When Care Meets Conflict

Violence in Aotearoa New Zealand's Emergency Departments

Australasian College for Emergency Medicine

acem.org.nz

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 Aotearoa New Zealand and Australia.

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 Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

In recognition that we are a bi-national College, ACEM acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our Australian 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.

Authorisation

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Contents

Introduction

Violence in emergency departments (EDs) across Aotearoa New Zealand, and world-wide, is becoming increasingly frequent and impacts everyone in the ED – staff, patients and whānau. However, the full extent of the problem remains unclear. In August and September 2024, the Australasian College for Emergency Medicine (ACEM; the College) conducted a survey to investigate the prevalence and impact of violence in EDs across Aotearoa New Zealand. This report, titled ***When Care Meets Conflict: Violence in Aotearoa New Zealand's Emergency Departments***, utilises survey data, international research and other publications to explore the prevalence of this issue and key factors contributing to and sustaining violence in EDs across the country. The report examines some of the root causes behind this growing problem and offers recommendations to address these at both a national and hospital level. This report is designed to help ACEM and its members advocate for solutions to reduce violent incidents and improve safety.

It is unacceptable for any healthcare worker to experience injury as a result of occupational violence. Worksafe New Zealand Mahi Haumaru Aotearoa states that workplace violence 'can take many forms - ranging from physical assault and verbal abuse to intimidation and low-level threatening behaviour'.[1] Workplace violence also includes abuse through technology (text, email and phone calls).[2] It can cause emotional exhaustion, mental health issues, and burnout leading to increased absenteeism, high staff turnover, diminished productivity and difficulties with recruitment and staff retention.[3] By law, employers must provide a safe environment for their employees – but this is not happening in our health services.

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.[4,5] The World Health Organization (WHO) estimates that between 8 per cent and 38 per cent of all healthcare workers globally have suffered violence during their careers.[6] International studies have found that up to 92 per cent of ED staff have experienced physical violence and that up to 98 per cent have experienced verbal forms of abuse.[7]

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 individual clinical conditions such as pain, grief, psychosis, dementia, intoxication from alcohol or other substances, and the effects of anaesthesia.[8] Additionally, broader systemic issues and human factors such as excessively long waiting times, crowded EDs, poorly understood triage systems, overburdened and stressed staff, and barriers to effective communication have been identified as contributing factors.

Workforce shortages continue to plague the Aotearoa New Zealand health system, with 60 per cent of the country's EDs having funded but unfilled specialist positions in 2024.[10] The health and wellbeing of ED staff is also being negatively impacted, with the ACEM 2022 Sustainable Workforce Survey finding that 40 per cent of emergency physician respondents across Aotearoa New Zealand and Australia reported they were likely to leave emergency medicine in the next decade. The top two workplace stressors reported 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).[9] Workplace health and safety, including violence in EDs, is consistently ranked within the top 10 stressors of ACEM's members.

ED violence is pushing the healthcare workforce to its breaking point. Urgent action is needed from the national government and individual hospitals. Without immediate systemic intervention, more highly skilled doctors and health professionals will leave the workforce, worsening patient care and further destabilising an already overwhelmed healthcare system.

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1 Worksafe New Zealand Mahi Haumaru Aotearoa. Managing workplace violence and threatening behaviour policy and procedure. Worksafe New Zealand: Wellington

2 ACT Government. Towards a Safer Culture. 2021

3 Richardson SK, Grainger PC, Joyce LR. Challenging the culture of Emergency Department violence and aggression. *New Zealand Medical Journal*. 2022 May 6;135(1554)

4 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.

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

6 World Health Organization. Violence against health workers. 2020

7 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

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

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

10 Australasian College for Emergency Medicine. Annual Site Census. Melbourne: ACEM. 2024.

Taking the next steps

It is time to restart the national conversation about the rising tide of violence and aggression in EDs across Aotearoa New Zealand.

EDs continue to operate under extreme pressure. Systemic overcrowding, access block and prolonged wait times contribute significantly to physical and verbal violence and aggression, which puts staff, patients and whānau at risk of harm. A comprehensive, country-wide response is long overdue.

EDs and the dedicated staff working in them play a crucial role in the health system, providing expert care for urgent and life-threatening medical emergencies to all, around the clock. But a culture of under-reporting, inadequate investment and the idea held by many that violence is 'just part of the job' means that we are increasingly working in conditions that are leading to experienced clinicians leaving an already dangerously understaffed system.

