Occupational Violence: Types, Reporting Patterns, and Variations between Health Sectors

CLAIRE MAYHEW
Industrial Relations Research Centre
University of New South Wales
SYDNEY NSW 2052
Australia

DUNCAN CHAPPELL
Mental Health Review Tribunal
PO Box 2019
BORONIA PARK NSW 2111
Australia

INTRODUCTION

This paper provides an overview of the types of occupational violence commonly experienced in Australia and other western industrialised countries, incidence and severity patterns, and identifies the most 'at risk' jobs.

At the outset it has to be recognised that occupational violence is multi-faceted, poorly enumerated, without monocausal explanations, and not amenable to simple preventive solutions.

Overall, the data indicate that the high-risk jobs are similar across western industrialised countries. However, the incidence varies across nation states because patterns of employment (and hence exposure), and other structural factors (such as firearms access) are diverse from one country to another, and between industry and occupational sub-groups. Organisational policies and strategies can also exacerbate or reduce the risks. While the level of risk appears to be rising over time, some forms of occupational violence are significantly under-reported.

A definition of occupational violence accepted by the National Occupational Health and Safety Commission of Australia is:

> *'Occupational violence is 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, 1999a: 1).

Occupational violence can include verbal abuse, threats, physical violence, homicide, 'behaviours that create an environment of fear', stalking, bullying amongst workers or between managers and workers, and behaviours that lead to stress or avoidance behaviour in the recipient. While there may sometimes be a fine dividing line between bullying behaviours and sexual harassment, sexual violence at work is not normally included within definitions of occupational violence.

A useful typology is to separate violence into three basic categories:

- 'External' violence which is perpetrated by persons outside the organisation, such as during armed hold-ups in shops
- 'Client-initiated' violence which is inflicted on workers by their customers or clients
- 'Internal' violence which occurs between employees within an organisation, such as between supervisor and employee, or employees and apprentices (CAL/OSHA, 1998).

Some authors identify a fourth 'systemic' form of violence that arises out of wider social and economic developments. For example, global economic pressures may lead to downsizing, work intensification, job insecurity, and contribute to a workplace culture where threatening behaviour is tolerated (Bowie, in press).

It is of crucial importance to note that while all these types of violence can occur on the one worksite, the perpetrators of the different forms of violence have distinct characteristics and the most effective prevention strategies vary markedly. (Note: violence prevention strategies will be examined in a second discussion paper, including proactive interventions such as 'situational crime prevention', and approaches that are designed to limit the impact after an event eg. counselling.)

INDUSTRIES AND OCCUPATIONS WHERE VIOLENCE IS MORE COMMON

The consistent pattern evident in data from the United Kingdom, the United States, and Australia is that jobs (a) where cash is on at hand (external violence), and (b) which require substantial face-to-face contact between workers and clients (client-initiated violence) are at higher risk (Chappell and Di Martino, 2000; LaMar et al, 1998:318). The probability and severity of violence varies markedly between these jobs and those where workers have little contact with their clientele and where money does not change hands. The potential for violence may increase at particular times of the day or night; on specific days of the week; on sites where groups of young males gather; at venues where intoxicated people congregate; if large amounts of cash and drugs are held in poorly secured premises; or if there are long client waiting periods. For night and shiftworkers, those who work alone, young workers and apprentices, or those in insecure employment, the risks may also be heightened.

There are gender variations. While the international evidence is patchy, it appears consistent. Female victims tend to experience higher levels of verbal and sexual abuse, while male victims tend to receive more overt threats and physical assaults (Fisher and Gunnison, 2001:146-151; Chappell & Di Martino, 2000:33; Mayhew & Quinlan, 1999). This variation in risk can be partially explained by the gender division of labour with women concentrated in lower status and 'caring' jobs with greater face-to-face contact. For example, homicides are now the leading cause of death for United States women workers because females are frequently employed in convenience stores - which are at higher risk (OSHA, 1998a: 1; Reiss & Roth, 1993:151). While one study found younger women were at increased risk (Fitzgerald, 1998), others have identified heightened risk for older females who may be perceived to be 'easy targets' (Nelson & Kaufman, 1996; Indermaur, 1995: 186).

Off-site or isolated work environments produce higher risk. One United Kingdom study of 800 women and 200 men reported that 1 in 3 professionals who went out to meet their clients had been threatened, and 1 in 7 male professionals working away from their office had been attacked (Vandenbos & Bulatao, 1996). Staff in a range of jobs who make off-site visits to the home of a client have been reported to be at risk, for example, a UK lawyer (Bibby, 1995: vii), a number of Australian taxi drivers (NOHSC, 1999:6), US community service workers (CAL/OSHA, 1998), as medical staff in car parks (NOHSC, 1999:6), and solo workers in high crime areas (OSHA, 1998b:2). Similarly studies have reported that transporting a stranger in a car presents a risk for estate agents (Bibby, 1995: vii) and for social workers (Bibby, 1994:37).

There are significant economic losses for organisations as well as personal costs for individuals following all types of occupational violence (Findorff-Dennis et al, 1999). Such costs can include diminished productivity, higher absenteeism and turnover, and even law suits. For example, a recent calculation by Australian experts has estimated that each case of 'internal' bullying costs employers $16,977 (Sheehan et al, 2001). There are early indicators from the United States that personal economic losses may be proportionately greater for female victims because (a) their average wages are lower than those of males, (b) females lose slightly more time from work to recuperate from assault-related injuries, and (c) women are, on average, required to spend more time attending to incident-related activities that are not covered by employment benefits e.g. court appearances (see Hoel et al, 2001: 39-51; Fisher and Gunnison, 2001:146-153).

REPORTING OCCUPATIONAL VIOLENCE

Comprehensive data covering all types of occupational violence are not available. As Flannery (1996:65) stated *'Empirical research on worksite violence is needed. Many of the studies … are methodologically deficient in a variety of fundamental respects'*.

