

4.1.1 Survey Participants

A total of 224 direct support staff who work in the South West MCSS region and spend at least some portion of their working hours in a residential group home setting responded to the provincial survey. Based on an estimate provided from an agency within the region, the total number of staff in the target population is approximately 650\(^2\). If all agencies in this region participated, that would suggest a response rate of just over 30%. However, for ethical reasons and to protect confidentiality, agency membership was not captured in the survey so it is not known if all agencies participated. As a result, 30% would represent the minimum possible response rate achieved based on the estimate of total eligible employees.

Respondent details are summarized in Table 1. Most respondents were female (86%) with a mean age of 37 years. With the exception of fewer staff having less than two years of experience, respondents were evenly represented across years of experience in the field. Most respondents were married or living common-law (66%) and the majority were born in Canada (93%) and had English as a first language (97%). Sixty-three percent indicated they had specialized education in the form of a nursing, child youth work or developmental services degree. A quarter of staff indicated they worked in at least one other work setting outside of the residential setting. The majority of staff had sick leave benefits, with 27% indicating they did not and 7% indicating they were not sure. A large proportion of staff reported working with dual diagnosis populations (co-occurring intellectual disability and psychiatric diagnosis), autism spectrum disorders and complex medical needs. Additionally some staff supported people with criminal justice involvement or acquired traumatic brain injuries (see Figure 3).

\(^2\)This estimate was provided by one of the participating agency’s Executive Director. This value is a best estimate at the time and may over-represent the actual response rate.
<table>
<thead>
<tr>
<th>Variable</th>
<th>N (%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>191 (85.7)</td>
</tr>
<tr>
<td>Male</td>
<td>32 (14.3)</td>
</tr>
<tr>
<td><strong>Mean Age</strong></td>
<td>37.3 ± 11.6</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married/Common-Law</td>
<td>147 (65.9)</td>
</tr>
<tr>
<td>Single, never married</td>
<td>47 (21.1)</td>
</tr>
<tr>
<td>Divorced/Separated/Widowed</td>
<td>29 (13.0)</td>
</tr>
<tr>
<td><strong>Foreign Born (outside of Canada)</strong></td>
<td>15 (6.8)</td>
</tr>
<tr>
<td><strong>English is second language</strong></td>
<td>7 (3.2)</td>
</tr>
<tr>
<td><strong>Years of Experience</strong></td>
<td></td>
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<tr>
<td>Less than 2 years</td>
<td>18 (8.0)</td>
</tr>
<tr>
<td>2-5 years</td>
<td>50 (22.3)</td>
</tr>
<tr>
<td>6-10 years</td>
<td>52 (23.2)</td>
</tr>
<tr>
<td>11-20 years</td>
<td>52 (23.2)</td>
</tr>
<tr>
<td>Over 20 years</td>
<td>52 (23.2)</td>
</tr>
<tr>
<td><strong>Specialized Education (Degree in DSW, CYW or Nursing)</strong></td>
<td>141 (62.9)</td>
</tr>
<tr>
<td><strong>Working in other non-residential setting</strong></td>
<td>57 (25.4)</td>
</tr>
<tr>
<td><strong>Hours Worked</strong></td>
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</tr>
<tr>
<td>Up to 20 hours/week</td>
<td>20 (9.0)</td>
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<tr>
<td>21-30 hours/week</td>
<td>36 (16.1)</td>
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<tr>
<td>31-40 hours/week</td>
<td>97 (43.5)</td>
</tr>
<tr>
<td>Over 40 hours/week</td>
<td>70 (31.4)</td>
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<tr>
<td><strong>Individual Net Annual Income</strong></td>
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<tr>
<td>Less than $20K</td>
<td>19 (8.5)</td>
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<td>$20-39K</td>
<td>127 (57.0)</td>
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<tr>
<td>$40-59K</td>
<td>72 (32.3)</td>
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<td>$60-79K</td>
<td>5 (2.2)</td>
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<td>$80K and over</td>
<td>0 (0.0)</td>
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<td><strong>Method of Payment</strong></td>
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<td>Salary</td>
<td>28 (12.6)</td>
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<tr>
<td>Hourly Wage</td>
<td>194 (87.0)</td>
</tr>
<tr>
<td>Combined</td>
<td>1 (0.4)</td>
</tr>
<tr>
<td><strong>Sick leave benefits</strong></td>
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</tr>
<tr>
<td>Yes</td>
<td>148 (66.4)</td>
</tr>
<tr>
<td>No</td>
<td>61 (27.4)</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>14 (6.3)</td>
</tr>
</tbody>
</table>

**Table 1. Characteristics of Survey Respondents.**

*some missing data removed
Figure 3. Recipient Populations Served by Survey Respondents. Respondents checked all that applied.
spe_dd = dual diagnosis (co-occurring intellectual disability and mental health diagnosis); spe_cri = criminal justice involvement; spe_cmn = complex medical needs; spe_bra = traumatic brain injury; spe_aut = autism spectrum disorders

4.1.2 Exposure to Aggression

Twenty-seven percent of staff were exposed to daily aggression when all types were considered. Only 4% of staff reported that they had never been exposed to aggressive behaviours in the prior six months (see Figure 4). In terms of the most serious form of aggression experienced toward them, verbal aggression was the most common, followed by physical aggression not resulting in injury, then physical aggression resulting in injury in nearly 20% of staff. Regarding aggression towards others, physical aggression not resulting in injury was actually the most serious aggression seen the most, followed by verbal and again physical aggression resulting in injury in over 20% of respondents. Self-injurious aggression resulting in injury was the most serious form of self-directed aggression observed for 40% of staff. Similarly, property aggression resulting in injury or damage was the most serious form of property aggression observed by 40% of staff (see Figure 5 (A-D)). The mean perceived severity score was 54.0±28.4 (out of maximum 100) (median=60, range 0 to 100). Fourteen staff (6.5%) had experienced physical aggression resulting in time off work. Over half of respondents (n=124, 57.1%) positively reported having experienced emotional difficulties they believed to be the result of working with aggressive behaviour in the prior six months.
Figure 4. Frequency of Experienced Aggression of all Types

Figure 5 (A-D). Most Serious Forms of each Subtype of Aggression Experienced.
4.1.3 Survey Measures – Construct Testing and Descriptive Findings

MBI-HSS: Confirmatory Factor Analysis

A confirmatory factor analysis (CFA) was conducted on each of the three established factors of the MBI-HSS using AMOS, an add-on for SPSS, after cases with missing data were removed (AMOS does not allow incomplete data sets for determination of modification indices (n=183 included in analyses)). Covariance of item errors was permitted based on modification indices (parameter change>0.2). For EE, the CFA indicated a very good fit, $\chi^2=23.78$, p=0.251, GFI=0.973, RMSEA=0.032. Factor loads ranged from 0.64 to 0.91. For DP, the CFA indicated an adequate fit, $\chi^2=6.784$, p=0.079, GFI=0.986, RMSEA=0.083. Factor loads ranged from 0.16 to 0.89. Items that loaded with a value less than 0.6 were: “I feel recipients blame me for some of their problems” (0.16), “I don’t really care what happens to some recipients” (0.36) and “I feel I treat some recipients as if they were impersonal objects” (0.42). Despite an acceptable model fit, examination of the standardized residual covariances strongly supported removal of item 22 (“I feel recipients blame me for some of their problems”). For PA, the CFA also indicated a good fit, $\chi^2=15.20$, p=0.295, GFI=0.975, RMSEA=0.031. Factor loads ranged from 0.46 to 0.68. Items that loaded with a value less than 0.6 included: “In my work, I deal with emotional problems very calmly” (0.46), “I deal very effectively with the problems of my recipients” (0.50) and “I feel very energetic” (0.55). Similar to the case with DP, the standardized residual covariances supported removal of the lowest loading item for PA, item 21 (“In my work, I deal with emotional problems very calmly”).

Scale Reliability

Scale reliability was determined for all measures used (see Table 2). The Difficult-Behaviour Self-efficacy Scale, PWMS and GPCS all had satisfactory reliability scores with Cronbach’s Alpha ranging from 0.84 to 0.87. The EE subscale of the MBI-HSS had very good reliability with Cronbach’s Alpha=0.94. The PA subscale of the MBI-HSS also had reasonable reliability, Cronbach’s Alpha=0.76. The DP subscale of the MBI-HSS however, had low reliability with Cronbach’s Alpha=0.67.
Comparisons to other Published Studies

In comparison to the MBI-HSS published norms for social services workers (Maslach, et al., 1996), the staff in this study had significantly lower mean scores for EE and DP and higher PA, indicative of overall lower burnout. Compared to other published studies of ID staff internationally there were no significant differences with the exception of marginally higher scores in PA compared to a sample from Australia (Mutkins, Brown, & Thorsteinsson, 2011) (see Table 3).

<table>
<thead>
<tr>
<th>Scale</th>
<th>Number of Items</th>
<th>Cronbach’s Alpha</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI-HSS EE</td>
<td>9</td>
<td>0.94</td>
<td>19.1 (12.4)</td>
</tr>
<tr>
<td>MBI-HSS DP</td>
<td>5</td>
<td>0.67</td>
<td>5.2 (5.4)</td>
</tr>
<tr>
<td>MBI-HSS PA</td>
<td>8</td>
<td>0.76</td>
<td>36.9 (6.8)</td>
</tr>
<tr>
<td>Difficult Behaviour Self-efficacy scale</td>
<td>5</td>
<td>0.84</td>
<td>25.7 (4.9)</td>
</tr>
<tr>
<td>Positive Work Motivation Scale (PWMS)</td>
<td>3</td>
<td>0.87</td>
<td>9.2 (1.9)</td>
</tr>
<tr>
<td>General Positive Contributions Scale</td>
<td>5</td>
<td>0.85</td>
<td>14.1 (2.9)</td>
</tr>
</tbody>
</table>

Table 2. Scale Reliability Coefficients
Cronbach’s alpha, for each of the six measures used.
MBI-HSS EE: Emotional exhaustion subscale of the Maslach Burnout Inventory-Human Services Survey; MBI-HSS DP: Depersonalization subscale of the MBI-HSS; MBI-HSS PA: Personal accomplishment subscale of the MBI-HSS

4.1.4 Resource Availability and Utilization

Respondents were asked about their access to resources within the workplace that supported emotional challenges related to working with aggressive behaviour. Eighty-one percent of staff indicated they had access to at least one type of resource. The survey contained seven resources for selection as well as an “other” option. The most commonly selected resources were leave of absence (LOA), modified work requirements (MWRQ) and the Employee Assistance Program (EAP). Additional resources included supervision (undefined), access to counselling, referral to a professional and a crisis line (see Figure 6). Other resources that were entered by respondents as free text included transfer, training, peer support and use of management.
Table 3. MBI-HSS Comparisons

Comparisons between the mean scores on the dimensions of the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) in this sample compared to other similar study samples internationally. Scores are means ± standard deviations.

EE: emotional exhaustion; DP: depersonalization; PA: personal accomplishment

<table>
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<tbody>
<tr>
<td>EE</td>
<td>19.1±12.4</td>
<td>18.7±11.5</td>
<td>17.90±12.84</td>
<td>19.19±13.34</td>
<td>20.59±11.99</td>
<td>21.35±10.51</td>
</tr>
<tr>
<td>t-value\a</td>
<td>0.46</td>
<td>0.74</td>
<td>0.080</td>
<td>1.02</td>
<td>2.92**</td>
<td></td>
</tr>
<tr>
<td>DP</td>
<td>5.2±5.4</td>
<td>4.7±4.9</td>
<td>4.58±5.39</td>
<td>Not reported</td>
<td>4.85±5.49</td>
<td>7.46±5.11</td>
</tr>
<tr>
<td>t-value\a</td>
<td>1.34</td>
<td>0.88</td>
<td>0.54</td>
<td>6.14***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>36.9±6.8</td>
<td>36.9±7.5</td>
<td>34.71±9.71</td>
<td>Not reported</td>
<td>35.29±7.79</td>
<td>32.75±7.71</td>
</tr>
<tr>
<td>t-value\a</td>
<td>0.00</td>
<td>2.19*</td>
<td>1.90</td>
<td>7.63***</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Among those staff who positively reported having had emotional problems related to working with aggression, 38% had accessed some resource(s) through their workplace. Most commonly these were “other” resources including transfer, training, peer support and use of management. Leave of absence was also used more often than other resources (see Figure 7). Among those staff that accessed resources the perceived utility of the resources was variable. For example, only 4% found them extremely helpful, while 12% found them not helpful at all (see Figure 8). Of the 29% of staff who found resources helpful or extremely helpful, half of them reported using ‘other’ resources entered as free text such as sick leave, transfer or peer support. More staff also found the EAP more helpful than not. The remaining resources accessed were more likely to be rated as unhelpful. The main reason for not accessing resources was a choice not to seek help. In addition some staff were not aware of resources or they were not available. Another reason for not accessing entered by some respondents was a feeling that they were not needed (see Figure 9).
Figure 6. Workplace Resources Available
For staff experiencing emotional difficulties related to working with aggressive recipients

Figure 7. Resources Used by Staff
Use of resources when experiencing emotional problems related to working with aggression.
4.1.5 Relationships Among Variables

No continuous variables were normally distributed and many variables were ordinal. As a result, Spearman correlations were calculated (Field, 2009) (see Table 4). The highest correlations were present between the positive contributions scales, GPCS and PWMS (ρ=0.63, p<0.001), DP and EE (ρ=0.56, p<0.001), age and experience (ρ=0.53, p<0.001), objective and
perceived severity of aggression ($\rho=0.50$, $p<0.001$), having benefits and hours worked ($\rho=0.49$, $p<0.001$) and report of emotional problems and EE ($\rho=0.45$, $p<0.001$). Significant positive correlations were also present between experience and hours worked, experience and benefits, high perceived severity of aggression and time off for physical injury, age and self-efficacy, male gender and self-efficacy, severity of aggression and EE, positive contributions and PA, severity of aggression and report of emotional problems, resource use and hours worked and resource use and benefits. Significant negative correlations were present between PWMS and experience, PWMS and age, EE/DP and PA, gender and DP and marital status and use of resources. Males had higher DP scores and married individuals were more likely to use resources.

