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Editorial Introduction

Although it is common knowledge that occupational violence against healthcare workers is a worldwide problem, there is a lack of criminological research exploring *how* and *why* these offences occur and how this victimisation affects a worker's wellbeing and perceptions of crime, in addition to the criminal justice system. Applying a criminological lens to better understand this worldwide problem offers an opportunity to develop innovative and targeted interventions to reduce these incidents of violence within healthcare settings.

This paper explores what we know about the prevalence of occupational violence against healthcare workers and the risk factors associated with this type of violence within the healthcare sector. By the conclusion of this paper, I propose two criminological lines of enquiry for understanding the situational characteristics of these cases of occupational violence and victims' reactions and responses

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Occupational Violence Against Healthcare Professionals: Applying a Criminological Lens

Dr Michael Chataway

Introduction

Healthcare professionals provide critical health services to our communities. However, while shouldering a heavy burden of responsibility during the COVID-19 pandemic, they have been reportedly abused and bullied by some members of the community for 'spreading or disseminating the virus' (Cant, 2020). Prior to the pandemic, an increasing number of healthcare professionals have reported experiences of verbal and/or physical assault while on the job (WorkSafe Victoria, 2020). The World Health Organization (WHO) estimates that 8–38% of healthcare workers have experienced physical violence at least once during their careers (International Labour Office et al., 2002). The WHO suggests that many more workers have reported experiences of non-physical violence, such as verbal abuse and harassment. When not addressed, this type of victimisation may have significant social, economic and psychological impacts on healthcare workers and on functioning of health systems (Mayhew & Chappell, 2003; Vento et al., 2020).

The Health Workforce: Who Are They?

Before describing the prevalence of occupational violence against healthcare workers, it is important to describe the healthcare workforce.

The global healthcare workforce consists of over 59 million workers across both public and private health sectors (World Health Organization, 2006). In Australia, the health workforce is large, diverse and comprises many occupations. The Australian Institute of Health and Welfare (2020) estimated that in 2018 there were more than 586,000 registered health practitioners in Australia. This figure includes 98,400 medical practitioners, 334,000 nurses and midwives, 20,600 dental practitioners and 133,400 allied health professionals. On average, the health workforce in Australia is predominantly female and aged between 20 and 34 years old. Given the considerable variability of roles and environments that health professionals may work in (e.g., in the community, clinics and hospitals), the risk of experiencing occupational violence also varies considerably, as described below.

Defining Occupational Violence in the Context of Healthcare Settings

Occupational violence, in the context of health settings (or work-related/workplace violence) can be defined as an incident where an employee is abused, threatened or assaulted by patients, consumers, relatives and friends of a patient, or members of the public in circumstances arising out of—or in the course of—their employment—irrespective of the intent for harm (Queensland Health, 2016).

Occupational violence includes (but is not limited to) physical violence and abuse (e.g., hitting and grabbing) and non-physical violence (e.g., shouting and verbal abuse; Speroni et al., 2014). The list below provides further examples of the types of violence reported in the literature:

- Verbal abuse
- Shouting or yelling
- Swearing or cursing
- Physical abuse
- Grabbing
- Scratching or kicking
- Bullying and harassment (from patients and colleagues)
- Racial Harassment and abuse

Note. [a] *Examples include personal victimisation of individual workers by patients and colleagues and exclude property victimisation or vandalism (e.g., damage to ambulances; Liu et al., 2019; Mayhew & Chappell, 2003; Speroni et al., 2014).*

Prevalence of Occupational Violence Against Healthcare Workers

There are a number of ways that incidents of occupational violence are recorded within health settings including administrative data collected by employers (i.e., workforce performance reports, health system and service reports), self-report surveys and interviews with staff (Mayhew & Chappell, 2003; Queensland Health, 2016). Two notable challenges to collecting information about incidents of violence are that systems of reporting differ across health systems and that many self-report studies focus on specific groups of workers, rather than entire healthcare cohorts (Mayhew & Chappell, 2003). Another challenge in estimating the extent of occupational violence in healthcare settings is the under-reporting of incidents (Liu et al., 2019).

Regardless of these contextual differences, scholars have found that healthcare workers are more vulnerable to occupational violence than people who are employed in other occupations (George et al., 2020; Liu et al., 2019; Mayhew & Chappell, 2003).

Liu et al. (2019), in their systematic review of 253 published studies on workplace violence against healthcare workers, found that of the 331,554 participants in their sample, 61.9% had reported exposure to workplace violence. In fact, over 40% of participants had been exposed to non-physical forms of violence and just under a quarter of participants (24.4%) reported experiencing physical violence in the workplace. Patterns also emerge when considering the different types of violence that these workers have experienced: verbal abuse was the most common type of non-physical violence reported by workers (57.6%), followed by threats (33.2%), and sexual harassment (12.4%).

Liu et al. (2019) also found that when compared to European countries, North America and Australasia (Australia and New Zealand) had higher rates of violence committed by patients in the workplace. High rates of physical and sexual violence in the workplace were observed in Australia, England, Ireland, US, Canada and New Zealand, compared to the lower rates observed in Europe. There are several reasons why the rates of occupational violence differ substantially in these countries, including under-reporting and limited access to quality administrative data.

