2025 Healthcare Crime Survey

IAHSS FOUNDATION

Dedicated to Research and Education in Healthcare Security and Safety

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Table of Contents

Note. This is the 2025 Healthcare Crime Survey produced by the International Association for Healthcare Security and Safety – Foundation (IAHSS Foundation) and reflects healthcare crime trends for 2012 to 2024.

ACKNOWLEDGEMENTS

We extend our sincere appreciation to the healthcare security professionals who operate daily in demanding, high-pressure environments. Their commitment to safety and resilience has been especially evident through the challenges of recent years. We also thank the facilities that completed the Healthcare Crime Survey; your participation strengthens the field, provides meaningful benchmarks, and supports shared learning across the healthcare security community. Finally, we acknowledge the IAHSS staff for their continued dedication to supporting both this survey and the broader mission of advancing healthcare security and safety.

INTRODUCTION

The International Association for Healthcare Security and Safety (IAHSS) Foundation was established to promote the welfare of the public through education, research, and the development of a comprehensive body of knowledge for healthcare security and safety. The Foundation supports research initiatives focused on improving healthcare security practices and provides scholarships to advance professional development within the field. Additional information about the IAHSS Foundation is available at www.iahssf.org.

The 2025 Healthcare Crime Survey was commissioned through the IAHSS Foundation's Research and Grants Program. The purpose of the survey is to provide healthcare security professionals with a data-driven understanding of the frequency, nature, and trends of crime and workplace violence (WPV) occurring in healthcare facilities across the United States. Healthcare security leaders were invited to participate, and when respondents were responsible for more than one facility, a separate survey was requested for each location.

Consistent with prior Crime Surveys, the 2025 edition collected data on ten primary crime categories:

- Murder
- Rape
- Robbery
- Aggravated Assault
- Other (Simple) Assault
- Burglary
- Theft
- Motor Vehicle Theft
- Vandalism
- Disorderly Conduct

To promote consistency and comparability, the survey incorporated the Federal Bureau of Investigation's Uniform Crime Reporting (UCR) definitions. These definitions were embedded directly within the survey instrument and are included in the Appendix for reference.

Rates were calculated primarily per 100 licensed beds using the formula (Incidents ÷ Beds) × 100. In select analyses, rates were also normalized per 100 security full-time equivalent (FTE) personnel to account for staffing variation across facilities. In cases where extreme values materially influenced results, adjusted rates excluding significant outliers were used and clearly identified.

2024 Data Overall Analysis

The 2024 IAHSS Foundation Healthcare Crime Survey reflects a high degree of continuity with prior survey years. Type 2 WPV—violence directed at staff by patients or visitors—remains the dominant driver of assaults and disruptive incidents across healthcare facilities. Facilities operating inpatient psychiatric or behavioral health (BH) units continue to experience significantly higher volumes of behavioral incidents, while simultaneously maintaining lower patient elopement rates. This pattern reinforces the long-standing protective effects associated with specialized behavioral health infrastructure and staffing models.

Facilities with Threat Management Teams (TMTs) and Visitor Management Systems (VMS) again reported higher overall incident rates. As in previous years, these elevated rates reflect facility size,

behavioral acuity, public interface complexity, and more mature reporting practices rather than increased inherent violence. Larger and more complex facilities consistently demonstrate greater risk visibility and documentation fidelity.

While overall patterns remained stable in 2024, several notable shifts emerged. Adoption of TMTs and VMS declined modestly compared to 2023, and facilities without BH units experienced rising behavioral incident rates when adjusted metrics were examined. These trends suggest increasing operational strain in non-specialty environments, particularly where behaviorally complex patients are managed outside of dedicated behavioral health settings.

