Breaking Point

An Urgent Call to Action on Emergency Department Safety

Australasian College
for Emergency Medicine

acem.org.au

About ACEM

The Australasian College for Emergency Medicine (ACEM; the College) is the not-for-profit organisation responsible for training emergency physicians and the advancement of professional standards in emergency medicine in Australia and Aotearoa New Zealand.

Our vision is to be the trusted authority for ensuring clinical, professional and training standards in the provision of quality, evidence-based, patient-centred emergency care.

Our mission is to promote excellence in the quality of emergency care to all communities through our committed and expert members.

Acknowledgement

ACEM acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia.

In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

Authorisation

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Introduction

This report, prepared by the Australasian College for Emergency Medicine (ACEM; the College), investigates the rising prevalence of violence in Australian emergency departments (EDs) and provides recommendations for addressing this issue. Utilising survey data, international research and other publications, ***Breaking Point: An Urgent Call to Action on Emergency Department Safety*** explores the key factors contributing to and sustaining violence. The report also examines the challenges in tackling this growing problem and offers a set of recommendations to support ACEM and its members in advocating for solutions at the Federal, State/Territory and local hospital levels to reduce violent incidents and enhance safety in Australian EDs.

Safe Work Australia defines workplace violence as any incident in which 'a person is abused, threatened or assaulted in circumstances arising out of or in the course of their work'.[1] Workplace violence also includes abuse through technology (text, email and phone calls).[2] By law, employers must provide a safe environment for their employees – but this is not happening in our health services.

It is unacceptable for any healthcare worker to be injured at work. Yet violence in healthcare settings and, more specifically, in EDs is a significant and growing problem both in Australia and worldwide. The ED is well recognised as a setting in which workplace violence is more likely to occur, although the true extent of violent incidents remains unclear due to a culture of under-reporting.[3][4] The World Health Organisation (WHO) estimates that between 8 per cent and 38 per cent of all healthcare workers globally have suffered violence during their careers.[5] International studies have found that up to 92 per cent of ED staff have experienced physical violence and 98 per cent have experienced verbal forms of abuse.[6]

While ACEM firmly believes that there is no justification for violent behaviour in the ED, understanding the underlying causes is essential as they influence the strategies used to manage such incidents. Causative factors that may be associated with violent behaviour include pain, grief, psychosis, dementia, delirium, intoxication via alcohol or other drugs, and anaesthesia.[7] Additionally, broader systemic issues and human factors such as excessively long waiting times at any stage throughout the patient journey, poorly understood triage systems, ED overcrowding and barriers to effective communication (including burnout and compassion fatigue) have been identified as contributing factors.

Having a comprehensive understanding of the experiences of ACEM members and trainees is essential for shaping the College's policy and advocacy efforts, training and education strategies, and workforce planning. ACEM gathers data from various sources and regularly reports on ED workforce trends, activity levels, workplace conditions, and the health and wellbeing of its members and trainees. According to ACEM's 2022 Sustainable Workforce Survey, 40 per cent of emergency physician respondents reported they were likely to leave emergency medicine in the next decade. The top two workplace stressors were overcrowding in the ED (77 per cent, an increase of 14 per cent from 2019), and access block (66 per cent, an increase of 10 per cent from 2019).[8]

The Australian healthcare system is in the middle of a workforce crisis, which has resulted in a significant shortage of trained professionals and a mass exodus of senior emergency staff due to burnout and stress. Workplace health and safety, including violence in EDs, is consistently ranked within the top 10 stressors of ACEM's members, and recently has risen to become one of the top five issues most negatively impacting on ED physicians.

Violence in Australian EDs is pushing the healthcare workforce to its breaking point. Urgent action is needed by Federal and State/Territory governments, as well as hospitals. Without immediate, systemic intervention, more highly skilled doctors and health professionals will leave, worsening patient care and further destabilising an already overwhelmed healthcare system.

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1   Safe Work Australia. Workplace violence: a definition [Internet]. Canberra ACT: Safe Work Australia; 2017

2   ACT Government. Towards a Safer Culture. 2021

3   Nikathil S, Olaussen A, Gocentas R, Symons E, Mitra B. Workplace violence in the emergency department: A systematic review and meta-analysis Emergency Medicine Australasia. 2017;29:265-75.

4   Victoria Auditor-General. Occupational Violence Against Healthcare Workers. Melbourne: Victorian Government Printer, 2015.

5   World Health Organisation. Violence against health workers. 2020

6   Caliban CJ, Johnston ANB. Review article: Identifying occupational violence patients risk factors and risk assessment tools in the emergency department: A scoping review. Emergency Medicine Australasia. 2019;31(5):730-740

7   Australasian College for Emergency Medicine. Violence in emergency departments (P32). Melbourne: ACEM. 2024

8   Australasian College for Emergency Medicine. Sustainable Workforce Survey 2022. Melbourne: ACEM. 2024

President's message

Emergency departments (EDs) and the staff working in them are always available when people are most in need of health care to manage urgent and life-threatening medical emergencies.

However, since COVID, ACEM members have been reporting that the public are becoming less tolerant and more aggressive, both verbally and physically. Violence in healthcare settings – and more specifically, in EDs – is a significant and growing problem. It's happening all over Australia, and it's happening every day. We're all seeing this and it's becoming harder to have a conversation and work things out in a reasonable manner.

Parts of the community view violence and aggression towards healthcare staff as an inherent part of working in an ED, but this is not what we signed up for. Healthcare workers choose this profession because we are passionate about health and wellbeing, and because we care about the health of the communities that we serve.

Violence in EDs has far-reaching consequences. It takes a toll on staff morale, contributes to burnout and is a significant factor in experienced healthcare professionals choosing to leave the workforce. High staff turnover places additional strain on already stretched resources, increasing costs and making it harder to provide timely, high-quality care.

We recognise the complex and nuanced issues that impact upon diverse population groups and that there are clinical factors associated with violent or unsafe behaviours – such as pain, grief, psychosis, dementia, and intoxication via alcohol and other drugs.

EDs across the country are seeing more and more patients every year due to growing gaps in health services. This enormous demand for care in our EDs, along with worsening access block, means that patients are experiencing increasingly longer wait times for care. Violence disrupts patient care, potentially leading to even longer delays and poorer outcomes, and negatively impacting everyone present – staff and other patients.

When we talk about violence in EDs, it is important to make a clear distinction between the medically unwell and those whose expectations were not met. Consistent reporting and access to data is desperately needed so that we can implement the right strategies to safely manage these incidents.