The relationships between continuous variables and the outcomes of interest, report of emotional problems and resource use, were examined with independent t-tests. T-tests require that test sample distributions be normally distributed although with sample sizes above 30, the test is usually robust enough unless there are large sample deviations from normality (Field, 2009). For the outcome of resource use, all variables were normally distributed within the groups as measured by non-significant Kolgomorov-Smirnov tests, degree of skew and kurtosis and visual inspection of the data distributions. However, for the outcome of experience of emotional problems, only the variable self-efficacy was normally distributed across groups. Given that group sizes exceeded the recommended minimum, the t-test was still performed. Confirmatory non-parametric Mann-Whitney U statistics were also generated and did not suggest alternative findings. Chi-square (or Fisher’s Exact for low counts) statistics were generated to examine relationships between categorical variables and the outcomes: reported emotional difficulties and resource use.

Significant associations were found between reported experience of emotional problems and higher experience level ($t(215)=-2.23$, $p<0.05$), more hours worked ($t(215)=-2.16$, $p<0.05$), higher frequency of experienced aggression ($t(215)=-3.96$, $p<0.001$), higher objective severity of aggression ($t(210)=-2.50$, $p<0.05$), higher perceived rating of severity ($t(213)=-4.61$, $p<0.001$), lower scores on the positive work motivation scale ($t(204)=2.57$, $p<0.05$), lower scores on the general positive contributions scale ($t(204)=2.03$, $p<0.05$), higher level of EE ($t(201.98)=-7.69$, $p<0.001$) and higher level of DP ($t(198.01)=-5.82$, $p<0.001$). There was a
significant association with having taken time off work for physical injury, Fisher’s Exact (1), \( p<0.05 \). Those who had taken time off were more likely to report having experienced emotional difficulties. Level of emotional exhaustion categorized as low, moderate or high was significantly associated with report of emotional difficulties, \( \chi^2(2)=41.82, p<0.001 \). All of those with high EE reported emotional difficulties, 73\% of those with moderate EE and only 39\% of those with low EE. Gender, marital status, age, level of education, availability of sick leave benefits, perceived self-efficacy and level of PA were not significantly associated with reported experience of emotional problems.

Among those respondents endorsing emotional difficulties, significant associations were found between resource use and more hours worked \( (t(118)=-2.90, p<0.01) \). Additionally, marital status was significantly associated with resource use, \( \chi^2(1)=4.03, p<0.05 \). Forty-five percent of married or common-law respondents reported using resources compared to 26\% of those who were single/divorced or widowed. Having sick leave benefits through work was significantly associated with resource use, \( \chi^2(1)=6.67, p=0.01 \). Forty-six percent of those with sick leave benefits had used resources compared to 21\% of those who did not have benefits or were unsure. Gender, age, education, experience, objective and perceived severity of aggression, self-efficacy, positive contribution scores and MBI dimensional scores (both continuous and categorized according to MBI cut-offs) were not significantly associated with resource use.

### 4.1.6 Regression Analyses

Hierarchical logistic regression analyses were conducted for the outcomes of reported experience of emotional problems and resource use. In the first model \( (n=187) \), the outcome variable reported emotional problems was coded as 0=no and 1=yes. Based on this sample size the model could accommodate up to 17 predictors according to the rules outlined in Field (2009). In step one, demographic and occupational variables were included in the model. These included gender with male as the reference category, marital status with married/common-law as the reference category, age, hours worked and years of experience (Table 5). Compared to a model without predictors, the model was significant, \( \chi^2(5)=13.54, p=0.019 \). The pseudo \( R^2 \) was weak with Cox and Snell’s \( R^2=0.070 \), Nagelkerke \( R^2=0.094 \). Only years of experience was significantly associated with reported emotional problems, Wald \( \chi^2(1)=6.58, p=0.010 \).
<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
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Table 4: Spearman Correlations Between Variables
For every unit increase in experience, there was a 1.47 times increased likelihood of endorsing emotional problems (95% CI=1.10, 1.98).

In step 2, the variables of PWMS, GPCS, self-efficacy and EE were entered (Table 6). The model was again significantly better than the model with demographic predictors only, $\chi^2(9)=50.46$, $p<0.001$. The strength of the model improved with Cox and Snell’s $R^2=0.24$ and Nagelkerke $R^2=0.32$. Years of experience remained significantly associated with the outcome, Wald $\chi^2(1)=4.15$, $p<0.05$. Controlling for other variables, with every increase in unit of years of experience, there was a 1.42 times increased likelihood of endorsing emotional problems (95% CI=1.01,1.98). In addition EE was significantly associated with emotional problems, Wald $\chi^2(1)=22.59$, $p<0.001$. With every unit increase in EE there was a 1.1 times increased likelihood of endorsing emotional problems (95% CI=1.06,1.15). In step 3, the aggression variables, objective severity and high perceived severity were entered into the model (Table 7). High perceived severity was coded as 0=a rating of less than 75 out of 100 and 1=a rating of 75 or higher. The variable representing time off for physical injury was meant to be entered in the model as well due to the hypothesis that having a serious physical injury would increase the likelihood of emotional problems. However, on examination of the distribution of the variable, only 2 people among those who had required time off for physical injury had not reported experiencing emotional difficulties. In addition, one of these was excluded from the regression because of missing data in another variable resulting in the other case appearing as an outlier. As a result, this variable was excluded from the model. The overall model was significantly better than step 2, $\chi^2(11)=51.63$, $p<0.001$. The strength improved further with Cox and Snell’s $R^2=0.24$ and Nagelkerke $R^2=0.33$. Years of experience and EE remained significantly associated with emotional problems, Wald $\chi^2(1)=4.34$, $p<0.05$, OR=1.44, 95% CI=1.02,2.02 and Wald $\chi^2(1)=17.75$, $p<0.001$, OR=1.09, 95% CI=1.05,1.14 respectively.

In a final model an interaction term created by multiplying the values for objective severity by the binary perceived severity, was added to the model to examine the moderating effect of perceived severity (Table 8). The final model was significant: $\chi^2(12)=60.1$, $p<0.001$. The strength of the model was slightly improved with Cox and Snell’s $R^2=0.28$ and Nagelkerke $R^2=0.37$. Years of experience was significant, Wald $\chi^2(1)=4.73$, $p=0.03$, OR=1.46, 95% CI=1.04,2.05 as well as EE, Wald $\chi^2(1)=18.50$, $p<0.001$, OR=1.10, 95% CI=1.05,1.14. In
addition the interaction term was also significant, Wald $\chi^2(1)=7.76$, $p=0.005$. In the final model there were 3 outliers identified. Examination of Cook’s distance and leverage values did not suggest any points of major influence. A separate linear regression was performed to assess collinearity of predictors with satisfactory values for both Tolerance and VIF.

<table>
<thead>
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<th>Wald</th>
<th>df</th>
<th>p value</th>
<th>OR</th>
<th>95.0% C.I.for EXP(B)</th>
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Table 5. Step 1 in the Logistic Regression (outcome: emotional difficulties)
Model with the outcome of reported experience of emotional difficulties related to working with aggression. The outcome variable is coded as 0=no and 1=yes. Only the demographic and occupational variables shown were entered into the model.
Gender: the comparator category is ‘female’; Marital status: the comparator category is ‘single/divorced/widowed’; CL: common-law

<table>
<thead>
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<th>p value</th>
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<td>.802</td>
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Table 6. Step 2 in the Logistic Regression (outcome: emotional difficulties)
Model with the outcome of reported experience of emotional difficulties related to working with aggression. The outcome variable is coded as 0=no and 1=yes. Positive contributions scales, self-efficacy and emotional exhaustion were entered on this step.
Gender: the comparator category is ‘female’; Marital status: the comparator category is ‘single/divorced/widowed’; CL: common-law; PWMS: positive work motivation scale; GPCS: general positive contributions scale; Efficacy: score on the difficult behaviour self-efficacy scale; EE: emotional exhaustion subscale score on the Maslach Burnout Inventory-Human Services Survey
Table 7. Step 3 in the Logistic Regression (outcome: emotional difficulties)

Model with the outcome of reported experience of emotional difficulties related to working with aggression. The outcome variable is coded as 0=no and 1=yes. Aggression exposure variables, high perceived severity (coded as 0=rating <75, 1=rating ≥ 75) and objective severity (a composite of frequency and injury potential) were entered at this level.

Gender: the comparator category is ‘female’; Marital status: the comparator category is ‘single/divorced/widowed’; CL: common-law; PWMS: positive work motivation scale; GPCS: general positive contributions scale; Efficacy: score on the difficult behaviour self-efficacy scale; EE: emotional exhaustion subscale score on the Maslach Burnout Inventory-Human Services Survey

In the final model, experience presented as being significantly associated with emotional difficulties with a positive association indicating more experience increased the likelihood of endorsing emotional problems related to working with aggression. The nature of this relationship was further explored to determine if it was non-monotonic. To test this, an additional variable, the square of experience, was added to the model. This term was not significant, thereby not supporting the presence of a non-monotonic relationship.

To further interpret the moderating role of perceived severity on the impact of objective composite aggression exposure on the experience of emotional difficulties, a graphical display of the unadjusted two-way interaction was examined using the SPSS syntax developed by Andrew Hayes and available for download on his website (MODMED, version 1.3) (Hayes & Matthes, 2009). When run in SPSS, a table of probability values for given factor and moderator
values are generated which can then be plotted (see Figure 10). Among those respondents who experienced low objective severity (based on frequency and injury/damage caused) and rated it as low, the probability of positively endorsing related emotional problems was close to 0.4. However, even if the objective severity was low but the perception was that it was severe, the probability of endorsing emotional problems was 0.85. In the case of high objective severity regardless of perception, there was little difference in likelihood of experiencing related emotional difficulties. This suggests that the relationship between perception of exposure and actual severity risk is only important in the case of low objectively severe aggression.

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Table 8. Step 4 in the Logistic Regression (outcome: emotional difficulties)

Model with the outcome of reported experience of emotional difficulties related to working with aggression. The outcome variable is coded as 0=no and 1=yes. An interaction term to account for the relationship between perceived and objective severity was entered.

Gender: the comparator category is ‘female’; Marital status: the comparator category is ‘single/divorced/widowed’; CL: common-law; PWMS: positive work motivation scale; GPCS: general positive contributions scale; Efficacy: score on the difficult behaviour self-efficacy scale; EE: emotional exhaustion subscale score on the Maslach Burnout Inventory-Human Services Survey
Figure 10. Plot of Moderating Effects of Perceived Severity on Emotional Outcomes

Moderating effect of perceived severity on the relationship between objective severity (a measure of frequency and injury incurred) and report of emotional problems. For low objective ratings, the probability of endorsing emotional problems is highly influenced by one’s perception whereas at high objective severity, the impact is nearly universal.

In the second model (n=114), the outcome variable of resource use was coded as 0=no and 1=yes. Based on the same rules applied to this sample size (Field, 2009), the model could accommodate between 8 and 10 predictors. In step one, demographic and occupational variables were included in the model. These included gender with male as the reference category, marital status with married/common-law as the reference category, age, sick leave benefits (no benefits or unsure as reference category) and years of experience (Table 9). Compared to a model without predictors, the model was not significant, $\chi^2(5)=10.49$, p=0.063. The pseudo $R^2$ was relatively weak with Cox and Snell’s $R^2=0.09$, Nagelkerke $R^2=0.12$. Having benefits was significantly associated with resource use, Wald $\chi^2(1)=4.43$, p<0.05, OR=2.72, 95% CI=1.07,6.89.

