Workplace Violence Against Healthcare Workers in Kentucky

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Abstract

Kentucky's healthcare workforce is disproportionately exposed to workplace violence relative to workers in other industries. When factors associated with workplace violence are examined, Kentucky performs poorly in measures of mental well-being and the prevalence of drug use, ranking in the top fifth for major depressive episodes, methamphetamine use, opioid misuse, and overdose deaths. These risk factors are especially pronounced in the state's Appalachia region, implying that healthcare workplace violence is likely higher there as well.

Recent legislative activity has aimed to improve the safety of healthcare workers. One example is increasing legal penalties for assaulting them. A 2026 bill that would allow hospitals to establish their own police departments passed the Kentucky House; however, hospitals would bear the considerable cost. Other bills proposed that mental health wellness examinations be covered without cost sharing, that opioid antagonists be provided on college campuses, and that Medicaid-related entities be prohibited from denying coverage of non-opioid pain treatments in favor of opioids. Given Kentucky's recent legislative considerations and performance in mental health and drug use measures, there appear to be multiple pathways for Kentucky to influence incidents of violence against healthcare workers. However, there is little evidence as to which interventions will be most effective. The overlap between mental health, drug use, and violence provides common ground for advocates of better mental health, reduced drug use, and safer healthcare workplaces.

Keywords: Kentucky, workforce, workplace, healthcare, violence

JEL Codes: I11, J21, J23, J63

I. Introduction

Workplace violence is a far greater concern for healthcare workers than for the typical US worker. In 2021 and 2022, healthcare workers comprised ten percent of the US workforce but experienced around forty-eight percent of non-fatal injuries caused by workplace violence (Chaumont Menendez et al., 2024). A 2025 report commissioned by the American Hospital Association (AHA) estimates that, in 2023, hospitals spent $3.62 billion on measures to prevent workplace and community violence, such as training, security staffing, and facility modifications. They also spent $14.65 billion spent addressing the consequences of violence, 90% of which was healthcare expenses to treat injuries (Graves et al., 2025).

This paper examines workplace violence statistics in healthcare for Kentucky and its neighboring states, statistics on key factors associated with workplace violence, and recent Kentucky legislation related to workplace violence against healthcare workers. We reach three key conclusions. First, Kentucky's healthcare workforce is disproportionately exposed to workplace violence relative to workers in other industries. Next, mental health and drug use are two key predictors of workplace violence, and Kentucky ranks in the top fifth of states for major depression, methamphetamine use, opioid misuse, and overdose deaths. These risk factors are especially high in Appalachian Kentucky, implying that healthcare workplace violence is likely also higher there compared to other parts of the state. Finally, several pieces of legislation have been introduced that aim to address healthcare workplace violence from multiple directions, and more evidence is needed to determine which types of laws will be most effective.

II. Violence Statistics for Kentucky and Its Neighbors

Healthcare workers face a relatively high risk of occupational injuries, which include but are not limited to incidents of workplace violence. In 2024, the national incidence rate of

nonfatal occupational injuries and illnesses was 2.3 per 100 full-time employees working fifty weeks in a year for private industries and 2.6 when including government positions (Bureau of Labor Statistics [BLS], 2026).[1] Such incidents are less frequent than the average in physician offices (1.8) but much more frequent in hospitals (5.1), ambulance services (5.9), and nursing and residential care facilities (5.5) (BLS, 2026). Incidence is higher still in state and local government hospitals and nursing care facilities, with rates of 6.9 and 8.3, respectively. While state data are less detailed, in 2024, private Kentucky hospitals saw an incidence rate of 5.4, and nursing and residential care facilities saw one of around 5.2 (BLS, n.d.).

Figure 1 displays the incidence rate of intentional injury by other persons per 10,000 full-time healthcare and social assistance workers in Kentucky and its seven border states using data from the BLS for 2011-2020 (BLS, n.d.). Kentucky's incidence rate generally falls in the middle for healthcare and social assistance workers. However, as seen in Figure 2, when compared to intentional injuries that occur in all industries, Kentucky's healthcare and social assistance workers experience relatively high rates of intentional injury. From 2011-2020, Kentucky's ratio was higher than all of its neighbors' ratios in 5 out of the 10 years and higher than all but one in 3 of the remaining 5 years.

The BLS made this workplace injury measure biennial starting in 2021. Figure 3 shows that, in 2021-2022, Kentucky's overall intentional injury incidence rate (1.2) was the lowest among its neighbors, but its incidence rate for healthcare and social assistance workers (7.8) placed it in the middle of the compared states and resulted in the highest ratio of these rates. Figure 4 shows the incidence rate for violent acts by other persons in 2023-2024. Kentucky's

[1] The rate of incidence is calculated as $\frac{\text{Number of incidents}}{\text{Total Hours Worked by All Employees for a Calendar Year}} \times 200{,}000$, where "200,000 = base for 100 equivalent full-time workers (working 40 hours per week, 50 weeks per year)" (BLS, 2026).

ratio of healthcare and social assistance incident rates compared to overall rates came in third behind Virginia and Indiana. However, Kentucky ranked second for its violent act incidence rates overall and for healthcare and social assistance.

III. Factors Associated with Risk of Workplace Violence

A review of studies on the characteristics of perpetrators of healthcare workplace violence by Gillespie et al. (2010) identifies poor mental health and drug use as important predictors. This section compares Kentucky's statistics on these factors to those of other states. Gillespie et al.'s review also finds sex, age, and ability to cope with stress to be predictive, but the first two of these are less amenable to policy while the third lacks reliable state-level data.

We begin with mental health. Figures 5 and 6 show maps of the prevalence of any mental illness and serious mental illness for Kentucky and its neighbors based on 2023-2024 National Survey on Drug Use and Health data from the Substance Abuse and Mental Health Services Administration (SAMHSA, 2025a). Kentucky ranks fifth highest among its neighbors and fifteenth nationally in the prevalence of any mental illness and third among its neighbors and eleventh nationally in serious mental illness. For major depressive episodes, Kentucky ranks second among its neighbors and ninth nationally, as shown in Figure 7.

Suicide is the most extreme mental health outcome. Figure 8 displays the number of suicides per 100,000 population for Kentucky and its neighbors using data from the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) from 2014-2023 (NCHS, n.d.-b). Kentucky had the second-highest suicide rate among its neighbors for seven of those years and the third highest for the other three years. In 2023, Kentucky was 20th in suicides per 100,000 nationally – one spot better than in 2014, but only because other states' rates rose slightly faster. Kentucky's suicide rate increased from just under 16 per 100,000 in 2014 to

almost 17.5 per 100,000 in 2023, with a high point of over 18 in 2022. In short, across all mental health-related categories examined in this study, Kentucky has ranked among the worst-performing half to fifth of states.

Turning to drug use, we use SAMHSA estimates for 2023-2024 to assess whether any particular drug is more prevalent in Kentucky than in its neighboring states or the rest of the US (SAMHSA, 2025a). Figure 9 shows the prevalence of marijuana use, as recent literature reviews have found a persistent association between cannabis use and the odds of violent behavior (Miller et al., 2020; Trotta et al., 2026). Nationally, Kentucky is ranked 39th in marijuana use, a ranking likely influenced by numerous other states allowing recreational marijuana. Among Kentucky's neighbors, only West Virginia appears to have a lower use rate for marijuana.

Kentucky performs much more poorly when it comes to the use of other drugs. Figure 10 shows the prevalence of methamphetamine use, a category in which Kentucky ranked fifth nationally and second among its neighbors, only behind West Virginia. Figures 11 and 12 show that Kentucky was third nationally for the misuse of prescription opioids specifically and opioids in general, leading all of its neighbors. Figure 13 displays overdose deaths per 100,000 population among Kentucky and its neighbors from 2014-2024 (NCHS, n.d.-a). Overdose deaths rose in every state during the pandemic before declining notably; Kentucky typically ranked third among its neighbors. In 2024, Kentucky ranked ninth in overdose deaths per 100,000 population, with neighboring states Tennessee and West Virginia ranking sixth (tied with Maine) and first, respectively. Figure 14 shows that Kentucky and most of its neighbors have a higher prevalence of substance use treatment (which proxies for prevalence of substance use disorders) than most other states. Kentucky ranked sixth nationally, but three of its neighbors ranked higher. Figure 15, which draws on a separate SAMHSA survey, indicates that Kentucky was typically

second highest among its neighbors in substance use clients in treatment per 100,000 population from 2021-2024 (SAMHSA, 2023a, 2023b, 2024, 2025b).