To address this issue, in September 2023 ACEM called for appropriately trained, supported, and embedded security staff available at all hours in every ED in Aotearoa New Zealand. A trial took place over the holiday season that year and, in the May 2024 Budget, the national government announced funding for eight EDs and 'surge support' for regional EDs, which was welcomed by ACEM as a promising start.

One year on, progress has stalled and there has been no additional expansion of services.

We continue to need greater equity of access and standardisation. There are currently no national standards for security staff, and the lack of specialised training means that implementation varies widely from one ED to another.

We still need better reporting. Access to data gained by consistent reporting can help identify effective strategies to improve safety and better enable the delivery of timely and equitable healthcare services.

Most urgently, we still need to address the underlying cause of so much of this violence in EDs – overcrowding, access block and long wait times caused by deficits in the broader healthcare system.

ACEM has prepared this solutions-based report, ***When Care Meets Conflict: Violence in Aotearoa New Zealand's Emergency Departments***, to investigate the key factors contributing to, and sustaining, violence within EDs and the many challenges preventing progress. It also provides practical recommendations for improvements both at government and hospital levels.

All people must be safe to receive, deliver and support care in Aotearoa New Zealand's EDs. Our recommendations can support more healthcare staff to focus on delivering crucial care and help make EDs safer – for everyone.

Dr Kate Allan
Chair, Aotearoa New Zealand Faculty Board

About the report

Survey

A survey to investigate the prevalence and impact of violence in EDs was sent to Directors of Emergency Medicine (DEMs) at the 20 ACEM-accredited EDs in Aotearoa New Zealand on 8 August 2024. The College accepted submissions for a period of seven weeks, from 8 August to 22 September 2024.

A total of 13 DEMs responded to the survey, representing 13 (65 per cent) of the 20 ACEM-accredited EDs in the country. In 2023-24, the 13 EDs reported 687,000 annual presentations, accounting for 61 per cent of 1,133,000 presentations across all ACEM-accredited EDs in Aotearoa New Zealand.

Workplace	Total ACEM-accredited EDs	Participating EDs	%
Metropolitan	11	7	64%
Regional	9	6	67%

Table 1: Distribution of participating Aotearoa New Zealand EDs by geographical location (based on Stats NZ Functional Urban Areas classification - EDs located in Auckland, Christchurch, Dunedin, Hamilton, Tauranga and Wellington are classified as metropolitan while other areas are considered regional).

Summary of the results

- **Eleven (85 per cent) of 13 responding DEMs 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. This included physical violence in 64 per cent of reported incidents.**
- **More than three-quarters (77 per cent) of respondents reported that verbal violence occurred daily or frequently (one or more times a week) in their ED.**
- **More than one-third (38 per cent) reported that physical violence occurred daily or frequently (one or more times a week) in their ED.**
- **DEMs in metropolitan EDs were more likely than those in regional EDs to report that verbal (86 per cent versus 67 per cent) and physical (43 per cent versus 33 per cent) violence occurred daily or frequently in their EDs.**
- **Violent incidents in EDs are not always reported to hospital executives. Less than half (six of 13) of the DEMs indicated that they 'always' report incidents of physical violence, while only one DEM reported that they 'always' report verbal violence.**
- **Six (46 per cent) of 13 responding DEMs reported having access to ED-based security officers. Of these six EDs, five had access to around-the-clock, ED-based hospital security officers. Only one reporting ED in a regional area had access to around-the-clock, ED-based security officers.**

The survey findings showed that violent incidents are significantly under-reported. The reasons for under-reporting are complex but there are three main contributing factors. Firstly, reporting systems are often complicated and time consuming, and incidents that involve medically impaired patients, or are considered minor, are often not reported. Secondly, survey respondents felt that their reports of ED violence were not being taken seriously enough by hospital executives, leading to a loss of confidence in reporting. Lastly, and most concerning, is the narrative that dealing with violence and aggression is part of working in the ED, which leads to a sense of resignation that reporting will not create change.

ED overcrowding and access block are major contributors of violent incidents. Rising patient demand and higher-acuity patients presenting in EDs are placing already overloaded hospitals under further stress, with EDs often not staffed adequately for their workload. As higher-acuity patients are prioritised, less-urgent patients often face prolonged waiting times to receive care in EDs, leading to frustration and increasing the likelihood of violence. Investment in ED infrastructure has failed to keep pace with growing demand, population increase and changing patient demographics.

