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ABSTRACT

Workplace violence is a growing social problem that that has caught the attention of public stakeholders and policymakers. Likewise, industry observers have pushed for more attention to be paid to how violence in the workplace uniquely impacts healthcare professionals. Recently, Texas legislators responded to these calls by passing the Workplace Violence Prevention Act. This new law represents a significant milestone in the effort to develop durable protections for employees in the healthcare Texas system and prevent future incidents of workplace violence. The aim of this technical paper is to provide policymakers and corporate stakeholders with an introduction to this issue and to suggest future improvements to this landmark piece of legislation. In what follows, we will provide a brief overview of the background and significance of workplace violence as a challenging issue that uniquely impacts the healthcare system, outline a working definition of workplace violence that respects the healthcare context, and review existing regulatory and corporate policies that have emerged to combat workplace violence in practice. We will then provide an overview of this new legislation and suggest several ways that this law can be strengthened in light of existing research.

INTRODUCTION

Background and Significance of Workplace Violence in Healthcare

Traditionally, the most common public perception of workplace violence has centered around a myth that such incidents are largely isolated, high-profile, traumatizing events that are largely carried out in a random fashion (Bowie, 2000). An unexpected assault during the late-shift, a mass-shooting event that is carried out by a stranger, a happenstance robbery, or a disgruntled former employee coming back to exact revenge all represent real workplace violence events. However, the extent to which these types of events dominate media coverage of this issue drive a popular false narrative that workplace violence is an undoubtably tragic but largely unavoidable part of any employment environment. As such, the characterization of workplace violence as a social problem evolved over time and only recently has become an issue of popular concern.

A stark reality is that workplace violence is a phenomenon that affects certain sectors and types of employees more than others. Specifically, those employed in human services jobs experience a disproportionate number of incidents of workplace violence. Research has found that workers in these types of jobs are nearly four times as likely to experience workplace violence in the course of their employment (Balloch et al., 1999). Likewise, a recent survey of nurses found that nearly

85% of respondents reported that they experienced more than one type of violence in the workplace over the previous year (Havaei, 2021). This presents a challenging picture of the state of the healthcare sector as a potentially hazardous environment.

Additionally, it is a misperception that violent acts in the workplace are primarily isolated, random chance events that are external to the occupational environment. Research has also revealed that a considerable amount of workplace violence is perpetrated internally by fellow workers and the clients that employees in human services sectors serve (Dillon, 2012). High job stress, coupled with a persistent workplace culture of silence, has contributed to a challenging environment where healthcare workers may lash out against one another or feel underequipped to report violent incidents that affect them due to a fear of professional retaliation.

Healthcare remains one of the largest human services sectors in the United States, and it is anticipated to experience employment growth by 13% between 2021 and 2031 (Bureau of Labor Statistics, 2022). The physical demands of this work, coupled with the cognitive and mental requirements to enter many specialized fields elevates the occupational risk for workplace violence among professionals in this space. Frontline caregivers are particularly susceptible to injury from these incidents as they are frequently tasked with working directly with people who have a history of violence or who may be experiencing symptoms of disorientation because of a medical condition. Such injuries can interrupt patient care, lead to property damage, and elevate personnel and security costs. Collectively, these represent critical threats to the viability of the healthcare system as a whole.

Problem

As one of the core drivers of economic growth, policymakers and corporate managers have taken an interest in developing more regulations to help mitigate the risk of workplace violence in the healthcare sector. To date, there is no federally mandated industry standard guiding employers on how to mitigate workplace violence. This has led many healthcare facilities to increasingly invest time, money, and effort into developing stronger deterrence initiatives in an ad-hoc fashion to manage employee concerns. Moreover, while an increasing number of states have legislated that employers develop such initiatives and have strengthened existing statutes that pertain to assault, there is wide variation across these state-level policies. Finally, workplace violence is a social problem that disproportionately affects healthcare workers.

Research Objective

The recently passed S.B. 240 in Texas aims to address workplace violence against healthcare workers. This paper will consider this law as the starting point rather than the conclusion of an effort to develop more comprehensive protections employees in the caring professions. In what follows, this paper will contextualize workplace violence as a social problem by providing an overview of patient-related, organizational, and societal factors that contribute to risk in a healthcare setting. Next, this paper covers existing policy responses to workplace violence to evaluate their effectiveness. Finally, this paper will advocate for a more comprehensive policy

model in Texas that takes into consideration the unique healthcare system challenges of the state to build on foundation provided by S.B. 240.

