

Police-recorded assaults on hospital premises in New South Wales: 1996-2006

Kirin Hilliar¹

Between 1996 and 2006 in NSW, there was a 50 per cent increase in the number of police-recorded assaults occurring on hospital premises. Many features of hospital assaults remained stable across this time period. On any given day of the week, most hospital assaults occurred between 3-9pm. Both the person of interest (POI) and the victim were most often male, with the POI (average age of 32.0 years) slightly younger than the victim (average age of 35.9 years). In over two-thirds of all hospital assaults, the victim was previously unknown to the POI (i.e. stranger assaults). In situations where the POI and victim were unknown to each other, the victim was most often either a hospital staff member or police officer. In contrast, where the victim was either a patient or visitor, they were more likely to be assaulted by someone they knew (e.g. a friend or family member). However, from 1996 to 2006 there were also some notable changes, in particular a clear decrease in the proportion of recorded assaults that resulted in injuries to the victim, a significant increase in the number of mental health-related hospital assaults and a significant decrease in the proportion of alleged hospital assaults that resulted in legal proceedings.

KEYWORDS: Assault, hospitals, trends, violence, police

INTRODUCTION

In the past decade in New South Wales (NSW) there has been a marked increase in the number of assaults recorded as occurring on hospital premises. From 1996 to 2006, police-recorded incidents of assault at hospitals across the state have steadily increased from 214 in 1996, to 322 in 2006 (a 50% increase).² Population-adjusted hospital assault rates also indicate an increase, with 3.5 police-recorded hospital assaults per 100,000 people in NSW occurring in 1996 and 4.7 hospital assaults per 100,000 people occurring in 2006 (see Figure 1).³ As shown in Figure 1, most of the growth in hospital assaults occurred between 1996 and 2001. This is reflective of a general increase in assault rates over this period (see also Moffatt & Goh 2007). Assaults in general have remained relatively stable since 2001. Assaults on hospital premises

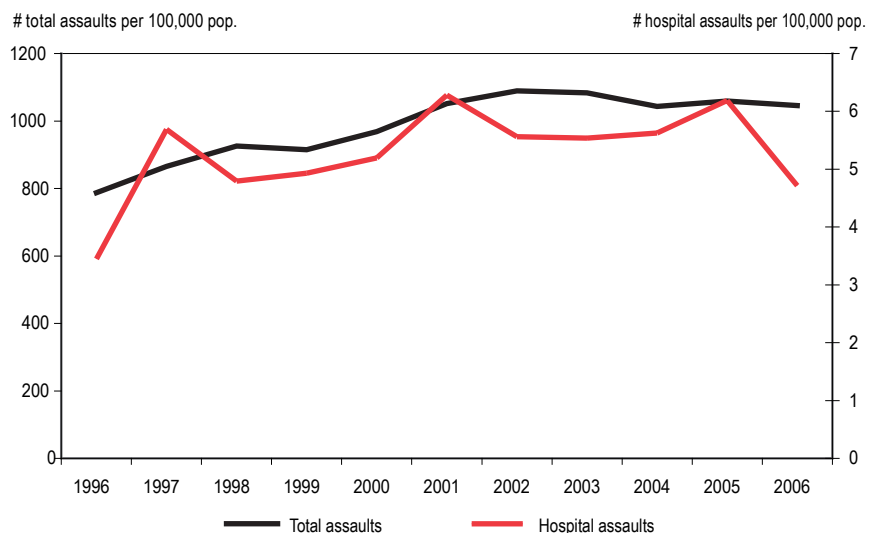
dropped notably between 2005

(6.2 hospital assaults per 100,000 people)

and 2006 (4.7 hospital assaults per

100,000 people).⁴

Figure 1: Total assault rates and hospital assault rates in NSW, 1996-2006



The cause of the increase in hospital assaults over the years remains unclear. One possibility is that the reporting of hospital assaults has increased; however, the Australian Bureau of Statistics' *Crime and Safety, New South Wales* surveys show no general increase in the willingness of victims of assault to report the offence to police (see Australian Bureau of Statistics 1996, 2006). It may be that parties other than the victim of assault (e.g. witnesses, responsible authorities) have become more willing to involve police. It is also possible, however, that the increase in hospital assaults is genuine, even if its cause remains unknown. Certainly the media has given a lot of attention to anecdotal evidence that hospital assaults are on the increase, particularly those related to methamphetamine presentations (e.g. Carney 2006).

The aims of this bulletin are twofold. The first is to characterise the police-recorded hospital assaults that occurred in 2006. The second is to analyse trends in the characteristics of hospital assaults between 1996 and 2006 to investigate whether any changes in these features can help account for the upward trend.

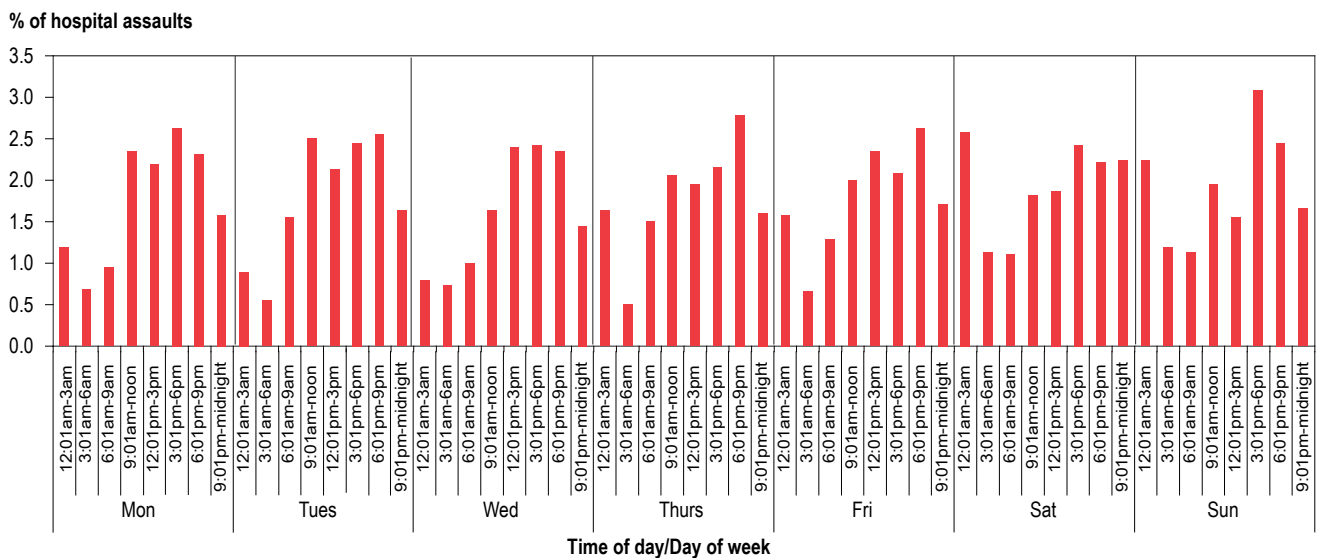
METHOD

Two datasets were extracted from the NSW Police Force Computerised Operational Policing System (COPS) for this bulletin. The purpose of generating these datasets was to identify the most common features of hospital assaults in NSW in 2006 and to examine whether any characteristics of hospital assaults had changed over the previous decade. Information on all assault incidents recorded by police as occurring on hospital premises (including hospital car parks) from 1996 to 2006 was extracted.⁵ These incidents are coded by attending police when they are entered into the COPS incident records. Within this dataset, the variables of interest were: the age and gender of the person of interest (POI); the age and gender of the victim; the Statistical Division (SD) where the assault took place;⁶ the time of day and day of week of the assault; whether the assault was aggravated or not;⁷ whether the assault involved a weapon or not; whether the victim was injured or not; and the seriousness of the victim's injuries. Injury seriousness was re-coded by the investigating author on a scale of 1 to 4, where 1="minor physical injuries" (e.g. red marks, swelling, bruising), 2="mid-

level physical injuries" (e.g. bleeding, sprain, whiplash), 3="major physical injuries" (e.g. fracture, severe lacerations, unconscious), and 4="fatal or life-threatening injuries" (e.g. spinal injury, internal injury).⁸