There is significant variation of access to ED-based, around-the-clock hospital security officers. The survey found that more than half of the responding EDs did not have access to ED-based security and were heavily reliant on a small number of hospital security officers who are responsible for covering the entire hospital. The efficacy of hospital security is largely determined by the level of training, resourcing and integration into the multidisciplinary team.

Limitations of the report

This report is primarily based on the experiences of DEMs at ACEM-accredited EDs in Aotearoa New Zealand, who responded to a survey sent to all DEMs at ACEM-accredited EDs across Aotearoa New Zealand and Australia. This report is designed for DEMs to be able to advocate for improved conditions at their EDs at government and hospital level. As such, it is not a comprehensive research piece into ED violence, with the scope of this report necessarily limited. It has not explored the experiences of other ED staff members, patients or whānau, nor has it explored the cultural or socio-economic factors that may contribute to violence, as they fall outside the remit of this report. There is existing literature that explores these perspectives, which could be a topic or perspective for another report.

Recommendations

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

The full extent and impact of violence in EDs cannot be properly understood, nor can resourcing for prevention and intervention strategies be appropriately provided, without a clear understanding of its scale.

It is incumbent on the government and on hospitals to take responsibility for addressing violence against ED hospital staff. EDs need to be supported with nationally consistent reporting tools, strong regulatory support, and instituting and supporting a culture where reporting is encouraged and action taken if any progress is to be made.

Recommendations for the Aotearoa New Zealand Government

a. The Aotearoa New Zealand Government should **establish stronger regulatory requirements** that clearly specify the obligations of hospitals and health services to be safe workplaces. This includes legislation, policies, procedures and risk assessment tools that can be adapted to the local hospital context.

b. The Aotearoa New Zealand Government should develop **simplified standardised reporting tools and establish a centralised incident reporting system.**

c. The Aotearoa New Zealand Government should **tie regular reporting on ED safety to hospital funding agreements** with hospitals. 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.

d. The Aotearoa New Zealand Government should ensure that **annual data on ED safety is made publicly available.**

e. The Aotearoa New Zealand Government should **ensure that a performance measure on health staff experience of violence and aggression is included as a metric** in the Health New Zealand Te Whatu Ora Statement of Performance Expectations.

f. The Aotearoa New Zealand Government, through the Te Tāhū Hauora Health Quality and Safety Commission, should **incorporate reporting on occupational violence as a quality domain within the Framework for Clinical Governance.**

g. The Aotearoa New Zealand Government, through the Te Tāhū Hauora Health Quality and Safety Commission, should **develop a National Standard on Violence and Aggression** in healthcare settings.

Recommendations for Hospitals

h. As employers of healthcare workers, hospitals and health services have a legal obligation to provide a safe work environment for their staff and must **take responsibility for enacting changes that lead to improved practices for preventing and responding to violence in the ED.**

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 management must **advocate for necessary resources** from Health New Zealand Te Whatu Ora where necessary, to support healthcare workers to prioritise reporting incidents.

Recommendations

2. System-wide interventions

To address system challenges, a whole-of-system approach is required. **Greater investment across the entire spectrum of the healthcare system in vital services, workforce and hospital infrastructure is essential to reduce access block.** It is incumbent on the government 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 whānau.

Recommendations for the Aotearoa New Zealand Government

a. The Aotearoa New Zealand Government 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.

b. The Aotearoa New Zealand Government should **take responsibility for the causative factors outside the control of EDs that contribute significantly to violent incidents** by committing to whole-of-system reforms to address ED overcrowding, access block and prolonged ED lengths of stay.

c. The Aotearoa New Zealand Government should **increase funding and service models for mental health and addiction services to meet rising demand.** This includes funding for community-based early intervention programs to divert patients from EDs, as well as increasing the number of inpatient units and associated staffing to meet the demand for care.

d. The Aotearoa New Zealand Government should **increase funding for aged care services to reduce avoidable ED attendances.** This should include improving the provision of high-level medical care provided within residential aged care facilities and increasing numbers of high-dependency beds in residential aged care facilities.

e. The Aotearoa New Zealand Government should **ensure that hospitals have timely access to police when required.** This should also include clear instructions requiring police to remain with violent offenders when requested by hospital staff.

Recommendations for Hospitals

f. 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.

g. Hospitals should **provide regular security training for all staff** in de-escalation, therapeutic crisis intervention and the use of appropriate restraint techniques in dangerous situations. Training should involve all staff, including nursing, medical, administration, hospital security officers 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 regional areas.

h. Hospitals should ensure that **all staff members should 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.

Recommendations

3. 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 as a required role within EDs, 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 whānau.

