A Systems Thinking Analysis of Work-Related Violence in the Australian Residential Disability Sector – Phase 2 Report

Report prepared for WorkSafe Victoria

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Contents

EXECUTIVE SUMMARY

Work-related violence (WRV) is widely acknowledged as a key hazard contributing to physical and mental injuries in the residential disability sector in Victoria. WRV involves incidents in which a person is abused, threatened, or assaulted in circumstances relating to their work (WorkSafe Victoria, 2024). Residential support workers are at risk of WRV from multiple sources: residents, family members, and colleagues.

WorkSafe Victoria partnered with National Disability Services (NDS) and Queensland University of Technology (QUT) to better understand the problem and identify solutions to drive systemic change.

Aims

The aims of this project were to:

- Understand disability residential support workers' experience of WRV in Australia,
- Identify the actors who share responsibility for WRV in the residential disability sector in Victoria,
- Identify the multiple, interacting factors contributing to WRV incidents in the Victorian residential disability sector, and
- Identify strategies to prevent and reduce the risk of WRV incidents in Victoria.

Method

The research involved a literature review (QUT, 2023), large cross-sectional survey of residential support workers in Australia (*n* = 261), semi-structured interviews with 31 stakeholders working in the residential disability sector, and workshops with key stakeholders. A systems analysis framework, Rasmussen's (1997) risk management framework, was used to guide our understanding of WRV incidents.

Findings

Workers' experience of WRV in the Australian residential disability sector

Most (83.9%) survey participants had experienced WRV in the past 12 months. 77% of participants had experienced 2 or more incidents of WRV and 33 % experienced WRV every week, day, or several times per day over the last year.

Survey participants reported that WRV was primarily perpetrated by residents (76.2%).

These rates are higher than previously found in a large survey of Australian disability workers *(n* = 1279), where over 50% had experienced any WRV in the previous 12 months (HACSU, 2021).

The survey examined a range of potential contributory factors to WRV:

- *Staff capability:* Moderate to high levels of confidence in managing WRV were reported. Most survey participants had received induction training that was specific to their role (60.3%). However, less than half (49.4%) agreed that this training sufficiently prepared them for this role.

- *Safety culture*: Participants perceived a moderate level of safety leadership behaviours from their supervisors and moderate to high levels of safety climate promotion from senior management.
- *Retention*: Although moderate levels of burnout were observed in the sample, participants reported low to moderate intention to leave the sector.

Survey participants reported four key themes about their experience of WRV in the residential disability sector.

- *WRV is an accepted part of the job:* WRV is often seen as unavoidable.
- *Priority is resident safety:* Management are often most concerned about maintaining regulatory compliance for resident safety, rather than staff safety.
- *Safety leadership:* There are poor management behaviours, including bullying and not reporting or escalating incidents to upper management.
- *Reporting culture*: There is a lack of time and support from managers to report WRV incidents.

Actors who share responsibility for WRV incidents

The systems analysis identified that 73 actors share responsibility for preventing WRV in the residential disability sector in Victoria, including 39 at the Government, Regulators and External Influences level, 3 at the Organisation Governance and Administration level, 6 at the Operations Management level, 15 at the Frontline level, and 10 at the Equipment and Surroundings level. All these actors were considered in the subsequent development of prevention strategies.

Contributory factors and prevention strategies for WRV incidents

Interviews with stakeholders in the sector identified 135 contributing factors and 70 prevention strategies for WRV in the residential disability sector. The factors clustered around four key themes:

1. Staff Capability

Frontline staff can play a significant role in preventing WRV, but stakeholders reported they often lack the skills and knowledge needed. Interview participants emphasised the importance of WRV-specific skills, person-centred support skills, complex communication skills, and specialised knowledge of disability, mental illness, and trauma.

The lack of skills and knowledge needed to prevent WRV is caused by low staffing entry requirements, staff shortages/casualised workforce, staff fatigue and burnout, inconsistent supervision, funding and budget constraints for training, and inaccurate and/or overly complex behaviour support plans.

Prevention strategies included:

- More stringent practice frameworks (e.g., related to trauma-informed support) and minimum entry requirements for frontline staff.
- Providing further training to frontline staff to facilitate professional development of knowledge and skills related to disability support (e.g., communication skills, mental health, behaviour support) and WRV (e.g., de-escalation).
- Local supervision from frontline managers (e.g., house manager), and the availability of on-call supports for staff to access when the risk of WRV is elevated.

- Implementing changes to staff behaviour (e.g., using active support, implementing WRV-related strategies, and maintaining consistent resident routines), and accurate, implementable, and digestible behaviour support plans.

2. Physical Environment

Poorly designed buildings contribute to WRV. Specific factors include single points of egress, low visibility, inadequate space, and low-quality materials.

Poorly designed buildings are a result of funding and budget constraints for building adaptation, unsuitable accommodation allocation for resident needs (e.g., location), and limited space for resident privacy.

Prevention strategies included:

- The availability of well-designed buildings (e.g., bespoke and designed for specific residents, including private living spaces, multiple points of egress, visibility, and space for staff to seek relief or retreat).
- Providers consideration of removing furniture and equipment that could be used as weapons, whilst also maintaining a therapeutic and homely atmosphere (i.e., avoiding overly hardening the environment to the detriment of resident well-being).
- Internal organisational policies related to the design, procurement, alteration and upkeep of properties (e.g., modification for resident needs).

3. Safety Culture and Safety Leadership

Several contributory factors were identified, indicating a poor safety culture for WRV. Staff accept violence as part of the job, prioritise client safety over their own, and fear repercussions for reporting incidents.

The poor safety culture is driven by management messaging around resident safety, a focus on resident safety at a regulatory level, and perceived tensions between the Disability Act and safety risk controls.

Leaders' behaviour in prioritising workplace health and safety is critical in preventing WRV. Capacity to demonstrate safety leadership is constrained by funding for safety initiatives, limited professional development opportunities and low entry requirements for leadership positions, inadequate supervision of frontline staff, and compliance-focused legislation.

Prevention strategies included:

- Legislative reform and more stringent regulation of provider Occupational Health and Safety (OHS) and psychosocial hazards to ensure all providers prioritise safety culture and safety leadership within the industry.
- Leaders demonstrating a commitment to both resident and staff safety, alignment of organisational communication to reflect this, and establishing well-funded workplace health and safety and practice quality teams.
- Frontline managers exhibiting safety leadership via: implementing workplace health and safety initiatives consistently, holding staff accountable for safety-critical behaviours, fostering a safe and open environment to discuss WRV and related issues such as burnout and mental health, and scheduling appropriate time to allow staff to report incidents.
- Strengthening reporting culture by encouraging staff to routinely report incidents.

4. Resident Compatibility

Resident compatibility refers to the match between the client and the provider, other residents, and the physical environment of the accommodation. Factors that can impact the suitability of resident compatibility include intake and exit processes as well as resident mix in group housing.

Poor resident compatibility outcomes are influenced by pressure to accept residents due to funding constraints and limited flexibility in funding guidelines to allow movement between accommodations when residents are incompatible.

Prevention strategies included:

- A need for more stringent regulation to ensure residents are placed in appropriate residences.
- Provision of support during crises relating to resident mix.
- Streamlined processes to allow for residents to move or exit when there is a high risk of WRV.
- The use of risk management resources, pre-admission reviews and a holistic approach to intake was suggested to prevent inappropriate client mix.
- Seeking resident feedback on their satisfaction with their home environment (e.g., resident mix) and using this information to support resident intake decisions and the moving of residents where necessary.

Options for consideration

Project findings were used to develop recommendations for consideration for reducing and preventing WRV in the Australian residential disability sector.

Options for government and regulators to consider include:

- Increase provider access to funding - to attract and retain highly skilled staff
- Review and redefine staff competency requirements in alignment with best care practices
- Increase provider access to funding – for the provision of relevant and timely education for staff and enable staff attendance
- Align regulatory obligations for providers by adopting a balanced regulatory approach that prioritises safety for all people
- Streamline regulatory frameworks to reduce administrative burden
- Regulate reporting of OHS incidents affecting staff
- Provision of WRV incident report summaries to industry to support practice improvements
- Encourage consistent regulatory framework for resident intake into accommodation
- Provide regulatory guidance for providers in relation to environment suitability
- Provide regulatory guidance for entry, exit and return from health settings
- Provide clarity on regulatory requirements to facilitate access to funds for housing adaptation
- Ensure regulatory guidance affecting housing options includes consultation with residents to ensure compatibility with resident preferences.

Options for organisations (e.g., support providers) to consider include:

- Provide funding and access for relevant staff education & professional development
- Provide adequate support and resources to address cognitive demands
- Demonstrate commitment to staff safety by increasing leadership investment/ involvement in WRV-prevention activities and discussions
- Implement rigorous recruitment, selection, induction and training processes to ensure optimal safety leadership recruitment
- Design work shifts and tasks to optimise staff safety
- Ensure ongoing consultation with residents and frontline workers in decision-making processes related to design and modification of properties
- Employ a supportive rather than punitive approach to compliance
- Strengthen resident matching within risk management procedures
- Ensure space available for residents' privacy and to 'not engage'
- Accurately define and communicate work demands, responsibilities and capabilities in recruitment, selection and induction practices
- Implement and monitor end to end reporting systems including consultation with staff for corrective actions and communication of outcomes
- Provide appropriate training and professional development opportunities for staff, and implement auditing procedures
- Promote a culture of openness and accountability – encouraging staff to acknowledge skills gaps.

Options for frontline staff to consider include:

- Actively encourage colleagues to report WRV incidents and engage in organisational health & safety consultation obligations
- Actively engage in and seek out ongoing training and professional development.

Conclusion

This research demonstrates that WRV is a significant and systemic problem in the residential disability sector in Australia. Most workers report that WRV is a frequent experience. The research also highlights that multiple system-wide factors contribute to the problem. Through consultation with stakeholders, multiple opportunities have been identified to drive system change to reduce and prevent WRV. The findings and recommendations will be presented at an industry forum in June 2024 to facilitate translation into policy and practice.

PROJECT TEAM AND ACKNOWLEDGEMENTS

QUT team

This research was led by Professor Sharon Newnam supported by a team including:

- Ms Olivia Dobson (Research Assistant in the School of Psychology & Counselling, Faculty of Health)
- Dr Olivia Miller (Postdoctoral Research Fellow in the School of Psychology & Counselling, Faculty of Health)
- Associate Professor Xiaowen Hu (Business School, Faculty of Business and Law)
- Dr Nadine Brayley (Lecturer in the School of Psychology & Counselling, Faculty of Health).

External contributors

Research activities were guided by an industry-led Steering Committee, who additionally provided expert peer review of project outputs.

Stakeholders represented in the Steering Committee included:

- WorkSafe Victoria (WSV)
- Department of Families, Fairness and Housing
    - Office of Professional Practice
    - Health Safety and Wellbeing Division
    - Victorian Senior Practitioner
- National Disability Insurance Scheme (NDIS)
- NDIS Quality & Safeguards Commission
- National Disability Insurance Agency (NDIA)
- Health and Community Services Union
- Yooralla
- Scope Australia
- People with lived experience of disability

The project team acknowledge and thanks the Steering Committee's generosity in donating their time to guide project activities, share their expert knowledge, and review project outputs to ensure they were appropriate and specific to the context of the residential disability accommodation sector.

This project was funded by WSV, who provided valuable feedback and input on methodological approaches and project outputs.

The project team received subject-matter expert guidance, peer-review and interview/ survey participant recruitment assistance from the National Disability Services (NDS) throughout the project.

INTRODUCTION

Background

The experience of work-related violence (WRV) is common for staff working in the residential disability sector (Health and Community Services Union, 2021). WRV is defined as incidents in which a person is abused, threatened, or assaulted in circumstances relating to their work. This definition includes behaviours described as acting out, challenging behaviour, and behaviours of concern (WSV, 2023). Residential disability accommodation includes facilities such as group homes, shared supported accommodation, and respite services where people with disability live either permanently or on a fixed short-term basis to receive appropriate support. Residential support workers are at risk of WRV from multiple sources: residents, family members, and colleagues.

Little is known about the factors contributing to WRV in the residential disability sector, or the broader systemic changes required to prevent WRV. A recent workforce report by National Disability Services (2021) raised three 'big themes' across the sector: pessimism, frustration, and distress. A recent systematic review found that most interventions to prevent WRV in care settings focus on the immediate work environment (QUT, 2023). Prevention strategies identified include: wearing of protective gear, risk assessment for WRV, decisional aides, team meetings, leadership walks, learning and incident reviews, improved client information resources, and various communication visualisation tools, staff training and support groups. No studies had considered prevention strategies in the broader regulatory and government environment.