In step 2, the additional variables of self-efficacy, EE categorized according to MBI cut-offs (low=0, moderate=1, high=2) were entered into the model (Table 10). The model was
significantly improved, $\chi^2(8)=18.23$, $p=0.020$ with improved strength, Cox and Snell’s $R^2=0.15$, Nagelkerke $R^2=0.20$. Having benefits remained significantly associated with resource use, Wald $\chi^2(1)=5.19$, $p<0.05$, OR=3.21, 95% CI=1.18, 8.74. There was a trend for lower self-efficacy to be associated with resource use, however it did not reach significance. A third step included the addition of perceived severity and time off for physical injury. The addition of these variables did not significantly add to the model, $\chi^2(10)=16.89$, $p=0.08$, and put the number of predictor variables above what would be recommended. As a result these were removed in the final model. In the final model, one outlier was identified but examination of Cook’s distance and leverage values did not suggest any points of major influence. A separate linear regression was performed to assess collinearity of predictors with satisfactory values for both Tolerance and VIF.

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<th>df</th>
<th>p value</th>
<th>OR</th>
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</table>

Table 9. Step 1 in the Logistic Regression (outcome: resource utilization)

Model with the outcome use of resources among those experiencing emotional difficulties related to working with aggression. The outcome variable is coded as 0=no and 1=yes. Only demographic and occupational variables were entered in this step. Gender: the comparator category is ‘female’; Marital status: the comparator category is ‘single/divorced/widowed’; CL: common-law; DK: don’t know.

To further investigate the nature of the relationship between sick leave benefits and resource use, additional post hoc analyses were done. There was a significant relationship between the reported availability of resources and their use ($\chi^2(1)=7.20$, $p<0.01$). An independent t-test was conducted to compare the mean number of resources available among staff with benefits compared to those who did not have benefits or weren’t sure. Those with benefits reported a higher number of available resources (mean 2.7 versus 1.8, $t(221)=3.57$, $p<0.001$). Those staff with benefits were more likely to report having access to leave of absence, modified work requirements and supervision, but no difference in access to crisis lines, EAP, counselling,
external referral, and other resources entered as free text such as training or transfer. Comparing those with sick leave benefits to those without, there were no significant differences in actual resources utilized by those who reported having experienced emotional problems.

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**Table 10. Step 2 in the Logistic Regression (outcome: resource utilization)**

Model with the outcome use of resources among those experiencing emotional difficulties related to working with aggression. The outcome variable is coded as 0=no and 1=yes. Emotional exhaustion scores categorized according to established cutoffs and self-efficacy were entered on this step.

Gender: the comparator category is ‘female’; Marital status: the comparator category is ‘single/divorced/widowed’; CL: common-law; DK: don’t know; EE: emotional exhaustion subscale of the Maslach-Burnout Inventory-Human Services Survey

### 4.2 Qualitative Results

#### 4.2.1 Interview Participants

Eighteen executive directors of the developmental services agencies in the South West were contacted by email to request their participation in the study. Six agency directors responded. One agency was deemed ineligible because they did not provide residential services. The five other agency directors were provided with the study recruitment notice to disseminate to their staff (see Appendix A). Three agencies circulated the notice by internal email, one posted it on their website and the fifth agency did not circulate the notice within the study period. Twenty-seven staff responded to the notice that was circulated by the 3 agencies that used internal email. Two agencies provided services to rural areas and one provided services to a mid-sized city.
Twenty-one staff participated in pre-interviews to screen eligibility. All screened staff were invited to participate in an interview, of which 19 agreed. Two declined because of personal time constraints. Semi-structured interviews ranging in duration from 40-70 minutes were conducted with the 19 participants.

The 19 participating staff represented over 7 different agencies as several staff worked part-time at more than one agency. All participants were currently supporting or had prior experience supporting adults in residential group home settings. Four participants were no longer working in those settings; three had transitioned to a day program and one was currently working in a children’s respite. The sample contained 14 female and 5 male direct support staff with a mean age of 38.6±7.6 years (range=24 to 59 years). The participants overall had a mean of 11.1±5.7 years of experience working in the field (range=3 to 24 years). Fifty-three percent worked days or afternoon shifts, 5% worked nights, 42% worked a combination. Eleven participants (58%) reported working with at least one other team member during shifts. Nine staff (47%) had specific training related to working with behaviours (for example, Enhanced Safe Space training (ESS)). The majority of participants (84%, n=16) reported having experienced physical or emotional consequences from working with aggressive behaviours. Just over one third of participants (37%, n=7) had sought help related to emotional difficulties at work.

4.2.2 Thematic Results

The following themes emerged in explaining the use of resources for challenges that arise in staff who work with aggression3.

**Innate Ability and Desire to work with Aggression**

Many participants discussed the innate qualities that some staff have that allow them to work more successfully with aggressive recipients. By extension it was felt that these staff are more able to tolerate and cope with the challenges that arise in the recipients and themselves relating to the aggressive behaviours and associated incidents. Attributes that contribute to a staff being “good with behaviour” included having a particular personality – one that enjoys intensity and

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3A number of quotes are presented to illustrate and support the themes discussed. Quotes were selected based on their representation of the quote being discussed. An effort was made to select quotes from a range of participants. Quotes are presented as close to their spoken form as was possible based on transcription abilities.
“adrenaline,” seeks to problem-solve and is able to mentally separate the emotional and physical. Personal characteristics like male gender, tone and quality of voice and style of interaction were also mentioned as potentially relevant.

“I would much rather deal with somebody that’s trying to punch me or somebody that’s butt naked that doesn’t wanna put clothes on and stuff than dealing with somebody that, um, needs a lot more physical help and that I need to, you know, assist in the bathroom…. It’s more mentally draining for me to do the physical work like that than it is for me to deal with the aggressions and the behaviours.” –Staff 0072

“We were like, you know what, I miss all the good days when it was more action going on in the house. Cause, I don’t know why, I guess it’s just part of the personality that you kind of need the adrenaline.” –Staff 0026

Workers were not criticized for not possessing these innate qualities, rather it was felt that all staff could contribute something to the field but they must figure that out and a good fit must be established for optimal performance. The importance of figuring out early where staff were best suited was emphasized by many participants.

“Cause there’s lots of times I’ve said ‘hmmm I don’t know (laughs), this person’s not great with behaviours, but I can see them working so successfully with these people’..you kind of have to be able to recognize .. where you’re best at, where your skills are. Um, ‘cause you still want to be challenged, but not feel like ugh! I’m in over my head..” –Staff 0028

“Because there’s some people that scare the bajeezus out of ya, right? And it’s okay. It’s okay to admit that and I think some staff, it’s very hard for them to admit that. It’s hard for staff, you know—some people are not cut out of for behaviours. I’m not cut out for a whole lot of personal care. I like behaviours. But there’s somebody that’s great with personal care that would be terrified of behaviours, right? And you just need to be able to find that out for yourself and identify that and not be ashamed by it.” –Staff 0072

Although it was not held against anyone, staff were clear that they did not want to work alongside someone who would not be able to handle behaviours and who would not be present to support a fellow colleague during an incident involving aggression. A couple of participants

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4 Participant identification is concealed for confidentiality reasons. Participants were automatically assigned a unique identifying number by the audio-recorder device used. This number has been retained in this report to identify quote sources. The higher the number the later in the study the participant was interviewed. Some numbers were not assigned meaning there are gaps between participant numbers. The total range of assigned numbers in this study was 0026 to 0073.
noted the possible implications, to the individual, the team and the people supported, of continuing to function in an uncomfortable role.

“\t\tI guess when we hire somebody if the person is not able to step up to the merit they usually get transferred to another location or they choose not to work for the agency and people who stay I guess there is some sort of an appreciation that they are able to handle situations” –Staff 0026

“\t\t...there have been times where I’ve seen staff come in and obviously they’ve passed their interview and they’ve been matched to our house… and… (short pause), whatever, pardon me, but they suck! Like (laughs)... you know, they don’t do their job. And I have actually gotten to the point where it’s like I don’t want them working, I don’t feel comfortable working with them. If a behaviour happened, I don’t think they’d be there for me.” –Staff 0042

Additionally, one’s ability to work with aggression and manage its physical and emotional consequences was noted to shift over the duration of one’s career and life trajectory. For example, one participant who had previously worked quite extensively in behavioural homes felt that due to her age and physical decline she could no longer function confidently in that role. She was concerned for her own well-being as well as her perceived inability to adequately support recipients and co-workers in times of crisis. Similarly, changes in another participant’s personal life impacted her comfort level with aggression at work. Specifically, the addition of children to her life made her more aware of the need for her health and physical well-being outside of work which made her less willing to put herself in potentially dangerous settings.

“\t\tBefore it was just me. I didn’t—I didn’t have to worry about me gettin’ hurt, right? You know, I got hurt, I got hurt. I took care of me. I gotta take care of my [kids], right? So, oh yeah, the change is huge…” –Staff 0070

This had several identified potential impacts on resource seeking. First, staff who believe they have these innate qualities may have higher tolerance for aggression and its consequences, however, they may also be more likely to ignore or deny problematic effects until they have surpassed some severe threshold. Secondly, staff who do not possess these qualities, may fear seeking support out of concern that they will be judged or compromise their job security (see the theme ‘Beliefs about self, illness and outcomes’). Staff felt that the hiring process could have more emphasis on matching employees to the best fit in terms of their interests and experiences. This could be done through more focussed interviewing with appropriate questions as well as orientations and trial periods.
“…depending on where you’re hiring, if it’s a behavioural house, you need to make sure your questions are behavioural-based. You need to make sure those questions are going to match the knowledge, skills, and abilities that that person needs to have in order to work at a behavioural house… because if they don’t have that present, they should not be working with behaviours.” –Staff 0042

**Ability to Find Relief**

A dominant theme that arose in relation to the consequences that staff experienced from working with aggression was the ability to find relief. This theme captured a variety of relief mechanisms that staff described that were contingent on some personal attributes, some organizational policies and procedures and some function of the team in which they worked. Relief could take the form of regulating exposure through physical separation in the form of safe spaces, breaks, sharing workloads and days off, or it could be through psychological distancing such as being able to “depersonalize,” “de-stress” and “leave work at work.” Even staff who were very successful at particularly the psychological separation, acknowledged that there was still a threshold beyond which these strategies became less effective and often transfer to a new location was sought at that point. Many staff would try to hang on for as long as possible for themselves, their recipients, their co-workers and also to relieve their managers of the need to find another staff to take their place. In hindsight, more experienced staff, or staff who had encountered a more severe challenge in their past, reported that they would be more likely to transfer sooner if they felt themselves struggling. Seniority also factored in, since it was generally believed that transfer opportunities increased with seniority level.

Informal, and in some cases formally organized switching off between staff was a commonly described strategy to regulate exposure. It was stated that the cumulative burden of working with someone with challenging behaviour is high and that most staff experience a sort of “shelf life.” This shelf-life was present on a day to day basis as well as presenting as a more long-term phenomenon.

“You have a shelf life at any location. You can only deal with certain adverse behaviours before you get burnt out on them, you know, where you need to just move to a different location, right?” –Staff 0045

“I think if the hours were shortened, because we’re still expected to work eight hour shifts and sometimes when you’re dealing with somebody, that’s too much. So
whether you break it down to two-hour shifts or four-hour shifts or whatever, but sometimes eight hours—‘cause it just—it can be just very intense dealing with this all the time.” –Staff 0071

“I know there are homes where if an individual is particularly challenging, they trade off staff every half hour. You know, they need to, to get the person supported, um, changed and to get the staff that relief because half an hour with this particular person is enough.” –Staff 0027

“I had another location that I called my Hawaiian vacation because (laughs) all of the guys were, none of them, there were no challenging behaviour. So that was my Hawaiian vacation, yeah, my break, when I needed it.” –Staff 0029

Needing to find relief was not without its challenges and consequences as well. For example, team members would provide coverage for one another following an incident or under conditions of high stress, however, only for a limited time until it was no longer perceived as fair or the colleague was felt to be avoiding the difficult work.

“But then again if it becomes an avoidance issue that’s probably something that’s gonna be addressed through a manager. Cause it’s not fair that one person is always working with someone they prefer to work with right. It’s reasonable that that person gets enough time to recover from whatever happened, but when it becomes just a work habit, uh, you know what I mean” –Staff 0026

Another challenge was the inability at times to get relief, such as in the case of policies that do not allow staff to leave the home or the lack of private space within the home for staff to congregate and seek temporary refuge. Staff described often needing a day off to regain energy and motivation but encountering difficulty when taking such a day due to requirements for medical permission, etc. While desiring more flexibility in taking “mental health days,” staff were also aware of the challenge for employers to offer this and the potential for some staff to take advantage of it, although participants who mentioned this issue felt it would not be a major problem. They wanted assurance that they could have a number of guaranteed days for self-care and rest without question since it was such a common experience. One participant mentioned that at her agency, mental health days were allowed, but recent changes to procedure required that you name a specific recipient who had contributed to the need for a day off. Her perception was that staff were not particularly happy with this change.

“Now, they did change the criteria behind it which none of us agree with….Now it has to be client-specific. But a lot of people are like, ‘How do you call up and say so
and so ticked me off, I don’t want to go to work today,’ ‘cause I’m really like a lot of places, like, you can’t do that. – Staff 0050

Relatively few participants discussed the need and desire for some education, support and training around coping with high levels of stress due to work, but some did comment on possible approaches.