Because several other variables of interest are not systematically coded in the existing COPS incident records, a second dataset of police event narratives for all police-recorded hospital assaults that occurred in 1996 or 2006 was also evaluated.⁹ These narratives were coded by the author to investigate the following variables: whether the assault was alcohol-related, drug-related (and if so, the type of drug involved), or mental health-related (as indicated by the attending officer);¹⁰ the relationship between the POI and the victim; whether the assault was domestic violence-related; the identity of the person who reported the assault; the outcome of the assault (i.e. whether legal proceedings were initiated or not); and the severity of the assault. Assault severity was coded on a scale of 1 to 4, where 1="verbal abuse/threats only", 2="minor physical contact" (e.g. single punch, slap, kick, spit), 3="major physical contact" (e.g. multiple kicks or punches to the victim, stab, choke), and 4="contact that resulted

Figure 2: Time of week of hospital assaults in NSW, 1996-2006



Note: Figure 2 details the proportion of hospital assaults that occurred during each three-hour time period in the week from 1996-2006. Data from these 11 years (rather than from just 2006) were used because of the high variability in the 2006 data that arose from only very small number of hospital assaults occurring in each three-hour time period.

in death or life-threatening injury". A small sample of case studies derived from the coded event narratives is presented in the Appendix.

RESULTS

HOSPITAL ASSAULTS IN 2006

Table 1 lists the dominant features of police-recorded hospital assaults that occurred in 2006, according to police-coded incident data. In 2006, the victim was injured in 16.5 per cent of all hospital assaults, and most of the time (69.8%) these injuries were only minor. There were twice as many male POIs as female POIs and the median age for POIs was 30 years. Victims, who were also usually male, tended to be slightly older than POIs (median age=35). Hospital assaults occurred relatively consistently across the week, with each day accounting for 12.1-16.8 per cent of incidents. Hospital assaults were also relatively evenly distributed across the twelve months of the year, although there was a spike in assaults in August, which accounted for 13.7 per cent of hospital assaults in 2006.

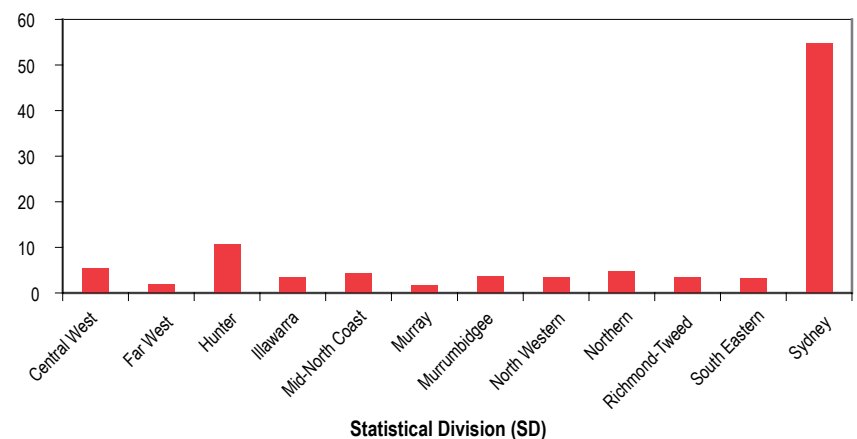
Figure 2 gives the proportion of hospital assaults that occurred in each three-hour time period across the week from 1996-2006. Across these 11 years, the highest proportion of assaults on any given day occurred between 3-9pm, although a large proportion also occurred on Saturday and Sunday evenings. The largest spike across the whole week was observed between 3-6pm on Sunday. It is not clear why this was the case; however, it could be that these time periods (weekday afternoons and weekends) coincide with popular hospital visiting hours. The large number of hospital assaults on weekends also coincides with the timeframes where alcohol-related assaults (across all locations) are most common (Briscoe & Donnelly 2001; Poynton et al. 2005). Early morning assaults remained fairly low across the week, except on Saturdays and Sundays. Overall, the lowest proportion of assaults on any given day occurred between 3-9am.

Table 1. Features of hospital assaults in NSW in 2006, according to police-coded incident data

<i>Variable of interest</i>	<i>Percentage</i>
Aggravated assault	26.1
Use of a weapon	5.9
Victim was injured	16.5
Seriousness of injuries to the victim	
- Minor injuries	69.8
- Mid-level injuries	7.5
- Major injuries	17.0
- Fatal or life-threatening injuries	0.0
- Data missing	5.7
Gender of POI	
- Male	58.7
- Female	28.0
- Data missing	13.4
Gender of victim	
- Male	59.3
- Female	40.4
- Data missing	0.3
Age of POI (mean age=32.0; median age=30.0)	
- <20 years	14.9
- 20-29 years	26.7
- 30-39 years	23.3
- 40+ years	21.1
- Data missing	14.0
Age of victim (mean=35.9; median=35.0)	
- <20 years	6.5
- 20-29 years	25.8
- 30-39 years	29.8
- 40+ years	34.2
- Data missing	3.7
Most common time of day: 3-9pm	35.4
Most common day of the week: Sunday	16.8
Most common month of the year: August	13.7
Most common Statistical Division: Sydney	54.7

Figure 3: Hospital assaults in NSW by location of assault, 2006

% of hospital assaults in each SD



The Sydney and Hunter SDs recorded the highest proportion of incidents, accounting for 54.7 per cent and 10.6 per cent of all hospital assaults in NSW in 2006, respectively. All the other SDs each accounted for less than 5.4 per cent of total hospital assaults (see Figure 3). However, when population-adjusted hospital assault rates were calculated for each SD, Sydney had a relatively low assault rate (4.1 police-recorded hospital assaults for every 100,000 people) compared to non-metropolitan areas, which had higher assault rates for their populations (see Figure 4).¹¹ This pattern (higher hospital assault rates in non-metropolitan areas) mirrors the geographic breakdown of assaults in general (Goh, Moffatt & Jones 2007).

