

Workplace violence in the health sector

State of the Art

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Contents

	<i>Page</i>
Executive summary	v
Introduction. Cary L. Cooper, University of Manchester Institute of Science and Technology, England, and Naomi Swanson, National Institute of Occupational Safety and Health, Cincinnati, Ohio, United States	1
Section 1. Workplace violence: Scope, definition and global context, Phil Leather, University of Nottingham, United Kingdom	3
Section 2. Information collection and reporting of violence at work in the health sector, Robyn R.M. Gershon, Columbia University, United States.....	19
Section 3. Existing evidence of the prevalence of violence in health services within different geographical, social, and economic settings, E. Lynn Jenkins, National Institute for Occupational Safety and Health, Division of Safety Research, Morgantown, West Virginia, United States.....	27
Section 4. Origins of violence at work, Barbara Curbow, John Hopkins School of Hygiene and Public Health, United States.....	35
Section 5. Knowledge about the impact of violence at work in the health sector, Elizabeth A. Stanko, Royal Holloway and Bedford College, University of London, United Kingdom	49
Section 6. Approaches to anti-violence action and achieved impact in the health sector, Naomi G. Swanson, Paula L. Grubb and Steven L. Sauter, National Institute for Occupational Safety and Health, Cincinnati, Ohio, United States.....	61
Section 7. Recommendations for future research on violence within the health sector, Cary L. Cooper and Helge Hoel, University of Manchester Institute of Science and Technology (UMIST), United Kingdom	71

Executive summary

Violence has become an issue of increasing concern in the workplace over the past 15 years, particularly in Europe, Australia and North America. In the United States, 85 per cent of all non-fatal assaults occur in retailing and service industries.¹ Within the service sector, health-care workers are at particular risk of workplace violence, with one author estimating that health-care workers face 16 times the risk of violence from patients/clients that other service workers face.² A recent United Kingdom study indicates that abusive actions from fellow workers (e.g., harassment, bullying/mobbing) may also be pervasive in health care. In this study, nearly 40 per cent of the NHS trust staff reported being bullied in the previous year.³ It is clear from these, and many other studies, that violence in the health-care sector needs to be addressed.

Definition of workplace violence

There are a number of definitions of workplace violence, with some defining it only in terms of actual or attempted physical assault,⁴ and others defining it as any behaviour intended to harm workers or their organization.⁵ Given that non-physical abuse, such as verbal abuse and threats, can have severe psychological and career consequences,⁶ a broad definition of workplace violence will be used in this document. We use the WHO⁷ definition of workplace violence as, “The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation”.

¹ BLS (1994). *Violence in the workplace comes under close scrutiny*. Washington, DC: United States Department of Labor, Bureau of Labor Statistics.

² Elliott, P. (1997). Violence in health care: what nurse managers need to know. *Nursing Management*, 28, 12, 38-41.

³ Quine, L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. *British Medical Journal*, 318, 228-32.

⁴ Kraus, J.F., Blander, B. and McArthur, D.L. (1995). Incidence, risk factors and prevention strategies for work-related assault injuries – a review of what is known, what needs to be known, and countermeasures for intervention. *Annual Review of Public Health*, 16, 355-379.

⁵ Folger, R. and Baron, R.A. (1996). Violence and hostility at work: a model of reactions to perceived injustice. In G. R. VandenBos & E. Q. Bulatao (eds.): *Violence on the Job*, Washington, DC: American Psychological Association.

⁶ Flannery, R.B., Hanson, M.A., and Penk, W.E. (1995). Patients' threats: Expanded definition of assault. *General Hospital Psychiatry*, 17(6), 451-53.

⁷ WHO (1995). *Violence: a public health priority*. Geneva: World Health Organization.

Prevalence of violence in different geographical locations

The true incidence of violence in the health-care setting is difficult to estimate, given the different definitions of workplace violence that may be adopted by different agencies, different data collection systems for different types of violence (e.g., homicides may be reported to different systems than non-fatal injuries), and significant under-reporting of violence incidents by health-care workers. Also, the majority of data on workplace violence come from a few geographical areas, namely northern Europe, the United Kingdom, North America, and Australia. Following are examples. In the United Kingdom, compared to the average risk for assaults and threats across all occupations, health-care workers have a three to four times higher risk for these forms of violence.⁸ In Finland, one in ten health-care workers reports experiencing a work-related violent incident within the past year,⁹ and approximately one-third of Swedish nurses have experienced violence at some point within their careers.¹⁰ In British Columbia, nurses have nearly four times the incidence of violence of any other profession,¹¹ and 73 per cent of the doctors working in rural areas in Australia report experiencing work-related verbal abuse and threats.¹² Data from developing nations is virtually non-existent, and the level of violence against health-care workers in these countries is largely undocumented.

Origins of violence in the health-care sector

Workplace violence has its origins in a number of factors. Individual factors may play a role. For example, female gender of workers, or mental illness, alcohol or drug use in patients, may heighten the risk of violence to health-care workers.^{13, 14} Organizational factors may play a role as well. Environmental factors, such as poor lighting, poor security, and accessibility of objects that can be used as weapons, can increase the risk of violence. Understaffing may increase the risk of violence due to longer patient wait times and workers being alone with patients.¹⁵ Workplace stressors, such as low supervisor support,

⁸ Health and Safety Executive (October, 1999). *Violence at Work: Findings from the British Crime Survey*. Home Office Information and Publications Group; Research, Development and Statistics Directorate, London.

⁹ Saarela, K.L. and Isotalus, N. (1999). Workplace Violence in Finland: High-risk groups and preventive strategies. *American Journal of Industrial Medicine Supplement 1*, 80-81.

¹⁰ Arnetz, J.E., Arnetz, B.B. and Petterson, I.L. (1996). Violence in the nursing profession: occupational and lifestyle risk factors in Swedish nurses. *Work & Stress*, 10, 119-127.

¹¹ Sibbald, B. (1998). Physician, protect thyself. *Canadian Medical Association Journal*, 159 (8), 987-989.

¹² Perrone, S. (1999). *Violence in the Workplace*. Australian Institute of Criminology Research and Public Policy Series No. 22.

¹³ Boyd, N. (1995). Violence in the workplace in British Columbia: A preliminary investigation. *Canadian Journal of Criminology*, (Oct.), 491-519.

¹⁴ Arnetz, J.E. (1998). The Violent Incident Form (VIF): A practical instrument for the registration of violent incidents in the health care workplace. *Work & Stress*, 12, 17-28.

¹⁵ Levin, P.F., Hewitt, J.B. and Misner, S.T. (1998). Insights of nurses about assault in hospital-based emergency departments. *Image: Journal of Nursing Scholarship*, 30, 249-254.

work overload, poor workgroup relationships, or impending workplace changes, such as downsizing or restructuring, may also increase the risk of aggression in the workplace.^{16, 17} Health-care settings are embedded in communities, which may influence the type or level of workplace violence experienced. High levels of violent crime, drug use or gang activity within a community, low levels of community resources, and mistrust or miscommunication between minority residents and majority providers, may contribute to violence in the health-care setting.¹⁸ Finally, larger societal factors, such as changing societal norms around the acceptance of aggression¹⁹ or downsizing²⁰ may have an impact on the risk for workplace violence. Health-care workers also provide care in dangerous environments, such as among war refugees or in war-torn regions, which by their nature expose the workers to heightened physical and mental hazards.²¹

Impact of workplace violence

Violence at work can trigger a range of physical and psychological outcomes in victims. For example, nearly one-half of all assaults at work in Great Britain caused some type of physical injury, ranging from bruises to broken bones. Most victims of workplace violence also report being affected emotionally by the experience.²² Emotional experiences to physical and emotional violence can include anger, shock, fear, depression, anxiety and sleep disruption. Additionally, workplace violence may affect a worker's career. Those who are bullied at work are much more likely to report planning to leave their jobs,²³ and patient assault and verbal abuse may have a similar impact although the latter has been little studied. There is virtually no information about the financial impact of workplace violence on individuals, in terms of lost wages from time off work or negative coping strategies, such as increased intake of drugs, alcohol and cigarettes. Health service delivery may suffer from the threat of workplace violence. If health-care providers fear a population they are serving, the quality of care they deliver may suffer as a consequence.

¹⁶ Cole, L.L., Grubb, P.L., Sauter, S.L., Swanson, N.G., and Lawless, P. (1997). Psychosocial correlates of harassment, threats and fear of violence in the workplace. *Scandinavian Journal of Work Environment and Health*, 23, 450-457.

¹⁷ Zapf, D., Knorz, C. and Kulla, M. (1996). On the relationship between mobbing factors, and job content, social work environment, and health outcomes. *European Journal of Work and Organizational Psychology*, 5 (2), 215-237.

¹⁸ Levin, P.F., Hewitt, J.B. and Misner, S.T. (1998). Insights of nurses about assault in hospital-based emergency departments. *Image: Journal of Nursing Scholarship*, 30, 249-254.

¹⁹ Kelleher, M.D. (1997). *Profiling the lethal employee*. Westport, CT: Praeger.

²⁰ McClure, L.F. (1999). Origins and incidence of workplace violence in North America. In T.P. Gullotta and S.J. McElhaney (eds.): *Violence in homes and communities: Prevention, intervention, and treatment*. Thousand Oaks, CA: Sage Publications, pp. 71-99.

²¹ WHO (2000). *Consultative meeting on management and support of relief workers*. www.who.int/eha/resources/

²² Budd, T. (1999). *Violence at Work: Findings from the British Crime Survey*. London: Home Office.

²³ Quine, L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. *British Medical Journal*, 318, 228-32.

Aggressive patients in long term care may be treated more forcibly by staff, be restrained more frequently, and face the possibility of abuse by the care givers.^{24, 25}

The most common employer action for reducing violence against health-care workers is training on how to minimize and manage violence.²⁶ However, there is no information about the cost of this training to employers, or how effective these programmes are for preventing violence. There is also little information about the costs or effectiveness of more comprehensive employer monitoring and safety programmes.

Prevention of workplace violence

In the last ten years, there has been a proliferation of violence prevention (or anti-violence) actions recommended for the health-care industry by governmental agencies and violence experts (i.e., OSHA²⁷). The recommendations can be divided into prevention actions for patient/client violence, and prevention actions for co-worker violence, although there is overlap between the two. Any prevention programme requires strong commitment from the health-care administration, and a clear written programme/policy for job safety and security which is communicated to all personnel. Additional preventive measures target the physical environment (e.g., removing items that can be used as weapons, proper lighting, security cameras, alarm buttons, etc.), and address administrative controls and training/education programmes for employees. Job stressors, such as high workload demands or poor communication between staff members, may increase the risk of both patient or co-worker abuse, and job redesign may be necessary to reduce stressors. Most recommendations state the need for a monitoring system which assesses the numbers, types and severity of violence and injuries within an institution, and which can be used to assess the effectiveness of prevention actions.

Monitoring/data collection

Uniform categories and definitions for violence in the health-care setting are needed. Within an institute, prompt, consistent reporting of violence incidents, and a standard format for reporting them can greatly improve violence monitoring and prevention activities. See, for example, OSHA²⁸ for guidelines on conducting worksite analyses, keeping and tracking records, and conducting employee surveys to identify risk factors for violence, as well as a sample incident report form, employee survey and security checklist.

²⁴ Brennan, S. (1999). Dangerous liaisons. *Nursing Times*, 44, 30-32.

²⁵ Saverman, B.-I., Astrom, S., Bucht, G. and Norberg, A. (1999). Elder abuse in residential settings in Sweden. *Journal of Elder Abuse and Neglect*, 10(1/2), 43-60.

²⁶ Stanko, E. (1996). "Warnings to Women: Police Advice and Women's Safety in Britain" *Violence Against Women March*, 2(1), 5-24.

²⁷ OSHA (1998). *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. Washington, DC: United States Department of Labor, Occupational Safety and Health Administration, OSHA 3148.

²⁸ *ibid.*

Research gaps and recommendations

Better (standardized, valid, reliable) research instruments need to be developed, and uniform categories and definitions for violence need to be agreed upon.

Studies need to include a broader range of health-care settings than clinic/hospital settings (e.g., emergency/ambulance care and home health-care environments), and need to examine how risk factors may vary across settings.

More emphasis needs to be given to employee conflict/bullying and the role of organizational factors on such conflicts.

There needs to be research on the full range of impacts of workplace violence beyond the traditionally examined individual physical and emotional outcomes. This includes the impact on a victim's personal life and financial situation, coping strategies, costs of absenteeism/time away from work, etc.

Various intervention and violence rehabilitation programmes need to be assessed and their effectiveness determined. Assessments should include costs and financial, health and safety benefits of these programmes.

Studies need to be done in developing countries to assess the prevalence and types of violence against health-care workers, and to determine effective violence intervention/prevention programmes.

Introduction

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Violence at work has become an alarming phenomenon worldwide. The real size of the problem is largely unknown and recent information shows that the current knowledge is only the tip of the iceberg. The enormous cost of violence at work for the individual, the workplace and the community at large, is becoming more and more apparent. Violence includes both physical and non-physical violence. Violence is defined as being destructive towards another person. It finds its expression in physical assault, homicide, verbal abuse, bullying, sexual harassment and mental stress.¹ Violence might be defined differently in different socio-cultural environments, and violence at work is often considered to be “just” a reflection of the more general and increasing phenomenon of violence in many areas of social life which has to be dealt with at the level of the whole society. Its prevalence has, however, shown increasing impact at the workplace which has *traditionally* been viewed, although not substantiated, as a violence-free environment. Employers and workers are therefore equally interested in violence prevention at the workplace. Society at large has a stake in preventing violence from spreading into working life and hence in recognizing the potential of the workplace to remove such obstacles to productivity, development and peace.

Violence occurs in all work environments. However, some economic sectors are particularly exposed to violence, such as the health services sector and related social services. Since this workforce is in its large majority female, the gender dimension of the problem is very evident. Besides the concern about the human rights of health workers to have a decent work environment, there is the concern about the consequences of violence at work which has a significant impact on the efficiency and effectiveness of health systems at large, particularly in developing countries. The equal access to primary health care is endangered if the scarce human resources, the health workers, feel under threat in certain geographical and social environments, in situations of general conflict, in work situations where transport to work, shift work and other health sector specific conditions make this work unacceptable. In such situations, the best educational system, labour market policies and workforce planning might have no impact.

This State of the Art paper explores the literature and issues associated with violence in the health sector. It draws on the expertise of leading international experts in the field of “violence at work”, getting them to focus on the health sector. We assess in this paper the scope, definition and global context of workplace violence, information and reporting of violence, existing evidence of the prevalence of violence, the origins of violence, the impact of violence, and prevention and interventions to minimize workplace violence in the health sector. The final section highlights some of the gaps in research and practice.

¹ Hoel, H., Rayner, C., and Cooper, C.L. (1999). Workplace Bullying. In Cooper C.L. and Robertson I.R. (eds.): *International Review of Industrial and Organizational Psychology*. New York & Chichester: John Wiley & Sons, pp. 195-230.

Section 1

Workplace violence: Scope, definition and global context

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Contents

	<i>Page</i>
The rise of workplace violence in the health sector	9
Explaining health-care settings as violence prone workplaces	13
Patient factors	15
Situational factors.....	16
Conclusions	18

The late 1980s and 1990s have seen a rapidly increasing concern with the burgeoning problem of workplace violence, particularly in North America, Europe and Australia.^{1, 2, 3, 4} Along with a surge in research interest has come a plethora of published guidance at the national and professional/occupational levels.^{5, 6, 7, 8, 9, 10, 11} Research and intervention alike were underpinned by a growing realization that violence was becoming a common reality in many workplaces the world over. Indeed, in the eyes of many commentators, the problem of workplace violence has risen to the point where, in many countries, it represents a “national epidemic”¹² and “an occupational health problem of significant proportion”.¹³

Although all researchers and practitioners are undoubtedly united in their quest to “do something” about the problem of workplace violence, there are some major difficulties to

¹ VandenBos, G.R. and Bulatao, E.Q. (eds.) (1996): *Violence on the Job*. Washington, DC: American Psychological Association.

² Chappell, D. and Di Martino, V. (1998): *Violence at Work*. Geneva: International Labour Office.

³ Giacalone, R.A. and Greenberg, J. (eds.) (1997): *Antisocial Behaviour in Organizations*. Thousand Oaks, CA: Sage.

