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Patient Violence Towards Counselors in Substance Use Disorder Treatment Programs: Prevalence, Predictors, and Responses

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ABSTRACT

Workplace violence disproportionately impacts healthcare and social service providers. Given that substance use and abuse are documented risk factors for the perpetration of violence, SUD treatment personnel are at risk for patient-initiated violence. However, little research has addressed SUD treatment settings. Using data nationally representative of the U. S., the present study explores SUD counselors' experiences of violent behaviors perpetrated by patients. More than half (53%) of counselors personally experienced violence, 44% witnessed violence, and 61% had knowledge of violence directed at a colleague. Counselors reported that exposure to violence led to an increased concern for personal safety (29%), impacted their treatment of patients (15%), and impaired job performance (12%). In terms of organizational responses to patient violence, 70% of organizations increased training on de-escalation of violent situations, and 58% increased security measures. Exposure to verbal assault was associated with age, minority, tenure, recovery status, 12-step philosophy, training in MI/MET, and higher caseloads of patients with co-occurring disorders. Exposure to physical threats was associated with age gender, minority, tenure, recovery status, and higher caseloads of patients with co-occurring disorders. Exposure to physical assault was associated with age, gender, and sample. Implications of these findings for organizations and individuals are discussed.

1. Introduction

The prevalence of workplace violence in organizations treating substance use disorders (SUDs), reactions to this violence, and predictors of its differential occurrence are the targets of this study. Workplace violence includes verbal assault, sometimes referred to as verbal harassment or psychological violence, and actual or threatened physical assault (Gillespie, Gates, Miller, & Howard, 2010). Workplace violence disproportionately impacts healthcare and social service providers. The annual rate of workplace violence among all industries in the United States is 5 violent incidents per 1,000 employed persons age 16 or older. However, more than 60% of non-fatal workplace assaults are directed at healthcare and social service providers by patients and clients (United States Bureau of Labor Statistics (BLS), 2005, 2006; Janocha & Smith, 2010; O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000). It has been reported that healthcare workers are the victims of workplace assault more often than any other worker group, including police officers (National Institute on Occupational Safety and Health, 1996).

Beyond the obvious potential for physical harm, workplace violence has other impacts: increased psychological and emotional distress including anxiety about workplace violence, feelings of compromised safety, a sense of powerlessness, feelings of reduced competency in dealing with violent patients, and symptoms of traumatic stress (Chen, Hwu, Kung, Chiu, & Wang, 2008; Flannery, Fisher, & Walker, 2000; Gates et al., 2011; Gillespie, Bresler, Gates, & Succop, 2013; Horejsi, Garthwait, & Rolando, 1994; May & Grubbs, 2002; McKinnon & Cross, 2008). Workplace violence also negatively impacts workplaces by increasing employee job dissatisfaction (Gates, Ross, & McQueen, 2006; May & Grubbs, 2002; Shin, 2011), absenteeism (BLS, 2005; McKinnon & Cross, 2008), and seeking employment elsewhere (Horejsi et al., 1994). In addition, workplace violence is associated with decreased organizational commitment (Shin, 2011), staff retention (Gates et al., 2006), and productivity (Kowalenko, Gates, Gillespie, Succop, & Mentzel, 2013). Further, workplace violence interferes with clinicians' ability to manage the cognitive demands of their work (Kowalenko et al., 2013) and to handle and manage their workloads (Kowalenko et al., 2013). Further impacts on clinicians include lower mental energy, work inefficiency, decreased participation in work processes and decisions, and decreased quality of care (Arnetz & Arnetz, 2001).

Research on this occupational hazard has focused on a variety of professionals, including emergency department personnel (i.e., Gates et al., 2011; Gillespie et al., 2013; Kowalenko et al., 2013), nurses (i.e., Arnetz, Arnetz, & Petterson, 1996; Crilly, Chaboyer, & Creedy, 2004), social workers (i.e., Jayaratne, Vinokur-Kaplan, Nagda, & Chess, 1996; Newhill,

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1996; Ringstad, 2005; Shields & Kiser, 2003), psychiatric staff (i.e., Chen et al., 2008; Cunningham, Connor, Miller, & Melloni, 2003; Flannery, 2004) and child welfare workers (i.e., Horejsi et al., 1994; Ringstad, 2009; Shin, 2011). The prevalence of workplace violence varies across fields and settings. For example, 98% of emergency department workers report at least one verbal assault; 68% experienced threat of physical harm, and 48% were victims of physical assault (Gates et al., 2011). A study of nurses found that 88% of emergency department, intensive care unit and general floor nurses reported being victims of verbal assault and 74% reported physical assault in a 1-year period; with rates highest among emergency department nurses and lowest among floor nurses (May & Grubbs, 2002). Among social workers, 62% of social workers experienced psychological assault, and 15% experienced physical assault in the prior year (Ringstad, 2005). High rates of verbal (83%) and physical (65%) assault have also been reported in psychiatric facilities with injuries resulting 39% of the time (Cunningham et al., 2003). Nearly a third (29%) of mental health providers reported that they feared for their lives at some point during their professional career (Arthur, Brende, & Quiroz, 2003). Rates are also substantial among child welfare workers, with verbal assault being experienced at a rate ranging from 70% to 97%, threats of physical assault at a rate of 33%, and actual physical assault at a rate ranging from 22% to 34% (Ringstad, 2009; Shin, 2011).

