Violence against emergency healthcare workers: different perpetrators, different approaches

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Abstract

Purpose – *This study aims to investigate whether emergency health-care workers distinguish between different categories of perpetrators of violence and how they respond to different types of perpetrator profiles.*

Design/methodology/approach – *Five focus groups with emergency health-care workers were held in Canada. The participants were asked whether they identified different groups of perpetrators of violence and how that impacted their approach. The focus group responses were transcribed verbatim and analysed thematically using a phenomenological approach.*

Findings – *Participants consistently identified five groups of perpetrators and tailored their approach on their assessment of the type of perpetrator involved. The five categories are: violence or aggressive behaviour from family members or bystander and violence related to; underlying mental health/illness issues; underlying physical health issues; addiction and substance use; and repeat visitors/offenders. Violence with an underlying (mental) health cause was handled professionally and compassionately by the health-care workers, while less patience and understanding was afforded in those instances where violence was associated with (recreational) alcohol or illicit substance use.*

Originality/value – *Emergency health-care workers can consistently distinguish between types of perpetrators of violence and aggression, which they then use as one factor in the clinical and situational assessments that inform their overall approach to the management incidents. This conclusion supports the need to move the focus away from the worker to the perpetrator and to an organisational rather than individual approach to help minimise violence against emergency health-care workers.*

Keywords *Violence, Aggression, Emergency medical services, Workplace violence, Paramedicine, Provider safety*

Paper type *Research paper*

1. Introduction

Violence against health-care workers is estimated to affect up to 95% of workers, presenting an enormous risk for workers and employers (Spelten *et al.*, 2017; Krug *et al.*, 2002; Longo and Phillips, 2016). Violence is defined 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 a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (Krug *et al.*, 2002). Violence can profoundly disrupt workers' lives, may result in post-traumatic stress injury and have serious financial implications such as lost income and increased health-care costs (Papa and Venella, 2013; Hassard *et al.*, 2019; Maguire *et al.*, 2018; Arif and Baig, 2016). For organisations there is an economic imperative, as the occurrence of violence results in lost days of work, work incapacity claims, staff turnover, loss of expertise and increased costs to enhance safe

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work environments (Hassard *et al.*, 2019; Maguire *et al.*, 2018). On a societal level, violence may result in poorer clinical care, and it raises questions about our societal values and norms.

Violence in health care has been described as a "wicked" problem (Alford and Head, 2017; Jacob *et al.*, 2021; McConnell, 2018), indicating that it is a complex problem requiring complex multifaceted solutions. In addition, wickedness indicates that there are potential barriers that restrict effective policy solutions. While there is societal outrage at every extreme violent incident against a health-care worker, the workers are also impacted significantly by the day-to-day smaller incidents such as spitting or name calling, which seem very hard to address. In fact, it took a pandemic for an offence for spitting to be introduced in both Australia and the USA (Hazzard, 2021; Hymes, 2020). There are concerns that violence against workers is becoming normalised and accepted as an everyday danger for the worker (Pich *et al.*, 2011; Ramacciati *et al.*, 2015).

Most interventions to tackle violence appear to put the worker at the centre of the solution focusing on managing violent incidents rather than preventing or minimising them, as is evident in the almost universal training of health-care workers in de-escalation techniques, pointing to a one-size fits all approach (Ramacciati *et al.*, 2016). By providing training, employers assume the workers have the tools to manage the situation and they are held responsible for resolving the situation, even when they are the victims of violence or aggression. We are interested in investigating if a better understanding of types of perpetrators may result in a more tailored approach to preventing or managing violent incidents, shifting attention to the perpetrators of violence and contributing to a safer work environment (Shafran-Tikva *et al.*, 2017).

