

# Preventing Violence against Health Workers

by

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## INTRODUCTION

Occupational violence occurs along a 'continuum of severity' and can include homicide, physical violence, threats, stalking, bullying, verbal abuse, and a range of other behaviours that negatively affect recipients.

A definition of occupational violence provided by WorkSafe Victoria is:

**'Occupational violence is defined as any incident where an employee is physically attacked or threatened in the workplace.'**

within this definition:

**"threat"** means a statement or behaviour that causes a person to believe they are in danger of being physically attacked

**"physical attack"** means the direct or indirect application of force by a person to the body of, or to clothing or equipment worn by, another person, where that application creates a risk to health and safety' (WorkSafe Victoria, February 2003:18).

The International Labour Organisation has accepted a broader definition, for example, the in-progress ILO Code of Practice states:

*'Violence includes both physical and non-physical or psychological violence, in the form of verbal abuse, physical assault, homicide, bullying, mobbing, sexual harassment and mental stress. Violence can occur internally within the enterprise, among managers, supervisors and workers; but it also takes place externally, between workers and intruders, as well as between staff, clients, patients, students, suppliers, and the general public' (ILO, 2003:3).*

## Extent of occupational violence

Occupational violence is most common in jobs: (a) where cash is on at hand, and (b) which require substantial face-to-face contact between workers and clients (Chappell & Di Martino, 2000). The incidence and severity of violence varies markedly between these jobs and those where workers have little contact with outside people and where money does not change hands.

There are gender variations: (a) *perpetrators* tend to more commonly be male; and (b) among *recipients*, females tend to experience higher levels of verbal and sexual abuse, and males tend to receive more overt threats and physical assaults (Shannon & Fisher, 2002; Fisher & Gunnison, 2001; Chappell & Di Martino, 2000; Mayhew & Quinlan, 1999). This variation in risk can be partially explained by the gender division of labour with women concentrated in lower status and ‘caring’ jobs with greater face-to-face contact with clients/customers.

The incidence and severity of occupational violence varies across jobs because the risk factors differ. Patterns of violence may also vary because some organizations apply better-targeted intervention strategies. There are overlapping jurisdictional responsibilities between the criminal justice system, the OHS authorities, and individual organizations – all of which record some occupational violence data in different ways. Thus, while the broad risk factors and overall patterns of occupational violence are known, the data are poor. Nevertheless, occupational violence is a predictable accompaniment to work in some jobs, and is in epidemic proportions in a few. Because employment in Australia is increasingly skewed towards the services industries, an increase in the incidence and severity of occupational violence can be expected.

It is important to distinguish the *incidence* (eg % per year) of violence from the *severity* (eg. homicides, assaults, intimidation, threats, and abuse). Only work-related homicides are reliably reported in Australia. As a baseline, the best available data indicates that around one Australian health care worker a year is killed on-the-job (NOHSC, 1999). An estimated 6% of European employees experience physical violence per year (2% from fellow workers, and 4% from ‘outsiders’) and at least 10% are subjected to bullying (Hoel et al, 2001).

It is also important to note that the physical severity of an incident is not necessarily correlated with the extent of impact on recipients. For example, the emotional impact of a slap across the face may be far lower than that following an armed hold-up. In recent studies, my colleagues and I have been measuring the extent of emotional consequences and have identified some interesting features. The early data suggests that the presence or absence of *malicious intent* by the perpetrator may be an important determinant of impact.

Under-reporting is widespread. The available data indicate that in health care, the propensity to formally report a violent incident is mediated by concern about the perpetrators condition. For example, a slap across the face of a nurse that causes no injury *is* likely to be formally reported when the perpetrator is an intoxicated young male – but *not* when the offender suffers from dementia. Only between 10 to 20% of all violent incidents can be expected to be formally reported; a proportion that is likely to increase with more severe incidents (Chappell & Di Martino, 2000; Mayhew & Chappell, 2002). Thus, the official databases significantly understate the extent of occupational violence. Non-reported incidents are known as the ‘dark figure’.