Aims

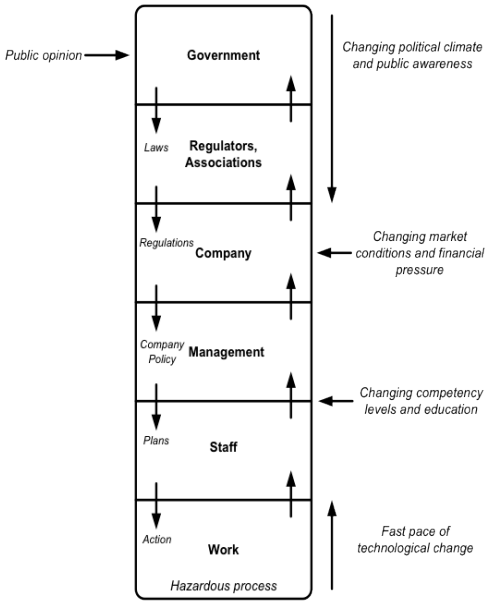
To address these gaps, WorkSafe Victoria partnered with National Disability Service (NDS) and Queensland University of Technology (QUT) to better understand the problem and identify solutions to drive systemic change. The aims of this project were to:

- Understand residential support workers' experience of WRV in Australia.
- Identify the actors who share responsibility for WRV in the residential disability sector in Victoria.
- Identify the multiple, interacting factors contributing to WRV incidents in Victoria, and
- Identify strategies to prevent and reduce the risk of WRV incidents in Victoria.

Systems thinking framework

The project utilises a systems thinking approach, Rasmussen's (1997) risk management framework, was used to guide our understanding of WRV incidents (Figure 1). This framework is now widely accepted within safety science as the most appropriate approach for understanding and preventing incidents in work systems.

Figure 1. *Rasmussen's (1997) risk management framework*



In applying this framework, five principles were derived to guide our approach to understanding and preventing WRV incidents in the residential disability sector:

1) ***Shared responsibility for safety***: WRV incidents are created by the decisions and actions of all actors across the system, not just front line workers and clients. To prevent incidents, actors across the system need to take steps to prioritise worker safety in their decision making.

2) ***Multiple, interacting factors***: WRV incidents are caused by multiple contributing factors, not just a single poor decision or action. To prevent incidents, strategies need to address multiple factors, focussing on the factors at the higher levels of the system, rather than on the behaviour of staff or clients.

3) ***Communication***: WRV incidents occur when information does not move between levels of the system. To prevent incidents, actors at the higher levels need to know what is happening in the work environment, and this information needs to inform the development of policies and procedures, which are then reflected in work practices.

4) ***Pressures in the system***: WRV incidents occur because work practices constantly adapt and change in response to various external pressures and conditions. To prevent incidents, risk controls should not be dependent on people performing many checks and closely following procedures.

5) ***Erosion of risk controls***: WRV incidents occur because risk controls become less effective over time as conditions changes. To prevent incidents, work systems need to have good processes in place for monitoring the implementation of risk controls over time.

WORKERS' EXPERIENCE OF WRV IN THE RESIDENTIAL DISABILITY SECTOR

A large-scale, cross-sectional survey of workers in the Australian residential disability sector was conducted to understand self-reported rates of staff WRV and describe factors contributing to WRV.

Methods

Survey participants

261 people working in the residential disability sector in Australia completed the survey. Table 1 shows the demographics of survey participants were generally representative of the broader Australian disability workforce who are predominantly female and permanent employees (NDS, 2020).

Table 1.
Survey participant Demographics

Demographics	Number (%)
Gender	
Male	73 (28)
Female	183 (70.1)
Identify as other or prefer not to answer	5 (1.9)
Age	
18-25	7 (2.7)
26-35	40 (15.3)
36-45	47 (18)
46-55	91 (34.9)
56-65	71 (27.2)
66+	5 (1.9)
Primary work role	
Frontline worker	132 (50.6)
Behaviour support practitioners	3 (1.1)
Team leader/ supervisor	65 (24.9)
Operations Management	27 (10.3)
Authorised program officer (APO)	3 (1.1)
Health and safety representative	19 (7.3)
Quality, risk and compliance manager	10 (3.8)
Provider size	
Micro (1-29 FTE staff)	23 (8.8)
Small (30-90 FTE staff)	16 (6.1)
Medium (60-199 FTE staff)	32 (12.3)
Large (200+ FTE staff)	189 (72.4)
Geographical area	
Metropolitan	118 (45.2)
Regional	123 (47.1)
Rural	20 (7.7)

Cont…

Demographics	Number (%)
State	
Victoria	128 (49)
NSW	35 (13.4)
QLD	70 (26.8)
WA	14 (5.4)
SA	11 (4.2)
Tasmania	3 (1.1)
Tenure with primary employer	
Less than 1 year	18 (6.9)
1 to 5 years	123 (47.1)
6 to 10 years	63 (24.1)
11 to 20 years	40 (15.3)
More than 20 years	17 (6.5)
Sector experience	
Less than 1 year	5 (1.9)
1 to 5 years	70 (26.8)
6 to 10 years	56 (21.5)
11 to 20 years	61 (23.4)
More than 20 years	69 (26.4)
Employment status	
Permanent – Full-time	143 (54.8)
Permanent – Part-time	84 (32.2)
Contract – Full-time	1 (0.4)
Contract – Part-time	6 (2.3)
Casual	25 (9.6)

Note. Missing data/ responses where numbers do not add up to 261.

Survey Measures

The survey was designed to understand self-reported rates of WRV exposure for staff working in the Australian residential disability sector and describe factors contributing to WRV. The items were developed based on a systemic review (QUT, 2023), and consultation with the project steering committee to ensure appropriate scope and correct terminology.

Table 2 outlines the variables included in the survey. Survey participants were invited to provide further qualitative comments regarding WRV in the residential disability sector through an open-ended question.

Table 2.

Measurement approach for variables captured within survey

Variable	Measurement approach
Training	Participants described their experiences and satisfaction with training received at their primary place of employment.
Built environment	Participants described the environment (e.g., number of residents, purpose-built) in which they provided support in their primary place of employment.
WRV experiences	Participants reported on their experience with workplace violence in the past year, including the frequency, perpetrator, reporting process, and post-incident support.

Cont…

Variable	Measurement approach
Confidence to manage WRV	6 items from the 'Confidence in Managing Aggressive Behaviour' subscale from the *Incidence of and Attitudes Towards Aggression in the Workplace Scale* (8 items; Deans, 2004) was used to assess confidence in managing WRV. Participants rated their agreement with each statement ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Responses were averaged (range 1-4) and higher scores indicated higher confidence to manage WRV.
Burnout	4 items from the *Copenhagen Burnout Inventory* (6 items; Kristensen et al., 2005) were used to measure burnout. Participants rated how often they felt symptoms ranging from 1 (*never/ almost never*) to 5 (*always*). Responses were averaged and higher scores indicated higher burnout.
Turnover intentions	The 'Turnover Intensions' subscale from the *Michigan Organizational Assessment Questionnaire* (Lawler et al., 1979) was used to measure intentions to leave the residential disability sector. Participants rated their agreement with each item ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Responses were summed (range 3-15) and higher scores indicated higher intention to leave the sector.
Perception of safety leadership from supervisors	The supervisor/ team leader version of the LEADRS survey (14 items; Casey et al., 2019) was used to measure perceived safety leadership from supervisors. Participants provided their perception of the extent to which their supervisor demonstrated safety leadership behaviours with responses ranging from 1 (*not at all*) to 5 (*to a very great extent*). Responses were averaged and higher scores indicated higher safety leadership.
Perceptions of safety climate	A 3-item scale (Neal & Griffin, 2006) was used to measure perceived workplace safety climate. Participants rated their agreement with each statement ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Responses were averaged and higher scores indicated better safety climate.

Data Analysis

The quantitative data was analysed through descriptive statistics and frequencies to characterise the sample, WRV exposure, and experiences of WRV contributory factors, and the qualitative data was analysed thematically.

Findings

WRV Exposure

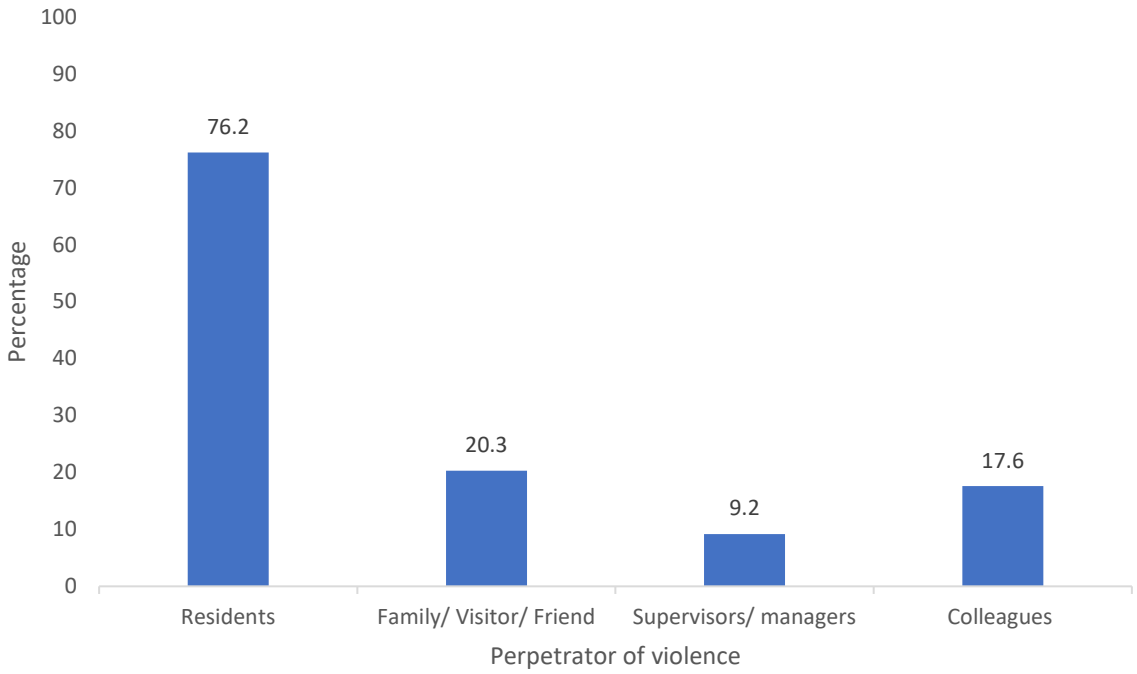
As seen in Table 3, most survey participants had experienced multiple incidences of WRV in the past 12 months. 77% had experienced two or more incidents of WRV. Of particular concern, 33% of the sample experienced WRV every week, every day, or several times per day. A very small proportion of participants (16.1%) had experienced no WRV in the past 12 months.

Table 3.
Percentage of survey participants exposed to WRV with varying frequency in the past 12 months

WRV frequency in the past 12 months	Percentage of participants
None	16.1%
1	6.9%
2 to 10	28.7%
10 to 20	11.1%
20 to 50	4.2%
Every week	21.1%
Every day	7.7%
Multiple times per day	4.2%

As seen in Figure 2, this violence was predominantly perpetrated by residents, followed by resident family members/ friends/ visitors, colleagues, and supervisors or managers, respectively.

Figure 2.
Percentage of survey participants exposed to WRV from different perpetrators within the residential disability sector



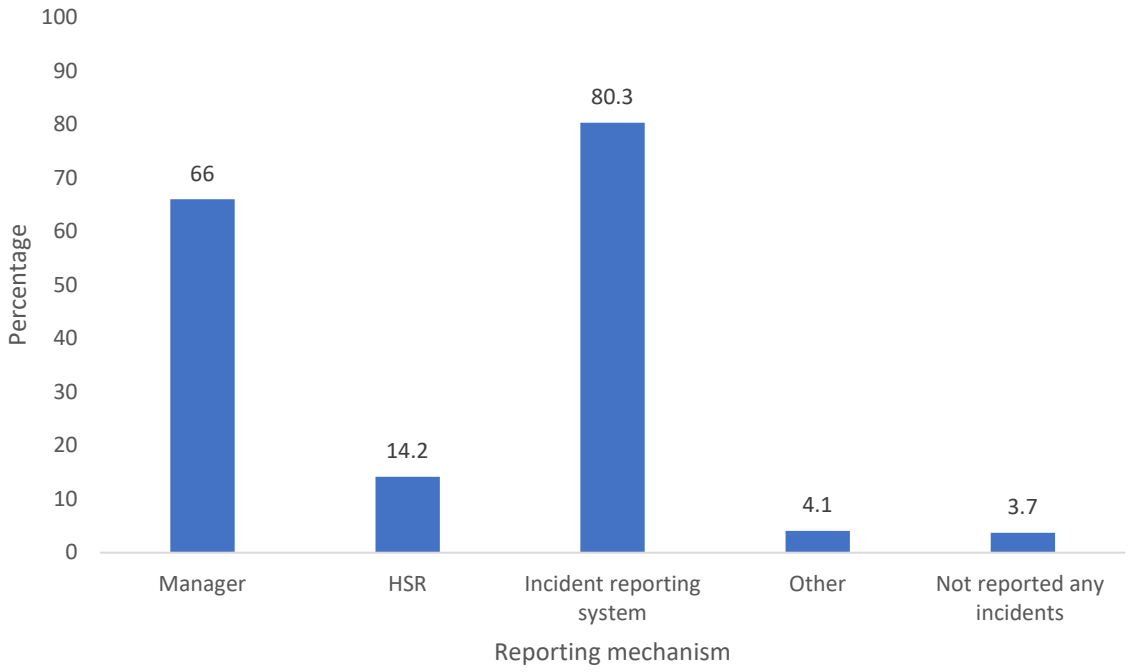
Of the staff who had experienced WRV from a resident, 79.4% said the resident in question had a behaviour support plan (BSP) (15.6% no, 5% unsure). This suggests that 20.6% of residents who engaged in violence did not have a BSP to appropriately guide staff in preventing or de-escalating violence. Of staff that experienced WRV from a resident with a BSP, 77.2% felt that they had sufficient time to read that BSP and 65.8% had received training on implementing BSPs (primarily from a behaviour support practitioner).

