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Pandemic-Related Workplace Violence and Its Impact on Public Health Officials, March 2020–January 2021

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Abstract

Objectives.—To characterize the experience and impact of pandemic-related workplace violence in the form of harassment and threats against public health officials.

Methods.—We used a mixed methods approach, combining media content and a national survey of local health departments (LHDs) in the United States, to identify harassment against public health officials from March 2020 to January 2021. We compared media-portrayed experiences, survey-reported experiences, and publicly reported position departures.

Results.—At least 1499 harassment experiences were identified by LHD survey respondents, representing 57% of responding departments. We also identified 222 position departures by public health officials nationally, 36% alongside reports of harassment. Public health officials described experiencing structural and political undermining of their professional duties, marginalization of their expertise, social villainization, and disillusionment. Many affected leaders remain in their positions.

Conclusions.—Interventions to reduce undermining, ostracizing, and intimidating acts against health officials are needed for a sustainable public health system. We recommend training leaders to respond to political conflict, improving colleague support networks, providing trauma-informed worker support, investing in long-term public health staffing and infrastructure, and establishing workplace violence reporting systems and legal protections.

The COVID-19 pandemic imposed social, economic, and health burdens on individuals and communities; strained health systems; and thrust public health into the spotlight. An immediate rise in attention on public health interventions nationally[1] was shadowed by reports of public backlash.[2,3] By June 2020, journalists were reporting cases of social media

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CONTRIBUTORS

All authors conceptualized the work and provided critical draft revisions. J. A. Ward, E. M. Stone, and P. Mui collected the data. J. A. Ward and E. M. Stone performed the analysis. J. A. Ward led article drafts and revisions. B. Resnick and P. Mui secured funding and provided supervision. All authors approved the final article as submitted and agree to be accountable for all aspects of the work.

CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

HUMAN PARTICIPANT PROTECTION

This study was reviewed and approved as not human participant research by the Johns Hopkins Bloomberg School of Public Health institutional review board.

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insults, doxing campaigns (i.e., public distribution of personal information), protests, and armed threats against public health officials.[4] By August 2020, conflict-related resignations and firings were also reported.[5] According to the National Institute for Occupational Safety and Health, such nonphysical violence (e.g., threats, harassment) and physical violence (e.g., assaults) directed at people while at work, like the acts targeting public health officials, constitute workplace violence.[6]

Public health officials are hired or appointed to a state health department (SHD) or local health department (LHD) as public servants. They work to protect and promote the health of all populations within their jurisdiction, including the responsibility to create, champion, and implement laws that affect health.[7] Thus, for public health officials, residents of their jurisdiction are analogous to patients in a health care setting. In health care settings, such as emergency departments, nonphysical workplace violence perpetrated by patients has been associated with reduced job satisfaction and burnout.[8] The experiences and consequences of nonphysical workplace violence in the form of harassment or threats from the public directed at public health officials remain unexplored. In addition, how such interactions may affect pre-existing public health workforce concerns related to job satisfaction, morale, and turnover is unknown.[9-11]

A team of public health policy researchers and practitioners, including an occupational health nurse and a former employee of the National Association of County and City Health Officials (NACCHO), collaborated with NACCHO to understand the extent of public health officials' pandemic-related experiences of violence in the form of harassment and threats. Our aim was to characterize the experience and impact of such acts on public health officials during the first 10 months of the COVID-19 pandemic. We selected a mixed methods approach to enrich and contextualize media reports. We discuss our findings in terms of nonphysical workplace violence implications on the public health workforce.

METHODS

We employed a convergent parallel mixed methods study design, an approach in which data are collected from multiple complementary sources in parallel, then jointly analyzed to generate a more complete understanding of a phenomenon within a time-sensitive context (Figure A, available as a supplement to the online version of this article at http://www.ajph.org).[12] The complementary sources leveraged were media content and a quantitative survey. The media content included a compilation of actual or threatened departures of public health officials and descriptive narratives for each case, derived primarily from local and national media coverage. The quantitative survey was developed by NACCHO and fielded among the LHD officials that comprise their membership.

Media Content

We developed an Excel-based database of media-reported departures or threatened departures among US state and local public health offcials (e.g., health officers, directors, commissioners), with or without experiences of harassment or other forms of violence between March 2020 and January 2021. To ensure thoroughness, we began with a Kaiser Health News and Associated Press (Kaiser/AP) deidentifed, jurisdiction-level

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list of 190 position departures (April 2020–mid-January 2021).[13] Kaiser/AP journalists systematically compiled the original list, verifying each case through public sources or direct communication.[13] We cross-referenced the Kaiser/AP list with departures reported to NACCHO. We also performed our own online search, inclusive of the full study period. Our search terms included location, position titles, and "resign*" or "depart*." Departures identified by our team were shared and confirmed by Kaiser/AP.

