Verbal abuse against home care aides: another shot across the bow in violence against health care and other workers

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It is disconcerting that while *physical assault* is perceived as a major consequence of work-related violence, *non-physical violence*—which includes threats, sexual harassment, verbal abuse and bullying—may result in even greater burdens for the victims.[1–4] In particular, verbal abuse involving another person yelling or swearing, engaging in name calling or using other words intended to control or hurt has consistently been reported as the most common form of workplace violence.[1 2 4 5] This is particularly the case in the Health Care and Social Assistance sector which is at highest risk of non-fatal violence in the USA and a major problem globally.[3 4]

The problem of verbal abuse is especially highlighted by Karlsson *et al*[6] from their occupational study of home care aides[7] who constitute an important proportion of healthcare workers.[8] Based on questionnaire survey data collected from 954 Health Care Aides who reported on verbal abuse from non-family clients and their family members, increased risks identified for verbal abuse involved caring for patients with limited mobility and working in homes with limited space in which to perform care tasks; a decreased risk was identified when predictable work schedules were maintained by the caregiver. Aides who reported verbal abuse within the last 12 months, compared with those who did not, were 11 times more likely to also report physical abuse. Importantly, this was consistent with previous documentation of verbal abuse as a risk factor for physical assault by Lanza *et al*.[9] In the current study, 22% reported at least one incident of verbal abuse within the last 12 months; other occupational studies have reported a range between 26% and 65% and beyond.

In contrast, physical violence has been reported in a range between 3% and 45%.[1 2 5] Karlsson *et al*[6] also noted that, in addition to this strong association identified with physical assault, verbal abuse has been previously reported to be related to negative emotional reactions, burnout, stress, sleep problems and depression—findings also reported by Gerberich *et al*,[1 2] relevant to non-physical violence, including verbal abuse; adverse outcomes of restricted or modified work, quitting or transferring from their positions and obtaining leaves of absences have also been involved.[1 2] Further, the WHO[4] has advised of the potential effects on job motivation and, thus, productivity, compromised quality of care, and ultimate immense financial loss in the health sector.

The cross-sectional study by Karlsson *et al*,[6] collected data involving self-report and 12-month recall of working conditions while a shorter period would ideally enhance recall of exposures.[1 2] The need for similar data collection over time, however, had to rely on this approach and it is important to recognise that there has been consistency among study findings of this persistently reported problem. Since there is no surveillance system that can accurately capture the magnitude of this problem, it remains necessary, while utilising such approaches, to recognise the limitations among the data sources associated with a lack of consistency in methodologies including data collection approaches, definitions and variety in exposures among the healthcare and other populations studied, to date. Clearly, these limitations do not negate this serious problem that has been repeatedly documented.

A particular contribution, by the Karlsson *et al* study,[6] is the focus on the understudied and vulnerable population of Health Care Aides, whose rate of workplace violence for injuries involving days away from work increased 87% between 2006 and 2016. Among the currently employed 20+ million workers in the Health Care and Social Assistance sector (currently the largest major sector) there are 3 million home health aides and personal care aides. Yet, while the overall sector is projected to grow 18% by 2026 in the USA, the proportion of home health and personal care aides is projected to grow 41%—faster than the average for all occupations.[8] Health Care Aides are primarily hired by private business (agencies) or directly by clients or their families; the majority are women, low-wage workers and increasingly racial/ethnic minorities and immigrants[10] who typically work alone without other professional assistance.

As noted by Phillips,[5] 'health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored'. To date, there is no federal standard that requires workplace or work-related violence protections.

The Occupational Safety and Health Act (OSHA), originally enacted in 1970 in the USA, includes a *General Duty Clause* that requires employers to provide a safe and healthful workplace—one that is *free from recognized hazards that are causing or likely to cause death or serious physical harm*.[11] Employers who do not take reasonable steps to prevent or abate recognised violence or other hazards in the workplace can be cited. However, OSHA does not require employers to implement workplace violence prevention programmes; but, it provides voluntary guidelines and may cite employers for failing to provide a workplace free from recognised serious hazards. Some states have legislated that employers develop violence prevention programmes while the majority of states have advanced laws that amend existing statutes for assaults of first responders by adding nurses and/or increasing the penalties associated with such behaviour. Yet, there is great variation among states relevant to requirements, healthcare personnel included,[12] and the degree to which the respective legislation is enforced.

As identified by The Joint Commission, management must communicate and enforce a policy of zero tolerance for violence that includes verbal violence.[13] No longer should employees have to believe that violence is a part of the job or accept this to maintain their employment. Enforcement of such policies complemented with engineering, administrative and work-practice controls, identified by The Joint Commission, is essential for successful prevention and control.

In 2014, the WHO estimated that the world will be deficient of 12.9 million healthcare workers by 2035.[14] Given this deficiency, and the need to retain existing and hire more qualified caregivers, it is essential to reverse the impact of non-physical as well as physical violence in the workplace that has implications

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for the health of all people, globally. This shot across the bow warns us again of 'The universal truth: No health without a workforce'.[14]

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