Of those who had experienced WRV in the last 12 months, 47.1% reported that they were not provided with adequate post-incident support and 72% reported all incidents of violence. This means 28% did not report all WRV incidents (some incidents may have been reported but not all). This is particularly significant, as it means that employers do not have an accurate understanding of workers' experience of WRV.

As seen in Figure 3, most survey participants had previously reported a WRV incident, primarily via incident reporting software (80.3%). Other approaches for reporting included directly to a manager (66%), to a health and safety representative (14.2%), or other approaches (4.1%). Only 3.7% of respondents reported no incidents. Common reasons for not reporting included the high frequency of violence, normalisation of violence, perceptions that certain forms of violence were "not serious enough" to report, fear of reporting due to employment repercussions or blame, time constraints, and feeling as though nothing would change after reporting.

Figure 3.

Percentage of survey participants who used various reporting mechanisms to report any WRV incident



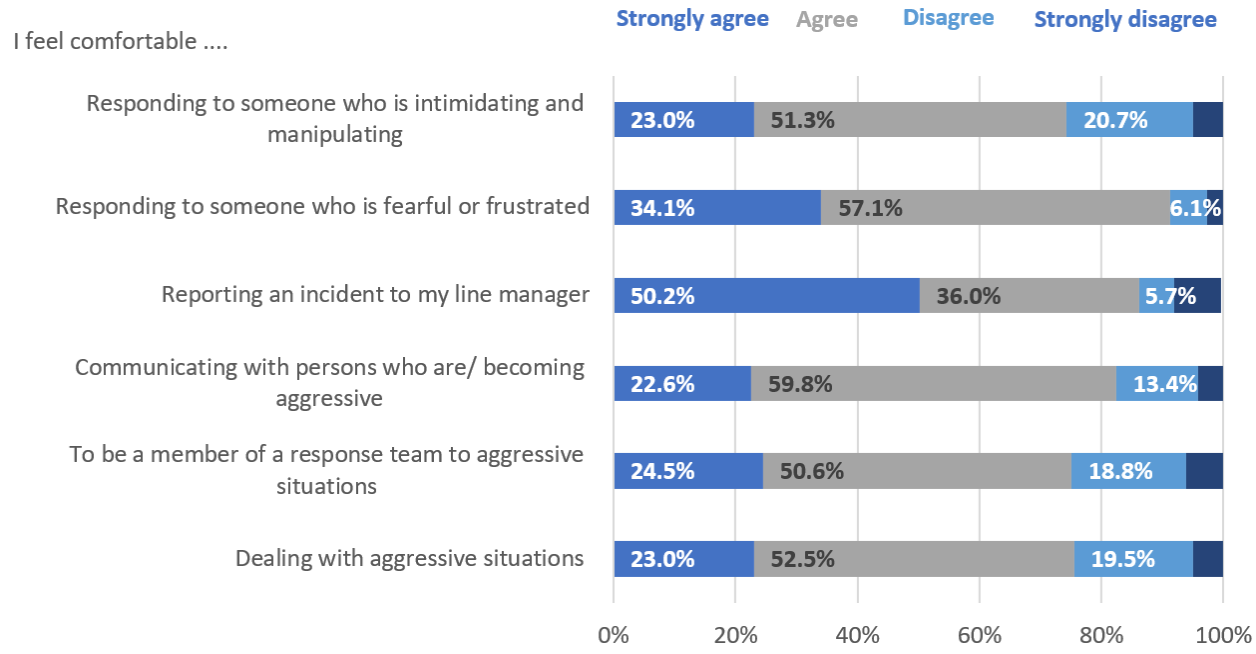
The rate of WRV identified in this study are higher than previously found in a large survey of Australian disability workers (*n* = 1279) where over 50% had experienced any WRV in the previous 12 months, 51% had experienced between 2 and 10 incidents of violence, and 5% experienced WRV daily (HACSU, 2021). Similarly, these rates of violence are higher than those observed in the adjacent healthcare sector. For example, a large-scale study of over 34,000 nurses from eight European countries found that patient perpetrated WRV was experienced monthly, weekly, or daily by approximately 22.2% of the sample (Camerino et al., 2008).

Contributory Factors to WRV

Confidence to manage WRV

The average confidence to manage WRV score was 3.01 (*SD* = 0.61; potential range 1-4), indicating moderate to high confidence. As seen in Figure 4, the results showed that most survey participants agreed with the confidence survey items, and very few strongly disagreed.

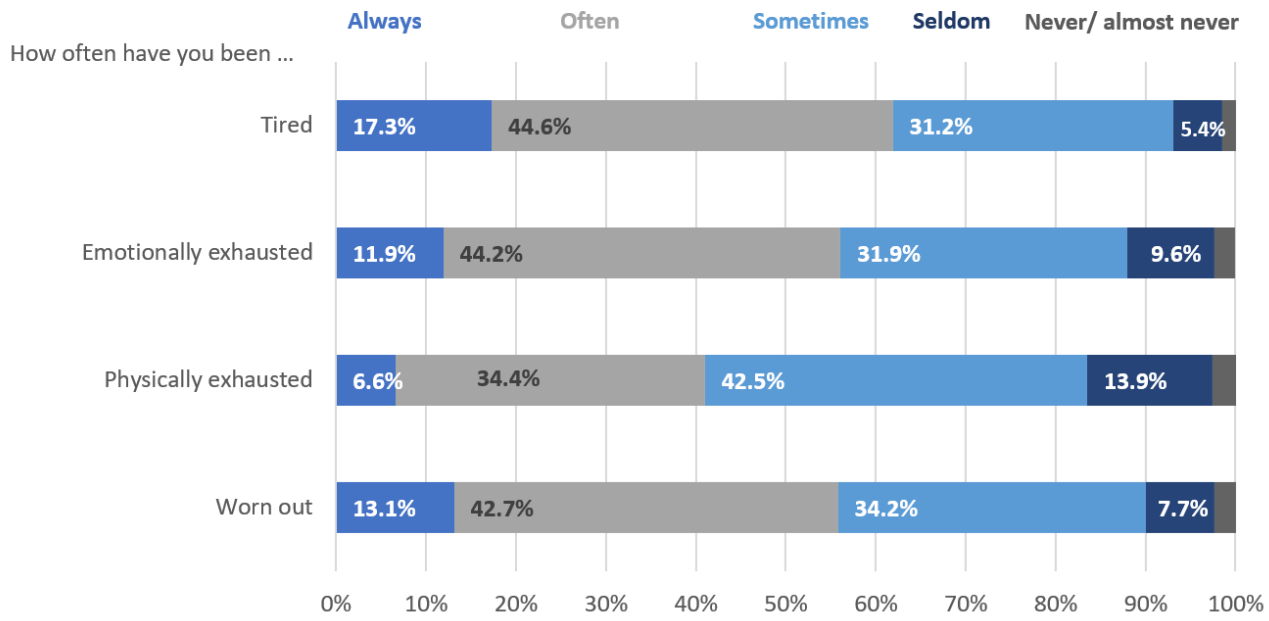
Figure 4.
Response rates for items measuring confidence to manage WRV



Burnout

The average burnout score was 3.52 (*SD* = 0.80; potential range 1-5), indicating moderate burnout. As seen in Figure 5, very few survey participants (less than 15%) indicated that they 'never' or 'seldom' experienced symptoms of burnout. Instead, burnout symptoms were most often experienced 'sometimes' or 'often'.

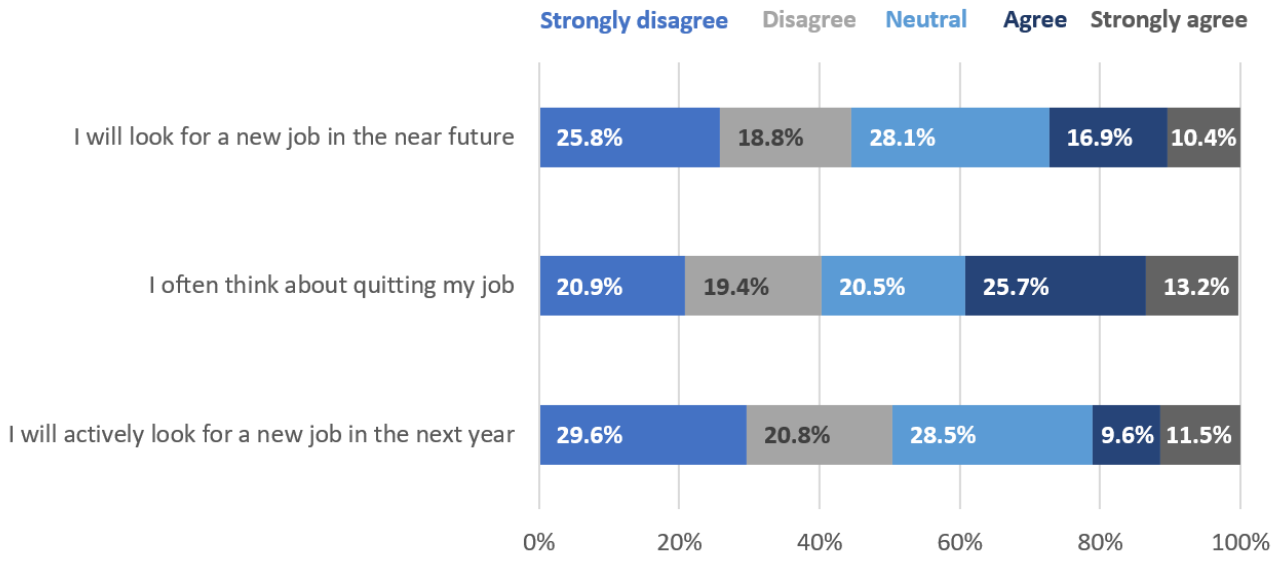
Figure 5.
Response rates for items measuring burnout



Turnover intentions

The average turnover intentions score was 8.09 (*SD* = 3.71; potential range 3-15), indicating low to moderate intentions to leave the sector. As seen in Figure 6, most survey participants (generally 40-50%) strongly disagreed or disagreed with items asking if they wished to leave their job, suggesting that approximately half of respondents wished to remain in their roles and the residential disability sector.

Figure 6.
Response rates for items measuring turnover intentions



Training experiences

As shown in Figures 7-9, most survey participants had received induction training (Figure 7; 94.6%) which was specific to their work location (Figure 8; 60.3%) and felt that the induction training sufficiently prepared them for their role (agreed or strongly agreed; Figure 9; 49.4%).

Figure 7.
Percentage of survey participants who had completed induction training with their primary employer

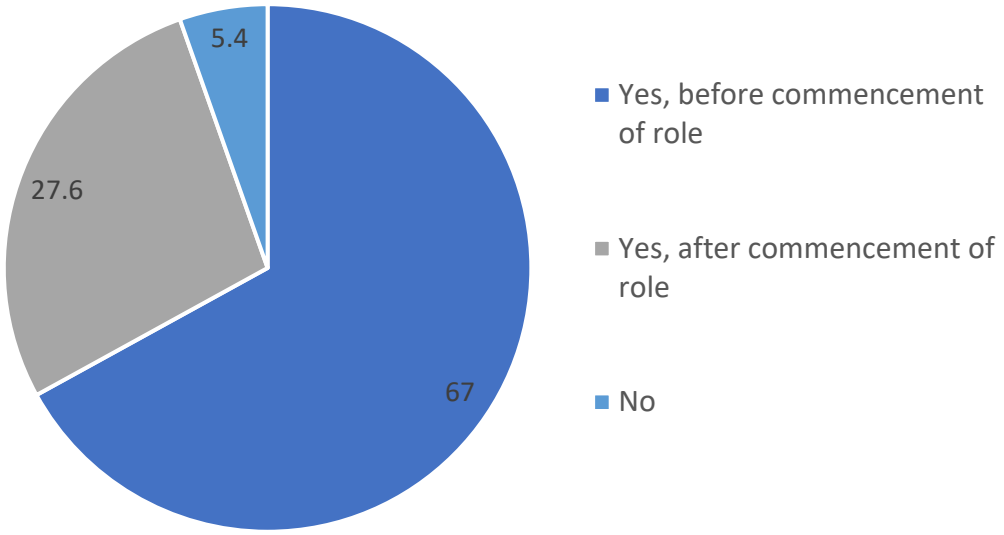


Figure 8.
Percentage of survey participants who had completed induction training specific to their work location