No professional should experience daily assaults at work. We dedicate our lives to saving others and we should not have to fear for our personal safety while doing so. It's time for a national conversation about violence. We call for greater protection for all healthcare workers and communities in EDs because everyone has the right to provide and receive health care safely.

Emergency doctors across Australia want hospitals to be safe spaces for healing. It is time to declare violence in healthcare settings a national crisis, with ACEM calling for urgent coordinated action from all levels of government.

All staff, patients and carers need to be safe to deliver, receive and support healthcare. We are urging long-term solutions to the system-wide issues that accelerate violence and aggression in EDs. Right now, we just need to keep everyone safe.

Dr Stephen Gourley
ACEM President

About the report

Survey

A snapshot survey to investigate the prevalence and impact of violence in EDs was sent to the Directors of Emergency Medicine (DEMs) at all 131 ACEM-accredited EDs. The College accepted submissions for a period of seven weeks, from 8 August to 22 September 2024.

A total of 123 submissions were received, representing 85 (65 per cent) of the 131 ACEM-accredited EDs in Australia. (*Multiple submissions were made from some sites.)

Workplace descriptors	Represented EDs	Number of respondents	%
Australian jurisdictions	85	123	
ACT	2	3	2%
NSW	22	31	25%
NT	2	2	2%
QLD	17	30	24%
SA	6	12	10%
TAS	2	2	2%
VIC	23	25	20%
WA	11	18	15%
Sector			
Public	80	118	96%
Private	5	5	4%
Primary workplace remoteness			
Major city	61	90	73%
Regional, rural, remote (RRR)	24	33	27%

Table 1: Distribution of participating Australian EDs by jurisdiction and by workplace/ED descriptor.

Summary of the results

- **Nine out of 10 respondents reported that there had been an incident (or multiple incidences) of violence exhibited by a patient or accompanying person in their ED within the past week, with 79 per cent reporting that this included physical violence incidents.**
- **Nine out of 10 respondents reported that verbal violence occurred daily or frequently (one or more times per week).**
- **More than half (55 per cent) reported that physical violence occurred daily or frequently in their ED.**

The survey findings showed that violent incidents are significantly under-reported. The reasons for under-reporting are complex but can be understood in three separate categories. Firstly, reporting systems range from very advanced to less sophisticated, and incidents that are caused by a medical reason or seen as minor are not reported due to the time-consuming nature of reporting. Secondly, survey respondents felt that their concerns regarding ED violence were not being taken seriously enough by hospital executives, leading to a loss of confidence in reporting. Lastly, and most troubling, is the narrative that violence and aggression are seen as part of working in EDs – which leads to a sense of resignation that reporting will not create change.

There was substantial variation in the level of training and access to hospital security officers. Slightly more than half of responding EDs (51 out of 85) have access to ED-based hospital security officers, with 44 out of those 51 EDs having access to around-the-clock ED-based hospital security officers. A considerable proportion

of responding EDs (39 per cent) had only limited access to security, relying on hospital security officers who were responsible for providing coverage to the entire hospital and surrounding grounds. The data indicated that the effectiveness of hospital security officers in increasing ED safety was entirely contingent upon the level of resourcing, training and their integration into the multidisciplinary team.

ED overcrowding and access block are the primary drivers of violent incidents and are further compounded by underinvestment in vital healthcare services, rising patient demand and overloaded and stressed hospitals. Inadequate ED infrastructure and inconsistent security measures contribute to safety concerns. Additionally, a lack of public awareness regarding the role of the ED, triage processes and non-hospital alternative care options contribute to patient frustration and increase the likelihood of violence.

A full analysis of the survey is presented from page 10, while a summary of the recommendations is located in the next section.

Recommendations

1. Improve reporting systems and foster a culture of reporting violent incidents

The full extent and impact of violence on ED staff cannot be properly understood, nor can resourcing for prevention and intervention strategies be appropriately provided, without a clear understanding of the scale and nature of violence happening in our EDs. **It is incumbent on all levels of government and on our hospitals to take responsibility for addressing violence against hospital staff.** Any progress towards eliminating violence in EDs will require nationally consistent reporting tools, strong regulatory support and instituting and supporting a culture where reporting is encouraged and action is taken.

Recommendations for the Federal Government

a. The Commonwealth should develop **standardised reporting tools** and establish a **centralised incident reporting system** for use across all Australian States and Territories.

b. The Commonwealth should **tie regular jurisdictional reporting on ED safety to hospital funding agreements** with the State and Territory Governments.

c. The Commonwealth should ensure that **annual data on ED safety is made publicly available**. ED safety data that includes a measure of staff experiencing violence and aggression should be included as a metric in the Australian Institute of Health and Welfare's Australian Health Performance Framework.

d. The Commonwealth, through the Australian Commission on Safety and Quality in Health Care (ACSQHC), should **incorporate public reporting on violence and aggression as a quality and safety measure into the ACSQHC accreditation standards.**

Recommendations for State and Territory Governments

e. State and Territory Governments and Health Departments need to acknowledge the severity of the problem. **Addressing violence against hospital staff should be made a priority issue** for health departments.

f. State and Territory Governments, through their respective health departments, should **establish stronger regulatory requirements** that clearly specify the obligations of hospitals and health services to provide safe work environments. This includes legislation, policies, procedures and risk-assessment tools that can be adapted to the local hospital context.

g. State and Territory Governments, through their respective health departments, should take an active role in monitoring and reporting on ED safety. This should include **monitoring and evaluation** of ED safety in public hospitals, **regular public reporting**, including incident trends and changes over time, and **providing necessary resources** to address barriers preventing a hospital from reporting.

Recommendations for Hospitals

h. As employers of healthcare workers, hospital and health services have a legal obligation to provide a safe work environment for their staff and must **take responsibility for enacting changes to prevent violence.**

i. Hospital and health service management need to **take the lead in fostering a culture of reporting.** As with other occupations, hospital staff deserve a workplace where reporting any violent incident is encouraged, expected and acted on regardless of the severity.

j. Hospital and health service managers must **advocate for necessary resources** from State and Territory health departments where needed, to support healthcare workers to prioritise reporting incidents.

Recommendations

2. Develop the hospital security officer role

Hospital security officers play a crucial role in enhancing ED safety when they are appropriately trained, integrated into the multidisciplinary team, and available in EDs when needed. These benefits will be most visible if hospitals move away from the practice of using contract and third-party providers. **To ensure effective security in healthcare settings, the hospital security officer role must be formally recognised, with clearly defined competencies, stronger professional and regulatory support, and adequate resourcing.** Security officer coverage should be aligned with the specific needs of each facility to maintain a safe environment for staff, patients and accompanying persons.