CONTEXTUALIZING WORKPLACE VIOLENCE IN THE HEALTHCARE SYSTEM AS A SOCIAL PROBLEM

Defining Workplace Violence in a Healthcare Context

Though distinctly concerning, violence represents only a subset of broader aggressive behavior in the workplace. Most acts of aggression in the workplace are passive, verbal, indirect, and/or non-physical in nature (Baron & Neuman, 1996). As such, workplace violence requires a definition centered around more extreme acts of aggression in an occupational setting. In the U.S., the Occupational Safety and Health Administration (OSHA, 2023) defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at work." However, academic research has argued for a more specialized definition of workplace violence that moves beyond this to consider the healthcare setting as a unique environment (Boyle & Wallis, 2016). With the rise of telehealth and emphasis on care beyond designated healthcare facilities, a more expansive definition is needed to capture how violence is connected to the type of work performed rather than simply the setting in which it occurs. As a result, there is a preference in this literature for definitions that are championed by international health organizations.

To this end, it may be useful to adopt the International Labour Organization and World Health Organization's (2014) definition: "[Workplace violence] includes incidents where staff are abused, threatened, discriminated against or assaulted in circumstances related to their work, including commuting to and from work, and which represent a threat to their safety, health, and well-being." This definition suggests that workplace violence can span both physical and nonphysical acts of extreme aggression.

Rather than focus on specific acts that fall under these respective umbrellas, the National Institute for Occupational Safety and Health (NIOSH) instead advocates for classifying forms of workplace violence into four basic categories (NIOSH, 2002). These categories include:

- Type 1: These acts involve "criminal intent." They are carried out by individuals with no relationship to the occupational setting.
- Type 2: These acts involve any customer, client, or patient. They are carried out by an individual who has a relationship to the occupational setting and typically occur while receiving services from the occupational setting.
- Type 3: These acts involve interpersonal worker disputes. In other words, they are carried out by one employee who attacks and/or threatens another employee.
- Type 4: These acts involve interpersonal relationship disputes. In contrast to Type 3 events, acts under this category involves at least two individuals who have a personal relationship, but do not have a relationship to the business.

Factors that Contribute to Workplace Violence in a Healthcare Setting

Patient-Associated Factors

Working in the healthcare system puts staffers in contact with a variety of different patients that may exhibit symptoms or conditions that elevate their risk of experiencing violent interactions (Gillespie et al., 2010). Common patient-associated factors that contribute to workplace violence in a healthcare setting include: (1) patient mental health, (2) substance abuse, (3) cognitivebehavioral disabilities, (4) histories of aggressive behavior, and (5) communication-related challenges.

Mental health disorders including dementia, schizophrenia, and anxiety have been associated with patient-instigated incidents of workplace violence. Such disorders can become more or less of a factor across different healthcare environments. For instance, research has identified that patient dementia was linked to 87% of assaults on nursing home assistants (Gates et al., 2003), while in non-nursing home healthcare settings other psychiatric disorders accounted for a larger proportion of violence against caregivers (Mandiracioglu & Cam, 2006).

Substance abuse can also motivate workplace violence by diminishing a patient's self-control. Excessive consumption of alcohol is often reported to underpin incidents of verbal harassment and can lead to physically aggressive behavior in more extreme cases. Additionally, sleep deprivation or disorientation associated with certain substance classes may cloud patient judgement and lead to unpredictable, violent reactions toward caregivers.

Cognitive-behavioral disabilities are also associated with workplace violence incidents in a healthcare setting. In some cases, patients are medically incapable of personal restraint or lack the capability to engage in rational decision-making. These interrelated issues can lead to unpredictable aggression against healthcare workers. Entry-level healthcare employees or caregivers with minimal experience who may be less prepared to manage patients that have a cognitive-behavioral disability are especially at risk under these contexts (Whittington et al., 1996).

Healthcare workers also tend to more frequently interact with patients with histories violent and/or aggressive behavior. Unsurprisingly, involvement with these patients is associated with higher rates of engaging in workplace violence (Barling, 1996). As healthcare workers can make decisions that invite disagreement in patient care, a history of violent behavior can be particularly risky when emotions run high.

