AIHA - White Paper on Prevention of Workplace Violence

Adopted December 13, 2000

Workplace violence continues to be a serious problem in the United States. Research by the National Institute for Occupational Safety and Health (NIOSH) and the U.S. Department of Justice revealed that workplace violence is the second leading cause of traumatic injury death on-the-job for men, the leading cause of traumatic injury death on-the-job for women, and accounts for some two million non-fatal injuries per year in the United States.(1,2,3)

Industrial hygienists are concerned with the anticipation, recognition, evaluation, and control of all occupational hazards. Although prevention of workplace violence has not been a major focus of industrial hygiene in the past, AIHA promotes the involvement of industrial hygienists in responding to new and emerging hazards such as this one. AIHA believes that industrial hygienists 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 brought to bear in establishing workplace violence prevention programs. In particular, industrial hygienists 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.

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

1. Initiation of the Occupational Safety and Health Administration (OSHA) stakeholder meetings to review workplace violence prevention initiatives and to explore the need for an OSHA violence prevention standard.
2. Participation of occupational safety and health professionals in developing intervention programs, standards, and research efforts geared towards preventing homicide and assault in the workplace.
3. The development and implementation of facility specific, written workplace violence prevention programs. Industrial hygienists should be included in interdisciplinary teams that develop and implement workplace violence prevention programs.
4. Environmental design, administrative controls, and behavioral strategies should all be considered in the development of site specific workplace violence prevention programs.
5. Robbery and crime (type I) and customer, client, patient (type II) are the categories that correlate with the greatest incidents of fatal and non-fatal violence compared to worker-on-worker and domestic violence. Type I and II are also more highly amenable to occupational safety and health intervention strategies. Therefore, occupational safety and health professionals should concentrate their efforts on these types. Worker-on-worker and domestic violence issues are more appropriately addressed by EAP, human resources, mental health, and organizational behavior specialists.
6. Continued corporate, academic, and governmental funding to support workplace violence prevention research in the areas of:

    - Characterizing environmental, organizational, and personal risk factors for workplace violence in particular industrial sectors;
    - Analysis of injury rates, lost work time, and costs associated with workplace violence;
    - Evaluating the effectiveness of controls such as security hardware, alarms, workplace re-design, emergency systems, training programs, written prevention programs, and trauma response;
    - Testing intervention strategies for effectiveness and particularly the implementation of the OSHA guidelines; and
    - Program evaluation.

Fatalities

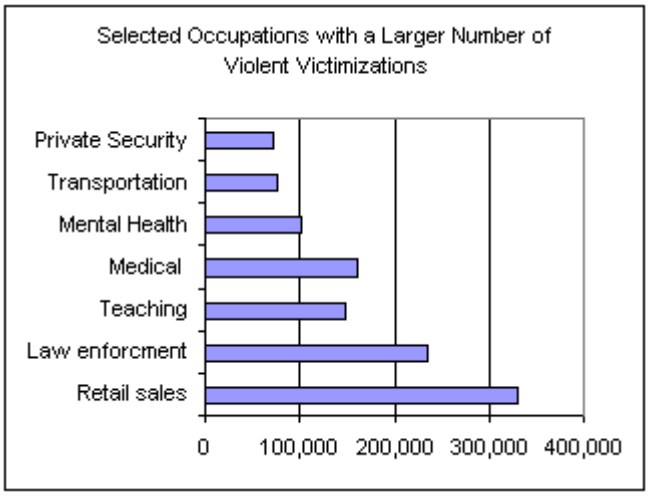
In 1998, the U.S. Bureau of Labor Statistics reported an estimated 709 fatalities as a result of job-related homicide. Although this is a significant decrease from the previous four years, workplace violence is still responsible for more than 10 percent of all workplace fatalities. The retail, taxicab industries, and police agencies have particularly high rates of workplace homicide. Twenty-two million workers are employed in retail trade(2), and job-related homicide in this industry accounted for 40 percent of all workplace homicides in 1998. The BLS chart below shows the decline in

violence-related fatalities in select industries between 1994 and 1998. The 18 percent decline from 1997 in workplace homicides was significantly greater than the overall 8 percent drop in homicides reported by the U.S. Department of Justice. Homicide was the leading cause of traumatic injury death on-the-job for women workers in 1998: 168 out of 482 fatalities (34 percent) and an increase from the 145 homicides in 1997.