Recommendations for the Aotearoa New Zealand Government

a. The Aotearoa New Zealand Government 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 its responsibilities.

b. The Aotearoa New Zealand Government 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 that are recognised by the Mana Tohu Mātauranga o Aotearoa New Zealand Qualifications Authority.

c. The Aotearoa New Zealand Government should **incentivise Industry Training Organisations (ITOs) 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.

d. The Aotearoa New Zealand Government, through Health New Zealand Te Whatu Ora, should **ensure that all hospitals are provided with dedicated, specifically trained, ED-based hospital security officers. These roles should be embedded within the ED team, employed directly by the hospital and always be available.** There should be dedicated funding allocated to ensure there is appropriate and equitable FTE available for these roles.

e. The Aotearoa New Zealand Government should **run a public recruitment drive** that describes the important role of hospital security officers and highlights the opportunities for a purposeful and fulfilling career in the healthcare sector.

f. The Aotearoa New Zealand Government should **provide legal frameworks and clear guidance** to ensure hospitals understand the legal obligations and safeguards that legally protect hospital security officers.

g. Health New Zealand Te Whatu Ora should **directly employ security officers as an integrated part of all multidisciplinary ED teams.** These roles should not be outsourced to private security companies.

Recommendations for Hospitals

h. Hospitals should **provide ongoing advice to Health New Zealand Te Whatu Ora regarding FTE requirements for hospital security officers** to ensure that officers are always available in every 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.**

Results

1. The prevalence of violence is unacceptably high

How frequently are violent incidents occurring?

The prevalence of violent incidents in EDs has always been difficult to capture due to historic and widespread under-reporting. However, in this survey 85 per cent of the responding DEMs (six of the seven metropolitan-based DEMs and five of the six regionally-based DEMs) reported that there had been one or more violent incidents involving a patient or accompanying person in their ED within the past week. Of these reported incidents, 64 per cent involved physical violence. Verbal violence was reported to be occurring daily or frequently (i.e. one or more times a week) by 77 per cent of DEMs, while 38 per cent of DEMs reported daily or frequent occurrences of physical violence in their ED.

There was a slight difference in the frequency of violence between metropolitan and regional EDs. While 86 per cent of DEMs at metropolitan EDs reported at least one verbal incident a week, 43 per cent reported one or more instances of physical violence a week. In comparison, 67 per cent of DEMs at regional EDs reported weekly occurrences of verbal incidents, and 33 per cent indicated that physical violence occurred at least once a week. The high prevalence of violent incidents reported across various geographical locations demonstrates how widespread the issue is and dispels the myth that only 'high-risk' locations require a targeted response. Rather, the data demonstrates the need for a national response.