Fatal incidents are most comprehensively reported in police, coronial, and workers' compensation data bases. However work-related homicides represent only the 'tip of the violence iceberg'. Peek-Asa and Howard (1999:647) have estimated that non-fatal assaults occur up to 100 times more frequently than do fatal incidents. Chappell and Di Martino (1998; revised 2000) published a key book for the tripartite International Labour Office that provides international comparisons on occupational violence. As a baseline, in the European Union it has been reported that an estimated 6% of employees are exposed to physical violence (2% from fellow employees, and 4% from 'outsiders') and at least 10% are subjected to bullying (European Foundation, cited Hoel et al, 2001:15,21). The latest British Crime Survey found police, social workers, probation officers, publicans and bar staff, security guards, nurses and other health staff, transport workers, and community and youth workers respectively were most at risk of violence at work (Budd, 1999:vi).

In Australia, about 3% of the expected 550 traumatic work-related fatalities each year are due to homicide (which is in marked contrast to the estimated 18% of fatalities in the United States). On average, about one person per month is murdered at work: 56% of these victims were shot, 22% stabbed with a knife or other sharp instrument, 16% assaulted with another weapon, and 6% deliberately hit with a car (NOHSC, 1999b:vii, 4, 9). Most at risk are taxi drivers, security guards and police (NOHSC, 199b: vii).

Because there is no uniform definition, some databases include only physical injuries, while others contain abuse, threats, sexual harassment, and even obscene phone calls (NOHSC, 1999a; Arnetz, 1998:18; Fisher et al, 1998:66; Wynne et al, 1996: 5). Because routine reporting only began around 1990, long-term trends cannot be charted. The *non-reporting* of many incidents adds to the difficulty in estimating incidence. One widely accepted estimate is that, at best, 1 in 5 incidents is reported (Turnbull & Paterson, 1999; LaMar et al, 1998:318; Barling 1996; Warshaw & Messite, 1996; Wynne et al, 1996: 10). Thus around 80% of incidents remain unrecorded. Non-reported or recorded incidents are commonly referred to as the 'dark figure' of occupational violence.

There is some evidence of a rise in non-fatal violent incidents at work over the past decade, despite low rates of reporting (see Wynne et al, 1996:4). This general increase may reflect, to some extent, improved *reporting* as awareness of occupational violence has grown (Long Island Coalition, 1996:2). For example, among workers in public agencies (where reporting is more consistent) increases in workers' compensation claims, organisational records, insurance claims, and police records have been identified (Perrone, 1999:82; Standing & Nicolini, 1997:26; Heskett, 1996:17-18; Nelson & Kaufman, 1996; CAL/OSHA, 1995b).

Four factors significantly influence reporting levels (see Mayhew, in press). The accuracy of occupational violence databases is affected by these factors:

Injury severity:

Severe incidents are more likely to be reported, for example, homicides. Minor injuries and the psychological impacts from threats and bullying are far less commonly reported.

Jurisdictional, departmental, and organisational responsibilities:

- 'External' violence is a matter for the criminal justice system and will almost always be reported to the local police force and recorded on their databases eg. following armed hold-ups. Any resulting injuries to workers will also normally be reported to workers' compensation authorities. However, some incidents on worksites will not be recorded on workers' compensation databases, for example a customer murdered in a retail shop would not be counted (Nalla et al, 1996; Myers, 1996; Wynne et al, 1996:9-10). Any psychological injury to a witness who is not an employee of that business is also unlikely to be recorded. In Australia, the self-employed are infrequently insured under workers' compensation insurance systems and as a result are unable to lodge claims and their violence-related injuries would not be recorded in workers' compensation databases.

- 'Client-initiated' violence that results in major or minor injuries to a worker should in theory always be reported to the employing body, and claims lodged with the relevant Occupational Health and Safety (OHS) authority. The reporting of *threats* and *abuse* to the OHS authority is unreliable as many adverse health consequences are emotional rather than physical, difficult to define precisely, and may manifest as 'stress'. Only when a significant stress-related illness results is a workers' compensation claim likely to be lodged. In Australia, the different State OHS authorities have not separated out violence from other causes of injury and illness, although there are plans in some states to remedy this limitation. (See the NOHSC *Compendium*, which is a collation of all Australian claims information.) Internal organisational records of *threat* and *abuse* incidents are unreliable, and may be collated in various ways on different sites. As a result of unreliable reporting, the warning signs of future assault 'hot spots' may be missed.

- 'Internal' violence (ie. bullying) is only intermittently reported and recorded in-house, and rarely subjected to public scrutiny.

Individuals propensity to report:

- Following 'external' violence there is often an insurance requirement to report incidents before a claim for loss of goods or cash can be lodged. Thus threats to a worker may be formally reported to an insurance company at the same time.

- With 'client-initiated' violence, the propensity to report may be mediated by concern for the perpetrator, such as among health workers caring for a senile patient. Further, it has been reported from both the US and the UK that in some caring jobs staff experience so much lower-level aggression that they would never be able to complete their job tasks if they were continually filling in incident forms for less serious incidents (see Turnbull & Paterson, 1999:9; Arnetz, 1998:18; Standing & Nicolini, 1997:24). Avoidance or denial of aggression has also been reported to be a common coping strategy - which may also diminish reporting (Arnetz, 1998:25)

- Violence *within* an organisation is unlikely to be formally recorded unless the bullying is repeated and has escalated in intensity.

Insecure employment:

A series of Australian studies have found that those with less job security tend to experience more occupational violence, mainly because precarious employment is concentrated in 'high risk' jobs (Mayhew and Quinlan, 1999). Precarious employment is usually taken to include casual, short-term contract, subcontractor, micro small business and outworker jobs. For many precariously employed workers there may be no formal mechanism to record occupational violence or other OHS incidents. Even when such mechanisms do exist, recipients may be unwilling formally to report all but the most severe incidents because of perceived future job and income insecurity.

In sum, police databases, those of the local OHS authority, and internal organisational records are likely to record quite different forms of violence. While the most severe 'external' violence incidents are likely to be formally recorded by the police, threats from clients and 'internal' bullying are poorly enumerated. Thus the 'dark figure' is likely to be greatest for threats and bullying.