Industry	1994	1995	1996	1997	1998
Total homicides	1,080	1,036	927	860	709
Retail trade	530	422	437	395	286
Grocery stores	196	152	146	141	95
Eating and drinking establishments	135	121	135	109	69
Gasoline service stations	41	36	23	34	24
Taxicab	87	68	50	74	48
Detective and armored car services	49	27	29	21	18
Police protection	65	61	45	61	50

Non-Fatal Assault

Data from the National Crime Victimization Survey (NCVS) for 1992¥996 indicates that each year there are two million non-fatal assaults in the workplace.1 Select occupations with a larger number of victimizations as reported by the NCVS are listed in the chart below:



In 1996, non-fatal assaults resulted in more than 876,000 lost workdays and $16 million in lost wages.1 A disproportionate number of non-fatal assaults involved public sector workers who made up 16 percent of the workforce in 1996, but were 37 percent of the victims.1

Employers of workplace violence victims, 1992¥996			
Non-fatal assaults		**Number***	**Percent**
Private employer		1,127,800	56.1
State/local government		677,600	33.7
Self-employed		134,500	6.7
Federal Government		62,900	3.1

Not ascertained		35,100	0.3
*Annual average, 1992¥996			

Source: U.S. Bureau of Justice, Crime Victimization Survey 1

Healthcare

Healthcare has had particularly high rates of assault. According to 1997 BLS data on non-fatal assaults causing lost time from work:

45 percent of the time the assailant was a healthcare patient;
54 percent of the victims were female;
the attack involved hitting, kicking, and beating in 47 percent of the cases; and
27 percent occurred in nursing homes, 13 percent social services, and 11 percent in hospitals.
Assault rates in psychiatric hospitals are especially high. A study by the Washington State Department of Labor and Industries of worker compensation claims for 1992¥997 showed that psychiatric hospitals had the highest average rate of claims related to workplace violence of all industries: 872 per 10,000 workers. The second, third, and fourth highest industries were also in health care, as follows: residential care 417/10,000 workers, skilled nursing care 254/10,000 workers, and nursing/personal care 240/10,000 workers. These rates compare to a rate of 19/10,000 workers for all industries. 4

Retail

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

Categorization of Workplace Violence Events
California OSHA and Washington State have developed a system of violence "typology" that focuses on the relationship between the perpetrator and the victim of violence.(5,6,7)

Type I: Violence by Strangers

- The assailant has no legitimate business relationship to the workplace.
- Usually a robbery or other criminal act is committed.
- Robbery accounted for 67 percent of the violence related fatalities in 1998. (8)

Type II: Violence by Customers or Clients

Assaults by customers, patients, or other people who are receiving services or under custodial supervision of the affected workplace or worker. Customers and client attacks accounted for only eight percent of the fatalities in 1998, but were the leading type of non-fatal assaults and were especially high in healthcare, retail, taxicab, and criminal justice.

Type III: Violence by Co-workers

Fatalities caused by attacks by co-workers are a small fraction of the work-related homicides and non-fatal assaults. However, media coverage has caused this type of workplace violence to receive a disproportionate amount of attention.

Type IV: Violence by Personal Relations

Domestic violence can spill over into the workplace. Relatives caused four percent of the fatalities in 1998.

From a statistical viewpoint, violence by strangers, customers, and clients (Type I and II) are the most frequent types of fatal and non-fatal assault. Furthermore, industrial hygiene occupational health protection strategies are most applicable to addressing Type I and II events. With the limited resources available for most occupational safety and health programs, it will be important to set priorities based on actual conditions, especially considering industry and site specific injury rates and experience.

One aspect of prevention of co-worker violence that industrial hygienists may contribute to is identification of occupational stress factors and their control. Occupational stress is often a factor in workplace violence and is a subject of importance in industrial hygiene. However, other specialists in labor relations, organizational psychology, security, and employee assistance should take primary leadership in addressing co-worker and domestic violence.

Legislation and Standard Setting

OSHA has no enforceable workplace violence prevention standard. However, it has issued citations to employers for violation of the general duty clause* of the occupational safety and health act. Labor unions, especially in healthcare, retail, and public sector, have lobbied OSHA to promulgate a standard. Furthermore, a number of states and localities have legislated requirements relating to workplace violence prevention including New Jersey, Florida, Washington, California, New York City, Chicago, and Baltimore, to name a few. For example, Washington State has Administrative Code 296-24-10203 which requires late night retail establishments to establish robbery prevention policies, train staff, minimize cash handling, and maintain adequate exterior lighting. The state of California has a law that requires healthcare institutions to conduct a security and safety assessment. Most recently, Washington State passed a law requiring healthcare facilities to develop and implement plans to reasonably prevent workplace violence.

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. Industrial hygienists can contribute to identifying cost effective and technologically feasible methods for protecting workers and organizations from the harmful effects of workplace violence.

*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, and e) the hazard was foreseeable, and f) an employee was exposed.