Next, the research team conducted in-depth reviews of each case to identify potentially relevant contextual factors and drivers of departure. For each case, we consulted supplementary sources until we exhausted public sources or reached saturation. Supplementary sources included departments' or officials' social media accounts, local boards of health meeting minutes, etc. (Figure A). We drafted summarizing narratives, capturing these details alongside descriptive or explanatory quotes. We analyzed the narratives by using an iterative process including inductive and deductive coding to identify cross-cutting themes and representative quotes. Separately, we extracted available data on identified public health officials' race, gender, and time in position; departure type (e.g., resigned, fired, retired, other, or not departed); departure date (where applicable); geographic characteristics (e.g., urban, rural jurisdiction); mention of workplace violence (e.g., threats or harassment); and mention of potentially precipitating policy event(s) (e.g., recent mask mandate, gathering restrictions). We calculated descriptive statistics by using Stata version 16.1 to quantitize media-portrayed case characteristics.[14]

Quantitative Local Health Department Survey

From October 2020 to February 2021, NACCHO fielded the Harassment and Changes in Local Health Department Roles and Authority supplemental survey module, a complement to the Forces of Change survey of LHDs' perceived public health infrastructure needs.[15] Subject-matter experts developed the supplemental module, which was piloted by NACCHO before fielding. The module was sent to NACCHO's full census of LHDs (n = 2430), administered online, and completed by the local public health official or their designee. SHDs were not surveyed.

The survey module included 2 multiple-choice harassment questions. Specifically, respondents were asked to "report any harassment of health officials or your agency in response to COVID-19 that has occurred between March 2020 and today." The 10 response options included general social media backlash; individually targeted messages; public broadcasting of personal contact information ("doxing"); direct threats to personal or family safety; coordinated demonstrations online, in a public setting, or at a personal residence or other private setting; vandalism of public property or personal property; and other (unspecified). Respondents indicated whether actions were targeted at the LHD, LHD leadership, or other personnel. Multiple selections were allowed. This article focuses on acts targeting leaders or affecting whole departments. Separately, respondents were also asked, "Have any agency leaders or other personnel resigned, been reassigned or been fired from your local health department specifically due to conflicts between public and political leaders or due to political pressure related to your COVID-19 response?" We focus

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on conflict-motivated departures among leaders. Staff experiences and departures are not directly discussed. We used Stata version 16 to calculate descriptive statistics.[14]

Quantified and Thematic Merged Analysis

We proportionately compared quantitized components of the media content with quantitative survey results. We assessed qualitative themes to examine experiential trends. Finally, we examined media content, survey results, and qualitative themes in unison to mutually clarify and validate findings. For participant validation, resulting inferences were discussed with a self-selected national sample of 30 public health officials at NACCHO's annual conference. Session participants assessed resonance of themes through anonymous polls and provided unstructured feedback in 3 online discussion groups.

RESULTS

From March 2020 to January 2021, a total of 256 cases, including 120 resignations, 58 retirements, 20 firings, 24 other departures, and 34 threatened nondepartures, were identified in media reports. These cases represented 42 states, involving 51 SHD and 205 LHD officials. Analyzed by departure date, we found a sustained spike in retirements beginning in May 2020 and a bimodal curve of resignations, peaking in July 2020 and again in December 2020 (Figure B, available as a supplement to the online version of this article at http://www.ajph.org).

Table 1 presents characteristics of the media-profiled cases. Across SHDs and LHDs, most leaders were White and female, consistent with public health leadership majority demographics; Black or Asian leaders were disproportionately affected (n = 26/256; 10%).[16] LHD cases were regionally overrepresentative of the Midwest (n = 75/205; 37%) and West (n = 83/205; 40%). SHD cases were regionally overrepresentative of the South (n = 18/51; 35%). Approximately half of LHD cases occurred in rural jurisdictions (n = 110/205; 54%). Policy precipitators of leadership turnover were not identified in most cases; where they were, mask mandates and multiple COVID-19 prevention policies were most frequently reported. Policy-associated departures tended to be from LHDs (n = 76/205; 37%) rather than SHDs (n = 11/51; 21%).

Quantitative Local Health Department Survey

From a total of 2430 LHDs, 583 responded to the survey (response rate: 24%; Table 2). The median and mean survey completion dates were November 25, 2020, and December 11, 2020. Responding departments were proportionately distributed across the Northeast, South, and Midwest but underrepresented the West (n = 119/550 [22%]; n = 206/731 [28%]; n = 208/855 [24%]; and n = 50/323 [15%], respectively).[17] Median population size of represented communities was 34 097 (range=76–2 387 728; data not shown). In total, 1499 acknowledgments of harassment targeting leadership, staff, or the LHD were reported by 335 departments (57%). The most common leadership-targeted act was general backlash through social media (n = 194/583), followed by individually targeted, not directly threatening messages (n = 173/583). Of 583 responding LHDs, 32 agency leaders from 25 departments resigned, were reassigned, or were fired due to political pressure or conflict.

