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Prevention of Workplace Violence

White Paper

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Workplace violence continues to be a serious problem in the United States. Violence was the second leading cause of traumatic injury death on the job in 2017. Workplace violence caused 9% of all occupational traumatic injury deaths for U.S. workers in 2017, resulting in 458 deaths, out of a total of 5,147 recorded fatalities. Workplace homicides increased by 83 cases in 2016 compared to the previous year.[1]

OSHA defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide."[2]

Industrial hygienists (IHs) are concerned with the anticipation, recognition, evaluation, and control of occupational hazards. Workplace violence is a recognized hazard, and AIHA promotes the involvement of IHs in helping workplace leaders develop effective, evidence-based prevention programs. AIHA believes that IHs should collaborate with other workplace professionals — employers, labor unions, government, and researchers — in the development and implementation of workplace violence prevention programs.

Industrial hygienists have special expertise in developing safety and health programs that may be useful in establishing workplace violence prevention programs. IHs have training and skills in evaluating and controlling environmental hazards and in designing and administering health and safety programs that should be adapted to workplace violence prevention.

Cal/OSHA and others have characterized workplace violence events as follows:

Type I: Criminal intent. The perpetrator has no legitimate relationship to the business or its employees and is usually committing a criminal act prior to the violence. Criminal acts include robbery, shoplifting, and loitering.

Type II: Customer/client. The perpetrator has a legitimate relationship with the business and becomes violent during a business transaction. This category includes customers, clients, patients, students, inmates, and any other group to which the business provides services.

Type III: Worker on worker. The perpetrator is an employee or past employee of the business who attacks or threatens another employee or past employee(s).

Type IV: Personal relationship. The perpetrator does not have a relationship with the business but has a personal relationship with the intended victim. This category includes victims of domestic violence assaulted while at work.[3]

AIHA is interested in several key areas surrounding workplace violence prevention:

1. OSHA's swift rulemaking on workplace violence prevention in healthcare and social service sectors
2. Employer implementation of facility-specific workplace violence prevention programs
3. Industrial hygienists' participation in development and implementation of workplace violence prevention programs
4. Advocacy for an expanded budget for public health research on gun violence
5. Continued corporate, academic, and government funding to support research in workplace violence prevention

FATAL ASSAULTS

The 2016 Bureau of Labor Statistics (BLS) Census of Fatal Occupational Injuries database reveals that 13% of the 500 work-related homicides were perpetrated by co-workers or former workers (type III), compared to 65% involving patients, clients, robberies or other crimes (types I and II).

In 2016, a greater proportion of female workers died from violence on the job than males. Homicides represented 24% of fatal occupational injuries to women in 2016, compared with 9% of fatal occupational injuries to men. Relatives or domestic partners were the most frequent assailant in work-related homicides involving women (type IV). Robbers were the most common work-related homicide assailant for men (type I).[4,5]

Cashiers incurred the largest number of workplace homicides in 2016 (54 homicides, up from 35 in 2015). Other occupations with high numbers of homicides were first-line supervisors of retail sales workers (50 homicides, up from 40 in 2015) and police and sheriff patrol officers (50 homicides, up from 34 in 2015).[5]

In 2016 about 1 in 5 victims of workplace homicide was a government employee.[6]

Table 1 details violence-related fatalities in select industries between 2012 and 2016.[6]

Table 1. Violence-related fatalities in select industries between 2012 and 2016

Industry	2012	2013	2014	2015	2016
Total homicides	475	404	409	417	500
Retail trade	108	95	106	98	120
Convenience stores	27	20	27	20	29
Eating & drinking establishments	62	65	47	56	58
Gas stations	21	25	22	26	37
Taxi and limousine	32	26	31	27	26
Protective services	90	65	78	68	106
Police protection	43	26	44	34	51
Healthcare and social services	20	10	14	15	29
Government	76	56	67	67	87

Source: BLS websites, https://www.bls.gov/web/osh/cd_r8.htm and https://www.bls.gov/news.release/pdf/osh2.pdf.

NONFATAL ASSAULT

The Bureau of Justice Crime Victims Survey documents that in 2009 there were approximately 572,000 nonfatal assaults in the workplace. Occupations experiencing the greatest number of nonfatal assaults include retail workers, nurses' aides, nurses, teachers, police, security guards, corrections officers, and taxi drivers. Select industries with large numbers of violent nonfatal assaults include retail sales, law enforcement, teaching, medical, mental health, transportation, and private security.[7]

Although rates of workplace violence have declined since 1993, they are declining more slowly for women than men, such that incidence rates for workplace violence against women are now approaching those previously published for men. Table 2 shows National Safety Council data on the number of injuries and deaths, by industry, due to violence in 2013.

