State-Based Legislation to Address Workplace Violence in Healthcare Settings: Trends, Strategies, and Policy Implications

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I. Introduction

Health care workers have borne the brunt of Workplace Violence (WPV) across occupations in the United States (U.S.), experiencing 73% of all nonfatal violent injuries in U.S. work settings in 2018.[1] Additionally, recorded WPV incidents have grown over time, with WPV reported across health care facility types increasing 30% from 2011 to 2021/2022.[2] Addressing WPV is critical not only for ensuring the safety of health care workers, but also because the effects of WPV have been shown to adversely impact psychological wellbeing and job satisfaction, increase turnover, and compromise patient care quality.[3-6]

Health systems and professional organizations in the U.S. have collectively worked to address WPV and protect workers through enhanced staff training and education, changes in environmental design (including panic buttons and security systems), support for impacted staff, and improved reporting[7] as well as the creation of toolkits, issue briefs, training webinars, and best practice sharing to bring attention to WPV prevention.[7-13] At the same time, states have enacted legislation to address WPV against health care workers. Recent findings by Ninan et al. (2024) concluded that WPV legislative efforts have reached almost all states and generally take two forms: increased penalties for perpetrators of WPV and required actions for health care facilities.[14] However, limited evidence exists on the details of state legislation to mitigate WPV.

Policy Implications

Forty-eight states have WPV legislation enacted to address WPV towards health care workers; however approaches to addressing WPV varies between states. Comparing WPV rates across states with different legislative approaches, such as penalty, prevention, or remediation-oriented laws, can help identify effective strategies that could be applied across states. Future state legislation should include evaluation and data collection mechanisms to measure effectiveness in reducing WPV and improving outcomes for health care workers and patients.

Gaps persist in our understanding of legislative approaches to address WPV against health care workers, particularly related to understanding the types of policy interventions present in legislation, including efforts to target perpetrators of WPV or aimed at organizations to implement prevention, penalty, and remediation strategies. Additionally, literature to date has not comprehensively analyzed which types of settings are being protected by legislation. This study provides a comprehensive review of WPV-related legislation in health care settings across all fifty states over the last 10 years, which could help inform policymakers and researchers on the evolution of WPV legislation and which types have been enacted more recently.

II. Methods

A comparative analysis of state-level legislation addressing WPV towards health care workers as of June 2024 aimed to understand: 1) the focus of the legislation (i.e., penalty, prevention, remediation); 2) the setting and type of health care worker protected; and 3) temporal trends in state WPV legislation in the post-pandemic period.

Data sources and collection methods. A literature review and a web-based search were used to develop an initial inventory of state WPV legislation and a protocol to systematically extract data on each state's WPV legislation. from state legislative archives, Legiscan database, and additional web-based searches. Statute history was analyzed over time using state archives and Justia database to see if legislative language changed, to then identify any underlying legislative changes prompting the change, and to ensure thorough coverage of the state's legislative evolution.

Categorization of State Policies. State policies were categorized based on the focus of legislative action. The three categories include penalty, prevention, and remediation. Penalty legislation included laws and policies that increase punishment for perpetrators who commit violence towards health care workers; one common example is assault penalties, which are legal measures involving sentencing, imprisonment, and/or monetary penalties. Prevention legislation pertains to laws aiming to head off violence before it occurs, including violence prevention planning, required training, and signage to raise awareness towards WPV. Remediation legislation serves to support and protect victims

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and collect WPV data in the state. We further categorized prevention and remediation laws into additional subcategories. Prevention legislation included four intervention types: violence prevention plans for organizations, including strategies to avoid and address workplace violence, training to develop staff skills, signage to display visual reminders about impermissible actions against staff, and other (spanning badging, awareness campaigns, and more). Remediation policies involved victim supports like counseling, victim protections like non-retaliation, record keeping, data reporting, and evaluation. While one piece of legislation can include multiple categories and subcategories, historically, legislation has often been either a penalty, targeting individual perpetrators, or targeting organizational-level prevention/remediation strategies.

Analysis. Legislation was collected, categorized, and descriptively summarized by three periods: pre-2015 (all WPV legislation enacted prior to 2015), 2015-2019, and 2020-June 2024, which allowed us to compare two five-year periods with earlier baseline data.