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Thus, 4.6% of responding LHDs reported leadership departures related to political pressure or conflict (data not shown).

Quantified Merged Analysis

Across the media content and the survey responses, we found proportionately similar experiences of harassment. Overall, 43% of LHD survey respondents reported 1 or more leadership-targeted forms of harassment (n = 253/583). Similarly, in the media content, 44% of SHD and LHD officials described experiencing at least 1 form of harassment (n = 112/256). Harassment experiences were reported by 36% of officials who left their positions (n = 80/222). Across both data sources, threats to individual or family safety affected 9% to 12% of officials (n = 30/256 cases; n = 55/583 respondents) and 15% of surveyed departments (n = 88/583). Position departure was associated with one third of the 30 SHD and LHD cases involving direct threats (n = 10/30; 7 by resignation). Demonstrations at private residences were reported in 2% of media cases (n = 6/256), targeting 2% of survey respondents' leadership (n = 12/583) and affecting 2% of responding LHDs (n = 14/583). Doxing was described as affecting approximately 3% of officials by the media (n = 7/256) and 7% of LHD officials on the survey (n = 42/583). One SHD departure was associated with residential protests and doxing, each. Social media backlash (such as Facebook groups calling for firings or circulating personal insults) and individually directed messages (such as e-mails or phone calls calling the health official "evil" or racial or gendered slurs) were reported by a larger portion of survey respondents than were portrayed by the media (Table 2).

Within the media analysis, COVID-19-related public protests were the category of harassment that differed most across SHDs and LHDs. Public protests were reported in 50% of SHD cases (n = 25/51) but just 13% of LHD cases (n = 27/205). Similarly, 10% of survey respondents reported that their LHD experienced public protests (n = 60/583).

Thematic Merged Analysis

Five themes emerged from the qualitative analysis of descriptive narratives, considered alongside the quantitized media content and LHD survey. Leaders described dealing with underrecognized expertise, an underresourced infrastructure, villainization, politicization, and disillusionment stemming from disrupted work–life balance and frustration with the constraints placed upon their professional capacities (Table 3). Member-checking polls indicated strong support across all themes, with at least 90% of members indicating they personally experienced the theme or observed it in other public health leaders.

Underrecognized expertise.—Among public health officials who resigned during the pandemic, many indicated that their expertise had been marginalized and disregarded. They identified multiple public health issues as co-occurring with the pandemic, including extreme weather events, an influx of vaping-related injuries, and calls to action on longstanding social inequities. All these emergent issues demanded public health expertise, yet public health officials believed their responses to these needs were underappreciated, criticized in personal attacks, and further constrained by forces beyond their control.

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“Matchsticks and Scotch tape” infrastructure.—Across media reports, officials lamented the limitations of the public health system’s infrastructure, describing it as underfunded, understaffed, and decapacitated. They cited outdated information technology as complicating time-sensitive processes and delaying contact tracing. Social media offered an affordable and accessible platform for disseminating public health information but also made leaders and agencies vulnerable to public backlash. Position vacancies added to tensions. Several states (e.g., Colorado, Washington, Montana) responded to leadership departures by uniting multiple counties under a single public health official, compounding system strain and workforce limitations.

The lifesaving villain.—Although many officials felt poorly positioned to leverage their expertise, many also felt overly situated as the villain of the policy response. In our media analysis, departures identified as potentially precipitated by mask mandates, business closures, or other policies or policy reversals were more common in LHDs (n = 76/205) than SHDs (n = 11/51). Particularly in rural communities, health officials described challenges in being the public representative of a policy that was not always within their authority to decide. The role of the villain, as described by affected public health officials, was often juxtaposed with the official’s previous persona as a public servant and a trusted community member.

Politicized public health.—In discussing the trajectory of the public health response, leaders both eschewed and embraced politics as essential to infrastructure needs and policy interventions. Political threats and job insecurities were not explicitly included in the 10 harassment categories used to analyze survey responses and media content. However, 4.6% of LHD survey respondents reported experiencing leadership turnover because of political pressure or conflict. Many media profiles coded as “other” forms of harassment similarly met these descriptions. For example, one former official described masking policies as being perceived as oppositional to economic interests; another described adequate departmental funding as being contingent upon continued political favor with the governor. Public health officials found it a “tough balance” to strike when political messaging and priorities were not aligned with public health priorities. For the public health official, the consequence was often confusion or a sense of futility.

