Violence in the workplace: awareness and prevention

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Abstract

Occupational violence is of growing interest to both individuals and organisations in the health field. Not surprisingly, staff who work directly on the front line are more vulnerable to episodes of physical violence from the general public. However, violence manifests in a number of ways, and any person in the workplace can experience it at anytime. Occupational violence should be viewed as an event to be identified, understood and managed, with a consequent need to identify types of violence in order to provide policy direction and preventive strategies to enhance workplace safety. Violence cannot be totally prevented but the risk of violence and its negative impacts on the individual can be reduced with carefully considered planning and swift action following a violent event. This paper reports various types of violence, the magnitude of the problem and who is at risk. Policy initiatives are suggested and methods of prevention discussed.

Occupational violence is a major concern

Occupational violence is receiving increasing attention from governments, employers, trade unions and professional groups, with a growing awareness of the serious impact it can have on victims and on the workplace generally. It presents in the workplace in a variety of ways, from murder through to bullying and harassment. A variety of international and national studies have demonstrated that violence occurs too frequently in the workplace and that the effect it has on victims and their families can be substantial (Budd, 2001; Injury Prevention Research Centre, 2000). Violence can range from physical assault by outsiders, in a one off event as in the Port Arthur massacre, to bullying by co-workers as a long-term occurrence involving one or a number of people singling out another for mistreatment.

The literature suggests that violence can no longer be seen as an individual issue but must be viewed in terms of a structural problem requiring action at an organisational level on a number of fronts (International Labour Organisation (ILO) 2001). While workplace violence can never be totally eliminated, a variety of preventive measures can be planned and implemented.

In the Australian health sector two initiatives have brought the issue of workplace violence to the fore: the announcement in 2001 by the NSW Minister for Health of a $5 million injection of funds into the health system to upgrade safety and security measures in public hospitals, and a further $5 million recurrent funding to deploy more security personnel in public hospitals (Health Public Affairs, July, 2001); and the Queensland government initiative of a new taskforce to examine workplace bullying.

Definitions of occupational violence

One of the difficulties of understanding this issue lies in defining what is meant by the term "violence", and this is partly a reflection of its social construction. In general terms, violence is discussed as if there is a shared meaning, yet what one person views as violence can be seen by another as insignificant. A variety of definitions of occupational violence are in use, with the European Commission defining it as:

> *incidents where persons are abused, threatened, or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being or health (Wynne et al, 1997),*

the U.S. National Institute for Occupational Safety (NIOSH) as:

> *any physical assault, threatening behaviour, or verbal abuse occurring in the workplace. It includes, but is not limited to, beatings, stabbings, shootings, rapes, suicide attempts and psychological traumas such as threats, obscene phone calls and intimidation or harassment of any nature including being followed, sworn at or shouted at (OSHA, 1998),*

and the National Occupational Health and Safety Commission of Australia (NOHSC) as:

> *the attempted or actual exercise by a person of any force so as to cause injury to a worker, including any threatening statement or behaviour which gives a worker reasonable cause to believe he or she is at risk (NOHSC, 1999).*

Bullying, sexual harassment and physical violence are included within the ILO classification of occupational violence, and inclusion of bullying within a definition of occupational violence is supported by a recent Australian report on the prevention of violence in the workplace (Mayhew & Chappell, 2001a). The rationale for inclusion is that violence occurs along a continuum and preventive measures are needed to address the full scope of the problem.

Types of occupational violence

Authors have found it useful to divide occupational violence into categories, with the following suggested as a starting point:

- criminal intent where the crime can include robbery, shoplifting and various other crimes
- customer/client violence where the client may become violent while being attended to by the worker. Doctors, health and welfare workers, police and prison staff are particularly vulnerable to this type of violence
- worker/worker violence where one worker attacks, threatens, or bullies another employee
- personal relationship where there is no relationship to the workplace but rather a personal relationship that carries over into the workplace (Injury Prevention Research Centre, 2000).

Mayhew and Chappell (2001) endorse the following typology separating violence into just three categories: external violence perpetrated by persons outside the organisation, such as during armed hold-ups; client initiated violence inflicted on workers by their customers and clients; and internal violence which occurs between employees within an organisation, such as between supervisor and employee, or employees and apprentices (OSHA, 1998).

Categorising violence enables greater understanding of its occurrence, as well as an increased ability to examine the phenomenon and the different approaches necessary for its control and management.