These statewide figures mask substantial variation within Kentucky, as mental health problems and drug use are considerably higher in the Appalachia region than in other parts of the state. Appalachian Kentucky faces relative high rates of chronic disease, addiction, and risky health behaviors (Courtemanche & Garuccio, 2026b). Adults in Appalachian Kentucky report feeling mentally unwell 15 percent more often than adults in the rest of the state (Appalachian Regional Commission [ARC], 2017), and 38 of the 40 Kentucky counties with the highest rates of depression are in Appalachia (Cross, 2023). From 2000 to 2019, drug-related mortality rates in Appalachian Kentucky were twice those of non-Appalachian Kentucky (Salunkhe et al., 2023), and between 2019 and 2021, opioid overdose fatality rates rose more steeply in Appalachian counties (Nigam et al., 2024). Therefore, while we are not aware of credible county-level data on healthcare workplace violence, Appalachian Kentucky's greater risk factors suggest that it is likely higher than the state-level numbers suggest. This could plausibly exacerbate the region's healthcare workforce shortages (Courtemanche & Garuccio, 2026a).

IV. State Legislation

Policymakers have considered several types of legislation that address healthcare workforce violence in different ways. However, they each face challenges, and there is little evidence as to which policies will be most effective.

In twenty states, including Kentucky, violence prevention plans and programs are required by state law (Dadika & Peters, 2026). In Kentucky, this stems from House Bill 176, enacted in 2023, which requires health facilities to conduct workplace safety assessments,

develop workplace safety plans, train employees, and maintain internal systems for reporting incidents of workplace violence (An act relating to health care workplace safety, 2023).

Other requirements serve as informational deterrents. For instance, states such as Illinois and Oregon require the posting of notices that verbal aggression will not be tolerated or of the legal penalties for violence (Health Care Violence Prevention Act, 2019; Relating to violence in health care settings, 2025). Kentucky proposed such as display requirement under House Bill 713, which passed the House but stalled in the Senate. This bill would have required "health facilities to display a notice in a prominent location advising of possible consequences of threatening or aggressive behavior toward health care workers" (An act relating to workplace violence against health care professionals, 2026).

Early in 2026, the American College of Emergency Physicians, the American Hospital Association (AHA), and several other prominent organizations wrote a letter to the Centers for Medicare and Medicaid Services (CMS) asking for clear guidance on such signage. According to the letter, healthcare entities have been warned against posting signs in emergency departments that would deter individuals from staying for medical assessment and condition stabilization, as is their right under the Emergency Medical Treatment and Labor Act (EMTALA) (American College of Emergency Physicians et al., 2026). CMS did not prohibit such signs but stated that they are permissible if it can be demonstrated that they do not deter individuals seeking treatment. However, what crosses the line into deterrence was left unclear, so the coalition requested specific guidance. Without it, state signage requirements could conflict with CMS's interpretation of federal law, a conflict that federal courts might ultimately need to resolve. As of November 2026, the AHA and its cosignatories await further CMS guidance.

House Bill 194, signed into law in 2024, extended Kentucky's Class D felony penalty for assaulting healthcare workers, previously focused on emergency departments, to a broader range of healthcare settings (An act relating to workplace violence against healthcare workers, 2024). However, stiffer penalties under the law are useful only so long as the penalty is known and readily enforceable. If hospitals cannot fully notify arriving individuals of the penalties for violent behavior, the increased penalty may have no preventative effect. Increased penalties would then reduce violence mainly by keeping offenders out of healthcare settings longer after they commit violent acts. Few perpetrators are likely to look up the penalty and weigh it before acting. Stiffer penalties are a stronger deterrent when potential perpetrators can see that enforcement is likely.

House Bill 248, which passed the House in 2026 but did not advance in the Senate, sought to expand enforcement by allowing hospitals to create and fund their own police departments (An act relating to hospital police departments, 2026). While this would ensure a law enforcement presence in any hospital with its own department, it would also mean added costs borne by hospitals. These would include not only the cost of employees but also the regulatory and liability costs that likely come with running and insuring a police department.

To explore how much additional cost hospitals might incur by employing their own police departments, we turn to available data from two Kentucky jurisdictions. Paris, Kentucky's financial statements for fiscal year 2023 indicate that the city paid $3.7 million for its police force, 82 percent of which was for salaries and wages (City of Paris, 2024). PoliceCensus lists 32 sworn officers in 2022 and more than 23 in 2025, along with 3 to 11 civilian employees, serving just under 10,200 residents (PoliceCensus, n.d.-a). Richmond, Kentucky, with a population of just under 36,900 in 2023, spent about $9.4 million on its police department of about 61 officers

and 15 civilian staff that year (City of Richmond, 2024; PoliceCensus, n.d.-b). Assuming that salary/wage costs alone will be about 82 percent of total costs for police in Kentucky, we can examine the per-officer salary/wage cost hospitals would face for employing their own officers.

As PoliceCensus is missing the number of officers for Paris in 2023, we use the 2022 values for number of officers (32) and total expenditures ($2.99 million), because the cited Paris document reports total police expenditures, but not salary expenditures, for 2022. Using these values gives the following:

$$\text{Per-Officer Cost Paris}_{2022} = \frac{0.82 \times \$2.99 \text{ Million}}{32} \approx \$76{,}600;$$

$$\text{Per-Officer Cost Richmond}_{2023} = \frac{0.82 \times \$9.38 \text{ Million}}{61} \approx \$126{,}100.$$

Because the salary and wage total also covers civilian staff, dividing by all employees rather than by sworn officers alone yields somewhat lower figures:

$$\text{Per-Officer Cost Paris}_{2022} = \frac{0.82 \times \$2.99 \text{ Million}}{35} \approx \$70{,}100;$$

$$\text{Per-Officer Cost Richmond}_{2023} = \frac{0.82 \times \$9.38 \text{ Million}}{76} \approx \$101{,}200.$$

In either case, this suggests that hospitals could face added costs in the hundreds of thousands of dollars for salaries and wages alone if they instituted their own small police forces to reduce violence against their workforce. Van Den Bos et al. (2017) find that the cost of measures to prevent workplace violence was over $200,000 per hospital. Staffing even a single post around the clock requires roughly five full-time officers after accounting for days off, leave, and training. For a hospital previously spending $200,000, a minimal force of five officers,

costing $70,000 per officer, would increase costs by 175 percent.[2] The ability to absorb these costs would likely favor financially stronger hospitals or healthcare systems.

Other legislation could affect workplace violence less directly. Senate Bill 56, proposed in 2026 but not enacted, seeks to prevent Medicaid entities, such as Medicaid managed care organizations, from denying coverage for the use of non-opioid analgesics in favor of opioid analgesics (An act relating to utilization controls for nonopioid analgesics in the Medicaid program, 2026). If enacted, and if it reduces downstream opioid misuse, the bill could translate into a lower risk of violence for healthcare workers. House Bill 431, which did not advance beyond committee, proposed to require the provision of opioid antagonists on college campuses and allow for such institutions to apply for funding from the state opioid abatement trust fund (An act relating to opioid antagonists, 2026). House Bill 470, which was signed into law in April of 2026, imposed greater restrictions on who can provide and bill for alcohol and drug peer support services beginning in 2027, with parts of the bill being an apparent response to concerns of fraudulent Medicaid billing for psychoeducation services (An act relating to behavioral health services and declaring an emergency, 2026). House Bill 634, which also did not advance beyond committee, proposed requiring insurance coverage without cost sharing for an annual mental health wellness examination, performed by a qualified professional (An act relating to coverage of mental health wellness examinations, 2026). The collective effect of reducing drug use and improving mental health could supplement efforts to increase safety for healthcare workers by reducing exacerbating factors associated with workplace violence.

[2] These figures may understate costs: salaries and wages exclude fringe benefits, which are substantial for sworn officers; larger hospitals would need more than one post; and the 82 percent salary share comes from Paris alone. On the other hand, many hospitals already pay for security staff or off-duty officers, so a police department would partly replace existing spending, and some university-affiliated hospitals may already have access to campus police.

V. Conclusion

Kentucky's healthcare workforce faces a disproportionately high risk of workplace violence compared with workers in other industries. While Kentucky's standalone rate of workplace violence against workers in the healthcare and social assistance industry is middle of the pack relative to its neighbors, t he ratio of violence in this industry compared to workers in all industries is high. This suggests that, relative to other Kentucky workers, healthcare and social assistance workers face unusually elevated risk compared with their counterparts in neighboring states. On factors associated with workplace violence, Kentucky performs relatively poorly nationally for mental health, suicides, misuse of methamphetamines and opioids, and overdose deaths. These risk factors are especially pronounced in the state's Appalachia region.