Disillusionment.—Across media accounts, public health officials described grappling with colliding identities as neighbors, parents, health care providers, and protectors. They described confusion and frustration with their sudden shift from being a trusted friend and public servant to being the face of an imperfect response or the leader of an attack on personal liberties. Some described conflict between the aspiration of their mission and the reality of their limited capacities. They described overwhelming professional demands, inadequate infrastructure, and fatigue alongside worry for their families and grief for their own losses. Across departure statuses and duration of time in leadership, a personal reassessment of the meaning, purpose, and sustainability of mission-driven work was ubiquitous.

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DISCUSSION

Consistent with national reporting,[18] our research identified high occurrence of harassment directed at public health officials from March 2020 to January 2021 and substantial turnover in public health leadership positions. A national survey of 583 LHDs (fielded October 2020–February 2021) identified 1499 reports of unique forms and targets of harassment across 57% of responding departments. Of surveyed officials, 43% said they had been targeted. Whether directly targeted or responsible for an affected department's operations, LHD officials were impacted. Across roughly 2500 SHDs and LHDs, we identified 222 public health officials who left their positions between March 2020 and January 2021. Of departures, 36% occurred alongside reports of harassment. However, our findings indicated that the relationship between leadership departures, harassment, and personal threats may not be as direct as a cursory review would imply.

Across media and survey sources, we found that a substantial portion of public health officials who experienced personal threats did not resign. Although 9% of surveyed officials (n = 55/583) and 15% of departments (n = 88/583) reported direct threats to individual or family safety, our media analysis only identified 10 safety threats that resulted in leadership departures (n = 10/256; 4%). Similarly, the specific experiences of residential protests and doxing appear to be relatively rare and generally separate phenomena from leadership resignations. Presuming leadership departures were primarily driven by threats to personal safety may oversimplify the larger dynamic of nonphysical workplace violence. Safety and retention interventions are warranted, but other, potentially more common and complex victim experiences pose additional workforce concerns. A Centers for Disease Control and Prevention survey of more than 26 000 public health workers in April 2021 identified symptoms of mental health conditions among half of respondents, including 37% with symptoms of posttraumatic stress disorder.[19] Many leaders and staff remained in their roles despite experiencing direct threats and other violence, calling for a detailed examination of what trauma-informed workforce protections and supportive services are needed.

Public hostilities, leadership targeting, and public health workforce turnover are incompletely understood through quantified analysis alone. A fuller understanding of the scope, scale, and consequences of harassment within the context of nonphysical workplace violence requires a synthesis of insights from the affected individuals. Our analysis of public health officials' perspectives on pandemic experiences and departures revealed that despite intense demand for their work, public health officials believed their expertise was underrecognized and underappreciated. They described a public health infrastructure that was underfunded and understaffed. Social media was effective for overcoming communication limitations and disseminating information widely. However, it also made officials highly visible and accessible to a public primed to react to policy changes, potentially facilitating villainization of the public health official. Constrained by poor infrastructure, politics, and the backlash of the public they aimed to protect, public health officials described grappling with personal and professional disillusionment, torn between what they felt they should do and their limited ability to pursue it. For some, the conflict was untenable. For those who remain, the reassessment of purpose, tactics, and capacities may have enduring effects.

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Previous research by Caillier on workplace aggression against federal government leaders and staff identified experiences of undermining conditions and behaviors (e.g., disregarded expertise, mismatches between demand and infrastructure capacity, political gamesmanship) and ostracizing (e.g., public villainization) as being a particularly toxic combination of stressors, predictive of lower work–stress tolerance and loss of meaningfulness in work.[20] In our research, public health officials' descriptions of disillusionment may have been a consequence of this ostracizing and undermining dynamic. Caillier's research further identified that additional exposures to intimidation (e.g., through threatening messages or acts) compounded the stressors and predicted 1.8 times higher likelihood of intention to resign.[20] This suggests that there may be opportunity to reduce position departures amid public backlash by ensuring workers' personal and professional safety, combined with efforts to strengthen public health system capacities, preparing leaders to respond to political conflict, and developing more cohesive and supportive public health networks.

Limitations

These interpretations should be considered alongside some limitations. Specifically, our media content may not be comprehensive for incidents of harassment because of our search's emphasis on leadership departures. This focus, combined with the media's potentially selective reporting, may bias our analysis toward overstated associations between public hostility and workforce turnover. Conversely, the media analysis may have been conservative in limiting identified contextual factors to within-jurisdiction characteristics. Instead, events leading to departures in one county may influence events and turnover in another.