Table 2 lists the characteristics of police-recorded hospital assaults in 2006 according to the author's coding of police event narratives. The coding revealed that in the vast majority (87.4%) of hospital assaults in 2006, the POI was alleged to have had only minor physical contact with the victim. About 31.7 per cent of hospital assaults in 2006 were coded as being mental health-related, 30.5 per cent were alcohol-related and 17.1 per cent were drug-related. Altogether, alcohol, drugs, and/or mental health issues were mentioned in 62.6 per cent of all police-recorded hospital assaults in 2006. The type(s) of drug involved were only specified in 54.3 per cent of drug-related assaults, but the drugs that were mentioned were cannabis (specified in 19.6% of all drug-related hospital assaults), sedatives (13.0%), methadone (10.9%), cocaine (4.3%), narcotics (4.3%), prescription drugs (4.3%), morphine (2.2%) and methamphetamine (2.2%).¹²

In over two-thirds of hospital assaults in 2006 (69.9%), the POI and victim were previously unknown to each other. When the victim was unknown to the POI, the victim was most often a hospital staff member¹³, a law enforcement officer (i.e. a police officer or prison guard), a hospital patient or visitor, or a hospital security guard. When the victim was known to the POI (26.0% of total hospital

Figure 4: Hospital assault rates in NSW, 2006

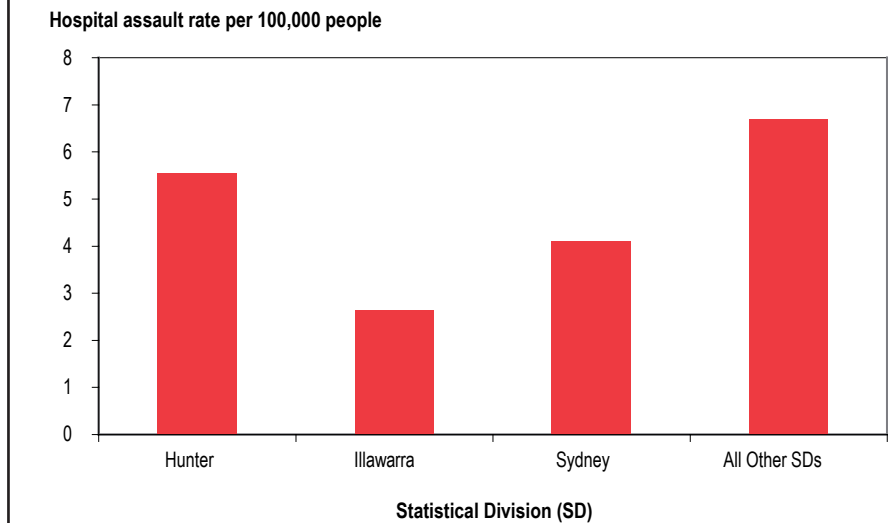


Table 2. Features of hospital assaults in NSW in 2006, according to author-coded police event narratives

Variable of interest	Percentage
Severity of the assault	
- Verbal threats/abuse only	8.5
- Minor physical contact	87.4
- Major physical contact	4.1
- Resulting in death or life-threatening injuries	0.0
Mental health-related	31.7
Alcohol-related	30.5
Drug-related	17.1
- Most common drug: Cannabis	19.6
POI and victim unknown to each other (69.9% of assaults)	
- Hospital health-care worker	37.4
- Law enforcement officer	26.3
- Hospital patient/visitor	17.0
- Hospital security guard	14.6
- Other	4.7
POI and victim known to each other (26.0% of assaults)	
- Friends/acquaintances	39.1
- Family	35.9
- Familiar health-care worker	12.5
- Work colleague	9.4
- Other	3.1
Domestic violence-related	11.8
Reporter of the assault	
- Victim	38.6
- Hospital staff	37.0
- Police	23.6
- Other	0.8
Resulted in charges being laid	49.6

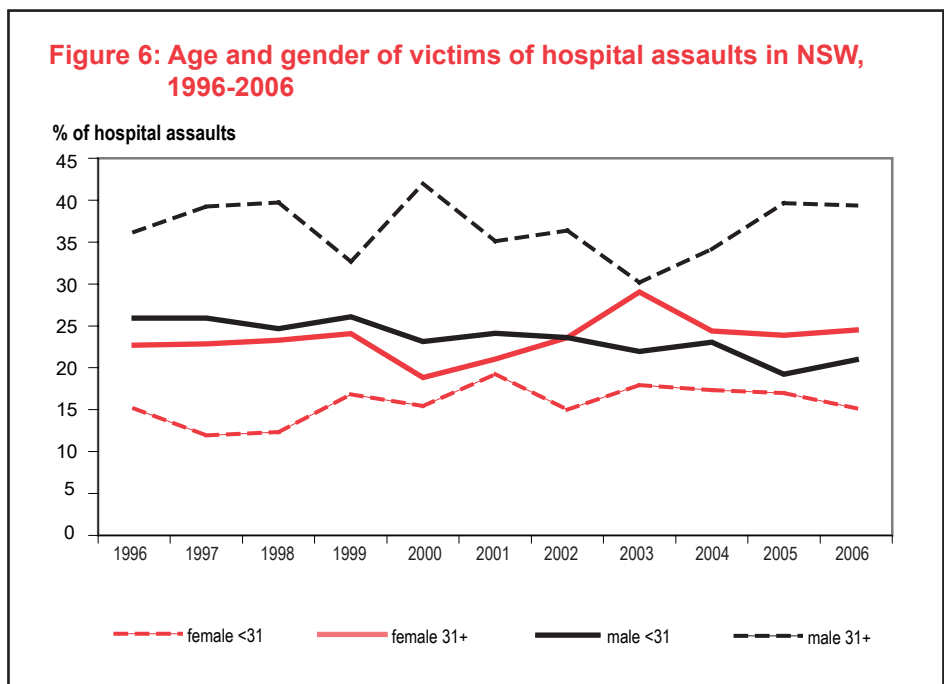
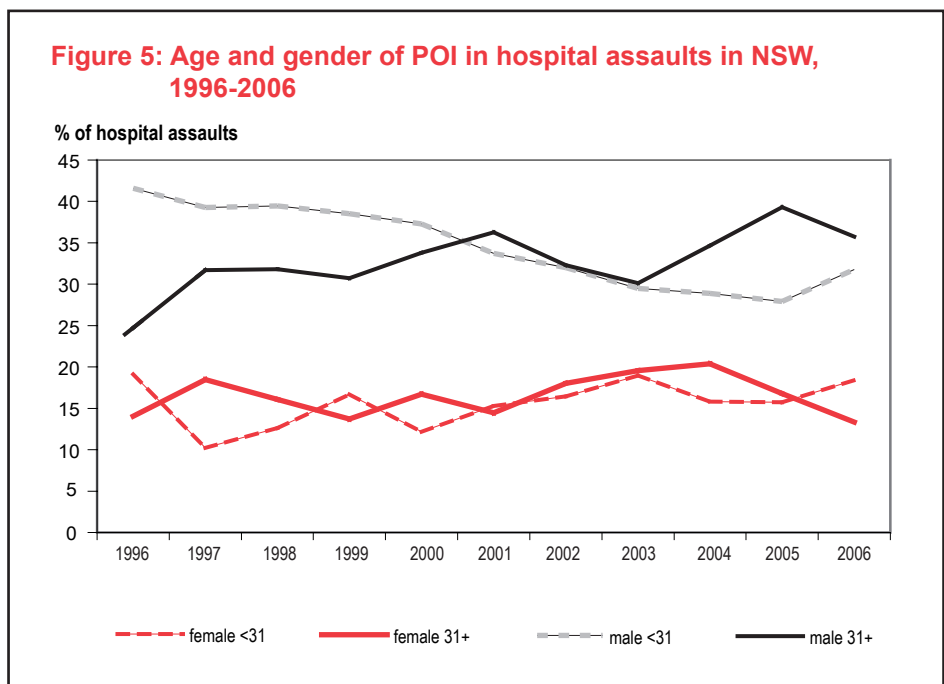
assaults; data missing in 4.0% of narratives), they were most often a friend/acquaintance, family member, familiar health care worker (e.g. their psychiatrist), or work colleague of the POI. This meant that, across all hospital assaults in 2006, the victim was most often a hospital staff member (33.3%), closely followed by a patient or visitor (31.2%), then a law enforcement officer (18.7%), then a hospital security guard (10.6%). When a hospital staff member was assaulted, the perpetrator was almost always a stranger (e.g. a patient they were treating in the emergency department). Patients and visitors, on the other hand, were more likely to be assaulted by someone they already knew (e.g. friend or family member) than by a stranger (e.g. another patient in the hospital). Overall, 11.8 per cent of all assaults in 2006 were classified as domestic violence-related.