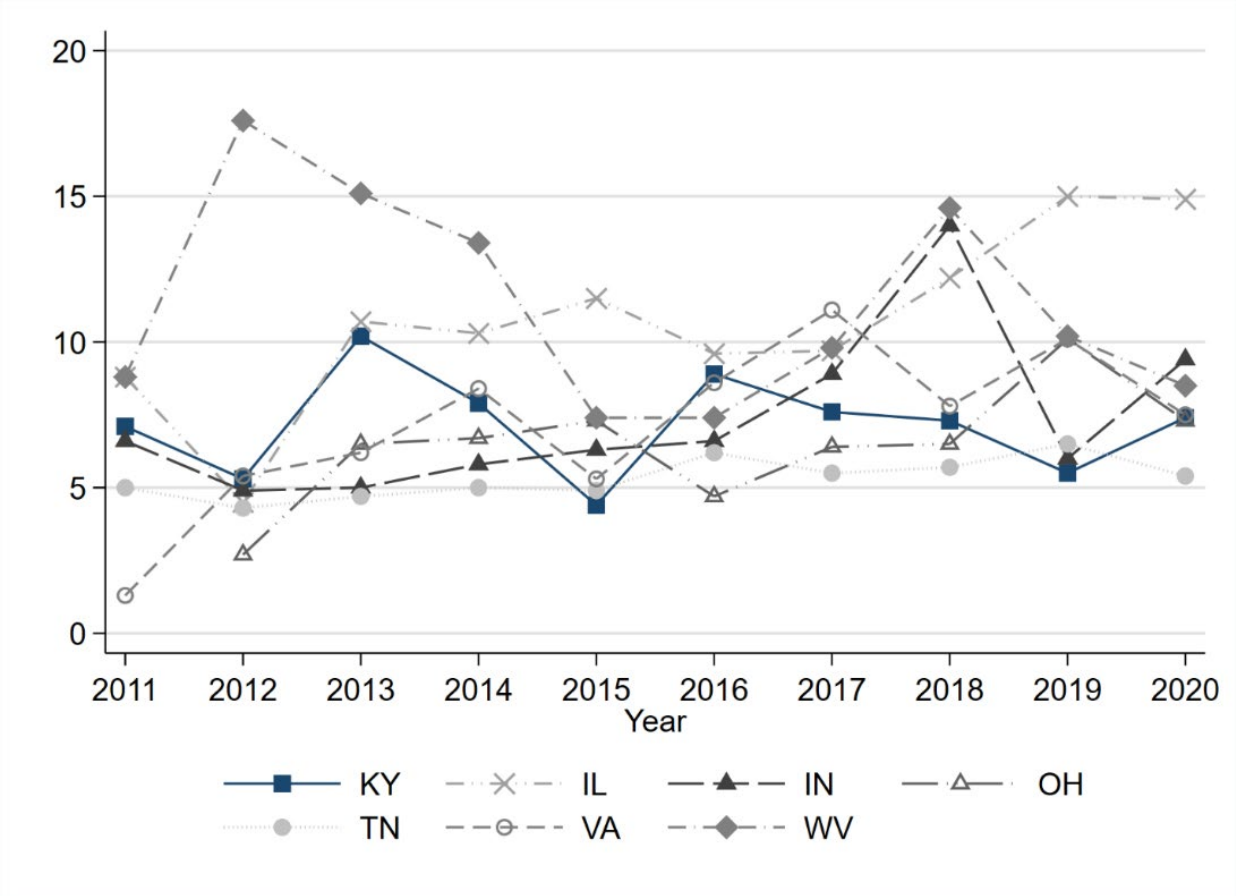
While Kentucky has increased penalties for assaulting healthcare workers in a medical setting, avenues to use this for deterrence are somewhat uncertain. Pending CMS clarification, it remains unclear what signage hospitals can use to deter aggression without discouraging individuals from seeking care. In other legislative developments, the Kentucky General Assembly has considered allowing hospitals to form their own police departments to deter violent behavior and ensure timely responses to it. However, this would entail significant cost increases for hospitals that did so, and expose them to new liability for the actions of officers.

While not directly aimed at reducing workplace violence, legislation that expands the provision of opioid antagonists and protects the use of non-opioid pain management could reduce the likelihood of workplace violence by mitigating factors associated with violent behavior. Adopting a broader perspective on violence mitigation would give advocates for reducing substance abuse, improving mental health, and reducing workplace violence common ground.

Acknowledgment

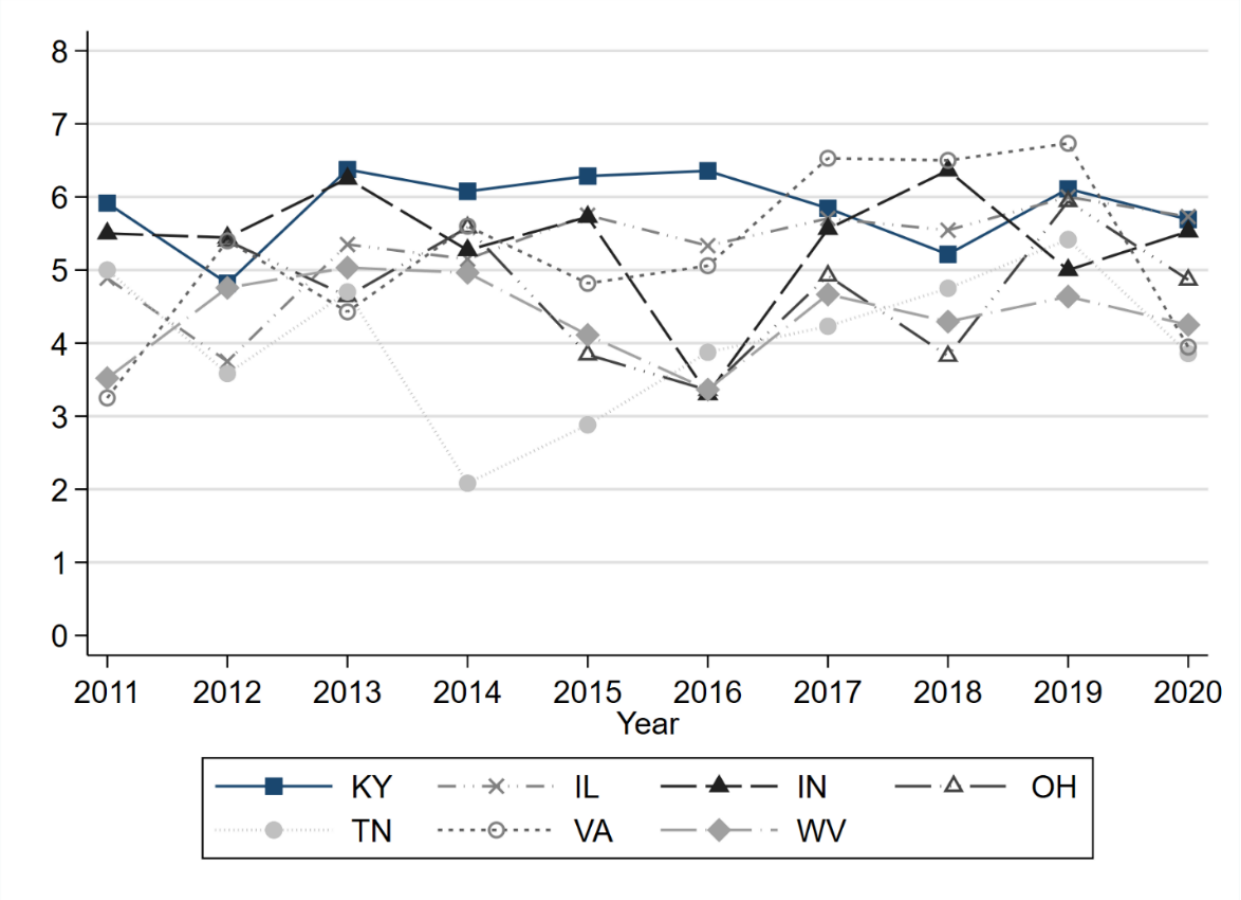
We acknowledge support for this research from the Kentucky Hospital Association under a grant entitled “An Economic Investigation of Regulations and Financial Challenges Facing Hospitals.” The views expressed in this paper are the authors’ and do not reflect those of the Kentucky Hospital Association. Claude AI was used to assist with background research; the formatting of references, figures, and tables; and final editing.