Finally, when patients suffer from an affliction that lowers their interpersonal communication skills or are being treated in a setting of minimal familiarity, this can lead to workplace violence in a healthcare setting. This type of issue is most common when there are language barriers between a caregiver and a patient, or if a patient is experiencing symptoms that lead to have diminished communication abilities. Frustration from an inability to understand treatment plans

or comprehend acts of caretaking that are perceived as frightening can prompt instances of aggression. This issue is especially sensitive in areas with high language diversity.

Organizational Factors

Given the variety of healthcare work settings, there are several organizational factors that contribute to the risk of violent incidents. For instance, hospitals are particularly prone to incidents of workplace violence as they employ the vast majority of caring professionals and vary in terms of their accountability to public and private stakeholders (Dressner, 2017). Common organizational factors that contribute to workplace violence include (1) job-related stress, (2) staff interaction, and (3) the cultural climate of safety.

Work stress can be measured through healthcare employee perceptions of the time available to strategize, execute, and reflect upon their work (Arnetz, 2010). The inability to plan and/or carry out tasks can elevate employee stress levels. This stress can directly impact day-to-day job satisfaction and potentially lead to incidents of workplace violence as burnout takes a toll on employee mental health. This issue is particularly concerning as job-related stress can motivate aggression both between employees and at patients. Moreover, persistent staffing shortages in the healthcare sector have elevated the potential for burnout by pushing caregivers to work longer hours than typically expected in other professions.

Interpersonal communication skills among healthcare employees can also drive violent interactions in the workplace. Promoting teamwork and fostering an inclusive environment where subordinate staff feel valued by superiors can go a long way toward developing a positive occupational environment with emotionally satisfied employees. However, the opposite features can promote conflict among employees that escalate the potential for violence. A workplace environment that is not well integrated can foster a more hostile climate where employees are isolated with lower morale and do not feel comfortable reporting difficult interactions to management.

Finally, an administrative culture that enforces best practices that are related to occupational safety can be an important intervention that reduces violence in the workplace. This can include having rapid response initiatives to potentially violent situations, harboring a managerial culture that advocates for processes, practices, and equipment that help to protect employees, and developing clear avenues for employees to push for accountability when faced with unsafe situations. Where organizations promote efficiency above safety in these domains, employees are at an elevated risk of experiencing the negative consequences of violent interactions.

Broader Societal Factors

Beyond patient-associated and organizational factors, there are societal factors that can elevate the potential for workplace violence in healthcare. Two prominent dimensions include (1) a broader cultural perception that workplace violence is a “part of the job” and (2) communityecological factors (Gillespie et al., 2010).

There is an unfortunate but persistent stereotype that workplace violence is inherent to the caring professions and that caring professionals need to simply endure it as an unavoidable occupational hazard. This stereotype has often been promoted even within the healthcare profession through educational coursework and even a persistent norm among healthcare providers to take an unnecessary amount of risk in the course of their employment. Moreover, healthcare settings can often be characterized by high co-worker tolerance for unsafe workplace environments. This can lead to peer-pressure to coerce newer employees to not be disruptive. Challenging these stereotypes is a necessary step toward reducing workplace violence in the healthcare sector more broadly.

Additionally, it is impossible to sidestep the discussion of community-ecological factors that contribute to elevated risk. Some healthcare organizations are located in areas where criminal behavior is more prevalent, and healthcare workers employed in these settings are often at a greater risk of experiencing workplace violence. Likewise, unpredictable mass-scale disruptive events can contribute to severe staff shortages. For instance, while rates of violence against healthcare workers were already on the rise prior to the COVID-19 pandemic, research has found that the pandemic had a dramatic impact, escalating frontline healthcare worker staffing issues, increasing wait times for accessing care, and cultivating a dangerous environment (Livanos, 2023).

Existing Policy Responses to Workplace Violence

Overview of Current Policy Approaches to Mitigating Workplace Violence

Addressing workplace violence is of key concern to regulators and corporations. In recent years, various policies and initiatives have been established to prevent and manage incidents that arise. However, specific regulations and corporate efforts vary across legal jurisdictions, countries, and companies. In this section, we aim to provide a more general overview of these existing policy approaches in a U.S. context.