During 2001/2002 an international joint program on occupational violence involving the International Labour Office (ILO), International Council of Nurses (ICN), World Health Organisation (WHO), and Public Services International (PSI) was established (2002a). A report summarizing the findings from studies of occupational violence in the health industry across a number of countries was subsequently published (Di Martino, 2002). The ILO/ICN/WHO/PSI (2002b) also released: *Framework Guidelines for Addressing Workplace Violence in the Health Sector*. The ILO/ICN/WHO/PSI country studies were linked with a concurrent Australian study (Mayhew & Chappell, 2002).

## Typology of occupational violence

A useful typology is to separate violence into basic categories:

- ‘External’ violence which is perpetrated by persons outside the organization, such as during armed hold-ups in shops;
- ‘Client-initiated’ violence which is inflicted on workers by their clients, such as patients attacking nurses; and
- ‘Internal’ violence (or bullying) such as between supervisor and employee, or employees and apprentices (CAL/OSHA, 1998).

Bowie (2002) has argued that there is a fourth ‘systemic’ form of violence that arises out of wider social and economic pressures. For example, restricted economic funding in a time of increased productivity demands may lead to work intensification, job insecurity, and contribute to a workplace culture where aggressive interpersonal communications and/or threatening behaviours are tolerated.

While all these types of occupational violence can occur on the one worksite, the perpetrators of the different forms of violence have distinct characteristics and the most effective prevention strategies vary markedly.

In addition, over the past two years most people in western countries have come to recognise that there is a risk of terrorism associated with some workplaces. Prior to 11 September 2001, few health care workers would have recognized the existence of this risk, and ever fewer senior health officers would have *planned to prevent* such incidents on Australian soil. The world has now changed. While at this stage the need for strict anti-terrorism precautions at all Australian health care sites may not be necessary, wise administrators will at least be reviewing access arrangements and considering the implementation of weapons screening devices. However, the purpose of this seminar is to focus on prevention of the more mundane (but still potentially fatal) violent incidents that appear to be increasing in both incidence and severity in Australian health care settings.

### High-risk jobs

There are four key risk factors associated with ‘*external*’ occupational violence: exchange of money with customers, few workers on site, evening or night trading, and workers who have face-to-face communication with customers (Mayhew, 2002). In large health care complexes, café, post office and other retail outlets may be vulnerable to ‘external’ violence. In addition, as there has been an exponential rise in hold-ups of chemist shops in Australia over the past five years (Taylor, 2002), health care sites/wards with drug cabinets must now be considered at significantly increased risk. Some strategies that have been found to be effective in preventing ‘external’ violence in other industry sectors – which may be helpful in higher-risk health care sites - have been identified (Mayhew, 2000b).

The jobs at highest risk of ‘*client-initiated*’ violence in the US, Britain, and Australia are: police, security and prison guards, fire service, teachers, health care and social security workers (Mayhew, 2002; Fisher & Gunnison, 2001; Chappell & Di Martino, 2000). That is, workers who: ‘...*provide care and services to people who are distressed, fearful, ill or incarcerated*’ (Warshaw & Messite, 1996: 999). Clients who are intoxicated with licit or illicit substances, young males with a history of violence, and/or those who suffer psychosis or a neurological

abnormality are also higher risk (Turnbull & Paterson, 1999). Research in the Australian health care sector also indicates that perpetrators of ‘client-initiated’ violence are disproportionately male, younger, affected by substances or suffering from dementia (Mayhew & Chappell, 2002).