Previous research in emergency departments (EDs) indicated that health-care workers can not only identify different groups of perpetrators but also vary their approach depending on the type of perpetrator (Spelten *et al.*, 2020). Two groups of patients were identified that are associated with violence incidents in emergency health-care settings and that require special attention. These are patients with mental health issues and those affected by drugs and alcohol (Kleissl-Muir *et al.*, 2018; Nikathil *et al.*, 2017). Both presentations place a substantial burden on EDs, where workers do not always feel equipped to deal with these patients (Creed *et al.*, 2018; Thomas *et al.*, 2021). Furthermore, the ED is not deemed an appropriate environment for many of these patients. They often wait for long periods of time in a highly stimulating environment, only to find that there are no suitable care pathways available to them (Creed *et al.*, 2018; Thomas *et al.*, 2021). In this context, we need to consider that for those with a mental health disorder, there is already a risk of stigmatisation, and these illnesses are associated with poorer health-care access and social marginalisation (Perry *et al.*, 2020).

In this study, we focussed on violence against paramedics and emergency health-care dispatchers in Canada. Emergency health-care settings are different to standard health-care settings because of their unpredictability and uncontrollability, which influences the violence staff experience (Tarraf *et al.*, 2020). The patient population emergency health-care workers interact with is more heterogeneous than a mental health ward or aged care facility; staff are less likely to have a previous relationship with the patient, unlike a family physician or a dialysis nurse for example. Additionally, patients and associates present to emergency health-care services with an element of already elevated stress (Byrne and Heyman, 1997).

In recent years, emergency presentations have increased considerably (Fitzgerald *et al.*, 2012; Australian Institute of Health Welfare, 2017; Health Analytics Branch and Emergency Health Regulatory and Accountability Branch, 2018; Ontario Association of Paramedic Chiefs, 2015). Patients rely on emergency health-care services more readily, often because they do not have access to a family physician, or because they feel they require more

specialised care. The staffing and resourcing of emergency health-care services has not always been in line with the increase in presentations (Considine *et al.*, 2012; Morley *et al.*, 2018).

Community paramedics were included in this study, even though they may respond less often to emergency situations. However, they do work in a relatively uncontrolled environment, usually work alone and are available as first responders. These factors introduce a heightened level of vulnerability on calls that become violent situations (Campeau, 2008).

To investigate if the focus of attention could be moved to the perpetrator, this study aimed to identify and discuss the perceptions, held by emergency health-care workers, about the perpetrators of occupational violence and aggression. In this study, we addressed the following research questions:

RQ1. Do emergency health-care workers distinguish between different categories of perpetrators?

RQ2. How do they respond to different perpetrator profiles?

2. Methods

2.1 Focus groups

Five focus groups with emergency health-care workers (paramedics and dispatchers) were held at different locations in Canada: three in Ontario and two in British Columbia. Three groups were in an urban setting and two in a rural setting. The participants were asked whether they identified different groups of perpetrators of violence and what their approach was based on their assessment. The term perpetrator is used in this study to describe a person who uses violence and is not intended to invoke legal or criminal connotations (Victorian State Government, 2018).

The focus groups had three to six participants (see Table 1) and lasted a maximum of 90 min. They were audio recorded for transcription and analysis. For the reporting of our results, we used the COREQ standard (Tong *et al.*, 2007). Ethical approval was granted by La Trobe University Ethics Committee under number HEC19009 and by the Hamilton Integrated Research Ethics Board, project 7031. This ethical approval process was recommended and supported by the paramedic services involved.

2.2 Data collection

The local organisations invited their emergency health-care workers to participate in the focus groups at a set time, resulting in purposive sampling (Battaglia, 2008). A participant information statement was provided, which explained the purpose of the study and the role of the researcher, with potential participants given the opportunity to ask questions and discuss the information with others if they wished. Written consent was obtained at the start of each focus group that was moderated by ES, a female researcher on the project. No additional persons attended the focus groups. The researcher sent an executive general

Table 1 Overview focus group participants

Focus group	*Location*	*No. of participants*	*Female participants*	*Profession*
1	Ontario, Canada, rural	6	0	Paramedics
2	Ontario, Canada, rural	5	0	Paramedics and one dispatcher
3	Ontario Canada, urban and rural	3	2	Paramedics/researchers
4	British Columbia, Canada, rural	5	1	Community paramedics
5	British Columbia, Canada, urban and rural	6	3	Paramedics

summary of the main results to their contact person at the organisation, for distribution among staff.