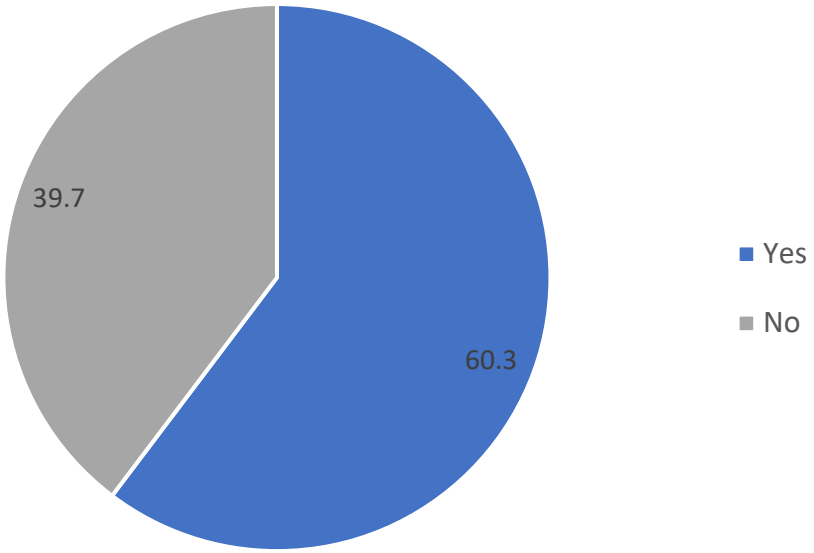
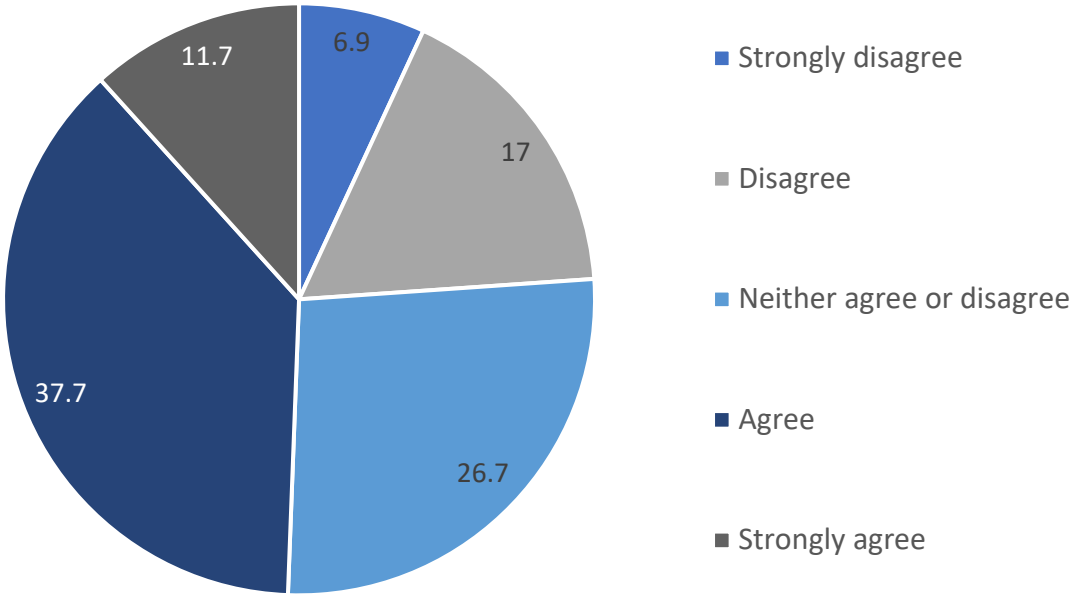


Figure 9.

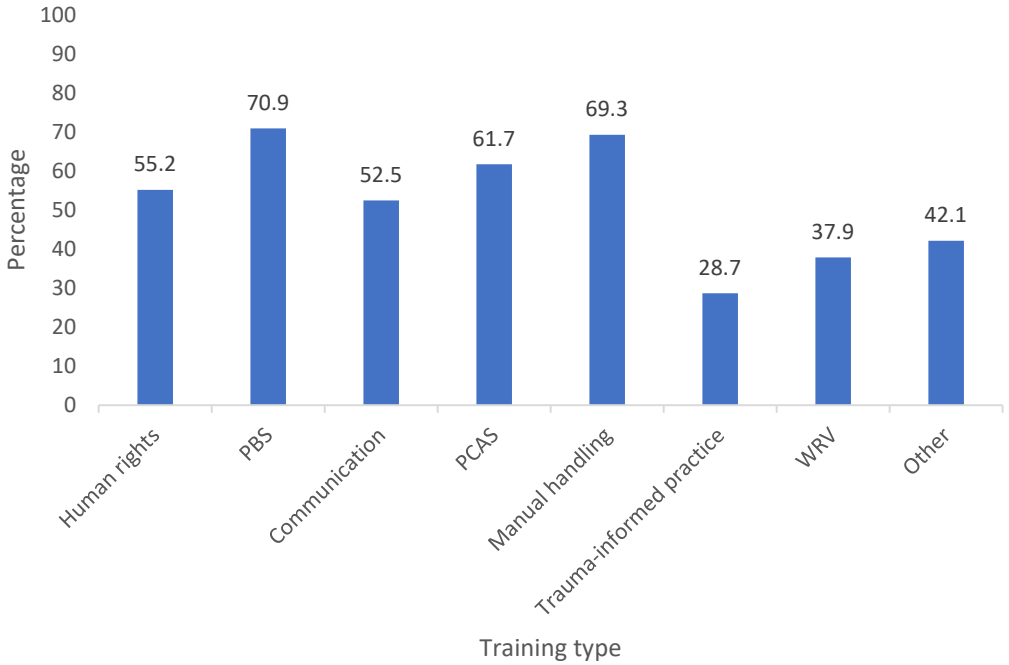
Percentage of survey participants who agreed that induction training prepared them for their role



Additionally, most survey participants had participated in human rights (70.1%), positive behaviour support (80.5%), communication (66.3%), person-centred active support (77%), and manual handling training (83.5%) at some point in their career. However, less than half of the sample had received trauma-informed practice (34.9%), WRV (46.4%), or other training (47.5%; e.g., medication management, seizure management) that may be relevant to managing behaviours of concern.

As seen in Figure 10, the percentage of survey participants who had received those trainings in the previous 2 years was lower than those who had ever received training, suggesting refresher training may be needed.

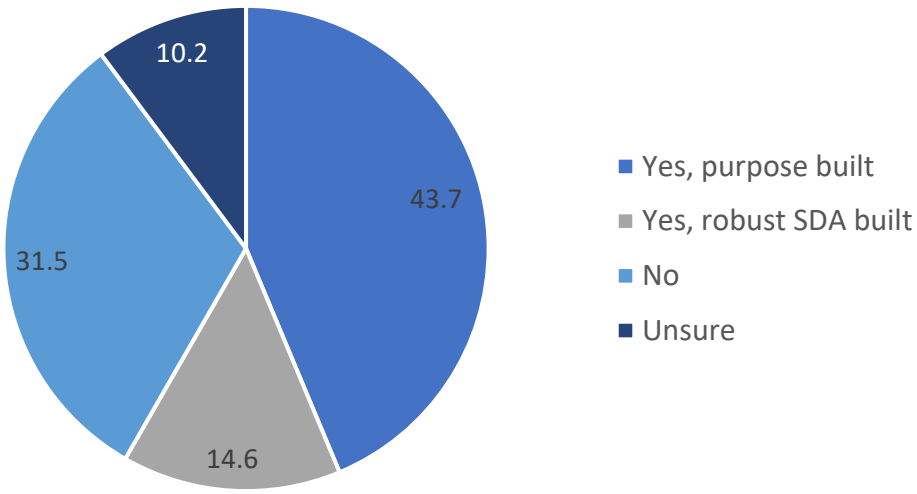
Figure 10.
Percentage of survey participants who had completed training on various topics within the last 2 years



Built Environment

As shown in Figure 11, a little over half of survey participants provided support to residents with a disability in accommodation that was fit-for-purpose (purpose built or specialist disability accommodation (SDA) built; 58.3%). However, a large percentage of participants (31.5%) worked in accommodations that were not fit-for-purpose.

Figure 11.
Percentage of survey participants who worked in accommodations built as a safe space

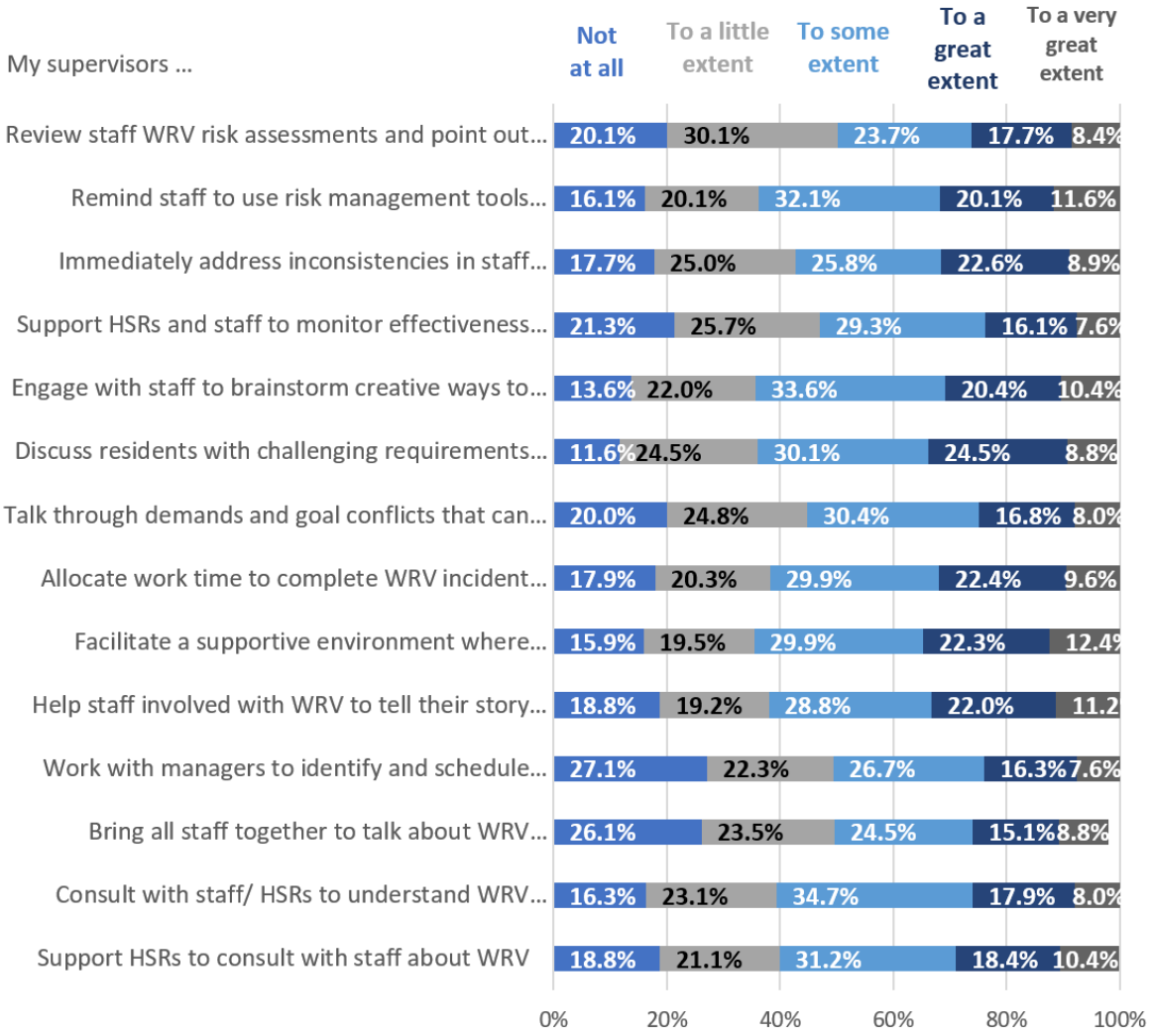


Supervisor safety leadership

The average safety leadership score was 2.78 (*SD* = 1.04; potential range 1-5), indicating that survey participants perceived that their supervisors were engaging in safety leadership behaviours a moderate amount. As seen in Figure 12, approximately 15-20% of participants felt their supervisors did not at all engage in safety leadership behaviours, suggesting there is opportunity for improvement in safety leadership.