Recommendations for the Federal Government

a. The Commonwealth should **formally recognise the hospital security officer role as an integral member of multidisciplinary teams.** This should include a nationally consistent description of the role and responsibilities.

b. The Commonwealth should **introduce a national set of competencies** that distinguishes the hospital security officer role from other security roles by specifying training requirements and professional competencies.

c. The Commonwealth should **incentivise registered training organisations to support the training of this workforce** by providing funding to deliver specific educational units that meet the competency requirements of the hospital security officer role.

Recommendations for State and Territory Governments

d. State and Territory Governments should ensure that dedicated, specifically trained hospital security officers are employed by hospitals as part of the ED team and **are always available.** There should be dedicated funding allocated to ensure there is appropriate FTE available for these roles.

e. State and Territory Governments should **run a public recruitment drive** that describes the important role of hospital security officers, highlights the opportunities for a purposeful and fulfilling career in the healthcare sector and promotes no-fee TAFE courses for people who successfully complete their training and serve a prescribed period of employment as a hospital security officer.

f. State and Territory Governments should **provide legal frameworks and clear guidance** to ensure hospitals understand the legal obligations and safeguards that legally protect hospital security officers.

Recommendations for Hospitals

g. Hospitals should **directly employ and train hospital security officers** as an integrated part of the multidisciplinary team. These roles should not be outsourced to private security companies.

h. Hospitals should **provide ongoing advice to State and Territory health departments regarding FTE requirements for hospital security officers** to ensure that hospital security officers are always available in the ED and that the coverage is commensurate with local needs.

i. Hospitals should **provide a thorough induction and ensure that all hospital security officers receive ongoing training and support.** It is imperative that in circumstances where all reasonable attempts to de-escalate a threatening situation have been unsuccessful, the 'rules of engagement' are clearly understood and adhered to.

Recommendations

3. System-wide interventions

To address these challenges, a whole-of-system approach is required. **Greater investment in primary care, non-hospital alternatives, mental health and addiction services, and aged care services is essential to reduce the number of avoidable ED presentations.** All levels of government need to take a coordinated approach to increase public awareness of when and where to seek care. Additionally, strengthening ED infrastructure and security measures is critical to protecting staff, patients and accompanying persons.

Recommendations for the Federal Government

a. The Commonwealth should **declare violence against healthcare workers a national crisis** and run a comprehensive campaign to raise greater public awareness of the prevalence and severity of the violence being inflicted and the profound impact it is having on healthcare workers across Australia.

b. The Commonwealth should **improve funding and service models for aged care services.** This should include increasing the occurrence of medical care that is provided in residential aged care facilities (RACF), providing adequate resourcing to improve the documentation and implementation of advance care directives in RACFs and expanding the availability of palliative care services.

c. The Commonwealth, through the Australian Commission on Safety and Quality in Health Care (ACSQHC), should **introduce a National Standard on violence and aggression** that sits alongside other standards contained within the *National Safety and Quality Health Service Standards* (NSQHS).

Recommendations for State and Territory Governments

d. State and Territory Governments should **take responsibility for the causative factors outside the control of EDs that contribute significantly to violent incidents** by committing to desperately needed whole-of-system reforms to address ED overcrowding, access block and prolonged ED lengths of stay.

e. State and Territory Governments should **have an explicit goal of preventing avoidable ED presentations.** This accountability should be shared with the Commonwealth and can be achieved through more effective funding, monitoring, evaluation and coordination of services.

f. State and Territory Governments should **improve funding and service models for mental health and addiction services.** This includes inpatient units and associated staffing to meet the demand for care, step-up/step-down services and community-based supports commensurate with the burden of disease.

g. State and Territory Governments should **ensure that hospitals have timely access to police when required.** This should also include clear instruction requiring police to remain with violent offenders when requested by hospital staff.

Recommendations for Hospitals

h. Hospitals should **ensure that ED staff have access to ongoing support and advice regarding their legal responsibilities and medico-legal protections.** This includes circumstances under which treatment can be refused or withdrawn or violent people removed from the ED if they do not have an illness or injury requiring time-critical care.

i. Hospitals should **provide regular training for all staff**, including nursing, medical, administration, hospital security staff and any other staff working in the ED. Training could also involve external stakeholders, including police, emergency services staff and other health services, especially in rural and regional areas.

j. Hospitals should ensure that **all staff members have access to personal and/or fixed duress alarms.** Patient alert systems that generate a signal to warn staff of any potential risk, to themselves and others, should also be encouraged.

Results

1. The prevalence of violence is unacceptably high

Nine out of 10 DEMs reported having experienced violent incidents in their ED in the past week

The prevalence of violence occurring within EDs has always been difficult to capture due to historic and widespread under-reporting. However, 91 per cent of DEMs reported there had been an incident(s) of violence exhibited by a patient or carers in their ED within the past week, with 79 per cent reporting that this included physical violence.
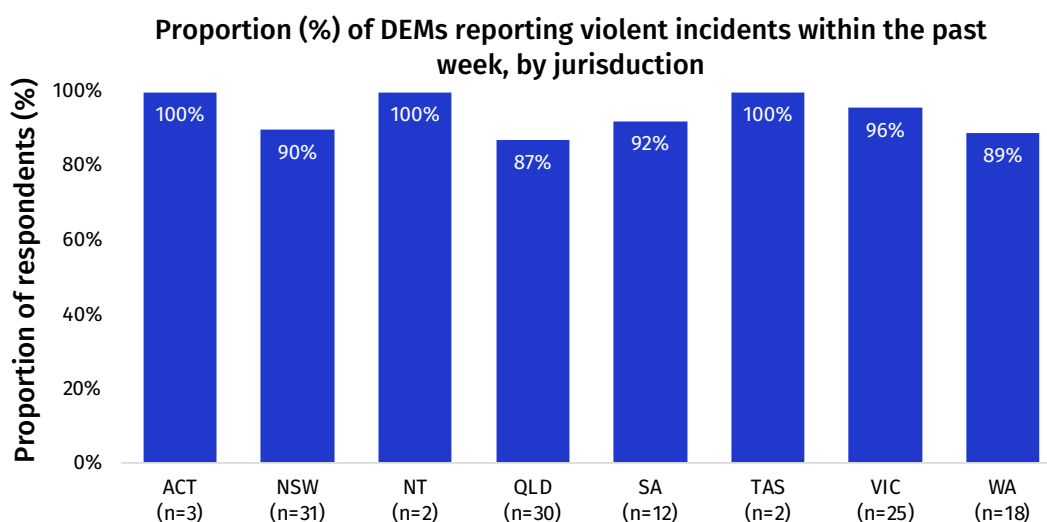
Proportion (%) of DEMs reporting violent incidents within the past week, by jurisduction

Figure 1: Proportion of DEMs (n=123) reporting an incident of violence in their ED within the past week of the survey, by jurisdiction.