Overall, it is very difficult to collate occupational violence data in a comprehensive way that identifies trends and 'high-risk' tasks and places. Nevertheless, the data that exist do provide useful indicators of the *incidence* and *severity* patterns of violence in different environments. These patterns will be discussed utilising the typology listed at the beginning of this paper.

'EXTERNAL' VIOLENT INCIDENTS

The jobs at highest risk of 'external' violence are similar across the industrialised world, and have remained relatively constant over time. There are four core business risk factors: the business exchanges money with customers, there are few workers on site, the business trades in the evening or night, and workers have face-to-face communication with customers (Heskett, 1996:16; Warshaw & Messite, 1996:996). Repeat and multiple victimisation is common in some areas ('hot spots'), and little crime occurs in others (Fisher & Looye, 2000). Bellamy (1996:4) explained this phenomenon in terms of 'attractive' or 'unattractive' targets. 'Attractive' targets are situated in high-crime areas, have minimal protection for workers, limited observation from passers-by, allow ready access to highways for get-away, and have a number of possible exits from the site (OSHA, 1998a: 4; Heskett, 1996:142).

Banks, post offices, gambling outlets, armored vehicles transporting cash, taxi drivers, 'convenience' stores, liquor sales, service stations, chemists, and jewellery shop workers are at high risk. (See Chappell & Di Martino, 2000:46; Mayhew, 2000a; TUC, 1999; Willis et al, 1999; DOJ, 1998; OSHA, 1998a: 1; US Bureau of Justice Statistics, 1998:2; Wilkinson, 1998:3-9; Standing & Nicolini, 1997:7-9; NIOSH, 1996:2-3; Myers, 1996; CAL/OSHA, 1995a: 4; Hancock, 1995.) Taxi drivers are at very high risk as they have become comparatively 'easy' targets since banks, chemists, service stations, and 'convenience' stores have tightened security progressively (Mayhew, 2000b).

While 'external' violence is currently quite uncommon in the health care sector, an increase can be expected due to the availability of drugs on many premises, including on hospital wards (OSHA, 1998b: 1). This inducement to robbery has been widely evidenced in chemist shops over the past decade. For example, a survey of 1,000 UK pharmacists revealed that over half felt unsafe at work and 15% had been attacked (Whitehall Laboratories, 1996: 227-229).

CLIENT-INITIATED VIOLENT INCIDENTS

'Client-initiated' violence appears to be increasing. High-risk tasks include:

> *'… jobs that require workers to handle money or valuables; carry drugs or have access to them; provide care and services to people who are distressed, fearful, ill or incarcerated; relate to people who have a great deal of anger, resentment, and feelings of failure, or who have unreasonable expectations of what the organization and the worker can provide; carry out inspection or enforcement procedures; or work alone'* (Warshaw and Messite, 1996: 999; see also Wynne et al, 1996: 4).

The jobs at highest risk of client-initiated violence in the United States, the United Kingdom, and Australia are: police, security and prison guards, fire service, teachers, welfare, health care and social

security workers. (See Fisher and Gunnison, 2001; Peek-Asa et al, 2001:146; Chappell and Di Martino, 2000:39; Mayhew, 2000c; Perrone, 1999:39; TUC, 1999:6-9,18; CAL/OSHA, 1998:1; DOJ, 1998:2; LaMar, 1998:321; Wilkinson, 1998:3-9; Standing & Nicolini, 1997:7-9; NIOSH, 1996:2.) Within the health care sector, a review of the predominantly US research literature has identified nurses, psychiatrists, psychologists, social workers, mental retardation specialists, nurses' aids, and substance abuse counsellors as being at particular risk (Flannery, 1996:63).

The causes of the increased levels of client-initiated violence are complex. Mullen (1997: 29) has argued that a high unemployment level and marginalisation of a disaffected and neglected underclass provides the backdrop for violence directed at community, health care, and other service industry workers. When cuts in public spending and services lead to a reduction in resources, the clients may respond violently believing they are being treated unjustly or unfairly (Mullen 1997:29). In such a scenario, solutions based on increased penalties are unlikely to be effective. Some commentators delineate between two basic types of perpetrators: clients with a violent history who can be expected to be aggressive such as prison inmates, and clients who are 'situationally' violent e.g. when frustrated by long waiting times or refusal of services (Long Island Coalition, 1996:14). Appropriate prevention strategies vary between these two groups.

There have been a number of substantive studies in the United Kingdom of occupational violence in the health care industry which provide insights for the Australian sector. Both welfare workers and nurses have cited comparatively high levels of violence and threats during the British Crime Surveys (Budd, 1999; Wykes, 1994:12). A National Health Service (NHS) study estimated that 1 in 7 reported work-related injuries were caused by violence (NHS, 2000:3). An earlier study estimated health care workers had a 1 in 200 chance of a major injury from violent clients each year, and 1 in 10 needed first aid (Wykes, 1994:1). Two recent British studies found between one third and 50% of British nurses had been abused or attacked over a 12-month period, with district nurses most at risk (Allen, 2000:12; TUC, 1999:3). There have been a few studies of violence among general practitioners in Britain which have found between 10% to 11% had been assaulted, 5% threatened with a weapon, and 91% verbally abused (Cembrowicz & Ritter, 1994). Home visits were higher risk, with over 70% of general practitioners attacked, threatened, or verbally abused during their working life (cited Bibby, 1995:19). In Ireland, between 32% to 45% of physicians were the victim of some form of violence in a 12-month period, with general practitioners in a working class suburb (100%) at far higher risk than those in a middle-class district (14%) (see Wynne et al 1996:13-15). (No further studies focused on socio-economic status have been identified as yet.) UK social workers are also reported to be frequently victimised, particularly those working in children's' homes and other residential settings (Bibby, 1994:19; Bute, 1994: 46-47, 52).