Figure 12.
Response rates for items measuring safety leadership

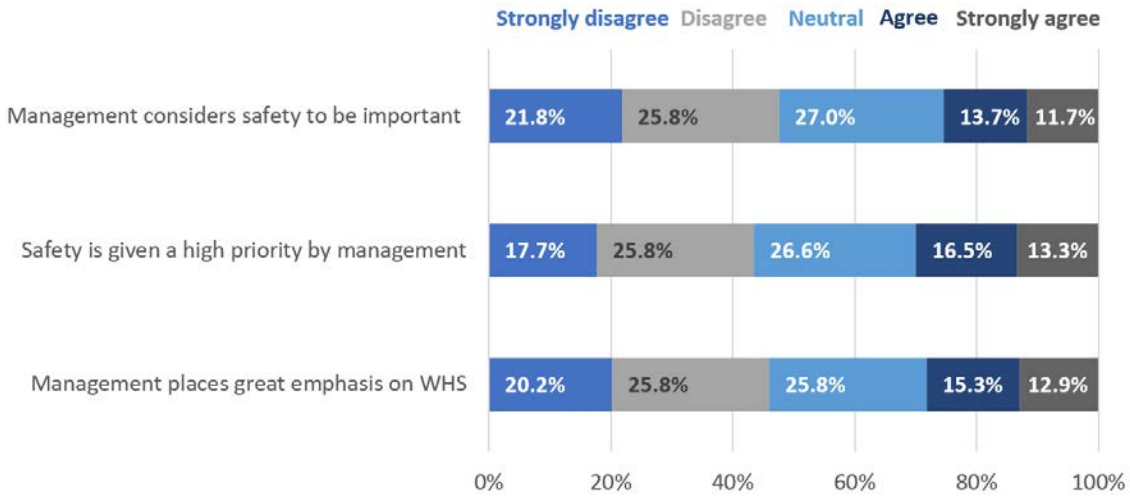
Note. Items have been slightly shortened to fit in the figure. See complete items in Appendix A.



Safety Climate

The average safety climate score was 3.25 (*SD* = 1.23; potential range 1-5), indicating that survey participants viewed senior management as promoting a safety climate to a moderate to high degree. As seen in Figure 13, less participants strongly disagreed or disagreed with each item as opposed to those that were neutral, agreed or strongly agreed.

Figure 13.
Response rates for items measuring safety climate



Qualitative feedback on experiences of WRV

Sixty-six survey participants (25.3%) responded to an open-ended question asking if they wanted to add anything related to WRV not covered by the survey. The key themes with selected quotes are presented in Table 4.

Table 4.
Key themes and supporting quotes

Themes	Supporting quotes
Violence as part of the job	"Management and staff think it [violence] is part of working in Disability." (Participant 189) "Workplace violence (client to staff) is often considered part of the job by support staff." (Participant 200) "There is only so much a workplace can do if the client's support needs are complex and the violence experienced is at times unavoidable." (Participant 237)
Resident safety and regulatory compliance trumps staff safety	"The whole disability sector puts clients first and staff third after family members." (Participant 112) "Management are only concerned with the residents and ticking boxes, not staff and their wellbeing. It is too focused on resident's safety only, and little to no support for staff and their safety." (Participant 116) "It feels more like [employer] are merely doing this [training] to meet legislation criteria rather than because it's what they want to improve their work practices and keep workers safe." (Participant 154) "A participant's right to "choice and control" far outweigh a worker's right to a safe workplace. Hands down, every time." (Participant 260)
Safety leadership	"The disability sector is full of managers with big egos that use their positions to continually threaten workers to change their rosters for no reason but other than bully staff" (Participant 48) "There is not adequate support after violent incidents. Staff often feel unsupported." (Participant 175) "Organization MAY ask you if you are OK after a MAJOR incident &/or advise you that the free counselling service is available if needed. H&S is a well forgotten area of the workplace." (Participant 180)
Reporting culture	"Not all staff report work-related violence as to not get the clients in trouble with their family members. There is not always time to report work related violence within the incident reporting system. Staff have different perspectives on what work related violence actually is." (Participant 73) "Staff are always blamed by management as being incompetent and triggering behaviours." (Participant 225) "A lot of incidents are not reported or deemed not as important as physical violence directed at staff." (Participant 239) "The reason I don't want to do disability work after 25 years is because now if we report incidents management will blame staff for not following procedures or plan, but as we are short staffed, inexperienced staff etc, and a part time workforce, it's almost impossible to follow plans consistently." (Participant 249)

Much of the written feedback described factors contributing to WRV in the residential disability sector as well as successful or desired interventions to prevent or reduce WRV. Therefore, the data was used to inform the systems analysis of WRV incidents in the residential disability sector.

SYSTEMS ANALYSIS OF WRV INCIDENTS IN THE RESIDENTIAL DISABILITY SECTOR

Through consultation with key stakeholders, this study aimed to comprehensively analyse the actors, contributing factors, and prevention strategies for WRV in the residential disability sector.

Methods

Data Collection

The following sources of data were used to inform the systems analysis:

- Semi-structured interviews with key stakeholders from the residential disability sector,
- A workshop with an industry-led Steering Committee,
- A scoping review of established contributory factors across associated care and support sectors (see QUT (2023) for further details on data collection procedures and findings),
- A systematic review of established preventative interventions across associated care and support sectors (see QUT (2023) for more information about data collection procedures), and
- Findings from the survey of workers within the sector (see section 'Workers' experience of WRV in the residential disability sector').

Interviews and workshop

Interview participants *(n* = 31) were recruited via NDS, who advertised the study and invited prospective participants. Interview participants had between 2 and 37 years (*M* = 15.4, *SD* = 9.6) experience in the residential disability sector and between 9 months and 8 years (*M* = 5.3 years, *SD* = 5.7 years) experience in their current role/with their current employer. As seen in Table 5, participants were representative of various systems levels, with the majority (55%) working in an operations management role.

Table 5.
Interview participant stakeholder groups

Stakeholder groups	Number (%)
Government, Regulators and External Influences (e.g., WorkSafe Inspectors)	2 (6.5%)
Organisational Governance and Administration (e.g., CEO, directors, Head of departments, general managers)	7 (22.5%)
Operations Management (e.g., Quality and Practice Managers, Authorised Program Officers, Occupational Health and Safety (OHS) Personnel, Frontline Managers, Behaviour Support Practitioners, and Operations Managers)	17 (55%)
Frontline Staff	5 (16%)

Interviews lasted between 39 and 71 minutes (*M* = 56.6, *SD* = 7.3), were conducted online, and were audio recorded. They were guided by a semi-structured interview schedule adapted to interview

participants' professional roles. The interview schedule intended to capture information on the contributing factors and preventative strategies related to WRV in the sector.

Thematic analysis (Braun & Clarke, 2006) was conducted to generate key themes related to WRV in the residential disability sector. Preliminary findings were presented in a 120-minute workshop to an industry-led Steering Committee to gain feedback regarding the system structure and actors identified at each level, the accuracy of the identified themes, the correct use of terminology, and areas to explore deeper insights.

Systems Analysis Methods

This project utilised three systems analysis approaches, including the ActorMap, AcciMap, and PreventiMap methods, underpinned by Rasmussen's (1997) risk management framework.

ActorMap

The ActorMap (Rasmussen & Svedung, 2000) technique was used to represent the actors who share responsibility for WRV in the residential disability sector. All actors identified in the data sources were compiled and categorised to respective system levels based on the levels described in Rasmussen's (1997) Risk Management framework (see Table 6 for a description of the system levels used to code the data).

Table 6.
Description of system levels described in Rasmussen's (1997) Risk Management Framework

Code/ system level	Description
Government	This level describes the responsibility for safety through laws, policies and provision of funding to ensure that organisations and individuals act responsibly.
Regulators and associations	This level describes the regulation of behaviour through guidance material, and enforcement activities
Company	This level describes the practices within the organisation that influence the health and safety environment.
Management	This level describes the practices that directly influence safety behaviour.
Staff	This level describes the behaviour of those that enact the day-to-day activities of the organisation.
Work	Refers to the work environment including other actors, equipment, and tasks.

AcciMap

The AcciMap (Rasmussen & Svedung, 2000) technique was used to identify the multiple and interacting factors contributing to WRV in the residential disability sector. These factors describe any actions, events, decisions, or conditions that led to a WRV incident.

PreventiMap

The PreventiMap technique (Goode et al., 2016) was used to map known or desired strategies to prevent or reduce WRV in the sector, corresponding to the identified AcciMap factors at each system level.

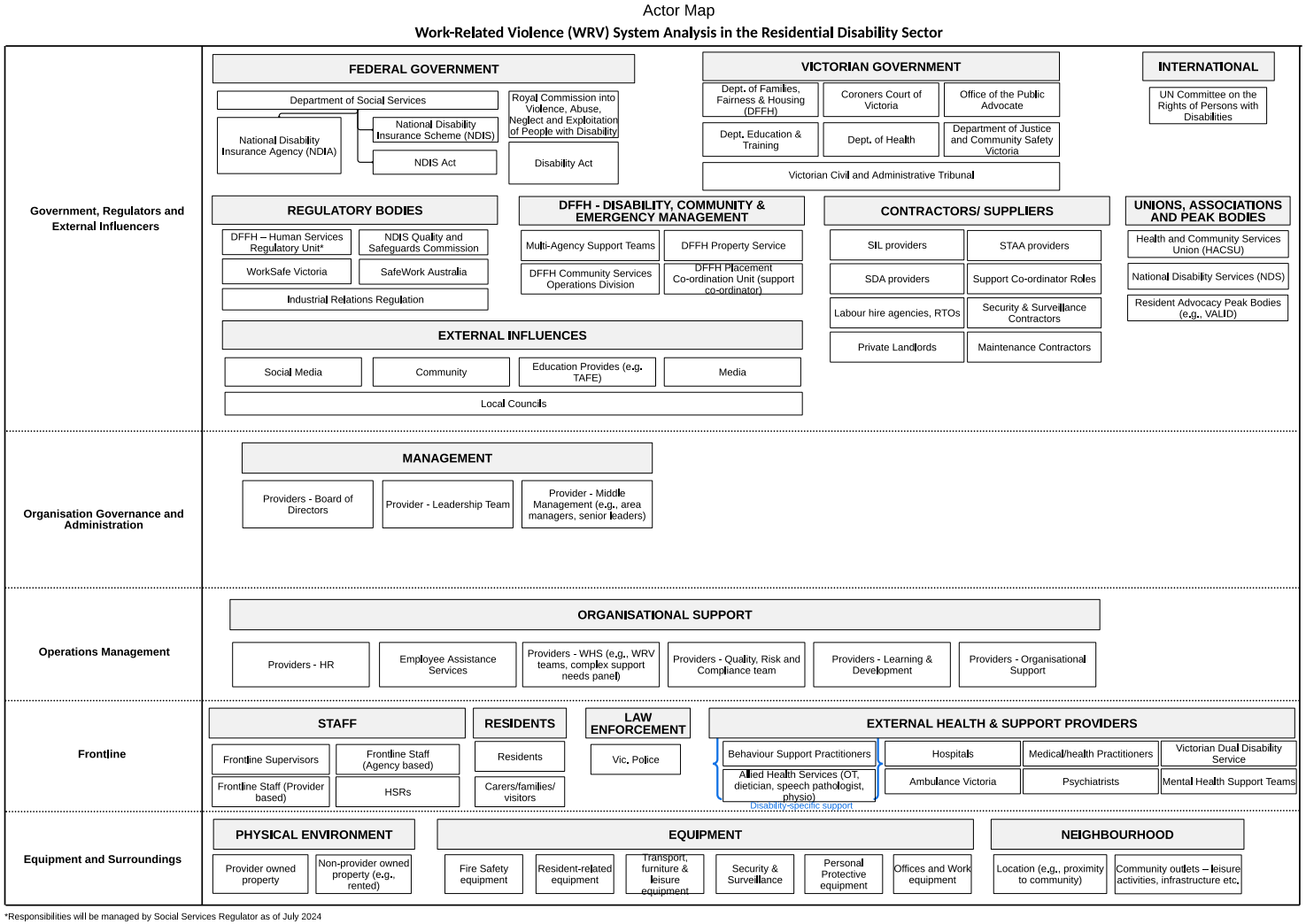
Findings

Actors with shared responsibility for safety

The ActorMap (view the full-sized map here; Figure 14) lists the actors with shared responsibility for safety in the Victorian residential disability sector.

The findings show that WRV in the residential disability sector involves many actors with various responsibilities spanning multiple levels of the disability support system. This map illustrates that WRV is not an issue that can be managed by only a few key actors, but that responsibility for the safety of workers should be shared across the system.

Figure 14. *Actors who share responsibility for managing or preventing WRV in the residential disability sector (ActorMap). Note*. View larger version here.



*Responsibilities will be managed by Social Services Regulator as of July 2024

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Contributory factors and prevention strategies for WRV incidents

The AcciMap (view the full-sized map here; Figure 15) identifies the 135 factors contributing to WRV in the residential disability sector as identified in participant interviews and stakeholder workshops and literature review. The relationships between these factors are described in the sections explaining in the key themes from the analysis.

The PreventiMap (view the full-sized map here; Figure 16) identifies 70 prevention strategies (existing or desired) for WRV in the residential disability sector as identified in participant interviews and stakeholder workshops and literature review.

Figure 15. *Contributing factors to WRV in the residential disability sector (AcciMap). Note*. Red outline = previously identified in the literature (see Phase 1 report; note some factors may be slightly reworded). Dashed outline = identified in survey. Black outline = newly identified in this study. View larger map here.