2.3 Analysis

The focus group responses were transcribed verbatim and analysed using a phenomenological approach, as this approach centres around the lived experience of participants (Sarantakos, 2013). Because of the exploratory nature of the study, inductive thematic analysis (Vaismoradi *et al.*, 2013) was used as it allowed themes to emerge from the data without the analyst searching for specific answers, which would be more in line with deductive analysis (Braun and Clarke, 2006). The data were coded by ES and JV.

3. Results

3.1 Participants

The focus groups were comprised of 25 participants in total (Table 1). They had been working in the field for an average of 13 years (range 5–38 years). There was a gender imbalance in the participants sample, with only six female participants, which is reflective of the workforce in these Canadian settings (Australian Institute of Health and Welfare, 2016; Spelten *et al.*, 2020; Canadian Institute for Health Information, 2019). No participants dropped out of the focus groups.

3.2 Categories of perpetrators and variation in approach

With thematic analysis, five categories of perpetrators were identified which are summarised in Table 2. Within each category, several subgroups of perpetrators could be identified. Table 2 summarised how the participants would approach each type of violence. Quotes from the focus groups have been added to illustrate both the perpetrator description and the chosen approach.

Participants differentiated between patient and family member or bystander perpetrators. There were several descriptions regarding the reason for violence or aggressive behaviour from family members or bystanders, including the belief that they were trying to help, they felt the patient was not getting the care they believed was required, or they were in a crisis or bereaved.

Participants identified four groups of patient-perpetrators. The participants generally sandwiched comments regarding perpetrators between explanations of the medical or psychiatric rationale for their behaviour. Participants divided perpetrators into those whose behaviour was caused by a medical reason, such as hypoglycaemic diabetics; people with substance use issues such as alcohol or illicit substances; repeat visitors or offenders; and people with mental health issues. The perpetrators with mental health issues also consisted of subcategories that varied greatly, incorporating elderly patients with dementia and those with other mental health issues, including suicide ideation. It was noted that repeat visitors/offenders were often associated with mental health issues or substance use or misuse.

While participants' attitudes and approaches differed among the groups, most participants had more empathy and patience with perpetrators whose behaviour was the result of a (mental) health issue outside their control. At the same time, less understanding was expressed for perpetrators who became violent because of recreational alcohol or substance use.

4. Discussion

4.1 Main findings

In this study, we investigated whether emergency health-care workers distinguish between different categories of perpetrators of violence and how they respond to different types of

Table 2 Description of category of perpetrators and chosen approach, both supported with quotes