Magnitude of the problem

A difficult question to answer concerns the magnitude of occupational violence; researchers have had a tendency to draw together a number of studies from different countries. An influential ILO report (Chappell & DiMartino 1998) argues that violence in the workplace is a global issue transcending cultures and boundaries. The key findings in the ILO study revealed the following:

- about 1000 people are killed at work each year in the United States. Homicide is the leading cause of death on the job for US women and the second leading cause for men
- France, Argentina, Romania, Canada and England report the highest rates of assaults and sexual harassment
- some workplaces and occupations, such as doctors, social workers, health care workers, taxi drivers, teachers, domestics in foreign countries and people working alone (especially at night), are at greater risk than others. Women are especially at risk as they are often employed in high risk occupations and often as casual workers
- psychological violence, such as bullying, mobbing, or group psychological harassment, is increasingly recognised by both workers and employers as a problem and is seen in Australia as an increasing problem.

The British Crime Survey (BCS) conducted in 2000 revealed 1.3 million violent incidents recorded in 1999, comprising 634,000 physical assaults and 654,000 threats. In total 604,000 British workers had experienced at least one incident in 1999, 304,000 workers had been assaulted at least on one occasion and 338,000 had been threatened (BCS, 2000). Additionally, Di Martino (2000) reported a 1991 national study in Germany which revealed that 93% of women interviewed had been sexually harassed in the workplace during their working lives. The international and national evidence compellingly suggests that violence in workplaces is not uncommon (Tjaden and Thoennes (2001).

Researchers are more recently turning attention to workplace bullying, which is reported to be a serious and growing concern across a number of countries (Di Martino, 2000). Workplace bullying is usually repeated and escalating in intensity over time (Mayhew & Chappell 2001 (b):12), often involving subtle strategies which can be an abuse of power vertically from supervisor to subordinate, or subordinate to supervisor, or horizontally between peers. Many studies have suggested that organisational culture is highly significant in increasing the risk of violence. Hierarchical and rigid management, strong divisions between supervisor and subordinate, highly competitive business environments, a management which tolerates bullying, job insecurity, staff who feel deprived of entitlements, and disciplinary suspensions are all risk factors for violence (Mayhew 2000d; Randall 1997; Myers1996).

Who is at risk?

Violence in the workplace occurs across a range of occupations and professions, industries and workplaces. However, medical staff and health workers have been found to be at very high risk (OSHA, 1998). The Bureau of Labor Statistics Census of Fatal Occupational Injuries for 1993 demonstrated that health care workers were 16 times more likely to experience violence than other service workers (OSHA, 1998). Health care workers have been shown to be at most risk in Sweden with social services workers the next highest risk (DiMartino, 2000), and evidence from the United States suggests that more violence occurs in the health and social services fields than any other workplace (OSHA, 1998). Researchers have also found that nursing homes, hospitals and establishments providing residential care and other social services are areas where violence is most likely to occur (Toscano & Weber, 1995; NIOSH 2000), the NIOSH data showing that 27% of workplace assaults occur in nursing homes, compared to 11% in hospitals.

Hospitals are likely to be dangerous places for workers for a variety of reasons. They are open day and night; people can move around unrestricted; some patients suffer from drug or mental health problems that may raise their level of anxiety and lead to a decreased ability to resolve problems; there are often long waiting times where patients may become angry and frustrated; and increasingly fewer staff are available to handle increasing workloads.

A 1994 British study estimated that health care workers had a 1 in 200 chance of a major injury from violent clients each year (Wykes), while studies on violence to British general practitioners have found that 10% - 11% had been assaulted, with home visiting incurring the much higher risk of 70% (Bibby 1995). Irish figures reported 32% - 45% of physicians as having been assaulted during their working lives, with this figure increasing to 100% in some geographical areas (Wynne et al 1996). A 1996 study of the health care sector (Flannery) estimated that nurses, psychiatrists, psychologists, social workers and nurses aides were at most risk. A recent paper in the Journal of the American Medical Association (Lamberg, 2000) reported that every year in the United States at least one medical practitioner is killed by a patient.