“If there was like a training course or something where… (short pause) for high stress situations, if people had good coping skills or good coping mechanisms to teach people who are in these situations ‘cause it’s very nerve-wracking. Um, I guess everybody’s coping skills would be different but there’s gotta be like a pretty common one, right?” – Staff 0070

“I think people, if they’re truly invested in their job, they’ll truly wanna be trained because they’ll wanna succeed and do better and make things easier. ‘Cause who wants to work at a job that they struggle with all the time? Why not learn, why not develop, why not be creative?” – Staff 0049

The Culture of the Workplace

The role of the workplace culture was present in all participants’ descriptions in varying ways. There were a number of sub-themes that arose in this category as the culture existed and was discussed at a range of different levels.

Organizational Promotion of Wellness

Some participants commented on the steps that were taken or were lacking with respect to promotion of wellness within their agency and the sector. A few staff who worked at multiple agencies were able to comment on differences and similarities they observed across the settings. For example, a participant who held two part-time jobs at different agencies commented that one agency seemed much more accessible and supportive than the other.

“You know, with [Agency A], you kind of just walk into anybody’s office where [Agency B] is more of the receptionist and receptionist calling and seeing if that person is in, seeing if they will accept an appointment, you know?” – Staff 0073

One participant identified a pre-emptive discussion she had with a boss upon starting in a behavioural home (a home which services individuals known to have behavioural challenges including aggression) which she felt established the basis for an open and supportive environment.
Then my boss too when I got hired...he said, ‘There’s always three staff on in this house. It does get rough, so if you need five or ten minutes out on the deck, do it. Just tell the staff where you’re going. They’re fine, they can cover it. Don’t even think about the house. Just go take a breather.’” -Staff0072

This was in contrast to another participant who felt that the issue was not openly addressed and felt that the burden was on the staff to find ways to cope with the challenges.

“It’s just almost… checked off as that’s just part of the job. That’s just part—just, nobody’s ever addressed that this is maybe something we need to look at and address and have a system in place that, you know? I think there is if somebody got shot or if somebody died, right?” -Staff0073

Other participants identified the desire to have more of an “open door” policy where staff were invited and felt comfortable raising concerns.

“Why not meet with the person and go over their own abilities, go over, you know what I mean, have a discussion, open the door!” – Staff0029

Work conditions such as low staffing levels or scheduling errors were often cited as an issue that lead to staff working longer hours or being put in more tense situations without adequate support.

Management and Supervisor Support

The role of managers and supervisors were discussed by many participants. Often particular management styles were compared and contrasted with a favouring of those managers who were described as involved, respectful and caring. Staff want a voice but also want a leader who is aware of and in tune with what is happening in the work environment. Some participants noted that they have figured out the “good” managers over the course of their career and only select positions under their supervision.

“You know, like, really, I understand there’s a lot of things but managers are supposed to be supporting the staff who are supporting the people we support and I think sometimes the managers are trying to look over staff shoulder instead of providing that support and that’s a big problem, a big problem.” –Staff0029

“. Um, my manager now is wonderful though. She listens to what we have to say and she preps us and, um, knows that because we’re there every day and we know how things run, um, that we know – or, she… she asks us, you know, what would be best. And actually listens to our opinion and takes suggestions from us.” -Staff 0033
“I think the managers have to be more involved in the positions, I think they need to understand more what we’re doing, what us the staff are facing every day, um those are two things I found that the three managers I work with, they do very well, are supportive, I mean being more supportive on the little things.” –Staff 0029

Generally, it was noted that the workplace culture was good at being reactive in response to major incidents, i.e. changing policy or protocol following injuries or accidents. However, participants noted that it could sometimes be challenging to get managers and supervisors to acknowledge a perceived issue and respond in a timely and responsive way.

“Um, fear that nothing’s gonna get done, ‘cause that’s my big thing, ‘cause I don’t think our supervisor will do anything. ‘Cause we’ll tell him stuff till we’re blue in the face and nothing gets done. It’s gotten to the point where we’re documenting stuff now.” –Staff 0070

At times they felt dismissed in raising concerns and longed for some transparency of the higher level issues, as there was an appreciation for their presence since they felt the effects of things like “cutbacks” and ministry mandates at the front-line. One participant thought that management could do a better job of communicating the reasons for the delay to assist staff in understanding how decisions are made.

“…I think sometimes getting staff perspective on a situation. And uh, cause sometimes staff don’t feel safe working and they’ll say, ‘well I don’t understand, why can’t we make supports work this way, this way everybody’s more safe.’ And it may be a very significant reason why it’s not done the way they are proposing but I find it useful when that message is communicated.” –Staff 0026

Participants longed for a more open and responsive culture where they had a voice and felt supported and listened to. They felt managers should be more involved and aware of what was happening in the houses they were overseeing. Suggestions ranged from managers having to spend time physically at the house on a weekly basis to just calling or checking in regularly. When staff were feeling burnt out and frustrated with what was going on in the house, simple acts such as acknowledgement of appreciation, reward for effort, and supportive comments were felt to be immensely meaningful.

“I mean I had this manager…I love that manager…He would text me every once in a while and say you know what, you’re doing a great job, thank you. You know what, it helps you throughout the day so..” –Staff 0029
“Um, it’d be nice to feel a little more appreciated. I mean, we do a lot … and then all the cutbacks. I mean to even get someone who goes above and beyond to, like, you know, give them a $5 gift card or something. Like some kind of appreciation would be nice.” –Staff 0031

“…you know, we need positive reinforcement as employees as well, and who are we gonna get that from? Well, our superiors, right? So by having them around a little more often and providing that sort of positive reinforcement in maybe a team setting, I think. One of my favourite supervisors was… that was probably one of the reasons why. She was really good at praising people without it being patronizing, right?” –Staff 0045

**Co-worker Relationships (the ‘Team’)**

The role of the team and the importance of team cohesiveness in the well-being of staff was mentioned so often in the early interviews it was later incorporated as a specific inquiry point. Most staff worked with at least one other colleague when on shift. Those staff who didn’t work directly with someone else still felt the presence of the team because of the importance of communication between shifts and the need for continuity of care across staff. The team climate really shaped how staff felt in their workplace and was often a source of support during times of struggle. An integrated, cohesive team was felt to be so powerful, it could make up for unsupportive or absent management:

“Teams are very, very important for support because everybody’s going through the same thing and I found that if you have that close-knit team, that’s able to, it doesn’t matter who their manager is, if the team is very supportive of each other, then that can provide that kind of support.” –Staff0029

The presence and absence of trust, reliability and unity were emphasized in relation to the team:

“Challenges would be working in a core team that aren’t properly trained or disciplined or have the same focus as yourself; ‘cause we all come from different backgrounds. We all have different focuses on what that looks like, that care.” – Staff 0049

“It’s also vital to have the team there because if I didn’t have that back-up staff with me and the other teammates, then I would’ve been put in very serious situations, but because we have, you know, um, walkie-talkies that we carry or, um, buttons that we can press that would set off an alarm so the staff would come running, right? Uh, I’ve never been in a situation where I’ve been in there for more than like ten, fifteen seconds without a staff coming in for back-up. So, without that back-up, I probably wouldn’t be here to this day.” –Staff 0072
“And, like I said, we weren’t really working as a team before, so that contributed to it as well because when you have that kind of stress, um, you need back-up and if you don’t have it, you don’t have any support system, it’s terrible. I don’t know how else to describe it. It’s just an awful feeling that you kind of don’t even want to go into work some days, so.” – Staff 0033

Teams worked together to provide mentorship, relief for one another, share workloads and follow-up on incidents. For example, more experienced team members would educate and guide newer staff, team members would cover for each other after a colleague was hurt or too stressed, and call to check in on a colleague off work due to injury. Several participants talked about how they often go by the workplace or call in to their co-staff on their days off just to check in on each other or discuss experiences. In particular, the use of humour within the team seemed to accentuate the relationship and create a higher morale at work.

Many participants discussed the desire among staff for team-building activities such as retreats or training sessions. In particular there was a desire for opportunities to learn from others, share experiences and enjoy each other’s company outside of work. Training sessions were seen as opportunities to share common experiences, seek validation, meet other staff and learn from how other teams deal with difficult situations. Mandatory training only occurred on an annual or biannual basis which was often cited as too infrequent an occurrence. Events organized outside of work were seen as enjoyable, collegial and good opportunities for team bonding. Things like casual get-togethers at the local pub, potlucks, organized dinners or larger events like breakaways and day trips were mentioned. Costs were often cited as the perceived reason for the absence or removal of such events, but many participants stated their willingness to pay for themselves if an event were to be organized. More formal team building workshops in the workplace setting were also mentioned as a possibly helpful intervention.

“I think it would be nice…if more time is spent on, um, building teams … sort of team dynamics….something on a regular basis where, you know, you can kind of have an opportunity every few weeks just to kind of have a laugh too, at the same time. A learning component to it so that you kind of can relate to each other better….you know, it’s with other teams that have those challenges too that you can kind of provide, kind of a network of sharing information and as well, in terms of, uh … you know, finding how other people benefit from, um, sort of, things they access or things they find useful too to themselves, things like that.” – Staff 0028
“Team building, team, we really have to work, some teams are really, really good and some teams aren’t and that’s something that might be an outside resource or whatever but teams are very, very important for support because everybody’s going through the same thing… You could have somebody come in and teach skills, um, you could have people go out.” –Staff 0029

A more experienced staff reflected on prior experience with team building initiatives and the positive impact it imparted on all who participated.

“Uh, we used to have team building. Um… when… back in the days, when there was money. We used to have team building days where the entire staff would… do team building activities… focused around being a support worker and it was focused around, you know, like personal outcomes….I loved those days. Those were—and the team usually came out of those, um… you know, with a—with a new… recharge, you know, recharged and a good sense of, uh, strong sense of purpose, right?” –Staff 0045

Team support could effectively help staff to compensate for their difficulties if the team was supportive and inclusive and able to help out in times of need. The role of having a solid, cohesive team was emphasized by all participants and so team building was perceived as a useful and needed intervention, particularly when homes were dealing with more intense situations.

There was also a culture among co-workers that influenced how staff viewed issues in the workplace and themselves. Some colleagues were not seen as supportive, the potential for gossip was mentioned as an issue and some participants feared judgment or dismissal from colleagues. Similarly, there was frequent mention of a divide between part-time and full-time employees or new and experienced staff which influenced how staff perceived their place in the workplace. Part-time employees were not always described as equal with both mention of their lack of commitment to the work and on the contrary the lack of supports available to part-time staff. Newer employees were felt to struggle to bring up issues in the workplace due to perceived and actual resistance among more experienced staff. New staff were perceived as not wanting to “rock the boat” and were fearful of raising suggestions at staff meetings or elsewhere.
**Rules are Lacking or Inflexible**

Staff spoke about rules in place that affected their ability to cope with a situation and how they sometimes found ways to modify the rules to create a more tolerable or safe environment.

> “You can’t just take things away [from recipients] because they were bad or whatever, sort of a thing. So we’re not supposed to have… which makes it, you know, you have to juggle around things, but there comes a point where, you know, [something has to be done].” –Staff 0031

> “It’s do it because it’s expected of ya no matter what. Sorry about your luck. You can’t find anybody, I guess you’ll have to come in anyway. So if you have a real sore back or a splitting migraine, it’s hard to work and communicate with others when you’re on that level and I believe that we need room in our policies and rules to confront issues like that. Not to have overtime, but to have people move around their hours, people to adjust, people to be proactive.” –Staff 0049

At other times, despite the existence of rules and guidelines, staff struggled to get their breaks and rest periods throughout the day.

> “According to our collective agreement, we’re supposed to have, you know, our breaks and stuff like that. You know, fifteen minutes, half hour, fifteen minutes. We don’t get a break at [work].” –Staff 0030

The use of Human Resources, consultant services and the union could serve as a mechanism through which staff would try to get things changed if they felt conditions were creating unsafe work or causing harm in some way.

> “So, but the union comes in and we kind of use them a little bit. Um, they come in and do health and safety and stuff and we kind of make sure somebody’s around there to say what needs to be fixed at that point. ‘Cause unfortunately, we have to go a little bit sneakily to get it back to management so that it gets fixed ‘cause that way it’s documented.” –Staff 0070

In the presence of policies that staff disagreed with or felt the need to violate in extreme circumstances, they often turned to teammates to cover them (eg. leaving the house when stressed), or on occasion would just act according to their instincts or needs and deal with consequences later. Transitional zones were areas where it was particularly challenging because often policies did not exist and outside of the regular environment things were more unpredictable.
Organizational Focus on Service Recipients

This theme of the focus of the organization being on the recipient was raised by the majority of participants in varying ways. Specific mention to recipient rights, confidentiality and goals of care was made. Several staff felt that the focus was sometimes so much on supporting recipients that there was little appreciation for the staff experience.