DATA ANALYSIS

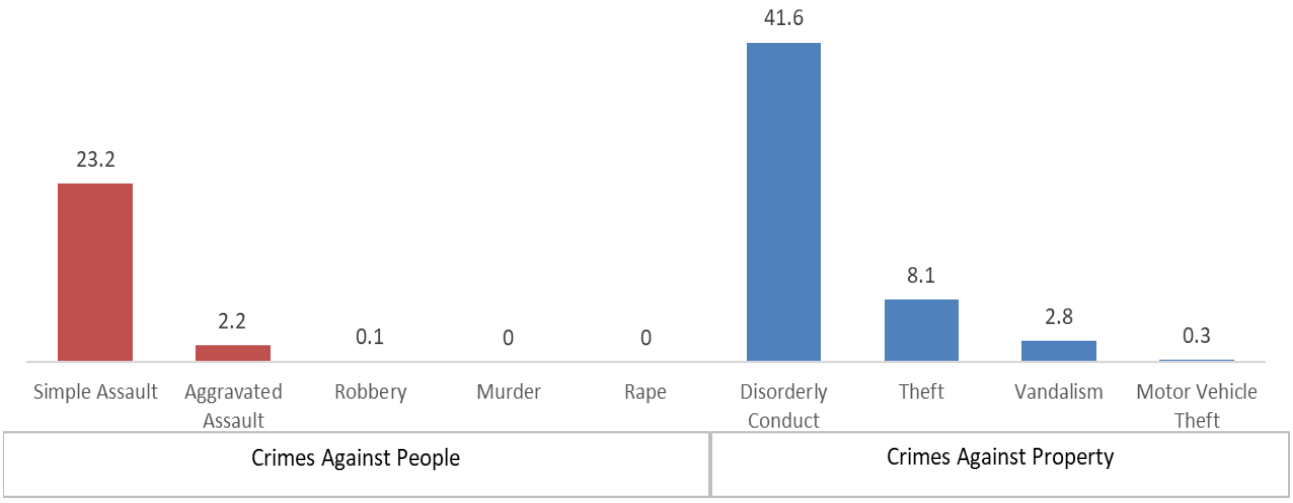
Crime Data

The 2025 IAHSS Foundation Healthcare Crime Survey presents an analysis of crime and security incident data reported by participating facilities for calendar year 2024. A total of **193** survey responses were received, consistent with recent survey cycles. Following data validation, **182** responses were deemed usable. As in prior years, a response was considered usable when the facility reported its licensed bed count and submitted the majority of core crime metrics, as these elements are essential for calculating reliable, exposure-adjusted rates.

The findings presented in this section reflect incidents occurring during the 2024 reporting period. Crime rates were calculated as incidents per 100 licensed beds, using the formula (Incidents ÷ Licensed Beds) × 100, to support standardized benchmarking and comparability across facilities of varying size, service mix, and patient population. In select analyses, adjusted rates were used to mitigate the influence of zero-bed facilities and statistical outliers, consistent with prior survey methodology.

This approach aligns with IAHSS Healthcare Security Industry Guidelines 01.05.01 Security Incident Reporting, 01.05.02 Incident Categories and Data Analysis, and 01.05.03 Security Metrics, which emphasize standardized data collection, normalized rate analysis, and longitudinal trending to support program evaluation, benchmarking, and performance improvement. The categorization of incidents reflects the IAHSS Incident Category and Data Collection Framework, which provides a structured and consistent approach to classifying healthcare security events.