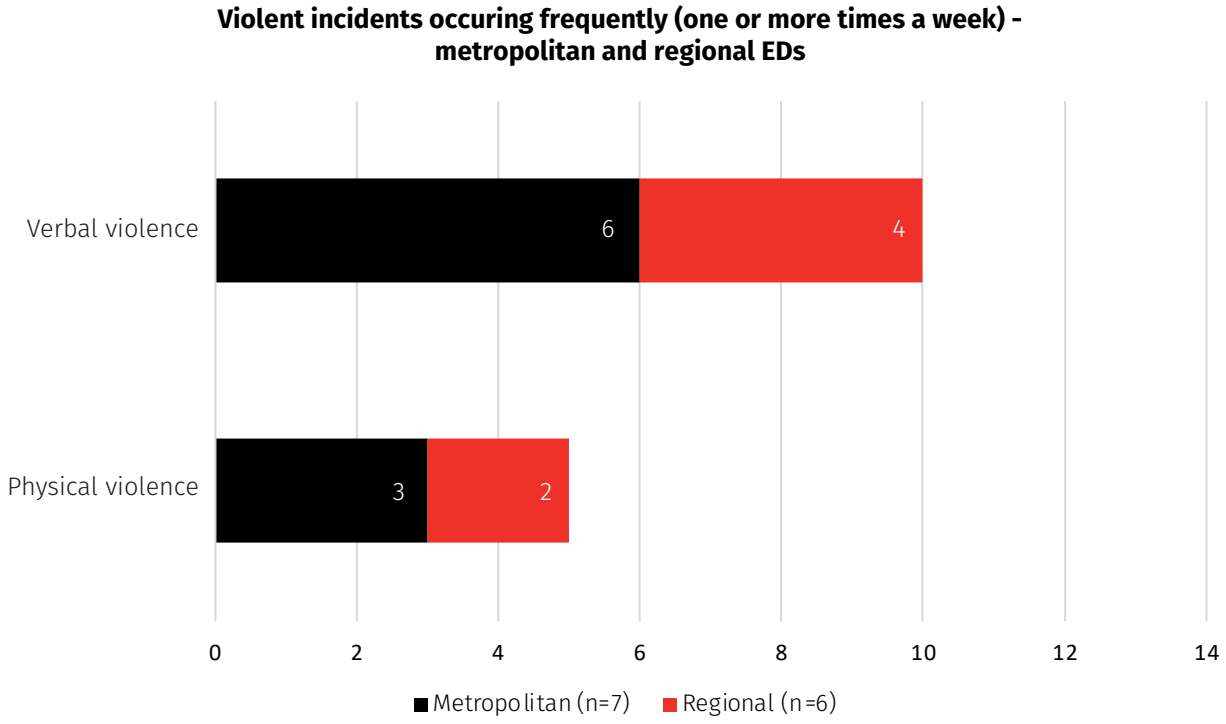

Figure 1: Number of responding DEMs reporting verbal and physical violent incidents occurring frequently (one or more times a week) by location: metropolitan and regional Aotearoa New Zealand EDs.

2. Violent incidents are under-reported

How often are violent incidents reported?

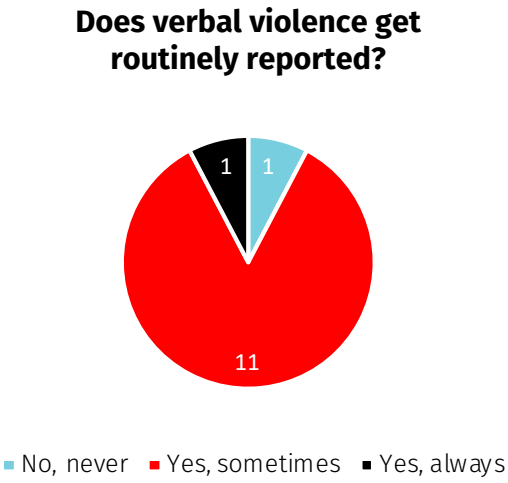

Figure 2: Number of respondents (n=13) indicating whether incidents of verbal violence in their ED were routinely reported.

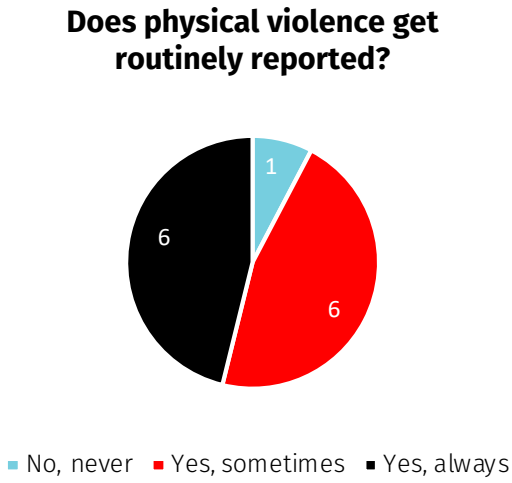

Figure 3: Number of respondents (n=13) indicating whether incidents of physical violence in their ED were routinely reported.

Why do so many violent incidents go unreported?

Figure 2 and Figure 3 show that physical and verbal violent incidents are largely under-reported. Workplace health and safety, including occupational violence and aggression, is increasingly identified by FACEMs and emergency medicine trainees as one of the top five issues affecting their wellbeing and greatly impacting their career longevity. As the data demonstrates that violent incidents are under-reported, only the tip of the iceberg is visible when it comes to understanding the prevalence of violence in EDs.

Reporting systems are often complicated and time consuming, and violence often goes unreported when attributed to a medical condition or deemed as minor. DEMs also reported that due to high workloads and staffing pressures, there is insufficient time for ED staff to record violent incidents in a timely and appropriate manner.

A common theme observed in the qualitative responses was that respondents felt that violence, especially verbal violence or 'near-misses' in EDs, was not being taken seriously by hospital executives, leading to feelings of dissatisfaction and disillusionment with the organisational response.

Several respondents felt that reporting incidents that had not resulted in physical injuries was largely futile, as it rarely prompted any action or change in the department. It was also reported that many staff were also concerned that reporting incidents may reflect badly on their personal ability to cope in an ED setting.