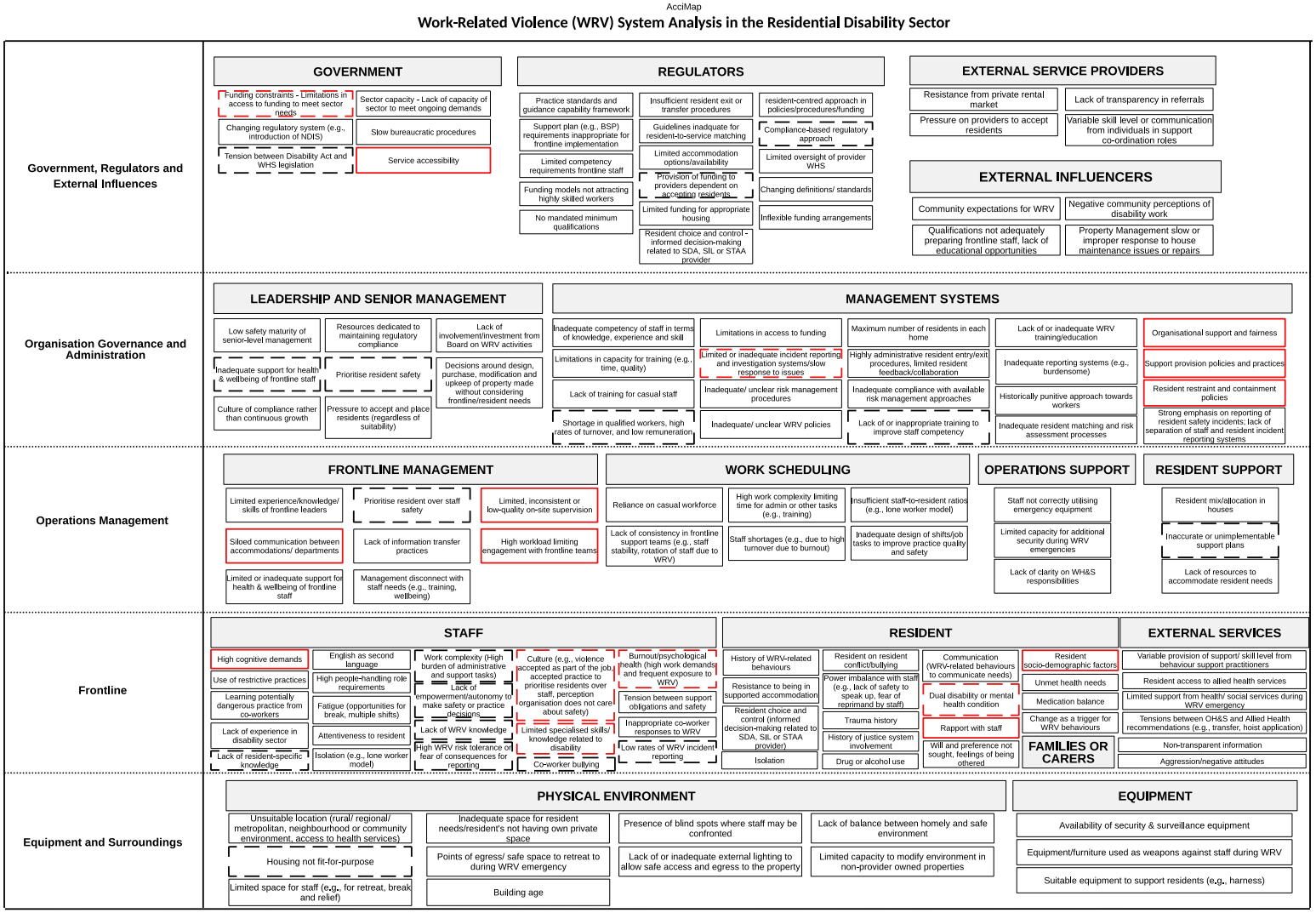
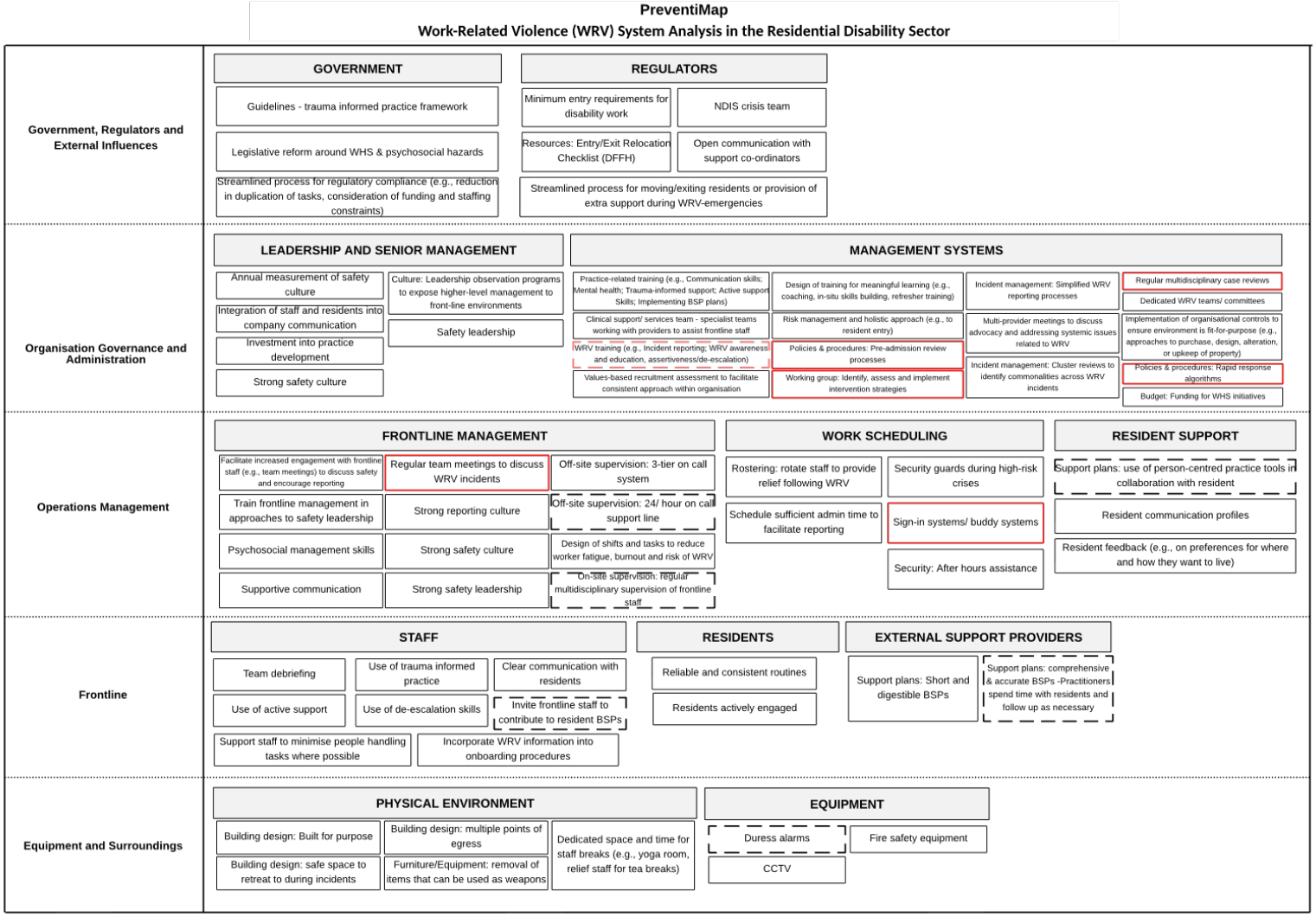


Figure 16. *Prevention strategies to reduce or prevent WRV in the residential disability sector (PreventiMap) Note*. Red outline = previously identified in the literature (see Phase 1 report; note some factors may be slightly reworded). Dashed outline = identified in survey findings. Black outline = newly identified in this study. View larger map here.



Key themes from the systems analysis

Data collection identified several key themes, which capture contributing factors and prevention strategies identified on both the AcciMap and PreventiMap. The key themes generated included: a) the role of staff capabilities in WRV, b) the role of the physical environment in WRV, c) the role of safety culture and safety leadership in WRV, and d) the role of resident compatibility in WRV. The thematic content and corresponding AcciMap and PreventiMap factors for each key theme are presented in the following sections, alongside illustrative quotes from interview participants.

The role of staff capabilities in WRV: Contributing factors (see Appendix A AcciMap)

Limitations in staff capabilities can contribute to WRV, and conversely, highly skilled staff are a protective factor. Stakeholders expressed concern that frontline staff frequently lacked disability-specific education to support them in providing high-quality support to residents and subsequently minimise WRV.

Broader systemic issues influenced this lack of education, including: a) lack of standardised minimum education or English language requirements b) a mobile, casualised workforce and c) reductions in government-funded training programs.

"*We've had the workforce transform in the last decade … now you have staff who have little or no training, maybe a [Certificate] III they've done online, working in highly complex environments*" (Participant 31, Company management)

Stakeholders also felt that frontline staff needed to gain specialised skills to support them in providing high-quality support and contributing to WRV prevention, including WRV-specific skills (e.g., recognising warning signs), person-centred support skills, complex communication skills, and specialised knowledge of disability, mental illness, and trauma.

"*There is a lack of understanding of how behaviour works, and how behaviour change works, as well as different client diagnoses, and how certain approaches or styles of engagement can exacerbate situations*" (Participant 12, Operations management)

Finally, stakeholders observed that staff lacked knowledge about individual residents, their triggers, their behaviours of concern, and strategies to best support them. Participants suggested this lack of knowledge prevented staff from providing tailored support. This was primarily attributed to the length and complexity of behaviour support plans (BSPs), which staff often did not fully engage with due to limited time and resources.

"*We're asking behaviour support people to write 60-page reports … they're writing them for the NDIS, they're not writing them for the people who are going to be implementing them*." (Participant 7, OHS personnel)

Stakeholders highlighted the importance of staff education and training; however, resource constraints were reported to limit opportunities for professional development. Training was often perceived as ineffective and generic, and there was a perceived prioritising of compliance with industry regulations over long-term impactful training on preventing WRV.

The role of staff capabilities in WRV: Prevention strategies (see Appendix A PreventiMap)

Interview participants identified several potential prevention strategies related to staff capabilities across all system levels including:

- More stringent practice frameworks (e.g., related to trauma-informed support) and minimum entry requirements for frontline staff.
- Providing further training to frontline staff to facilitate professional development of knowledge and skills related to disability support (e.g., communication skills, mental health, behaviour support) and WRV (e.g., de-escalation).
- Local supervision from frontline managers (e.g., house manager), and the availability of on-call supports for staff to access when the risk of WRV is elevated.
- Implementing changes to staff behaviour (e.g., using active support, implementing WRV-related strategies, and maintaining consistent resident routines), and accurate, implementable, and digestible behaviour support plans.

The role of the physical environment in WRV: Contributing factors (see Appendix B AcciMap)

Interview participants reported a poorly designed building that was not fit for purpose could contribute to WRV, while a well-designed building could prevent WRV. Examples of poor building design included single points of egress, low visibility for staff, physical furniture that could be used as weapons, inadequate space for residents and staff to navigate safely, narrow doorways that prevented quick access to required support equipment, and the use of low-quality building materials.

"*You need wide corridors into the home for the wheelchairs, you need wide corridors into all the rooms, you need houses that are hardened so that wheelchairs don't keep bashing into walls … you need all of those aspects and you get that with the purpose built homes … but so many of our clients have been institutionalised for a long time and their homes that they're in are still reflective of that institutionalisation*." (Participant 1, Company management)

Factors at the higher system levels largely determine the physical environment. For example, limited funding prevents the development and availability of built-for-purpose accommodations, and prevented residents from moving to better-fit accommodation. It was also noted that limitations in available housing could prevent residents from staying within their communities, contributing to the risk of WRV.

The role of the physical environment in WRV: Prevention Strategies (see Appendix B PreventiMap)

Interview participants identified several potential prevention strategies including:

- The availability of well-designed buildings (e.g., bespoke and designed for specific residents, including private living spaces, multiple points of egress, visibility, and space for staff to seek relief or retreat).
- Providers consideration of removing furniture and equipment that could be used as weapons, whilst also maintaining a therapeutic and homely atmosphere (i.e., avoiding overly hardening the environment to the detriment of resident well-being).
- Internal organisational policies related to the design, procurement, alteration and upkeep of properties (e.g., modification for resident needs).

The role of safety culture and safety leadership in WRV: contributing factors (see Appendix C AcciMap)

Interview participants identified that a significant contributing factor to WRV was provider safety culture and safety leadership.

They felt that frontline staff had accepted violence as part of the job – often excusing violence as a result of resident disability and/ or saw violence as a product of poor support that reflected negatively on staff competence.

"*[There's a] mentality that that's just what [clients] do. You're just going to get hurt. You're just working in that space*." (Participant 31, Company management)"

It was reported that staff tended not to report incidents of violence (particularly psychological and verbal violence) out of fear of repercussions (e.g., losing their job, reprimands).

"*There's really bad stigma around doing incident reports. People are quite often fearful that they'll get in trouble*." (Participant 11, Frontline worker)

Other contributing factors included staff not feeling empowered to protect themselves from WRV (e.g., by taking action such as stepping away from a resident) and an administratively burdensome reporting system which added to the high work complexity faced by frontline staff.

The poor safety culture was driven by higher systemic factors, including management-level messaging around resident safety, which was driven by legislative requirements for reporting on resident safety. There were perceived tensions between applying the Disability Act and safety risk controls (e.g., balancing staff safety with the resident's rights and support responsibilities).