“I feel like, I mean, we’re support workers and I just feel like we don’t get much support ourselves. Um, it’s … um (short pause) – I’m not saying that it should be all focused on us but it seems like it’s so focused on the people you support that there’s no support for the support worker.” –Staff0033

“Sometimes we don’t show the same empathy for our employees as we do for the people we support. It only seems like there’s a disconnect and there’s two different things that’s happening there but it’s the same environment.” –Staff 0049

Staff safety was sometimes felt to be put second to the recipient‘s overall experience and cause frustration among staff. Particularly in the movement towards inclusive care, efforts to create as normal as possible living environments for the recipients had resulted in staff not having private space to seek relief and feel safe. In addition, sometimes recipients were placed in settings that may not have been the best fit with staff lacking adequate training, thus creating a higher risk environment.

“…(mimicking manager response)…I understand you guys don’t feel safe about this particular part but there is nothing we can do cause once we do it, it requires this and this and this and once we do it that person is going to be isolated and not being isolated is a significant part of their well-being so that is the reason we can’t change it, you know.” –Staff 0026

“[The recipient] was put there because there was really nowhere else for [the recipient] to be. And it wasn’t good. It wasn’t safe for the staff” -Staff 0027

“[Interviewer: Do you have any private space—something like an office?] No, because a few years ago they came up with this, um… not, I guess it would be a part of accreditation and outcomes and stuff like that where it’s the person’s home, so it has to look like the person’s home, but unfortunately we still have a job to do and we’re staff, right? We don’t get an office. It’s kind of in their home, so no, we don’t get a private area. Yeah.” –Staff 0070

Participants did not argue that the focus should be taken off of the recipients, in fact many appreciated the changes and the improvements in quality of life it meant for the people they
support. They more felt that the focus on the staff needed to increase and a greater appreciation had for the difficulties staff struggle with. They also felt that although policies and procedures may be applicable in most cases, they wanted to feel like their concerns and well-being were considered and taken seriously in special or extreme scenarios rather than total deference to the existing policies.

**Beliefs about self, illness and outcomes**

The theme of beliefs relates to those ideas or perceptions that staff have about themselves and illness as well as how they believe others will react or what the negative consequences of seeking help may be. For example, in terms of beliefs about self, many participants cited concerns about personal vulnerability, weakness or inadequacy, roles and responsibilities. Illness-related beliefs encompassed the perceived cause of the problem, the anticipated duration and the role for intervention. Several staff noted the episodic nature of difficulties, akin to a “seasonal depression” as one person put it. Staff often delayed seeking any support out of belief that things would resolve with time.

“Um, but yeah I still delayed it a little bit, thinking nah it’ll get better, you know with the season change, maybe we’ll find new stuff to do, yeah and it just wasn’t improving. So –“ –Staff 0027

“Even just in general in the house, like seasonal changes are… you see that frequently. Um, and then for whatever reason the daylight—the amount of daylight changes and everything’s okay, you know? Um… so you tell, you know, so having gone through several of those situations… you never know the duration that it’s gonna last but you know that it’s not gonna last forever. It’s just a matter of, you know, a matter of time, right?” –Staff 0045

Finally, outcomes oriented beliefs were those that related to what the expected outcome of seeking help would be. Some cited concerns about job loss or unwanted transfer.

“I believe they don’t want to feel stupid, that they don’t know their job. I think that’s the biggest, um… you know, one of the biggest reasons. Um, or they don’t want to feel like they’re inadequate, that they don’t know what they did or they don’t know what they’re doing. I think those are the big… the big reasons. Um, and then the fear that if they did, you know, go somewhere or tell like their supervisor, that they would be removed from the home and work somewhere else. Um, so it’s those fears, and fear of everybody else knowing, like ‘Oh, you went to your
supervisor,’ and blah, blah, blah. So it’s that fear of... like, your supervisor seeing you or others seeing you as being inadequate, that you can’t do the job.” –Staff 0042

It was also felt that there was a stigma, not only against mental health problems, but against not being able to function in the workplace and some feared potential consequences that may come if others assigned that label to them.

“I don’t want to be weak. I want to be able to handle every situation. I work in—with adverse behaviours. We pride ourselves on being able to deal with difficult situations and being strong enough to power through with situations and uh, and come out, um... in a better place than where we started. So I guess there’s kind of the mindset that maybe by your accepting defeat that you’re accepting weakness as well.” –Staff 0045

Less experienced employees in particular worried that they would be ostracized for not being able to deal with challenging situations.

“I think as being a new employee, certainly for me, I don’t want to be perceived as... that it’s a challenge that [I’m] having difficulty with. It’s almost... I feel that it’s almost accepted that an experienced, knowledgeable employee will just know how to deal with that on his own. Nobody’s ever said that, but that’s my... how I interpret things. That, you know, experience... employees with twenty years’ experience just handle this really well and because I’m new, I’m struggling with it because I’m new and inexperienced, right?” –Staff 0073

These beliefs were sometimes perpetuated by feeling dismissed or blamed by co-workers and supervisors.

“But then, once again, I think my supervisor would question, ‘Well, why is it that you are the only one that feels this way and why...’ Um, I think [the supervisor] would somehow be suspicious that ‘Well, why is it that you can’t work with this person? Why can’t you handle this kind of a situation?’ So [the supervisor] would make like, um... make me feel inadequate as a team player, right?” –Staff 0044

Beliefs functioned very strongly to influence what a staff would do in difficult situation; both in terms of something happening at work that they wanted to bring the attention of others to (for example, an unsafe situation) and also in terms of their own suffering. Beliefs about the expected outcome, anticipated duration of problems and sensitivity to judgment by self and others were major factors.
**Personal Impact**

The degree to which someone was impacted by their experiences and the extent to which they were aware of that impact factored into whether or not they would seek some help. In addition, the impact it had on their family and social life also played a role, particularly in the case where friends or family identified a problem and encouraged the seeking of support.

“People are having dreams before going to work that they’re gonna get hit the day before that they go to work. Um, gettin' stressed out and just thinkin’ about it all the time and… so, it’s nerve-wracking.” -Staff 0070

“[Interviewer: How do you know you’re under that extreme stress? What do you notice?] Ummm… I’m thinking about it more outside of work, generally. Um… I’m over-anticipating things. Umm… there’s a—I have a physical response. I can feel it, you know, my body expresses stress in certain ways that I’m aware of. I’ve seen it enough that I’m aware of when… when that’s going on. I also try to take stock of myself and have self-awareness just to evaluate, okay, how do I, you know, what’s going on right now within myself. Um… I get tired, irritable… I lose that sense of, um, the rewarding part of the job doesn’t feel very rewarding anymore… I try to maintain the status quo, right?… I’m not stressed out and nobody else is stressed out, you know?” –Staff 0045

**Availability and Utility of Personal Resources**

Resources available to people outside of work that mitigate their emotional struggles were cited as very helpful although many participants acknowledged the challenge of discussing workplace issues with friends and family. Main concerns were issues of confidentiality which they felt restricted them from talking about any specific recipients or incidents with people outside of the setting they worked in, as well many staff felt their friends and family could not understand their experiences at work and at times felt dismissed by them.

“Um, sometimes I talk about those things at home [with my partner]. I’m not supposed to I guess but without mentioning a name I guess it’s not really a breach of confidentiality, it’s a slippery slope… If it’s about clients, I think it’s better to speak with co-workers just because some situations are quite bizarre, and people outside of that field have no idea how to understand and how to react cause sometimes you are just basically expecting humour back and you tell somebody oh guess what happened today and they’re like oh my god, why are you still working there, why don’t you find another job. And that’s not the reaction you were looking for so you just get more frustrated and like oh ok, I think I had enough coffee I think I better go and call somebody else who knows what to say” -Staff 0026
“I started doing counselling for myself because I didn’t feel like there was anywhere I could turn. And like friends and stuff like that, like, they can get tired of hearing you say the same things over and over.” –Staff 0033

“..You know, I’ll go home and I’ll call my mom or I’ll call my best friend, but confidentiality—and sometimes they just don’t get it, right?” –Staff 0072

Other personal resources people mentioned included physical exercise, diet, social activities, relaxation, and hobbies.

“I like … I like to read. Um, I like to go for walks. I’m a big music fan, so I enjoy that. I have sisters, girlfriends that I would spend a day with, or … you know, things like that. I, um, I’ve recently, um, discovered massage (laughs) and that’s a really great thing too. Yeah, so, yeah, things like that.” –Staff 0028

Personal resources could function to mitigate some difficulties if they were available and supportive. Good self-care and the development of positive, adaptive coping strategies were described as being very helpful. Some participants commented on the challenge in being able to maintain their hobbies and activities outside of work because of low motivation, costs (i.e. gym membership) and time. Also in the absence of spouses or a social network, personal support was less available.

**Availability and Utility of Workplace Resources**

The awareness of, availability of, access to and utility of resources was mentioned as a considerable factor in staff seeking support from supervisors and colleagues. Many participants were aware that there were resources although many were unsure as to what resources were available and how to access them. In addition, many participants questioned if what was available was what would actually be useful to affected staff. Concerns about confidentiality and stigma were cited. Additional deterrents were cost, limited benefit coverage and availability of time to attend appointments. One recently hired full-time staff remarked on the availability of massage coverage with her new benefit package.

“Um, so one of the things I do is I go for monthly massages too, just to kind of work out the tension and just to have that hour of strict relaxation. Um, and one of the things is having—being full-time and having the benefits—our benefit—er, package covers that. So it’s also a load off my mind knowing that I can do that and it’s not coming out of my pocket.” –Staff 0072
Some agencies had Employee Assistance Programs available and one agency had recently established a peer-based support program with counsellors available by geographical region across that agency’s service catchment area. Attitudes towards these programs were mixed. Generally EAP’s were seen as positive, but no one had accessed support there specifically for dealing with consequences of working with aggressive recipients. More commonly these programs were used for help around personal and family problems. Peer-based support received mixed feelings with a few participants commenting that it would be more helpful because peers could relate better, while one participant worried about being able to connect.

“But I don’t know if I would be comfortable – I never met the person, I’m talking to somebody I don’t know on the phone, I don’t know what their personality is like, I don’t know what their experiences are like, I don’t know how they gonna react. And maybe it would be a great experience I just don’t think I would do that.” –Staff 0026

Sector cutbacks were felt to have a probable impact on available resources and even the occurrence of staff meetings and incident debriefing.

“When there is a really big behaviour, you usually do need kind of a (short pause) debriefing. But they don’t always do that either. Especially with cutbacks now, less meetings and stuff.” -Staff0031

It was noted that support for physical injuries and protocol adherence was fairly consistent in most places, however, participants did not feel that there was adequate follow-up in terms of emotional and coping support.

“I mean, the managers, you know, like, when we have something that’s called a serious occurrence – so, if it’s something with an individual that happens. You know, obviously, and then, you know, our manager refers to it as debriefing. ‘Cause she wants to go over it afterwards and discuss it, but as far as, you know, what can I do for you to help you through this … kind of not there.” –Staff 0027

There was a large expressed need for resources to be subject matter sensitive. For example, participants felt like often their work was not understood by those who do not work in the field, and even those in the field who are not on the front-lines. In general, staff wanted support from someone who could relate to their experiences. More than specific resources, participants focussed on preventative strategies like team building, supportive management, job flexibility and personal strategies to deal with stress. In the case of more serious difficulties, some participants mentioned programs such as the EAP, counselling (from peers or outside the
organization), use of medical specialists, and frequently job modification or transfer. Participants emphasized the importance of these resources being useful and matched to the staff’s needs. While peer counselling was desired by some, confidentiality concerns were also present – particularly in the smaller agencies.

4.3 Combined Data Interpretation

The emergent themes from the qualitative data were further analyzed and interpreted in combination with the quantitative data and existing theories including the Behavioural Model of Health Services Use, the Health Belief Model and the Self-Regulation Model. The qualitative findings were found to fully complement the quantitative survey results with no identified contradictions. The qualitative data also served to provide more elaborate explanation for quantitative findings. For example, in the case of benefits being associated with resource use, qualitative data provided examples in staff who expressed concerns regarding cost and time to attend appointments. Further, benefits are often associated with more full-time and stable employment which also factored into staff help-seeking because of feared consequences of job loss or unwanted transfer and fewer opportunities available to those with less seniority. Similarly, the trend for self-efficacy to be negatively associated with resource use in the regression model could be considered in relation to the theme of innate abilities. Those staff who possess higher innate ability and desire to work with aggression are likely to have higher self-efficacy for managing aggression. A consequence of this relationship may be that they are more likely to engage in denial and thus be less likely to seek support. Support was evident in the finding that staff who had high motivation to work with behaviours often cited probable denial or belief that they should be able to handle situations as barriers to seeking support.

Many themes and variables overlapped with what has been reported in established models of service utilization. Examining the three selected models, I felt that none neatly fit, although all of my findings could be classified under a combination of categories from all three. Four categories overall fit the data well: Preventing and Coping, Severity Threshold, Enabling Factors and Cost versus Benefit Appraisal (see Table 11).
Preventing and Coping

Reference to proactive preventing and coping is not specifically present in the existing models but some elements of it are discussed under the predisposing characteristics in the Behavioural Model and the perceived susceptibility and seriousness in the Health Belief Model. The Self-Regulation Model has a separate component labelled coping which entails the strategies used once recognition of the illness is evident (Leventhal, et al., 1998). In the data from this study, discussion of the importance of prevention and coping strategies was so prevalent that I felt it deserved its own heading. Under preventing and coping were all those themes and variables that worked to keep staff healthy and functioning. These included: innate ability and desire to work with aggression, self-efficacy, ability to find relief, availability and utility of personal resources and the sub-themes of workplace culture relating to organizational promotion of wellness, management and supervisor support, and co-worker relationships.