Perhaps most troubling is the narrative that violence and aggression are seen as an inherent part of working in EDs. ED staff have become de-sensitised to violence, particularly verbal violence, as it occurs so frequently. Violence has become normalised, leading to a rationalisation and acceptance of some unreasonable or aggressive behaviours unless the violence results in physical injury or if police become involved. This has led to a degree of despondency among ED staff that change is not possible. This is most evident when reports are made and no action is seen to be taken, or the blame is attributed to an ED staff member rather than the person responsible for the violence.

When asked to share their experiences regarding violent ED incidents, survey respondents said the following:

'It [verbal violence] has become far too accepted as "just part of the job".'

'Verbal violence has become so commonplace that nobody thinks to report it. Also, if it is reported, nothing happens. Reporting is a waste of time.'

'We have found that some incidents that were deemed minor or from an impaired patient were not being reported always. We made a push to improve this by making an alternative easier way of reporting not using the official system which is very time consuming.'

'[We are] too busy and there appears to be no outcome from the organisation on changing the determinants of such violence such as overcrowded ED with prolonged wait times and lack of proper model for mental health care.'

3. 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. Since 2015-16, the demand for ED services in Aotearoa New Zealand has increased by 15 per cent to almost 1.4 million annual ED presentations to public hospitals in 2023-24.

Widespread underinvestment in vital services across the full spectrum of the healthcare system – particularly in primary care, mental health and addiction services, allied health and aged care – are widely understood to be the key contributors that drive up the demand for ED and hospital-based care. Patients whose healthcare needs are unmet in the community are increasingly presenting to the ED at higher rates and with more severe health conditions, requiring hospital-based care which in turn exacerbates access block and ED overcrowding.

The extreme pressure EDs are under has been further compounded by the extreme workforce challenges being experienced, with gaps in experienced emergency medicine staffing contributing to increased wait times in EDs for patients. Aotearoa New Zealand has fewer FACEMs than comparable countries such as Australia (eight FACEMs per 100,000 in Aotearoa New Zealand compared with 12 FACEMs per 100,000 in Australia).[11] **In 2023, more than 50 per cent of ACEM-accredited EDs in Aotearoa New Zealand had unfilled emergency medicine trainee vacancies and almost 60 per cent had unfilled emergency medicine specialist vacancies.**[10]

Recognising the need to address increasing ED lengths of stay, the Aotearoa New Zealand Government has set a target for 95 per cent of all patients presenting in the ED to be admitted, discharged or transferred within six hours. In Quarter 2 2024-25, 72 per cent of patients were admitted, discharged or transferred from ED within six hours. This was an improvement from the previous quarter (68 per cent) but still well below the 95 per cent target.[12]

When asked to share their beliefs regarding the factors that are contributing to violent incidents, survey respondents said the following:

'Drugs, mainly alcohol and methamphetamine. Frustrations in delays to care.'

'Increased methamphetamine use, increased poverty, increased access block and length of stay especially for psychiatric patients.'

'Much more frustration and anger towards staff regarding long waits or not being able to be seen by community providers.'

'[The] Health system [is] under strain. Can't get seen in the community, so everyone comes here and the ED is overloaded. They get frustrated and wait times for everyone add to this frustration.'

Emergency department infrastructure and security measures are often inadequate

A common theme to emerge from the DEMs' feedback was that their EDs had insufficient security measures in place to prevent or manage violence. The vast majority of DEMs reported that their ED had access to panic buttons (85 per cent) and CCTV (69 per cent), while just 15 per cent had access to restraining equipment. Many DEMs also reported that their hospital lacked appropriate facilities (such as behavioural disturbance rooms) to manage violent or potentially violent patients such as those intoxicated by alcohol and/or other drugs.

11 Australian College for Emergency Medicine. FACEM and FACEM Trainee Demographic and Workforce 2023 Report. ACEM Report: Melbourne. 2024.

12 Health New Zealand Te Whatu Ora. Health Targets performance. 2025.

Only 54 per cent indicated that their hospital had provided staff with access to de-escalation training. It was also reported that ED staff found it difficult to get time off to attend security training, and even more challenging for ED staff and hospital security officers to undergo training together. It was noted that the lack of these opportunities further limits the effectiveness of ED staff and security officers during violent and potentially violent situations, with staff more likely to be unfamiliar with each other and with processes to be followed as a team.

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

'As always need more [security support]. Challenge to get time for staff especially doctors to de-escalation etc. training. Challenges with timely access to police when needed.'

'Resources and policies needed.'