We sought to buffer these limitations with a national survey of LHD experiences of harassment. However, given COVID-19 demands on LHDs, the low response rate of 24% may be biased toward more affected departments. Alternatively, most affected departments may have been less responsive because of overwhelming workloads. Either selection bias could limit generalizability. Noninclusion of SHDs is also a limitation. However, the proportionate concordance of harassment experiences reported across survey respondents and media-profiled cases implies a legitimacy of findings, bolstered through intentional source integration. Resulting inferences, conveyed through the 5 themes presented, were confirmed through member checking. Member affirmations suggested that pervasive challenges may transcend pandemic-specific drivers of public backlash. We examined 1 period within the pandemic; experiences of violence continued.[18] More formalized reporting systems are needed to detect, monitor, and respond to work-related harassment. Future research should examine disparities in victimization by race, possible sociopolitical characteristics associated with SHDs and LHDs affected by such violence, and restorative workforce interventions that validate public health leaders' expertise.

Public Health Implications

Presuming leadership departures were primarily driven by threats to personal safety may oversimplify the larger dynamic of workplace violence and overlook needed workforce protections and assurances. During the COVID-19 pandemic and other co-occurring public health challenges, public health officials described experiencing threats and intimidation,

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social villainization and exclusion, and the undermining of their professional duties by poorly aligned politics and an inadequate public health infrastructure. These conditions maximize concerns for stress intolerance, loss of meaning in work, and increased turnover.[20] In a field where recruitment and retention relies on mission commitment and meaningful work, stress intolerance and loss of perceived meaningfulness among leadership could be detrimental to the discipline, regardless of whether turnover directly results.[10,21]

Coordinated interventions are needed to minimize the threat of undermining, ostracizing, and intimidation. First, stronger collaborations with the political sector and leadership training in health policy, advocacy, and media management may help counteract messages of underappreciation and improve system capacities. Second, colleague networks that promote belonging and reinforce strategies for balancing professional ideals alongside system constraints, potentially following models of new graduate nursing consortiums in health care, should be considered.[22] Third, long-term staffing and infrastructure investments that support reintroduction of comprehensive programming while retaining surge capacity are needed.[23] Finally, safety assurances must be promoted throughout the public health workforce, beginning with better reporting systems and increased awareness and access to legal protections.[24] No public health employee should be made to feel unsafe or devalued for protecting the health and safety of the public. Collectively, these strategies will begin to prioritize worker safety and well-being as a core function of all health departments, an essential step toward creating a more enduring public health system.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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REFERENCES

1. Google Trends. Quarantine; social distancing; shutdown; stay at home; reopening. Available at: https://trends.google.com/trends/explore?

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

date=2020-01-01%202020-12-31&geo=US&q=quarantine,social%20distancing,shutdown,stay%20at%20home,reopening. Accessed May 11, 2021.

2. Mello MM, Greene JA, Sharfstein JM. Attacks on public health officials during COVID-19. JAMA. 2020;324(8):741–742. 10.1001/jama.2020.14423 [PubMed: 32777019]
3. Underfunded and under threat. Kaiser Health News. Available at: https://khn.org/news/tag/underfunded-and-under-threat. Accessed May 11, 2021.
4. Weber L, Barry-Jester AM, Smith MR, Associated Press. Public health officials face wave of threats, pressure amid coronavirus response. Kaiser Health News. June 12, 2020. Available at: https://khn.org/news/public-health-officials-face-wave-of-threats-pressure-amid-coronavirus-response. Accessed May 20, 2021.
5. Smith MR, The Associated Press, Weber L. Public health officials are quitting or getting fired in throes of pandemic. Kaiser Health News. August 11, 2020. Available at: https://khn.org/news/public-health-officials-are-quitting-or-getting-fired-amid-pandemic. Accessed October 1, 2021.
6. Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. Workplace violence prevention strategies and research needs (DHHS Publication No. 2006–144). US Department of Health and Human Services. 2006. Available at: https://www.cdc.gov/niosh/docs/2006-144/default.html. Accessed October 14, 2021.
7. Centers for Disease Control and Prevention. 10 Essential Public Health Services. March 18, 2021. Available at: http://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html. Accessed October 14, 2021.
8. Copeland D, Henry M. The relationship between workplace violence, perceptions of safety, and professional quality of life among emergency department staff members in a level 1 trauma centre. Int Emerg Nurs. 2018;39:26–32. 10.1016/j.ienj.2018.01.006 [PubMed: 29402717]
9. Sellers K, Leider JP, Gould E, et al. The state of the US governmental public health workforce, 2014–2017. Am J Public Health. 2019;109(5):674–680. 10.2105/AJPH.2019.305011 [PubMed: 30896986]
10. Leider JP, Coronado F, Bogaert K, Sellers K. A multilevel workforce study on drivers of turnover and training needs in state health departments: do leadership and staff agree? J Public Health Manag Pract. 2021;27(1):30–37. 10.1097/PHH.0000000000001082 [PubMed: 32000170]
11. Pourshaban D, Basurto-Dávila R, Shih M. Building and sustaining strong public health agencies: determinants of workforce turnover. J Public Health Manag Pract. 2015;21(suppl 6):S80–S90. 10.1097/PHH.0000000000000311
12. Creswell JW, Clark VLP. Designing and Conducting Mixed Methods Research. 2nd ed. Los Angeles, CA: SAGE Publications Inc; 2010.
13. The Associated Press. Public health official departures. Available at: https://data.world/associatedpress/public-health-official-departures/workspace/project-summary?agentid=associatedpress&datasetid=public-health-official-departures. Accessed January 21, 2020.
14. Stata release 16.1. College Station, TX: StataCorp LLC; 2020.
15. National Association of City and County Health Officials. Forces of Change Surveys. Available at: https://www.naccho.org/resources/lhd-research/forces-of-change. Accessed October 1, 2021.
16. Health Resources and Services Administration. Defining rural population. April 28, 2017. Available at: https://www.hrsa.gov/rural-health/about-us/definition/index.html. Accessed July 31, 2021.
17. National Association of City and County Health Officials. 2019 National Profile of Local Health Departments. 2019. Available at: https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf. Accessed July 10, 2021.
18. Smith MR, Associated Press, Weber L, Recht H. Public health experts worry about boom-bust cycle of support. Kaiser Health News. April 19, 2021. Available at: https://khn.org/news/article/public-health-experts-worry-about-boom-bust-cycle-of-support. Accessed July 9, 2021.
19. Bryant-Genevier J. Symptoms of depression, anxiety, post-traumatic stress disorder, and suicidal ideation among state, tribal, local, and territorial public health workers during the COVID-19 pandemic—United States, March–April 2021. MMWR Morb Mortal Wkly Rep. 2021;70(26):947–952. 10.15585/mmwr.mm7026e1 [PubMed: 34197362]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