Description	Approach
Category 1: Violence or aggressive behaviour from family members or bystanders	
This category consists of non-patients, for example, family member or bystanders	Participants mentioned that often these people think they are being helpful, even when they are impeding the care process. Participants often dealt with these people by assigning them tasks so that they would leave, freeing the participants to deal with the patient. One reason for aggressive behaviour from family members was if they felt the health-care worker was not giving the patient the treatment they desired or felt appropriate. Bereavement violence came up in one focus group under this category as well, with participants being more tolerant in this instance
Quotes	*Quotes*
Conversation: *Researcher: "What do you do with family members?"* *Paramedic 1: "Can you go boil some water and get some clean sheets?"* *Paramedic 2: "Give them something to do."* *"It was a family member that was being really, really verbally harassing and aggressive. And had gotten in our face." (P)*	*"But if you want talk about violence that is acceptable, bereavement violence. That is a whole separate class. You know, that's okay because they lost someone." (P)* *"Family members of patients that want a certain treatment. And if you're not providing it to their family member, they get so upset, emotional about it that they start taking it out on you." (P)*
Category 2: Violence that is related to underlying mental health/illness issues	
Description	*Approach*
This category refers to patients whose violence related to underlying mental health issues	Participants understood that for patients in this category, mental health issues influenced behaviour and they took that into account in their approach, often based on de-escalation. However, participants did comment that mental health could be seen as an excuse for violent behaviour, which led to no consequences for that individual. For patients with dementia or delirium, most people did not take offense or would not report violent incidents, as they felt it was not the patients' intention
Quotes	*Quotes*
"I've had numerous chats with police about transporting mental health patients, and the stance that a lot of them are taking is that this is not a criminal patient. This is somebody with mental health problems." (P) *"I myself don't take offense from the elderly with issues of cognitive ability. Getting angry and frustrated and lashing out." (P)* *"With dementia patients that can be violent. … But we're not necessarily going to report that because we know it wasn't an intentional choice on their part" (P)*	*"Mental health, especially suicidal patients, because if they're intending on harming themselves, you're an obstacle that can be dealt with pretty easily. If they're looking to harm themselves, then there is no risk to them harming you." (P)* *"And a large amount of the situations that I have been involved with … commonly dealing with substance misuse or mental health related issues or the combination of both." (CP)* *"Elderly patients dealing with infectious processes, primarily UTIs or different forms of infectious processes that have led or contributed to delirium or possibly delirious states has resulted in some incidences for myself." (CP)*
Category 3: Violence is related to underlying physical health issues	
Description	*Approach*
This category refers to patients whose violence related directly to underlying physical health issues	The participants felt the best approach was to diagnose correctly and provide adequate treatment
Quotes	*Quotes*
"It's, you know, the diabetic, who takes a swing at you in the midst of a hypoglycaemic episode, who's incredibly apologetic afterwards." (P) *"Diabetics with low blood sugars. And people coming here with seizures. They can be violent too." (P)*	*"Or are they hyperglycemic or something like that? Do they have something underlying going on? This behaviour, what is causing this behaviour." (CP)* *"Or the diabetic that, because of a medical condition, they start to get aggressive when you treat that everything goes back to normal." (P)*

(*continued*)

Table 2

Description	Approach
Category 4: Violence that is related to addiction and substance use	
Description This category included a mix of patients and non-patients	*Approach* People who are intoxicated with alcohol were difficult to deal with because they could be unpredictable. Patients with addiction could also get violent if they were searching for their "next fix." Participants did not see drug or alcohol misuse as an excuse for violent behaviour
Quotes *"I myself perceive more problems with drunk patients, and I don't excuse them because they're drunk." (P)* *"All who ingest drugs or alcohol. It doesn't matter the age range." (P)* *"It's the drunk." (P)*	*Quotes* *"But when it comes to the other stuff that is in their control – like especially drunk people, I think, are the most annoying and dangerous that we deal with on a regular basis. Because they're unpredictable." (P)* *"But even for people under the influence of alcohol or illicit drugs, it's not an excuse. You still don't have to attack a paramedic." (P)*
Category 5: Violence that is related to repeat visitors/offenders	
Description These patients used emergency services frequently enough for the participants to become familiar with individual patients	*Approach* With regards to repeat presenters, it became apparent in the focus groups that the participants were frustrated that little is done to either flag the patients' addresses or that they face few consequences for their actions
Quotes *"We have one resident who calls more than 900 times in a year, which you believe is almost impossible given the days in the year. And they are known to abuse, spit at, and verbally harass paramedics. And is really distressful for paramedics." (P)* *"Once people have gone there, the pattern becomes easier to repeat. Which is why you repeatedly see violent patients. Once they've lashed out once and realised there are limited repercussions for this." (P)*	*Quotes* *"Yeah we have one regular that has been so bad that now we are mandated to only transport when we either have a second witness in the back or police officer in the back. How is that okay? How has that person not just been refused care?" (P)* *"I think if we look at the flagging of an address, there's been a patient in X, that we probably go to 5 times a day. He'll call us. And without question, every time he'll at least throw a punch at a paramedic, if not spit, yell." (P)*

perpetrator profiles. The findings showed that across the work settings participants consistently identified five groups of perpetrators and tailored their approach on their assessment of the type of perpetrator involved (Table 2). The results showed that violence with an underlying (mental) health cause was handled professionally and compassionately by the health-care workers, while less patience and understanding was afforded in those instances where violence was associated with (recreational) alcohol or illicit substance use.