⁴ Leather, P., Brady, C., Lawrence, C., Beale, D. and Cox, T. (eds.) (1999): *Work-Related Violence: Assessment and Intervention*. London: Routledge.

⁵ Bowie, V. (1996). *Coping with Violence. A Guide for the Human Services*. London: Whiting and Birch.

⁶ Health and Safety Executive (1996). *Violence to Staff at Work: a Guide for Employers*, IND(G)69L (Rev). Sudbury, Suffolk: HSE Books.

⁷ California Occupational Safety and Health Administration (Cal/OSHA) (1995). *Cal/OSHA Guidelines for Workplace Security*, San Francisco, CA: State of California Department of Industrial Relations, Division of Occupational Safety and Health.

⁸ NHS Executive and the Royal College of Nursing (1998). *Safer Working in the Community: A Guide for NHS Managers and their Staff in Reducing the Risks from Violence and Aggression*, London: Royal College of Nursing.

⁹ Occupational Safety and Health Administration (1996). *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*, OSHA 3148-1996. Washington, DC: United States Department of Labor, Occupational Safety and Health Administration.

¹⁰ Poyner, B. and Warne, C. (1988). *Preventing Violence to Staff*. Health and Safety Executive. London: HMSO.

¹¹ Wynne, R., Clarkin, N., Cox, T. and Griffiths, A. (1997). *Guidance on the Prevention of Violence at Work*. Luxembourg: European Commission, DG-V.

¹² NIOSH (1992). *Homicide in the US Workplace: a Strategy for prevention and Research*. Department of Health and Human Services, Public Health Service, Centers for Disease Prevention, National Institute for Occupational Safety and Health (NIOSH Publication No. 92-103). Washington, DC: United States Government Printing Office.

¹³ Fletcher, T.A., Brakel, S.J and Cavanaugh, J.L. (2000). Violence in the workplace: new perspectives in forensic mental health services in the USA. *The British Journal of Psychiatry*, 176, 339-344.

be overcome when trying to summarize findings and experiences both from around the world and within a single country, profession or occupation. At the national level, there are widespread differences between countries in their awareness and recognition of the very problem of workplace violence. A recent cross-national study,¹⁴ for example, showed wide variation between European countries in the extent to which violence on psychiatric wards was recognized and acknowledged. The Netherlands and Italy lag behind Norway, Sweden and the United Kingdom in respect to both the research attention given to violence on psychiatric wards and the amount of education and training offered to staff as a means of combating it.

As Poster¹⁵ points out, in different countries the meaning of workplace violence is embedded in different socio-political realities. These different socio-political realities give rise both to different conceptions of the very nature and character of the problem itself, as well as acceptable ways of tackling it. The most obvious example of this is the predominant emphasis given to “worker-on-worker” violence in American treatments of the subject,¹⁶ compared to the client or customer-initiated violence focus in United Kingdom research.¹⁷

The biggest problem at all levels of analysis is the lack of a consistent definition of workplace violence. At one end of the spectrum are those who advocate a restricted focus upon actual or attempted physical assault,¹⁸ while at the other are those who define it as any form of behaviour that is intended to harm current or previous co-workers, or their organization.¹⁹ In terms of both the scope and consequences of workplace violence, a broad rather than a restrictive definition is needed, e.g. the definition agreed by the European Commission: “Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health”,²⁰ or the definition of WHO²¹ “The intentional use of power, threatened or actual, against another person or against a group, in work-related circumstances, that either results in or has a high degree of likelihood of resulting in injury,

¹⁴ Bowers, L., Whittington, R., Almvik, R., Bergman, B., Oud, N. and Savio, M. (1999). A European perspective on psychiatric nursing and violent incidents: management, education and service organisation. *International Journal of Nursing Studies*, 36, 3, 217-222.

¹⁵ Poster, E.C. (1996). A multinational study of psychiatric nursing staffs’ beliefs and concerns about work safety and patient assault. *Archives of Psychiatric Nursing*, 10(6), 365-373.

¹⁶ VandenBos, G.R. and Bulatao, E.Q. (eds.) (1996): *Violence on the Job*. Washington, DC: American Psychological Association.

¹⁷ Leather, P., Brady, C., Lawrence, C., Beale, D. and Cox, T. (eds.) (1999): *Work-Related Violence: Assessment and Intervention*. London: Routledge.

¹⁸ Kraus, J.F., Blander, B. and McArthur, D.L. (1995). Incidence, risk factors and prevention strategies for work-related assault injuries – a review of what is known, what needs to be known, and countermeasures for intervention. *Annual Review of Public Health*, 16, 355-379.

¹⁹ Folger, R. and Baron, R.A. (1996). Violence and hostility at work: a model of reactions to perceived injustice. In G.R. VandenBos and E.Q. Bulatao (eds.): *Violence on the Job*, Washington, DC: American Psychological Association.

²⁰ Wynne, R., Clarkin, N., Cox, T. and Griffiths, A. (1997). *Guidance on the Prevention of Violence at Work*. Luxembourg: European Commission, DG-V.

²¹ WHO (1995). *Violence: a public health priority*. Geneva: World Health Organization.

death, psychological harm, maldevelopment or deprivation". Only by accepting such broad definitions can the full range of circumstances be accommodated in which a worker might be attacked while in the workplace, while at work or on duty, or in any other circumstances related to their job. Due weight is also given in such definitions to both psychological as well as physical violence and harm. As Chappell and Di Martino²² point out, violence at work is a global health problem encompassing many forms, e.g. the land-mines and "booby traps" facing international peacekeepers, the ill-treatment and abuse of migrant workers, racial and sexual discrimination at work, as well as the more "local" problems of aggression and antisocial behaviour faced by the teacher, nurse, police officer, bar tender or sales assistant in the course of their normal daily round. All forms of workplace violence must be acknowledged and taken into account in both research and intervention activity.

Set within this broad context, it is clear to see how certain national and global trends will demand that the problem of workplace violence be taken even more seriously in the future. Such factors as the increasing use of international peacekeeping forces, rising levels of global occupational migration, the increased numbers of women in the workplace, the movement in many developed countries to service-based economies, corporate downsizing and rationalization, "care in the community" programmes, job insecurity in the face of technological and economic change, and rising levels of client and customer expectation are all likely to contribute to increased levels of workplace violence in the future, especially as there is a corresponding increase in the importance of upholding and maintaining human rights.

The rise of workplace violence in the health sector

Although health-care professionals are known to be particularly at risk of exposure to workplace violence^{23, 24, 25, 26, 27} it is only in the past decade or so that the topic has received serious attention.²⁸ Actual exposure estimates vary because of the lack of a consistent definition of violence and the absence of any standardized measuring

²² Chappell, D. and Di Martino, V. (1998). *Violence at Work*. Geneva: International Labour Office.

²³ Arnetz, J.E., Arnetz, B.B. and Petterson, I.L. (1996). Violence in the nursing profession: occupational and lifestyle risk factors in Swedish nurses. *Work & Stress*, 10, 119-127.

²⁴ Brady, C. and Dickson, R. (1999). Violence in health care settings. In P. Leather, C. Brady, C. Lawrence, D. Beale and T. Cox (eds.): *Work-Related Violence: Assessment and Intervention*. London: Routledge.

²⁵ Hewitt, J.P. and Levin, P. (1997). Violence in the Workplace. *Annual Review of Nursing Research*, 15, 81-99.

²⁶ Poster, E.C. (1996). A multinational study of psychiatric nursing staffs' beliefs and concerns about work safety and patient assault. *Archives of Psychiatric Nursing*, 10(6), 365-373.

²⁷ Smith-Pittman, M.H. and McKoy, Y.D. (1999). Workplace violence in healthcare environments. *Nursing Forum*, 34, 3, 5-13.

²⁸ Rippon, T.J. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing*, 31, 2, February, 452-460.

instrument.²⁹ What is clear, however, is that all health-care workers come into contact with violence or its sequelae, not just those working in such vulnerable locations as psychiatric settings and emergency rooms.^{30, 31}

While reports of patient violence were rare prior to the mid 1980s,³² the picture now is very clear: verbal and physical abuse are characteristic hazards faced by all members of the nursing profession.³³ While the majority of published statistics emanate from North America and the United Kingdom, exposure statistics are beginning to emerge from elsewhere. Van Londen, Hes and Ameling,³⁴ for example, report annual assault rates for nurses working in comparable general hospitals in Amsterdam and Tel Aviv as being 15 per cent and 45 per cent respectively. Yassi³⁵ attributes the variation in exposure rates to the socio-economic and cultural conditions in the two countries.

In a study of a Norwegian special secure psychiatric unit, Bjorkly³⁶ reports the following rates of different forms of inpatient aggression: verbal threats (13.5 episodes per patient per year); physical threats (6.5 episodes per patient per year); physical assault (5.9 episodes per patient per year). In other parts of the world, particularly the developing nations, there are few, if any, published statistics on the incidence of patient assault. Poster³⁷ however, reports informal evidence that in South Africa the same rising trend is seen in patient violence as that reported in the United States, Canada and the United Kingdom. To a large extent, Poster³⁸ observes, workplace violence is a "hidden problem embedded in socio-political issues" in South Africa. It seems likely that this is true for many developing countries.³⁹

²⁹ Leather, P., Brady, C., Lawrence, C., Beale, D. and Cox, T. (eds.) (1999): *Work-Related Violence: Assessment and Intervention*. London: Routledge.

³⁰ Sullivan, E.J. (1999). Violence and nursing. *Journal of Professional Nursing*, 15, 5 (September-October), 259-260.

³¹ Whittington, R., Shuttleworth, S. and Hill, L. (1996). Violence to staff in a general hospital setting. *Journal of Advanced Nursing*, 24, 326-333.

³² Poster, E.C. (1996). A multinational study of psychiatric nursing staffs' beliefs and concerns about work safety and patient assault. *Archives of Psychiatric Nursing*, 10(6), 365-373.

³³ Stephen, H. (1998). Yellow card for violent patients, *Nursing Standard*, 12, 52, Sep., 14.

³⁴ Van Londen, L., Hes, J., Ameling, E.H. et al. (1990). Staff attitudes towards violence in the general hospital: a comparison between Amsterdam and Tel Aviv. *Gen Hosp Psychiatry*, 12, 252-256.

³⁵ Yassi, A. (1994). Assault and abuse of health care workers in a large teaching hospital. *Canadian Medical Association Journal*, 151, 9, 1273-1279.

³⁶ Bjorkly, S. (1999). A ten-year prospective study of aggression in a special secure unit for dangerous patients. *Scandinavian Journal of Psychology*, 40, 57-63.

³⁷ Poster, E.C. (1996). A multinational study of psychiatric nursing staffs' beliefs and concerns about work safety and patient assault. *Archives of Psychiatric Nursing*, 10(6), 365-373.

³⁸ *ibid.*

³⁹ Chappell, D. and Di Martino, V. (1998). *Violence at Work*. Geneva: International Labour Office.

The picture that emerges from the published exposure statistics is both simple and clear: violence is a significant problem afflicting a wide range of occupations within both hospital and community-based health care. Elliot⁴⁰ calculates that the risk of health-care workers experiencing violence is some 16 times greater than it is for other service workers. Not surprisingly, then, Blair and New⁴¹ concluded that the majority of health-care workers will experience workplace violence at least once during their professional careers.

Although there is a high risk of workplace violence across all health-care occupations, most commentators now agree that it is members of the nursing profession who are most at risk.^{42, 43, 44, 45, 46} While emergency departments and psychiatric settings still constitute particular “hot spots” for violence, the rationalization of health-care services, leading to large numbers of disgruntled clients, and the advent of “care in the community programmes”, with their consequent early discharge from health-care agencies, have both resulted in an increased risk of violence across many health-care settings.

The acknowledgement that it is nurses who are particularly at risk of workplace violence followed a marked shift in research focus. During the 1970s and early 1980s, the majority of workplace violence research in health care examined the rate of exposure experienced by psychiatrists, social workers, psychologists, counsellors and other such therapists, rather than nurses.^{47, 48, 49, 50, 51} In common with the later nursing statistics,

⁴⁰ Elliott, P. (1997). Violence in health care: what nurse managers need to know. *Nursing Management*, 28, 12, 38-41.

⁴¹ Blair, D. and New, S. (1991). Assaultive behaviour: know the risks. *Journal of Psychosocial Nursing and Mental Health Services*, 29, 11, 25-29.

⁴² Aquilina, C. (1991). Violence by psychiatric in-patients. *Medicine, Science and the Law*, 24, 199-207.

⁴³ Binder, R.L. and McNeil, D.E. (1994). Staff gender and risk of assault on doctors and nurses. *Bulletin of the American Academy of Psychiatry and the Law*, 22, 4, 545-550.

⁴⁴ Bjorkly, S. (1999). A ten-year prospective study of aggression in a special secure unit for dangerous patients. *Scandinavian Journal of Psychology*, 40, 57-63.

⁴⁵ Carmel, H. and Hunter, M. (1989). Staff injuries from inpatient violence. *Hospital and Community Psychiatry*, 40, 1, 41-46.

⁴⁶ Noble, P. and Rodger, S. (1989). Violence by psychiatric inpatients. *British Journal of Psychiatry*, 155, 384-390.

⁴⁷ Bernstein, H.A. (1981). Survey of threats and assaults directed towards psychotherapists. *American Journal of Psychotherapy*, 35, 542-549.

⁴⁸ Madden, D.J., Lion, J.R. and Penna, M.W. (1976). Assaults on psychiatrists by patients. *American Journal of Psychiatry*, 133, 422-425.

⁴⁹ Shick-Tryon, G. (1986). Abuse of therapists by patients: a national survey. *Professional Psychology: Research and Practice*, 17, 4, 357-363.

⁵⁰ Schultz, L.G. (1987). The social worker as a victim of violence. *Social Casework News and Views*, Apr., 240-244.

however, these earlier studies also showed the majority of health-care workers to be very much at risk of violence. Shick-Tryon⁵² for example, reported that 81 per cent of a sample of 300 psychologists in private practice had experienced attack, abuse or harassment from clients. Similarly, 74 per cent of Whitman et al.'s⁵³ sample of 101 psychiatrists, psychologists and social workers described at least one incident of assault against them.

The final observation to make concerning the violence to which all health-care personnel are exposed is that serious aggressive incidents, e.g. those culminating in a homicide, are rare.^{54, 55, 56, 57, 58, 59} While actual physical assaults can and do take place in health-care settings, as the data reported above clearly testify, it remains the case that verbal aggression and threats of violence are much more common than actual physical violence.^{60, 61} Whatever its exact form, however, the fact remains that health-care workers are disproportionately at risk of workplace violence. What now needs to be examined are some of the reasons why the health-care setting is a particularly dangerous workplace when it comes to workplace violence.

⁵¹ Witman, R.M., Armao, B.B. and Dent, O.B. (1976). Assault on the therapist. *American Journal of Psychiatry*, 133, 426-429.

⁵² Shick-Tryon, G. (1986). Abuse of therapists by patients: a national survey. *Professional Psychology: Research and Practice*, 17, 4, 357-363.

⁵³ Witman, R.M., Armao, B.B. and Dent, O.B. (1976). Assault on the therapist. *American Journal of Psychiatry*, 133, 426-429.

⁵⁴ Benjaminsen, S., Gotsche-Larsen, K., Norrie, B., Hader, L. and Luxhoi, A. (1996). Patient violence in a psychiatric hospital in Denmark. Rate of violence and relation to diagnosis. *Nordic Journal of Psychiatry*, 50, 233-242.

⁵⁵ Cooper, A. and Mendonca, J. (1991). A prospective study of patient assaults on nurses in a provincial psychiatric hospital. *Acta Psychiatrica Scandinavica*, 84, 163-166.

⁵⁶ Lanza, M.L. (1983). The reactions of nursing staff to physical assault by patients. *Hospital and Community Psychiatry*, 34, 44-47.

⁵⁷ Lion, J.R. and Reid, W.H. (1983). *Assaults Within Psychiatric Facilities*. New York: Grune and Stratton.

⁵⁸ Litwack, T.R. (1996). "Dangerous" patients: a survey of one forensic facility and review of the issue. *Aggression and Violent Behaviour*, 1, 97-122.