Figure 1. Incidence Rate of Intentional Injury by Other Person Per 10,000 Full-Time Healthcare and Social Assistance Workers in KY and Its Neighbors



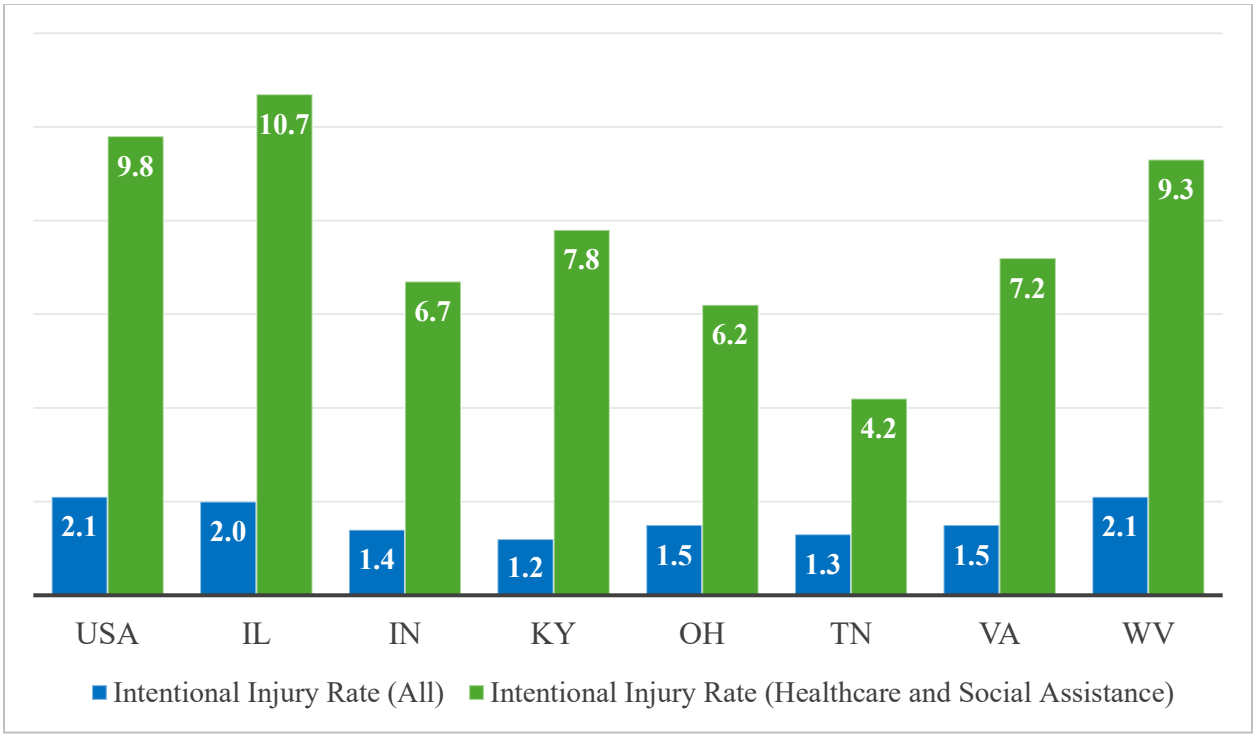
Note: Missouri is omitted because intentional injury data by-industry-by-all-ownership types within the state from 2011-2020 is either suppressed or missing from the BLS's data.

Figure 2. Ratio of Healthcare and Social Assistance Workers to All Workers of Intentional Injury by Other Person Rates for KY and Its Neighbors 2011-2020



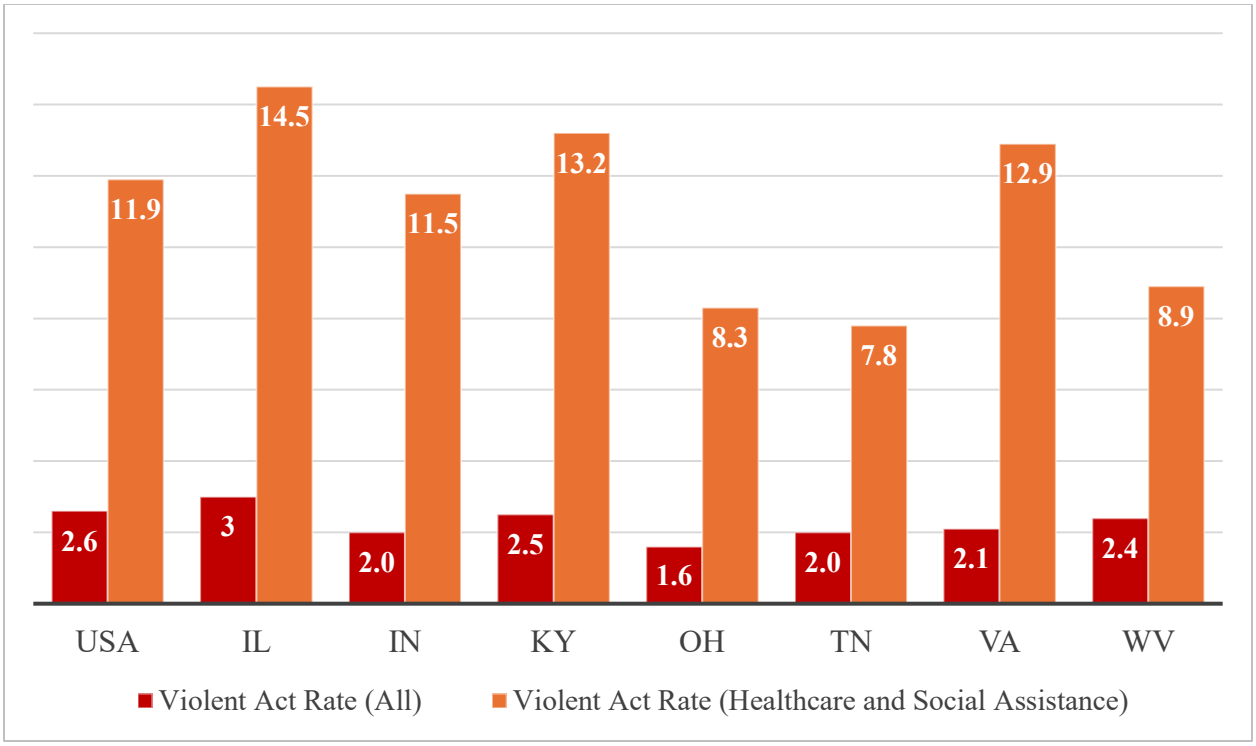
Note: Missouri is omitted because intentional injury data by-industry-by-all-ownership types within the state from 2011-2020 is either suppressed or missing from the BLS's data.

Figure 3. Incidence Rate of Intentional Injury by Other Person Per 10,000 Full-Time Healthcare and Social Assistance Workers in KY and Its Neighbors in 2021-2022



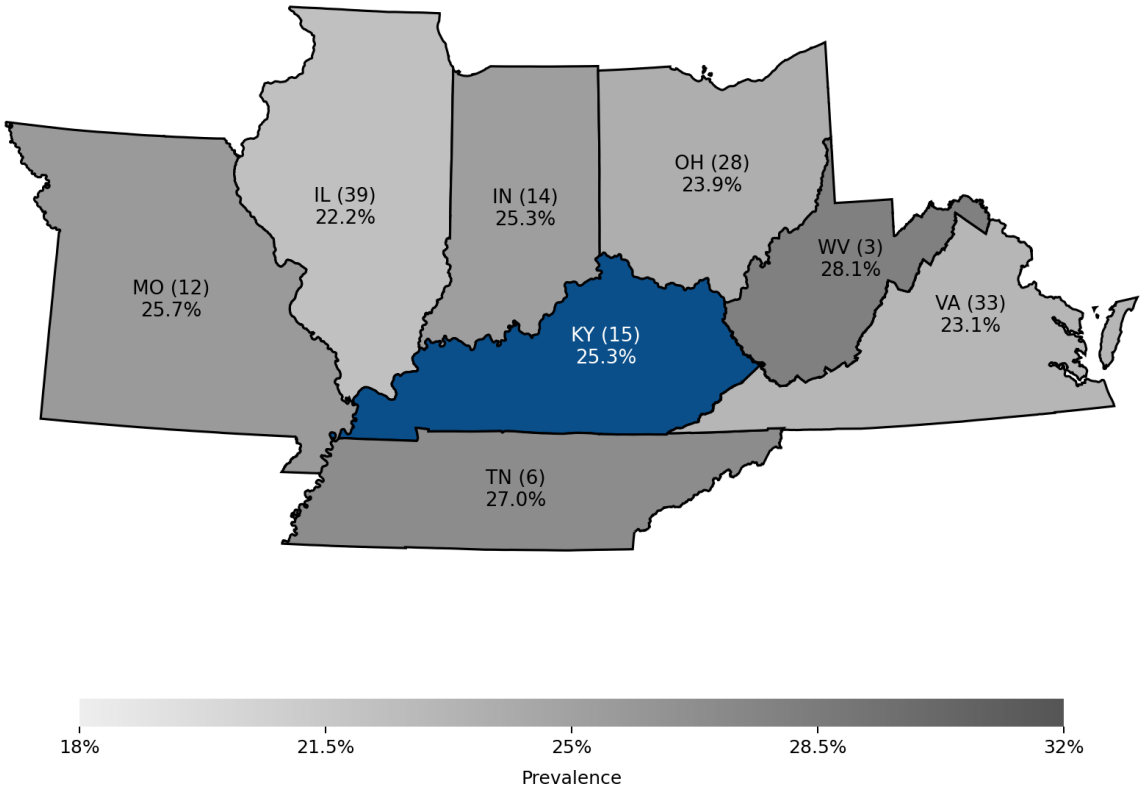
Note: Missouri is omitted because intentional injury data by-industry-by-all-ownership types within the state from 2021-2022 is either suppressed or missing from the BLS's data.