An increased level of risk is seen in north America. A survey of Canadian nurses found 54% had been assaulted and 81% verbally abused in the previous 12-month period (cited Wynne et al, 1996:12). In the US (where the risk factors are somewhat different to Australia), between 46% to 100% of nurses, psychiatrists, and therapists in psychiatric facilities are reported to have been assaulted during their worklife (CAL/OSHA, 1998:1). Another US study of 5,000 emergency nurses identified that they were at high risk of physical assaults (Coffey and Hanley, 2000). Non-reporting was common due to a perception that violence was 'part of the job', a belief that individual weaknesses contributed to aggression, because the administrative environment was non-supportive, and through fear of ridicule or reprisals (Coffey and Hanley, 2000; Birman, 1999:18). Information about work-related *stalking* is very limited, although a recent study in California found that health care workers being stalked suffered an increased incidence of violence compared with other groups of workers (Feldmann et al, cited Schell and Lanteigne, 2000:13).

The risk of occupational violence also varies between health care tasks and locations. The British 1998 survey identified work with mental health clients and those with learning disabilities as at highest risk of violence (NHS, 2000:3). Other UK studies have reported that workers in accident and emergency departments, psychiatric hospitals, caring for people with a mental handicap, and the ambulance service as being at greatest risk (Cardwell, cited Standing & Nicolini, 1997:13-14; Turnbull & Paterson, 1999:14-15; Wykes, 1994:19). The risks in Britain are also reported to vary between maternity (8.7%), children (13.8%), community (18.7%), and mental health (30.7%) work (Turnbull and Paterson, 1999:10; Wykes, 1994:18–19). A Swedish study of staff in a large regional general hospital found 31% of practical nurses, 23% of nurses' aids, 19% of registered nurses, and 18% of physicians experienced a violent or threatening event over a 12-month period (Arnetz et al, 1998:113). Community welfare and social workers are reported to be at increased risk when they visit clients in their homes, take children into care, or work in hostels (CAL/OSHA, 1998:3). In a Californian study, the risks were also found to vary by location with psychiatric, emergency, medical, surgical and paediatric units respectively most at risk (CAL/OSHA, 1998:1). For example, a 16% annual assault incidence was identified for psychiatric nursing staff (ibid). Correctional and juvenile detention workers are at particular risk from young males with a history of violence (Flannery, 1996:60).

Clients who are intoxicated or who have used illicit substances pose an increased risk. A US study found that in 50.2% of the violent crimes committed against members of the medical profession, the offenders had been drinking and/or on drugs (Fisher et al, 1998:74). A Swedish study found around 12% of perpetrators were under the influence of alcohol or narcotics (Arnetz, 1998).

Some people with mental disorders pose a risk (Flannery, 1996). For example, clients with dementia may threaten every worker who attempts to wash them. Younger males who suffer psychosis or a

neurological abnormality, and who have a history of violence and of substance abuse, are more likely to assault staff (Turnbull & Paterson, 1999:17; Flannery, 1996:63; Simonowitz, 1996:282; Warshaw & Messite, 1996:996). Similarly, clients with paranoid schizophrenia may have delusions of persecution and unrealistic perceptions of events, and may strike out in self-defence against these perceived threats (Capozzoli & McVey, 1996: 66). The presence of other staff members does not necessarily deter assaults; in one US study, nearly 84% of the mental health professionals who were the victim of a violent crime had someone else present at the time (Fisher et al, 1998:76).

There has been little substantive occupational violence research in the Australian health care sector. The data are patchy, but an overall 'picture' can be constructed from different sources of information. The patterns identified appear to be similar to those identified in the UK research studies referred to earlier. In collating violence data it is important to try to separate out *incidence* from *severity* eg. homicides, assaults, intimidation, threats, and abuse.

In Australia, a traumatic work-related fatalities study (based on coronial records over the period 1989–1992) found that 3 of the 4 medical workers killed on-the-job during that time were attacked by patients (NOHSC, 1999b: 6-7). This study suggests that around one Australian health worker is killed each year by a client. The risk of client-initiated *assault* is far higher. In NSW for example, 85% of all violence-related workers' compensation insurance claims were from: health, welfare and community services; education; property and business services; retail trade; public administration; and road and rail transport (Estreich, 1999). By occupation, the most 'at risk' jobs were miscellaneous labourers, registered nurses, miscellaneous para-professionals (such as welfare, community and prison workers), personal services (refugee support, home companion, enrolled nurse and family aid), police, road and rail transport, and schoolteachers respectively (Estreich, 1999:4). Over the period 1997/98 a total of 952 violence-related injuries were reported to Workcover NSW (or 2.2% of the total) with additional workers' compensation claims classified as 'stress-related' (Delaney, 2001:22). Unfortunately, separation of all successful workers' compensation claims from the health workforce was not possible. A study of 300 rural physicians in Western Australia, NSW and the Gippsland region of Victoria reported that 73% had abused, threatened or assaulted (cited in Perrone, 1999: 43-44). In an early study conducted among nurses by the Royal Australian Nurses Federation, it was reported that about 86% had experienced aggression by patients, 42% from visitors, and 31% reported verbal abuse by co-workers at some stage (cited in Bowie and Malcolm, 1989:162). In South Australia, 7% of reported injuries in the aged care sector were the result of violence (WorkCover 7/11/99). However a significant proportion of violent incidents are likely to go unreported in aged care due to consideration for clients who are 'not themselves'. Thus, as the proportion of the population cared for in the aged care sector increases, the 'dark' figure of occupational violence will undoubtedly also increase.

The carrying of weapons by clients increases the risks. In the US for example, many homeless people are reported to carry weapons such as screwdrivers to protect themselves on the street (CAL/OSHA, 1998:10). Thus clients who have been on leave from hostels, psychiatric support units, or community homes, should be screened for weapons on their return (CAL/OSHA, 1998:10; Simonowitz, 1996:281). The high levels of risk in accident and emergency departments can also be exacerbated by weapons with one US study finding that 25% of major trauma patients treated in emergency rooms carried them (Reich & Dear, 1996).