III. Findings

As of June 2024, we identified 112 laws related to WPV in health care settings across 48 states. Only South Carolina and Wyoming had no enacted WPV legislation. Of the states that had WPV laws in place, states ranged from having one to five different laws, with a mean of 2.3 laws.

Focus of Legislative Action. 45 states (90%) have enacted laws that aim to penalize individual perpetrators of WPV towards health care workers, which include guidelines on sentencing, length of imprisonment, and monetary penalties. 27 states have passed legislation requiring prevention policies, and 23 states have passed laws to require remediation policies (See Figure 1). The most common prevention policies are those that require health systems to implement violence prevention plans (36%) or training programs (34%). Within remediation, requiring WPV incidents to be recorded and documentation maintained by the health setting was most prevalent at 38% of states, followed by victim protections like non-retaliation and personal information safeguards at 28% of states.

Across the 48 states with WPV laws, 18 states have enacted only penalty legislation, and three states have only enacted prevention and remediation, but no penalties. States often have more than one type of legislative action, with 10 states enacting legislation for penalty and either prevention or remediation and 17 states covering all three categories.

Setting protected by WPV Legislation. State laws vary in defining the health care settings covered by WPV legislation (Figure 2); 13% of states protect emergency services only (emergency response services (EMS) or Emergency Departments), 11% protect hospital workers only, and 76% protect a broad range of healthcare facilities. Within prevention legislation, 4% of states cover emergency services, 22% cover hospitals only, 70% cover a broad range of healthcare facilities, and 4% cover other settings. Within remediation, 30% cover hospitals only, 65% cover a broad range of healthcare facilities, and 4% cover other settings.

The types of health care settings included in WPV legislation changed over time. Prior to 2015, close to half (45%) of WPV legislation was targeted to EMS or emergency departments specifically, while 7% covered hospitals specifically and 45% covered health care settings broadly. As of June 2024, nearly three-quarters (72%) of WPV legislation broadly covered all health care settings, representing an increase in coverage across different settings.

Temporal trends in WPV legislation. Prior to 2020, 46 states had enacted at least one type of WPV legislation, suggesting that WPV laws are not a new strategy to address violence against health care workers. The majority of legislation prior to 2015 focused on penalties for perpetrators of WPV (Figure 3). However, beginning in 2015, more states began enacting legislation aimed at preventing and remediating WPV incidents. Prior to 2015, only 11 states had laws related to organizational policies to prevent WPV, compared to 27 states that have laws related to prevention as of June 2024. Similarly, prior to 2015, only eight states had organizational remediation laws to address WPV, as compared to 23 states as of June 2024.

The type of legislation (penalty, prevention, and remediation) was compared by state over the three time periods (Figure 4). Prior to 2020, only eight states had all three types of WPV legislation, four states had no WPV legislation, two states (MD, OR) had only organization prevention and remediation policies, while the vast majority of states (n=32) had only penalty legislation. As of June 2024, 17 states had all three types of legislation, two states had no WPV legislation, three states (MD, OR, RI) had only prevention and remediation, and 18 states had only penalty laws. In addition, several states that only had penalty legislation prior to 2020 added either organization prevention policies (n=7) or organizational remediation policies (n=3; CO, MO, MT).

IV. Conclusion

This analysis of state-based legislation that aims to prevent and address WPV in health care settings reveals that while most states had already enacted WPV-related legislation prior to 2020, there has been a notable shift in the types of policies enacted from penalties to prevention and remediation, coupled with a broadening of health care settings covered. This shift may reflect a growing recognition of the need for more organizational and preventive approaches to WPV. The increase in prevention policies, like requiring health systems to implement violence prevention plans and staff training, indicates a shift toward proactive strategies that aim to reduce the incidence of WPV toward health care workers before it occurs. Similarly, the growth in remediation policies, including victim support and data reporting requirements, reflects an emerging commitment to supporting affected health care workers.