⁵⁹ Noble, P. and Rodger, S. (1989). Violence by psychiatric inpatients. *British Journal of Psychiatry*, 155, 384-390.

⁶⁰ Morrison, E.F. (1998). The culture of caregiving and aggression in psychiatric settings. *Archives of Psychiatric Nursing*, XII, 1, 21-31.

⁶¹ Peek-Asa, C. and Howard, J. (1999). Workplace-violence investigations by the California Division of Occupational Safety and Health, 1993-1996. *Journal of Occupational and Environmental Medicine*, 41, 8, 647-653.

Explaining health-care settings as violence prone workplaces

A consistent theme in much of the published literature on workplace violence is that the key to prevention lies in the validity of the underpinning explanatory model.^{62, 63, 64} With respect to predicting violence in health-care settings, there is a growing consensus that the role of individual patient factors has been overemphasized at the expense of situational factors.^{65, 66, 67, 68, 69, 70, 71} This is not to say that patient factors are unimportant, but that they are only one contributing element in the generation of violent incidents.

The importance of situational factors in the aetiology of violent incidents is most strongly emphasized in social interactionist views of aggression and violence.^{72, 73, 74} Applied to the workplace, aggression and violence are herein seen as a possible outcome of negative interpersonal interactions, which are, in turn, embedded in the broader social and organisational context in which they occur. Particular attention is therefore paid to *any*

⁶² Chambers, N. (1998). "We have to put up with it – don't we?" The experience of being the registered nurse on duty, managing a violent incident involving an elderly patient: a phenomenological study. *Journal of Advanced Nursing*, 27, 429-436.

⁶³ Leather, P., Cox, T. and Farnsworth, W. (1990). Violence at work: an issue for the 1990s. *Work & Stress*, 4, 3-5.

⁶⁴ Leather, P., Brady, C., Lawrence, C., Beale, D. and Cox, T. (eds.) (1999): *Work-Related Violence: Assessment and Intervention*. London: Routledge.

⁶⁵ Binder, R.L. and McNiel, D.E. (1986). Victims and families of violent psychiatric patients. *Bulletin of the American Academy of Psychiatry and the Law*, 14, 131-139.

⁶⁶ Binder, R.L. and McNiel, D.E. (1994). Staff gender and risk of assault on doctors and nurses. *Bulletin of the American Academy of Psychiatry and the Law*, 22, 4, 545-550.

⁶⁷ Bjorkly, S. (1999). A ten-year prospective study of aggression in a special secure unit for dangerous patients. *Scandinavian Journal of Psychology*, 40, 57-63.

⁶⁸ Carmel, H. and Hunter, M. (1989). Staff injuries from inpatient violence. *Hospital and Community Psychiatry*, 40, 1, 41-46.

⁶⁹ Davis, S. (1991). Violence by psychiatric inpatients: a review. *Hospital and Community Psychiatry*, 42, 585-590.

⁷⁰ Litwack, T.R., Kirschner, S.M. and Wack, R.C. (1993). The assessment of dangerousness and predictions of violence: recent research and future prospects. *Psychiatric Quarterly*, 64, 3, 245-273.

⁷¹ Powell, G., Caan, W. and Crowe, M. (1994). What events precede violent incidents in psychiatric hospitals? *British Journal of Psychiatry*, 165, 107-112.

⁷² Felson, R.B. and Tedeschi, J.T. (eds.) (1993): *Aggression and Violence: Social Interactionist Perspectives*. Washington, DC: American Psychological Association.

⁷³ Leather, P. and Lawrence, C. (1995). Perceiving pub violence: the symbolic influence of social and environmental factors. *British Journal of Social Psychology*, 34, 395-407.

⁷⁴ Lawrence, C. and Leather, P. (1999). The social psychology of violence and aggression. In P. Leather et al.: *Work-Related Violence: Assessment and Intervention*. London: Routledge.

factor that might influence the nature of the exchange between the interacting parties. Such factors extend from characteristics of the individuals involved, through the nature and motive for their interaction, to the environmental and socio-cultural context in which the interaction takes place. In this way, the focus of explanation for aggression and violence in health-care moves beyond a preoccupation with patient factors to include a full situational analysis. This applies, moreover, to the whole gamut of possible interactions encountered in the workplace, i.e. employee-client/customer; employee-employee; employee-supervisor/manager, and so on.

Importantly, this kind of social interactionist analysis is better able to explain the underlying character of the majority of violent and aggressive incidents reported in health-care settings. The point, here, is that not all forms of violence are identical in their social and psychological underpinnings. Rather, a number of types of work-related violence can be distinguished. One widely adopted classification scheme is that proposed by the California Occupational Safety and Health Administration.⁷⁵ Here, three broad types of workplace violence are identified:

- *Type I*, where the assailant has no legitimate relationship to the workplace and the main object of the attack is cash or some other valuable commodity.
- *Type II*, which involve some form of assault by a person who is either the recipient or the object of a service provided by the affected workplace or the victim.
- *Type III*, where an assault is perpetrated by another employee, a supervisor, or an acquaintance of the worker.

As a number of commentators have recently observed, the majority of incidents of workplace violence experienced and reported in health-care settings fall under the type II classification.^{76, 77} As Peek-Asa and Howard⁷⁸ conclude, on the basis of their analysis of over 200 inspections undertaken by the California Division of Occupational Safety and Health, “Inspections in the health-care industry were performed primarily in response to type II events (69.1 per cent) and most of these were in response to patient assaults”.

It should be obvious, however, that health-care workers are potentially at risk of all three types of violence. For example, the GP who is mugged and has their medical bag snatched by someone looking for drugs is a victim of type I violence, as is the community nurse who is robbed of her money and other personal belongings while en route to visit a patient at home. Meanwhile, the agency nurse who is abused or harassed by colleagues on the basis of race or gender is a victim of type III violence, as is any member of staff who is bullied by a co-worker. It is perhaps the vulnerability of health-care staff to all three types

⁷⁵ California Occupational Safety and Health Administration (Cal/OSHA) (1995). *Cal/OSHA Guidelines for Workplace Security*, San Francisco, CA: State of California Department of Industrial Relations, Division of Occupational Safety and Health.

⁷⁶ Hewitt, J.P. and Levin, P. (1997). Violence in the Workplace. *Annual Review of Nursing Research*, 15, 81-99.

⁷⁷ Peek-Asa, C. and Howard, J. (1999). Workplace-violence investigations by the California Division of Occupational Safety and Health, 1993-1996. *Journal of Occupational and Environmental Medicine*, 41, 8, 647-653.

⁷⁸ *ibid.*

of violence that makes them particularly at risk of violence, e.g. 16 times more at risk than other service workers.⁷⁹

The importance of this is obvious. Intervention aimed to prevent or reduce violence towards health-care staff must be informed by a valid and appropriate understanding of its causes. What works to reduce or prevent one type of violence may have no beneficial bearing upon another type. Moreover, each common type of violent incident must be analysed for its constituent factors. Notwithstanding the fact that different “types” of violence in health care can have different social and psychological underpinnings, research has uncovered a number of important contributory factors to violent incidents in health care.

Patient factors

Precisely because violence occurs across a myriad of occupational settings, the inference is drawn that at least some of its antecedents must be found in a set of common characteristics amongst perpetrators, such as a prior record of violent behaviours, a history of drug or alcohol abuse, a mental disorder, poor coping skills and social resources, etc.^{80, 81, 82, 83, 84, 85, 86, 87, 88, 89}

⁷⁹ Elliott, P. (1997). Violence in health care: what nurse managers need to know. *Nursing Management*, 28, 12, 38-41.

⁸⁰ Bensimon, H. (1994). Crisis and disaster management: violence in the workplace. *Training and Development*, 28, 27-32.

⁸¹ Eastly, R. and Mian, I. (1993). Physical assaults by psychogeriatric patients: patient characteristics and implications for placement. *International Journal of Geriatric Psychiatry*, 8, 515-520.

⁸² Fletcher, T.A., Brakel, S.J. and Cavanaugh, J.L. (2000). Violence in the workplace: new perspectives in forensic mental health services in the USA. *The British Journal of Psychiatry*, 176, 339-344.

⁸³ Klassen, D. and O’Conner, W.A. (1988). A prospective study of predictors of violence in adult male mental health admissions. *Law and Human Behaviour*, 12, 143-158.

⁸⁴ Levin, R.L. (1995). Workplace violence: navigating through the minefield of legal liability. *The Labor Lawyer*, 11, 2, 71-87.

⁸⁵ Miller, R.J., Zadolinyj, K. and Hafner, R.J. (1993). Profiles and predictors of assaultiveness for different psychiatric ward populations. *American Journal of Psychiatry*, 150, 1368-1373.

⁸⁶ Noble, P. and Rodger, S. (1989). Violence by psychiatric inpatients. *British Journal of Psychiatry*, 155, 384-390.

⁸⁷ Palmstierna, T. and Wistedt, B. (1989). Risk factors for aggressive behaviour are of limited value in predicting the violent behaviour of acute involuntary admitted patients. *Acta Psychiatrica Scandinavica*, 81, 152-155.

⁸⁸ Smith-Pittman, M.H. and McKoy, Y.D. (1999). Workplace violence in healthcare environments. *Nursing Forum*, 34, 3, 5-13.

Notwithstanding the likelihood that each, or a combination, of these factors makes a person more likely to engage in violent behaviour, the fact remains that the individual propensity for violence, however strong it is, still needs to be triggered.^{90, 91} This fact immediately brings a range of situational factors to the fore.

Situational factors

While anyone who works in health care is a potential victim of violence, there are, as stated earlier, discernible differences in risk between the major occupational groups involved. Put simply, nurses are at the greatest risk of becoming a victim of some form of violence.⁹² Within nursing itself, further differentiation in the quantification of risk is possible, with psychiatric settings and emergency departments being most vulnerable.⁹³

Service provider characteristics, such as gender, race and age, have been studied as possible predictors of victimization. However, the evidence is inconsistent. For example, the United States Bureau of Labor statistics reported^{94, 95} that, nationally, nursing personnel, who are predominantly female, experience the highest risk of assault-related injury. Liss and McCaskell,⁹⁶ however, conclude that, on the basis of compensation data, it is men in the health-care industry who are at greatest risk of physical assault and injury. Brady and Dickson⁹⁷ conclude that both men and women working in health care are vulnerable to violence and that any gender-based differences in rates of assault are likely to be related to gender differences among the workforce in particular high-risk jobs.

⁸⁹ Umiker, W. (1997). Workplace violence: the responsibility of employers and supervisors. *Healthcare Supervisor*, 16, 1, 29-41.

⁹⁰ Novaco, R.W. (1978). Anger and coping with stress. In J.P. Foreyt and D.P. Rathjen (eds.): *Cognitive Behaviour Therapy*. New York: Penguin.

⁹¹ Novaco, R.W. and Welsh, W.N. (1989). Anger disturbances: cognitive mediation and clinical prescriptions. In K. Howells and C.R. Hollin (eds.): *Clinical Approaches to Violence*. Chichester: Wiley.

⁹² Hewitt, J.P. and Levin, P. (1997). Violence in the Workplace. *Annual Review of Nursing Research*, 15, 81-99.

⁹³ Smith-Pittman, M.H. and McKoy, Y.D. (1999). Workplace violence in healthcare environments. *Nursing Forum*, 34, 3, 5-13.

⁹⁴ Bureau of Labor Statistics (1995, February). *Number of nonfatal occupational injuries and illnesses involving days away from work by selected injury or illness characteristics and industry, 1992*. Washington, DC, US Department of Labor.

⁹⁵ Bureau of Labor Statistics (1996, May). *News: characteristics of work injuries and illnesses resulting in absences from work, 1994*. Washington, DC, Department of Labor.

⁹⁶ Liss, G.M. and McCaskell, L. (1994). Injuries due to violence: workers' compensation claims among nurses in Ontario. *AAOHN Journal*, 42, 384-390.

⁹⁷ Brady, C. and Dickson, R. (1999). Violence in health care settings. In P. Leather, C. Brady, C. Lawrence, D. Beale and T. Cox (eds.): *Work-Related Violence: Assessment and Intervention*. London: Routledge.

Whittington et al.⁹⁸ in line with Carmel and Hunter⁹⁹ found that it was recently employed staff who were more likely to be assaulted as compared with more experienced staff. The experience of staff is likely to be related to the quality of care provided. The demonstrated inverse relationship between assault frequency and staffing levels can be explained in the same way, i.e. low staffing levels are likely to impinge upon the quality of care provided, thereby leading to frustration and complaint on the patient's part. This, in turn, makes for more "difficult" staff-patient interactions, with an increase in patient violence and aggression an obvious outcome.

By the same token, a lack of staff, or the presence of inexperienced and untrained staff, can provide the opportunity for those who use violence as a coping strategy to engage in it. Similarly ward overcrowding is likely to contribute to increased violence by increasing patient arousal, impacting negatively on the perceived quality of patient care, and increasing the opportunity for patient grievances with staff or other patients.^{100, 101}

Perhaps the strongest piece of evidence in support of the need for a situational analysis of violence in health care is the demonstrated relationship between violence towards staff and their involvement in "limit setting" activities. Whittington and Wykes,¹⁰² for example, found that 86 per cent of assaults by psychiatric patients on nurses were preceded by: the nurse demanding something of the patient, refusing a request by the patient, or needing to physically touch the patient in some way. In another study of psychiatric patients, Bensley, Nelson, Kaufman, Silverstein et al.¹⁰³ report that staff and patients alike recognized the role of restrictions on patients' smoking and access to the outdoors antecedents of violent and aggressive interactions.

When the explanatory focus shifts from the individual to the situation, it is clear to see how organizational and socio-political factors come to be related to incidents of violence and aggression. Organizational rules can provide obvious sources of grievance, e.g. those limiting smoking and building access. Staff are then particularly at risk of violence when they have to enforce those rules and regulations. At the level of organizational culture, impersonal, restrictive and authoritarian treatment regimes are likely to be conducive to violence, because they increase patient feelings of frustration, unfairness and injustice. At a broader level still, political decisions about the very structure and organization of health-care services can be seen to impact upon the nature and quality of resulting staff-patient interactions. Any restructuring of health-care provision, for

⁹⁸ Whittington, R. and Wykes, T. (1996). Aversive stimulation by staff and violence by psychiatric patients. *British Journal of Clinical Psychology*, 35, 1, 11-20.

⁹⁹ Carmel, H. and Hunter, M. (1989). Staff injuries from inpatient violence. *Hospital and Community Psychiatry*, 40, 1, 41-46.

¹⁰⁰ Lanza, M.L., Kayne, H.L., Hicks, C. et al. (1994). Environmental characteristics related to patient assault. *Issues in Mental Health Nursing*, 15, 319-335.

¹⁰¹ Owen, C., Tarantello, C., Jones, M. and Tennant, C. (1998). Violence and aggression in psychiatric units. *Psychiatric Services*, 49, 11, 1452-1457.

¹⁰² Whittington, R. and Wykes, T. (1996). Aversive stimulation by staff and violence by psychiatric patients. *British Journal of Clinical Psychology*, 35, 1, 11-20.

¹⁰³ Bensley, L., Nelson, N., Kaufman, J., Silverstein, B. et al. (1995). Patient and staff views of factors influencing assaults on psychiatric hospital employees. *Issues in Mental Health and Nursing*, 16, 5, 433-446.

example, will inevitably impact upon the relationship between service user and service provider. It is as much in the resulting characteristics of this relationship between health-care professional and service recipient that the potential for violence is to be found as it is in the characteristics of the individual service user.

Conclusions

The key to a better understanding of workplace violence – and thereby the route to more effective intervention strategies – lies in the development of more sophisticated means of situational assessment. The majority of violent incidents across all health-care settings result not simply from individual psychopathology, but from “the interaction of a number of factors related to the environment, the staff member, the perpetrator, and the interaction between them”.¹⁰⁴ Explanatory models of violence in health care must therefore start from the realization that “an individual patient’s potential for violence is not predictable with accuracy or certainty”.¹⁰⁵ Yet, despite the growing amount of research that demonstrates the importance of the interaction between personal and environmental factors in predicting violent behaviour, this connection has been largely neglected in clinical evaluations of dangerousness.¹⁰⁶ The challenge now is to correct this deficit. As Fletcher et al.¹⁰⁷ observe, models addressing both personal and workplace factors are in their infancy, but hold considerable promise.