Studies have reported that tendencies to violence can be exacerbated by waiting periods in excess of 20 minutes, refusal of preferred services, prolonged and untreated pain, anxiety, misconceptions where language translations or cultural traditions vary, or inadequate design of the environment (Mayhew, 2000c). Unwelcome and coercive treatments have also been reported to provoke violent reactions from both children and adults, as have specific events such as too much ward activity at one time, overcrowding, or negative staff attitudes (Flannery et al, 1994:25). Nevertheless, the available Australian data do not include comprehensive contextual data about violent situations. As a result a number of key factors that contribute to anxiety and aggression are unknown, and preventive interventions cannot be tightly focused and tailored to site-specific local risk factors.

In the accident and emergency department of a hospital in The Netherlands, staff identified the local risk factors: annoyance at being kept waiting, dissatisfaction with treatment, intoxication with alcohol and/or illicit drugs, understaffing, no smoking rules, impersonal waiting areas, and small treatment rooms. Aggression was found to be worst in the evenings, weekends, public holidays and on late-shopping nights. The most effective prevention measures introduced were found to be an extra nurse on night shift, a silent alarm, and security surveillance (Chappell and Di Martino, 2000: 94; Birman 1999). Another study found that Wednesday (the day claimants collected unemployment benefits) was a particularly dangerous night for British ambulance and hospital staff; so staff were warned and prepared for increased risks on that evening (TUC, 1999:24).

Other risk factors that have been correlated with ‘client-initiated’ violence include:

- Young males who have been affected by alcohol (CAL/OSHA, 1998:3; Warshaw & Messite, 1996:997-998; Bibby, 1994:9; Simonowitz, 1996:277);
- clients who use illicit drugs, particularly cocaine or multiple drugs (OSHA, 1998b: 1-2,4);
- insufficient staff resources, particularly at high activity times such as during visiting hours at health facilities (CAL/OSHA, 1998:3; OSHA, 1998b);
- over-crowding and lack of privacy in facilities (Warshaw & Messite, 1996:999-1000);

- staff shortages and low staffing numbers at night (CAL/OSHA, 1998: 3);
- unrestricted client access to staff areas (OSHA, 1998b:5);
- the de-institutionalisation of those who have mental health problems and who are without sufficient community support resources (CAL/OSHA, 1998:2; OSHA, 1998b; Warshaw & Messite, 1996:996; Simonowitz, 1996:281); and
- clients who are non-compliant with psychotropic medication regimes (CAL/OSHA, 1998:2; OSHA, 1998b; Simonowitz, 1996:281).

In addition, threats of violence may occasionally be used as a deliberate tactic to obtain preferred services or quicker responses. The families of patients may also present a risk of violence if they are upset, anxious, uninformed about medical procedures, and/or have a range of emotions to confront. Those patients and relatives who come from cultures that are 'openly expressive' may be irritated when health workers are unable to deliver on a range of expectations, and loud complaints may be interpreted as aggression.

In sum, a high-risk violence scenario is an accident and emergency department on a weekend night, where the client is a young intoxicated male in pain, and there is a long waiting period. At such predictable high-risk times, adequate staffing ratios may decrease the immediate risk of client-initiated violence (Mayhew and Quinlan, 1999; CAL/OSHA, 1998:3; Warshaw & Messite, 1996:999).

'INTERNAL' VIOLENT INCIDENTS, INCLUDING BULLYING

'Internal' violence is committed by other employees within the same organisation. Bullying incidents are usually *repeated* and *escalate in intensity* over time. When the recipient leaves the workplace, another victim is usually selected. Many bullying tactics involve subtle and covert strategies, although violent or degrading initiation rites have been reported to be common (see Keashly, 2001; Chappell & Di Martino, 2000:13, 104; Workers' Health Centre, 1999; Neales, 1997; McCarthy et al, 1996; UNISON, 1996). Multiple perpetrators may be involved ('mobbing'). The direction of violence is not always a simple abuse of power from supervisors to subordinates: older workers can intimidate apprentices, or employees can harass their supervisors.

Management style and organisational culture is of central importance. A quasi-military hierarchy with a rigid management style, marked supervisor/employee divisions, and a highly competitive business environment enhances the probability of violence. Additional risk factors include management toleration of bullying, cultures where horseplay and practical jokes are normalised, job insecurity, workers with a strong sense of entitlement who feel cheated, and disciplinary suspensions

(Mayhew, 2000d; Mullen, 1997; Randall, 1997:50-53; Myers, 1996:3; WCBBC, 1995:8; Witkowski, 1995).

Disgruntled former employees who have been dismissed have been responsible for some of the worst US mass shootings. White males in the age range 30 to 50 who are married with families, and who have been employed with the organisation for some time have been reported to be common perpetrators (Mayhew, 2000d: 15; Capozzoli and McVey, 1996: 50). Recent or imminent job loss can be another high-risk factor (Myers, 1996:3). While young males who are intoxicated have been linked with most forms of violence, perpetrators can also include older men, women and the elderly (Standing and Nicolini, 1997:43; Simonowitz, 1996:277). Thus relying on profiles is a dangerous practice as a range of people under a variety of circumstances have committed all forms of violence, and a personality-based or psychological profile of the 'typical offender' remains elusive (Standing and Nicolini, 1997:44).

Nevertheless, a number of studies have indicated that many violent incidents are preceded by warning signs such as belligerent or intimidating behaviours (Chappell & Di Martino, 2000: 55-57; Cherry & Upston, 1997:120; Speer, 1997). However, sometimes bullying behaviours evolve slowly over time, perpetrators are unaware of the impact of their conduct, and a 'culture of denial' where victims are blamed develops. The perpetrators of 'internal' violence actions can be motivated by envy, personal inadequacy, positive consequences from childhood bullying, aggressive and or narcissistic tendencies, or they may be unable to control their aggressive tendencies (Gaymer, 1999:12-13; Warshaw & Messite, 1996:996).