Among the most commonly recommended interventions to prevent workplace violence is the development of policies and practices designed to increase worker safety (Calnan, Kelloway, & Dupre, 2012). In addition, training in the prevention and management of violence is a cornerstone of organizational efforts to minimize the occurrence of workplace violence (Beech & Leather, 2006). The factors leading to patient violence are multi-factorial, thus an integrated organizational approach to dealing with the problem has been advocated (Leather, Beale, Lawrence, Brady, & Cox, 1999). Such an approach involves examining what might be done at the level of the staff member, the work group, and the organization as a whole before, during, and after incidents occur (Beech & Leather, 2006).

1.1. Correlates of patient violence

1.1.1. Worker characteristics

Existing evidence has shown that patient violence may be correlated with demographic characteristics of workers. Gender has proven to be an inconsistent risk factor, with some studies failing to find an association between victim gender and rates of patient violence (Kowalenko et al., 2013), while others provide evidence that in some settings gender is indeed a risk factor. Male workers in both inpatient psychiatric units and similar settings reported significantly more violent assaults than female workers (Campbell et al., 2011; Gillespie et al., 2010). In three different studies, male social workers were more likely to experience client violence than female social workers (Jayaratne et al., 1996; Newhill, 1996; Ringstad, 2005). Though age of worker has not often been studied, our finding that older counselors are less likely to experience patient violence is consistent with prior research (Åström, Bucht, Eisemann, Norberg, & Saveman, 2002).

Studies have found that healthcare workers with a graduate education are less likely to experience threats of physical harm and physical assault (Kowalenko et al., 2013). On the other hand, Shin (2011) found educational level to be positively associated with victimization. Though few studies have examined the race/ethnicity of the worker, one study found that White nurses were more likely to be physically assaulted than either Black or Asian/Pacific Islander nurses, and White nurses were more likely to experience psychological violence than Black nurses (Campbell et al., 2011).

1.1.2. Perpetrator characteristics

There are also inconsistent associations that have been found between patient/perpetrator gender and workplace violence (Cunningham et al., 2003; Kowalenko et al., 2013). Patients with a current SUD are more likely to be violent towards providers (Bye, 2007; Crilly et al., 2004; Fernandez-Montalvo, Lopez-Goni, & Arteaga, 2012; May & Grubbs, 2002). Alcohol, cocaine, and methamphetamine use/abuse is more consistently associated with violence than are heroin and marijuana use/abuse (Baskin-Sommers & Sommers, 2006; Bye, 2007; Darke, Torok, Kaye, Ross, & McKetin, 2010; Ostrowsky, 2010; Parker & Auerhahn, 1998). Patients demonstrating irrational and erratic behavior are also more likely to be violent towards staff (Crilly et al., 2004; Cunningham et al., 2003; Gillespie et al., 2010). Further, child or adolescent patients were more likely to commit assault against workers than adult patients, and the number of assaults increased with the number of psychiatric diagnoses in the patient population (Cunningham et al., 2003).

1.2. Workplace violence in SUD treatment settings.

Very few studies have been published about workplace violence in SUD treatment settings. In a study of violence experienced by social workers, Newhill (1996) found that drug and alcohol services was second among three high-risk areas of practice, preceded by criminal justice and followed by child and youth services. Approximately three-quarters (76%) of those in drug and alcohol services reported at least one incident of violence in the course of their career. Using past year data, Lipscomb et al. (2012) reported that 37% of staff in a state's residential addiction treatment centers reported verbal violence, 6% reported being physically threatened, and 1% reported being physically assaulted. In a study of aggressive incidents on an in-patient detoxification unit in the United Kingdom, Rajesh and Day (2005) reported that 5% of patients displayed aggression towards nursing staff with, 67% of incidents being verbal threats. Lastly, Palmistierna and Olsson (2007) conducted a study of violence perpetrated by women involuntarily admitted to three specialized inpatient treatment institutions for severe drug abuse in Sweden, reporting that 42% of the patients engaged in aggressive behavior during their treatment, with most incidents directed at staff.

1.3. Purpose of the study

Given that substance use and abuse are documented risk factors for the perpetration of violence (Baskin-Sommers & Sommers, 2006; Bye, 2007; Dack, Ross, Papadopoulos, Stewart, & Bowers, 2013; Parker & Auerhahn, 1998), SUD treatment personnel are likely at risk for patient-initiated violence. There is a paucity of research that has addressed workplace violence in SUD treatment settings. Using data nationally representative of the U.S., the present study explored SUD counselors' experiences of violent behaviors perpetrated by patients. The aims were to: (1) estimate the extent to which counselors in SUD treatment settings experience workplace violence; (2) describe organizational and counselor responses to violence; and (3) identify variables associated with counselors' exposure to workplace violence.

2. Methods

2.1. Sampling and data collection procedures

The data analyzed in this study are derived from the National Treatment Center Study (NTCS), a family of NIH-funded studies, conducted by the University of Georgia's Center for Research on Behavioral Health and Human Service Delivery, that each focus on a specific segment of the U.S. SUD treatment system. We used two of these studies as a platform to collect preliminary data on workplace violence in SUD treatment programs. As such, this study utilized counselor-level data from two national samples of SUD treatment programs. The first sample includes 318 (80% response rate) publicly funded, community-based treatment programs recruited through a two-stage sampling strategy. In the first stage, all counties in the United States were assigned to 1