Under-reporting of violence

Although these figures appear quite high, a variety of studies indicate that the incidence of occupational violence is under-reported (Barrett, 1997; Gates, 1995; Le Mar, Gerberich, Lohman & Zaidman, 1998; Macdonald, Sirotich, 2001; Rowett, 1986; Crane 1986). This may be particularly the case in health care settings for two major reasons, the first reason being that violence is seen by many health professionals as part of everyday professional life. Health professionals deal frequently with patients who suffer from dementia, mental illness, or who suffer emotional or physical trauma that then leads to unpredictable violent behaviour (Lanza, 1992). The second reason is that poor reporting mechanisms influence the response that professionals have to occupational violence. If there are few mechanisms in place and few systemic changes following reporting, then professionals are unlikely to highlight the issue to management.

The National Crime Victimization Survey in the United States reported by Bachman (1994) indicated that 40% of respondents did not report a violent incident because they believed it to be a private matter. Other researchers have pointed out that the way violence is judged may determine whether or not a behaviour is seen as being violent. Rowett (1986) discussed the importance of understanding that violence does not have the same meaning for everyone, with socialisation, childhood experiences, culture, mental health, moral and ethical positions and previous experience of violence all colouring perception.

Norris (1990) systematically examined the issue of reporting and found that those who reported violence against them did so because of organisational expectations that they should, they believed their line managers would act on the reports, they sought support, or they wanted to protect their colleagues.

Their reasons for not reporting included a belief that nothing could or would be done by management, management would not have been supportive, fear of a negative reflection on their competence, incidents were not deemed serious, violence was part of the job, the perpetrator (usually a client) would have faced prosecution, or reporting was too time consuming.

Additionally, MacLachlan (1987) points out that research exposes a common incidence of self-blame by assaulted staff. This may be because such workers feel that as professionals, they should have been able to recognise and defuse any potential threat of aggression, or that their professional intervention was clumsy, inappropriate or unintentionally provoking of the assault.

The cost of occupational violence

Occupational violence has a considerable impact on the person and the organisation. Economic losses to the organisation can be considerable, a recent Australian study estimating that each case of internal bullying costs organisations nearly $17,000 (Sheehan, et al, quoted in Mayhew & Chappell, 2001). Australian research concludes that workplace bullying affects one in four workers and cost industry in Australia an estimated $12 billion in 2000 (Mayhew and Chappell, 2001).

Emotional costs can be more hidden, involving the effects of trauma resulting in depression, isolation, heightened anxiety, sleep disturbance, re-experiencing the event, feelings of incompetence or powerlessness, absenteeism, increased HR costs as staff exit the system, decreased workplace activity, increased sick leave and negative effects on the family. If the worker has been traumatised by exposure to childhood physical, emotional or sexual abuse, rape or other violent crime such as domestic violence, the effects of workplace violence can be overwhelming.

> *The impact of violence in the workplace produces low morale, emotional trauma, absenteeism, poor public image, and higher costs associated with lost productivity, worker's compensation premiums and medical expenses (Queensland Health, 1994).*

Disruptive incidents in workplaces often stem from high levels of unresolved conflict and poor communication. Healthy positive ways of resolving problems must be established to halt potential escalation of problems.

Methods of prevention

To prevent occupational violence, organisations and staff need to understand both violent activities and their development in the workplace. Four distinct elements usually precede the emergence of a violent situation - a perpetrator, causative factors, an encouraging environment and a target person(s) (Smith-Pitman & McCoy, 1999).

The Registered Nurses' Association of Nova Scotia in their Resource Guide (1997) suggests that four factors could be considered significant in risk management programs: client characteristics such as history of violent behaviour, emotional disorders, or head trauma; environmental factors such as high activity areas, noise, lighting levels, inflexible organisational policies, units accommodating patients such as Departments of Emergency Medicine; staff characteristics such as staff dynamics, attitudes and behaviour; and lack of organisational policies and programs.

Organisations can take a number of steps to promote occupational safety. They include risk assessment of the physical environment; developing policies and procedures to govern staff movements (for example in home visiting) and behaviour; establishing a documenting process which is then kept centrally to determine the level of violence in the organization; establishing a Safety or Risk Management Committee; introducing physical devices such as duress alarms linked to Security Services, improved lighting (particularly in car parks), toughened glass panels in areas handling money, staff identification badges, alert systems on the records of violent clients; limiting the number of access points; removing potential weapons from desks (letter openers etc); arranging furniture to avoid the possibility of trapping staff, ensuring furniture is either very heavy and cannot be thrown or light enough to do little damage; security access to buildings, especially after hours; ensuring staff lock offices after hours; limiting client access to work areas; training staff in identifying, defusing and handling violent behaviours, including horizontal or vertical bullying by other staff; and introducing support services for victims.