'Less patients and overcrowding and decrease access block. Better mental health services. A behavioural disturbance unit.'

'Improving the long waits and overcrowding, in particular waits sometimes up to 24 hours for mental health reviews. The environment creates increased agitation and events.'

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. In Aotearoa New Zealand, Urgent Care Centres provide low-acuity medical care and help to divert patients from EDs with urgent but non-life-threatening conditions. However, these alternative services are not readily available in regional areas, leaving EDs to cover service gaps well beyond the limit of what they can feasibly manage.[13] **Low levels of access to healthcare services contributes to the view held by some members of the public that it is appropriate to present to the ED for any medical issue, which is connected to a broader issue regarding the public awareness of how EDs operate and the services they can provide.**

There is a widespread misconception that EDs operate on a first-come, first-served basis, a narrative that needs to be corrected given the links between prolonged waiting times and violent incidents. The literature highlights other factors including a lack of understanding of the triage process, communication barriers, and unmet expectations regarding the services available to patients in EDs. Furthermore, research has demonstrated that there is a correlation between unrealistic patient expectations and aggressive behaviour.[3]

The lack of public awareness regarding the availability of healthcare settings and the services they can provide demonstrates a greater need for health promotion activities to increase public awareness of where people can go, what they should expect and the kinds of support and information available to them when concerns arise regarding their condition or waiting time for care.

13 Jones P, Faure S, Munro A. Variation in resources and impact on performance: results of the emergency department benchmarking survey. *New Zealand Medical Journal*. 2021;134(1540)

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

How many sites have access to hospital security officers?

ACEM has long advocated for all EDs to have access to around-the-clock, ED-based hospital security officers who are recruited, trained and employed by the hospital (not third-party providers) and appropriately trained in trauma-informed care and de-escalation techniques, to safely respond to and manage violent incidents.

Over the 2023-24 holiday period, a number of hospitals were allocated funding to employ additional security officers. The College welcomed the action taken by the government to provide enahnced security at a number of EDs that were categorised as high-risk. However, according to responding DEMs, many of these security officers failed to positively contribute to reducing instances of violence as they lacked appropriate training and were unable to be integrated into the ED team.

DEMs were asked to identify the hospital security arrangements applicable to their ED and were asked to share their views on the efficacy of these roles. The survey asked about the three common models of hospital security, with the first being 'hospital-wide' security staff, who are responsible for providing coverage of the entire hospital facility and surrounding grounds. The second model is 'ED-based' security staff, who are posted within the ED and primarily focused on responding to and managing violence in the ED. The third is '24/7 ED-based' hospital security officers, who are posted within the ED around-the-clock.

Figure 4 shows that **less than half (six of 13) of responding DEMs indicated that they have access to ED-based hospital security officers in their department.** Of the six DEMs, five (primarily from metropolitan EDs) reported having access to around-the-clock, ED-based hospital security officers, with only one based in a regional ED. Five of the six responding DEMs with access to ED-based hospital security officers reported that their security officers were employed by the hospital, while one reported that their hospital security officers were employed by an external contractor.

More than half of responding EDs reported that they did not have an ED-based security presence. DEMs in regional EDs (67 per cent) were more likely than their metropolitan-based counterparts (29 per cent) to report having only hospital-wide security staff. One DEM from a regional ED reported having no access to hospital security officers at all.

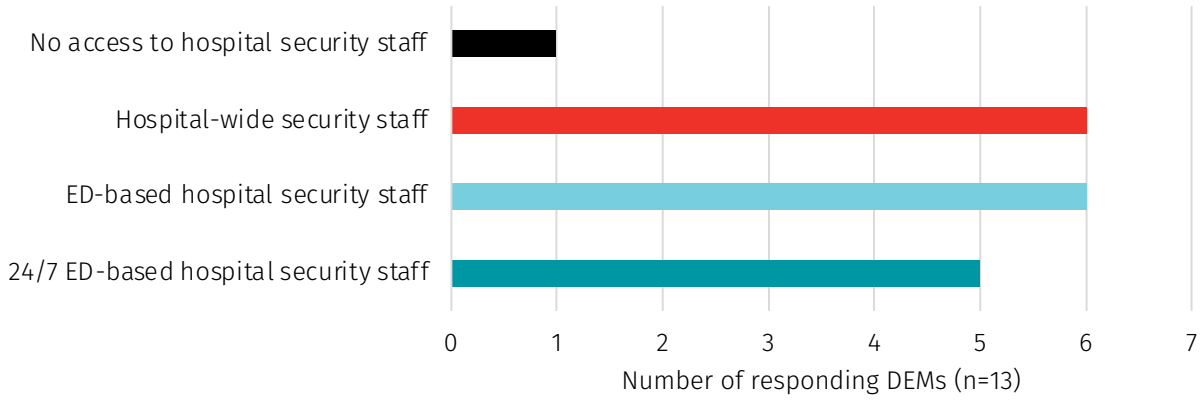

Figure 4. Access to different models of hospital security officers.