Federal OSHA Guidelines

In 1993, NIOSH published an alert to encourage action to prevent workplace homicide. This was followed in 1996 by more detailed research revealing the significant role that workplace violence plays in our society overall burden of occupational morbidity and mortality. The growing recognition that workplace violence is a significant occupational hazard that is often predictable and preventable influenced federal OSHA to develop guidelines. The OSHA guidelines for Healthcare and Social Service Workers were based largely on work done by California OSHA and State of Washington Department of Labor and Industries.

In 1998, a second set of OSHA guidelines were issued, "Recommendations for Workplace Violence Prevention Programs in Late-Night Retail Establishments," which were the result of discussions with industry, labor, and a victim's group. The guidelines include the same basic program elements as in healthcare and include specific examples of engineering controls.

Key Elements of OSHA Violence Prevention Guidelines:

- Management Commitment and Employee Involvement
- Written Program
- Worksite Analysis
    - Records Analysis and Tracking
    - Monitoring Trends and Analyzing Incidents
    - Screening Surveys

    - Workplace Security Analysis
- Hazard Prevention and Control
- Engineering Controls and Workplace Adaptation
- Administrative and Work Practice Controls
- Medical Management and Post Incident Response
- Training and Education
    - All Employees
    - Supervisors, Managers, and Security Personnel
- Recordkeeping and Evaluation of the Program

In May 2000, OSHA released a factsheet entitled, "Risk Factors and Protective Measures for Taxi and Livery Drivers." It outlines the extent of the violence problem in this industry, defines the risk factors, describes specific safety measures such as automatic vehicle location systems to locate drivers in distress, caller ID to help trace location of fares, in-car surveillance cameras to aid in apprehending perpetrators, and the proper use of partitions or shields to protect drivers from would-be perpetrators. Employer responsibilities and employee rights are also addressed in this fact sheet.

Since the release of the OSHA healthcare and social service guidelines there has been a proliferation of publications, conferences, and prevention initiatives by professional associations, industry, labor government, and academia. However, systematic research on the effectiveness of implementing the OSHA guidelines and other approaches has not been completed. The University of Iowa Injury Prevention Research Center, with NIOSH support held a national "Workplace Violence Intervention Research Conference" in March 2000. Key stakeholders from industry, labor, government, and academia attended and four white papers were written and will be published in the American Journal of Preventive Medicine.

There is a current and pressing need for OSHA to bring together key stakeholders to further the process of identifying populations at risk, risk factors, and intervention effectiveness. In addition to providing leadership in moving the workplace violence prevention agenda, OSHA may use this forum to evaluate its regulatory outlook on workplace violence.

Role of Health & 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 should participate in developing and implementing violence prevention programs such as operations managers, department heads, union leaders, and line staff.

Health and safety professionals use the industrial hygiene 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 doesn 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 effectively reduce the risk of violence. Examples of these categories for violence prevention are:

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

Administrative controls: written violence prevention programs, staff and supervisory training, threat assessment, access control, trauma response, alarm systems, and emergency procedures.

Personal protective equipment: body armor, face shields, and helmets.

Conclusion

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

1. OSHA should conduct stakeholder meetings to review current approaches to prevention of employee injury due to workplace violence and to get stakeholder views on the need for, proposed scope, and provisions of an OSHA Standard to protect employees from injury due to workplace violence.
2. Occupational safety and health professionals should actively contribute to developing intervention programs, standards, and research efforts geared towards preventing homicide and assault in the workplace.
3. The development and implementation of facility specific, written Workplace Violence Prevention programs to protect all personnel from exposure to occupational violence. Industrial hygienists should be included in an interdisciplinary team that develops and implements workplace violence prevention programs.
4. The application of the industrial hygiene control strategy as the most comprehensive method for protecting workers from exposure to workplace violence. In applying the hierarchy of engineering controls and administrative controls, and personal protective equipment, it may be necessary to consider a combination of controls to prevent or minimize exposure.
5. Given that type I (robbery and crime) and II (customer, client, patient, etc.) are the categories that correlate with the greatest incidents of fatal and non-fatal violence and are more highly associated with occupational safety and health intervention strategies, occupational safety and health professionals should concentrate their efforts on these types. Worker-on-worker and domestic violence issues are more appropriately addressed by EAP, human resources, mental health, and organizational behavior specialists.
6. Continued corporate, academic, and governmental funding to support workplace violence prevention research in the areas of:

    - Characterizing environmental, organizational, and personal factors for workplace violence in particular industrial sectors;
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    - Evaluating the effectiveness of controls such as security hardware, alarms, workplace re-design, emergency systems, training programs, written prevention programs, and trauma response;
    - Testing intervention strategies for effectiveness; and
    - Program evaluation.

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