Regulatory Policies

Currently, there are no specific federal laws that have been established to address incidents of workplace violence. Likewise, while the federal OSHA has released several guidelines for private employers to follow in their efforts to reduce workplace violence, none of these are specifically tailored the unique needs of healthcare workers. Despite this, there are several federal laws that are indirectly related to providing workers with legal avenues of relief when faced with hostile workplaces.

The Occupational Safety and Health Act of 1970 mandates that all employers are responsible for providing a safe and healthy working environment for their employees. Though this legislation does not directly discuss workplace violence, there is language in this law that guides employers to address conditions that have been shown to be associated with violent incidents. Specifically,

the General Duty Clause of this act requires employers to provide a workplace that is free of hazards that could cause an employee to experience serious harm or death. Employers can and have been cited for failing to take necessary measures to prevent or manage the consequences of workplace violence through this clause.

The Civil Rights Act of 1964 also has provisions that protect employees from potential violence in the workplace. Title VII of this act, which prohibits workplace discrimination based on race, color, religion, sex, or national origin, can be invoked as a regulatory avenue of relief when employees suspect that workplace violence may have been motivated by the victim's membership in one of these protected classes. The Americans with Disabilities Act provides similar regulatory protections for workers that are cognitively or physically disabled.

Many states have also enacted laws that specifically address workplace violence directly. Specifically, California, Connecticut, Illinois, Maryland, Minnesota, New Jersey, Oregon, Washington, and now Texas have laws that require employers to implement a workplace violence prevention program. The vast majority of U.S. states have also elevated penalties for assault against specific types of healthcare workers as well.

Currently, most states have followed the lead of the California OSHA which has issued rules for enhancing workplace security in response to the Workplace Violence Prevention in Healthcare Act that was passed through the state legislature in 2017. These rules required healthcare facilities to develop a workplace violence prevention plan, maintain records that log incidents of workplace violence, and provide trainings to staff (CAL/OSHA, 2017). Certain employees are also mandatory reporters when they become aware of violent incidents.

Corporate Policies

Healthcare facilities also have an intrinsic interest in adopting policies and practices that facilitate a safe working environment. These policies and practices help to reduce worker turnover and protect them from litigation. They are often times also useful for saving money in the longer term. Some of the more common initiatives include: (1) violence prevention policies, (2) risk assessments, (3) standardized training, (4) employee assistance programs (EAPs), and (5) security protocols (Braverman, 1998).

Violence prevention polices are typically implemented by healthcare organizations to provide a detailed outline of acceptable and unacceptable workplace behaviors. These policies often explicitly state that there is a zero-tolerance stance toward violence. What constitutes a violent act is also commonly defined in these policies. Strong workplace violence prevention policies will also provide a comprehensive overview of the consequences of specific prohibited behaviors, including various sanctions that can result.

Routine risk assessments are another initiative that can help mitigate incidents of workplace violence. By evaluating the workload of employees, monitoring patient-to-patient and patient-tostaffer interactions, and carefully considering how community-ecological factors uniquely

impact a respective healthcare facility, managers can assume greater control over maintaining a safe work environment. As a part of this strategy, healthcare organizations may consider implementing a standardized system of incident reporting that encourages staff to notify a designated party or log violent interactions that they experience and/or witness. This standardized system can improve transparency and work to combat the stereotype that workplace violence is a normalized component of being a healthcare professional.

It Is common to have a set of standardized trainings that are provided on a routine basis to employees that educate them on workplace violence prevention. Topics that could be covered include techniques of de-escalation, learning how to recognize early warning signs, and how to appropriately respond to violent interactions in the workplace. Upper-level staff may also be trained on how to facilitate a positive work environment for employees through continuing education programs that train them on strategies of workload management to reduce staff burnout or that coach them on specific conflict resolution strategies that can help to defuse volatile interactions between employees.

If the resources are available, healthcare organizations may also offer employee assistance programs (EAPs). These are internally funded, typically short-term counseling services that are established to support employees who may have been victimized. These programs help individuals who may be struggling with emotional and psychological consequences associated with incidents of workplace violence that are affecting them. EAPs are a strong intervention to help mitigate disruptions in the workplace that can result from post-incident recovery.