The most common person to report the assault was the victim (38.6%) or a hospital staff witness (37.0%). Police were listed as the reporter if the POI was already in their custody at the time of the assault, or they happened to witness the assault themselves; subsequently, police were the reporter in 23.6 per cent of hospital assaults in 2006. Finally, when the POI could be identified, they were just as likely to have no legal action taken against them (50.4%) as they were to be charged in relation to the assault (49.6%).¹⁴

LONG-TERM TRENDS IN HOSPITAL ASSAULTS IN NSW

Police-coded hospital assault incident data, 1996-2006

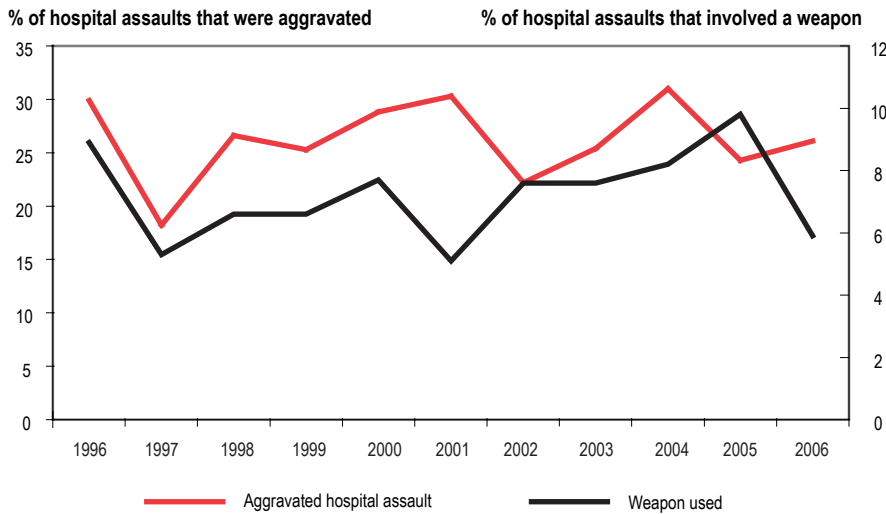
As shown in Figure 5, while most POIs from 1996 to 2006 were male, the proportion of male POIs aged less than 31 years decreased across the years, whereas the proportion of male POIs aged 31 or older increased. There was no difference in the proportion of female POIs aged 30 or younger or 31 or older. The demographic distribution of victims of hospital assaults remained fairly stable, with victims most often being male and aged 31 or older (see Figure 6).



While there was a lot of variability in the incidence of aggravated hospital assaults and assaults involving a weapon from year to year, overall their trends were relatively stable. From 1996 to 2006, the proportion of hospital assaults that were aggravated ranged from 18.2 per cent (in 1997) to 31.0 per cent (in 2004) and the proportion that involved a weapon ranged from 5.1 per cent (in 2001) to 9.8 per cent (in 2005; see Figure 7).

There was little change in relation to the geographic location and the time of year that hospital assaults occurred. First, across the decade, Sydney accounted for around half of all hospital assaults across NSW. While there is little evidence of a trend, the data in Figure 8 suggests that Sydney's proportion of hospital assaults has shown a very gradual increase since 1997. The Hunter SD consistently had the second-highest proportion of

Figure 7: Aggravated hospital assaults and hospital assaults involving a weapon in NSW, 1996-2006



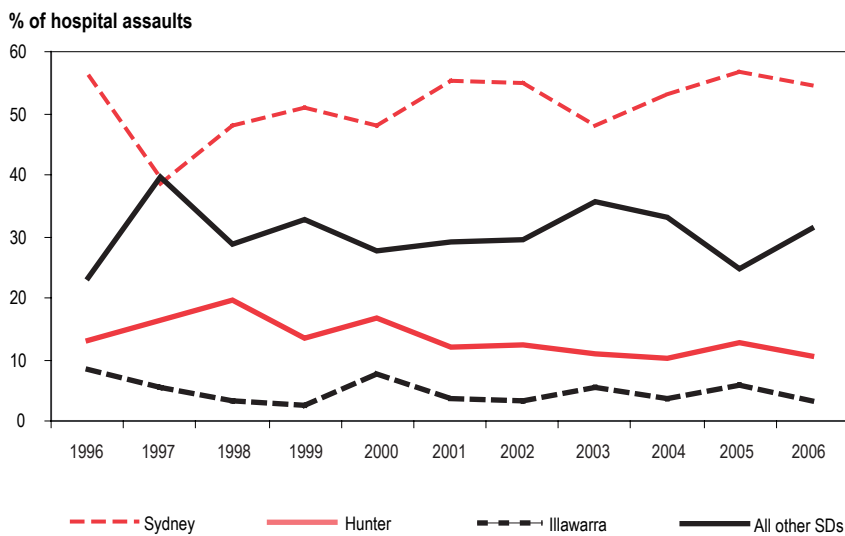
hospital assaults that resulted in injuries to the victim decreased substantially between 1996 (50.9% of all hospital assaults) and 1997 (24.1% of assaults), with a more gradual decline thereafter (with only 16.5% of hospital assaults resulting in injuries to the victim in 2006; see Figure 10). However, the distribution of the types of injuries remained stable, with most injuries being only minor (see Figure 11).

Author-coded police event narratives, 1996 and 2006

As can be seen from Table 3, coding of police event narratives by the author indicated little change between 1996 and 2006 in the relationship between the POI and the victim (they were usually unknown to each other); the proportion of hospital assaults that were alcohol-related (average of 29.4% across the two years) or drug-related (average of 15.6%); and the person who reported the assault to police (usually the victim or a hospital staff witness). In both years, the victim of a hospital assault was most often a hospital staff member (average of 34.2% across the two years) or a hospital patient/visitor (32.3%), a law enforcement officer (19.0%), or a hospital security guard (9.0%). While hospital staff members, law enforcement officers and hospital security were almost always assaulted by strangers, hospital patients and visitors were more likely to be assaulted by someone they already knew than by a stranger.