"*We do find that it can go too far towards the client. You know, locking that cabinet might be a restrictive intervention, but we're locking that because it's going to be unsafe for the staff [to have it unlocked]. Not because we want to restrict the client*." (Participant 20, OHS personnel)

Interview participants emphasised the importance of safety leadership in preventing or reducing WRV. Safety leadership encompasses behaviours by people in leadership positions that influence others to prioritise workplace health and safety. Participants noted examples of both good (e.g., leadership consistently communicating that staff safety is a priority, and emphasising the importance of reporting of WRV incidents) and poor (e.g., reprimands for reporting WRV) safety leadership.

"*Setting that clear expectation around how you are to be a leader in this sector, at either a house level, or for a region or a cluster or a state level … it has never been a thing in this sector … If you don't have the leadership around this, nothing's going to shift*." (Participant 1, Company management)

Interview participants noted that the ability of leaders to exhibit safety leadership was constrained by systemic factors. For example:

- Insufficient funding for safety initiatives,
- Limited opportunities for professional development in safety leadership skills,
- Time constraints and heavy workloads hindering reporting and investigation,
- Low entry requirements for leadership positions,
- Inadequate supervision of frontline staff due to shift scheduling,
- Rapidly evolving regulations with a strong compliance focus diverted organisational resources towards maintaining compliance rather than fostering safety leadership.

A clear relationship between safety leadership and safety culture was identified. For example, management's emphasis on reporting (safety leadership) heavily influenced the reporting culture. In turn, safety initiatives could often only be implemented with sufficient evidence from WRV incident reports (safety culture).

The role of safety culture and safety leadership in WRV: Prevention Strategies (see Appendix C PreventiMap)

Interview participants identified several potential preventative strategies were identified across four system levels, including:

- Legislative reform and more stringent regulation of provider OHS & psychosocial hazards to ensure all providers prioritise safety culture and safety leadership within the industry.
- Leaders demonstrating a commitment to both resident and staff safety, alignment of organisational communication to reflect this, and establishing well-funded workplace health and safety and practice quality teams.
- Frontline managers exhibiting safety leadership by implementing workplace health and safety initiatives consistently, holding staff accountable for safety-critical behaviours, fostering a safe and open environment to discuss WRV and related issues such as burnout and mental health, and scheduling appropriate time to allow staff to report incidents.
- Strengthening reporting culture by encouraging staff to routinely report incidents.

The role of resident compatibility in WRV: contributing factors (see Appendix D AcciMap)

Resident compatibility refers to the match between the client and the provider, other residents, and the physical environment of the accommodation. Interview participants stated that a good match can reduce potential for WRV, while a poor match can increase the risk of WRV. Residents who are not suited to living together (e.g., significant age discrepancies between residents), causes tension and potentially leads to behaviours of concern and violence.

"*The different clients we work with and their various backgrounds, trauma histories, or offences might mean that the profile of another client doesn't sit well with one of the other clients. That causes friction in the house and staff have to intervene and manage* that." (Participant 12, Operations management)

Participants described how difficulties with the resident intake process can contribute to a poor match. For example, receiving limited or inaccurate information about resident behaviours and needs and systemic pressure (e.g., from the court system) to accept residents even when there were indicators of potential issues.

Interview participants noted that there were limited exit pathways or alternative accommodations for residents, who already have minimal choice in their living arrangements. This was particularly relevant for residents who had previously engaged in WRV towards staff members, as staff must return to this high-risk environment with limited options for relief during the lengthy process of requesting resident transfer/ exit via the NDIS.

"*There has been times where the program wanted to exit the client … it takes time and it's not always a guarantee because where are we going to exit them to? We don't want to exit them into homelessness, but we also want to provide a safe working environment for our people*." (Participant 19, OHS personnel)

Several systemic issues were identified that contribute to resident incompatibility. For example, inadequate funding for individualised resident accommodation or adapting accommodation, regulations prioritising resident acceptance over compatibility, organisational dependence on accepting residents for funding regardless of suitability, and a scarcity of alternative specialist disability support options.

The role of resident compatibility in WRV: Prevention Strategies (see Appendix D PreventiMap)

Interview participants identified several potential preventative strategies were identified across the system levels, including:

- A need for more stringent regulation to ensure residents are placed in appropriate residences
- Provision of support during crises relating to resident mix.
- Streamlined processes to allow for residents to move or exit when there is a high risk of WRV.
- The use of risk management resources, pre-admission reviews and a holistic approach to intake was suggested to prevent inappropriate client mix.
- Seeking resident feedback on their satisfaction with their home environment and resident intake decisions (e.g., resident mix) and using this information to support moving of residents where necessary.

OPTIONS FOR CONSIDERATION

The evidence from this project has been used to develop options for consideration for stakeholders across system levels to reduce and prevent WRV in the Australian residential disability sector. These options and their supporting evidence are summarised in Tables 7 – 9.

Table 7.
Options for government bodies and regulators

Options for consideration	Supporting evidence
Increase provider access to funding - to attract and retain highly skilled multidisciplinary staff	• Key theme: Staff Capabilities • Previously suggested by NDS (2023)
Review and redefine staff competency requirements in alignment with best care practices	• Key theme: Staff Capabilities
Increase provider access to funding - for the provision of relevant and timely education for staff and enable staff attendance	• Key theme: Staff Capabilities • Figure 9 and 10: Training experiences • Table 4: Resident safety and regulatory compliance trumps staff safety
Align regulatory obligations for providers by adopting a balanced regulatory approach that prioritises safety for all people (including residents and staff)	• Key theme: Staff Capabilities • Figure 19: Safety Culture and Safety Leadership • Figure 15: Regulators • Table 4: Resident safety and regulatory compliance trumps staff safety
Streamline regulatory compliance frameworks to reduce administrative burden associated with compliance (e.g., reporting, review of incidents)	• Key theme: Safety Culture and Safety Leadership
Regulate reporting of OHS incidents affecting staff (e.g., WRV incidents) in the same manner as violence against residents	• Key theme: Safety Culture and Safety Leadership • Figure 3: Reporting mechanisms to report WRV incidents • Table 4: Resident safety and regulatory compliance trumps staff safety; Reporting culture
Provision of WRV incident report summaries to industry to support practice improvements	• Key theme: Safety culture and leadership
Encourage a consistent framework for resident intake into accommodation clarifying procedures for holistic assessment of resident suitability flexible to context and that includes consultation and information sharing	• Key theme: Resident Compatibility • Key theme: Physical environment (e.g., suitability of existing accommodation environment o to resident needs)
Provide regulatory guidance for providers in relation to environment suitability e.g., maximum number of residents allowed in each home, taking into account factors such as space availability and support needs	• Key theme: Physical Environment
Provide regulatory guidance for entry, exit and return from health settings (e.g., hospital) to include current state support needs and areas of concern and staffing capabilities required	• Key theme: Staff Capabilities • Key theme: Resident Compatibility
Provide clarity on regulatory requirements to facilitate access to funds for housing development and adaptation	• Key theme: Physical Environment
Ensure regulatory guidance relating to housing options includes consultation with residents to ensure compatibility with resident preferences	• Key theme: Resident Compatibility

Table 8.
Options for organisational governance and management

Recommendation	Supporting evidence
Provide funding and access for relevant staff education & professional development (e.g., coaching/mentoring programs, opportunities for supervision, team meetings, debriefs)	• Key theme: Staff Capabilities • Figures 7-9
Provide adequate support and resources to address cognitive demands (e.g., assistive technology, additional staff)	• Key theme: Staff Capabilities
Demonstrate leadership commitment to staff safety by increasing leadership investment/ involvement in WRV activities and discussions	• Key theme: Safety Culture and Safety Leadership • Table 4: Resident safety over staff safety; Safety Leadership
Implement and review rigorous recruitment, selection, induction and training processes to ensure optimal safety leadership recruitment	• Key theme: Safety Culture and Safety Leadership
Design work shifts and tasks to optimise staff safety, including the presence of on-site supervision	• Key theme: Staff Capabilities
Ensure ongoing consultation with residents and frontline workers in decision making process related to the design and modification of properties to ensure all needs are met	• Key theme: Physical Environment
Employ a supportive rather than punitive approach to compliance, emphasising learning and improvement rather than blame	• Key theme: Safety Culture and Safety Leadership
Strengthen resident matching within risk management procedures to address compatibility issues	• Key theme: Resident Compatibility
Ensure space available for residents privacy and to 'not engage' i.e., with support staff or other residents	• Key theme: Physical Environment • Key theme: Resident Compatibility • Figure 11: Fit-for-Purpose Homes
Accurately define and communicate work demands, responsibilities and capabilities in recruitment, selection and induction practices	• Key theme: Staff Capabilities
Implement and monitor end to end reporting systems including consultation with staff for corrective actions and communication of outcomes	• Figure 3: Reporting mechanisms to report WRV incidents • Table 4: Reporting Culture • Key theme: Safety Culture and Safety Leadership
Provide appropriate training and professional development opportunities for staff and **implement auditing procedures** for completion, knowledge retention and skill development	• Figure 9 and 10: Training experiences • Table 4: Resident safety and regulatory compliance trumps staff safety • Key theme: Role of Staff Capabilities
Promote a culture of openness and accountability - encouraging staff to freely acknowledge skill gaps without concern for negative consequences	• Figure 9 and 10: Training experiences • Table 4: Resident safety and regulatory compliance trumps staff safety

Table 9.
Options for frontline staff

Recommendation	Supporting evidence
Actively encourage colleagues to report WRV incidents and engage in organisational health & safety consultation obligations	• Key theme: Safety Culture and Safety Leadership • Figure 3: Table 5 Reporting culture
Actively engage in and seek out ongoing training and professional development opportunities provided	• Key theme: Staff Capabilities • Figures 7-9

CONCLUSIONS AND NEXT STEPS

Considered together, Phases 1 (see QUT (2023)) and 2 of this project have provided novel insights into residential disability workers' experiences of WRV. This research is the first comprehensive investigation into the complex web of contributory factors and prevention strategies for WRV in the sector, underpinned by systems-thinking principles.

In consideration of these findings, this work has presented several options to reduce and prevent WRV in the sector, including for government, regulators and external influences, organisational governance and management, and frontline staff. These options align with those presented in reports from key sector stakeholders (e.g., HACSU, 2021; NDS, 2023, 2022). Any prevention strategies that are implemented should be evaluated for their effectiveness in preventing or reducing WRV and promoting positive staff and resident outcomes.

The findings and recommendations will be presented at an industry forum in June 2024 to facilitate translation into policy and practice.

