INSIGHTS: Summarizing Recent Research on Workplace Violence in Hospitals

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Publication: The Mental States of Aggressors: A Biopsychosocial Analysis of Workplace Violence Reports in Hospitals (link to original article)

Key Findings

An analysis of more than 2,600 reported violent incidents from two large U.S. hospitals (2019–2023) found that incidents more than doubled during the COVID-19 period and have remained elevated since.

Most incidents involved **physical violence**, often accompanied by verbal abuse. Nearly all events were classified as **Type II workplace violence**, meaning the aggressor was a patient or visitor rather than a coworker or external criminal.

A central contribution of the research is its identification of **two distinct aggressor mental-state profiles**:

1. **Clinically driven (involuntary) aggression** – behaviors associated with medical or psychiatric impairment such as delirium, dementia, intoxication, or acute mental illness.
2. **Intentional or unremorseful aggression** – behaviors not clearly linked to clinical impairment, where aggressors deny, minimize, or justify their actions.

> *Policies that recognize* ***why*** *violence occurs—not just that it occurs—enable safer, fairer, and more effective responses.*

These two profiles occurred at similar rates and were associated with different staff reactions. Incidents involving intentional aggression generated greater emotional distress among staff, while clinically driven incidents often elicited more neutral or compassionate responses.

Why This Matters

Most hospital violence prevention policies treat WPV as a single problem with a uniform response. This research shows that **violence in hospitals is not a single phenomenon**, and that mismatched responses can undermine staff safety, morale, and trust in leadership.

Failing to distinguish between types of aggression can lead to:

- Inconsistent security responses
- Staff perceptions that intentional violence is tolerated
- Burnout and morale injury following repeated incidents
- Missed opportunities for prevention and resource targeting

Strategic Implications & Recommended Actions

Area	Recommendation
Training & Prevention	Provide de-escalation training that distinguishes clinical impairment (e.g., delirium) from intentional aggression to improve staff safety and response effectiveness.
Risk Assessment	Incorporate mental status screening or situational triggers (e.g., long wait times, intoxication, confusion) into violence risk protocols.
Reporting & Support	Ensure robust, non-punitive incident reporting systems and trauma support services to address staff distress, especially following unremorseful aggression.
Security Policies	Tailor security practices to different types of violence (e.g., increased presence in high-risk units, rapid response teams for physical threats).
Collaborative Care	Engage clinical teams and mental health professionals in safety planning to manage behaviors linked to involuntary states.

Bottom Line

Policies that recognize **why violence occurs—not just that it occurs—enable safer, fairer, and more effective responses**. Hospitals that integrate these insights are better positioned to protect staff, meet regulatory expectations, and sustain a safe care environment.