20. Caillier JG. The impact of workplace aggression on employee satisfaction with job stress, meaningfulness of work, and turnover intentions. Public Pers Manage. 2021;50(2):159–182. 10.1177/0091026019899976

21. Yeager VA, Wisniewski JM, Amos K, Bialek R. Why do people work in public health? Exploring recruitment and retention among public health workers. J Public Health Manag Pract 2016;22(6):559–566. 10.1097/PHH.0000000000000380 [PubMed: 26910865]

22. Asber SR. Retention outcomes of new graduate nurse residency programs: an integrative review. J Nurs Adm. 2019;49(9):430–435. 10.1097/NNA.0000000000000780 [PubMed: 31436741]

23. McGinty MD, Binkin N, Arrazola J, Israel MN, Juliano C. Epidemiology workforce capacity in 27 large urban health departments in the United States, 2017. Public Health Rep. 2019;134(4):386–394. 10.1177/0033354919856935 [PubMed: 31211646]

24. Torton B. Legal protections for public health officials during the COVID-19 pandemic. The Network for Public Health Law Resource Collection. January 25, 2021. Available at: https://www.networkforphl.org/resources/legal-protections-for-public-health-officials-during-covid-19. Accessed July 20, 2021.

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TABLE 1

Characteristics of Media-Profiled Cases of Actual or Threatened Position Departures Among Public Health Officials: United States, March 2020–January 2021

	State Leadership (n = 51)						Local Leadership (n = 205)					
	Total, No. (%)	Resigned (n = 26), No.	Fired (n = 6), No.	Retired (n = 11), No.	Other, Left Position (n = 5), No.	Not Departed (n = 3), No.	Total, No. (%)	Resigned (n = 94), No.	Fired (n = 14), No.	Retired (n = 47), No.	Other, Left Position (n = 19), No.	Not Departed (n = 31), No.
Gender												
Female	27 (53)	13	4	5	3	2	127 (62)	24	8	23	9	24
Male	22 (43)	12	2	5	2	1	67 (33)	31	5	20	4	7
Other or undetermined	2 (4)	1	0	1	0	0	11 (5)	0	1	4	6	0
Race/ethnicity												
White	42 (82)	20	10	10	4	3	153 (75)	74	11	35	10	23
Black	2 (4)	1	1	0	0	0	9 (4)	0	2	2	0	0
Asian	2 (4)	1	0	0	1	0	13 (6)	4	0	3	1	4
Hispanic	1 (2)	1	0	0	0	0	6 (3)	1	0	1	0	1
Other or undetermined	4 (8)	3	0	1	0	0	24 (12)	3	1	6	8	3
Years in position												
0–5	36 (71)	21	5	6	2	2	100 (49)	61	8	12	6	13
6–10	8 (16)	3	0	4	1	0	30 (15)	10	3	9	2	6
11–15	2 (4)	1	1	0	1	0	15 (7)	7	1	6	0	1
16	0 (0)	0	0	0	0	0	22 (11)	3	1	15	1	2
Unknown	5 (10)	2	0	1	1	1	38 (19)	13	1	5	10	9
Rurality[a]												
Urban	NA	NA	NA	NA	NA	NA	53 (26)	19	5	17	3	9
Rural	NA	NA	NA	NA	NA	NA	110 (54)	57	9	16	14	14
Mixed	51 (100)	26	6	11	5	3	42 (20)	18	0	14	2	8
Region												
Northeast	10 (20)	3	2	2	3	0	8 (4)	2	0	2	3	1