How frequently are violent incidents occurring?

Startlingly, 55 per cent of DEMs reported that physical violence occurs in their ED daily or frequently (i.e. one or more times per week), while 90 per cent of DEMs reported verbal violence occurred daily or frequently. There were similarities in the prevalence of violent incidents reported by DEMs working in metropolitan and rural, regional and remote (RRR) EDs: verbal violence (91 per cent metropolitan vs. 88 per cent RRR) and physical violence (53 per cent metropolitan vs. 61 per cent RRR).
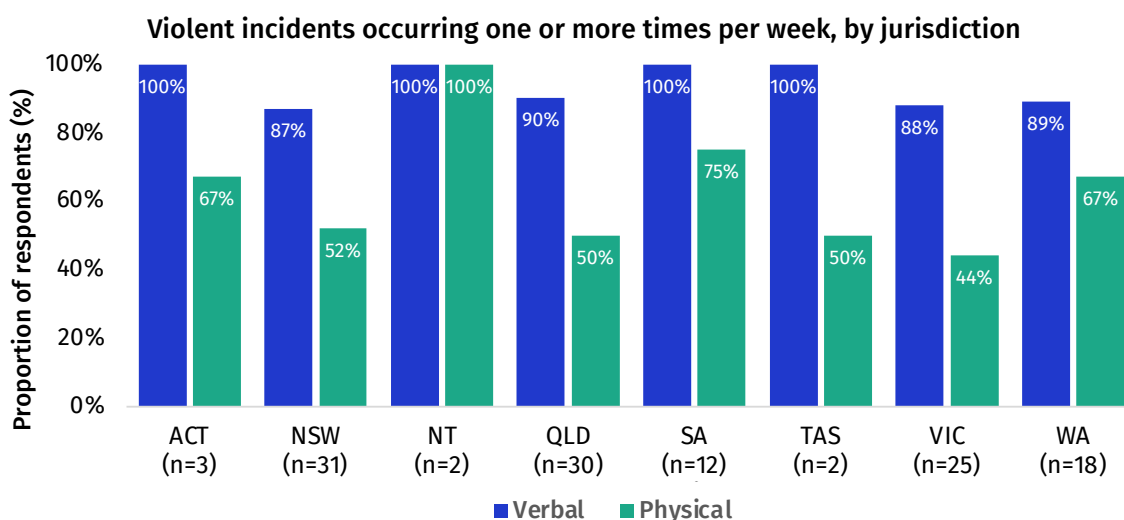
Violent incidents occurring one or more times per week, by jurisdiction

Figure 2: Proportion of DEMs (n=123) reporting frequent occurrences of verbal and physical violence in their ED, by jurisdiction.

2. Violent incidents are under-reported

How often are violent incidents reported?

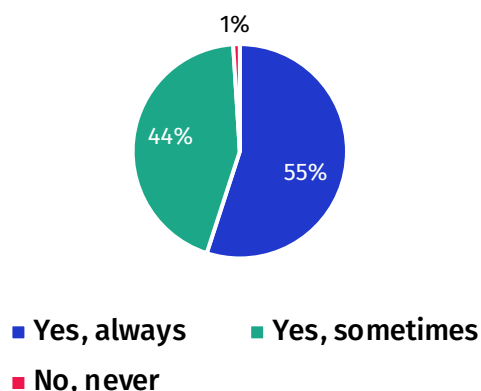#### Does physical violence get routinely reported?

■ Yes, always　■ Yes, sometimes
■ No, never

Figure 3: Proportion of DEMs (n=123) indicating whether incidents of physical violence in their ED were routinely reported.

Does verbal violence get routinely reported?

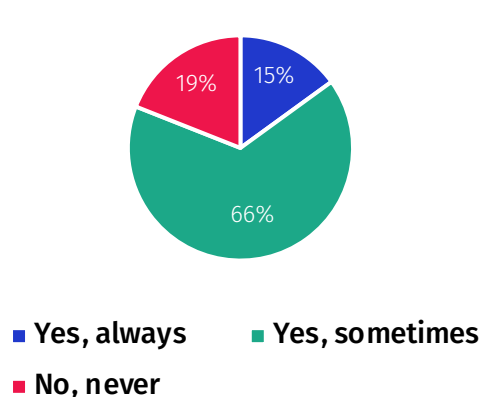■ Yes, always　■ Yes, sometimes
■ No, never

Figure 4: Proportion of DEMs (n=123) indicating whether incidents of verbal violence in their ED were routinely reported.

Why do so many violent incidents go unreported?

The reasons for under-reporting of violent incidents are many and varied, but there are two key factors identified by DEMs and in the literature that explain this: there are inconsistent reporting systems and many workplaces lack a strong culture of reporting.

Reporting systems are often complicated and time consuming, and violence often goes unreported when due to a medical reason, unless the police become involved or there is a major injury. Furthermore, state/ territory and local reporting is often performance related, and the quality of information captured ranges from very advanced to less sophisticated.

A common theme observed in the qualitative responses was that respondents shared the view that violence in EDs was not being taken seriously enough by hospital executives and that ED teams felt unsupported in understanding and addressing the issue.

Perhaps most troubling is the narrative that violence and aggression are seen as an inherent part of working in EDs.[3] There is a degree of despondency among ED staff about change being possible, and this is most evident when reports are made and no action is seen to be taken, or the blame is attributed to the ED staff member rather than the perpetrator.

> *'The ED is becoming a more hostile environment to work in. Daily occurrences of physical or verbal violence likely cause a degree of desensitisation. Most are afraid to take action for fear of complaints or legal repercussions.' – Emergency Physician, Queensland*
>
> *'(Violence) has become so routine that it doesn't feel worth doing the form. Executives do not act on the countless examples of violence.'- Emergency Physician, Western Australia*
>
> *'We have been lobbying the health service executive for nearly two years now but they are not listening. We log every incident (at their request) but they do not have interest in looking at the data.' – Emergency Physician, South Australia*
>
> *'The reporting system is onerous and not easily accessible. As nothing seems to change there is a learnt helplessness to report. Some staff think someone else will report. A recent audit on Code Blacks revealed only 25-30 per cent of Code Blacks are reported in the safety event system.' - Emergency Physician, Tasmania*

3. Access to appropriately trained hospital security officers is highly varied

How many sites have access to hospital security officers?