Table 2. Industry of nonfatal workplace violence victims in 2013

Sector	Injuries
Government	37,110
Education & health services	22,590
Professional & business services	4,460
Retail	2,680
Leisure & hospitality	2,380
Financial activities	1,100
Transportation & warehousing	840
Construction	680
Manufacturing	570

Source: NSC website www.nsc.org/work-safety/safety-topics/workplace-violence (accessed Dec. 11, 2018).
Note: The numbers are based on BLS data, which is recognized as underreporting actual cases of injury.

Workplace violence is estimated to cost $121 billion per year.[8] A 2017 survey by the Workplace Bullying Institute estimated that 19% of U.S. workers have experienced bullying at work.[9]

HEALTHCARE

Healthcare workplace violence is most frequently from an assaultive patient or patient's family member according to NIOSH, based on 2013 BLS data on nonfatal assaults.10 According to a report from the Government Accounting Office, there were 730,000 cases of healthcare workplace assaults over the five-year span from 2009 through 2013, based on Bureau of Justice Statistics data. BLS reports that healthcare and social service workers suffered 69% of all workplace violence injuries caused by persons in 2016 and are nearly five times as likely to suffer a workplace violence injury as workers overall. Incidence rates for workers at psychiatric and substance abuse hospitals are an order of magnitude larger than other healthcare workers.

Table 3. Incidence rates for nonfatal occupational injuries and illnesses involving days away from work per 10,000 full-time workers related to workplace violence for healthcare and social assistance, private industry, 2016–2017

Industrial sector	Incidence rates	
	2016	2017
All Industry	2.8	2.9
Healthcare and social assistance	13.3	13.7
Hospitals	15.1	16.6
Psychiatric and substance abuse hospitals	122.2	179.7
Nursing and residential care	30.8	33.4
Social assistance	17.1	10.7
Home health services	6.9	8.9

Incidence rates for nonfatal occupational injuries and illnesses involving days away from work per 10,000 full-time workers related to workplace violence for healthcare and social assistance, private industry, 2016-2017

Industry	Violence and other injuries caused by persons
All Industry 2016	2.8
All Industry 2017	2.9
Health care and social assistance 2016	13.3
Health care and social assistance 2017	13.7
Hospitals 2016	15.1
Hospitals 2017	16.6
Psychiatric and substance abuse hospitals 2016	122.2
Psychiatric and substance abuse hospitals 2017	179.7
Nursing and residential care facilities 2016	30.8
Nursing and residential care facilities 2017	33.4
Social assistance 2016	17.1
Social assistance 2017	10.7
Home Health Services 2016	6.9
Home Health services 2017	8.9

Source: Bureau of Labor Statistics 2017 & 2018 table R-8

Source: BLS 2017 and 2018, https://www.bls.gov/web/osh/cd_r8.htm table R–8 and https://www.bls.gov/news.release/pdf/osh2.pdf.

RETAIL

The disproportionate rate of nonfatal assaults in the retail sector is related to its high degree of public contact. Many retail stores have unrestricted public access. Other risk factors include cash handling and 24-hour operating hours in the case of late-night convenience stores.

STATE LEGISLATION

Several states have promulgated state laws and regulations addressing workplace violence prevention. Many of these laws are directed at healthcare and social services, retail operations, or taxi and limousine drivers. State regulations can be found in California, Connecticut, Florida, Michigan, New Jersey, New York, Ohio, and Washington. Cal/OSHA promulgated a comprehensive workplace violence standard in 2017 for healthcare. Other states, including Maryland and Massachusetts, have proposed legislation.

The scope of these requirements varies. Some require comprehensive workplace violence prevention programs, whereas others address training, specific workplace controls, or whether guns may be on the employer's property. Some 34 states have laws increasing the penalty for assaulting nurses or other specific professionals.

OSHA AND CONGRESSIONAL ACTION

OSHA has no enforceable workplace violence prevention standard. However, it has issued citations to employers for violation of the general duty clause, Section 5(a)(1) of the Occupational Safety and Health Act. The general duty clause of the OSH Act requires employers to provide a place of employment that is free of recognized hazards that are causing or are likely to cause death or serious physical harm. This section is used when no specific health and safety standard exists.

The compliance officer must be able to demonstrate the following elements in a general duty case: (a) the hazard exists, (b) the hazard is serious in that it is likely to cause death or serious injury, (c) the employer has knowledge of the hazard, (d) there is industry recognition of the hazard, (e) the hazard was foreseeable, and (f) an employee was exposed.