Potential consequences from 'internal' violence can include high levels of anxiety, absenteeism and turnover; diminished productivity; poor industrial relations; difficulties in recruiting and retaining valued staff; and poor organisational reputation (Randall, 1997:57; UNISON, 1996; Wynne et al, 1996:16). It is reported that recipients of bullying may have twice the rate of stress-related illness, with the impact aggravated by non-supportive colleagues (Speer, 1997:10). Some victims may be so severely affected that they contemplate suicide (Einarsen, cited Hoel et al, 2001: 28) .

A European international review of bullying reported that *'… on relatively safe ground when we conclude that at least 10% can be considered as being currently subjected to bullying'* (Hoel et al, 2001:21). In Australia, there has been little substantive research of bullying in health workplaces. However, a non-random study of 270 Tasmanian nurses found that 30% were subjected on a daily or near-daily basis to aggression from nurse managers and colleagues which resulted in significant levels of distress (Farrell, 1999, 538). Further investigation is warranted.

SYSTEMIC VIOLENCE

This final type of occupational violence occurs where an organisation, by commission or omission, creates an environment where job insecurity fears are rampant, overwork is expected, resources are restricted, and reports of intimidation and threatening behaviour are ignored (Bowie, in press). This form of violence is essentially *systemic* across an organisation, and limited resources may proscribe quick CEO responses. The underlying *causal* factor is usually economic stress.

CONCLUSION

The data indicate that occupational violence is a predictable accompaniment to work in some jobs, and is in epidemic proportions in a few. A typology commonly used to identify forms of violence was discussed:

(a) 'External' forms of violence originate outside of a worksite. The risks are highest in jobs where cash – or other desired goods - are at hand. This form of violence may increase in health care jobs where drugs are held in poorly secured places.

(b) 'Client-initiated' violence is a common experience for workers who have a lot of face-to-face contact with clients and their relatives, particularly those who are distressed, frightened, inebriated, ill, or angry. There are no substantive data on client-initiated violence in the Australian health care sector, although the indicators are consistent with studies from the UK. The international research studies suggest that those most at risk are workers in accident and emergency departments, the ambulance service, and mental health sections; those who decide over allocation of scarce resources; and those who work in community care or with clients affected by alcohol and illicit substances. Workers in aged care are likely to face increasing risks over time as the population ages.

(c) 'Internal' violence has a quite different profile and originates within the workforce. The research studies indicate that 'internal' violence is most common in organisations where dominant/subordinate hierarchical relationships exist and that it results in significant productivity losses.

In sum, the incidence and severity of occupational violence varies across the health care occupations because the risk factors differ. Patterns of violence may also vary because some health care sites apply better-targeted intervention strategies. Only work-related homicides are reliably reported in Australia. There are a number of pressures on health care workers that encourage non-reporting of non-fatal violent incidents. At best, 1 in 5 incidents is formally recorded, and as a result the official databases significantly under-state the extent of occupational violence. The lack of a uniformly accepted definition of occupational violence is a core reason for inadequate and inconsistent

recording. Within Australia there are also overlapping jurisdictional responsibilities between the criminal justice system, the OHS authorities, and individual health care organisations – all of which record some occupational violence data in different ways. Overall, the incidence and severity of occupational violence in the Australian health care sector is poorly recognised, and there are no solid data available.

REFERENCES

Allen, B. (March/April 2000), 'Zero tolerance?', *Occupational Health Review,* issue 84:12-18.

Arnetz, J. (1998), 'The violent incident form (VIF): A practical instrument for the registration of violent incidents in the health care workplace', *Work and Stress,* vol. 12 (1): 17–28.

Arnetz, J. Arnetz, B. and Soderman, E. (1998), 'Violence toward health care workers: prevalence and incidence at a large regional hospital in Sweden', *AAOHN Journal,* vol. 46 (3): 107-114.

Barling, J. (1996), 'The prediction, experience, and consequences of workplace violence', in G. Vandenbos and E. Bulatao (eds), *Violence on the Job: Identifying Risks and Developing Solutions,* American Psychological Association, Washington DC: 29-49.

Bellamy, L (1996), 'Situational crime prevention and convenience store robbery', *Security Journal,* vol. 7: 41-52.

Bibby, P. (1995), *Personal Safety for Health Care Workers,* report commissioned by the Suzy Lamplugh Trust, UK.

Bibby, P. (1994), *Personal Safety for Social Workers,* report commissioned by the Suzy Lamplugh Trust, UK.

Birman, J. (1999), 'Covert violence in nursing', *Australian National Safety Journal,* Safety Institute of Australia, vol. 7 (2): 17-21.

Bowie, V. (in press), 'Overview of occupational violence', in Gill, M. Fisher, B. and Bowie, V. *Occupational Violence in Industrialised Countries,* Willan Press, United Kingdom.

Bowie, V. and Malcolm, J. (1989), 'Violence against human service workers', in J. Sheppard (ed.), *Advances in Behavioural Medicine,* Cumberland College of Health Sciences, Sydney, vol. 6, chapter 11:157–86.

Budd, T. (1999), *Violence At Work: Findings From The British Crime Survey,* Home Office, London.

Bute, S. (1994), 'Violence to social workers', in Wykes, T. (ed.), *Violence and Health Care Professionals,* Chapman and Hall, London.

CAL/OSHA(1998), *Guidelines for Security and Safety of Health Care and Community Service Workers,* Division of Occupational Safety and Health, Department of Industrial Relations, San Francisco.

CAL/OSHA (1995a), *Guidelines For Workplace Security,* Division of Occupational Safety and Health, Department of Industrial Relations, San Francisco.

CAL/OSHA (1995b), *Injury and Illness Prevention Model Program for Workplace Security,* Division of Occupational Safety and Health, Department of Industrial Relations, San Francisco.

Capozzoli, T. and McVey, R. (1996), *Managing Violence in the Workplace,* St. Lucie Press, Delray Beach, Florida.

Cembrowicz, S. and Ritter, S. (1994), 'Attacks on doctors and nurses', in J. Shepherd (ed), *Violence in Health Care: A Practical Guide to Coping with Violence and Caring for Victims,* Oxford University Press, United Kingdom: 13-41.