Both the *incidence* and the *severity* of occupational violence appear to be increasing over time, although the causes are complex. There are widespread indicators that poverty, disadvantage, poor health and limited education are correlated with a range of violence indicators in the criminology literature (see BCS&R, 2002a, b & c). Mullen (1997) has argued that a high unemployment level with marginalisation of some groups provides the backdrop for violence directed at community, health care, and other service industry workers. When cuts in public spending and services lead to a reduction in resources, the clients may respond violently believing they are being treated unjustly or unfairly (Mullen 1997). Such scenarios may arise in the health care industry when public access to non-urgent services is restricted, there are very long waiting times, or co-contributions are required or increased.

The incidence of violence on health workers is unlikely to be distributed homogenously across health occupational groups, or even within them. Rather, violence tends to be clustered around ‘hot spots’ (high-risk places) and ‘hot tasks’ (for example, when ‘at risk’ child patients are taken into government care), and is likely to be disproportionately perpetrated by ‘hot people’ (or those with higher-risk conditions e.g. drug and alcohol clients) (Mayhew, 2000a; Mayhew & Chappell, 2002). As is already well known, emergency departments and drug and alcohol clinics are higher risk places in the health industry (see Brookes & Dunn, 1997). In addition, maternity and childrens’ wards can be the site of high-tension events. Broadly speaking, ambulance officers appear to have the highest incidence of victimisation, and ancillary staff the least (with the important exceptions of security officers and admissions staff) (see NHS, 2000; Mayhew & Chappell, 2002). The core challenge is to prevent the risks of violence arising in the first place.

### ***PREVENTION OF OCCUPATIONAL VIOLENCE IN THE HEALTH INDUSTRY***

All the indicators are that a *pre-planned, multi-faceted* and *organization-wide* approach has to be adopted in the prevention of occupational violence (see Hoel et al, 2001).

The available evidence suggests that the preventive strategies that are most likely to decrease the risk of occupational violence have *not* been widely adopted in the health industry. That is, the occupational violence preventive interventions that are higher up the OHS ‘hierarchy of control’ have tended to be ignored, and only lower-order strategies adopted (e.g. training).

Arguably, one of the reasons for this inadequacy is that the occupational violence scientific research appears to be split into three quite distinct bodies of literature: (a) criminology; (b) OHS; and (c) health. Very little overlap appears to have occurred. As a result, strategies that have worked very well in some industry sectors (e.g. hold-up prevention in the retail industry) have not been taken up in the health industry. At the same time, the ‘health’ violence literature appears to have been concentrated around the utility of training – an area which is towards the bottom of the OHS ‘hierarchy of control’.

#### **Applying the OHS ‘hierarchy of control’ to occupational violence**

- Eliminate through design or engineering

- Substitute
- Enclosure
- Administrative controls
- Training

### **‘Crime prevention through environmental design’ (CPTED)**

The OHS ‘hierarchy of control’ approach to managing hazards is consistent with the criminological construct of ‘Crime prevention through environmental design’. CPTED is effective in reducing the risk of both the ‘external’ and ‘client-initiated’ forms of occupational violence. Risks are minimized during design and refurbishment of a building by focusing on the doors and windows, the immediate surroundings, and the placement of fittings and furniture (Caple, 2000; NHS, 1997; Jeffery & Zahm, 1993; Clarke, 1992).

CPTED changes are usually long-term permanent features and do not need continuing financial support. Over time they may therefore be comparatively cheap if the cost of refurbishments is compared with economic losses from acts of violence that result in days lost, damaged property, and turnover of staff. CPTED strategies are usually tailored to site-specific risks for maximum benefit.

Specific strategies include ‘target hardening’ (making violence more difficult to execute), ‘increased visibility’ (to more easily identify perpetrators), and ‘decrease the rewards’ through better cash/drugs/valuables control that reduces the temptation of instrumental violence (Crowe & Adams, 1995).

#### **Target hardening**

Target hardening involves architectural or engineering designs (or re-designs) that control access to specific areas to make violence more difficult e.g. deadlocks on areas where ‘hot products’ are stored (e.g. computers), reduced face-to-face contact during the supply of high-value goods (e.g. pharmacy), wider and higher counters at enquiry desks with raised floor height on staff side (e.g. in outpatients), designated safe escape rooms (e.g. in emergency departments), two exit doors in all interview rooms, and metal detectors built into all entrances.