4.2 Interpretation of the findings

The findings confirm that shifting the focus from the worker towards the perpetrator may be an important step in the development of future interventions to reduce violence against emergency health-care workers. The differentiation between different groups of perpetrators might lay the foundation for variations in strategies to tackle violence and move away from a one-size-fits-all approach. It is relevant to note that because of the uncontrolled and dynamic environment in which they practice (Campeau, 2008), emergency health-care workers often make rapid assessments of patients and scenes on which they base their immediate response. This workplace characteristic emphasises the importance of taking an organisational approach to violence rather than leaving the responsibility with the individual worker.

As identified in previous studies (Kleissl-Muir *et al.*, 2018; Nikathil *et al.*, 2017; Spelten *et al.*, 2020), this study found that patients with mental and behavioural disorders are perceived as a distinct and large group within the context of violence against emergency health-care

workers and a group that needs special consideration, taking into account there is a risk of stigmatisation, poorer health care access and social marginalisation. According to the WHO International Classification of Disease and Health Problems, this category (metal and behavioural disorders) includes patients with psychoactive substance use, as well as other mental and behavioural disorders in the same category (WHO, 2019). Our findings show that the workers are less tolerant of violence associated with alcohol or substance use. It is relevant to note that in this study, this generally referred to the recreational use of alcohol as opposed to substance use as part of a mental or behavioural disorder, which was considered a different issue, with a different approach. Despite its prevalence, there is a distinct lack of attention given to the impact of alcohol-related violence against health-care workers. At the same time, there is sufficient evidence demonstrating that recreational misuse of alcohol and other substances often results in violence and is an important cause of ED attendance (Myran *et al.*, 2019). There might be value in making distinctions between alcohol or substance use as a mental health issue, as distinct from recreational alcohol and drug use – a distinction that has not often been made in the violence in health care literature.

The participants in this study did not express great concern for violence associated with mental and behavioural disorders, reporting that they have had success with de-escalation approaches. This contrasts with reports from ED nurses who found this cohort of patients challenging and did not always feel equipped to deal with them; this difference in perception could be related to the often-long waiting times in the ED. In the same study, ED nurses corroborated the participants' views in this study who suggested that mental health could be used as an excuse to avoid consequences of violent or aggressive behaviour (Spelten *et al.*, 2020).

4.3 Limitations and strengths

While the study samples were small, they were diverse and included both urban and rural settings. To our knowledge, this is the first study to identify the perpetrators of violence and the subsequent approach in the prehospital emergency health-care setting. Although this study of the prehospital perspective from emergency health-care workers might restrict the generalisability of the results, the findings extend the evidence base and complement similar research conducted in EDs with nurses.

4.4 Recommendations

Based on the results of this study, the following recommendations can be made.

First, organisations need to address violence by considering different types of perpetrators and moving away from equipping workers with a one-size-fits-all approach.

Second, interventions need to be developed at an organisational level for two distinct categories of perpetrators. For mental health patients, pathways need to be developed to reduce preventable ED visits. Strategies need to be developed to identify and reduce the impact of violence from perpetrators under the influence of recreational alcohol or drug use. And finally, future research is needed to evaluate intervention as most current interventions are not evidence based (Longo and Phillips, 2016; Maguire *et al.*, 2018; Ramacciati *et al.*, 2016; Stiphout *et al.*, 2020).

5. Conclusions

Emergency health-care workers can consistently distinguish between types of perpetrators of violence and aggression, which they then use as one factor in the clinical and situational assessments that inform their overall approach to the management of cases and incidents. These findings support the suggestion to move the focus away from the worker to the

perpetrator and to an organisational rather than individual approach to the prevention and management of workplace violence and aggression in emergency health-care settings.

The study identified concerns with two distinct categories of perpetrators. The first category is mental health patients, for whom an emergency health-care setting may not be the best care situation and where there appears to be no repercussions for violent behaviour. The second category concerns the considerable impact on health-care workers of violence caused by perpetrators under the influence of misuse or alcohol or drugs. This requires additional attention as the current WHO classification does not distinguish between recreational substance misuse and mental health presentations.

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