Because violence has a range of causes, no single solution will work to dispel it in the workplace. A comprehensive organisation-wide approach to prevention is most effectively achieved by a range of site–specific measures (Mayhew and Chappell 2001c). Equally important is a process in which employees are enabled to have ownership in design of these measures through a collaborative partnership with employers.

Learning to recognise the signs of violence and how to handle it should be part of training for all health workers. Training should focus upon how to identify escalating violent behaviour, identifying the risk factors precipitating violence, what methods are available to prevent or defuse violence, how to manage anger, what customary responses to violence exist, and developing an action plan (OSHA, 1998). It should also be based on an analysis of the legality of the proposed strategies.

Training and retraining ought to be conducted regularly so staff are better equipped to function proactively, not reactively to individual incidents. It should not, however, be used as the principle violence prevention strategy: there is no substitute for a well constructed, comprehensive plan which includes risk assessment analysis, regular safety audits, staff acceptance, management support and sufficient resourcing.

Establishing a method of documentation for workplace violence is a major priority for prevention. The nature and magnitude of the problems must be documented in the workplace in order to quantify risk. Information can then be used to provide data on areas requiring specific action in order to assist prevention and reduce any further harm.

Program development

Many different approaches can be used to develop plans for a workplace violence strategy. Some broad guidelines advanced for consideration are to develop and implement policies and procedures, based on current research findings, for handling potential and actual violent situations; develop a formal process for recording all violent incidents; provide prevention and intervention programs for staff; offer support programs for staff affected by violence; and develop awareness-raising programs for staff on issues of occupational violence.

Staff also have a role to play. The individual has a responsibility to participate in programs provided by the employer, to use the appropriate reporting channels and to support colleagues who have been victims of violence. It goes without saying that any necessary medical care and debriefing immediately following an incident should be provided. It is very important, however, to also offer longer term follow up counselling as the effects of the traumatic incident may not be fully realised for a time.

It is helpful for regular surveys to be undertaken to determine whether or not staff report all incidents of violence, or if they are underreporting because of concerns that it may reflect negatively on them in the workplace, or they may be scapegoated by the employer or peers for doing so (Mayhew and Chappell 2001). Accurate reporting enables research to determine patterns of violent incidents and hot spots where these occur, and is not possible without a comprehensive database of all incidents, including bullying and any near misses (National Security Institute 1995).

Threats of violence should be taken seriously and acted upon quickly; staff may not feel inclined to report potential danger situations if they think management will not address their concerns.

Zero tolerance approach

We believe that a strong management focus of zero tolerance to workplace violence is needed. This policy should be part of the workplace strategic plan, with clearly articulated principles, definition of acceptable and unacceptable behaviour and statement of penalties for violation. A workplace audit of risk identification and appropriate risk minimisation strategies should be performed and findings documented. It is preferable that this audit be performed annually and after any incidents of violence; this not only objectively assesses risk, it also contributes to staff awareness that theirs is a workplace culture which does not tolerate violence and that this issue is taken seriously by their employer.

In these days of cost containment, many organisations function with minimal or below minimum levels of staffing. This can be conducive to escalation of violence; for instance, it may be optimal for service delivery to high-risk hospital patients to be provided by two staff members but if staffing is limited, this may not be possible. Staffing of areas at high risk of violent incidents should be flexible enough to ensure an adequate staff to patient ratio; safety audits should therefore include a review of staffing levels and work practices to ensure that zero tolerance policies are most effectively implemented.

A national policy on how to fight violence and how to make health facilities safer is long overdue. Legislation has been introduced in the Netherlands and Sweden relating specifically to workplace violence, and Belgium has legislated against harassment (Mayhew & Chappell, 2001b). There is currently no Australian legislation, simply recommendations or advice.

At the local level, organisations should establish policies and procedures to assist workers in learning how to respond to violent situations. Multidisciplinary violence prevention teams could be introduced into workplaces to provide safety audits, review incident reports, identify problematic areas and develop policy and program initiatives.

Workers also require training to assist them to handle potential outbreaks of violence; a variety of interventions could be taught to workers including self-protection, verbal and physical prevention skills. At the very least, security measures such as duress alarms and locking devices should be installed in all high-risk areas.

Conclusions

Many health practitioners are vulnerable to workplace violence and may suffer considerably as a consequence. It is time for organisations to take action and put in place methods to prevent events occurring. At a management level, there are many advantages to be gained through concerted action.

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