When viewed alongside data regarding the prevalence of violence in EDs, as well as an analysis of how the hospital security officer role varies across sites, it is clear that better regulation and minimum standards are necessary for ensuring safer EDs, no matter where they are located.

What did the respondents say about their hospital security officers?

Ten DEMs commented on the effectiveness of hospital security officers in protecting the safety of the staff, patients and whānau in the ED. DEMs in metropolitan EDs with around-the-clock, ED-based hospital security officers reported that they were satisfied with the level of support they received. However, DEMs from regional EDs, where the majority of EDs only had access to hospital-wide security, were less satisfied with the effectiveness of their hospital security officers. Negative feedback regarding the utility and availability of security officers came exclusively from DEMs based in regional EDs that relied solely on hospital-wide security staff.

'They are amazing at de-escalation and looking after both patients, their whanau and staff alike.'

'Very good, well trained and work closely with us as they are also orderlies. They have become very skilled at prevention and de-scalation.'

'Great but not enough of them'.

'Our "security staff" are most often orderlies, not actual security staff. When we had regular security staff over the Christmas holidays, they were clearly inexperienced and not at all deterrents.'

'Not always effective. Their powers are severely limited.'

'Terrible, poorly trained, slow to arrive. I don't feel safe at all when they attend – I will usually call the police.'

'Reasonably easy [to access] but they don't work on the same page as us. The rule governing them seems different from ours, or at least the health and safety philosophy.'

Why is the feedback so mixed?

The reported effectiveness of hospital security officers across EDs in Aotearoa New Zealand was mixed among respondents. The two key factors associated with the effectiveness of these roles are the level of training and support provided to hospital security officers and their integration into the ED team.

While some metropolitan-based hospitals reported having access to effective, well-trained security officers, this is not the case for other respondents. Several DEMs reported that hospital security officers, especially in regional areas, were poorly trained, did not feel empowered to manage violent behaviour proactively and effectively, and tended to arrive after the violence had already occurred. It was noted that security officers often lack clarity about their legal rights, particularly regarding the management of involuntary patients, and were reluctant to use physical force out of fear of repercussions.

Despite being a highly specialised role, there are no national standards in Aotearoa New Zealand that describe the core competencies for security officers to work in healthcare settings. Instead, security training is left to individual hospitals so the level of training may differ greatly across the health system. Security officers employed directly by the hospital and based in the ED are seen to be more effective, benefiting from training with the wider ED team and officially being part of that team themselves. However, the security industry is experiencing a workforce shortage, with decreasing enrolments in security training. The inability to fill permanent positions due to skills shortages has led to 'casualisation' of the security workforce. While some hospitals employ security officers directly, many others are reliant on contract or agency staff that are reported to be less effective as they are not integrated into the ED team.

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

'Empower security staff to intervene in dangerous situations. Better, safer facilities for agitated intoxicated/mental health patients. Rapid access to mental health crisis teams.'

'Actual security guards that are empowered to restrain patients (we're often told the security guards can't touch patients)'.

'Visibly present security based in ED.'

'Security 24/7 would be helpful.'

'ED-based trained security staff, staff duress alarms to be worn.'

Conclusion

The findings of this report confirm that despite recent government attention, violence in Aotearoa New Zealand 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. However, such incidents are occurring daily, mostly unreported, and are often considered to be 'just 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 training, an 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 the Aotearoa New Zealand Government and healthcare institutions. Unprecedented pressures are already driving experienced professionals out of emergency medicine and pushing an overworked 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, the government 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 harm becomes irreversible.

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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 the ACEM statement S12 Statement on the Role Delineation of EDs and Other Hospital-based Emergency Care Services.

Emergency department overcrowding
Emergency department 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 Security Officer
Refers to security personnel who have been specifically trained to work in healthcare 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 all people seeking treatment.

Violence
The 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
Worksafe New Zealand Mahi Haumaru Aotearoa states that workplace violence 'can take many forms - ranging from physical assault and verbal abuse to intimidation and low-level threatening behaviour.' 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.

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