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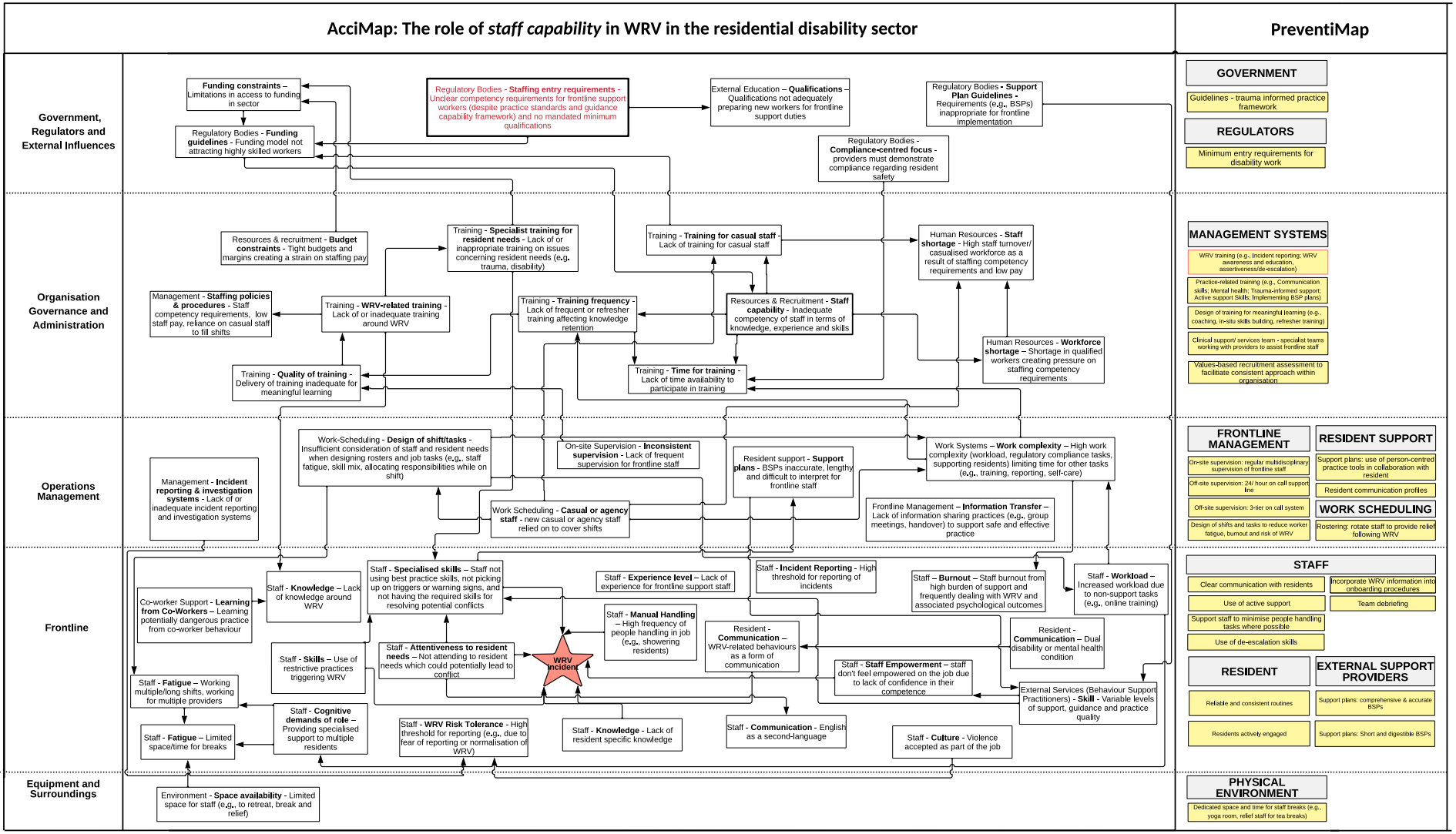
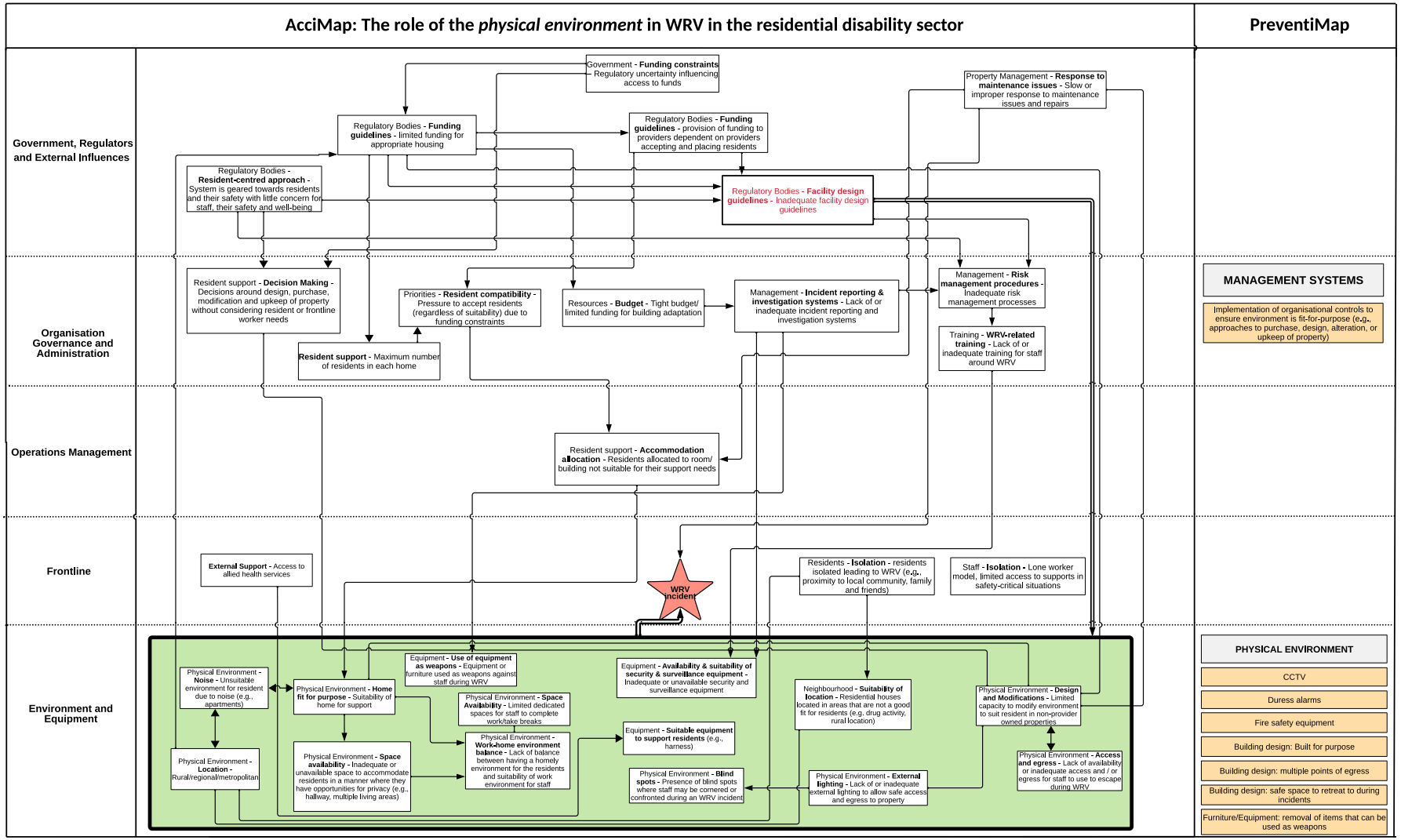
Appendix A: AcciMap and PreventiMap demonstrating how staff capabilities are related to WRV in the residential disability sector



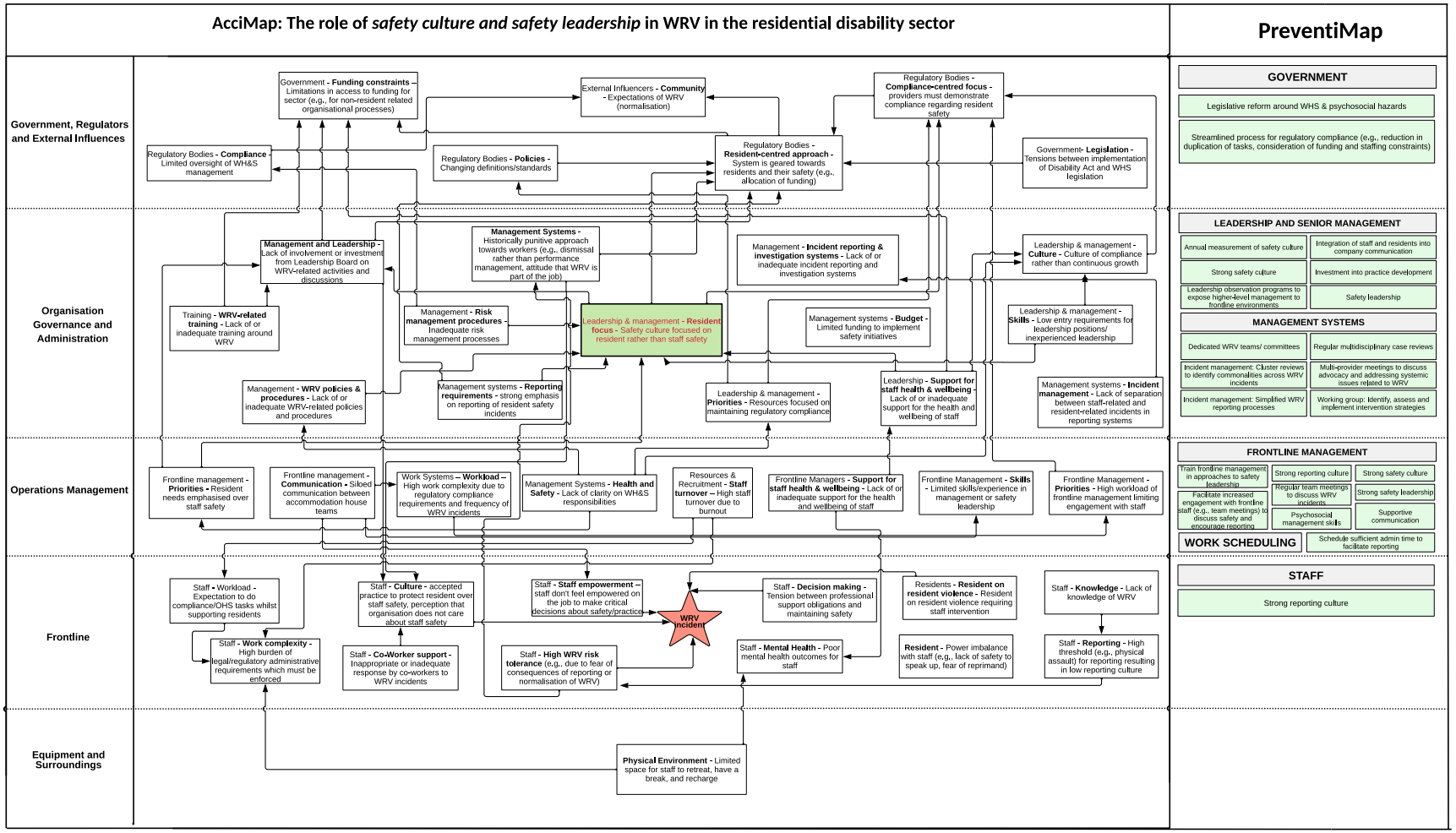
Note. View larger map here.

Appendix B: AcciMap and PreventiMap demonstrating how the physical environment relates to WRV in the residential disability sector



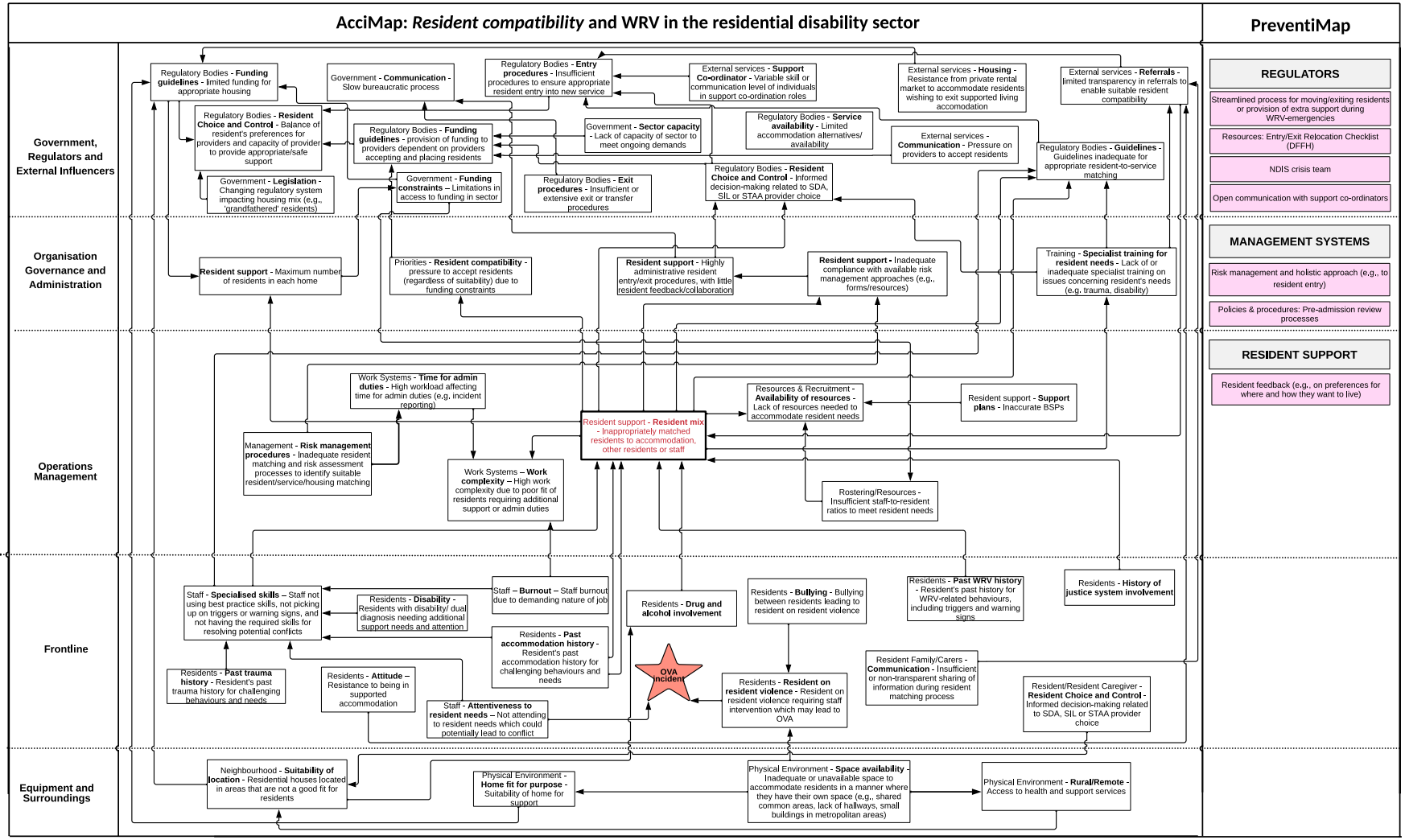
Note. View larger map here.

Appendix C: AcciMap and PreventiMap demonstrating how safety culture and safety leadership relates to WRV in the residential disability sector.



Note. View larger map here.

Appendix D: AcciMap and PreventiMap demonstrating how resident compatibility relates to WRV in the residential disability sector.



Note. View larger map here.

Further information

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