However, across these two years, there were changes in the severity of hospital assaults, the proportion of hospital assaults that resulted in charges being laid, and the proportion of hospital assaults that were coded as being mental health-related. First, there was a significant change in the distribution of the severity of hospital assaults ($\chi^2_3=6.5, p=.040$), with the largest change observed in hospital assaults that were classified as involving only verbal abuse and/or threats. These types of assaults increased from 2.8 per cent of police narratives in 1996 to 8.5 per cent in 2006. By comparison, assaults involving “minor physical contact” were evident in 94.4 per

Figure 8: Location of hospital assaults across NSW, 1996-2006



hospital assaults although the data in Figure 8 suggests that the proportion of hospital assaults in the Hunter decreased slightly between 1998 (a peak of 19.7% of hospital assaults in NSW) and 2006 (10.6%). All other SDs recorded low figures very similar to each other. Second, while there was a lot of variability in the proportion of assaults that occurred in each season of the year, overall, each of

the four seasons accounted for about the same proportion of all hospital assaults (see Figure 9). This is surprising given the general seasonality of total assaults (with a larger proportion of total assaults occurring in the summer months; see Moffatt & Goh 2007).

From 1996 to 2006, there was a decrease in the likelihood of the victim being injured in a hospital assault. The proportion of

Table 3: Characteristics of assaults on hospital premises in 1996 and 2006, according to police narratives

Features of hospital assaults	1996 (n=177)	2006 (n=246) ^a	p-value
Victim unknown to POI	74.0%	69.9%	
Identity of the victim			
- Hospital staff member	35.0%	33.3%	
- Hospital patient/visitor	33.3%	31.2%	
- Law enforcement officer	19.2%	18.7%	
- Hospital security guard	7.3%	10.6%	
- Other	5.2%	6.2%	
Drug-related	14.1%	17.1%	
Alcohol-related	28.2%	30.5%	
Mental health-related	19.2%	31.7%	.004
Reporter of the assault			
- Victim	41.8%	38.6%	
- Hospital staff witness	39.0%	37.0%	
- Police	19.2%	23.6%	
- Other	-	0.8%	
Seriousness of assault			.040
- Verbal abuse/threats only	2.8%	8.5%	
- Minor physical contact	94.4%	87.4%	
- Major physical contact	2.8%	4.1%	
- Fatal or near-fatal force	0.0%	0.0%	
Outcome of assault (overall)			.031
- Charges laid against the POI(s)	60.5%	49.6%	
- No further action taken	39.5%	50.4%	

cent of police narratives in 1996, and in 87.4 per cent of narratives in 2006. “Major physical contact” was seen in only 2.8 per cent of narratives in 1996 and 4.1 per cent of narratives in 2006.

Second, and consistent with the increase in less serious assaults, from 1996 to 2006 there was a significant shift away from laying criminal charges against POIs who had allegedly committed hospital assaults. In 1996, 60.5 per cent of police narratives where the POI was identified indicated that the assault resulted in legal action being taken, while 39.5 per cent of narratives ended with “no further action taken”. This differed significantly from the outcomes observed in 2006, where just under half (49.6%) of police narratives indicated the assault resulted in charges against the identified POI, while 50.4 per cent ended with no further action being taken ($\chi^2_1=4.6$, $p=.031$). Thus, in 1996 there was a tendency for police to take legal action against the POI, but in 2006 this tendency disappeared.

Finally, from 1996 to 2006 there was a significant increase in the proportion of assaults that were classified as being mental health-related. In 1996, 19.2 per cent of all narratives mentioned mental health issues; in 2006 that proportion increased to 31.7 per cent (a 65.1% increase; $\chi^2_1=8.3$, $p=.004$; see Table 3). It has been recognised that people with mental health problems often have co-morbid alcohol or drug abuse problems (Paterson, Claugnan & McCornish 2004) and this tendency was reflected in the police narratives. In 1996, a substantial proportion of mental health-related hospital assaults were also drug-related (24.0%) or alcohol-related (6.0%; no assaults were classified as mental health-, drug-, and alcohol-related in 1996). In 2006, mental health-related hospital assaults were also identified as involving drugs (24.0%), alcohol (25.3%), or drugs and alcohol (21.1%) to an even greater extent. It is unclear why incidents deemed to be mental health- and alcohol-related increased over time.

While mental health-related hospital assaults were no less (or more) severe than non-mental health-related assaults,

^a There are fewer police event narratives describing hospital assaults than police-recorded incidents of hospital assaults because one narrative can describe multiple incidents.

Figure 9: Hospital assaults in NSW by season, 1996-2006

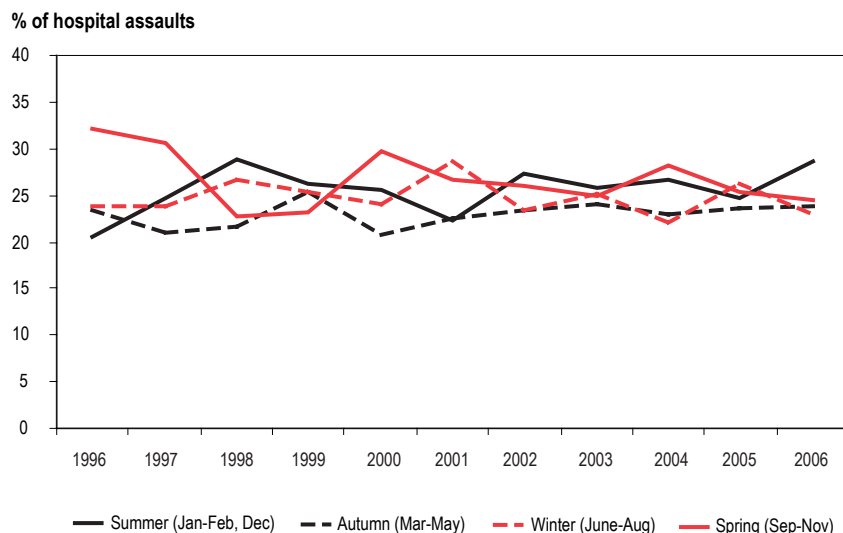
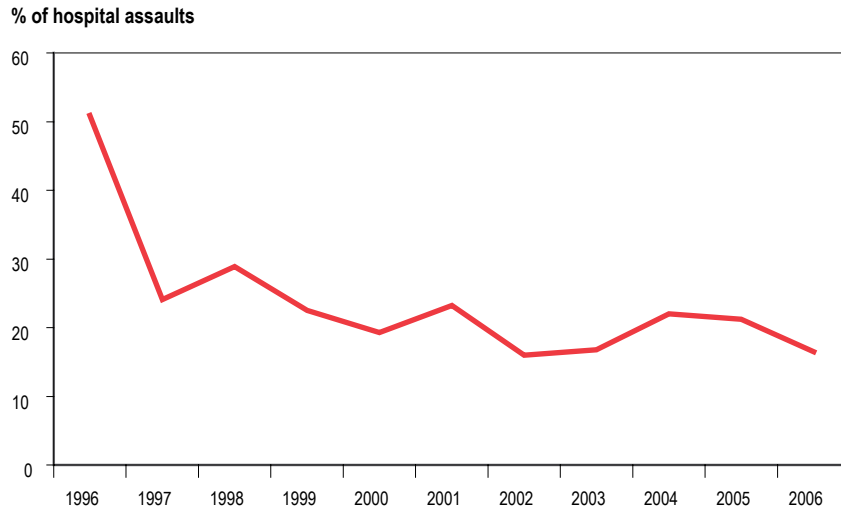