Chappell, D. and Di Martino, V. (2000), *Violence at Work,* second edition, International Labour Office, Geneva.

Cherry, D. and Upston, B. (1997), *Managing Violence and Potentially Violent Situations: A Guide for Workers and Organisations,* Centre For Social Health, Heidelberg West, Victoria.

Coffey, M. and Hanley, J. (2000), 'Population-based strategy for preventing violence in the health care workplace', *Nurse Advocate.* See www.nurseadvocate.org/coffey.html

Delaney, J. (2001), *Guidelines for the Prevention and Management of Workplace Aggression: Case Studies from the NSW Health Industry*, draft report, WorkCover New South Wales, Sydney.

Department of Justice (DOJ) (1998), 'About 2 million people attacked or threatened in the workplace every year', press release 26/7/1998.

Estreich, P. (26/8/99), 'The management of violence in the workplace - a best practice approach', paper presented at the *Occupational Violence* seminar, 26 August 1999, Faculty of Law, University of Sydney, Sydney.

Farrell, G. (1999), 'Aggression in clinical settings: nurses' views – a follow-up study', *Journal of Advanced Nursing*, vol. 29 (3): 532-541.

Findirff-Dennis, M. McGovern, P. Bull, M. and Hung, J. (1999), 'Work related assaults: the impact on victims', *AAOHN Journal*, vol. 47 (10): 456-465.

Fisher, B. and Gunnison, E. (2001), 'Violence in the workplace: gender similarities and differences', *Journal of Criminal Justice*, vol. 29: 145-155.

Fisher, B. Jenkins, E.L., and Williams, N. (1998), 'The extent and nature of homicide and non-fatal workplace violence in the United States: implications for prevention and security', in Gill, M. (ed.), *Crime At Work: Increasing the Risk for Offenders*, vol. 11, Perpetuity, Leicester.

Fisher, B. and Looye, J. (2000), 'Crime and small businesses in the midwest: an examination of overlooked issues in the United States', *Security Journal*, vol. 13 (1): 45-72.

Fitzgerald, S. (December 1998), 'Games people play: the high cost of bullying and harassment in the workplace', *Occupational Health and Safety Magazine*, CCH Australia, Sydney: 10–14.

Flannery, R. (1996), 'Violence in the workplace, 1970–1995: a review of the literature', *Aggression and Violent Behavior*, vol. 1 (1): 57–68.

Flannery, R. Hanson, M. and Penk, W. (1994), 'Risk factors for psychiatric inpatient assaults on staff', *The Journal of Mental Health Administration*, vol. 21: 24–31.

Gaymer, J. (1999), 'Assault course', Occupational *Health, vol*. 51 (2): 12-13.

Hancock, M. (1995), 'Violence in the retail workplace', *Accident Prevention*, May/June: 16-21.

Heskett, S. (1996), *Workplace Violence: Before, During and After*, Butterworth-Heinemann, Boston.

Hoel, H. Sparks, K. and Cooper, C. (2001), *The Cost of Violence/Stress At Work and the Benefits of a Violence/Stress-Free Working Environment*, Institute of Science and Technology, University of Manchester, report commissioned by the International Labour Organisation, Geneva.

Indermaur, D. (1995), *Violent Property Crime*, The Federation Press, Sydney.

Keashly, L. (2001), 'Interpersonal and systematic aspects of emotional abuse at work: the target's perspective', *Violence and Victims*, vol. 16 (3): 233-268.

LaMar, W. Gerberich, S. Lohman, W. and Zaidman, B. (1998), 'Work-related physical assault', *Journal of Occupaitonal and Environmental Medicine*, vol. 40 (4): 317-324.

Long Island Coalition for Workplace Violence Awareness and Prevention (1996), *Workplace Violence Awareness and Prevention: an Information and Instructional Package for use by Employers and Employees*, Long Island Coalition, United States.

Mayhew, C. (in press), 'Occupational violence in industrialised countries: types, incidence patterns, and 'at risk' groups of workers', in Gill, M. Fisher, B. and Bowie, V. (eds.), *Occupational Violence in Industrialised Countries*, Willan Press, United Kingdom.

Mayhew, C. (2000a), *Violence in the Workplace-Preventing Armed Robbery: A Practical Handbook*, Research and Public Policy series no.33, Australian Institute of Criminology, Canberra.

Mayhew, C. (2000b), 'Violent assaults on taxi drivers: incidence patterns and risk factors', *Trends and Issues in Crime and Criminal Justice*, no. 178, Australian Institute of Criminology, Canberra.

Mayhew, C. (2000c), *Preventing Client-Initiated Violence- A Practical Handbook,* Research and Public Policy series, no. 30, Australian Institute of Criminology, Canberra.

Mayhew, C. (2000d), *Preventing Violence Within Organisations: A Practical Handbook,* Research and Public Policy series, no. 29, Australian Institute of Criminology, Canberra.

Mayhew, C. and Quinlan, M. (1999), 'The relationship between precarious employment and patterns of occupational violence: survey evidence from thirteen occupations', in K. Isaksson, C. Hogstedt, C. Eriksson, and T. Theorell (eds), *Health Effects of the New Labour Market,* Kluwer Academic/Plenum publishers, New York: 183-205.

McCarthy, P. Sheehan, M. and Wilkie, W. (eds) (1996), *Bullying: From Backyard to Boardroom,* Millenium Books, New South Wales.

Mullen, E. (1997), 'Workplace violence: cause for concern or the construction of a new category of fear', *Journal of Industrial Relations,* vol. 39 (1): 21–32.

Myers, D. (1996), 'A workplace violence prevention planning model', *Journal of Security Administration,* vol. 19 (2): 1-19.

Nalla, M. Morash, M. Vitoratos, B. and O'Connell, T. (1996), 'Benchmarking study of workplace violence prevention and response: forty-two components from leading-edge programs', *Security Journal,* vol. 7: 89-99.

