Perspectives on Legal Strategies to Prevent Workplace Violence

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ABSTRACT

Workplace violence is a continuing problem in the United States, accounting for approximately 1,000 deaths each year and for more than 1.5 million incidents of nonfatal injuries. State and federal agencies have published guidelines for preventing workplace assaults, but there is a need for a strong research agenda to address the effectiveness of intervention strategies. After an overview, this article provides a discussion of workplace violence from three perspectives. One section discusses the process used in a manufacturing setting to install a workplace violence prevention program. A second section provides insight into the processes used to fully implement a workplace violence prevention program in a health care setting. A final section provides insight to the processes brought to bear in one state to mandate prevention of workplace violence in the health care setting. There is a critical need to evaluate alternative strategies to address workplace violence, to make the findings available to legislative and executive branches of government, and to implement effective strategies to counter violence in the workplace.

Workplace violence causes a significant number of workplace fatalities and injuries throughout the United States every year. In any given week, approximately twenty workers are murdered and thousands are assaulted while working. Of course, these numbers went up dramatically in 2001, since the vast majority of those killed in the World Trade Center and Pentagon attacks were working at the time. The National Crime Victimization Survey (2001) estimated that 1.7 million violent victimizations per year occurred against persons age 12 or older while they worked or were on duty.

In general, persons unknown to the victims commit most workplace homicides. Moreover, most of the victims work in retail trade, security services, or transit services occupations. These circumstances are in contrast to those that characterize non-fatal workplace assaults. The majority of non-fatal workplace injuries occur in settings in which the victim and the attacker are in a custodial or client-caregiver relationship, such as in health care or social services. According to Bureau of Labor Statistics data for rates of lost-time injuries related to violence and assaults by persons, the public sector is at substantially greater risk than the private sector. This is particularly the case for employees of state government, as demonstrated in Figure 1, which compares the rate of lost-time injuries of workers in United States private firms, private firms in the State of Washington, Washington local governments, and Washington State government.

Figure 1. Comparison of rate of lost-time injuries of workers

	1995	1996	1997	1998	1999
US Private	2.8	2.2	2.5	2	1.8
WA Private	2.5	2.2	2.8	2	1.7
WA State Gov		21.3	31.7	32.6	36.1
WA Local Gov	6.4	6.9	7.7	13.5	10.1

The definition of violence in the workplace includes verbal threats, threatening behavior, or physical assault. The four basic types of workplace violence are:

1. Violence by strangers where the assailant has no legitimate business relationship to the workplace (for example, entering the workplace to commit a robbery);
2. Violence by customers (current or former) or clients (patients, prisoners, students, passengers), usually to those who provide direct service to the public;
3. Violence by current or former co-workers—employees, supervisors, or managers who often seek revenge for perceived unfair treatment; and
4. Violence by an assailant who confronts an individual in the workplace with whom an outside personal relationship exists. Such actions appear to be motivated by perceived difficulties in the relationship or psychological or social factors specific to the assailant.

Workplace violence and assaults are not random; rather, risk factors are associated with such events. For example, common risk factors include

1. Contact with the public;
2. Exchange of money;
3. Delivery of passengers, goods, and services;
4. Having a mobile workplace, as in the case of taxi drivers and police officers;
5. Working with volatile, unstable persons;
6. Working in isolation;
7. Working late at night or in the early morning;
8. Working in high crime areas;
9. Guarding valuables; and
10. Working in community-based settings.

Mental health care workers are at particular risk of assault from patients. Violence directed toward mental health care workers has an extensive and frightening history, including the recent brutal death of Nicole Castro, a Maryland social worker who was conducting a home visit at the time of her murder. According to data collected as part of the Department of Justice National Crime Victimization Survey (NCVS), mental health professionals and custodial workers are at nearly four times the risk of assault relative to all health care workers.[1] In fact, health care workers in all fields are at risk. In 1999, 43% of all non-fatal assaults (n=2,637) resulting in lost work days in all industries in the United States were against workers in the health care industry.[2]

State and federal agencies have responded to these data by publishing guidelines on prevention of workplace assaults. Federal Occupational Safety and Health Administration (OSHA) voluntary guidelines followed a period of several years of federal enforcement activity in workplaces in which violence was a "recognized hazard." From 1993-1995, OSHA issued eight Section 5(a)(1) general duty clause citations for workplace violence. However, OSHA's use of the general duty clause to address workplace violence was curtailed after the agency lost a case at the trial level challenging citations issued in 1995.[3] OSHA did not appeal the administrative law judge's decision.