DEMs were asked to provide detail regarding what level of access their ED had to hospital security officers. Less than two-thirds (60 per cent) of responding EDs have access to ED-based security staff. Of these 51 EDs, 44 had access to around-the-clock ED-based hospital security officers. **A considerable proportion of responding DEMs (39 per cent) confirmed that they only had access to hospital-wide security staff, meaning that they did not have an ED-based security presence.** Hospital-wide is distinct from ED-based, in that they are a resource shared across the entire hospital and surrounding grounds.
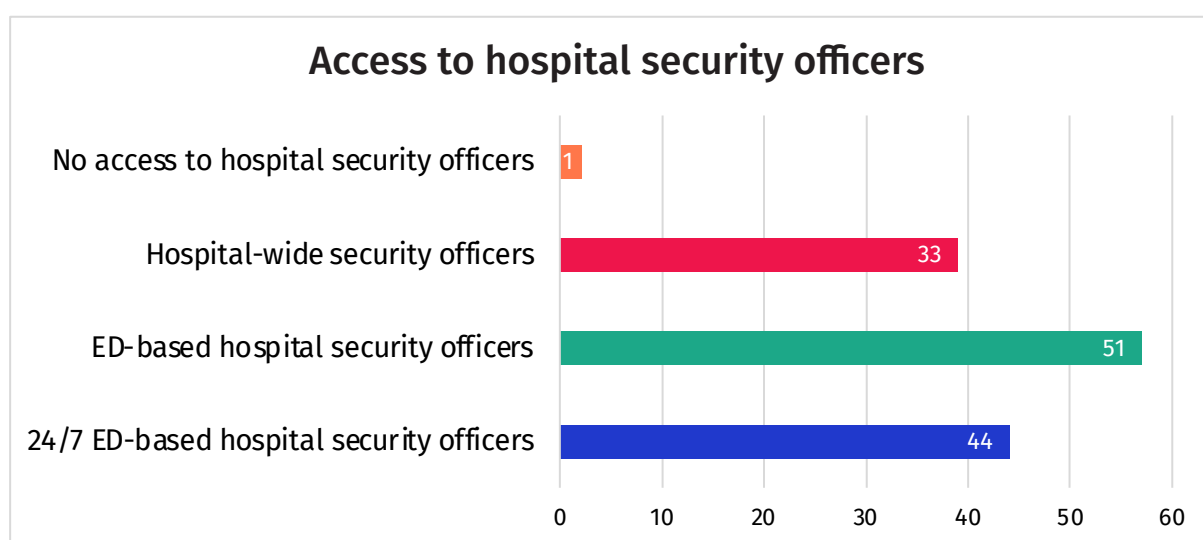
Access to hospital security officers

Category	Value
No access to hospital security officers	1
Hospital-wide security officers	33
ED-based hospital security officers	51
24/7 ED-based hospital security officers	44

Figure 5: Access to hospital security officers.

What did the respondents say about their hospital security staff?

A total of 108 DEMs commented on the effectiveness of hospital security officers in protecting the safety of the staff, patients and accompanying persons. About half of the respondents indicated that hospital security officers were effective when they were present, although many also mentioned the effectiveness of these roles would be greater if there were enough ED-based hospital security officers available.

> *'We have an extremely good security service with excellent staff. We consider the security staff part of our ED team.' – Emergency Physician, New South Wales*
>
> *'The number of security staff is insufficient to cover the need. When present, they are effective.' – Emergency Physician, New South Wales*
>
> *'Very good staff. Good awareness. Very interactive and communicative. Only there are limited numbers, so if (there are) issues across multiple areas, (it) can be difficult for them.' – Emergency Physician, Queensland*
>
> *'They are very effective when present but frequently attend codes in other parts of the hospital. Concurrent Code Grey/Black occur frequently in our health service and there is insufficient FTE to meet the demand.' – Emergency Physician, Victoria*

Those who reported only having access to hospital-wide security consistently expressed that they needed at least two ED-based hospital security officers. Many respondents identified several limiting factors that could be grouped into three key themes: that the system is too overstretched to meet the demands, that some hospital security officers lack an adequate level of training and support for the hospital setting, and the outsourcing of these roles to a third-party provider often meant that there was a lack of clarity regarding their roles and responsibilities.

'They are a physical presence only. Some are not fit enough for the job or too timid. Many won't get involved physically. Refusal to search or physically get involved for fear of legal ramifications as NSW doesn't give security special constable powers.' – Emergency Physician, New South Wales

'It is less than ideal to have a third-party provider. They are not trained and often don't seem to have a good understanding of their role and responsibility in the ED.' – Emergency Physician, Northern Territory

'Not being employed directly by the hospital/ED, there is more turnover of security staff and less of a feeling of membership of the team.' – Emergency Physician, Victoria

'Bring security staff under the ED staffing model and have them employed and trained in-house.' – Emergency Physician, Northern Territory

'We need more security personnel in ED 24 hours per day (and…) employed by ED so that they cannot be redeployed to the rest of the hospital.' – Emergency Physician, Queensland

Why is the feedback so mixed?

Insufficient numbers of hospital security officers came through as the strongest limitation to the effectiveness of these roles. Of the responding EDs that only had access to hospital-wide hospital security officers, with no ED-based security presence, it was common that a small team (two to four staff) needed to cover the entire hospital and the surrounding grounds, making it almost impossible to arrive on the scene until after the incidence of violence had already occurred.

The next-most-identified limitation was training and support for hospital security officers. **There are no national standards for security officers in healthcare settings.** Each jurisdiction has developed its own guidelines which assign the responsibility for security at the hospital level, despite the commonalities between each hospital in terms of risk profile. In addition to there being a lack of consistent guidance, only a limited number of registered training organisations (RTOs) provide training in healthcare security across Australia. Additionally, regulatory changes that apply only to the care of specific patient cohorts have created widespread confusion regarding the management of involuntary or behaviourally disturbed patients. As a result, hospital security officers often do not feel empowered to control violent behaviour effectively. They are therefore reluctant to use physical force due to lack of certainty around their legal rights and are subsequently fearful of any potential repercussions.

Contracted or agency security were seen to be far less effective than hospital security officers who were employed and trained by the hospital. The Occupation Shortage List (OSL), produced by Jobs and Skills Australia, lists security officers as an occupation in short supply in every State and Territory except for Victoria.[9] The heavy reliance on the private sector to provide in-demand skilled workers often means that in addition to having high turnover of hospital security officers, there are also significant challenges in ensuring that every shift of every day is filled. There is a lack of consistency and feeling of membership of a team. Contracted or agency security are also not getting the training and support they need to be effective in de-escalation and managing violent behaviour.