Finally, a robust security protocol is an essential component of corporate strategies of workplace violence prevention. Thoughtful use of camera and alarm systems, employing security personnel, and monitoring high risk areas can help to mitigate risk. Additionally, collaborating with the appropriate law enforcement agencies to develop emergency response protocols are also commonly employed tactics that have proven to be effective. Ensuring that there are open lines of communication with local law enforcement officers and demonstrating a willingness to integrate their expertise in workplace violence prevention plans can be a significant way to improve the effectiveness of corporate-sponsored policies more broadly.

Evaluating the Effectiveness of Existing Interventions

Research that evaluates the effectiveness of existing regulatory or corporate policy interventions tend to advocate for a combination of approaches, rather than relying on one type of intervention alone (Somani et al., 2021). Research has shown that regulatory policies that include a mandatory reporting requirement are quite effective at uncovering incidents of workplace violence and painting a more accurate picture of the extent of workplace violence as a general social problem (Doucette et al., 2022). Violence prevention training and educational programs are particularly effective at promoting positive changes like increased healthcare worker confidence and stronger communication skills but fail to decrease rates of workplace violence on their own. Combination approaches, or what are referred to as “multicomponent interventions” (Somani et al., 2021:292), have a demonstrated impact on reducing actual rates of workplace

violence against healthcare workers. Coupling training and educational programs with changes to the occupational setting such as increasing surveillance systems, installing panic buttons, and increasing security staff, have proven to be more effective strategies that elevate staff competencies and access to external support systems. As such, best practices dictate that policymakers and corporate decision makers consider a package of interventions that are mutually supportive and responsive to the patient-related, organizational, and societal factors outlined in the preceding section.

TOWARD A MORE COMPREHENSIVE POLICY MODEL FOR MANAGING WORKPLACE VIOLENCE IN THE TEXAS HEALTHCARE SYSTEM

S.B. 240: A Paradigm Shift in Combatting Workplace Violence Against Healthcare Workers in Texas

In the 2023 legislative session, Texas lawmakers took the extraordinary step of passing S.B. 240, otherwise known as the "Workplace Prevention Act." This bill strengthens protections for healthcare workers by directing healthcare facilities to establish a workplace violence prevention plan and to implement a system for reporting incidents of workplace violence. It also outlines new anti-retaliation protections. This historic bill was an overwhelmingly bipartisan effort that was lauded by industry groups that represent healthcare workers as an important step in the effort to combat growing rates of violence in the workplace. It was signed into law on May 15, 2023, and it goes into effect September 1, 2023.

The passage of this act was somewhat unusual as a political move in two notable ways. First, it centers the state of Texas as a leader in the broader movement to develop a standardized workplace violence prevention policy nationally. It also deviates from certain established standards put forward by the California OSHA that have been followed by states. Likewise, this legislation also preempted the release of a report that will contain recommendations for a draft regulatory framework sponsored by the federal OSHA to implement a national standard for workplace violence prevention in the healthcare system (OSHA, 2023).

Under this new law, healthcare facilities are intentionally broadly construed to include hospitals, nursing facilities, urgent care facilities, mental hospitals, ambulatory surgical centers, and athome/community support service agencies that employ registered nurses. These facilities are now required to appoint a workplace violence prevention committee that is tasked with developing a written workplace violence prevention policy and a written workplace violence prevention plan. Notably, the prevention policies that healthcare facilities develop must include the following language as a part of their definition of workplace violence:

> "An incident involving the use of a firearm or other dangerous weapon, regardless of whether a healthcare provider or employee is injured by the weapon" and "an act or threat of physical force against a healthcare provider or employee that results in, or is likely to result in, physical injury or psychological trauma."

One of the major ways that this new law deviates from existing precedent put forth by federal and state OSHA regulations is that it does not outline a citation and penalty structure for healthcare organizations that are found in violation (Surma and Swink, 2023). However, S.B. 240 does contain language that implies that healthcare organization licenses could be suspended or revoked for failing to implement the workplace violence prevention initiatives that the law requires. Interestingly, while it does outline protections for staffers that wish to file complaints about incidents of violence in the workplace, it does not provide a clear avenue for employees who allege that they have been retaliated against to seek out relief.