In 1996, OSHA responded to research findings, union petitions, and growing awareness of the problem of workplace violence by publishing the document "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers." It should be noted that unions originally petitioned OSHA for a regulatory standard addressing workplace violence and that these union efforts continue. The Federal OSHA guidelines were based largely on guidelines developed in 1993 and incorporated in California's state OSHA plan. The 1996 OSHA guidelines provide an overview and a framework for addressing the problem of workplace violence; the guidelines include the basic elements of any proactive health and safety program: management commitment and employee involvement, worksite analysis, hazard prevention and control, and training and education. These guidelines primarily address Type 1 and Type 2 violence. Examples of recommended control strategies appear in Table 1.

Table 1. Violence Prevention Guidance for Type I and Type II Violence

Type 1 Advice or Requirements	Type 2 Advice or Requirements
Training workers in de-escalation techniques	Training workers (de-escalation techniques)
Posting signs that there is minimal cash in register	Controlling access to worksite
Addressing employee isolation factors	Addressing employee isolation factors
Using a drop safe with limited access	Setting up worksite so workers are not trapped from exiting
Providing outside lighting	Eliminating easy access to potential weapons (e.g., scissors)
Providing a clear, unobstructed view of the cash register	Establishing a client referral/ assistance program
Providing security personnel	Providing security personnel
Establishing a communication method to alert police	Providing a quick communication method to alert security
Increasing police patrols	
Posting laws regarding assault, stalking or other violent acts	Posting laws regarding assault, stalking or other violent acts

The effectiveness of these control measures has been studied only rarely. In those few cases in which rigorous methods have been applied to their study, the measures have been found effective. For example, Loomis et al. found that outside lighting and adequate staffing significantly reduced the risk of fatal assaults due to robberies, as did any combination of five or more administrative controls.[4] Lipscomb is currently studying the effectiveness of a comprehensive violence prevention program in the mental health care setting. A 2000 violence prevention workshop in Washington, D. C. has called for a strong research agenda to address the effectiveness of intervention strategies.[5,6] In the absence of additional research, legislators, administrators, and employers must act in the face of uncertainty. The next two sections provide examples of actions to address the problem of workplace violence, one in the manufacturing and one in the health care setting.

Violence Prevention in the Manufacturing Setting

Violent behavior can occur anywhere, including in manufacturing settings. Although violence may be less common in workplaces closed to the general public and in which most people present in the facility have been subject to some type of pre-employment review of physical and social skills, it is no less traumatic.

This fact was brought home to International Truck & Engine Corporation on February 5, 2001, when an ex-employee who had been fired for theft two years previously and was to surrender to begin serving a prison sentence the following day forced his way into a diesel engine plant and went on a shooting rampage that left four employees and the ex-employee dead. It was a watershed moment for International in the same way that September 11 was for the country as a whole.

Although the scope of violence was a shock, the possibility of violence was not totally unexpected. Ironically, an hour before the shootingbegan, a violence prevention plan had been presented to the executive council of the company in response to recent problem indicators. One such indication was that employee assistance plan (EAP) utilization had increased in recent years. International's EAP provides counseling services for a wide range of problems: financial, family, and psychological. In 2001, 16 % of all beneficiaries (employees and families) made use of the services, about double the historical average. Another indicator was mental health drug costs paid under the company's prescription drug plan, which accounted for 8 % of total pharmacy costs; most of the usage was prescribed outside a treatment program. In the prior three months, an unusual number of threats or physical violence had required disciplinary action. If there were any doubts about the need for a program to address workplace violence, events later in the day erased them, and International soon had a violence prevention program in place.