In December 2016, OSHA published a Request for Information to solicit information primarily from healthcare employers, workers, and other subject matter experts on the impacts of violence, prevention strategies, and other information. The public comment period closed in May 2017.

OSHA was petitioned for a standard preventing workplace violence in healthcare by a broad coalition of labor unions and in a separate petition by National Nurses United. On Jan. 10, 2017, OSHA granted the petitions. As of fall 2018, workplace violence was identified as a regulatory priority and moved to OSHA's short-term regulatory agenda, and the "Prevention of Workplace Violence in Health Care (1218-AD08)" was assigned a prerule status.[11]

In November 2018, U.S. Rep. Joe Courtney introduced H.R. 7141, the Workplace Violence Prevention for Health Care and Social Service Workers Act. It directs OSHA to issue a standard requiring healthcare and social service employers to write and implement a workplace violence prevention plan to prevent and protect employees from violent incidents. The bill would require OSHA to develop a standard within one year, with an implementation within 42 months of enactment.[12]

GUN VIOLENCE

The increasing number of school and other mass shootings has necessitated active shooter preparedness programs, including written policies and procedures, training, drills, and coordination with criminal justice and health authorities. Since 2013, there have been 290 school shootings, and since 2014 there have been 1333 mass shootings and 56,755 deaths by guns, according to the Union of Concerned Scientists.[13,14]

Government research on gun violence by the CDC National Center for Injury Prevention and Control was effectively eliminated by an appropriations rider that reduced its budget by 90% in 1996. Public access to data regarding guns used in crimes from the Bureau of Alcohol, Tobacco, Firearms and Explosives database was eliminated by the Tiahrt Amendment in 2003.[13]

ROLE OF HEALTH AND SAFETY PROFESSIONALS

Workplace violence is a serious occupational hazard that is often predictable and preventable. Occupational safety and health professionals have training and experience in evaluating risk and establishing occupational injury and illness prevention programs. The expertise and training of these professionals should be used in combination with others with relevant expertise such as organizational psychologists, human resources, employee assistance, and security professionals. All key workplace stakeholders, such as operations managers, department heads, union leaders, and line staff, should participate in developing and implementing violence prevention programs.

Health and safety professionals use the IH hierarchy of control measures in designing hazard control interventions. Highest in the hierarchy are approaches that engineer out hazards, followed by administrative measures such as training and development of policies and procedures. Personal protective equipment is least desirable because it does not eliminate the hazard — it merely provides a barrier between employees and exposures, and it is often uncomfortable and may interfere with productivity.

Prevention of workplace violence requires an industry and site-specific risk analysis that evaluates environmental, organizational, and personal risk factors. Based on that analysis, a variety of control measures will most likely need to be implemented to reduce the risk of violence. Examples of these categories for violence prevention are:

- Engineering controls: installation of security hardware, lighting, barriers, access control, and cash-drop boxes.

- Administrative controls: written violence prevention programs, staff and supervisory training, increased staffing, threat assessment, emergency response teams, alarm systems, personal communication devices, and emergency procedures.
- Personal protective equipment: body armor, face shields, and helmets.

Industrial hygienists should especially be prepared to develop violence prevention programs if they are working in affected industries or in locales and states that have promulgated violence prevention standards. The drive to promulgate state and local, and ultimately national standards will likely increase as public awareness of the negative impact of workplace violence rises. IHs can contribute to identifying cost-effective and technologically feasible methods for protecting workers and organizations from the harmful effects of workplace violence.

CONCLUSION

In conclusion, AIHA recognizes the destructive impact that workplace violence has had on industry, government, and labor, and the human pain and suffering of the affected employees. Therefore, AIHA supports:

1. OSHA's swift rulemaking on workplace violence prevention in healthcare and social services and H.R. 7141, Workplace Violence Prevention for Health Care and Social Service Workers Act, which directs OSHA to issue a standard.
2. Employer implementation of facility specific workplace violence prevention programs to protect all personnel from exposure to occupational violence, especially in industries with high rates of workplace violence.
3. Industrial hygienists' participation in interdisciplinary teams that develop and implement workplace violence prevention programs. Environmental design, administrative controls, and behavioral strategies should all be considered in the development of site-specific workplace violence prevention programs.
4. Advocacy for an expanded budget for public health research on gun violence in the National Center for Injury Prevention and Control at the CDC and the National Institute of Justice (Department of Justice), and for the release of data about gun crimes from the Bureau of Alcohol, Tobacco, Firearms and Explosives.
5. Continued corporate, academic, and government funding to support research in workplace violence prevention, particularly in the areas of:
   - characterization of environmental, organizational, and personal factors for workplace violence in high-risk industries and occupations;
   - analysis of injuries, lost work time, and costs associated with workplace violence;
   - evaluation of the effectiveness of controls such as security hardware, alarms, workplace redesign, emergency systems, training programs, written prevention programs, and trauma response;
   - the testing of intervention strategies for effectiveness; and
   - program evaluation.