If this challenge is to be met, then three principal problems will have to be tackled. First, the residual and chronic problem of incident underreporting will have to be overcome. Second, researchers, practitioners, institutions and governments alike will have to come to closer agreement on the issue of the definition of workplace violence. Without such agreement, the current tendency for divergence, rather than convergence, in knowledge and application will continue unabated. Third, situational analyses will need to be undertaken for all types of workplace violence.

Finally, a concentrated effort is needed to raise awareness and knowledge of the problem of workplace violence outside North America, western Europe and Australia. Workplace violence, whether in health care or elsewhere, is a global issue, not just a problem confronting the most developed nations.

¹⁰⁴ Brady, C. and Dickson, R. (1999). Violence in health care settings. In P. Leather, C. Brady, C. Lawrence, D. Beale and T. Cox (eds.): *Work-Related Violence: Assessment and Intervention*. London: Routledge.

¹⁰⁵ American Psychiatric Association (1974). Task Force on Clinical aspects of the Violent Individual. Washington, DC: APA.

¹⁰⁶ Fletcher, T.A., Brakel, S.J and Cavanaugh, J.L. (2000). Violence in the workplace: new perspectives in forensic mental health services in the USA. *The British Journal of Psychiatry*, 176, 339-344.

¹⁰⁷ *ibid.*

Section 2

Information collection and reporting of violence at work in the health sector

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Contents

	<i>Page</i>
Definition of health services sector	23
United States estimates of the population at potential risk from workplace violence in the health-care sector.....	23
Non-hospital health-care workers	24
Issues related to information collection and reporting	24
Surveillance in the United States.....	25
Different approaches to illustrate, categorize and explain the phenomenon.....	25
Indicators and categories of data.....	25

Definition of health services sector

It is important to define the population of employees potentially at risk for health-care violence in order to determine the magnitude of risk. However, international estimates of either the number of health-care facilities or the number of health professionals are extremely difficult to obtain. The World Health Organization (WHO) has published estimates on the rates of physicians, nurses, midwives, dentists and pharmacists per 100,000 population by country, but these estimates have not been updated in some cases in more than eight years. Readers are directed to the WHO health personnel web site for information on specific countries. More reliable estimates are available from United States data sources as described in the next section.

United States estimates of the population at potential risk from workplace violence in the health-care sector

In 1998, the Bureau of the Census estimated that there were 11 million health-care workers (HCWs), representing the third largest class of employees in the United States. The health-care industry is divided into eight major sectors, consisting of nearly 500,000 establishments, including 5,600 hospitals. While hospitals account for only 1.6 per cent of all health-care facilities, they employ nearly 50 per cent of all HCWs. The remaining 50 per cent work in a wide variety of occupations and work settings, with doctors' and dentists' offices the most common setting. Table 1 below summarizes the distribution of employees in each of the health sectors.

Table 1. Percent and number of employees and establishments in the eight health service sectors, 1997

Establishment type	Percent establishments (n = 460,000)	Number and percent employees
Private (and public) hospitals	1.6	4 909 000 39.6%
Offices of physicians	41.8	1 853 000 18.5%
Nursing and personal care facilities	4.3	1 762 000 18.1%
Home health-care services	3.3	672 000 7.3%
Offices of dentists	23.8	646 000 6.5%
Offices of other health practitioners	18.7	450 000 4.5%
Other health and allied services	3.1	339 000 3.4%
Medical and dental labs	3.4	199 000 2.0%

Source: United States Bureau of Labor Statistics web site, <http://www.stats.bls.gov>

Non-hospital health-care workers

Non-hospital based HCWs, employed in the remaining seven health-care sectors, tend to work in smaller establishments, with approximately one-third working in facilities with less than 1,000 employees, and 16 per cent working in establishments with fewer than five employees. This is important to consider in terms of both workplace violence risk factors (i.e., workplaces with fewer than five employees are at increased risk of exposure to violence) and violence prevention interventions (e.g., the presence of security guards). The types of non-hospital sectors are summarized in table 2.

Table 2. Non-hospital segments of the health services industry

Industry segment	Types of services	Types/numbers of employees
Nursing and personal care facilities	In-patient nursing, rehabilitation and health-related personal care; convalescent and assisted living care	Nursing aides and nurses
Offices and clinics of physicians, including osteopaths	Private and group practice, including clinics, free-standing emergency care centres, and outpatient facilities	Physicians, nurses, and nursing aides
Home health-care services	Skilled home care, in particular elder-care, and the application of in-home medical technologies	Physicians and nurses
Offices and clinics of dentists	General and specialized dental care and dental surgery	Dentists and hygienists
Offices and clinics of other health practitioners	Non-traditional and alternative health-care services; services provided are highly variable according to patients' ability to pay	Chiropractors, optometrists, podiatrists, occupational and physical therapists, psychologists, audiologists, speech-language pathologists, dieticians, and alternative medicine practitioners among others
Other health and allied services	Includes services not covered elsewhere, such as kidney dialysis centres, drug treatment clinics and rehabilitation centres, blood banks, childbirth preparation classes, etc.	Physicians, nurses, technicians, therapists, and support and ancillary staff
Medical and dental labs	Medical analytic and diagnostic services, such as analysing blood, taking x-rays, and other clinical tests; making dentures, artificial teeth, and other orthodontic appliances	Technicians

Source: United States Bureau of Labor Statistics web site, <http://www.stats.bls.gov>

Issues related to information collection and reporting

It is important to have uniform categories and definitions for violence in the health-care setting for a wide range of reasons, not the least of which is to have a uniform surveillance system. Unfortunately, there are no standard reporting definitions or mechanisms for health-care workplace violence, and this would be a necessary first step in determining the prevalence and scope of the problem at the international level.

Additionally, several studies have found that violent events are seriously under-reported, especially non-physical violent events.¹ Some reasons that have been given to explain this include: lack of reporting mechanisms, fear of reprisals and embarrassment.^{2, 3}

Surveillance in the United States

In the United States, data on general and health-care workplace violence is collected and reported by the Bureau of Justice Statistics. The source of the Bureau's data is the National Crime Victimization Surveys, an annual survey of a large sample of United States households. The survey is not dependent on police reports, which is important since many workplace violence incidents may go unreported to both the employer and the police. Data on homicides in the United States workplace are collected from the Federal Bureau of Investigation's Uniform Crime Statistics Reports. This is an active collection system that obtains homicide reports from the nations' law enforcement agencies. Many developed nations have similar reporting mechanisms. However, as mentioned, there are no international databases on either workplace violence or more specifically health-care workplace violence.

Different approaches to illustrate, categorize and explain the phenomenon

Health-care workplace violence should be treated as any other public health problem of considerable magnitude. There should be active surveillance of cases, clear and well defined case definitions, and appropriate risk management strategies developed to help minimize the risk of this public health threat. However, violence in general, and workplace violence, in particular, is generally managed as a criminal justice problem, and this limits the effectiveness of the public health community.

International committees should develop uniform definitions and surveillance systems, and a formal network of public health specialists working in this area should be encouraged.

Indicators and categories of data

Several sets of guidelines for the health-care industry provide information about the types of data to collect, and how to collect it. See, for example, OSHA⁴ which contains a sample incidence reporting form, a sample employee survey, and a checklist of security risks, and guidelines for a violence risk assessment.

¹ Lauza, M. (1992). Nurses as Patient Assault Victims: An Update, Synthesis, and Recommendations. *Archives of Psychiatric Nursing*, 31, 163-171.

² *ibid.*

³ Anglin, D., Kyriacou, D.N., Hutson, H.R. (1994). Residents' perspectives on violence and personal safety in the emergency room. *Annals of Emergency Medicine*, 23, 1082-1084.

⁴ OSHA (1998). *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. Washington, DC: United States Department of Labor, Occupational Safety and Health Administration, OSHA 3148.

Section 3

Existing evidence of the prevalence of violence in health services within different geographical, social, and economic settings

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Contents

	<i>Page</i>
National statistics	31
Studies in specific settings	32

National statistics

Differences in definitions of workplace violence, work-relatedness, and the scope of the health-care industry make compilations of data regarding the prevalence of violence in health services across countries impossible. Further, even within a single country, different definitions may be employed by different agencies and different data may be collected based on where the incident occurred (e.g., a public versus private hospital; a hospital versus a physician's office) or the severity of the injury (e.g., homicides may be captured in systems completely separate from non-fatal assaults). This, in conjunction with known under-reporting, makes understanding the true magnitude of workplace violence in the health-care sector virtually impossible. In some of the developed countries, ongoing or recent surveys provide some sense of the magnitude of the problem, but existing knowledge is far from complete.

In the United States, an ongoing data collection of the Bureau of Labor Statistics entitled the Census of Fatal Occupational Injuries (CFOI), includes information on work-related homicides. The system includes information from multiple sources including death certificates, medical examiner records, workers compensation files, and newspaper reports. In 1999, CFOI documented seven homicides in the health services industry. The average number of homicides in this industry in the preceding five-year period (i.e., 1994 to 1998) had been 13 annually.¹ During the 11-year period from 1980 through 1990, another national surveillance system – the National Traumatic Occupational Fatalities (NTOF) surveillance system – documented 106 homicides of health-care workers. Of these, 27 of the victims were employed as pharmacists, another 26 were physicians, 18 were registered nurses, and 17 were nurse's aides.²

With regard to non-fatal assaults, the United States Bureau of Justice Statistics conducts an ongoing household-based survey entitled the National Crime Victimization Survey; this survey captures information on victimizations (including threats as well as completed assaults) that occur “while at work or on duty”. Based on data for 1992 through 1996, there were an estimated 2 million victims of non-fatal workplace violence in the United States annually. Approximately 150,300 persons in medical occupations – including physicians, nurses, technicians, and other health-care workers – reported victimizations annually. Another 94,300 workers in mental health occupations – including professional and custodial staff – reported being the victim of workplace violence each year.³

¹ United States Department of Labor (2000). *National Census of Fatal Occupational Injuries, 1999 – Homicide Tables*. Bureau of Labor Statistics. USDL 00-236, August 17, 2000.

² Goodman, R.A., Jenkins, E.L. and Mercy, J.A. (1994). Workplace-related homicide among health care workers in the United States, 1980 through 1990. *Journal of the American Medical Association*, 272(21); 1686-1688.

³ United States Department of Justice (1998). *Bureau of Justice Statistics Special Report, National Crime Victimization Survey: Workplace Violence, 1992-1996*. NCJ 168634.

The British Crime Survey (BCS) measures crime against people living in private households in England and Wales.⁴ It collects information on the nature of crime, including where and when offences occur. The definition of violence at work used was, “All assaults or threats which occurred while the victim was working and were perpetrated by members of the public”. Based on combined data from 1994, 1996, and 1998, the categories “nurses”, “care workers”, and “other health professionals” were all considered high risk for assaults. The average risk for all occupations was 1.2 per cent; the risk for nurses was 5 per cent (four times the national average). The risk was 2.8 per cent for care workers, and 1.4 per cent for other health professionals. With regard to threats, other health professionals had a risk of 4 per cent and nurses had a risk of 3.1 per cent compared to an average risk of threats across all occupations of 1.5 per cent.

In Finland, a telephone survey conducted by the Finnish Institute for Occupational Health revealed that 10.5 per cent of health-care and social-service workers reported violent incidents – defined as “violence or threat of violence at work or on the way to, or from, work during the 12 months preceding the survey”.⁵ A report on the lifetime prevalence of occupational violence among a representative national sample of 2,600 Swedish registered nurses indicated that 29 per cent have at some time in their careers been victims of violence and 35 per cent have been victims of threat.⁶

In British Columbia, workers compensation rates for health-care workers quadrupled between 1982 and 1991. Health-care workers accounted for 55 per cent of claims and nurses had the same risk of workplace violence as police officers with a rate nearly four times the incidence of any other profession.⁷ In Australia, a review of incident statistics at a New South Wales public psychiatric hospital found that 82 per cent of the reports of injury occurred as the result of an assault. In addition, a study of 300 doctors in Western Australia, New South Wales, and the Gippsland area of Victoria found that 73 per cent of the doctors working in rural areas reported they had been victims of work-related abuse, including verbal insults and threats.⁸

Studies in specific settings

A number of studies have focused on a specific geographic area, occupational group, or health-care facility and have used widely varying methods and sources of data – from compilation of administrative records to employee surveys.

⁴ Health and Safety Executive (1999). *Violence at Work: Findings from the British Crime Survey*. Home Office Information and Publications Group; Research, Development and Statistics Directorate, London.

⁵ Saarela, K.L. and Isotalus, N. (1999). Workplace Violence in Finland: High-risk groups and preventive strategies. *American Journal of Industrial Medicine*, Supplement 1, 80-81.

⁶ Arnetz, J.E., Arnetz, B.B. & Petterson, I.-L. (1996). Violence in the nursing profession: Occupational and lifestyle risk factors in Swedish nurses. *Work & Stress*, 10, 119-127.

⁷ Sibbald, B. (1998). Physician, protect thyself. *Canadian Medical Association Journal*, 159(8), 987-989.

⁸ Perrone, S. (1999). *Violence in the Workplace*. Australian Institute of Criminology Research and Public Policy Series No. 22.

In the United States, for example, researchers from the State of Washington Departments of Health and Labor and Industries compiled information from workers compensation data, hospital-recorded incident reports, and a survey of ward staff to describe assault injuries among psychiatric hospital employees.⁹ They report that the rate of workers compensation claims for assault was 13.8 per 100 employees per year. Based on the survey data, there were 415 assaults per 100 employees per year; of the respondents, 73 per cent reported at least a minor injury during the year immediately prior to the survey. Pane and colleagues¹⁰ conducted a one-year retrospective review of university police log records and staff incident reports to compile a comprehensive description of violence experienced by emergency department staff at a university teaching hospital. They found that university police responded to the emergency department at least twice daily and that the night shift experienced 32 per cent of the violence incidents, although only 13 per cent of the patient volume occurred during the night shift. Another review of workers compensation data conducted by Sullivan and Yuan¹¹ focused on assaults against minority health and mental health-care workers in a major metropolitan area of California. They found that the majority of assaults (86 per cent) were committed by patients and that the risk of assault varied by type of facility with the very highest rates occurring in psychiatric hospitals (185 per 1,000,000 employment days). Inpatient nursing attendants were the occupational group with the highest rates of workplace assault (49 per 1,000,000 employment days).

The Nordic countries held a workshop to review current and planned work in this area and published a useful compendium of papers entitled, *Research on Violence, Threats and Bullying as Health Risks among Health Care Personnel*.¹² This volume includes papers describing threats against health-care personnel, the effects of aggression, the extent and nature of bullying, and sexual harassment in the health-care sector. In a more recent effort in Finland, Kivimäki and colleagues (2000) studied the effects of workplace bullying against hospital staff on sickness absence. They found that 5 per cent of the health-care workers in the study reported being victims of bullying. Even after adjustment for baseline sickness absence as well as other covariates, the risk of medically certified sickness absence was 26 per cent greater in the group that had experienced bullying than among other hospital staff. This difference was not dependent on demographic characteristics, health risk behaviours, or baseline health.

In the United Kingdom, Quine¹³ studied the prevalence of workplace bullying in an National Health Service community trust and found that 38 per cent of employees reported

⁹ Bensley, L., Nelson, N., Kaufman, J., Silverstein, B., Kalat, J. and Shields, J.W. (1997). Injuries due to assaults on psychiatric hospital employees in Washington State. *American Journal of Industrial Medicine*, 31, 92-99.

¹⁰ Pane, G.A., Winiarski, A.M. and Salness, K.A. (1991). Aggression directed toward emergency department staff at a university teaching hospital. *Annals of Emergency Medicine*, 20, 283-286.

¹¹ Sullivan, C. and Yaun, C. (1995). Workplace assaults on minority health and mental health care workers in Los Angeles. *American Journal of Public Health*, 85, 1011-1014.

¹² Author (1995). *Research on violence, threats and bullying as health risks among health care personnel: Proceedings from the Workshop for Nordic researchers in Reykjavik*, 14-16 August 1994. Edited by R. Bast-Pettersson, E. Bach, K. Lindström, A. Toomings and J. Kiviranta. TemaNord 1995: 583.