There are several other notable elements of this law as it is currently enrolled. The law makes no changes to the Texas penal code to create a novel criminal offense for workplace violence or revise sentencing guidelines for any existing violent criminal offenses to account for the context of the workplace (Public Health Committee, 2023). It also does not grant any additional rulemaking authority to a state officer, institution, or agency (Senate Research Center, 2023). In a more pointed move, it does require healthcare agencies to provide post-incident services to victims of workplace violence. Post-incident services are considered fairly open-ended in the current language of the law as it is enrolled.

As S.B. 240 has yet to take effect, research evaluating the effectiveness of this policy is still in the early stages of development. No peer-reviewed academic research has emerged to date that systematically considers how the provisions of S.B. 240 have impacted rates of workplace violence in the state. However, some of the provisions in this new law suggest that it may be more usefully treated as the opening refrain in a broader discussion about how to prevent workplace violence against healthcare workers in Texas rather than as the final word on the matter. Some legal observers have pointed out that language in this law may be intentionally open-ended so that if and when the federal OSHA releases their new standard this act is not rendered contradictory or obsolete (Surma and Swink, 2023).

Building on S.B. 240 to Strengthen Protections for Healthcare Workers

It is important to note that S.B. 240 has received praise from independent industry associations, including the Texas Nurses Association and the Texas Hospital Association, for driving forward a uniform statewide effort to reduce rates of workplace violence against healthcare workers. We likewise see S.B. 240 as a strong foundation to build upon. In light of the research outlined above that supports multicomponent interventions, there are several opportunities for future policy revisions that could strengthen employee protections and workplace violence prevention programs.

First, the current law does not contain a mandatory reporting requirement. The current language of the law requires facilities to develop workplace prevention plans that "allow" healthcare workers to report incidents through existing occurrence reporting systems. However, there is not a clear mandate that workplace violence prevention plans must broadly require or specifically require certain classes of healthcare workers to report incidents of workplace violence. It is understandable

to have reservations about imposing a uniform system on healthcare agencies. Given the multitude of patient-related, organizational, and societal factors that can increase the risk for workplace violence, policymakers may be apprehensive about mandating that certain classes of healthcare workers become the point people for reporting incidents. However, efforts to gather a comprehensive view of the extent of workplace violence as a social problem in Texas may benefit from having (1) a centralized clearinghouse that links these reporting systems in some meaningful way or (2) a standardized form of reporting beyond these independent data collection efforts. Additionally, a mandatory reporting system could be instrumental in providing workers with additional protections from retaliatory behavior.

Second, the current law does not explicitly mandate the use of employee assistance programs as a post-incident service. The minimum requirement is that a healthcare worker involved in an incident of workplace violence is to be provided with acute medical attention. However, providing victims of workplace violence with short-term counseling services is a critical component to improving post-incident job satisfaction, reducing employee absenteeism, minimizing turnover, and supporting productivity. In conjunction with existing mandates under S.B. 240, encouraging the inclusion of EAPs as a component of workplace prevention plans could help to develop this as an industry standard.

Finally, the current language of the law does not require healthcare facilities to conduct routine risk assessments as a part of their workplace prevention plans. While providers presumably will be encouraged to incorporate risk assessments as a part of their respective strategies and be intrinsically motivated to conduct risk assessments to protect their employees, there is an opportunity to develop an industry standard that ensures that employees will receive a baseline level of protection from the patient-related, organizational, and societal-level factors that contribute to rates of workplace violence more broadly. Additionally, this guidance would be useful for tailoring individual workplace violence prevention plans to address unique situational factors that affect their respective facilities.

CONCLUSION

Workplace violence is a complex social problem that uniquely impacts healthcare workers nationwide. In addition to becoming an issue of growing public attention, policymakers have increasingly worked to develop a standardized set of principles to help guide healthcare facilities in workplace violence prevention protocols. This paper contributes to this effort to develop a working definition of workplace violence in the context of healthcare, providing a technical overview of factors that increase the likelihood of experiencing an incident of workplace violence, and reviewing existing regulatory and corporate policy interventions designed to respond to, and prevent, workplace violence. Additionally, this paper summarizes the recently enrolled Workplace Prevention Act to provide Texas policymakers with a roadmap to move forward in future efforts to strengthen this legislation and further protect the state's healthcare workers.

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