References

1. U.S. Department of Labor, Bureau of Labor Statistics: *National Census of Fatal Occupational Injuries in 2016*, USDL–17–1667, Dec. 19, 2017. Available at www.bls.gov/news.release/pdf/cfoi.pdf (accessed Dec. 11, 2018).
2. OSHA: *Workplace Violence*, Safety and Health Topics. Available at www.osha.gov/SLTC/workplaceviolence (accessed Dec. 11, 2018).
3. Barish, R: Legislation and regulations addressing workplace violence in the United States and British Columbia. *Am J. Prev Med 2001*:20(2). Available at www.ajpmonline.org/article/S0749-3797(00)00291-9/pdf (accessed Dec. 11, 2018).
4. U.S. Department of Labor, Bureau of Labor Statistics: Census of Fatal Occupational Injuries. Static charts, 2016. Available at www.bls.gov/iif/oshwc/cfoi/cfch0015.pdf (accessed Dec. 11, 2018).
5. U.S. Department of Labor, Bureau of Labor Statistics: "There were 500 workplace homicides in the United States in 2016." *The Economics Daily*, Jan. 23, 2018. Available at www.bls.gov/opub/ted/2018/there-were-500-workplace-homicides-in-the-united-states-in-2016.htm (accessed Dec. 11, 2018).
6. U.S. Department of Labor, Bureau of Labor Statistics: Injuries, Illnesses, and Fatalities: Workplace homicides by selected characteristics, 2011–2016. (Excel spreadsheet download shows 87 of 500 fatalities were government employees in 2016.) Available at https://docs.google.com/viewer?url=https%3A%2F%2Fwww.bls.gov%2Fiif%2Foshwc%2Fcfoi%2Fwork_homicide.xlsx (accessed Dec. 11, 2018).
7. Harrell, E.: *Workplace Violence*, 1993–2009 (Bureau of Justice Statistics special report). Washington, DC: U.S. Department of Justice, Office of Justice Programs, March 2011.
8. Costs of Violence in the Workplace, Recommendations for Workplace Violence Prevention Programs. Available at: http://www.nationalacademies.org/hmd/~/media/37A028BB410045DA8A7142BECFC17581.ashx (Accessed April 11, 2019).
9. Namie, G. 2017 U.S. Workplace Bullying Survey, Workplace Bullying Institute, 2017. Available at www.workplacebullying.org/multi/pdf/2017/Prevalence.pdf (accessed Dec. 11, 2018).
10. Hartley, D.: "Violence in Healthcare" (blog). NIOSH, March 27, 2013. Available at https://blogs.cdc.gov/niosh-science-blog/2015/03/27/violence-in-healthcare.
11. Office of Management and Budget: *Prevention of Workplace Violence in Health Care and Social Assistance* (OSHA regulatory review at prerule stage). Office of Information and Regulatory Affairs, Spring 2018. Available at www.reginfo.gov/public/do/eAgendaViewRule?pubId=201804&RIN=1218-AD08 (accessed Dec. 12, 2018).
12. Johnson, C.: "CDC Scientists Plea to Congress: Let Us Research Gun Violence" (blog). Union of Concerned Scientists, Feb. 16, 2018. Available at https://blog.ucsusa.org/charise-johnson/cdc-scientists-plea-to-congress-let-us-research-gun-violence (accessed Dec. 12, 2018).
13. Young, R. "Why Data on Tracing Guns Is So Difficult To Find." Interview excerpt from *Here and Now*, National Public Radio, April 3, 2018. Available at www.wbur.org/hereandnow/2018/04/03/gun-research-trace-data (accessed Dec. 12, 2018).
14. OSHA: *Workplace Violence*, Safety and Health Topics. Available at www.osha.gov/SLTC/workplaceviolence/standards.html (accessed Dec. 12, 2018).
15. U.S. Government Accountability Office: *Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence* (Report GAO–16–11). March 17, 2016, publicly released April 14, 2016. Available at www.gao.gov/products/GAO-16-11 (accessed Dec. 12, 2018).