Although this study observed trends in increasing prevention and remediation strategies to address violence towards health care workers over time, it is unclear whether this shift was occurring as a result of a desire to utilize evidence-based strategies for WPV or whether penalty-focused legislation was ineffective towards WPV.[15-19] The majority of WPV research in healthcare has focused on prevalence and the impact of workplace violence on workers, with emerging studies of interventions.[4,20] Presently, no evidence conclusively supports one particular strategy to reduce the incidence of WPV,[4,21] and consensus on best practices is limited due to insufficient intervention design, mixed results, and violence underreporting.[4,20,21] Overall, the research points to using comprehensive interventions in lieu of singular interventions[21-23] and suggests using systems-based approaches that address the organizational-level, not just the individual worker-level.[24,25]

V. Policy Implications

Comparing differences in WPV rates across states with different types of legislation (i.e., penalty, prevention, remediation) could identify best practices and inform future policy development. Further research is needed to evaluate the real-world impact of different legislative approaches, particularly in terms of reducing WPV incidents, improving worker well-being, and ultimately enhancing patient care. Although there is a need to study the effectiveness of different legislative approaches in reducing WPV incidents and improving outcomes for health care workers, only one state specifically included program evaluation in the legislation. Eleven states now require centralized data collection, which could create opportunities to evaluate the effectiveness of state-wide strategies to reduce health care WPV. Future work would benefit from improving methodological design and analysis to assess the causal impact of environmental and organizational strategies to reduce WPV[4,23,26-28] as well as examining the effectiveness of different strategies across different health care settings,[27,29] and types of workers.[28,29]

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APPENDIX

Figure 1. Focus of Legislative Action and Types of Policies States Enacted to address WPV Towards Health Workers, June 2024

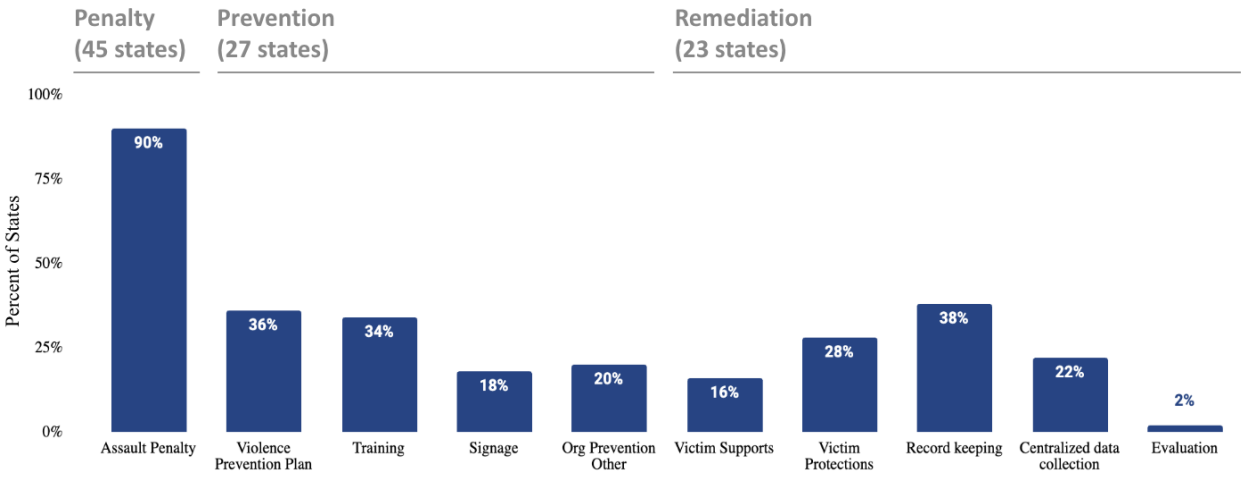


Figure 2. Types of health care settings included in WPV legislation, Overall and by Time Period