¹³ Quine, L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. *British Medical Journal*, 318, 228-232.

experiencing one or more types of bullying in the previous year, while 42 per cent had witnessed the bullying of others. Staff who had been bullied had significantly lower levels of job satisfaction. Mackin¹⁴ used a telephone questionnaire to assess the level of violence against trainee paediatricians in three regions of the United Kingdom (Northern Ireland, South Thames, and North West England). Sixty-eight per cent of the trainee paediatricians had experienced at least one incident of workplace violence and 62 per cent of these had occurred during the one-year period prior to the survey. Forty-one per cent had experienced threats on at least one occasion.

So, it is clear that the health-care sector has a significant, but still under-reported and under-recognized occupational safety and health problem in the form of workplace violence. No consistent national data exist in any country that allow comprehensive description of fatal and nonfatal incidents or the full range of incidents from bullying, harassment, and threats to assaults and homicides. The studies summarized here represent only a fraction of all of the available studies looking at various components of workplace violence or the specific subsectors of the health-care industry. They do, however, represent the range of approaches taken to compiling statistics to describe the extent of workplace violence in health care. One of the real challenges for the future is a more complete assessment of the true magnitude of workplace violence in health care across countries and settings, preferably using similar definitions and data collection techniques.

¹⁴ Mackin, J.G. (2001). Violence against trainee paediatricians. *Arch Dis Child*, 84 (2), 106-108.

Section 4

Origins of violence at work

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Contents

	<i>Page</i>
A conceptual model.....	39
Use of the conceptual model	43
Individual factors	44
Interaction factors	45
Organizational factors	45
Community/neighbourhood factors	46
Societal factors.....	47
Is there a definite answer?	48

Understanding the origins of violence within the health-care industry is complicated by three factors. First, health-care workers are employed within a wide range of organizational structures where they perform a variety of different duties. Elliott¹ described a three-level classification system within medical centres to assess the level of risk for violence. Level I settings (high occurrence) include the emergency department, ambulatory care, main lobby, radiology and the outpatient pharmacy, cafeteria, substance abuse and psychiatry service programmes and the executive suite. Level II settings (moderate occurrence) include medical-surgical areas and outpatient clinics. Level III settings (minimal or no violent occurrences) include the medical library, classrooms, and educational offices. In addition, many health-care workers are employed outside the medical centre in settings such as client homes, neighbourhood clinics, and long-term care facilities. Settings may range from working alone and providing in-home care to a single client, to working on a locked ward, such as in a psychiatric care facility, with multiple high-risk patients.

Second, health-care workers are subject to violence from multiple sources: clients, family members of clients, co-workers, and outside assailants. While the primary source of physical violence is believed to be initiated by clients,² verbal violence is often associated with physician behaviours.^{3, 4} In addition, health-care workers may be victims of domestic violence or community-based violence that spills over into health-care settings (e.g. gang-related violence that erupts in emergency rooms).⁵

Third, health-care workers are subject to a variety of different modes of violence – some intentional (e.g. robbery associated assault), some unintentional (e.g. providing care to a grossly cognitively impaired patient), some physical (e.g. pushing, shoving, biting), and some verbal or emotional (e.g. derogation by a co-worker). Because of the interplay between these three distinguishing characteristics of this occupation, no single conceptualization of the origins of violence exists and if it did exist, it would likely be inadequate.

A conceptual model

General taxonomies of factors associated with an increased risk of violence have been offered in the literature. Two general listings, one from the National Institute of

¹ Elliott, P.P. (1997). Violence in health care: What nurse managers need to know. *Nursing Management* (Dec.).

² Beck, J.C. and Schouten, R. (2000). Workplace violence and psychiatric practice. *Bulletin of the Menninger Clinic*, 64, 36-48.

³ Diaz, A.L. and McMillan, J.D. (1991). A definition and description of nurse abuse. *Western Journal of Nursing Research*, 13, 97-109.

⁴ Keashley, L.; Trott, V.; MacLean, L.M. (1994). Abusive behavior in the workplace: A preliminary investigation. *Violence and Victims*, 9, 341-357.

⁵ Hospital Security and Management (1993). *Special report: Violence in hospitals: What are the causes? Why is it increasing? How is it being confronted?*, 13(9), 5-10.

Occupational Safety and Health⁶ and one from Bulatao & VandenBos⁷ are presented in table 1. It could be argued that the majority of health-care workers are employed in settings that reflect high levels of risk on the majority of the NIOSH factors (at least seven out of ten). The list by Bulatao and VandenBos⁸ seems especially relevant to health-care workers – often times clients have long waits in an uncomfortable physical environment, only to be asked highly personal and intrusive questions. This tension-heightened situation can be exacerbated by perceived prejudice (or discrimination), perceived hostile attitudes from staff, the client's own use of drugs or alcohol, and mental instability due to altered states or biological causes. A third list of violence-related factors, particular to health care⁹ is also presented in table 1. This list includes organizational, community, and societal factors.

Table 1. General and health-care-specific factors associated with workplace violence

Factors from NIOSH (1996)	Health-care settings	Factors from Bulatao & VandenBos (1996)	Health-care settings	Factors from Elliott (1995) – specific to health care
1. Contact with the public.	High	1. Feeling aggrieved.	High	1. 24-hour open door policies for patient access.
2. Exchange of money.	Low	2. Being forced to wait.	High	2. Decrease in available treatment for mentally ill and substance abuse patients.
3. Delivery of passengers, goods or services.	High	3. Perceived intrusions into private life.	High	3. Availability of drugs and money in hospitals.
4. Having a mobile workplace such as a taxicab or police cruiser.	Low	4. Prejudice.	High	4. Prevalence of weapons in patients.
5. Working with unstable or volatile persons in health-care, social services, or criminal justice settings.	High	5. Staff attitudes.	High	5. Current cost-cutting focus and widespread downsizing.
6. Working alone or in small numbers.	High	6. Uncomfortable physical environment.	High	6. Working alone during the night or in the early morning hours.
7. Working late at night or during early morning hours.	High	7. Alcohol.	High	7. Traditional staffing patterns that may have low staff during high flow.
8. Working in high-crime areas.	High	8. Mental instability.	High	8. Circumstantial factors: gang members, trauma patients, distraught family members, long wait, inability to get care.
9. Guarding valuable property or possessions.	Low			
10. Community-based setting.	High			

⁶ National Institute of Occupational Safety and Health (1996). NIOSH Current Intelligence Bulletin 57. Violence in the workplace: Risk factors and prevention strategies.

⁷ Bulatao, E.Q. and VandenBos, G.R. (1996). Workplace violence: Its scope and the issues. In G.R. VandenBos and E.Q. Bulatao (eds.) *Violence on the Job*. Washington, DC: American Psychological Association, pp. 1-23.

⁸ *ibid.*

⁹ Elliott, P.P. (1997). Violence in health care: What nurse managers need to know. *Nursing Management* (Dec.).

Another approach in the general literature has been to present conceptual models or lists of factors that lead to workplace violence. Many of these models include three levels of factors – individual, organizational, and societal.^{10, 11, 12, 13, 14} The exact content of the factors within the levels varies by authors and the inclusion is often based on theoretical evidence. Other authors have taken a more explicit occupational stress model to examine causal factors.^{15, 16}

Based on this general literature on the origins of violence at work and the scant literature that focuses on health-care workers in particular, a basic conceptual model is presented in figure 1. Specific variables, based primarily on the literature, which can be placed within the conceptual model are presented in table 2. Three additional components have been added that make the model different from the multi-level models cited earlier. Bulatao and VandenBos¹⁷ noted that “A violent incident in a workplace is seen as the culmination of stressful interaction, aggravated by a vicious cycle of misconceptions, frustration, and anger” (page 17). The first difference in this model is that its focal point is the specific interaction between a worker and an aggressor (depicted as client in the model, but other sources of violence could also be inserted, such as co-worker). The second difference is to distinguish between community/neighbourhood factors and more global societal factors. Finally, unlike other models that are more linearly represented, this model assumes that the levels of causal factors are embedded within each other.

¹⁰ Beugre, C.D. (1998). Understanding organizational insider-perpetuated workplace aggression: An integrative model. In S.B. Bacharach, P.A. Bamberger & W.J. Sonnenstuhl (eds.) *Research in the Sociology of organizations. Deviance in and of organizations* (pp. 163-196). Stamford CT: JAI Press, Inc.

¹¹ Folger, R. and Baron, R.A. (1996). Violence and hostility at work: A model of reactions to perceived injustice. In G.R. VandenBos and E.Q. Bulatao (eds.) *Violence on the Job*. Washington, DC: American Psychological Association, pp. 51-85.

¹² Levin, P.F.; Hewitt, J.B.; Misner, S.T. (1998). Insights of nurses about assault in hospital-based emergency departments. *Image: Journal of Nursing Scholarship*, 30, 249-254.

¹³ Neuman, J.H. and Baron, R.A. (1998). Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. *Journal of Management*, 24, 391-419.

¹⁴ Paul, R.J. and Townsend, J.B. (1998). Violence in the workplace – a review with recommendations. *Employee Responsibilities and Rights Journal*, 11, 1-13.

¹⁵ Barling, J. (1996). The prediction, experience, and consequences of workplace violence. In G.R. VandenBos & E. Q. Bulatao (eds.) *Violence on the Job*. Washington, DC: American Psychological Association, pp. 29-48.

¹⁶ Cole, L.L.; Grubb, P.L.; Sauter, S.L.; Swanson, N.G.; Lawless, P. (1997). Psychosocial correlates of harassment, threats and fear of violence in the workplace. *Scandinavian Journal of Work Environment and Health*, 23, 450-457.

¹⁷ Bulatao, E.Q. and VandenBos, G.R. (1996). Workplace violence: Its scope and the issues. In G.R. VandenBos and E.Q. Bulatao (eds.) *Violence on the Job*. Washington, DC: American Psychological Association, pp. 1-23.

Figure 1

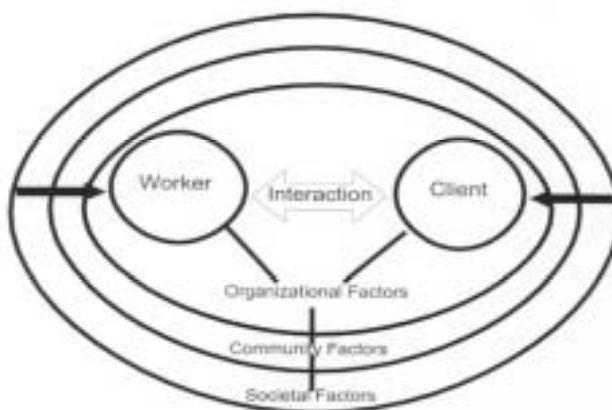


Table 2. Factors associated with violence against health-care workers

Factor level	Worker characteristic	Violence initiated by:		
		Client	Other employee	Outside assailant
Individual				
• Cognitive deficits		X		X
• Psychiatric diagnosis	X	X	X	X
• Use of drugs or alcohol	X	X	X	X
• Length of stay		X		
• Victim of violence or other trauma	X	X	X	X
• Level of hostility	X	X	X	X
• Fatigue	X		X	
• Level of professionalism	X		X	
• Training in violence prevention	X		X	
• Age	X	X	X	X
• Gender	X	X	X	X
• Job title	X		X	
• Personality variables	X	X	X	X
Interactional				
• Confrontational style	X	X	X	
• Rushed	X		X	
• Presence of others	X	X	X	X
Work organization				
• Job demands and control (and other factors associated with job stress)*	X		X	
• Wait time for service		X		
• Level of bureaucratic demands	X	X	X	
• Presence of security features		X	X	X
• Visibility of work area		X	X	X

Factor level	Worker characteristic	Violence initiated by:		
		Client	Other employee	Outside assailant
• Shift worked	X		X	
• Job turnover rates	X		X	
Community/neighbourhood				
• Level of crime		X		X
• Level of poverty		X		X
• Level of drug use		X		X
• Density		X		X
• Home ownership		X		X
• SES		X		X
• Level of gang violence		X		X
Societal				
• Economic situation (e.g., expanding vs. shrinking number of jobs, unemployment rate, global competition)	X	X	X	X
• Cultural acceptance of the expression of anger	X	X	X	X
• Cultural acceptance of the expression of violence	X	X	X	X
• Increased diversity in the workplace.	X	X	X	X
• Shifting family structures	X	X	X	X

Use of the conceptual model

If we were to attempt to describe a particular interaction, we would see that the nature of the interaction is influenced by individual factors of both the worker and the client but it is embedded within the organizational, community, and societal environments. Depending upon the actual work setting (e.g. client's home, emergency room, critical care unit, outpatient or clinic office) and the source of aggression, the actual variables that come to play would differ in importance and in content. For example, the most salient client characteristic in a residential care setting might be cognitive deficits or confusion while the most salient characteristic in an emergency room setting might be recent illegal drug use.

As noted earlier, the literature on causes of violence in health-care settings is limited and fragmented, making it impossible to fill in the components of the model in a comprehensive, evidence-based manner. However, the general and health-care specific literatures do suggest factors that should be considered within each component.

Individual factors

Worker characteristics

Unlike other occupations that generally find that males are more at risk of being victims of violence (e.g. in public health field workers)¹⁸ or that there are no gender differences (e.g. in state government workers, Lord, 1998), there is evidence in the health-care field that younger female workers with lower level job titles (e.g. nurse's aide) are at a higher level of risk for being the victim of violence. In a review of 684 violent incidents in health-care settings in Stockholm, Arnetz¹⁹ found that the most frequent victims were practical nurses with special training in mental health or psychiatry (40 per cent) and registered nurses (27 per cent). Factors that may lead to a lack of stability within the worker (e.g. psychiatric diagnosis that is untreated, use of drugs or alcohol, extreme fatigue, and unresolved or acted upon hostility) could also place her or him at higher risk. Results from focus groups with nurses²⁰ indicated that nurses felt they needed to display confident, assertive body language. Protective factors for workers would include training in how to negotiate potentially harmful situations (e.g. aggression management skills)²¹ and a high level of professionalism (e.g. being able to calm a distraught patient).

Perpetrator characteristics

In the study by Arnetz²² noted above, it was found that in 91 per cent of the cases, the aggressor was a client. Of these, 44 per cent were mentally ill, 37 per cent were senile, and 12 per cent had used alcohol or drugs. Other client factors that have been found to be associated with increased levels of aggressive behaviours are also listed in table 2: longer length of stay (e.g. residential care), high level of hostility or anger, and male gender.

Many authors have attempted to characterize a general profile of persons who are likely to be perpetrators of violence within the workplace – the factors that have been listed include demographic factors (e.g. male sex, age under 45 years, low socio-economic status, low level of education, non-white race,²³ traumatic life events (e.g. abuse, parental loss, lack of bonding)²⁴ psychological and/or behavioural disorders²⁵ and personality factors

¹⁸ Schulte, J.M.; Nolt, B.J.; Williams, R.L.; Spinks, C.L.; Hellsten, J.J. (1998). Violence and threats of violence experienced by public health field workers. *American Journal of Public Health*, 280, 439-442.

¹⁹ Arnetz, J.E. (1998). The Violent Incident Form (VIF): A practical instrument for the registration of violent incidents in the health care workplace. *Work & Stress*, 12, 17-28.

²⁰ Levin, P.F.; Hewitt, J.B.; Misner, S.T. (1998). Insights of nurses about assault in hospital-based emergency departments. *Image: Journal of Nursing Scholarship*, 30, 249-254.

²¹ *ibid.*

²² Arnetz, J.E. (1998). The Violent Incident Form (VIF): A practical instrument for the registration of violent incidents in the health care workplace. *Work & Stress*, 12, 17-28.

²³ Mossman, D. (1995). Violence prediction, workplace violence, and the mental health expert. *Consulting Psychology Journal: Practice and Research*, 47, 223-233.

²⁴ *ibid.*

(e.g. negative affectivity, Type A behaviour, hostile attribution style, locus of control;²⁶ Type A behaviour, hostile attribution style, locus of control.²⁷ Others have criticized this approach as being inexact and not helpful in a given situation.²⁸

Interaction factors

While some violent episodes are unintentional, opportunistic, or spontaneous, others occur as a result of a faulty interaction. Many of the factors listed in both the individual and organizational categories may cause an interaction to spiral downward. The issue of hostile attribution style as a causal factor^{29, 30} is of interest – it reflects the tendency to interpret the actions of others in a negative or threatening manner. This variable is likely important to both workers and perpetrators as they attempt to interpret the actions of the other; misattributions of intent could lead to confrontation. Health-care workers who are rushed due to their workload or other organizational factors, may not have the resources necessary to take the time to step back and reflect on the type of interaction style that is needed with a particular patient. The presence of others near the site of the interaction has been found to be protective.