Figure 4. Incidence Rate of Violent Acts by Other Person Per 10,000 Full-Time Healthcare and Social Assistance Workers in KY and Its Neighbors in 2023-2024



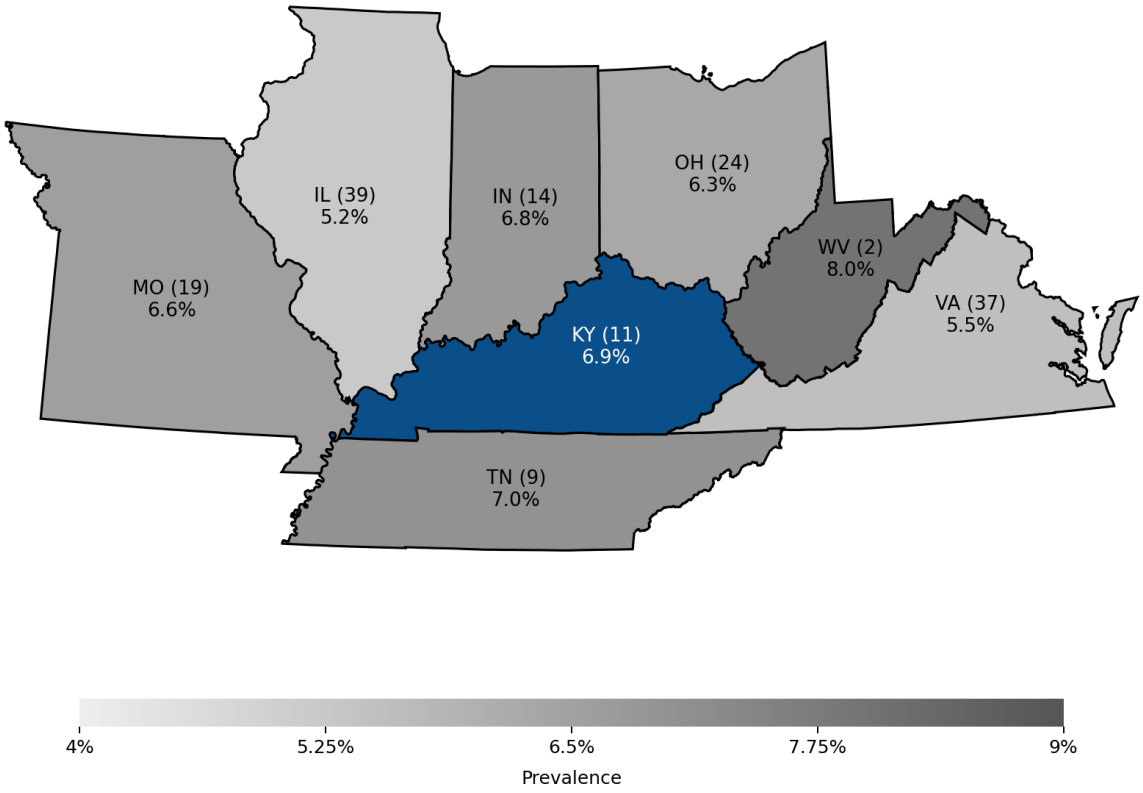
Note: Missouri is omitted because violent act data by-industry-by-all-ownership types within the state from 2023-2024 is either suppressed or missing from the BLS's data.

Figure 5. Any Mental Illness, Ages 18+, 2023-2024



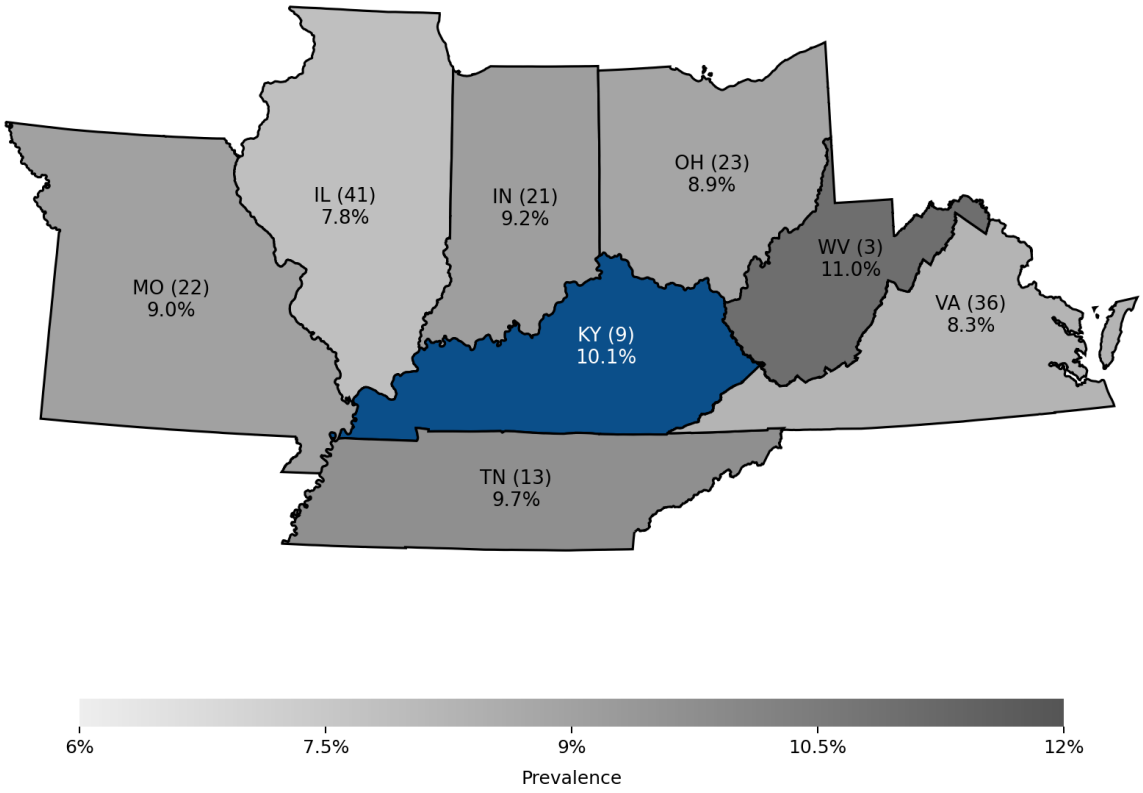
Notes: Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2023–2024*, Table 33. State estimates are annual averages based on the survey-weighted hierarchical Bayes small-area estimation approach. Legend ranges are based on values from all US states. These maps were generated using artificial intelligence (AI) based on the estimates reported in the cited SAMHSA data. Each state's national rank is in parentheses beside the state abbreviation.

Figure 6. Serious Mental Illness, Ages 18+, 2023-2024



Notes: Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2023–2024*, Table 34. State estimates are annual averages based on the survey-weighted hierarchical Bayes small-area estimation approach. Legend ranges are based on values from all US states. These maps were generated using artificial intelligence (AI) based on the estimates reported in the cited SAMHSA data. Each state's national rank is in parentheses beside the state abbreviation.

Figure 7. Major Depressive Episode in the Past Year, Ages 18+, 2023–2024



Notes: Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2023–2024*, Table 38. State estimates are annual averages based on the survey-weighted hierarchical Bayes small-area estimation approach. Legend ranges are based on values from all US states. These maps were generated using artificial intelligence (AI) based on the estimates reported in the cited SAMHSA data. Every value was verified against the SAMHSA tables. Each state's national rank is in parentheses beside the state abbreviation.