Figure 10: Percentage of hospital assault victims in NSW who sustained injuries, 1996-2006

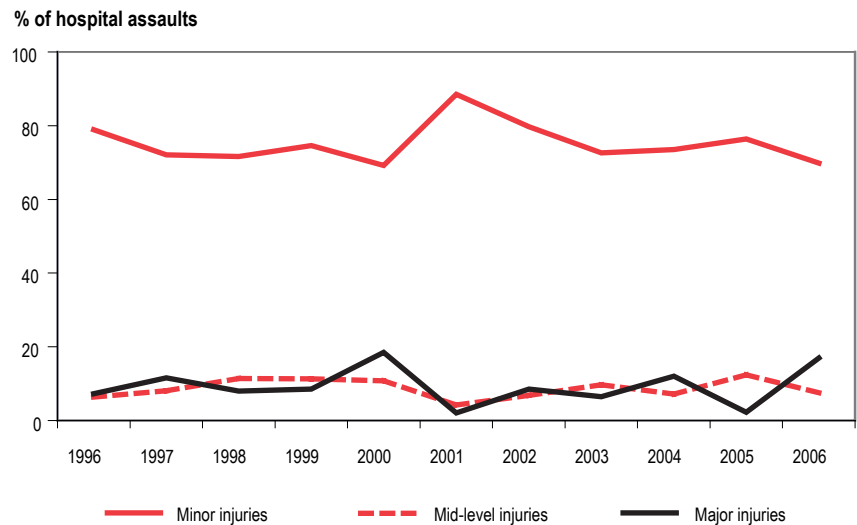


was not aggravated, involved only minor physical contact and resulted in no visible injuries to the victim. The POI was male and aged around 30 years, while the victim was a male, aged around 35 years and not personally known to the POI. The assault was most likely to be reported by either the victim or a hospital staff witness. The POI had about a 50 per cent chance of being charged for the assault; this chance decreased if the assault was classified as mental health-related but increased if the assault involved drugs or alcohol.

The second aim was to see whether any characteristics of hospital assaults had changed between 1996 and 2006. Numerous features of hospital assaults were found to have remained stable across these years. These features included the seriousness of the injuries sustained by the victim, the incidence of aggravated hospital assaults or assaults involving a weapon, the person reporting the assault, the characteristics of the victim (e.g. their gender, age and relationship to the POI), and the proportion of hospital assaults that were alcohol- or drug-related. The stability of drug-related assaults is somewhat surprising, considering the extensive media coverage suggesting that aggressive drug-related presentations to emergency departments are increasing (e.g. Carney 2006). It is possible that hospital staff effectively handle these presentations before an assault takes place. Alternatively, large numbers of drug-related hospital presentations may occur at only certain hospitals in areas where drug consumption is more common. Only further research can shed light on the patterns and outcomes of drug-related hospital presentations.

The coding of police event narratives indicated that hospital staff members and hospital patients and visitors are consistently the most frequent victims of hospital assaults. However, law enforcement officers also are common victims of or witnesses to hospital assaults. This suggests that a large proportion of hospital assaults occur when the POI is already in custody or

Figure 11: Seriousness of hospital assault victims' injuries in NSW, 1996-2006



Note: these percentages do not represent proportions from total hospital assaults; they only represent proportions from the small number of assaults that resulted in injuries to the victim in the first place (see Figure 10).

assaults that involved only mental health issues were far less likely to result in legal proceedings. Across both years, hospital assaults that involved only mental health issues (n=77) resulted in legal proceedings an average of only 22.1 per cent of the time. This is a significantly lower rate than for all other hospital assaults combined (61.5%; $\chi^2=46.3$, $p<.001$).

SUMMARY AND DISCUSSION

The first aim of this bulletin was to characterise the types of assaults that occurred on hospital premises in NSW in 2006. A 'typical' hospital assault in NSW in 2006 occurred on a weekend in Sydney, did not involve a weapon and

being accompanied by police or prison officers. In addition, hospital patients and visitors are far more likely to be assaulted by someone they have an existing relationship with (e.g. a friend or family member) than by a stranger (e.g. another patient they have never met before), whereas all other types of victims are almost always assaulted by strangers. Thus, the biggest threat of violence to the minority of patients who have been assaulted on hospital premises comes from the people who are visiting them. This is consistent with the spike in assaults between 3pm and 6pm on Sundays, as this is a time when there are likely to be a high number of patient visits.

While many features of hospital assaults were found to have remained stable across the years, there were several features that did change substantially. These changes might help to partly explain the increasing trend in hospital assaults in the last decade. First, there was a change in the age distribution of male POIs from 1996 to 2006. Across the decade, the proportion of male POIs aged 30 years or younger decreased, whereas the proportion of male POIs aged 31 years or older increased. In other words, male POIs for hospital assaults appear to be getting older. We cannot currently provide an explanation for why this is the case.

Second, on a positive note, there was a decrease in the proportion of hospital assaults that resulted in injuries to the victim from 1996-2006. It is therefore possible that the increase in total hospital assaults is being driven at least in part by an increase in less-severe assaults that do not result in any visible injuries (e.g. assaults that involve only verbal abuse and/or threats). This suggests victims and witnesses may be more willing to report these 'minor' incidents to the police. Such a possibility would be consistent with the third observed change: a significant decrease in the proportion of assaults that resulted in legal proceedings against the identified POI in 1996 and 2006. It may be that in cases of 'minor' assaults, it is more likely that legal proceedings will not be initiated, either because the victim

requests that no action be taken, police have insufficient evidence to warrant prosecution, and/or police do not think it is beneficial to prosecute the POI.

However, it is also possible that the decrease in the proportion of hospital assaults that were proceeded against is related to the fourth observed change, that being the significant increase in the proportion of hospital assaults that were classified as mental health-related. It was found that mental health-related assaults had a much lower rate of prosecution than non-mental health-related assaults, and from 1996 to 2006 there was a 65.1 per cent increase in the proportion of assaults that involved mental health issues. In addition, there was an increase in the proportion of mental health-related assaults that also involved alcohol or drug consumption. Unfortunately, we are unable to determine whether either the increase in mental health-related assaults or the increased rates of comorbidity with drug and/or alcohol consumption reflects real increases in these types of presentations at hospitals, better identification of mental health and comorbidity issues by police and hospital staff, more extensive reporting to police of these types of assaults (that might have previously been handled by only hospital administration), or a combination of all these factors. One possible influence is the introduction of a "zero tolerance towards violence" policy by NSW Health in 2003 (see NSW Health 2003), which might have encouraged hospital staff to report more assault incidents to the police. There may have been other policy changes in individual hospitals that also influenced reporting patterns. Only further research, perhaps using hospital records, would be able to clarify the driving mechanisms behind this trend.

It is important to note that this bulletin only used information on hospital assaults that were reported to police. Data from NSW Health suggests that an average of eight assault incidents a day occur across the entire health system (NSW Health 2004), so it certainly seems to be the case that a lot of assaults that occur at hospitals are not reported to police. Therefore, we

cannot say whether the characteristics of hospital assaults that are reported to police accurately represent all hospital assaults.