Organizational factors

Three distinct, but related, perspectives on organizational factors are evident in the literature. One perspective focuses on physical aspects of the environment, one on staffing and personnel issues, and one on workplace climate, including sources of stressors. It is clear that the most basic element to protect against violence in the workplace is to have safe working conditions – such as good lighting, high visibility of work areas, room to manoeuvre around patients and equipment, inaccessible storage for drugs and money, and reduced hiding places for perpetrators. In a review of the general workplace literature,

²⁵ Kelleher, M.D. (1997). *Profiling the lethal employee*. Westport, CT: Praeger.

²⁶ Beugre, C.D. (1998). Understanding organizational insider-perpetuated workplace aggression: An integrative model. In S.B. Bacharach, P.A. Bamberger & W.J. Sonnenstuhl (eds.) *Research in the Sociology of organizations. Deviance in and of organizations* (pp. 163-196). Stamford CT: JAI Press, Inc.

²⁷ Folger, R. and Baron, R.A. (1996). Violence and hostility at work: A model of reactions to perceived injustice. In G.R. VandenBos and E.Q. Bulatao (eds.) *Violence on the Job*. Washington, DC: American Psychological Association, pp. 51-85.

²⁸ McClure, L.F. (1999). Origins and incidence of workplace violence in North America. In T.P. Gullotta and S.J. McElhaney (eds.) *Violence in homes and communities: Prevention, intervention, and treatment*. Thousand Oaks, CA: Sage Publications, pp. 71-99.

²⁹ Beugre, C.D. (1998). Understanding organizational insider-perpetuated workplace aggression: An integrative model. In S.B. Bacharach, P.A. Bamberger & W.J. Sonnenstuhl (eds.) *Research in the Sociology of organizations. Deviance in and of organizations* (pp. 163-196). Stamford CT: JAI Press, Inc.

³⁰ Folger, R. and Baron, R.A. (1996). Violence and hostility at work: A model of reactions to perceived injustice. In G.R. VandenBos and E.Q. Bulatao (eds.) *Violence on the Job*. Washington, DC: American Psychological Association, pp. 51-85.

Neuman and Baron³¹ noted that “hot temperatures, high humidity, extreme cold, poor lighting and air quality, high noise levels, and crowding all have been linked to increased levels of human aggression” (page 404).

In their focus groups with nurses, Levin et al.³² found that there was a widespread acknowledgement of the importance of safety personnel – especially well-trained personnel – as a deterrent. The nurses also believed that understaffing placed them at increased risk for violence, partly because it increased patient wait times, and partly because it left them alone with patients.

Most of the literature in organizational factors has examined the workplace climate and its associated stressors. For example, Cole et al.³³ found that low work group harmony, low supervisor support, a late night work schedule, and having professional status were associated with increased risk for having been personally threatened at work. Baron and Neuman³⁴ found that increasing diversity within the workplace, employee monitoring, change in management, pay cuts or freezes, and use of part-time help were all associated with having experienced aggression in the workplace.

Community/neighbourhood factors

Factors that lead to the destabilization of a community or neighbourhood can spill over into the health-care centre through several pathways. First, community factors such as the level of violent crime, illegal drug use, and gang activity can affect both the types of patients that are treated and the problems that they present.³⁵ Patients who are treated for gun shot or knife wounds or who are high on drugs or alcohol may be more combative in their interactions. Second, community factors such as high poverty rates and high percentages of minority cultures may have strained relationships with health-care facilities that are staffed by primarily majority cultures. Based on past encounters with a health-care system that has not been sensitive to their needs, there may be a lack of trust and a low level of tolerance for the intrusiveness that often comes with care. Third, low levels of community resources may affect the quality of the care received through the inability of the health-care system to provide adequately for all who are in need. This, in turn, may increase levels of distrust and suspicion.

³¹ Neuman, J.H. and Baron, R.A. (1998). Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. *Journal of Management*, 24, 391-419.

³² Levin, P.F.; Hewitt, J.B.; Misner, S.T. (1998). Insights of nurses about assault in hospital-based emergency departments. *Image: Journal of Nursing Scholarship*, 30, 249-254.

³³ Cole, L.L.; Grubb, P.L.; Sauter, S.L.; Swanson, N.G.; Lawless, P. (1997). Psychosocial correlates of harassment, threats and fear of violence in the workplace. *Scandinavian Journal of Work Environment and Health*, 23, 450-457.

³⁴ Baron, R.A. and Neuman, J.H. (1996). Workplace violence and workplace aggression: Evidence on their relative frequency and potential causes. *Aggressive Behavior*, 22, 161-173.

³⁵ Levin, P.F.; Hewitt, J.B.; Misner, S.T. (1998). Insights of nurses about assault in hospital-based emergency departments. *Image: Journal of Nursing Scholarship*, 30, 249-254.

Societal factors

Many researchers have speculated about the association of larger societal factors that may be associated with workplace violence. These factors, however, are difficult, if not impossible to establish outside of cross-cultural, longitudinal studies. Some of the factors that have been noted include increased workplace diversity,^{36, 37, 38} changing norms surrounding the acceptance of aggression,^{39, 40} downsizing, global competition, and constantly changing technology⁴¹ and financial stress associated with not having the means to maintain a chosen lifestyle, shifting family structures, and social isolation.⁴²

In the health sector, recent changes in developed countries may have increased the potential for patient and patient family dissatisfaction, thus inadvertently increasing the potential for violence in health care. In the US, many of these industry changes were driven by an effort to control rapidly increasing health-care costs. In response to increased technology and anticipated Medicare/Medicaid revenues, the number of private, for-profit hospitals increased rapidly, driving up health-care expenses.⁴³ When the Government reduced Medicare and Medicaid payment levels, revenue reductions were passed on to the commercial insurance market and to the general public (i.e., patients). Despite government efforts to limit these increases through price control legislation and central planning, health-care costs continued to rise. This resulted in further national efforts to decrease hospital costs through managed care initiatives, such as regulations that determine the length of hospital stay, capitated payment and managed-care systems. These market economy pressures have precipitated wide-ranging changes for health-care organizations. For the most part, three major approaches have been taken: (1) managed care; (2) hospital

³⁶ McClure, L.F. (1999). Origins and incidence of workplace violence in North America. In T.P. Gullotta and S.J. McElhaney (eds.) *Violence in homes and communities: Prevention, intervention, and treatment*. Thousand Oaks, CA: Sage Publications, pp. 71-99.

³⁷ Neuman, J.H. and Baron, R.A. (1998). Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. *Journal of Management*, 24, 391-419.

³⁸ Paul, R.J. and Townsend, J.B. (1998). Violence in the workplace – a review with recommendations. *Employee Responsibilities and Rights Journal*, 11, 1-13.

³⁹ Kelleher, M.D. (1997). *Profiling the lethal employee*. Westport, CT: Praeger.

⁴⁰ Neuman, J.H. and Baron, R.A. (1998). Workplace violence and workplace aggression: Evidence concerning specific forms, potential causes, and preferred targets. *Journal of Management*, 24, 391-419.

⁴¹ McClure, L.F. (1999). Origins and incidence of workplace violence in North America. In T.P. Gullotta and S.J. McElhaney (eds.) *Violence in homes and communities: Prevention, intervention, and treatment*. Thousand Oaks, CA: Sage Publications, pp. 71-99.

⁴² Kelleher, M.D. (1997). *Profiling the lethal employee*. Westport, CT: Praeger.

⁴³ Sochalski, J.; Aiken, L.H.; Fagin, C.M. (1997). Hospital restructuring in the United States, Canada and Western Europe: An outcomes research agenda. *Medical Care*, 35(10), 513-525.

mergers and acquisitions to form integrated health-care delivery systems; and (3) redefining roles for nurses and other health-care workers.⁴⁴

In the context of managed care, the health-care community now emphasizes the more cost-effective health promotion/disease prevention model over the old primarily curative medical model. The number of hospital beds and the average length of stay are decreasing, and patient acuity is increasing. As a result of the overall movement toward improved patient care delivery and controlled costs, the nursing profession, the single largest health-care occupation, is undergoing rapid change as the delivery of patient care is being redesigned. While patients are older and have greater acuity than in the past, the skilled nursing staff is shrinking, and serious shortages of registered nurses have been reported. This combined with rapid turnover of patients, increases stress on the health-care system as a whole and thus may also increase the potential for violence. Studies have shown that hospital re-engineering to control costs, through downsizing by rapidly reducing staff and cost cutting by a reduction in medication use or laboratory tests, may also result in a decrease in the quality of patient care.⁴⁵ There is a general perception that these changes have had a negative impact on several aspects of health care, including (1) the quality of care received, (2) the satisfaction of the general population, and (3) a negative impact on the health and well being, job satisfaction and retention of care givers in the health system, particularly nurses.⁴⁶ However, the relationship between these important changes in the health-care systems of developed countries and violence in the health-care setting has not been studied.

Is there a definite answer?

Unfortunately, while there are many clues about the factors that might contribute to causing violence against health-care workers, there is little hard evidence to lead the way to finding solutions. While we wait for data to be collected on a wide spectrum of causal factors, it might be best to focus on aspects of the work setting that place health-care workers at most immediate risk – such as working alone with high risk patients, not having adequate security personnel, being understaffed, working in poorly lighted or low visibility places, and not being trained in the management of aggressive patients.

⁴⁴ Greiner, A. (1997). *Cost and Quality Methods: Workplace Innovations in the Health Care Industry*. Washington: Economic Policy Institute.

⁴⁵ Aiken, L.H.; Sochalski, J; Lake, ET. (1997). Studying outcomes of organizational change in health service. *Medical Care*, 35(11), NS6-18.

⁴⁶ Parker, S.K.; Chamiel, N.; Wall, T.D. (1997). Work characteristics and employee well-being within a context of downsizing. *Journal of Occupational Health Psychology*, 2(4), 289-303.

Section 5

Knowledge about the impact of violence at work in the health sector

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Contents

	<i>Page</i>
The impact of workplace violence on health sector workers as individuals	53
Psychological impact	54
Consequences of workplace violence on career.....	56
Financial consequences to the individual.....	56
The impact of workplace violence on health sector delivery of service to clients and patients.....	57
The impact of workplace violence on health sector institutions and enterprises	59
Consequences for the health sector	60
Consequences for economy and society at large.....	60

Although there is a growing awareness of the impact of violence at work, there is little empirical evidence exploring the detail of this impact. Most of the work on the impact of violence assumes that those who perpetrate assaults on health sector workers are clients and patients. However, there is evidence that bullying within the health sector stems from relationships within the workplace. Colleagues, managers and other workers may also be sources of workplace violence.¹ Those working in the health sector may travel to and from areas that pose a risk for robbery or other forms of assault. Health workers who serve the needs of refugees in areas of civil conflict and war may be at risk of other forms of violence as well.²

This section explores the impact of violence against health sector workers. Much of the available literature explores the impact of violence to health workers from clients or patients. It is important, however, to keep in mind that the behaviour of those who are serviced by the health sector is only one contributor to the context within which health workers face possible threat, intimidation and violence.

The following categories set the structure for this section's discussion:

- the impact of workplace violence on health workers as individuals, including psychological, career path and financial consequences;
- the impact of workplace violence for health sector delivery of service to clients and patients;
- the impact of workplace violence for health sector institutions and enterprises;
- the consequences for the health sector and society at large.

The impact of workplace violence on health sector workers as individuals

There is little empirical research that explores the consequences of workplace violence for health sector workers. Many of the campaigns against workplace violence use research on the consequences of violence for crime victims and extend the findings of this research to thinking about victims of workplace violence. This crime survey research notes the outcomes of violence in terms of injuries sustained as well as the psychological impact of experiences of violence. The most extreme form of violence, homicide, is rare. Other forms of violence experienced by workers are assault, robbery, and sexual assault. The United States Occupational Safety and Health Administration (OSHA) cites the Bureau of Labor Statistics data showing health care and social service workers having the highest incidence of assault injuries.³

¹ Quine, L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. *British Medical Journal*, 318, 228-32.

² WHO (2000). Consultative meeting on management and support of relief workers, www.who.int/eha/resources/

³ Department of Labor (1993). Bureau of Labor Statistics, Washington DC.

The 1997 British Crime Survey showed that just under half (46 per cent) of all assaults at work resulted in some type of injury, primarily bruising and black eyes.⁴ However, one per cent of the injuries resulted in broken bones. Workplace violence also has an emotional impact on victims. Seven of ten victims of workplace assault and nearly three out of four victims of workplace threat reported being affected emotionally.⁵

Psychological impact

Reactions to personal violence and threat vary from individual to individual. In general, a range of emotional costs of violence are noted by those who study the impact of bullying, sexual and other forms of harassment, threats, and physical assaults. These emotional reactions include anger, shock, fear, depression, anxiety, stress, sleep disruption, tearfulness, hyper alert state, panic attacks and dread of returning to work.

Anxieties, irritability, lack of sleep and depression disproportionately affect those who experience workplace bullying, for instance,⁶ and workplace threat and violence from clients may have a similar impact. Quine's survey documents the additional harm caused by workplace bullying through the affected employees' increased consumption of alcohol and cigarettes.

Individuals may feel the impact of workplace violence more acutely on site because they are at the place where the violence took place. This may contribute to workers being continually reminded of violent events, and re-experiencing anxiety associated with its potential threat. Victims may then be aware of detrimental effects of the violence and may notice these in their relationships with colleagues, managers and their clients. The British Crime Survey noted that just under half of those assaulted while working asked for, or were offered help following an incident, with two out of five asking for or being offered support following a threat.⁷ Such offers of help by employers may help assuage the impact of violence, but we have no evidence that it does.

Those affected by the emotional consequences of experiencing violence at work are likely to take these experiences home with them. Other than issues of training, there is little in the available literature about the possible soothing effects of a working environment which supports health workers when they are faced with violence and threat. The kinds of support available through relationships with friends and family will also vary. Those experiencing strained relationships at home may feel more acute consequences of anxiety and threat at work. We have no detailed information about the kinds of support workers receive from family and friends following a particular attack or while managing a day-to-day threatening work environment. Moreover, we do not know whether this support is helpful in restoring health workers' well-being following violence. OSHA's Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers (1998) recommends a strong follow-up support programme to ease the impact of personal

⁴ Budd, T. (1999). *Violence at Work: Findings from the British Crime Survey*. London: Home Office.

⁵ *ibid.*

⁶ Quine, L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. *British Medical Journal*, 318, 228-32.

⁷ Budd, T. (1999). *Violence at Work: Findings from the British Crime Survey*. London: Home Office.

problems arising from workplace violence and, interestingly, to prepare employees to confront or prevent future incidents of violence.⁸

There is clear evidence of the differential psychological impact of workplace violence on individuals depending on personal characteristics. Gender differences are marked, with women reporting higher levels of sexual harassment as a form of threat.⁹ Carroll's¹⁰ survey of 586 nurses in seven United States states reported that sexual harassment was included in the definition of workplace violence by 78 per cent of the nurses. Such differences perhaps are embedded in the gendering of particular occupations. Nurses, for instance, are more likely to be women, and as an occupation, nursing receives a higher proportion of assaults and intimidation at work than other health-care occupations.¹¹ Ambulance staff, more likely to be men, may face the threat of weapons, and as a result, are likely to be injured when encountering violence at work.¹² The 2000 survey of health-care staff carried out in the United Kingdom by UNISON found that nearly one in two ambulance workers knew of a colleague who required medical attention for an injury while at work. One in three nurses, on the other hand, reported knowing a colleague injured at work. Interestingly, when the same survey asked about injury to self, one in twelve ambulance workers and one in sixteen nurses reported seeking medical attention for injury. One in three ambulance workers and nurses reported suffering at least one incident of violence not requiring medical attention.