Figure 1 *All crimes per 100 beds, 2024*



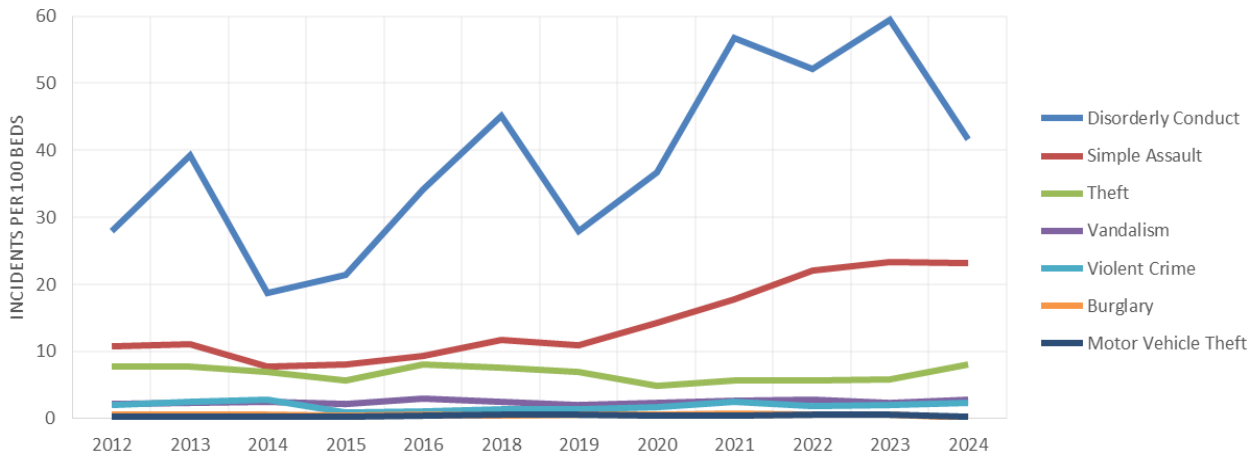
The 2024 findings reaffirm that behavior-driven and interpersonal incidents continue to dominate the security landscape in healthcare facilities. Other (Simple) Assault remained the most frequently reported crime against persons, with a weighted rate of 22.9 incidents per 100 beds. Disorderly Conduct, a category capturing behavioral escalation, agitation, and disruptive conduct, reached 41.28 incidents per 100 beds, exceeding all other reported crime categories. Together, these two categories account for the majority of crime-related activity occurring within healthcare facilities.

Traditional property crimes continued their multi-year decline. Theft remained the most frequently reported property offense at 8.06 incidents per 100 beds, followed by Vandalism at 2.82, Motor Vehicle Theft at 0.25, and Burglary at 0.17 incidents per 100 beds. Collectively, property crimes accounted for approximately 11 incidents per 100 beds, underscoring the sustained reduction of traditional criminal activity within healthcare environments.

Violent felonies remained exceedingly rare in 2024. Weighted rates for Murder (0.01), Rape (0.02), and Robbery (0.06) per 100 beds were negligible across reporting facilities. Aggravated Assault, while substantially less frequent than simple assault, remained an important operational concern at 2.18 incidents per 100 beds, particularly in higher-acuity environments and facilities with significant emergency department volume or behavioral health exposure.

The longitudinal dataset collected through the IAHSS Foundation Healthcare Crime Survey illustrates how facility crime patterns have evolved over time. Figure 2 presents weighted crime rates per 100 licensed beds for major crime categories reported between 2012 and 2024, enabling year-over-year comparison and trend analysis.

Figure 2 *Crime rate trends per 100 beds, 2012-2024*



The 12-year trend line highlights several key and sustained shifts:

1. **Growth in behavioral and interpersonal incidents**
   Rates of Simple Assault and Disorderly Conduct increased substantially over the past decade, particularly between 2016 and 2022. These categories reflect rising behavioral health acuity, substance use, social instability, and emotional distress that frequently manifest in emergency departments, public-facing areas, and high-activity clinical settings.
2. **Stabilization of serious violence**
   Aggravated Assault and other violent felonies increased modestly between 2019 and 2022 but have stabilized since 2023. This plateau may reflect maturation of threat management practices,

behavioral response protocols, and sustained organizational investment in WPV prevention and mitigation.

3. **Decline in property crime**
   Theft, Burglary, and Motor Vehicle Theft have steadily declined since 2017. Continued investments in surveillance coverage, access control, parking security, and asset-protection technologies appear to have produced durable reductions in traditional property crime exposure.
4. **Relative stability in vandalism**
   Vandalism rates have fluctuated minimally year over year, suggesting persistent environmental and external pressures rather than meaningful changes in offender behavior or facility type.

Taken together, the 2024 findings and the broader historical dataset present a consistent and evolving narrative regarding healthcare facility risk. Crime exposure has shifted away from traditional property offenses toward behavior-driven, interpersonal, and clinically influenced incidents. While violent felonies remain rare, the persistence of aggravated assaults reinforces the need for structured threat management, interdisciplinary collaboration, and proactive WPV mitigation strategies.