IMPLICATIONS

Alcohol, drugs, and mental health problems were evident in over 60 per cent of hospital assaults in 2006, and the proportion of mental health-related hospital assaults increased dramatically from 1996 to 2006. These findings are consistent with the large body of research that suggests the consumption of alcohol or drugs, or the presence of mental health problems, are all associated with higher risks of violence (see Mayhew & Chappell 2001a; Wand & Coulson 2006). Training and educating hospital staff on how to effectively handle alcohol, drug, and mental health presentations may be one strategy to help reduce the incidence of assaults at hospitals. In addition, the provision of adequate security personnel, effective duress alarms, and building designs that promote the safety of staff and patients, have all been shown to be beneficial in reducing violent incidents (Mayhew & Chappell 2001b). Each of these developments were targeted by the NSW Health Taskforce on Prevention and Management of Violence in the Health Workforce when it was established in July 2001. A number of initiatives were rolled out during 2002 and 2003 (e.g. see NSW Health 2002, 2003).¹⁵ However, it seems that no research has been conducted to determine whether these initiatives have made hospitals safer for staff, patients or visitors. An evaluation of these initiatives could help hospitals determine where more attention should be focussed to address the issue of violence in hospitals.

In addition to hospital-driven initiatives, the police can also play a vital role in reducing assaults at hospitals. The NSW Police Force has recently introduced a pilot Mental Health Intervention Team (MHIT) program. Among the primary aims of the MHIT is to train police in recognising the signs and symptoms of mental illness and substance-induced psychosis, dealing with mentally ill people in ways that involve minimal harm to the

person(s) or police, and reducing the time taken to transfer mentally ill people to the healthcare system (see Campbell 2007). Such training has been found to be successful in several US jurisdictions (e.g. Compton et al. 2006; Teller et al. 2006). Again, rigorous evaluation of the effectiveness of this approach in NSW would be beneficial for police and policy makers.

ACKNOWLEDGEMENTS

I would like to thank Jim Baldwin of NSW Police Force and Victor Korabelnikoff of the NSW Bureau of Crime Statistics and Research (BOCSAR) for their assistance with data extraction. I would also like to thank Dr Don Weatherburn, Craig Jones, Laura Rodwell, Jacqueline Fitzgerald, Nadine Smith and Steve Moffatt from BOCSAR for their instructive advice, and thanks to two anonymous reviewers for their comments and suggestions. Finally, thank you to Florence Sin from BOCSAR for desktop publishing this bulletin.

REFERENCES

- Australian Bureau of Statistics 1996, *Crime and safety New South Wales*, Australian Bureau of Statistics, Canberra.
- Australian Bureau of Statistics 2006, *Crime and safety New South Wales*, Australian Bureau of Statistics, Canberra.
- Briscoe, S & Donnelly N 2001, *Temporal and regional aspects of alcohol-related violence and disorder*, Alcohol Studies Bulletin no. 1, NSW Bureau of Crime Statistics and Research, Sydney.
- Campbell, D 2007, *Special unit to address mental health issues*, NSW Government media release, 30 July 2007, viewed 17 January 2008, http://www.pennysharpe.com/ebrief_number/ebrief__number/22?page=3
- Carney, M 2006; 'The ice age', *Four Corners*, 20 March 2006, Australian Broadcasting Corporation, viewed 12 February 2008, <http://www.abc.net.au/4corners/content/2006/s1596788.htm>
- Compton, MT, Esterberg, ML, McGee, R, Kotwicki, RJ, & Oliva, JR 2006, 'Crisis intervention team training: changes in knowledge, attitudes, and stigma related to schizophrenia', *Psychiatric Services*, vol. 57, pp. 1199-1202.
- Goh, D, Moffatt, S, & Jones, C 2007, *New South Wales recorded crime statistics 2006*, NSW Bureau of Crime Statistics and Research, Sydney.
- Mayhew, C & Chappell, D 2001a, *Occupational violence: types, reporting patterns, and variations between health sectors*, Discussion Paper no. 1, Taskforce on the Prevention and Management of Violence in the Health Workplace, University of New South Wales, Sydney.
- Mayhew, C, & Chappell, D 2001b, 'Prevention of occupational violence in the health workplace', Discussion Paper no. 2, Taskforce on the Prevention and Management of Violence in the Health Workplace, University of New South Wales, Sydney.
- Moffatt, S & Goh, D 2007, *An update of long-term trends in property and violent crime in New South Wales: 1990-2006*, Bureau Brief no. 36, NSW Bureau of Crime Statistics and Research, Sydney.
- NSW Health 2002, *Taskforce on prevention and management of violence in the health workforce: Final Report*, NSW Health, Sydney.
- NSW Health 2003, *Zero tolerance response to violence in the NSW Health workplace: policy and framework guidelines*, NSW Health, Sydney.
- NSW Health 2004, *Zero tolerance for violence in health system*, NSW Health media release, 4 March, viewed 18 February 2008, http://www.health.nsw.gov.au/news/2004/20040304_00.html
- NSW Health 2006, *The health of the people of NSW: report of the Chief Health Officer*, 2006, NSW Health, Sydney.
- Paterson, B, Claughan, P & McCornish, S 2004, 'New evidence or changing population? Reviewing the evidence of a link between mental illness and violence', *International Journal of Mental Health Nursing*, vol. 13, issue 1, pp. 39-52.
- Poynton, S, Donnelly, N, Weatherburn, D, Fulde, G & Scott, L 2005, *The role of alcohol in injuries presenting to St Vincent's Hospital Emergency Department and the associated short-term costs*, Alcohol Studies Bulletin no. 6, NSW Bureau of Crime Statistics and Research, Sydney.
- Teller, JLS, Munetz, MR, Gil, KM & Ritter, C 2006, 'Crisis intervention team training for police officers responding to mental disturbance calls', *Psychiatric Services*, vol. 57, pp. 232-237.
- Wand, TC & Coulson, K 2006, 'Zero tolerance: A policy in conflict with current opinion on aggression and violence management in health care', *Australasian Emergency Nursing Journal*, vol. 9, pp. 163-170.

NOTES

1. Masters of Forensic Psychology student, University of New South Wales.
2. It is not the case that 1996 was an unusually low year for hospital assaults, as there was an even lower number of hospital assaults (n=149) in 1995.
3. Based on hospital separation data from the NSW Chief Health Officer's report (NSW Health 2006), it is estimated that for every 100,000 hospital separations across NSW, there were 9.85 hospital assaults in 1996, and 11.07 hospital assaults in 2006.
4. This bulletin only refers to information about hospital assaults that were reported to the police. Hospital assaults that were not reported to the police were not captured in our datasets.
5. An 'assault incident' was defined as any event that involved the threat or actual infliction of bodily harm. An incident was coded as an 'assault incident' if the attending police recorded it as involving either 'actual bodily harm', 'common assault', 'assault officer', 'grievous bodily harm, including malicious wounding',

and 'shoot with intent other than to murder'.