Severity threshold

The severity threshold reflects the need domain in the Behavioural Model and the perceived seriousness and perceived threat categories in the Health Belief Model. This heading captured the theme of personal impact and also included some aspects of beliefs about illness. More specifically, those beliefs related to the awareness and acceptance of problems and the anticipated trajectory. Similar elements of illness perceptions are also present in the Self-Regulation Model and have predicted mental health service utilization in the general population (Baines & Wittkowski, 2013). The severity threshold represented the point at which coping was no longer working effectively and staff became aware of the presence of unmanageable challenges.

Enabling Factors

Enabling factors are present in both the Behavioural and Health Belief models in different ways. The Behavioural Model includes variables like the availability of services, personal and family characteristics, cultural factors and financial enablers. The Health Belief Model, on the other hand, includes cues to action which come from the media or others, and structural variables including previous experience with illness. In this study, the themes personal impact, personal
believes about self, illness and outcomes, availability and utility of workplace resources, workplace culture (including organizational promotion of wellness, management and supervisor support, co-worker relationships, rules and organizational focus on recipients) were considered relevant to enabling factors. In addition, the quantitative finding of the importance of access to benefits also figured under enabling factors. Benefits represented a larger issue of structural support in general which can refer to things like understaffing and available time (Banerjee, et al., 2012). Aspects of personal impact are similar to the Health Belief Model’s cues to action in that staff discussed the awareness of the severity of symptoms from bodily dysfunction, impact on relationships and work performance.

Two interesting themes within this category are ‘rules’ and ‘organizational focus on recipients.’ I felt these themes belonged under enabling factors because they function to dissuade staff from acting. For example, certain rules lead staff to feel powerless and their expectation is that the outcome will not be in their favour. Similarly, a belief that the focus of care is solely on the service recipients leaves staff feeling like there is little support for their needs and they are left to their own resources to find ways to cope while preserving the quality of care expected.

Cost versus Benefit Appraisal

The final category was borrowed from the Health Belief Model. This category relates to the perceived cost of seeking support in comparison to the perceived likelihood of benefit. Themes which fell into this category included beliefs about self and outcomes and perceived utility of resources. For example, some participants indicated that if they sought help in the workplace they would be subject to gossip or unwanted transfer or even fired. In participant descriptions of perceived costs, the workplace culture with respect to management and co-worker support also often factored in as it functioned to perpetuate or modify beliefs.

Although there were no significant findings in terms of demographic or occupational variables, some trends in the data do reflect what has been reported in the literature on help-seeking for mental health needs in the general population. For example, older age and female gender have been associated with higher likelihood to use services (Fleury, et al., 2012). The direction of the relationships between these demographic factors and resource use in this study’s analysis are consistent with this pattern. In addition, there was a positive association between work
experience and resource use which is not a variable that is relevant to the general population. Other studies that have examined help-seeking in professional populations have noted positive associations with concerns over career trajectory (a factor more applicable to people early on in their career) (Adams, et al., 2010) and having a clinical license (applicable to job security) (Siebert & Siebert, 2007). The interview data also supported the possibility that less experienced staff may be less likely to bring up issues because of concerns about job security and disrupting workplace relationships.

<table>
<thead>
<tr>
<th>Category</th>
<th>Preventing and Coping</th>
<th>Severity Threshold</th>
<th>Enabling Factors</th>
<th>Cost versus Benefit Appraisal</th>
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<tr>
<td><strong>Elements from Data</strong></td>
<td>- Innate ability and desire to work with aggression</td>
<td>- Personal impact</td>
<td>- Personal impact (cues to action)</td>
<td>- Beliefs (outcomes)</td>
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<td>- Self-efficacy</td>
<td>- Beliefs (illness-related)</td>
<td>- Availability of Workplace Resources</td>
<td>- Utility of Workplace Resources</td>
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<td>- Personal resources</td>
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<td>- Access to Benefits (structural support)</td>
<td>- Management and Supervisor support</td>
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<td>- Organizational Promotion of Wellness</td>
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<td>- Ability to Find Relief</td>
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**Table 11. Categories affecting Service Utilization**
Findings are based on combined interpretation of quantitative and qualitative data in consideration of three prominent theories of help-seeking and service utilization: The Behavioural Model of Health Services Use (Andersen, 1995), the Health Belief Model (Rosenstock, 1974) and the Self-Regulation Model of Illness Behaviour (Leventhal, et al., 1998). See text for details.
Chapter 5: Discussion

This study quantitatively and qualitatively examined exposure to aggressive behaviour among ID staff who work in community residential settings, the consequences (physical and emotional) they experience, their service utilization and their perceived service needs. Statistical analyses were conducted on quantitative survey data to examine factors associated with subjective emotional problems related to working with aggression and likelihood to use workplace-provided resources. Qualitative interviews with a sample of front-line residential support staff allowed for a more in depth exploration of these issues with emphasis on help-seeking behaviour and perceived service needs. For both methods of data collection staff from the South West region of Ontario were used as the sample population.

5.1 Emotional Problems Secondary to Working with Aggressive Behaviour

Quantitative data analysis revealed that in the prior 6 months, many staff had been exposed to challenging aggressive behaviour on a daily or weekly basis, and many had either personally experienced physical injury or observed others being physically injured. Time off work for physical injury was required in 6.5% of staff survey respondents and 57% reported having had emotional difficulties related to working with aggression. In the adjusted regression analysis, factors significantly associated with experiencing emotional problems related to working with aggressive behaviour included having more experience, higher emotional exhaustion scores on the MBI, higher perceived severity of aggression and an interaction term between perceived and actual severity. Further examination of the interaction term suggested that when the perceived severity is high, the likelihood of endorsing emotional problems is high regardless of what the objective severity (i.e. frequency and injury potential) is. On the other hand, if perceived severity is low and objective severity is low, there is a low chance of subjective emotional suffering. In the case of high objective severity, even if perceived severity is low, there is a high likelihood of staff being emotionally affected.
5.1.1 The Role of Experience

Having more experience may not intuitively fit with a higher reported experience of emotional problems from dealing with aggressive behaviour because there may be a tendency to think that more experienced staff are better able to cope with these occurrences at work. This can be compared with some reports in the burnout literature (Maslach, et al., 2001) which suggest a survival-like bias, with lower rates of burnout found among those with the longest experience. It is probable that many ID staff do burnout quickly contributing to high early turnover (Hall & Hall, 2002). However, many staff may actually choose to stay with the organization despite struggles because of limited alternative opportunities and job security. This was particularly highlighted by study participants working in more rural settings. Although comparison can be made to the burnout literature, this study examined the role of experience with respect to emotional problems in the setting of working with aggressive behaviour. Indeed, findings in the qualitative data did support that staff may experience a change over time in their ability to cope with challenging aggressive behaviour at work as their life circumstances or physical health changes. For example, staff who had children found they started to worry more about being hurt at work because of the impact it may have on their ability to care for their family. Aging staff who were experiencing a decline in their physical health, similarly may became more affected by the aggression at work. Alternatively, accumulation of exposure over time may begin to affect previously well adapted staff in a more severe way. This is akin to what was reported by interview participants as a “shelf life” over time which leads to a build up of frustration and exhaustion and need for relief. This may suggest that there are unique attributes to working with aggressive behaviour that differ from factors frequently studied in relationship to burnout and work stress, such as job demands, job control and supervisor support, among others.

5.1.2 The Role of Burnout (Emotional Exhaustion)

Higher levels of emotional exhaustion were associated with more often reported emotional difficulties related to working with aggression as may be expected. Working with aggressive behaviour has been associated with burnout, of which emotional exhaustion is a component, in several studies (Evers, et al., 2002; Hastings, 2002; Hensel, et al., 2012; Howard, et al., 2009; Mills & Rose, 2011; Neben & Chen, 2010). It has been suggested that there is likely a causative
relationship between working with aggression and the development of burnout in these human service workers, although it is only one of many implicated factors (Hastings, 2002). Not only is it a possible stressor that can contribute to the development of burnout, but a higher level of burnout that may be present for other unrelated reasons (such as unreasonable work demands, or lack of perceived job control), is likely to lower one’s threshold for being negatively affected by working with aggressive behaviour. Depersonalization, another dimension of burnout, was not examined in the regression models because of low reliability on the measurement tool in this staff sample (similar to what has been reported elsewhere in other ID staff samples (Chao, et al., 2011)), but may also have an impact on emotional stress due to working with aggression, although the direction of the relationship could be the reverse. Staff who have become more depersonalized may actually be less emotionally affected by regression. This remains to be studied, and alternate or revised measures for DP may be necessary for staff who work in this sector. Qualitatively, staff did describe the role of being able to ‘shut off,’ but also emphasized a learned strategy which involved ‘ignoring the behaviour, not the person.’ Unique to working with aggression, there may be a role for transient effective depersonalization as a coping strategy that is independent of the concept of depersonalization in burnout.

5.1.3 The Role of Severity of Aggression

High perceived severity, but not objective severity, was independently associated with reported emotional difficulties but further to that there was evidence of its moderating effect on the relationship between the objective severity and the likelihood of emotional impact. The relevance of the appraisal of the violent event was also discussed in a qualitative study of ID staff working with children in schools (Howard & Hegarty, 2003). The presence of this significant interaction between perceived and objective severity and experienced emotional problems may also be interpreted with reference to the qualitative data collected here. For example, the theme of innate qualities that staff possess which enable them to work with aggression may inherently relate to how they perceive threat and aggressive behaviour in general. If one enjoys the adrenaline rush of aggression, thrives on the problem solving approach demanded and seeks out opportunities to work with those individuals, they are likely to have a higher tolerance for it. Fear of assault has been shown to be a moderator of the
relationship between aggressive behaviour and emotional exhaustion (EE) and it has been suggested that some staff may self-select to work in those settings because they enjoy it and find it rewarding (Howard, et al., 2009). Alternatively, staff who are less experienced, have less behaviour-specific training or exposure, or are not working in a setting where they feel uncomfortable, may perceive relatively low objective aggression as quite severe. These individuals may be more prone to endure emotional consequences of exposure to aggression. In an examination of a larger provincial sample, of which these staff are a subgroup, those who subjectively appraised aggression as more severe had a higher likelihood of being emotionally affected (Hensel, et al., 2013).

5.2 Utilization of Resources

Although 81% of staff noted available resources, only 38% of those endorsing problems had utilized them. Of those who had utilized resources there were only about a third who found them helpful. There may be many reasons for staff not utilizing resources. For example, their difficulties may have resolved and they were no longer in need, or they may have gotten support from outside the organization. Indeed, 45% of staff indicated that did not use services because they chose not to seek them. In the adjusted regression analysis, having sick leave benefits was the only factor significantly associated with resource use, with a trend for lower self-efficacy as well. In post hoc analyses, those with benefits had access to a higher number of available resources and were more likely to have access to leave of absence, modified work requirements and supervision. However, there were no differences in the actual resources used between the two groups. Benefits were highly associated with the number of hours worked, with staff working more hours being more likely to report having benefits.

Age, gender, marital status and experience were not significant after adjusting for other variables but the directions of the associations were consistent with reports of mental health service utilization among the general population. Similar to what has been reported in a study of social workers and help seeking for depression, scoring higher in burnout was not related to whether resources were sought (Siebert & Siebert, 2007). Positive contributions staff receive from their work were also not significantly associated with use of resources. Most staff interviewed reported a great deal of positive personal benefit from their work and these factors
may be more independent of one’s emotional suffering (Hastings, 2010) and likelihood to seek support. As indicated in the qualitative data, there is a sense that staff are often not aware of their symptoms or engage in denial and delay taking any action. Denial is a common and often effective coping strategy (Paterson, Leadbetter, & Bowie, 1999). Additional reasons volunteered that may be related to the use of denial were the expectation of transiency, a high level of commitment to the work, a desire not to let co-workers and recipients down, and fear of negative judgment by others or of being dismissed. These factors have also been cited as barriers in studies of help-seeking behaviour in other populations (Adams, et al., 2010; Elwy, et al., 2011; Siebert & Siebert, 2007).