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9   Jobs and Skills Australia [internet]. Occupation Shortage List. Canberra ACT: Commonwealth of Australia. 2025.

4. Systemic issues are the main causative factors of violence

EDs are under more pressure than ever before in a poorly resourced system

The vast majority of respondents identified access block and ED overcrowding as the primary causative factors that contribute to violent incidents in EDs. Access block is the single most serious issue facing EDs and the major contributor to ED overcrowding.

Widespread underinvestment across all parts of the healthcare system – particularly in the public health system, including mental health and addiction services, primary care, allied health, and aged care – are widely recognised as key contributors to the rising number of ED presentations. **Patients whose healthcare needs are unmet in the community often arrive at EDs with more severe conditions, requiring hospital-based care, which in turn exacerbates access block and overcrowding.**

Between 2014-15 and 2023-24, the demand for ED services in Australia has increased by 20 per cent to more than 9 million, outpacing population growth which is estimated to have increased by 14 per cent over the same period.[10] [11] [12] Since 2019-20, 90 per cent of all ED visits across Australia were completed within 10 hours and 45 minutes, an increase of 3 hours and 15 minutes. The ED length of stay was even longer among those requiring hospital admission, where it took more than 18 hours for most (90 per cent) patients to leave the ED for an in-patient hospital bed. ACEM recommends that most (90 per cent) patients requiring hospital admission leave the ED within eight hours.

In addition to the increasing number of ED presentations to public hospitals, there was an increased proportion of ED presentations for First Nations Australians and older patients aged over 65. The proportion of presentations that required hospital admission remained high at 30 per cent, and worse, nearly one in every 10 patients left the ED before their treatment completion. Only two-thirds (67 per cent) of total ED presentations were seen on time based on the respective triage categories.[10]

All of this means that patients are presenting to EDs with increasingly complex health needs, requiring more time and more resources from across the entire healthcare system. Hospital occupancy remains a significant issue, placing immense pressure on hospitals and directly affecting the functioning of EDs. ACEM recommends an occupancy rate of 85-90 per cent (or lower) to ensure there is capacity in the system to accommodate surges in demand. However, hospitals across Australia are frequently operating at or above full capacity, often exceeding 100 per cent occupancy. **When hospitals are full, EDs are unable to transfer patients who require inpatient care, ultimately hindering their ability to provide timely treatment to incoming patients.**

When asked to comment on the reasons behind the deterioration of the situation, survey respondents said the following:

'Many factors: 1. Worsening mental health of consumers related to cost of living and lack of availability of bulk-billed medical care. 2. Increasing community use of drugs and alcohol. 3. Emergency department overcrowding resulting in long waits to be seen. 4. Unrealistic community expectations of what the role of emergency departments are in the broader delivery of health care. 5. The changes to restrictive intervention laws in the new mental health act reduce the use of restrictive interventions but may increase the risk of verbal and physical violence.' – Emergency Physician, Victoria

'Waits: in the waiting room/in the ED for an inpatient bed/for a mental health bed (sometimes for days). System overload compounded by 25 per cent down on nursing FTE and that we have replaced 80 per cent of our nursing staff in the past three years (all much more junior so the functional FTE is much lower).' – Emergency Physician, Northern Territory

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10   Australian Institute of Health and Welfare. Emergency department care 2023-24: Australian hospital statistics. Canberra ACT: AIHW; 2025.

11   Australian Bureau of Statistics [internet]. National, state and territory population. Canberra ACT: Commonwealth of Australia; June 2015 (released 17 December 2015).

12   Australian Bureau of Statistics [internet]. National, state and territory population. Canberra ACT: Commonwealth of Australia; June 2023 (released 14 December 2023).

'Violence is proportional to overcrowding (and) also affected by lack of staff/junior nature of staff/ burnt-out staff/number of patients in the ED who should be in a secure unit but can't get access due to lack of beds ... we have enacted all the usual things but there comes a point where overcrowding is so severe that violence breaches good systems.' – Emergency Physician, Northern Territory

'Increases in the number of presentations with drug-induced psychosis especially associated with methamphetamines. Police transporting patients to ED with aggressive/erratic behaviour as concerned that underlying medical or psychiatric issue and for 'medical clearance' prior to arrest. Police less risk tolerant. Lack of mental health beds so patients stay in the ED longer.' – Emergency Physician, New South Wales

'Increasing access block resulting in increased waits. Still no Acute Psychiatric Unit within the region, resulting in acutely psychotic patients remaining within the ED for multiple days, often more than five days.' – Emergency Physician, Western Australia

Emergency department infrastructure and security measures are often inadequate

Although the survey did not include specific questions about ED infrastructure, many respondents identified the design of their ED as a common contributing factor. They reported that their EDs were often unable to adequately meet the needs of staff, patients and accompanying persons. Additionally, feedback on the availability and effectiveness of security measures such as duress alarms and CCTV in preventing violent incidents was mixed.

When asked to identify problems and opportunities to improve the security and safety in their ED, DEMs made the following remarks:

'Personal duress alarm availability. Uncontrolled exit point for aggressive patients to leave ED from - this was removed last week as a response to an involuntary patient leaving through it. If that patient had remained in the department the safety of everyone else within the department would have been at risk.' – Emergency Physician, Western Australia

'The duress alarms are hopeless. They go off like the boy who cried wolf, and they are complicated to deliberately activate. If doctors start wearing them there is constant alarm for some hours until they give up.' – Emergency Physician, New South Wales

'Improved infrastructure, larger waiting room and breakout area for paediatric and vulnerable patients.' – Emergency Physician, Queensland

'Pretty hard problem to solve really ... build EDs with a whole section of individual rooms that can be quiet and more contained for mental health patients.' – Emergency Physician, Western Australia

Limited public awareness of the services EDs can provide

EDs play a crucial role in the healthcare system, providing expert medical care for undifferentiated, unscheduled patients with illnesses and injuries at all hours of the day or night. However, there remains a significant lack of public awareness regarding their function and proper utilisation. **The over-reliance on EDs stems in part from decades of underinvestment in vital healthcare services. EDs are too often called upon to cover service gaps well beyond the limit of what they can feasibly manage.** As a result, they have become the primary entry point into the broader hospital and healthcare system for many members of the community. While there has been an increase in non-hospital alternatives (Urgent Care Centres, after-hours medical centres and telehealth services) to manage urgent but non-life-threatening conditions, the existence of these services is not widely known by all members of the public, while others may view the ED as a catch-all for any medical issue.