In July 1998 the Workers' Compensation Board, Canada, released its own study on resident violence against care providers in long-term care which found that nine out of ten violent aggressions were toward female workers.¹³

Differential impact will also be influenced by the kinds of risks posed by different work settings within the health sector. Research findings suggest strongly that there is something intrinsic to the nature of the work itself that contributes to an environment within which some health workers are more at risk for violence and threat. Health staff working with those in psychiatric hospitals, residential facilities (especially for those for those with learning difficulties, Alzheimer's Disease and other mental impairments) are at greater risk of violence (State of Washington, 2000). For example, staff employed in psychiatric hospitals, residential care, skilled nursing care and nursing/personal care were the four top claimants for Workers Compensation from 1992-95 in Washington State, United States. The NHS Executive in the United Kingdom notes in its Health Service

⁸ Flannery, R.B.; Fulton, P.; Tausch, J.; DeLotti, A.Y. (1991). A programme to help staff cope with psychological sequelae of assaults by patients. *Hospital Community Psychiatry*, 42, 935-38.

⁹ Elston, M.A.; Gabe, J.; Patton, R. (2000). *Violence in NHS General Medical Practice: A qualitative study of practice experience and strategies for prevention and management*. Final Report, Department of Health & North Central Thames Primary Care Research Network, June, Royal Holloway, University of London, Department of Social and Political Science, Egham, Surrey TW20 OEX.

¹⁰ Carroll, V. (1998). Workplace violence affects one-third of nurses. *Nursing World*, September/October.

¹¹ Nurse Advocate, www.nurseadvocate.org.

¹² UNISON (2000). Survey on Violence Against Health Workers.

¹³ Hospital Employees' Union (1999). *Violence against health care workers in the news*, November 17, 1999 Newsletter (Canada).

Circular of 1999 that nurses working in a mental health/learning disability setting had higher rates of violence incidents per month, with the lowest number of violent incidents reported by those working in acute health settings.¹⁴

The impact of violence for staff working within an environment with a higher incidence of violence may be cumulative because the threat of violence seems constant. Flannery et al.,¹⁵ for instance, found in one United States study that some verbal threats to staff resulted in as much psychological distress as did some physical assaults. Personal characteristics of the recipient of violence, such as age of the employee, physical and social skills, and race may also affect the frequency and impact of workplace intimidation.

Consequences of workplace violence on career

In addition to the personal impact of workplace violence, its threat and its reality have adverse consequences on victims' choices of career path, occupational mobility and job satisfaction. Quine,¹⁶ in a study of bullying in an NHS trust in the United Kingdom, found that those who were bullied (38 per cent of staff) scored higher on the propensity to leave the job scale. Poster's¹⁷ study of 999 staff working with psychiatric patients in the United States, Canada, United Kingdom and South Africa found that assaults are expected as part of the job. However, the extent to which this knowledge about the potential for assault contributes to staff disillusionment or burnout, and staff turnover is unknown. To what extent leaving a violent worksite affects one's career over time is unknown. The high turnover of staff in care homes and the inability of employers to retain health-care staff may in part be fuelled by an intimidating and violent environment within which some staff must work.

Financial consequences to the individual

Exploring the economic consequences of violence at work to individuals is one way of calculating the costs. Little evidence exists on employees purchasing their own technology to help give assurance against violence (such as mobile phones or personal alarms), on employees' lost wages for time off work, or the financial costs of the debilitating psychological impact of violence and threat. A 1995 study of the Royal College of Nurses in the United Kingdom found that nearly half of the respondents incurred personal financial losses not reimbursed by health authorities or insurers due to attack on their personal property while at work.

Legislation in some countries requires serious incidents to be reported to central databases. In the United Kingdom, the Health and Safety Executive requires all serious

¹⁴ NHS Executive (1999). *Working Together, Securing a Quality Workforce for the NHS: Managing Violence, Accidents and Sickness Absence in the NHS*. NHS Executive, Department of Health, London, www.doh.gov.uk/coinh.htm .

¹⁵ Flannery, R.B.; Hanson, M.A.; Penk, W.E. (1995). Patients' threats: Expanded definition of assault. *General Hospital Psychiatry*, 17(6), 451-53.

¹⁶ Quine, L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. *British Medical Journal*, 318, 228-32.

¹⁷ Poster, E.C. (1996). A multinational study of psychiatric nursing staffs' beliefs and concerns about work safety and patient assault. *Archives of Psychiatric Nursing*, 10(6), 365-73.

injuries and incidents to be reported to them via 1995 legislation (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulation). In the United States, OSHA requires an entry to the Injury and Illness Log of any injury that requires more than first aid, is a lost-time injury, requires modified duty, or causes loss of consciousness.¹⁸ Most threat and violence experienced at work falls below these required reporting standards. However, there is limited information on the costs of violence in the United States. There, workplace violence results in over 1.75 million days of lost work annually, with an average of 3.5 days lost per crime, and victims lose on average, more than \$55 million dollars each year in lost wages.¹⁹ It has been calculated that a single physical violence act in a workplace costs on average, \$250,00 per incident (BJS, 2000). In one company, the death of an administrator cost the company \$1.2 million.²⁰ Additionally, workplace violence leads to increased health care utilization, increased workers' compensation costs, increased insurance premium costs, decreased productivity, decreased efficiency in the delivery of services, business interruptions, turn-over of employees, increased legal expenses, and negative coping strategies (e.g. increased intake of drugs, alcohol and cigarettes).

The impact of workplace violence on health sector delivery of service to clients and patients

Health sector employees deliver a special kind of service. Their jobs treat wounds and disease, diagnose ill health, and facilitate the well-being and health of the world's population. Health sector workers are faced with dealing with people who are often in desperate need of attention and care, who may, through ill health, age or other circumstances, be unable to care for themselves. Health sector workers who feel at risk from those they serve may come to believe that intimidation is "part of the job". This may mean however that those who pose that risk are treated with less trust, less commitment or neglected altogether.

Evidence that links higher levels of violence to problem populations is consistent. People living in deprived areas or people with problems (such as those with mental illness or those with learning difficulties living residentially) may pose a greater risk of violence to health care staff. In a recent survey of general practitioners in the United Kingdom, GPs serving deprived populations reported higher levels of verbal abuse and higher risk of more serious incidents than GPs working in other areas.²¹ Fear of working with such client populations may impact the quantity and quality of health care available in deprived areas.

¹⁸ OSHA (1998). Guidelines for prevention workplace violence for health care and social service workers. US Department of Labor, Occupational Safety and Health Administration, 3148 (see, www.osha-slc.gov/).

¹⁹ NIOSH: *Violence in the Workplace: Risk Factors and Prevention Strategies*. US Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Institute for Occupational Safety and Health, DHHS, Publication # 96-100.

²⁰ Stultz M.S. (1993). Crime in Hospitals 1986_1991. *Journal of Healthcare Protection Management*, 9,1-25.

²¹ Ness, G.J.; House, A.; Ness, A.R. (2000). Aggression and violent behaviour in general practice: population based survey in the north of England. *British Journal of Medicine*, 320, 1447-8.

Health-care staff servicing the need of those affected by mental illness may introduce more controlling and less responsive services because of fear of client violence.²² A number of studies of residential care of dementia patients show the circularity of abuse in patient/staff interaction. Meddaugh,²³ in a small study in a single home in the United States, found that aggressive patients were treated more forcibly by staff than non-aggressive ones. In the United Kingdom, a recent survey of nurses in elder care found that the aggression of patients toward staff was accompanied by a high use of various forms of restraint.²⁴ A Swedish study of the abuse of older people includes examples of strained relations between caregivers and care receivers.²⁵

Health staff who come into contact with victims of domestic violence may be hesitant to ask patients about this threat to patient health. Staff are concerned about their own risk at the hands of violent partners. Midwives, in a recent study of domestic violence in pregnancy in London, for instance, reported to researchers that they felt intimidated by some of the partners of the women they screened during antenatal clinic visits.²⁶ A resource manual published by the Department of Health in the United Kingdom notes the concern about the failure to ask patients about domestic violence. However, there is no advice about how to monitor whether midwives, gynaecologists, or other antenatal and post pregnancy health visitors experience intimidation or threat from a violent partner.²⁷ As a consequence, we do not know whether health staff hesitation to inquire about domestic violence, even if suspected, is related to their own concerns about violence to themselves.

Those health sector workers who treat victims of violence may face additional risks of violence themselves. Not all victims of violence seek treatment for any resulting injuries. However, many victims do seek medical attention via hospital casualty departments. Shepherd²⁸ reports that many A & E departments in England and Wales see and treat more victims of violence than are recorded by the police. Ambulance workers have a higher risk of violence due to their intervention into acute violent incidents and encounters with high-risk populations of people. We do not know whether treatment of drunken and violent patients in accident departments is different than that of patients who are in full control of their emotional capacities. Recent evidence exploring the reporting and prosecution of violence in the leisure industry (which often spills over into accident and emergency

²² Rose, N. (1998). Living dangerously: risk thinking and risk management in mental health care. *Mental Health Care*, 1(8), 263-66.

²³ Meddaugh, D.I. (1993). Covert elder abuse in the nursing home. *Journal of Elder Abuse and Neglect*, 5(3), 21-37.

²⁴ Brennan, S. (1999). Dangerous liaisons. *Nursing Times*. 95, 44: 30-32.

²⁵ Saverman, B.-I.; Astrom, S.; Bucht, G.; Norberg, A. (1999). Elder abuse in residential settings in Sweden. *Journal of Elder Abuse and Neglect*, 10(1/2), 43-60.

²⁶ Mezey, G. (2000). *Report on ESRC study of violence in pregnancy*, Swindon, ESRC.

²⁷ Department of Health (1999). *Domestic Violence: A resource manual for health care professionals*. London: Department of Health.

²⁸ Shepherd, J. (1998). An Epidemiological Perspective on Violence, in Stanistreet, D.; Jeffrey, V.; Bellis, M. (eds.), *Violence and Public Health*, University of Liverpool, UK.

departments) suggests that few of those assaulted by door staff report incidents to police, and if incidents are reported, they are rarely prosecuted.²⁹

Clients and patients also experience chaotic, overstretched and often inadequately funded health care facilities in many countries around the world. Staff downsizing, high staff turnover, staff concerns and self protective measures for their own safety affect the environments within which health care is offered. In some parts of England, for instance, patients removed from general practitioner practices because of violence may be offered health care by doctors who are accompanied by “mobile” security officers. Some English Health Trust areas have considered setting up limited doctors’ surgeries in police stations for doctors to safely deliver much needed health care to violent and vulnerable patients.

The impact of workplace violence on health sector institutions and enterprises

Action against workplace violence in the health sector is focused largely on the training of staff, the auditing of the working environment for potential danger, and the potential legal liability for not protecting workers from what might be considered “expected” violence. It might be a useful exercise to calculate the insurance costs of protecting health-care employees adequately while at work.

It is important to note that offering training on violence minimization to health-care staff has become the most common employer action for reducing violence against health workers. Awareness campaigns, encouraging employees to report and to monitor violence, and the introduction of personal training on violence are common to many schemes around the world.³⁰ We have no information about the costs of this training to health sector institutions and enterprises. Nor do we know much about the effectiveness of these training programmes for the minimization of violence. We know little about the nature of any increased reporting of incidents as a result of awareness campaigns (e.g. are these incidents that happened previously but went unreported and unrecorded?). We also do not understand fully the impact of violence minimization training on the safety of workers. Without more information, training may serve to minimize the legal liability of employers without providing the necessary safety for staff. Also, such training, while potentially helpful, often places the burden of minimizing and managing violence onto the shoulders of staff themselves.³¹

Ultimately, employers may set policies in place to help managers and employees minimize the almost expected violence within the health sector. However, some health-care workers are especially at risk because of the issues associated with wider societal conflicts. Health care providers in abortion clinics in some parts of the United States, for instance, are under constant threat of violence by anti-abortion campaigners. The advice on security issued to such staff take on the expectation that such workers could be the target

²⁹ Lister, S.; Hobbs, D.; Hall, S.; Winlow, S. (2000). Violence in the Nighttime economy; Bouncers: The reporting, recording and prosecution of assaults. *Policing and Society*, 10(4), 383-402.

³⁰ State of Washington, US (2000). *Workplace violence: Awareness and prevention for employers and employees*, see www.Ini.wa.gov/wisha/.

³¹ Stanko, E. (1996). Warnings to Women: Police Advice and Women's Safety in Britain. *Violence Against Women*, 2(1), 5-24.

for very serious violence and abuse at all times.³² Similar high security needs may also exist for health-care providers serving refugees in areas of high conflict around the world, such as the Balkans or Rwanda.³³

In summary, the kind of information that might focus the attention of health institutions and enterprises would be the financial costs of staff turnover, sickness and absences, anti-violence training, technologies of security (such as CCTV, personal alarms and mobile phones), and insurance. Little of this information exists.

Consequences for the health sector

The violence clients face in their personal lives spills into the health sector. Those injured by domestic violence in the home, leisure violence or other conflicts that are embedded in social relations use the health sector to treat wounds. Those who are vulnerable, such as those suffering from mental dementia, mental illness, learning disabilities or other mental impairment, may be threatening and violent to health-care staff as well. Staff-staff relations too are commonly a source of conflict for employees. Finally, the financial constraints of a service (whether it is public or private provision) exacerbate often strained and emotionally laden interaction between health-care staff and patients.

Violence as an issue for the health service is often treated as an inevitability. But violence is not inevitable. The evidence suggests that its impact can be minimized, and its occurrences managed and reduced. We have, however, limited evidence that systematically evaluates the source of minimization. Does it come from the behaviour of employees specially trained and readied for inevitable violence? Does it come from committed employers who systematically audit the dangers their employees face? Such information is crucial for taking forward evidence-based good practice. What is interesting in a review of literature from around the world is that there is a general consensus from employees and health and safety executives that employers could do better.

Consequences for economy and society at large

Clearly, alongside the growing concern about violence in society at large, violence against health-care workers has become a major issue. It is crucial for the well-being of the world's populations that the health and well-being of health-care workers is taken seriously. Ultimately, the safe delivery of health care, especially for vulnerable groups in society, will contribute to the overall safety of society.

³² National Task Force on Violence Against Health Care Providers (2000), web site address.

³³ WHO (2000). Consultative meeting on management and support of relief workers, www.who.int/eha/resources/

Section 6

Approaches to anti-violence and achieved impact in the health sector

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Contents

	<i>Page</i>
1. Categories of anti-violence action.....	65
1.1. Prevention actions.....	65
1.2. Post-incident actions	69
2. Initiating persons, groups, institutions, structures, networks	69
3. Evidence and measuring of the impact of anti-violence action.....	70
4. Conditions for success of anti-violence action.....	70

In this section, anti-violence actions are defined as preventive measures taken against workplace violence, and the terms “anti-violence” and “violence prevention” will be used interchangeably. In recent years, guidelines for the prevention of workplace violence have been published in the scientific literature and by various government agencies, and there is fairly strong concurrence amongst these guidelines. Some of the governmental guidelines are designed as general recommendations applying to any occupation or industry¹ while others are specific to the health-care industry.^{2,3} The following section will summarize the violence prevention actions recommended for the health-care industry, discuss initiators of these prevention actions, and how to measure their effectiveness. Because of the probable differences in risk factors for violence perpetrated by patients/outside and violence perpetrated by co-workers (e.g. harassment, bullying), recommended prevention/intervention strategies also differ, and these two categories of violence will be discussed separately below.

1. Categories of anti-violence action

1.1. Prevention actions

Prevention actions for patient/outside violence

Strong commitment from the health-care administration to preventing violence in the workplace. This includes allocating sufficient resources for security, risk assessment and surveillance, worker and management training in violence prevention, and care for worker victims.⁴

A written programme or policy for job safety and security. This programme or policy should be clearly communicated to all personnel. It should provide a definition of workplace violence, clearly state a zero-tolerance stance for workplace violence and management commitment to employee safety and health, encourage prompt reporting of violence, ensure that employees who report violence do not face reprisals, provide a plan for maintaining security in the workplace, provide actions for employees to take when

¹ NIOSH (1996). *Violence in the Workplace: Risk Factors and Prevention Strategies*. Cincinnati, OH: US Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. DHHS (NIOSH) Publication No. 96-100.

² Health Services Advisory Committee (1987). *Violence to Staff in the Health Services*. London: Health and Safety Executive, Health and Safety Commission, Health Services Advisory Committee.