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	State Leadership (n = 51)						Local Leadership (n = 205)					
	Total, No. (%)	Resigned (n = 26), No.	Fired (n = 6), No.	Retired (n = 11), No.	Other, Left Position (n = 5), No.	Not Departed (n = 3), No.	Total, No. (%)	Resigned (n = 94), No.	Fired (n = 14), No.	Retired (n = 47), No.	Other, Left Position (n = 19), No.	Not Departed (n = 31), No.
South	18 (35)	11	2	3	0	2	39 (19)	19	3	12	2	3
Midwest	9 (18)	6	2	1	0	0	75 (37)	29	6	19	7	14
West	14 (27)	6	0	5	2	1	83 (40)	44	5	14	7	13
Reporting of harassment: harassment described	31 (61)	16	2	7	3	3	81 (40)	37	6	6	3	29
Reporting of recent policy event												
Mask mandate	0 (0)	0	0	0	0	0	16 (8)	7	2	1	0	6
Business closure or gathering restrictions	1 (2)	1	0	0	0	0	14 (7)	4	2	1	0	7
(Dis)continuation of public health measures	4 (8)	2	0	0	1	1	24 (12)	3	1	3	1	3
Other or multiple[b]	6 (12)	1	1	1	1	0	22 (11)	9	2	0	0	9
None or undetermined	40 (78)	22	10	10	3	2	129 (63)	6	7	42	18	6

Note. NA = not applicable. Data extracted from media reports and researcher-procured supplementary sources, including departments' and officials' social media accounts, local boards of health meeting minutes, other local reporting, and personal correspondence.

[a] Rurality was measured using the Rural Health Grants Eligibility tool, where "rural" is defined as regions not containing urban areas of more than 50 000 residents.[16]

[b] Includes policies to facilitate contact tracing or other COVID-19 mitigation strategies described as co-occurring policies.

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TABLE 2

Experiences of Workplace Violence in the Form of Harassment Against Public Health Departments and Their Leaders, Media- and Self-Reported: United States, March 2020–January 2021

	Media Reported/State Leadership[a] (n = 51)						Media Reported/Local Leadership[a] (n = 205)						Self-Reported[b]/Local Health Departments (n = 583)[c]	
Harassment Experience Type	Total, No. (%)	Resigned (n = 26), No.	Fired (n = 6), No.	Retired (n = 11), No.	Other, Left Position (n = 5), No.	Not Departed (n = 3), No.	Total, No. (%)	Resigned (n = 94), No.	Fired (n = 14), No.	Retired (n = 47), No.	Other, Left Position (n = 19), No.	Not Departed (n = 31), No.	Leadership Directed, No. (%)	Departments Affected,[d] No. (%)
General social media backlash	12 (24)	6	1	4	1	0	40 (20)	18	3	3	1	15	194 (33)	296 (51)
Individually directed messages[e]	3 (6)	2	0	0	0	1	28 (14)	6	2	1	1	18	173 (30)	230 (39)
Public broadcast of personal information	1 (2)	1	0	0	0	0	6 (3)	0	0	0	0	6	42 (7)	51 (9)
Threats to individual or family safety	3 (6)	2	0	0	0	1	27 (13)	5	2	1	0	19	55 (9)	88 (15)
Online coordinated demonstrations	5 (10)	4	0	1	0	0	7 (3)	0	1	0	0	6	55 (9)	95 (16)
Coordinated demonstrations in physical public space	25 (50)	14	1	7	3	0	27 (13)	12	4	2	2	7	33 (6)	60 (10)
Coordinated demonstrations in private or home space	1 (2)	1	0	0	0	0	5 (2)	0	0	0	0	5	12 (2)	14 (2)
Vandalism of public property	1 (2)	1	0	0	0	0	2 (1)	0	1	0	0	1	4 (1)	14 (2)
Vandalism of personal property	1 (2)	0	0	0	0	1	1 (<1)	0	0	0	0	1	7 (1)	7 (1)
Other[f]	7 (14)	4	1	0	2	0	31 (15)	15	4	2	1	9	12 (2)	16 (3)
Any type	31 (61)	16	2	7	3	3	81 (40)	37	6	6	3	29	253 (43)	335[g] (57)

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[a]Overall and by employment status.