Overall, the data confirm that the primary security burden in healthcare facilities is now rooted in behavioral and interpersonal risk rather than conventional criminal activity. This shift necessitates security strategies centered on incident reporting fidelity, data-driven analysis, clinical partnership, staffing alignment, and evidence-based WPV prevention—consistent with IAHSS guidance for modern healthcare security programs.

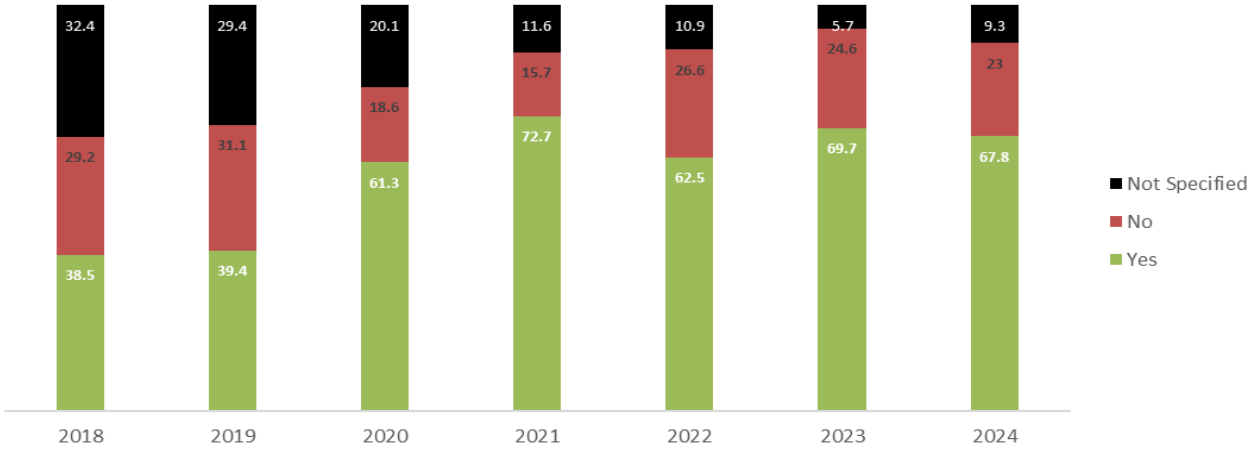
Workplace Violence Typology

To further characterize the nature of assaults occurring in healthcare environments, the 2024 survey asked participating facilities whether they classify WPV incidents using the Workplace Violence Typology framework. The WPV Typology categorizes violent events into four primary types based on the relationship between the perpetrator and the workplace:

- **Type 1:** Violence committed by individuals with no legitimate relationship to the facility
- **Type 2:** Violence directed at staff by patients, visitors, or others receiving services
- **Type 3:** Violence between current or former employees
- **Type 4:** Violence involving individuals with a personal relationship to an employee but no direct connection to the facility