Figure 8. Suicides Per 100,000 Population 2014-2023

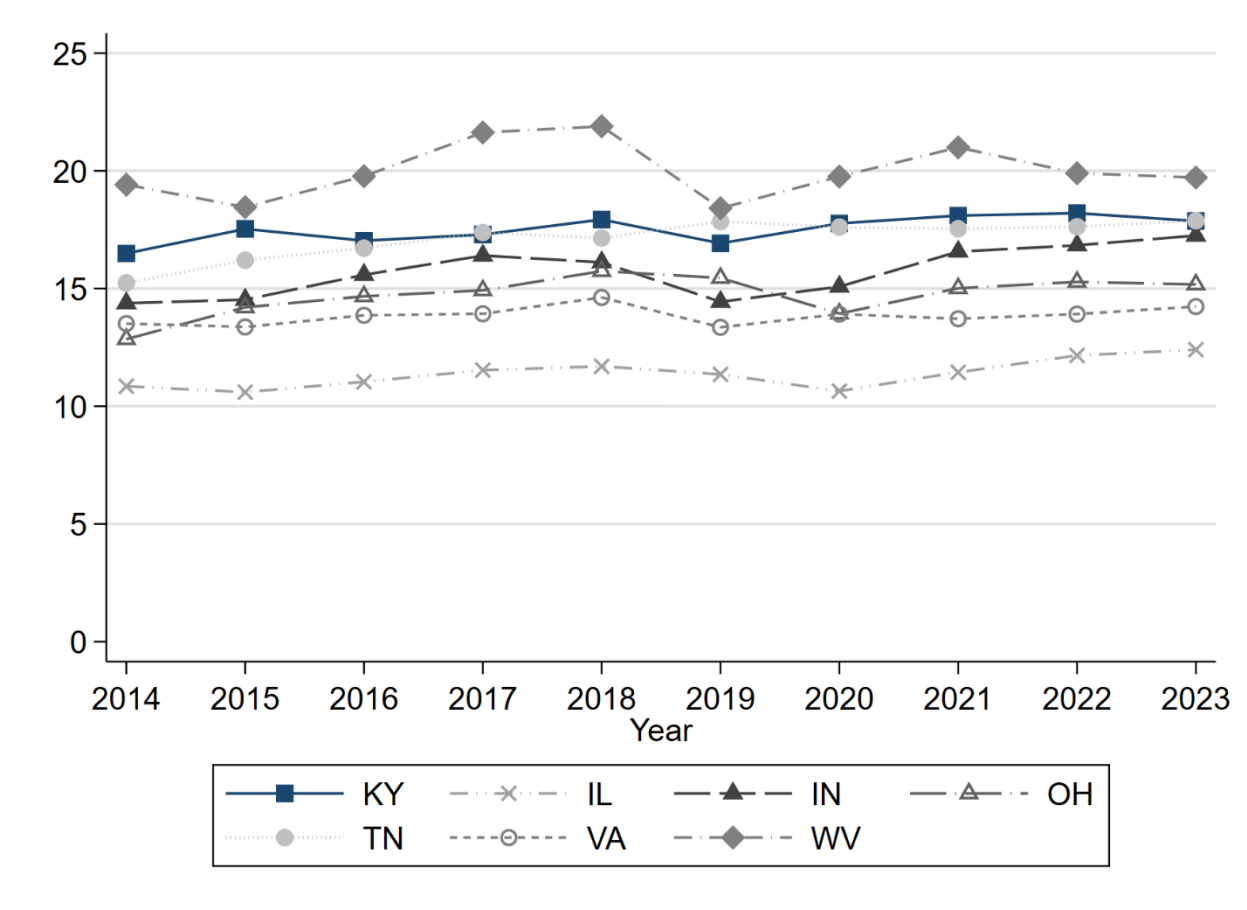
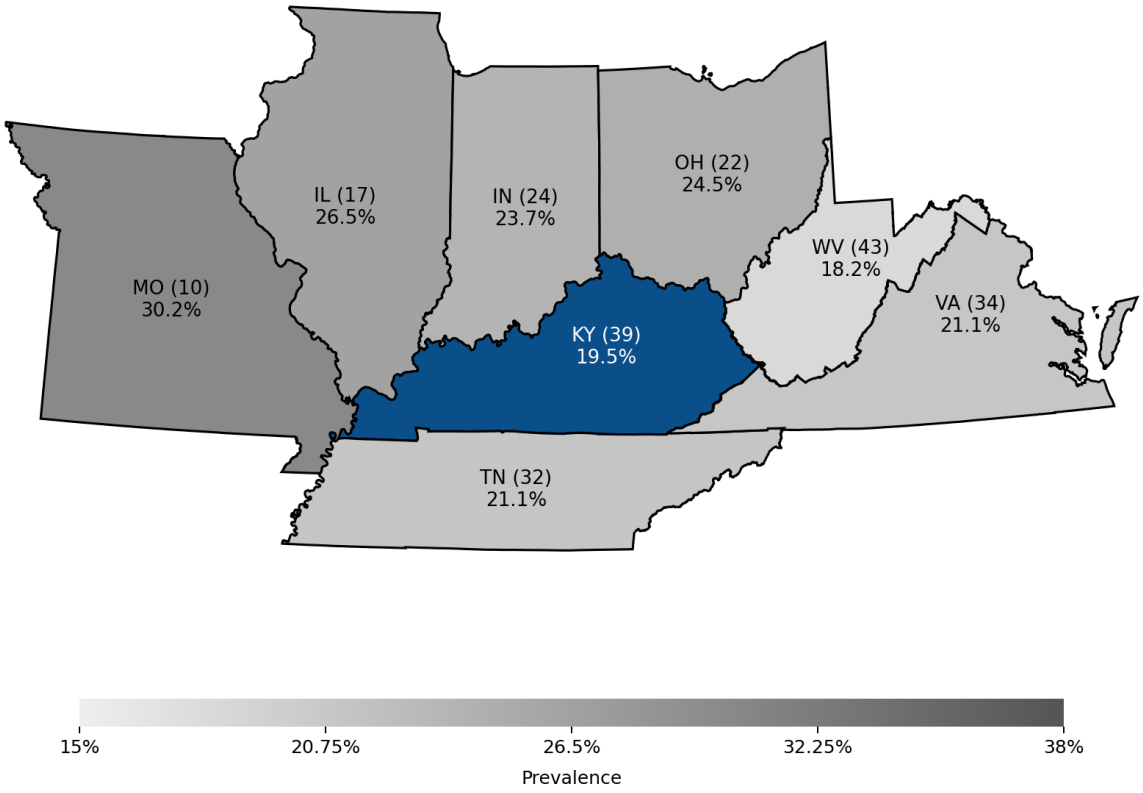
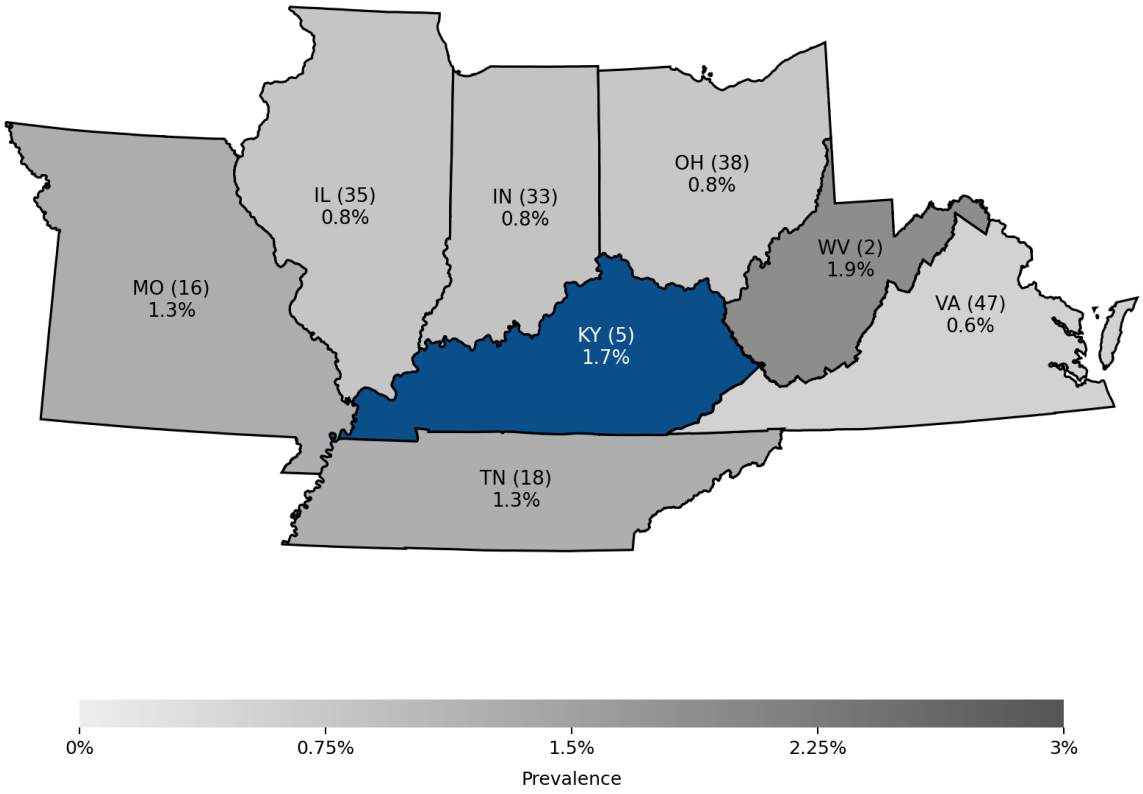