International's violence prevention program aims to prevent hostile and violent, not merely illegal, behavior. The program's several elements include written policies and procedures, hiring practices that screen for violence proneness, mental health self-assessment tools, crisis management/threat assessment teams, training in

awareness and prevention, and a plan for post-incident management and services.

Health and productivity are powerful motivators in a manufacturing setting. The precursors of violence create a climate that is both destructive and counterproductive. Most companies strive to promote a positive, high-performance culture. Increasingly, the characteristics of violence-prone behavior are being recognized as incompatible with establishing that kind of work environment. Thus, a violence prevention program is not merely a tool to prevent tragedy, but a vital part of a strategy to improve health and productivity.

Violence Prevention in the Health Care Setting

The OSHA guidelines discussed previously provide an outline for developing a violence prevention program, but because they are performance-based, it is up to stakeholders within the industry to do the painstaking work of implementing them in a manner that will yield results. The New York State Office of Mental Health (OMH) and the Multi-Union Health and Safety Committee (MUHSC) are the first to evaluate the effectiveness of these guidelines in the institutional mental health setting.

In 1999, the National Institute for Occupational Safety and Health funded a collaborative effort between the University of Maryland School of Nursing and the MUHSC to evaluate the guidelines. The primary goal of the project is to reduce violence against health care workers in state mental health institutions. To achieve that goal, the project will document and describe a process for implementing OSHA violence prevention guidelines within in-patient mental health facilities and compare assault rates, risk factors for assault, and job satisfaction in these facilities one year prior to and one year following implementation of a comprehensive OSHA guideline-based violence prevention program.

Several factors have made this kind of study possible. The unions representing OMH workers have strong health and safety contract language that supports such efforts; the MUHSC provides a forum to develop violence prevention initiatives. Pilot projects had been conducted at two OMH facilities in 1996, and in 1998 OMH issued a Safe and Therapeutic Environment Program policy requiring each mental health facility to develop a violence prevention program according to OSHA guidelines. The existence of these conditions made OMH an ideal setting in which to conduct and evaluate this natural experiment.

Early in the project, a statewide advisory group was formed and a Request For Application was sent to all 28 facilities. The criteria for site selection included the existence of management commitment of resources to develop and implement a program, the presence of an active health and safety committee, and the availability of computerized assault data. Of seven applications received, OMH selected four facilities as intervention facilities. Later, three mental health facilities were selected to serve as controls. Joint labor-management advisory groups at the facility level took responsibility for implementing a facility-specific program at each intervention site.

A primary activity of these advisory groups was to conduct a comprehensive risk assessment of the wards to be studied, with strong input from direct care providers and from an architect who specializes in design of secure state buildings. This assessment, which included a baseline staff survey, provided direction to develop the specific intervention activities.

The intervention consists of a number of distinct, ongoing hazard control activities. One activity was administration and study of results of an environmental survey, which identified a multitude of short- and long-term recommendations that were presented to the local advisory groups for discussion and action. A one-day"solutions-mapping" training session was conducted within the four facilities in May/June 2002. Focus group, environmental, and staff survey data were presented to direct care staff during these sessions. These data were then used in the solutions mapping exercise.

Results of the study to date include the implementation of most short-term environmental recommendations and an action plan for addressing the long-term items. Focus group discussions led to the identification of the following strategies for preventing workplace violence and its consequences:

1. Ensuring equal commitment to worker safety and health and patient/client safety, along with zero-tolerance for threats and physical assaults and communication of this message to managers, supervisors, staff, patients and visitors.
2. Maintaining alarm systems and other security devices and arranging for a reliable response system when an alarm is triggered.
3. Implementing a comprehensive program of medical and psychological counseling and debriefing for staff experiencing or witnessing violence, together with support for staff choosing to file charges against alleged perpetrators.
4. Ensuring adequate and qualified staff coverage at all times, in particular during patient transfers, emergency responses, meal times, and at night.

The staff survey was pilot tested, revised, and completed by nearly 500 OMH direct care staff (90% response rate) in spring/summer 2001. A post intervention survey will be administered in the spring/summer of 2003. A comparison of pre- and post-intervention survey data will follow.