The number of entry points to a building can be reduced, pathways can be designed to ensure pedestrian walkways are in clear view of people *routinely going about their business*, bollards can be placed outside pharmacy areas to prevent ram raids, bushes only planted outside where muggers are not likely to hide while they wait for victims, and narrow dark underpasses or lanes leading to public transport or car parks designed out (Swanton & Webber, 1990).

Duress alarms may be fitted at all desk areas or worn by staff. Such alarms may be silent internally but link with computers that raise *automatic* emergency responses.

#### **Increased visibility**

Careful design of a building and its surroundings and fittings to increase visibility is a core component of an overall violence prevention strategy. The underlying belief is that if the risk of a perpetrator being caught is increased, this may act as a deterrent. Ideally, an activity that creates a risk of attracting a violent perpetrator is placed where many other potential witnesses gather. For example, a methadone clinic might be placed in an area where numerous pedestrians

pass by. (This principle is routinely adopted when sites for ATM's are selected.) Similarly, interview rooms may be designed with large shatter-proof windows that are overlooked by numerous people routinely going about their normal tasks (Swanton & Webber, 1990).

If high-risk times (such as Friday or Saturday nights) have been identified, the number of potential witnesses can be deliberately increased around such periods (Mayhew, 2003). The installation of closed-circuit television (CCTV) may also deter violence if potential perpetrators know they are being recorded. Prominent signs that video monitoring is on-going may help in this process.

Good lighting and high visibility are of increased importance during evening and night hours, including in car parks, rarely used corridors and storage areas. The type and intensity of lighting can also be varied. For example, a form of sodium street lighting that accentuates pimples (colloquially known as zit lighting) has been successfully used to discourage young males from congregating in particular areas (Painter & Farrington, 1997).

However, it is important to remember, that the 'increasing visibility' tactic is unlikely to work with those perpetrators of violence who are not rational.

### **Fittings and furniture**

Wherever patients/clients have to wait for services, careful choice of furniture and fittings is crucial to reducing the risks. Waiting areas should be comfortable and spacious, and have a clear path to popular common-use fittings such as cold water dispensers (CAL/OSHA, 1998). Ventilation and thermal controls are also important as violence may be more frequent at high temperatures (Chappell & Di Martino, 2000). Pastel colour schemes and soft furnishings can easily co-exist with CCTV, discreet alarm systems, chairs that are fixed to the floor (or too heavy to be lifted and thrown), and other CPTED features tasks (Swanton & Webber, 1990).

Members of the public may have escalated anxiety levels if there are long waiting periods. Hence television and reading materials suitable for the particular social group (e.g. by age) can be provided. One important risk factor is the potential for misconceptions about queue jumpers when waiting patients/clients are not seen in the order when they arrive. Hence clear signs and explanations are needed for any delays in service provision e.g. in emergency departments. For this reason, new hospitals can be planned with a waiting room window over-looking an ambulance bay.

### **Counter design**

The following design guidelines may be helpful:

- Counters should be sufficiently wide that it is difficult for a patient/client to strike a worker (Swanton & Webber, 1990)
- Counters should be sufficiently high that it is difficult for an adult to climb or jump over (Mayhew, 2000a)
- The floor height can be raised on staff side so employees are higher than patients (Chappell and Di Martino, 2000)
- A horizontal fixture can be built along the length of a counter about 165cm from the floor (just below patient's head height) to reduce the risk of downward blows (CAL/OSHA, 1998)
- If there are a series of interviewing positions along a counter, vertical partitions between these may protect the privacy of disclosed information (Swanton & Webber, 1990)

- Duress alarms may be fitted at each counter (Swanton & Webber, 1990).