[b]Responses were provided by a single representative of each local health department on the Harassment and Changes in Local Health Department Roles and Authority module of the National Association of County and City Health Officials' Forces of Change survey.

[c]Responding departments included n = 119 from the Northeast, n = 206 from the South, n = 208 from the Midwest, and n = 50 from the West region. Employment status of targeted persons is unknown.

[d]Affected departments refers to departments that agreed the corresponding harassment type targeted their leadership, staff, or the department on whole.

[e]Excludes safety threats.

[f]Includes political or job security threats.

[g]Across all department, leadership, and staff targets, 1499 acknowledgments of harassment were reported.

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TABLE 3

State and Local Public Health Officials' Perspectives on COVID-19 Related Public Backlash: United States, March 2020–January 2021

Theme	Illustrative Quote (Region)	Employment Status (Time in Position)
Underrecognized expertise	"I leave my post today with deep disappointment that during the most critical public health crisis in our lifetime, the health department's incomparable disease control expertise was not used to the degree it could have been. Our experts are world renowned for their epidemiology, surveillance, and response work. The city would be well served by having them at the strategic center of the response not in the background." (East)	Resigned August 2020 (4 y)
"Matchsticks and Scotch tape" infrastructure	"This has been an extraordinarily humbling and challenging event. We have this system that sometimes feels like it's made of matchsticks and Scotch tape. We're trying to put this enormous, heavy burden on this pretty underdeveloped infrastructure. Not surprisingly, it breaks." (West)	Remains in position
	"I feel like I've been very transparent about those challenges and a lot of them go back to an outdated IT infrastructure where not a lot of things are automated. Also, we don't have a very deep bench. The public health professionals we have are fantastic, but they're exhausted and overworked. I think what we're seeing is a symptom of underfunding public health for decades." (South)	Resigned July 2020 (< 1 y)
	"We were really just very underfunded from a federal and then down through the state and then to the local level. So we walked into a pandemic without the resources that we even needed to do basic core public health services, and then to be thrown into a pandemic in which the pace is unrelenting. We've been asked to run at a sprint, where really, this is an ultramarathon." (West)	Resigned December 2020 (3 y)
The lifesaving villain	"I've kind of gone from small-town kid who goes home to his hometown to practice medicine to this villain, and I don't comprehend how that's occurred. … My role has been to try to keep people healthy and save lives." (Midwest)	Remains in position
	"I was trashed on Facebook, like, every day. My kids were accosted at school. They would get e-mails about the fact that their dad was shutting down restaurants and requiring masks. So, you know, people talked to my kids. My wife was accosted at the grocery store. I know one county health officer, south of me, who ended up with a death threat. And so it's surprising the amount of anger that came out over this. They'll still buckle your seat belt, they'll put their tray table up when they're on the airplane, they'll give their kid an MMR shot before they go into sixth grade. And all of a sudden the mask becomes this huge invasion of their private liberty and so that was surprising." (West)	Fired November 2020 (10 y)
Politicized public health	"It's shocking how politicized this has all become. And hard to understand from my point of view, just because I look at it as such a health thing. And I don't know why people are so against, you know, the mask thing, when to keep things open—which is what they want economically—that they won't wear a mask. And then that's really—we've learned that that's the only way to really keep things open when you can't socially distance." (West)	Resigned July 2020 (3 y)
	"We did everything we could, but the governor is the one who made these choices and these decisions. If we lost funding, there would be no response to COVID, there would not be any contact tracing, any investigation, no response to this at all. For [the state] to threaten to pull that, that was going to hurt the community as a whole even more. It was a tough balance." (West)	Resigned August 2020 (3 y)
Disillusionment	"At the very start of the pandemic—early March—I had some optimism that this would be an opportunity for the broader public to see the value of what public health does and hopefully push for a better system—that we would transform the system. And at this point, I worry that things will be gutted even more and there will be even less willingness to have a strong infrastructure." (West)	Fired May 2020 (6 y)
	"I get threatening messages from people saying they're watching me. They followed my family to the park and took pictures of my kids. I know it's my job to be out front talking about the importance of public health—educating people, keeping them safe. Now it kind of scares me … when they start photographing my family in public, I have to think—is it really worth it?" (Midwest)	Resigned November 2020 (1 y)
	"You care about community, and you're committed to the work you do and societal role that you're given. You feel a duty to serve, and yet it's really hard in the current environment. … We are driving a great aunt's Pinto when what you need is to be driving a Ferrari." (South)	Resigned June 2020 (2 y)

Note. IT = information technology; MMR = measles, mumps, rubella.