Another significant issue is the widespread misconception that EDs operate on a first-come first-served basis. As noted, prolonged waiting times and ED overcrowding are frequently linked to violent incidents. Additional contributing factors include a lack of understanding of the triage process, communication

barriers, and unmet expectations regarding the services available to patients. Many individuals expect immediate treatment upon arrival, unaware that patients are prioritised based on clinical urgency through triage. This misunderstanding often leads to frustration, particularly when patients with less critical conditions experience long waits. Prolonged waits are not just inconvenient – they are also linked to increased violent incidents in the ED, particularly in the triage area.

'Primarily, our society seems to accept that anger and aggression is ok. It's not ok. The community is not held to any behavioural standards when they enter the ED. Prolonged waiting times are often a factor - waiting for a doctor, waiting for a bed, waiting for tests. Even when this is explained to patients, some get angry when their expectations are not met.' – Emergency Physician, Victoria

'Some of the violence we experience is a sad reflection of our society. We are not alone in experiencing this phenomenon. But the consequences of this on staff and other patients are significant.' – Emergency Physician, Victoria

'The main reason is the lack of accountability and repercussions the community experience as a result of attacking staff. Most are, at worst, escorted out of the building. Very few are arrested and fewer still are prosecuted. A large number of these people are drug-affected with some form of psychosis and people feel that pursuing legal recourse is a waste of our time.' – Emergency Physician, Queensland

Conclusion

The findings of this report confirm that violence in Australian EDs is an escalating crisis that demands immediate and systemic intervention.

It is unacceptable that healthcare workers continue to face verbal and physical violence in their workplace, yet such incidents are occurring daily, mostly unreported, and are often normalised by parts of the community as part of the job. The consequences of this ongoing crisis are severe, not only for the safety and wellbeing of healthcare professionals, but also for the sustainability of the healthcare workforce and the quality of patient care that is available in EDs.

The root causes of violence in EDs are multifaceted, with, access block, overcrowding, underinvestment in healthcare services, and inadequate security measures all recognised as significant structural causative factors beyond the control of EDs to address.

The prevalence of violence is further exacerbated by a lack of security training, insufficient hospital security presence, and public frustration stemming from long wait times and unmet expectations of patients.

Addressing these systemic failures requires decisive action from Federal, State/Territory governments, and healthcare institutions. The conditions we are reporting on will drive experienced professionals out of emergency medicine and push an already overworked and burnt-out ED workforce into a deeper crisis.

ACEM's advocacy efforts, as outlined in this report, provide a clear roadmap for change. To protect healthcare workers and ensure patient safety, governments and hospital leadership must commit to systemic reforms that address the core issues contributing to violent incidents in EDs. This includes investment in hospital infrastructure, appropriate resourcing for the development and expansion of the hospital security officer role, and improved security protocols.

A cultural shift is also required – one that acknowledges the severity of ED violence, strengthens reporting mechanisms, and fosters a workplace environment where safety is a priority, not an afterthought. The time for action is now, before the crisis becomes irreversible.

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Recommendations for the Federal Government

- The Commonwealth should develop standardised reporting tools and establish a centralised incident reporting system for use across all Australian States and Territories.

- The Commonwealth should tie regular jurisdictional reporting on ED safety to hospital funding agreements with the State and Territory Governments.

- The Commonwealth should ensure that annual data on ED safety is made publicly available. ED safety data that includes a measure of staff experiencing violence and aggression should be included as a metric in the Australian Institute of Health and Welfare's Australian Health Performance Framework.

- The Commonwealth, through the Australian Commission on Safety and Quality in Health Care (ACSQHC), should incorporate public reporting on violence and aggression as a quality and safety measure into the ACSQHC accreditation standards.

- The Commonwealth should formally recognise the hospital security officer role as an integral member of multidisciplinary teams. This should include a nationally consistent description of the role and responsibilities.

- The Commonwealth should introduce a national set of competencies that distinguishes the hospital security officer role from ordinary security roles by specifying training requirements and professional competencies.

- The Commonwealth should incentivise registered training organisations to support the training of this workforce by providing funding to deliver specific educational units that meet the competency requirements of the hospital security officer role.

- The Commonwealth should declare violence against healthcare workers a national crisis and run a comprehensive campaign to raise greater public awareness of the prevalence and severity of the violence being inflicted and the profound impact it is having on healthcare workers across Australia.

- The Commonwealth should improve funding and service models of aged care services. This should include increasing the occurrence of medical care that is provided in residential aged care facilities (RACF), providing adequate resourcing to improve the documentation and implementation of advance care directives in RACFs and expanding the availability of palliative care services.

- The Commonwealth, through the Australian Commission on Safety and Quality in Health Care (ACSQHC), should introduce a National Standard on violence and aggression that sits alongside other standards contained within the National Safety and Quality Health Service Standards (NSQHS).

Recommendations for State and Territory Governments

- State and Territory Governments and Health Departments need to acknowledge the severity of the problem. Addressing violence against hospital staff should be made a priority issue for health departments.

- State and Territory Governments, through their respective health departments, should establish stronger regulatory requirements that clearly specify the obligations of hospitals and health services to provide safe work environments. This includes legislation, policies, procedures and risk-assessment tools that can be adapted to the local hospital context.

- State and Territory Governments, through their respective health departments, should take an active role in monitoring and reporting on ED safety. This should include monitoring and evaluation of ED safety in public hospitals, regular public reporting, including incident trends and changes over time, and providing necessary resources to address barriers preventing a hospital from reporting.

- State and Territory Governments should ensure that dedicated, specifically trained hospital security officers are employed by hospitals as part of the ED team and are always available. There should be dedicated funding allocated to ensure there is appropriate FTE available for these roles.

- State and Territory Governments should run a public recruitment drive that describes the important role of hospital security officers, highlights the opportunities for a purposeful and fulfilling career in the healthcare sector and promotes no-fee TAFE courses for people who successfully complete their training and serve a prescribed period of employment as a hospital security officer.

- State and Territory Governments should provide legal frameworks and clear guidance to ensure hospitals understand the legal obligations and safeguards that legally protect hospital security officers.

- State and Territory Governments should take responsibility for the causative factors outside the control of EDs that contribute significantly to violent incidents by committing to desperately needed whole-of-system reforms to address ED overcrowding, access block and prolonged ED lengths of stay.

- State and Territory Governments should have an explicit goal of preventing avoidable ED presentations. This accountability should be shared with the Commonwealth and can be achieved through more effective funding, monitoring, evaluation and coordination of services.

- State and Territory Governments should improve funding and service models for mental health and addiction services. This includes inpatient units and associated staffing to meet the demand for care, step-up/step-down services and community-based supports commensurate with the burden of disease.