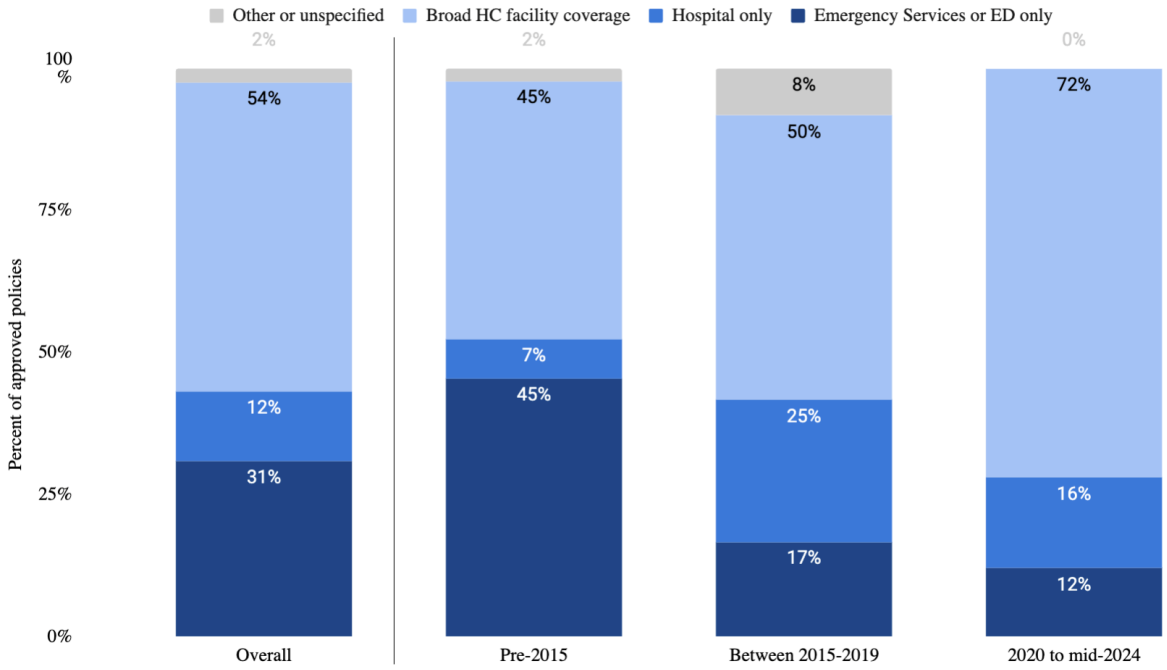
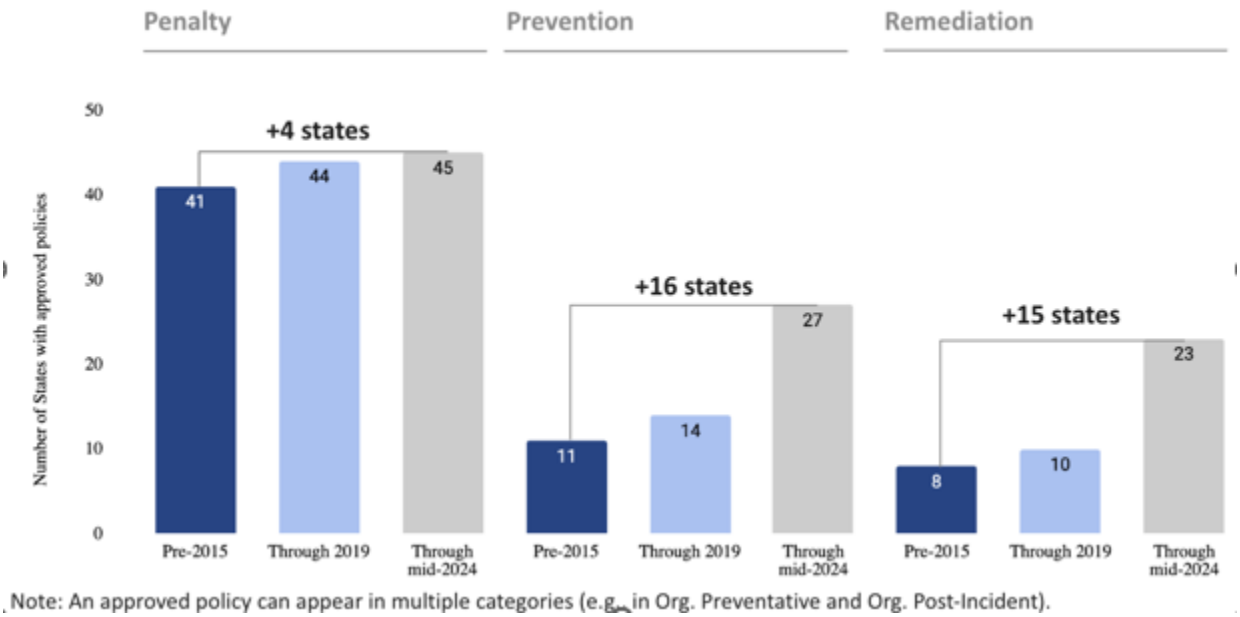


Figure 3. Number States with Enacted WPV Towards Health Workers Over Time, By Focus of Legislative Action



Note: An approved policy can appear in multiple categories (e.g., in Org. Preventative and Org. Post-Incident).

Figure 4. States with Enacted WPV Policies by Category, prior to 2020 and 2024