National Health Service (NHS) (2000), *We Don't Have To Take This Resource Pack,* NHS Zero Tolerance Zone, NHS, UK. See www.nhs.uk/zerotolerance

National Occupational Health and Safety Commission (NOHSC) (any year), *Compendium of Workers' Compensation Statistics, Australia,* NOHSC, AusInfo, Canberra.

National Occupational Health and Safety Commission (NOHSC) (1999a), 'Program One Report: Occupational violence', 51st Meeting of NOHSC, 10 March 1999, Hobart.

National Occupational Health and Safety Commission (NOHSC) (1999b), *Work-Related Traumatic Fatalities in Australia, 1989 to 1992,* written by Driscoll, T. Mitchell, R. Mandryk, J. Healey, S. and Hendrie, L., NOHSC, Ausinfo, Canberra.

Neales, S. (6/9/1997), 'When rites go wrong', *Sydney Morning Herald,* Good Weekend section: 32-35.

Nelson, N. and Kaufman, J. (1996), 'Fatal and nonfatal injuries related to violence in Washington workplaces, 1992', *American Journal of Industrial Medicine,* vol. 30: 438–46.

NIOSH (1996), *Violence in the Workplace: Risk Factors and Prevention Strategies,* Current Intelligence Bulletin, no. 57, Atlanta, USA.

Occupational Safety and Health Administration (OSHA) (1998a), *Recommendation For Workplace Violence Prevention Programs in Late-Night Retail Establishments,* United States Department of Labor, Washington DC.

Occupational Safety and Health Administration (OSHA) (1998b), *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers,* United States Department of Labor, Washington DC.

Peek-Asa, C. Runyan, C. and Zwerling, C. (2001), 'The role of surveillance and evaluation research in the reduction of violence against workers', *American Journal of Preventive Medicine,* vol. 20 (2): 141-148.

Peek-Asa, C. and Howard, J. (1999), 'Workplace-violence investigations by the California Division of Occupational Safety and Health, 1993-1996', *Journal of Occupational and Environmental Medicine,* vol. 41 (8): 647-653.

Perrone, S. (1999), *Violence in the Workplace,* Research and Public Policy series no. 22, Australian Institute of Criminology, Canberra.

Randall, P. (1997), *Adult Bullying: Perpetrators and Victims,* Routledge, London.

Reich, R. and Dear, J. (1996), 'Guidelines for preventing workplace violence for health care and social service workers', in G. Vandenbos and E. Bulatao (eds), *Violence on the Job: Identifying Risks and Developing Solutions,* American Psychological Association, Washington DC: 399–415.

Reiss, A. and Roth, J. (1993), *Understanding and Preventing Violence,* National Academy Press, Washington DC.

Schell, B. and Lanteigne, N. (2000), *Stalking, Harassment and Murder in the Workplace,* Quorum, Connecticut.

Sheehan, M. McCarthy, P. Barker, M. and Henderson, M. (2001), 'A model for assessing the impacts and costs of workplace bullying', paper presented at the Standing Conference on Organisational Symbolism (SCOS), Trinity College, Dublin, 30 June to 4 July 2001.

Shepherd, J. (1994), *Violence in Health Care: A Practical Guide to Coping With Violence and Caring for Victims,* Oxford University Press, Oxford.

Simonowitz, J. (1996), 'Health care workers and workplace violence', *Occupational Medicine: State of the Art Reviews,* vol. 11 (2): 277-291.

Speer, R. (1997), 'Workplace violence: moving beyond the headlines', *Women Lawyers Journal,* vol. 83 (1): 6-12.

Standing, H. and Nicolini, D. (1997), *Review of Workplace-Related Violence,* report for the Health and Safety Executive, No. 143/1997, Tavistock Institute, United Kingdom.

Trades Union Congress (1999), *Protect Us From Harm: Preventing Violence at Work,* a TUC health and safety report by Julia Gallagher, TUC Health and Safety Unit, London.

Turnbull, J. and Paterson, B. (eds) (1999), *Aggression and Violence: Approaches to Effective Management,* MacMillan, London.

UNISON (1996), *Bullying at Work: Guidance for Safety Representatives and Members on Bullying at Work and How to Prevent It,* UNISON, London.

United States Bureau of Justice Statistics (1998), *Workplace Violence, 1992–96: National Crime Victimization Survey,* Department of Justice, United States.

Vandenbos, G. and Bulatao, E. (eds) (1996,) *Violence on the Job: Identifying Risks and Developing Solutions,* American Psychological Association, Washington DC.

Warshaw, L. and Messite, J. (1996), 'Workplace violence: preventive and interventive strategies', *Journal of Occupational and Environmental Medicine,* vol. 38 (10): 993–1005.

Whitehall Laboratories (1996), *Survey By Fusion Communications,* Chiswick, London.

Wilkinson, C. (ed) (1998), *Violence in the Workplace: Preventing, Assessing and Managing Threats at Work,* Government Institutes, Maryland, United States.

Willis, A. Beck, A. and Gill, M. (1999), 'Violent victimization of staff in the retail sector', *Journal of Security Administration,* vol. 22 (2): 23-30.

Witkowski, M. (1995), 'Workplace violence: problems and preventions suggested by CAL/OSHA workplace security guidelines', *Security Journal,* vol. 6: 213-18.

WorkCover South Australia (7/11/99), 'Workplace violence claims rise', *Media Release,* WorkCover Authority, Adelaide.

Workers' Compensation Board of British Colombia (WCBBC) (1995), *Take Care: How To Develop and Implement a Workplace Violence Program: A Guide For Small Business,* Workers' Compensation Board of British Colombia, Vancouver.

Workers' Health Centre (1999), *Health and Safety Fact Sheet: Violence at Work,* Workers' Health Centre, Sydney.

Wykes, T. (ed) (1994), *Violence and Health Care Professionals,* Chapman and Hall, London.

Wynne, R. Clarkin, N. Cox, T. and Griffiths, A. (1996), *Guidance on the Prevention of Violence at Work,* European Commission, Brussels.