Legislative Action on Workplace Violence

Often, legislators find themselves needing to act before research on a problem is complete. The legislative process has been used to bring various stakeholders together to develop a viable plan for tackling social problems through regulation. Several states, including California, Florida, and Washington, have used the legislative process to address workplace violence prevention, primarily in late night retail and health care settings. A catalyst is often a dramatic event, such as a workplace homicide, or a series of events that are brought to the public's and therefore legislators' attention via the media. Once concerned citizens contact their legislators, legislative staff members must conduct research and check with various agencies and researchers for information, determine what other states have done on the issue, and bring together concerned stakeholders to craft legislation to address the issue. A series of negotiations take place within the legislative chambers, in the governor's office and with stakeholders to develop an acceptable bill that begins to address controversial issues.

Washington State provides one example of state political action to address workplace violence. In 1990, legislation directed the Department of Labor and Industries to develop and implement regulations to prevent workplace violence in late night retail facilities; in 1999, legislation addressed the problem in health care settings, and in 2000 an act extended provisions to psychiatric hospitals. A brief history of the process involved in passing legislation to address workplace violence in health settings can be instructive for other states considering similar legislation.

Assaults at the state psychiatric hospitals had been reported in the press in the early 1990s. The Service Employees International Union (SEIU) and the American Federation of State, County and Municipal Employees (AFSCME), representing workers at these and other hospitals, demanded action by the legislature. The legislature requested that the Department of Labor & Industries conduct a study of the problem. That department's research group, Safety and Health Assessments and Research for Prevention (SHARP), analyzed workers compensation claims, interviewed management and workers at the hospitals, and conducted a survey of employees. The survey identified more than four physical assaults per caregiver per year. The incidence of assault-related workers compensation claims was 14 per 100 worker-years.[7] SHARP developed a number of recommendations to address workplace violence problems, including (a) providing for adequate facility staffing to

ensure that all staff attend de-escalation, restraint, and containment training, and (b) staffing for acuity and installing personal alarm systems. Another recommendation was to provide structured psychological support for assaulted employees. Additionally, in 1997, a Department of Labor and Industries technical report on workers compensation claims rates for work-related assaults called attention to the high rates in health care, particularly in psychiatric hospitals.[8]

Senate bill 5312, an act relating to prevention of workplace violence in health care settings, was introduced in the 1999 legislative session. The bill required health care employers, including state and private hospitals, mental health evaluation and treatment facilities, home care agencies, and community mental health programs, to develop and implement workplace violence protection programs. SEIU and AFSCME were the main proponents of the bill. The Department of Social and Health Services (DSHS) successfully excluded state hospitals from the legislation by having a null and void clause added. Later in 1999, several highly publicized assaults resulting in injuries occurred in the state psychiatric hospitals. In the 2000 session, House bill 2899 was introduced to develop a workplace safety plan for state hospitals. This time, DSHS requested coverage by the legislation, and the bill passed both chambers. Together, the enacted bills called for employers to conduct assessments to identify potential security and safety hazards. Employers were to identify actual and potential violent actions and to determine and implement appropriate preventive action to address hazards, including making appropriate changes in the physical environment, staffing, training, personnel policies, first aid, and reporting procedures.

Health care settings (excluding nursing homes, but including state mental hospitals) were required to have their plans in place and to begin keeping records and training employees by July 1, 2000. To date, the Department of Labor & Industries has not begun any enforcement initiative. However, the department, responding to complaints, has issued several citations. The effectiveness of a regulation without an enforcement initiative remains to be determined. Workers compensation claims rates for assaults will continue to be monitored and reported to the Department, to the legislature, and to the affected communities.

Conclusion

Workplace violence is a threat to virtually all workplaces. It is not random; risk factors have been identified across work settings. There have been a number of regulatory and legislative actions to address workplace violence where it is most prevalent (e.g., late night retail, health and social services). The efficacy of different strategies to prevent workplace violence has not been adequately studied, and a critical need exists to evaluate strategies and to make findings available to legislative and executive branches of government, as well as to business and labor organizations, so that effective strategies can be widely implemented.

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