These prevalence rates also vary across working environments and roles in the health sector. For example, Liu et al. (2019) found that reported incidents of physical violence were the highest in psychiatric and emergency department settings. Nurses, physicians, healthcare professionals working in urban settings and those working longer hours were found to have a greater level of exposure to physical violence in comparison to other groups assessed in their systematic review.

Risk Factors Associated with Occupational Violence in Health Settings

There are many factors that contribute to the risk of experiencing physical and non-physical violence. In some cases, violence might be due to the characteristics of a patient's medical condition (e.g., dementia, delirium, mental illness or head trauma). In these cases, violence or aggression might be considered a potential clinical symptom that could be further exacerbated by situational factors (e.g., waiting times; Gates et al., 2011). In other cases, occupational violence can be attributed to the specific individual characteristics of offenders (Gillespie et al., 2010). For example, an offender might have a history of violent behaviour (Koritsas et al., 2018).

The organisational setting and environment can also contribute to the risk of occupational violence (Gates et

al., 2011). For example, the physical layout of a work setting, the procedures and policies within a workplace, wait times and staffing availability (i.e., a lack of security guards within a particular setting) may increase the opportunity for violence to occur (Liu et al., 2019; Mayhew & Chappell, 2003). Researchers have found that occupational violence is more likely to occur in high-risk settings, such as uncontrolled environments (where paramedics work and are often first on the scene), emergency departments, maternity/delivery wards, child/paediatric wards, remote-rural sites at night (where staffing is low), psychiatric wards, emergency and outpatient facilities, and aged care settings (Liu et al., 2019; Mayhew & Chappell, 2003).

Reducing the Opportunity for Occupational Violence within Healthcare Settings

Given the significant variation in job roles, personnel, work settings and environments, there are many challenges associated with mapping incidences of occupational violence within healthcare settings. Methods used to examine occupational violence must consider the dynamic nature of workplaces and the roles performed within them in order to identify the context- and role-specific circumstances that increase the risks and opportunities for this type of crime to occur. Much of the literature discussed above has not clearly established the steps and actions undertaken by offenders who commit these offences. Therefore, understanding the steps and actions of individuals who perpetrate violence against healthcare workers, along with their reasons and intentions for committing these crimes, may provide an opportunity to identify strategies for preventing or disrupting this type of violence.

One criminological method used to understand the procedural aspects of the crime commission process is Crime Script Analysis (CSA). CSA has been successfully used to understand the steps and actions taken by offenders during their enactment of a crime, including burglary (Koritsas et al., 2018), organised crime (Chiu et al., 2011), sexual offences (Beauregard & Field, 2008; LeClerc & Wortley, 2013), domestic violence (Boxall et al., 2018) and cybercrime (Hutchings & Holt, 2015). CSA is particularly useful for understanding how crimes can be motivated by opportunities present in an individual's immediate environment and for identifying areas of the crime commission process where potential interventions can be used to disrupt and/or prevent the continuation of such offences. A CSA of occupational violence against healthcare workers would make a significant contribution to our knowledge of the violence that these employees experience and the instigators present in the environment (as well as the preconditions) that might motivate individuals to commit violence against healthcare workers, or other people who work in these settings. These crime scripts can then be used to inform and introduce specific prevention measures that could reduce instances of these offences. These scripts would complement already established training models within healthcare sectors and services in Australia and make a global impact, for example, through employee training on Crime Prevention Through Environmental Design (Queensland Health, 2016).

Exploring Reactions and Responses to Occupational Violence in Healthcare Settings

In addition to understanding the steps and actions undertaken by perpetrators of violence against healthcare workers, scholars have also called for more research on individual responses to occupational violence, including the long term and adverse effects associated with this type of victimisation (Havaei, 2021; Mayhew & Chappell, 2003).

Criminologists have argued that exposure to crime in the community has a negative affect on an individual's fear of crime, as well as their emotional wellbeing (Chataway & Hart, 2016; Killias, 1990). However, less is known about how exposure to crime in high-risk occupations (e.g., healthcare) affects one's wellbeing and whether such exposure shapes ongoing concerns about crime and perceptions of risk when undertaking specific roles in a workplace, or when working in a particular location. Research of this nature is critical for creating safer working environments for healthcare workers, as well as identifying further areas of support for workers who wish to report their concerns and perceived safety risks in the workplace.

Finally, there is a need for researchers to explore the long-term effects of experiences of occupational violence in healthcare environments. For example, along with assessing reports of fear of crime in healthcare settings, studies could also assess the adverse effects that this type of harassment has on physical and emotional wellbeing, job satisfaction, and broader perceptions of the criminal justice system and how it responds to perpetrators of this form of violence.

Summary

Occupational violence against healthcare workers is a significant worldwide problem. Studies have found that this form of violence occurs within specific settings, towards groups of workers who have greater contact with patients and members of the community (e.g., nurses).

In this paper, I have argued that criminologists need to explore the situational characteristics of this type of victimisation further. Specifically, more research is needed to unpack the steps and actions associated with occupational violence in order to identify *how* these offences occur and the environments in which they occur. By exploring the procedural elements of these offences in greater detail, targeted interventions can be developed to disrupt and prevent this form of occupational violence from occurring.

In addition to understanding the steps and actions involved in these offences, I have also argued that researchers need to examine how employees react to occupational violence, and perceived threats of violence in the workplace, with a greater focus on how this type of harassment might affect one's physical and emotional wellbeing, and perceptions of crime and the justice system among this group of workers.

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