5.2.1 The Role of Benefits

Having benefits is typically associated with more full-time work and job stability. In most cases, staff are required to work for a specified length of time before being eligible. In the qualitative interview, costs were often cited as a barrier to accessing resources – in this case referring mostly to outside counselling and psychological support. One staff remarked that since acquiring her benefit package as a permanent full-time staff, she could now access massage with more ease, which she found profoundly helpful. It also seemed that staff who had benefits were more eligible for sick time and leaves of absence. Given the close association between benefits and hours worked, those staff working more hours are more likely to receive benefits and also have access to resources. This was also alluded to in the qualitative interviews with reference being made to part-time staff having difficulty missing any time from work and not having access to the same supports. Interestingly however, having benefits did not make a difference on which resources were accessed. It was expected that perhaps staff with benefits would more often access the resources uniquely available to them, or would be more likely to access more anonymous resources such as crisis lines or EAPs. This could represent the fact that certain resources are preferred because of the expectation of utility, availability or ease of access. There was high utilization of ‘other’ resources reported on the survey which staff indicated as training, transfer, talking to management and peer support. Similarly, these resources were commonly mentioned in the interview data as well.
5.2.2 The Role of Self-Efficacy

Although it did not reach significance, there was a trend towards higher perceived self-efficacy for dealing with aggressive behaviour being associated with a lower likelihood of seeking resources. Staff who rate themselves higher in self-efficacy may be those with more of the ‘innate’ abilities and traits that make them more comfortable and able to deal with aggression. In these staff, emotional difficulties may be more transient and/or they may have more effective personal coping strategies and outside resources. Those with lower self-efficacy may not be well suited to working with aggression or have inadequate training which leads them to seek training, supervision or transfer to a new location in the context of working with a lot of aggression. There was a lot of reference in the qualitative data to this issue of a person’s innate ability and desire to work in high behaviour homes and the importance of a good fit between staff and job role. A number of participants indicated their concern about working with someone who did not feel comfortable dealing with aggression and the fact that they wouldn’t hesitate to bring that to a supervisor’s attention so that the individual could get additional training or consider an alternate location. In some cases, support in the form of training or transfer may be forced on those individuals with low comfort (and presumably low self-efficacy). Self-efficacy has been found to moderate the negative effects of working with aggressive behaviour in ID staff (Howard, et al., 2009) as well as staff in other fields exposed to stressful demands at work (eg. rescue workers (Prati, Pietrantoni, & Cicognani, 2010)).

5.3 Understanding Workplace Resource Use in ID Staff

From the combined interpretation of the quantitative and qualitative data, and in consideration of existing theories of service utilization, the factors applicable to help-seeking behaviour of front-line support staff who work with adults with ID were formulated into four domains (refer to Table 11). These domains are adapted from popular and widely generalizable theories of health services resource use. These are: preventing and coping, severity threshold, enabling factors and cost/benefit appraisal. In the case that staff experience low enabling factors and high perceived cost relative to perceived benefit this will lead to worse outcomes for staff, recipients and the organization. For example, staff are likely to have reduced on the job productivity, higher levels of absenteeism and ultimately turnover. Quality of care is likely to suffer and
recipient outcomes may be affected. In addition, co-workers may suffer from the lack of needed back-up during behavioural crises and increased demands due to having to pick up extra duties for an underperforming colleague. Alternatively, in the presence of strong coping strategies, and if that fails, high levels of enabling factors and high perceived benefit over cost, staff are likely to be better able to manage their difficulties and if that is not sufficient, to seek timely and effective help.

Investing in and promoting the preventative and coping strategies can be a primary focus of prevention whereas fostering the positively enabling factors and limiting the perceived cost will work to facilitate help seeking in the setting of developed problems. Of course these areas do not exist in isolation, rather they are inter-related and inter-dependent in many ways. For example, strong relationships with co-workers are likely to function as a strong preventative strategy as well as an enabling factor particularly when there is a culture of trust and support among team members. In the survey data, peer support was also occasionally entered in free text as a ‘resource’ often used by staff struggling with problems at work. The important role of the team has also emerged in other studies of ID staff working in schools (Howard & Hegarty, 2003), as has the oft encountered difficulty in sharing with family/friends who may not understand the work. Having support and the ability to share experiences with the people you work with can really lead to improvement in both personal and work-related outcomes. Team cohesiveness and group-level helping have been studied in other organizations and touted as important issues in the optimal performance of working units (J. Choi, 2009; Marks, Mathieu, & Zaccaro, 2001). In a study of employees working in divisions at a large electronics company, J. Choi (2009) demonstrated that perceived competence of co-workers had the greatest positive impact on group-level helping with supportive management a close second. This highlights the need for recruitment of qualified and competent staff, adequate training and a strong management system.

Similarly, staff spoke often about the need for adequate relief, which may occur through some combination of training staff in how to psychologically distance or separate oneself from incidents at work, and physically allowing for temporary and intermittent separation from the exposure. The concept of ‘relief’ in the form of ‘time-outs’ or ‘refreshment breaks’ was also present in a study of ID teachers (Howard & Hegarty, 2003). This practice has also been
discussed as an important coping strategy among nurses who are exposed to violence at work (Paterson, et al., 1999). Of note, individual interventions targeting psychological acceptance and mindfulness have shown some benefit on negative outcomes including stress and burnout (Noone & Hastings, 2009; Singh, et al., 2009).

A highly important variable is the effect of the cultural framing of the issues within the organization. When a culture of tolerance exists (Howard & Hegarty, 2003; Whittington, 2002) and where the focus is predominantly on the recipients serviced, there is some perception among staff that they need to be able to handle difficult situations, that their well-being is somehow less important, and that concerns will be dismissed or shelved because of regulations, priorities or unsupportive management. In this setting, problems build over time slowly leading to poor outcomes. Moreover, the organizational response to the injured or traumatized staff member can play an important part in recovery, and a dismissive or inconsiderate response may inadvertently add to the level of distress and dysfunction that ensues (Paterson, et al., 1999). The issue of aggressive behaviour unfortunately can rarely be completely avoided in this population of recipients, therefore staff need to be guided, trained and supported in their experiences of working with it.

5.4 Practical Implications

As suggested in the data presented, there are numerous opportunities for interventions among ID staff to both prevent and manage emotional problems that arise in the context of working with aggression. The findings discussed here provide a framework to begin to understand what factors contribute to staff well-being and their likelihood to seek support within the workplace for difficulties encountered. Study participants described a range of desired services and programs, targeting multiple levels from individual staff up to the highest organization and sector levels. The existing literature on interventions for staff largely focuses at the individual level with implemented programs teaching skills including mindfulness (Singh, et al., 2009) and acceptance (Noone & Hastings, 2009). This study’s participants did not often discuss the need for individual level interventions, aside from an occasional mention of needing some stress management strategies. This may be due to staff feeling very skilled in this area (as evidenced by many staff describing a mastery of exactly the types of skills taught in these workshops),
staff underestimating the role of individual level interventions, or staff feeling focused on higher level issues and attributing many challenges to those factors primarily. This does not mean that individually targeted workshops are ineffective but they may have limited benefit in some staff who already possess a high level of skill and/or there may be limited motivation for staff to attend if they do not attribute their problems to their own deficits.

Interview participants focused much more on team level interventions, needed changes to management and the philosophy of how the sector as a whole was perceived to support their front-line employees. Most staff described a need for more ‘team-building,’ something which was described by some as being more present historically but which had recently diminished. The change was often attributed to financial cutbacks. Team building was felt to function at multiple levels: to bring team members closer together and building a greater sense of unity and trust, to allow team members to enjoy each other’s company outside of work-related duties, to build networks for peer support and to allow staff to learn from each other and feel validated in having the same experiences. In addition to typical team building opportunities like workshops or breakaways, staff also mentioned case conferences with teams from other residences or agencies, organized team meetings, and training opportunities that brought together a range of staff and allowed them to share opinions and experiences.

Participants frequently discussed the role of managers and direct supervisors. There was a strong emphasis on what was desired in a manager and several staff reflected on those who were ‘good’ and those who were ‘bad’ and the difference in their work experience as a result. Staff felt that managers could be more involved in front-line work or at least what was happening with service recipients, could work harder to recognize staff performing well, and could be more transparent as to how decisions are made. In addition, staff hoped that managers could more often seek their perspective and consider special circumstances that may not fit well with existing policies or procedures.

At the organization and sector level, staff wanted more of an ‘open door’ policy and a greater recognition for the work that front-line support staff do in what was perceived to be a recipient-focused care culture. Several staff discussed how their needs were often perceived to be second to the needs of recipients and that there was at times a lack of ‘reciprocal compassion.’
Staff also wanted the organizations to acknowledge the challenges that staff can experience when working with aggression and have resources to support them. They felt that agencies could try to do a better job of matching staff to the positions that best fit them based on their interests and experiences, with adequate orientation and trial periods in case things didn’t go as planned.

In reviewing the perceived needs of staff, it is evident that there are multiple areas for potential targeted intervention. However, there are various ways of approaching this. In a review of stress intervention studies in workplaces, it was discovered that very few implemented interventions targeted a combination of the organization, the individual and the interface between the two (Dollard & McTernan, 2011) although this approach is likely to have the most benefit. As a result, organizations should try to consider multi-faceted interventions or approaches that aim to address issues across multiple dimensions. This may require a more top-down approach where organizations embrace some fundamental changes in how they aim to support staff followed by the delivery of more individual and team-targeted interventions. This approach allows the lower level interventions to be delivered within a framework that staff feel supports them and aims to create a psychologically safe and productive work environment. Of course, these types of changes are not easily achieved and remain to be empirically demonstrated in this field with respect to short and long-term outcomes.

5.5 Strengths and Limitations

The strengths of this study include the use of a mixed methods approach to gain information about the topic of interest. The presence of qualitative interview data enabled a more in depth analysis and comprehensive interpretation of quantitative findings. The focus on one region of the province caused data to be narrow and in theory limits generalizability. However, findings here were consistent with findings reported in the overall provincial sample (Hensel, et al., 2012) and with findings reported in other qualitative studies of ID staff both locally (Neben & Chen, 2010) and internationally (Howard & Hegarty, 2003). Quantitative analyses used regression techniques which allow a number of variables to be explored while controlling for the effects of other factors. The sample size for the qualitative component of the study was consistent with what has been described as adequate (Creswell, 2007) and was based on
theoretical sampling and data saturation. Moreover, the composition of the interview sample closely aligned with the composition of the survey respondents and the workforce overall. A limitation of the survey data analysis was not being able to delineate the positions of staff. It was only discovered when I started talking one-on-one with staff that the number of hours they were working may be completely unrelated to their actual position or tenure in the agency. For example, a staff may be working upwards of 30 to 40 hours per week but officially be a part-time employee which can affect salary and benefit entitlement. As these staff could not be separated in the survey data, differences between these groups could not be analyzed. A second limitation of the survey data is the fact that the exact response rate is not known. Although there is an estimate for the number of staff working in the region, it is not known how many agencies participated in the survey (due to confidentiality reasons this information was not collected) and therefore the size of the population of eligible respondents. However, the estimate based on the overall regional population represents the lowest possible response rate and therefore the actual response rate is likely somewhat higher than that.

Another limitation is that the survey was conducted just prior to the implementation of Bill 168 which mandated that organizations have resources in place to deal with the consequences of aggression. It was evident in the interviews that some agencies had since implemented new resources including a peer-based counselling program. The resources were still quite new, however, and no staff had used them and therefore could not comment on their utility. The quantitative findings may have underrepresented the number of available resources to staff but given the very recent introduction of these programs, it is unlikely they would have resulted in significantly different results with respect to the utilization of services.

A final limitation is that despite recruitment efforts, there were relatively few staff in both the survey and interviews who were really new to the field of work. Partly, this may be due to the fact that new staff are frequently not working the equivalent of full-time hours (Ministry of Training, Colleges and Universities, 2014) and therefore would not have been captured in our sample. In addition, this study did not target staff who had left the field and may have been able

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Although the exact composition of the workforce from which study participants were drawn is not known exactly, extrapolations from agency reports, ID organizational literature and student trends supports the assumption that the sample is representative (i.e. majority female, majority within typical salary range).
to offer different insights. That being said, a range of staff experience levels were captured and many staff had had interactions with newer staff, or staff who had left the field and could contribute some perspective on their experiences. This is not as ideal as a first-hand account but still allows some information about these workers.

5.6 Conclusions

The aim of this study was to examine factors associated with subjective experience of emotional problems related to working with aggressive behaviour and identify the barriers and enablers of accessing workplace support. Drawing on established theories and models of service use, a framework for resource utilization by ID staff was developed which highlights the role of preventing and coping, severity threshold, enabling factors and the cost versus benefit appraisal of taking action. Many factors are similar to what has been reported in the literature examining other groups of staff who may be accessing support for various emotional problems ranging from burnout to clinical depression. These include factors such as personal beliefs, concerns about stigma or being regarded as incompetent (Adams, et al., 2010; Siebert & Siebert, 2007), illness expectations (Elwy, et al., 2011), available and useful resources (Elwy, et al., 2011), and a supportive organizational culture (Azzone et al., 2009; Putnam & McKibbin, 2004). Some unique factors that emerged in my study of ID staff and workplace resource use include the role of innate ability and desire to work with aggression, the emphasis on the team and co-worker relationships, organizational focus on the service recipients, and the need for relief through physical separation from exposure and psychological distancing. The successful application of existing theories of health services utilization to this workplace context lends support for this approach in future research. Many factors could be considered in parallel to factors that may affect the general population (eg. workplace culture parallels personal family and societal culture), however, there is a need to further adapt and operationalize elements to organizational settings. The applicability of these theories to service utilization in the workplace remains to be empirically evaluated and is an area for future work.