### **Interview rooms**

The following design features may be useful:

- Two doors in each room, with the staff member sitting close to one of these (CAL/OSHA, 1998)
- Patient/client access to interview rooms should be controlled (CAL/OSHA, 1998)
- A duress alarm may be discreetly fitted in each room (Mayhew, 2000a)
- Windows of shatterproof glass fitted so that clients and workers are in full view
- Furniture minimized, but sufficiently robust that it cannot be thrown (CAL/OSHA, 1998)
- Equipment minimized e.g. staplers can be used as a weapon.

### **Working off-site**

Those who work off-site or in community settings will need additional security. Global positioning systems (GPS) can be fitted to vehicles and linked with mobile phones, rapid key access to cars restricted to driver door only, and a series of administrative controls instituted such as detailed call-in systems with *inevitable* checks if no response is received (see examples in Mayhew, 2000a).

The best available evidence is that ambulance officers are at significant risk of occupational violence, particular when attending patients who have been injured during brawls, outside pubs, and in some isolated areas (see NHS, 2000; Mayhew & Chappell, 2002). The existing risk management strategies will probably need to be refined if the threats faced by ambulance officers increase over time, including changes to vehicle design, emergency alarms, back-up systems, and protocols with police officers (which are already in place in most areas). In remote areas, the risks faced by health workers can be accentuated because of limited resources, potential delays in the arrival of support personnel, and additional demands by clients during crisis times (see Fisher et al, 1995; NH&MRC, 2002).

## ***REDUCING RISK THROUGH ADMINISTRATIVE CONTROLS***

As with other OHS hazards, the risk identification, assessment and control process has been found to be an effective strategy, as well as being a legal requirement under OHS statutes in Australia. Risk management of occupational violence may include:

- CEO commitment to zero tolerance of violence
- Regular *violence vulnerability audits* of the site and work process (Long Island Coalition, 1996)
- Investigation and assessment of all reports and threats (Standing & Nicolini, 1997)
- Review of premises by crime prevention officers (Capozzoli & McVey, 1996)
- Correction of unsafe sites and processes (e.g. lighting)
- Security personnel in 'hot spots' (CAL/OSHA, 1998)
- *Rapid emergency response plan*: the adequacy of the rapid emergency response strategy to deal with threats to staff members needs to be regularly evaluated, as well as the extent to which this plan is understood, and rapidity of access to emergency contact numbers etc.

- Training and mock exercises for emergency response teams is needed, including for high-risk scenarios e.g. following a street brawl when rival gang members are being simultaneously treated in an emergency department
- Consideration needs to be given to allocation of the necessary powers for security officers to exclude or remove people from the site
- Regular maintenance testing of security devices (Mayhew & Chappell, 2002)
- ‘Universal precautions’ so that new staff and casuals are aware of risks and control strategies (CAL/OSHA, 1998)
- Multiple communication channels are needed to communicate with workers (Capozzoli & McVey, 1996). For example, information may be attached to pay slips, or on notice boards in canteen areas. Additional efforts will be needed to reach casual staff.
- Regular training and re-training of all staff is needed to increase security awareness and enhance capacities, possibly including: risk factors for occupational violence, early warning signs, organizational policy and strategies, universal precautions, legal rights, progressive behaviour control strategies, and hands-on training with security hardware (CAL/OSHA, 1998; Mayhew & Chappell, 2002). Paterson and Leadbetter (2002) have also provided detailed guidance on content and standards for occupational violence training programs. However, it is important to note that while the *severity* of incidents may be reduced by improved aggression de-escalation interpersonal skills, the *incidence* is unlikely to change.
- Development of relationships and protocols with local police
- High quality data assists with tight targeting of prevention. The database should include information on incidence in particular units, severity categories, perpetrator characteristics, possible causes/contributing factors, location features, other risk factors e.g. time of shift.
- It is important that no penalties are attached to reporting (including undue time required to fill out forms). The establishment of a confidential electronic reporting system may be considered.
- Consideration needs to be given to banning patient *visitors* who are aggressive (NHS, 2002)
- Consideration needs to be given to the flagging of aggressive patient files, with sanctions for serial perpetrators (see NHS, 2002)
- For repeat offenders in smaller towns, Apprehended Violence Orders (AVO’s) can be taken out in the name of the department rather than the individual victimised (as perpetrator and victim usually know each other’s home as well as work addresses). The potential to access AVO’s in organisational name varies from state to state
- There is evidence from both OHS and from criminology that the *certainty* of sanction on a perpetrator is a greater deterrent than is the *severity* of the sanction (Zdenkowski, 2000; Scholz & Gray, 1990)
- The human resource information system could record financial costs attributable to violence, similar to the ways by which workers’ compensation costs can be separated out, e.g. flow-on expenses from absenteeism, sickness absence, workers’ compensation insurance costs, turnover, short-term replacement of staff, diminished productivity, lost opportunity costs and poor reputation effects
- If the risks cannot be eliminated, then the organisation of work can be reconfigured to reduce the risks, e.g. increased staffing in ‘hot spots’ and at ‘hot times’ (Chappell & Di Martino, 2000; Mayhew & Chappell, 2002); and
- Independent evaluation of prevention strategies is essential, including worksite security.