- State and Territory Governments should ensure that hospitals have timely access to police when required. This should also include clear instruction requiring police to remain with violent offenders when requested by hospital staff.

Recommendations for Hospitals

- As employers of healthcare workers, hospital and health services have a legal obligation to provide a safe work environment for their staff and must take responsibility for enacting changes to prevent violence.

- Hospital and health service management need to take the lead in fostering a culture of reporting. As with other occupations, hospital staff deserve a workplace where reporting any violent incident is encouraged, expected and acted on regardless of the severity.

- Hospital and health service managers must advocate for necessary resources from State and Territory health departments where needed, to support healthcare workers to prioritise reporting incidents.

- Hospitals should directly employ and train hospital security officers as an integrated part of the multidisciplinary team. These roles should not be outsourced to private security companies.

- Hospitals should provide ongoing advice to State and Territory health departments regarding FTE requirements for hospital security officers to ensure that hospital security officers are always available in the ED and that coverage is commensurate with local needs.

- Hospitals should provide a thorough induction and ensure that all hospital security officers receive ongoing training and support. It is imperative that in circumstances where all reasonable attempts to de-escalate a threatening situation have been unsuccessful, the 'rules of engagement' are clearly understood and adhered to.

- Hospitals should ensure that ED staff have access to ongoing support and advice regarding their legal responsibilities and medico-legal protections. This includes circumstances under which treatment can be refused or withdrawn or violent people removed from the ED if they do not have an illness or injury requiring time-critical care.

- Hospitals should provide regular training for all staff, including nursing, medical, administration, hospital security staff and any other staff working in the ED. Training could also involve external stakeholders, including police, emergency services staff and other health services, especially in rural and regional areas.

- Hospitals should ensure that all staff members have access to personal and/or fixed duress alarms. Patient alert systems that generate a signal to warn staff of any potential risk, to themselves and others, should also be encouraged.

Definitions

Access block
Access block refers to the situation where patients requiring admission to hospital from the emergency department (ED) have an ED length of stay greater than eight hours. This includes patients who were referred for admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital, or who died in the ED.

Behavioural disturbance
Behavioural disturbance is defined as the combined physical actions made by an individual which are in excess of those considered contextually appropriate and are judged to have the potential to result in significant harm to the individual themselves, other individuals or property. Acute behavioural disturbance is characterised by a rapid onset and severe intensity. The aetiology is commonly a mental disorder, physical illness or intoxication with alcohol and/or other substances. Often the behaviour is considered to be under the voluntary or legally competent control of the individual.

Director of Emergency Medicine
The Director of Emergency Medicine (DEM) has overall clinical and administrative responsibility for all patients in the ED. All staff in the department are responsible to the DEM on operational and clinical matters. This does not preclude matters of policy and ethical responsibility which multidisciplinary team members have to others in the hospital.

ED length of stay
The ED length of stay is the time difference between the arrival time and departure time. A recording with accuracy to within the nearest minute is appropriate.

Emergency department
An emergency department (ED) is a dedicated hospital-based facility specifically designed and staffed to provide 24-hour emergency care. An ED cannot operate in isolation and must be part of an integrated health delivery system within a hospital both operationally and structurally. The minimum standards for the different levels of the ED are defined in S12 Statement on the Role Delineation of EDs and Other Hospital-based Emergency Care Services.

Emergency department overcrowding

Overcrowding refers to the situation where ED function is impeded because the number of patients exceeds either the physical and/or staffing capacity of the ED, whether they are waiting to be seen, undergoing assessment and treatment, or waiting for departure.

Emergency medicine
Emergency medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis, and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. Emergency medicine is recognised as a principal speciality. The speciality further encompasses pre-hospital and in-hospital emergency medical systems.

Emergency physician
An emergency physician is a registered medical practitioner trained and qualified in the specialty of emergency medicine (EM). The recognised qualification of an emergency physician in Australia and Aotearoa New Zealand is the Fellowship of the Australasian College for Emergency Medicine (FACEM). Emergency physician is the preferred term to describe a registered medical practitioner trained and qualified in the specialty of EM. Other acceptable terms include emergency medicine (or EM) specialist, emergency medicine (or EM) consultant, or FACEM. Emergency physician and emergency specialist are titles protected by law in Australia and Aotearoa New Zealand.

Harm

Harm means any detrimental effects on a person's physical, psychological, or emotional wellbeing. Harm may be caused by financial abuse, neglect and/or sexual abuse or exploitation whether intended or unintended.

Hospital emergency codes

As part of the hospital system, many EDs in Australia and Aotearoa New Zealand utilise a recognised set of colour codes to organisationally prepare, plan, respond and recover from internal and external emergencies. While codes are based on standardised information to provide minimum standards for practice, they can differ across jurisdictions and health services. The Australian Standard 4083 (AS 4083-2010) deals specifically with emergencies usually attended by staff in healthcare facilities and specifies emergency response colour codes. Generally, Code Black denotes a hospital-wide coordinated clinical and internal security response to a serious threat to personal safety. Some Australian jurisdictions use Code Grey to distinguish between a violent emergency and an armed threat (Code Black).

Hospital security officer

Refers to security personnel who have been specifically trained to work in health care settings. The hospital security officer should be employed directly by the hospital, receive additional localised training and be integrated into the ED clinical team.

Patient

A patient refers to any person seeking treatment.

Violence

The World Health Organisation (WHO) defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in, or has the likelihood to result in, injury, death, psychological harm, mal-development or deprivation.
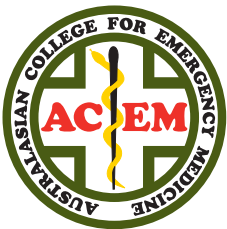
More specifically, physical violence is described as the use of physical force against another person or group that results in physical, sexual or psychological harm and includes (among others) beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching. Psychological violence is described as the intentional use of power, including threat of physical force, against another person or group that can result in harm to physical, mental, spiritual, moral or social development and includes (among others) verbal abuse, bullying, harassment and threats.

Workplace violence

Safe Work Australia and WorkSafe Aotearoa defines workplace violence as an incident in which 'a person is abused, threatened or assaulted in circumstances arising out of or in the course of their work'. Workplace violence is a broad term and covers a range of actions and behaviours that create a risk to the health and safety of all workers and includes:

- Biting, spitting, scratching, hitting, kicking
- Punching, pushing, shoving, tripping, grabbing
- Throwing objects
- Verbal threats and intimidation
- Psychological abuse
- Gender-based and racial abuse
- Sexual harassment, sexual abuse, and any form of indecent physical contact
- Aggravated assault
- Threatening someone with a weapon or armed robbery.