A variety of ideas for intervention were expressed by the study participants including a combination of preventative and responsive solutions. Interventions implemented in isolation may have some benefit, but it is less likely to be robust or sustained (Allen, 1999; Dollard
&McTernan, 2011; Rycroft-Malone, et al., 2002). In addition, staff suggested a need for relatively little of what have been historically implemented (i.e. individual level interventions) and more interest in team and management-targeted changes. Additional research is needed to evaluate the benefit and cost-effectiveness of intervention strategies. Greater consideration is warranted for a more system-wide approach within the developmental services sector as well as other organizations. Some important barriers, enablers and other factors to consider have been outlined in this study and may inform the implementation of future interventions.
References


Appendix A: Recruitment Notice

Are you having a hard time at work? Do you feel down, drained or on edge a lot of the time? Have you ever experienced a really difficult incident that you couldn’t seem to shake? Or do you feel like you have a really good ability to cope with challenges at work and wonder why others struggle?

If yes then, YOU ARE INVITED TO PARTICIPATE IN A RESEARCH STUDY being conducted by a research group from the Centre for Addiction and Mental Health in Toronto. We want to speak to front-line support staff about their work challenges and how it impacts their well-being. In particular we are interested in how you are affected by and cope with challenging situations with the people you support. This study is a follow-up to a survey that was administered in 2010 (reports available at http://knowledgex.camh.net/researchers/projects/crewh/) and will focus on staff needs. Interested participants will take part in a one-on-one interview with a researcher. Participation is entirely voluntary and is kept anonymous from your agency and employer.

To be eligible to participate, you must be:

- Over 18 years of age
- Working more than 20 hours/week in a residential group home that supports adults with intellectual and developmental disabilities
- Be comfortable with conversational English and be able to participate in a one hour interview that will be arranged at a time and location convenient for you

If you are interested in participating or for more information please contact:

[insert study investigator contact]

There is a small financial compensation for taking part in the study.
Appendix B: Pre-Interview

PRE-INTERVIEW
DATE/TIME:
NAME:
CONTACT NUMBER:

Introduce yourself as the researcher/research assistant.

“First, I want to thank you so much for your interest in this study. Do you have 10 to 15 minutes now to talk briefly? I can tell you a little more about the study and I can answer any questions you have. By having this conversation, you are not committing to anything, and you may choose not to participate at any time.”

Summary of study:

“This study is a follow-up to a survey we did 2 years ago which asked staff about their work experiences. We are now really excited about the opportunity to talk to front-line staff about their work. The study will involve meeting one-on-one with the researcher, Jennifer and talking about your work experiences, both good and bad, and specifically the role of working with challenging behaviours, since that is a fairly unique aspect of this work. We are working collaboratively with the agencies and the goal is to increase support for staff and determine what staff need to manage these challenges at work.”

Either tell staff that some additional information will be sent to them (if first contact) or remind them that they were sent this information for their reference.

“I have about 7 or 8 questions to ask you to find out a little more about your background and confirm that you meet our study’s eligibility criteria. Unfortunately we can’t talk to everyone, so it is possible that you may not be selected for participation but we would like to know more about you to help us make that decision. Would it be OK if I ask you these questions?”

Questions:

How old are you?

How many years have you been working in this field?

Do you work full-time? (More than 20 hours/week)

YES       NO

DAYS       NIGHTS       AFTERNOONS       COMBINATION
Do you mainly support adults with intellectual and developmental disabilities?

YES       NO

Is the setting you work in considered to be a residential or respite 24 hour setting?

YES       NO

What city is your workplace located in?

How many individuals do you support?

Do you work alone or with other team members?

ALONE       TEAM

How many team members?

Would you say that you are exposed to, or at risk of being exposed to, some challenging behaviour in your work?

YES, exposed       YES, at risk only       NO

How often?

Do you have any special training related to working with behaviours beyond the required agency training? (examples include ESS, advanced support) (CPR and CPI are standard agency required training)

YES ___________________ NO

Without telling me the details right now, would you say you have experienced any physical or emotional consequences related to this work?

YES       NO

Again without telling me the details, would you say you have ever sought help from your agency or other resource for personal problems, either physical or emotional, related to your work?

YES       NO

“Those are my questions. Do you have any questions about the study or your participation?”
“Interviews will probably be held in ___ (insert month) ______. If you are selected for an interview, we would like to do it at a time and location convenient for you. What days are you available? Do you have an idea for where could it occur?”

Some options include: at the workplace, agency office, CAMH regional office (London only – near the university), coffee shop, staff home (last resort). The researcher is available Tuesday, Wednesday and Thursday – which day(s) are best for you?

Are you willing to be contacted for an interview if you are selected?

YES     NO

How do you prefer to be contacted?

EMAIL ________________________________    PHONE ____________________

“Thanks again for your interest. Someone will be in touch in the coming weeks to let you know about the interview. In the meantime, please feel free to call or email with any questions that you have.”
Appendix C: Letter of Information and Consent Form

STUDY INFORMATION

Name of Study: A qualitative study of help-seeking behaviours and service need of community staff in the adult developmental disabilities sector who are exposed to or at risk of being exposed to aggressive and challenging behaviour and associated emotional difficulties.

Responsible Investigators:
Jennifer Hensel, 416-535-8501, ext.[]
Carolyn Dewa 416-535-8501, ext.[]

Purpose: The purpose of this study is to understand the help seeking behaviour and service need of community residential group home staff who support adults with intellectual and developmental disabilities. In particular, we are interested in help-seeking for emotional and physical difficulties that arise due to exposure to aggressive challenging behaviour. Approximately 20-30 staff will take part in this study.

Procedures: As a participant in this study you will be asked to take part in a one-on-one in person interview with one of the researchers where you will be asked questions about your experiences of working with aggressive clients, how it affects you and your feelings, attitudes and beliefs about help-seeking for these consequences. The interview will take approximately one hour. The interview will be audio-recorded and later transcribed with all personal information removed. You may be contacted at a future time for a second follow-up interview to take place either in person or over the phone. You are under no obligation to participate in a second interview.

Eligibility: To participate in this study you must work full-time in a residential group home for adults who have developmental disabilities. You must also have been exposed to or feel at risk of exposure to aggressive challenging behaviour by the people you support. You must be over the age of 18, be comfortable with conversational English and be able to provide reasonably detailed answers about your experience(s).

Confidentiality: Your identity will be kept confidential to the full extent provided by law. In addition, neither your name nor any other personal identifier will be used in any reports or publications arising from this study. As part of continuing review of the research, your study records may be assessed on behalf of the Research Ethics Board. A person from the research ethics team may contact you (if your contact information is available) to ask you
questions about the research study and your consent to participate. The person assessing
your file or contacting you must maintain your confidentiality to the extent permitted by
law. As part of the Research Services Quality Assurance role, studies may be audited by
the Manager of Quality Assurance. Your research records and CAMH records may be
reviewed during which confidentiality will be maintained as per CAMH policies and to the
extent permitted by law.

In the case that you provide any information concerning possible harm to yourself or to
others, we will be legally required to report this information.

We may use quotes from your interview in scholarly publications. Where we do this, all
personally identifying information will be removed and an alias will be used. It is
possible, however, that you may be identifiable based on the content of the quote.

Compensation: You will receive a $15 gift card for Tim Horton’s to compensate you for
your time in participating in this study.

Risks: The study interview requires an hour of your time plus travel time and may be an
inconvenience. The content of the interview may potentially trigger stressful memories or
cause you to feel upset. If this happens, the interview will be stopped and a decision about
whether to proceed will be made collaboratively between you and the researcher. You
may also choose to stop at any time for any reason. If you experience high levels of
distress, you will be offered information about how to seek help and supported in this as
necessary. You will also receive a list of available local resources at the conclusion of the
interview.

Benefits: By participating in the study you can potentially contribute to a better
understanding of help-seeking and service need among community staff in the
developmental disabilities sector which may inform policies and intervention development
in the future. You may also find it beneficial just to talk about your experiences.

Voluntary Participation: Your participation in this study is voluntary. You may choose to
withdraw from the study at any time. You may also choose to skip questions or end the
interview at any point. Similarly, the investigators or their staff responsible for this study
may, at their discretion, end your participation at any time. If your participation ends early
for whatever reason, you will still receive compensation.

Additional Information: If you have questions about the study that are not answered in
these Information Sheets, please ask the researcher. In addition, if you have questions in
the future you may contact the study investigators at the telephone numbers given on the
first page.

Dr. Padraig Darby, Chair, Research Ethics Board, Centre for Addiction and Mental Health,
may be contacted by research subjects to discuss their rights. Dr. Darby may be reached
by telephone at 416-535-8501 ext. 6876.
AGREEMENT TO PARTICIPATE

I, _________________________, have read (or had read to me) the Information Sheet for the study named ‘A qualitative study of help-seeking behaviours and service need of community staff in the adult developmental disabilities sector who are exposed to or at risk of being exposed to aggressive challenging behaviour and associated emotional difficulties.’ The purpose of this study is to understand how staff who work with aggressive clients and suffer emotional difficulties view their needs and when and how they decide to seek help for this. This information may or may not be useful in informing policy developments or designing interventions to help staff in the future. My questions, if any, have been answered to my satisfaction. By signing this consent form I do not waive any of my rights.

Dr. Padraig Darby, Chair, Research Ethics Board, Centre for Addiction and Mental Health, may be contacted by research subjects to discuss their rights. Dr. Darby may be reached by telephone at 416-535-8501 ext. 6876.

☐ I agree to participate.

Research Volunteer:

Signature: ______________________________________
Date: ______________________________________
Name: ______________________________________

Please Print

Person Obtaining Consent:

Signature: ______________________________________
Date: ______________________________________
Name: ______________________________________

Please Print

☐ I have been given a copy of this form to keep.
Appendix D: Interview Guide

Interview Guide (subject to change)

“A qualitative study of help-seeking behaviours and service need among community staff in the adult developmental disabilities sector who are exposed to, or at risk of being exposed to, client aggression and associated emotional difficulties”

Basic demographic information/Start-up

1. What is your relationship status? Dependents?
2. Were you born in Canada?
   a. If not, where were you born and when did you come to Canada?
3. How long have you been working with adults who have intellectual and developmental disabilities?
   a. How long have you been with this agency?
   b. Are you in a worker’s union?
4. Do you currently receive sick benefits from your work?
5. Can you tell me a little bit about what your job involves?
   a. Location, type of people supported, services provided, typical day, team or alone, environment, etc.
6. What lead you to work in this field? What draws you to work with these clients? What do you learn from this work? What keeps you doing your job?

Exposure to Aggressive Challenging Behaviour

1. Do you support any individuals who you would say engage in aggressive challenging behaviour?
   a. How many and how often?
   b. What types of behaviour?
2. How does this affect you?
   a. What do you do?
      i. How does the environment contribute/help you?
      ii. Do staff have private space in the workplace?
   b. How do you feel?
   c. What personal consequences are you aware of?
   d. How does it affect your relationship to the person/people you support?
   e. Are there any positive aspects?

Emotional Consequences

1. Have you or anyone you know who does this type of work had emotional or psychological problems that were the result of being exposed to aggressive challenging behaviour?
   a. What did you/they experience?
   b. How did it manifest?
   c. How serious was it?
   d. How did it affect your/their life at work and outside of work?
   e. Did you ever think of leaving your job?
Help-seeking Behaviours

1. Have you ever felt like you needed help for any consequences you have had related to being exposed to aggressive challenging behaviour at work?
   a. Physical consequences?
   b. Emotional consequences?
   c. Other?

2. What did you do/would you do if you were experiencing these kinds of problems?
   a. Who do/would you talk to/seek support from?
   b. What is the role of working with other staff during your shifts?
   c. When and how would you talk to your manager/supervisor? What is your contact with them? How often do you think you need to have contact? How effective has it been for you?
   d. Have you/would you ever seek help through your agency?
   e. What would be involved if you wanted or needed to take time off?

If chose not to seek help:

   a. Were there any reasons/could you foresee any reasons you didn’t/would not choose to seek help if you were experiencing these kinds of problems?

      i. Were you/would you be concerned about how it might affect your work life? Relationship with people you support? Relationship with co-workers/manager?
      ii. Was it/is it determined at all by how you view your role/job expectations?
      iii. Did/do you have certain expectations about how the problems would resolve?
      iv. Did/do you have certain expectations with respect to how helpful the options are/would be?

If sought help:

   a. What was the outcome of that?
   b. How satisfied were/are you with the outcome?
   c. Were there any really positive or negative consequences?
   d. How did/do you feel about your decision to seek help for these problems?
   e. Did/does it have any impact on your future likelihood to seek help?

3. Do you have any other examples of times when you were experiencing these kinds of problems?
   a. Probes as above
Service Need

1. What types of services or resources do you think are needed for staff experiencing these types of problems?
   a. What about in the workplace?
   b. Outside of the workplace?
   c. During training and development?
   d. What would those resources look like?
2. How do you think these problems could be best managed where you work?

Conclusion

1. Is there anything else you would like to add?
2. Why did you volunteer for the study?