Figure 9. Marijuana Use in the Past Year, Ages 18+, 2023–2024



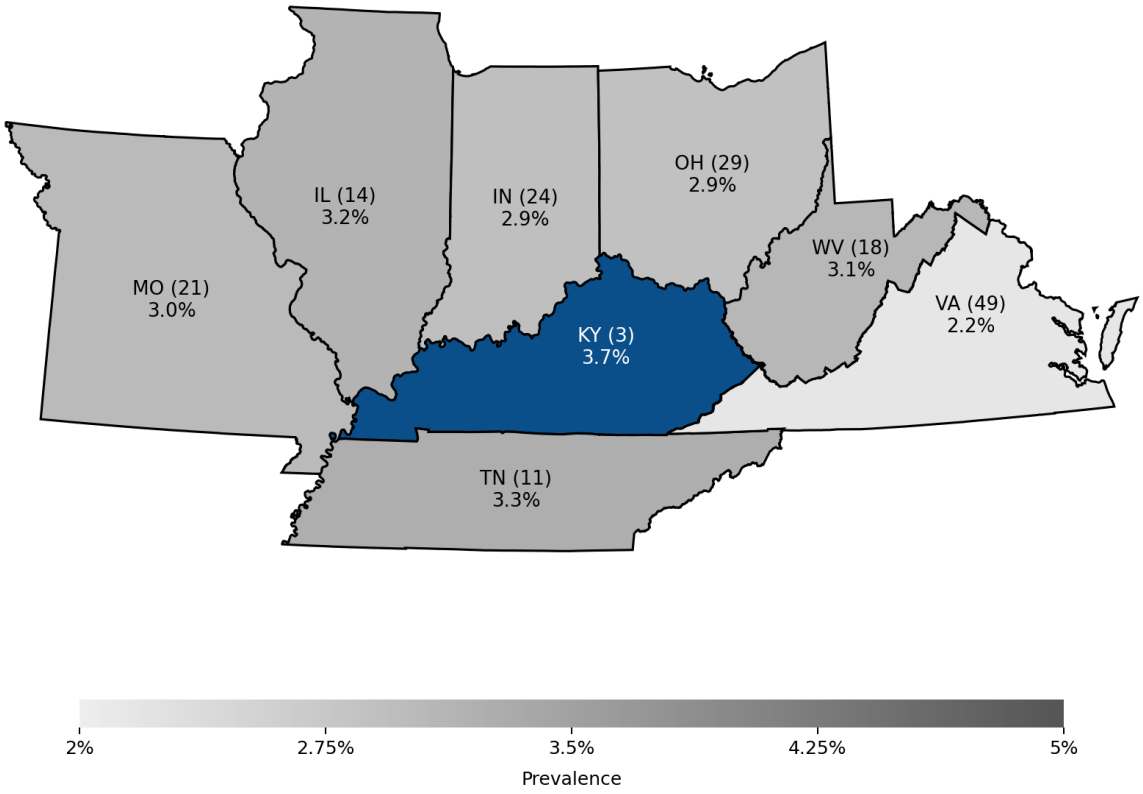
Notes: Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2023–2024*, Table 2. State estimates are annual averages based on the survey-weighted hierarchical Bayes small-area estimation approach. Legend ranges are based on values from all US states. These maps were generated using artificial intelligence (AI) based on the estimates reported in the cited SAMHSA data. Each state's national rank is in parentheses beside the state abbreviation.

Figure 10. Methamphetamine Use in the Past Year, Ages 18+, 2023–2024



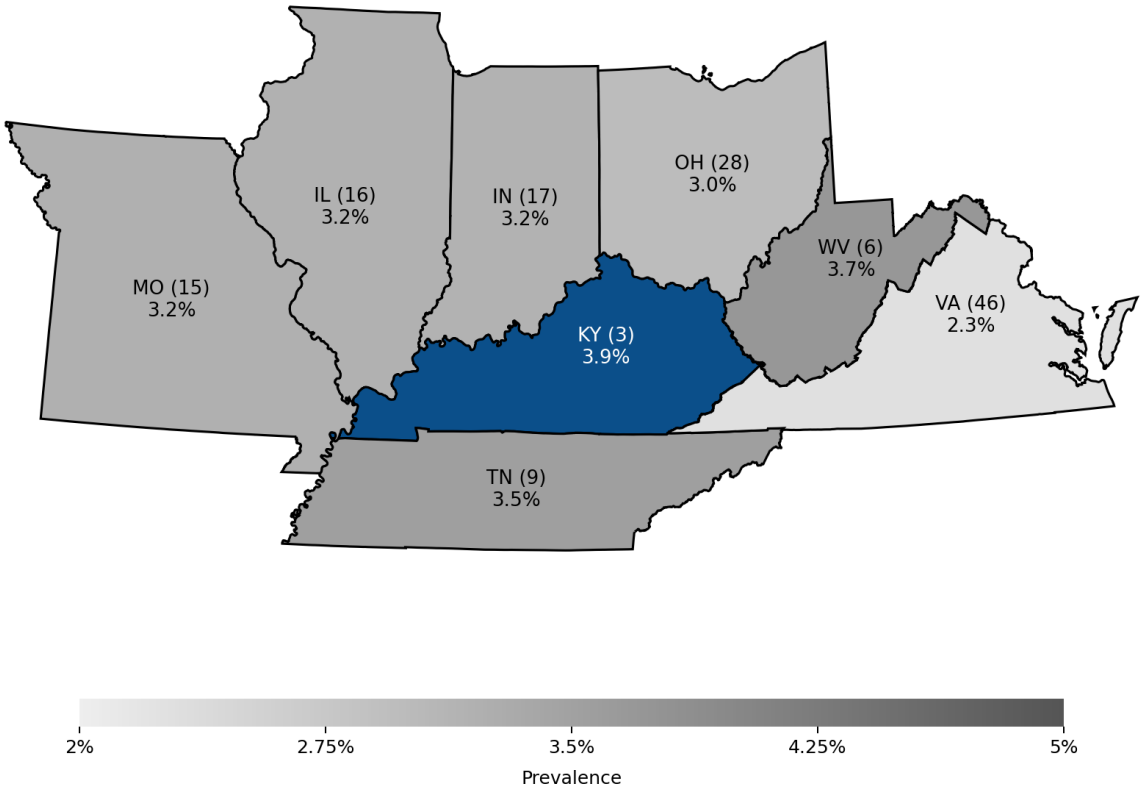
Notes: Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2023–2024*, Table 12. State estimates are annual averages based on the survey-weighted hierarchical Bayes small-area estimation approach. Legend ranges are based on values from all US states. These maps were generated using artificial intelligence (AI) based on the estimates reported in the cited SAMHSA data. Each state's national rank is in parentheses beside the state abbreviation.

Figure 11. Prescription Opioid Misuse in the Past Year, Ages 18+, 2023–2024



Notes: Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2023–2024*, Table 13. State estimates are annual averages based on the survey-weighted hierarchical Bayes small-area estimation approach. Legend ranges are based on values from all US states. These maps were generated using artificial intelligence (AI) based on the estimates reported in the cited SAMHSA data. Each state's national rank is in parentheses beside the state abbreviation.

Figure 12. Opioid Misuse in the Past Year, Ages 18+, 2023–2024



Notes: Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2023–2024*, Table 14. State estimates are annual averages based on the survey-weighted hierarchical Bayes small-area estimation approach. Legend ranges are based on values from all US states. These maps were generated using artificial intelligence (AI) based on the estimates reported in the cited SAMHSA data. Each state's national rank is in parentheses beside the state abbreviation.