³ OSHA (1998). *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. Washington, DC: US Department of Labor, Occupational Safety and Health Administration, OSHA 3148.

⁴ Morrison, J.; Lantos, J.; Levinson, W. (1998). Aggression and violence directed toward physicians. *Journal of General Internal Medicine*, 13(8), 556-561.

violence is experienced, and provide a contact list (e.g. law enforcement, security, management, medical assistance).^{5,6}

Formation of an interdepartmental/multidisciplinary anti-violence team. The team can identify and resolve security problems, address violence incidents⁷ conduct violence risk assessments and provide prevention recommendations to the administration. The team should include staff representing senior management, operations, employee assistance, security, human resources, the legal department, and employee safety and health. It should have worker representatives, particularly from areas at higher risk for violence within the health-care organization.

Training and education programmes for employees, supervisors, managers and security personnel. In addition to familiarizing employees with the workplace violence policies and procedures, resources, security contacts, etc., training should include recognition of signs of impending violence, verbal and non-verbal de-escalation skills which may reduce hostility and the possibility of violence,^{8,9} methods of containing violent patients, and self-defence skills which allow worker protection without patient harm.¹⁰

Identifying and tagging patients with a high likelihood of being assaultive. Such patients can be identified based on prior violent incidents and/or observations of patient behaviour while in the health-care setting (e.g. high level of agitation, threats, etc.). Included should be a protocol for dealing with such patients.

Identifying and correcting physical risk factors for violence. This includes, for example, removal of items that can be used as weapons by patients (e.g. sharps, blunt objects, such as oxygen tanks, ashtrays, vases, etc.), restriction of number of patient entrances and 24-hour monitoring of these entrances, proper lighting, security cameras, metal detectors, alarm or panic buttons, employee "safe rooms" seclusion areas for aggressive patients, and coded card entrances for medical personnel.^{11, 12, 13, 14}

⁵ Cal/OSHA (1993). *Guidelines for Security and Safety of Health Care and Community Service Workers*. Los Angeles, CA: California Occupational Safety and Health Administration.

⁶ OSHA (1998). *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. Washington, DC: US Department of Labor, Occupational Safety and Health Administration, OSHA 3148.

⁷ Claravall, L. (1996). Healthcare violence: A nursing administration perspective. *Journal of Nursing Administration*, 26(2), 41-46.

⁸ Saines, J.C. (1999). Violence and aggression in A & E: Recommendations for action. *Accident and Emergency Nursing*, 7(1), 8-12.

⁹ Morrison, J.; Lantos, J.; Levinson, W. (1998). Aggression and violence directed toward physicians. *Journal of General Internal Medicine*, 13(8), 556-561.

¹⁰ Flannery, R.B. Jr. (1996). Violence in the workplace, 1970-1995: A review of the literature. *Aggression and Violent Behavior*, 1(1), 57-68.

¹¹ Claravall, L. (1996). Healthcare violence: A nursing administration perspective. *Journal of Nursing Administration*, 26(2), 41-46.

Administrative and work practice controls. This includes measures such as requiring the reporting of all incidents of violence to staff, and maintaining logs or records of these reports. It also includes policies and procedures for secured areas or retrieving patients outside the hospital/emergency department entrance, policies and procedures for home health care that address hazardous situations, prompt management response and support during emergencies, and adopting procedures to reduce patient wait times and to provide timely information to waiting patients.¹⁵

Redesign of jobs to reduce stressors that may affect patient care. For example, high workload demands, low staff-patient ratios, and intense time pressure may contribute to prolonged patient waits, or to patient perception of substandard care that may set the stage for frustration and possible patient aggression. High staff morale and effective communication between junior and senior staff members have also been shown to be associated with reduced incidences of patient violence in long term health-care settings.¹⁶

Prevention actions for co-worker violence

Poor work organization and work climate may foster co-worker conflict. Lack of role clarity, low job control or autonomy, poor social support, poor communication, ineffective leadership/supervision, strained and competitive work environments, and major impending changes in the workplace have all been associated with higher levels of staff conflict (including bullying and harassment), stress/burnout, turnover, and psychological and

¹² Fairbourne, C.L. (2000). Violence in the workplace: Violence prevention strategies in the operating room. *Seminars in Perioperative Nursing*, 9(1), 22-26.

¹³ Health Services Advisory Committee (1987). *Violence to Staff in the Health Services*. London: Health and Safety Executive, Health and Safety Commission, Health Services Advisory Committee.

¹⁴ OSHA (1998). *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. Washington, DC: US Department of Labor, Occupational Safety and Health Administration, OSHA 3148.

¹⁵ *ibid.*

¹⁶ Nolan, P.; Dallender, J.; Soares, J.; Thomsen, S.; Arnetz, B. (1999). Violence in mental health care: The experiences of mental health nurses and psychiatrists. *Journal of Advanced Nursing*, 30(4), 934-941.

physical health complaints.^{17, 18, 19, 20} Suggested prevention measures include the following.^{21, 22, 23}

Establish, publicize, and enforce a written policy that states a zero-tolerance stance toward violence in the workplace, including harassment. The policy should provide a clear statement about what behaviours are considered unacceptable. It should outline steps to be taken if violence occurs, including reporting procedures, any formal conflict resolution procedures, and disciplinary actions toward the aggressor. It should also provide contacts and resources for victims (e.g. law enforcement, management, security, medical assistance).

Provide contact people who can assist in conflict resolution. These individuals should be from a number of different departments so that a victim can find a neutral party to provide assistance. The contacts must be thoroughly trained for the task, and must have the authority to propose changes/solutions where necessary. The contacts should have a strictly neutral expert consultant (perhaps from outside the organization) with psychological and legal knowledge who can assist them, or take over, in very difficult or time-consuming cases.

Change the work design. Examples include increasing job/task control and autonomy, clarifying job tasks and supervisory chains of command, and improving communications about job tasks and workplace changes. Employees should play an active role in the design and implementation of any job or workplace changes.

Provide leadership training to supervisors. This includes training in recognizing conflicts and in conflict resolution skills, the importance of early intervention and supervisory/coaching skills. Employee evaluations can help determine whether the training has been effective.

Identify and correct physical hazards. For physical assaults and threats, many of the same prevention actions as proposed for patient violence apply (e.g., panic buttons, removal of items that can be used as weapons).

¹⁷ Cole, L.L.; Grubb, P.L.; Sauter, S.L.; Swanson, N.G. (1997). Psychosocial correlates of harassment, threats and fear of violence in the workplace. *Scandinavian Journal of Work, Environment and Health*, 23, 450-457.

¹⁸ Leymann, H. (1996). The content and development of mobbing at work. *European Journal of Work and Organizational Psychology*, 5(2), 165-184.

¹⁹ Vartia, M. (1996). The sources of bullying – psychological work environment and organizational climate. *European Journal of Work and Organizational Psychology*, 5(2), 203-214.

²⁰ Zapf, D.; Knorz, C.; Kulla, M. (1996). On the relationship between mobbing factors, and job content, social work environment, and health outcomes. *European Journal of Work and Organizational Psychology*, 5 (2), 215-237.

²¹ Leymann, H. (1996). The content and development of mobbing at work. *European Journal of Work and Organizational Psychology*, 5(2), 165-184.

²² Resch, M. and Schubinski, M. (1996). Mobbing – prevention and management in organizations. *European Journal of Work and Organizational Psychology*, 5(2), 295-307.

²³ Smith-Pittman, M.H. and McKoy, Y.D. (1999). Workplace violence in healthcare environments. *Nursing Forum*, 34(3), 5-13.

1.2. Post-incident actions^{24, 25}

Provide medical care to the victim. Fully document the circumstances surrounding the incident as well as the injuries (the latter with photographs, if possible).

Debrief the victim (critical incident debriefing). The psychological sequelae of patient violence is addressed through counselling by a qualified staff person or outside consultant, sometimes supplemented with a peer-support group.

File a report of the incident. Have the multidisciplinary team described above, or a joint labour-management health and safety committee, investigate the incident. Findings can be used to enhance violence prevention activities.

Assist the worker with injury claims. If the worker chooses to file a worker's compensation claim as a result of the injury, a worksite contact person should be available to provide proper forms and assist the worker in filling them out.

2. Initiating persons, groups, institutions, structures, networks

A number of European countries and the United States have legislation that holds employers responsible for providing a safe and healthy workplace for their employees, while Sweden has a specific regulation, "Threat and Violence in the Working Environment" (AFS 1993:2) that legislates employer actions to prevent workplace violence. In many countries, then, health-care administrators are legally responsible for providing reasonable protection against violence in the workplace.²⁶ Employees and management-union groups can make recommendations regarding violence prevention actions, but it is ultimately the responsibility of hospital administrators to implement these actions (i.e. hire sufficient security, provide staff training, etc.). That said, violence prevention actions can be suggested by a variety of individuals and groups.

Individual workers can singly, or in conjunction with other employees, report violence problems to management and request anti-violence actions. Employees also have the responsibility of learning and complying with the workplace anti-violence programme and policies, participating in appropriate training, promptly reporting incidences of violence, and participating on any health and safety teams or committees dealing with workplace violence issues.

Unions can partner with management (and also external researchers or government agencies) to initiate anti-violence actions. Unions can play a powerful role by mobilizing their membership to participate in anti-violence activities. They can survey their membership about anti-violence needs and about the effectiveness of anti-violence actions.

²⁴ Flannery, R.B. Jr. (1996). Violence in the workplace, 1970-1995: A review of the literature. *Aggression and Violent Behavior*, 1(1), 57-68.

²⁵ Warshaw, L.J. and Messite, J. (1996). Workplace violence: Preventive and interventive strategies. *Journal of Occupational and Environmental Medicine*, 38(10), 993-1006.

²⁶ Claravall, L. (1996). Healthcare violence: A nursing administration perspective. *Journal of Nursing Administration*, 26(2), 41-46.

They can also train and educate members about workplace violence, and advocate for and assist victims of violence.

Internal violence prevention teams, or labour-management health and safety teams can be key players in any anti-violence actions undertaken by a health-care organization. With top management and multi-departmental participation, and administration support and resources, these teams can very effectively gather and evaluate data to monitor the workplace violence situation and suggest and oversee the implementation and evaluation of any violence prevention actions. These teams can also be instrumental in networking with outside law enforcement resources, victim assistance resources, researchers/research institutes, and government agencies.

3. Evidence and measuring of the impact of anti-violence action

A surveillance system can be very helpful in assessing the initial or baseline rate of violence in a health-care setting, assessing how numbers, types, and severity of violence may vary between departments, and determining precipitating factors. Included in the surveillance measures should be medical reports of violence-related injuries, lost workdays and health-care or worker's compensation costs due to violence-related injuries. Such a system requires an accepted definition of violence as stated in the written programme, and the reporting of incidents as they occur (generally with incident report forms). All of this information can be used to guide the development of anti-violence actions. To accurately evaluate the effectiveness of these actions, there must be careful documentation of changes made, and systematic evaluation of the effects of these changes on levels/types of violence, injuries and costs. Employees can also be surveyed before and after any changes to assess the perceived effectiveness of the changes, and any impact on their stress levels and general health. See OSHA²⁷ for information about identifying violence risk factors, monitoring incidents of violence, and for a sample incident report form, employee survey, and security risk checklist.

4. Conditions for success of anti-violence action

Anti-violence actions will not succeed without the solid backing and commitment of the administration of the health-care institution. Also, employees must be committed to becoming familiar with policies/procedures for preventing or dealing with violence, and to promptly reporting all incidences of violence. There must be open lines of communication between the administrative layers of the organization and employees, with employee input solicited and utilized, and prompt notification to employees of new or changing violence prevention activities.

²⁷ OSHA (1998). *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers*. Washington, DC: US Department of Labor, Occupational Safety and Health Administration, OSHA 3148.

Section 7

Recommendations for future research on violence within the health sector

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Contents

	<i>Page</i>
The scope of future violence research.....	75
Understanding workplace violence	75
The effects of violence at work	76
An agenda for change.....	76
Research methods.....	76

This report should contribute significantly to our knowledge about the experience of violence within the health-care sector. In spite of growing research effort and interest in this area in recent years, a number of issues still need further exploration. Based on recommendations from the chapter contributors and members of the advisory group, this section will identify some main areas of research requiring further attention.

The scope of future violence research

In the report it is pointed out that the concept of violence is often used as an umbrella term encompassing a number of specific forms of violence. This reflects the way the term often is used in the field, making little distinction between the various types of violence. However, in order to progress and develop our understanding of the many aspects of violence at work and their interconnectivity, a clearer differentiation of type and nature of violence and anti-social behaviour is needed by both researchers and practitioners.

A particular area in need of interest is the phenomenon of bullying and emotional abuse, which not only seems to be the most common form of workplace violence, but which also appears to be the single greatest source of distress and discomfort to workers and managers alike.

Most of the studies referred to in this report were undertaken in a clinic or hospital setting. However in order to acknowledge the risk of violence to other occupational groups the scope needs to be extended to include other work environments such as emergency calls and care in the community.

Readers will have noticed the sparse reference to countries in the developing and newly industrialized world. On the basis of the limited evidence currently available, there is no reason to believe that violence is less of a problem for workers in such countries than in the industrialized world. It is, therefore time to expand the focus of research to include these countries.

Understanding workplace violence

Many studies of workplace violence have focused on the impact of personal or individual characteristics. Whilst the impact of such characteristics should not be denied, future studies need to focus more on situational perspectives and contextual antecedents of violence. As part of such a change in focus, the relative importance of different risk factors needs to be addressed. Moreover, the degree to which such risk factors may vary, or alternatively, converge across settings should also be investigated. Improving our knowledge in this area will greatly improve our chances to successfully address the problem at a local level.

In exploring situational antecedents of violence, the role of culture (national, professional and organizational) needs greater consideration. As part of a greater understanding of the impact of culture on violence and the reproduction of violent behaviour, process development, and in particular the role of socialization and learning, needs to be better understood.

Future research should also look outside the organization to assess the impact of societal factors on violence in the health sector. As part of such an expanded research agenda, the impact of economic globalization, restructuring and downsizing on levels of violence, as well as on the general standard of health care provision, should be considered.

The effects of violence at work

A number of studies in recent years have investigated the impact or effect of violence on the individual as well as the organization. Future studies focusing on the individual need to incorporate the impact of violence on private life and the financial situation of victims. When considering the organizational effects of exposure to various forms of violence, more attention should be directed to cost implications. In addition, the cumulative effects of repeated violence on both individuals and organizations needs addressing. Of particular interest is the impact beyond health impairment which may contribute to an organizational climate of fear.

An agenda for change

In order to combat and reduce the problem of violence at work, scientifically rigorous and valid intervention studies are needed. The effectiveness of individual preventive measures, for example, workplace design and security measures, needs to be evaluated and better understood. When monitoring violence, minor events or incidents of a less dramatic nature should be included. Similarly, as far as effects are concerned, factors such as absenteeism and poor lifestyle habits must also be taken into consideration. The issue of rehabilitation has so far received comparatively little attention and the development of such programmes and their effectiveness needs to be assessed. It would also be of interest to evaluate and compare the effectiveness of different intervention studies and rehabilitation programmes. In doing so the choice and rationale of specific measures as well as their effectiveness should be considered. One possible way of assessing the effectiveness of individual programmes and initiatives could be to apply a cost-benefit approach. Such an approach is likely to strengthen the “business-case” for violence interventions. In other words, preventing workplace violence of any kind makes good business sense.

Research methods

Future research needs to build on the important experiences and progress of current research. However, better research instruments need to be developed. In this sense a greater emphasis on standardization and validation of instruments is strongly needed. As a means of standardizing instruments, a triangulation method of multiple measuring techniques could be used. For example, by using a combination of reporting procedures, survey instruments and diary-keeping, the validity of individual instruments may be clarified.

Longitudinal studies of workplace violence are rare, limiting the ability of researchers to identify causal relationships between workplace factors and violence. Longitudinal studies are needed to identify the antecedents to workplace violence, long-term effects of workplace violence on both individual workers and organizations, and effective prevention strategies.

To date, quantitative research methods have dominated the field of violence research. However, our understanding of the various forms of workplace violence, in particular, how perceptions of violence and their antecedents may vary between individuals, is likely to benefit from the use of more qualitative research methods.