## CONCLUSION

All the indicators are that the incidence and severity of occupational violence is increasing over time. The best available evidence is that *at least* 10% of health care workers will experience some form of occupational violence at work each year. Hence wise health administrators will be prioritizing prevention strategies. There are extensive direct and indirect costs.

It has been argued in this paper that a *pre-planned, multi-faceted and organization-wide* approach has to be adopted to reduce the risks from occupational violence. It is of core importance that those in the health industry begin to implement prevention strategies that are known to be effective in other industry sectors. It is no longer sufficient to focus on violence training and emergency responses as these are not effective *prevention* strategies on their own.

In the health industry (as in other service industry sectors) it is important to note that obligations under the OHS legislation are not diminished by the rights of patients/clients or their privacy. That is, CEO's have a duty of care to provide both a safe *place* and a safe *process* of work for their employees. In most jurisdictions, this non-delegable responsibility includes *everyone* on a site, including visitors and sub-contractors (see Johnstone, 1999 & 1997). The prevention of occupational violence (and possibly bullying) falls under this obligation.

Higher level controls must be implemented as a matter of urgency, not least because of the looming risks from terrorist attacks. A series of prevention strategies have been trialed and evaluated over a period of years in other industry sectors and have been found to be effective in reducing the risk of occupational violence. Yet these strategies are rarely understood and implemented in the health care industry. Most important among these new strategies is CPTED.

Finally, if I had a magic wand and could change two things – it would be to:

- (a) Encourage every CEO to adopt a zero-tolerance of violence policy that was *enforced*; and
- (b) Ensure that every purchasing officer in every health care setting had a comprehensive understanding of CPTED, and would therefore refuse to 'sign-off' on the purchase of any buildings, refurbishments, or purchases (even of chairs) unless these were 'best practice' in terms of violence prevention.

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### **On-line occupational violence information sources links**

Occupational Violence Prevention Strategies Database at [www.aic.gov.au](http://www.aic.gov.au) There are three sections: (a) an annotated bibliography of the research literature; (b) a listing of the prevention initiatives in each of the Australian states and territories; and (c) a 'links' section to access international web sites on specific violence issues. The data base is updated approximately every three months.

The three Discussion Papers written by Dr Claire Mayhew and Professor Duncan Chappell for the *Taskforce on the Prevention and Management of Violence in the Health Workplace* are available online at: <http://www.health.nsw.gov.au/health-public-affairs/campaigns> and <http://www.aic.gov.au/research/CVP/occupational/index.html>

National Health Service, *We Don't Have To Take This Resource Guide* publications are all available at: <http://www.nhs.uk/zerotolerance>.