6. It should be noted that there is a lot of variance in the number of hospitals in each SDs in NSW. Metropolitan SDs will have a larger number of hospitals than more rural SDs due to the larger populations residing in those SDs.
7. An "aggravated" assault included all other types of assault except common assault, for example 'actual bodily harm', 'grievous bodily harm', 'shoot with intent other than to murder', and 'resist/hinder/assault officer'.
8. The vast majority of hospital assaults only involved one POI and one victim. However, if more than one victim was involved, the youngest age and the most serious injury type listed for that incident was selected. If more than one POI was involved, the youngest age was selected.
9. Police event narratives were only included in the analysis if the narrative indicated the assault actually took place on hospital premises. Assaults that were mistakenly listed as occurring at a hospital (e.g. the victim was taken to hospital after the assault) were excluded.
10. When police record a criminal incident on COPS, they have the option of nominating a range of factors that they believe were associated with the incident. Alcohol, drugs, and mental health are all possible associated factors although, of these, alcohol is the only associated factor recorded reliably. For the purposes of this study, a narrative was coded as involving alcohol, drugs, or mental health if (a) any of these were nominated as associated factors or (b) this factor was explicitly mentioned in the narrative itself. As a consequence, these factors were only identified if a police officer explicitly mentioned them. Thus, the data in this bulletin

can only be taken as a rough guide on the actual rates of drug-, alcohol-, and mental health-related hospital assaults. It should also be noted that the presence of any of these factors does not necessarily mean they played a causal role in the assault. A narrative was coded as involving "mental health issues" if the POI was mentioned to have a mental illness, a personality disorder, or an intellectual or developmental disability.

11. The assault rates per 100,000 for the Central West, Far West, Mid-North Coast, Murray, Murrumbidgee, North Western, Northern, Richmond-Tweed and South Eastern SDs were combined into a single assault rate for "All Other SDs" because the small number of assaults occurring in some SDs made rate calculations unreliable.
12. If more than one drug was mentioned in the police narrative, each drug was counted separately.
13. "Hospital staff member" included all hospital-affiliated health care workers (e.g. doctors, nurses and psychiatrists) and administration staff (e.g. receptionists).
14. A narrative was coded as "no action taken against the POI" if this was requested by the victim, police did not have enough evidence to lay charges, or police did not believe it would be beneficial to prosecute the POI. Hospital assaults where the POI was unable to be identified by police (which occurred in 7.3% of police narratives in 1996, and 2.0% of narratives in 2006) were excluded when analysing the legal outcome of hospital assaults.
15. Further details on the Taskforce can be found at <<http://www.health.nsw.gov.au/communications/campaigns/antiviolence.html>>.

APPENDIX

Case Study 1: Mental health-related hospital assault

Police were called after witnesses observed a 25-year-old male offender interfering with private property and displaying irrational and incoherent behaviour on the streets. Police formed the opinion that the offender appeared to be mentally unstable. As staff were concerned for the offender's welfare, they did not want to press charges in relation to the initial complaint. The offender was subsequently transported to the local hospital. He was assessed by the Mental Health Team, and it was decided he would be scheduled as a mental health patient. As police waited with the offender he became very violent, and attempted to assault police. In an effort to calm him down, a male nurse attempted to inject him with a sedative. The offender grabbed the syringe and threatened police and hospital staff with it. As police attempted to restrain him, he squeezed the syringe, squirting the contents onto two police officers. The offender was eventually sedated and transported to another hospital located nearby. It was later ascertained that the offender has a history of schizophrenia and mental illness. No charges were laid.

Case Study 2: Hospital assault of a staff member arising from theft

The victim was a 43-year-old female nursing professor. After going to the bathroom, she returned to her office at the hospital to find one 16-18 year-old male running from the door, and the 16-18 year-old offender standing behind her desk. The victim asked him what he was doing, and the offender said that he was lost. When she took hold of him and walked him out into the hall, they got into a scuffle. The offender pushed the victim up against the wall and ran down the hallway. The assault was witnessed by a hospital receptionist, who called police. The victim returned to her office to find her purse missing. The police arrived shortly after and spoke to the victim and the witness. The victim suffered a bruised left hand as a result of the assault. The victim stated she got a good look at the offender's face, and was prepared to look at offender photos. The area was patrolled, but neither the offender nor his accomplice was found.

Case Study 3: Domestic violence-related hospital assault – assault of a patient by a family member

The 32-year-old male offender attended hospital to visit his 60-year-old father, who was a patient in the hospital for breathing difficulties. During the visit an argument between the offender and his father ensued. As a result of the argument, the offender ripped a breathing mask off his father's face and punched him in the face, knocking him to the ground. Security were called by the nurses. They apprehended the offender as he was kicking his father on the floor, and then called the police. The father suffered bruising to his left forearm, back pains, and further trouble breathing. The offender was charged with assault.

Case Study 4: Domestic violence-related assault – assault of a patient by their spouse

The 28-year-old female victim had given birth in the hospital three days prior. The baby was born drug-dependent, and as a result was being treated in the neonatal section of the hospital. The victim and the male offender were in the neonatal section visiting the baby when they began arguing about the fact that the child was drug-dependent. The offender became aggressive and head-butted the victim and punched her in the right cheek area of her face. The offender then left the hospital. Hospital security have then spoken to the victim. The victim told security that she did not want to report the matter, and refused to give any details about the identity of the offender. Security then contacted police. Police visited the victim in the maternity ward, and she again told them she did not want to report the matter. The police told the victim to contact them if she changed her mind. Hospital security were advised of the situation. Police contacted the victim a few days at her residential address, and she again stated she did not want to report the matter. Police again informed the victim that she could call them if she changed her mind. Police suspected the offender was the victim's 37-year-old de facto partner, but as the victim refused to provide any details, no further action was taken.

Case Study 5: Alcohol-related hospital assault

Ambulance officers transported the drunk 55-year-old female offender to the triage area of a local hospital. The ambulance officers advised the victim, a 25-year-old nurse, that the offender was well intoxicated by alcohol and very abusive before they then left. A second nurse (the witness) sat with the offender until she could be seen by the victim. Five minutes later the victim called in the offender to be assessed. The witness remained with the offender and tried to organise a bed for the offender in the rehabilitation unit. A short while later the victim finished her assessment of the offender. As the victim went to remove the blood pressure band from the offender's arm, the offender slapped the victim across the face and began verbally abusing her. A short while later the offender left the hospital. Police then attended the hospital, where the victim provided them with a signed statement. The victim had no visible injuries from the assault. About an hour later police went to the offender's residence. The offender answered the door, and appeared to be affected by alcohol. She was arrested and charged with assault and breach of bail.

Case Study 6: Drug-related hospital assault

Police were called to a residence after an elderly couple called to say that their 37-year-old son had taken drugs (type unknown) and was now demanding that they 'give him money or he would stab them'. Police found the offender passed out in one of the rooms of his parents' house and, concerned about the amount of drugs he may have in his system, transported him to the local hospital. As the offender awoke in the police car he began to get aggressive, and wrestled violently until police handcuffed him. When the police seated the offender in the emergency waiting room he appeared calm, so the police removed his handcuffs. Immediately the offender attempted to leave, and a struggle ensued between him and the police. In the struggle the offender punched one police officer in the ribs, causing some pain. Police managed to subdue the offender and handcuff him, and the hospital refused to admit him because there was no facility available to hold him (the usual facility was already full). The offender was then told he would be taken to the police station and charged with assault and resisting arrest. At the police station the offender appeared to calm down, as the effects of whatever drug(s) he had taken appeared to wear off.