Figure 13. Overdose Deaths Per 100,000 Population 2014-2024

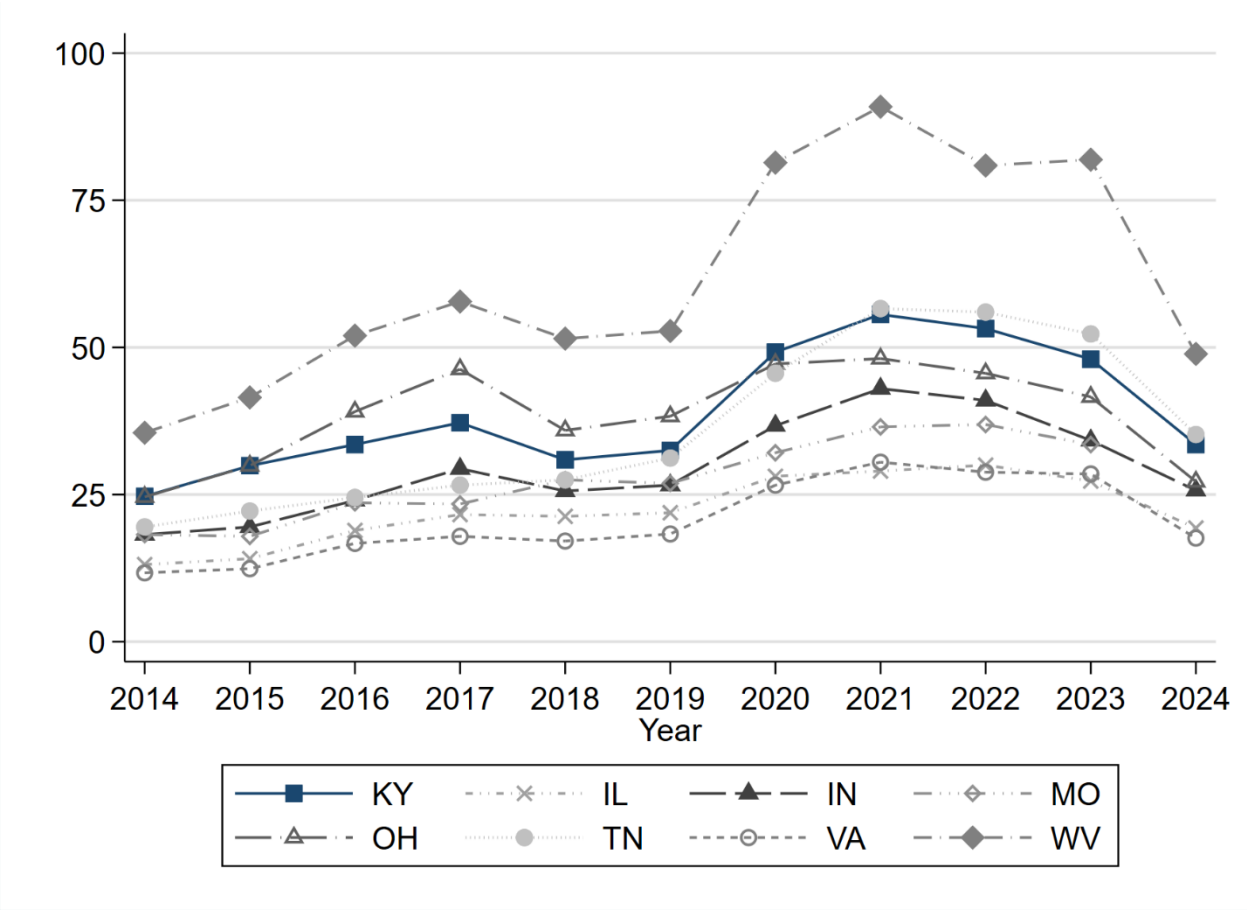
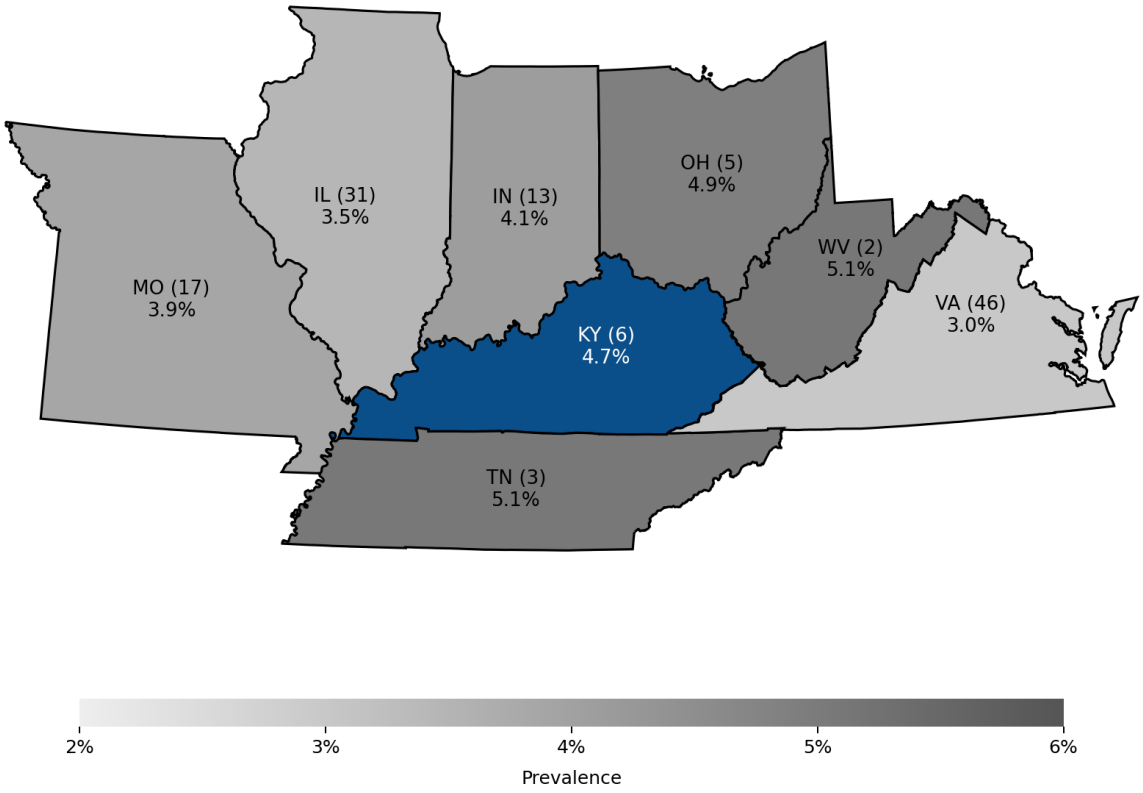
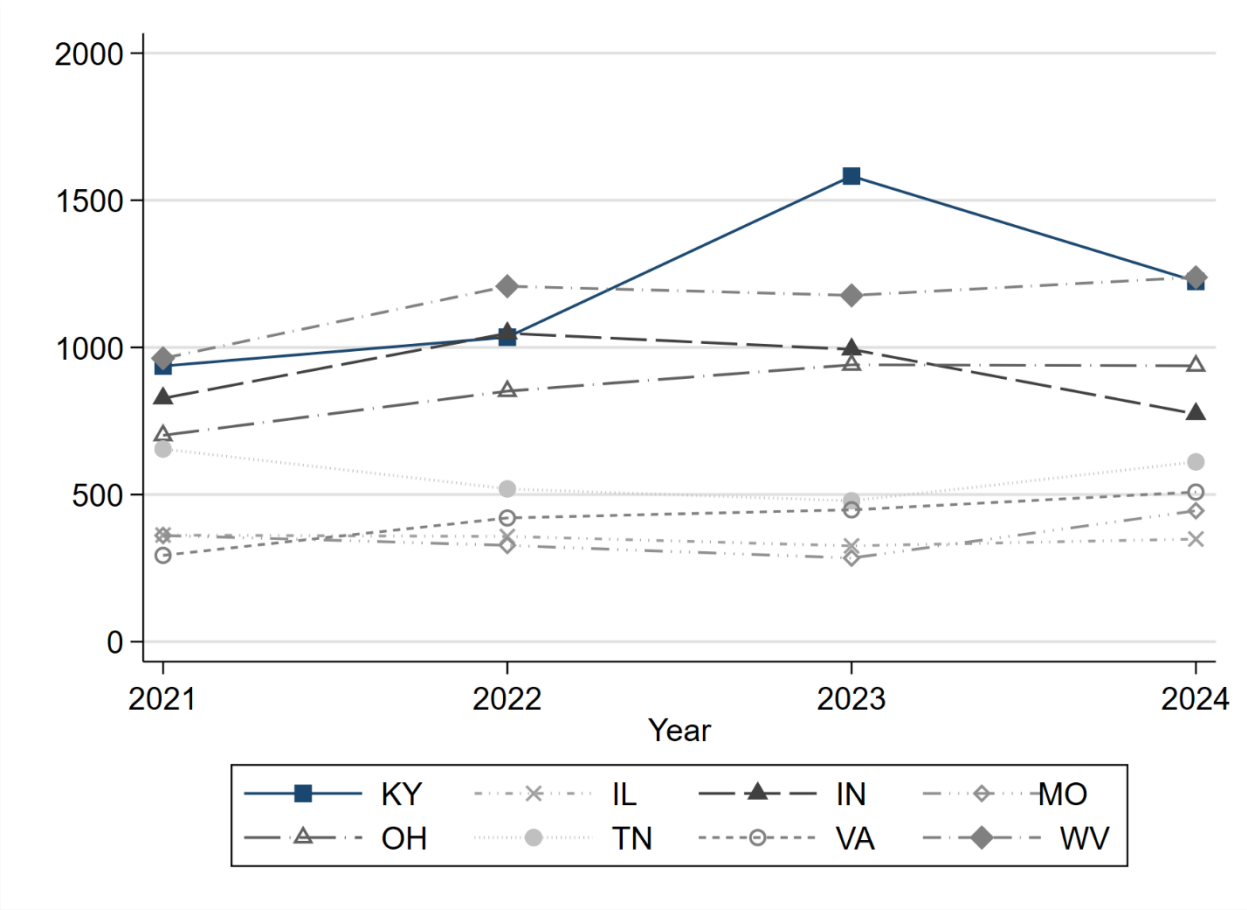


Figure 14. Received Substance Use Treatment in the Past Year, Ages 18+, 2023-2024



Notes: Data source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2023–2024*, Table 30. State estimates are annual averages based on the survey-weighted hierarchical Bayes small-area estimation approach. Legend ranges are based on values from all US states. These maps were generated using artificial intelligence (AI) based on the estimates reported in the cited SAMHSA data. Each state's national rank is in parentheses beside the state abbreviation.

Figure 15. Substance Use Clients in Treatment Per 100,000 Population 2021-2024



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