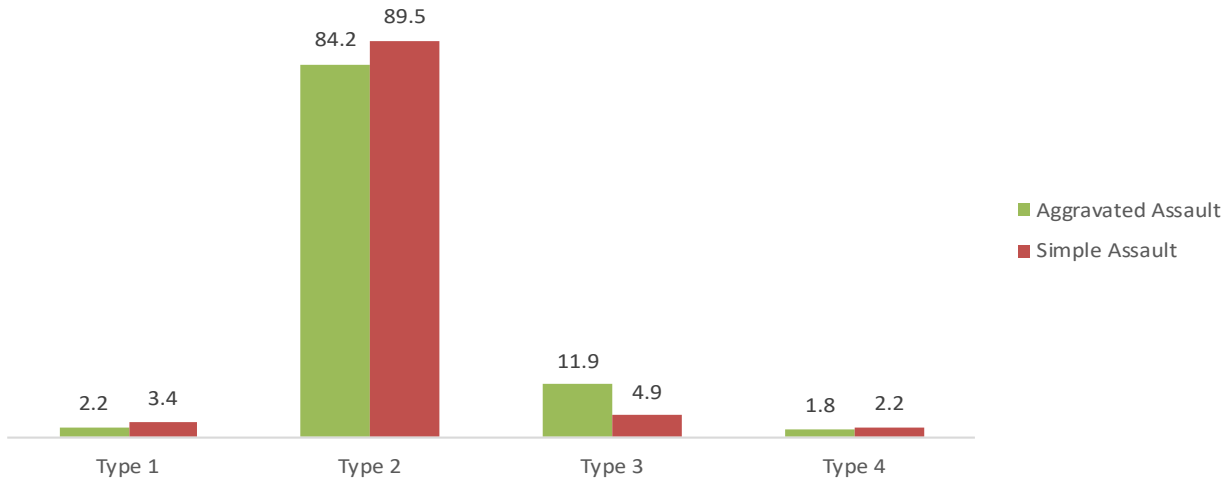
Use of WPV Typology is a recognized indicator of organizational maturity and aligns with regulatory and industry expectations for structured incident reporting and analysis. Its application is supported by IAHSS Healthcare Security Industry Guidelines 01.05.01 Security Incident Reporting and 01.05.02 Incident Categories and Data Analysis, which emphasize consistent classification of incidents to support trend analysis, benchmarking, and prevention planning

Figure 3 *Facilities utilize WPV typology (%), 2018-2024*



In 2024, 67.8 percent of responding facilities reported using the WPV Typology to classify assaults. This represents a slight decline from 2023 (71.0 percent) but remains consistent with the stabilization observed over the past several survey cycles. After a period of steady growth, typology adoption appears to have plateaued, suggesting that most facilities with sufficient infrastructure and analytic capacity have institutionalized typology-based reporting. Facilities not using the typology continue to be disproportionately smaller or more resource constrained. Among facilities that reported using WPV Typology, the distribution of assault types remained highly consistent with prior years.

Figure 4 *WPV typology distribution by assault type (%), 2024*



In 2024, Type 2 WPV continued to overwhelmingly define healthcare violence. Facilities reported that 84.2 percent of aggravated assaults and 89.5 percent of simple assaults were classified as Type 2 events. This pattern reinforces the clinical and behavioral realities of healthcare delivery, particularly in emergency departments, inpatient behavioral health settings, and other high-acuity, high-contact environments.

The remaining typology categories represented substantially smaller proportions of total assaults:

- **Type 3 (Worker-on-Worker)** incidents accounted for 11.9 percent of aggravated assaults and 4.9 percent of simple assaults, reflecting persistent but relatively low levels of interpersonal conflict within healthcare workforces.
- **Type 1 (No Relationship to Facility)** incidents represented 2.2 percent of aggravated assaults and 3.4 percent of simple assaults, indicating that external criminal activity remains a minor contributor to overall WPV exposure.
- **Type 4 (Personal or Domestic Relationship)** incidents were the least common, comprising 1.8 percent of aggravated assaults and 2.2 percent of simple assaults.

Across the 2021–2024 period, several WPV typology patterns have remained stable:

- Type 2 incidents consistently account for the vast majority of assaults, generally exceeding 80–90 percent annually.
- Type 3 incidents remain low but persistent, reflecting ongoing interpersonal pressures in high-stress clinical environments.
- Type 1 and Type 4 incidents remain rare, together accounting for less than 10 percent of all assaults in any given year.
- Typology adoption has stabilized, indicating that structured WPV classification has become embedded in facilities with more mature security and reporting programs.

The consistent dominance of Type 2 WPV underscores that violence in healthcare is behavior-driven, clinically influenced, and structurally predictable, rather than random or externally driven. This finding aligns with IAHSS Healthcare Security Industry Guideline 01.09 Violence in Healthcare, which emphasizes the need for multidisciplinary prevention strategies addressing patient- and visitor-generated aggression through early identification, de-escalation, environmental controls, and coordinated response processes.

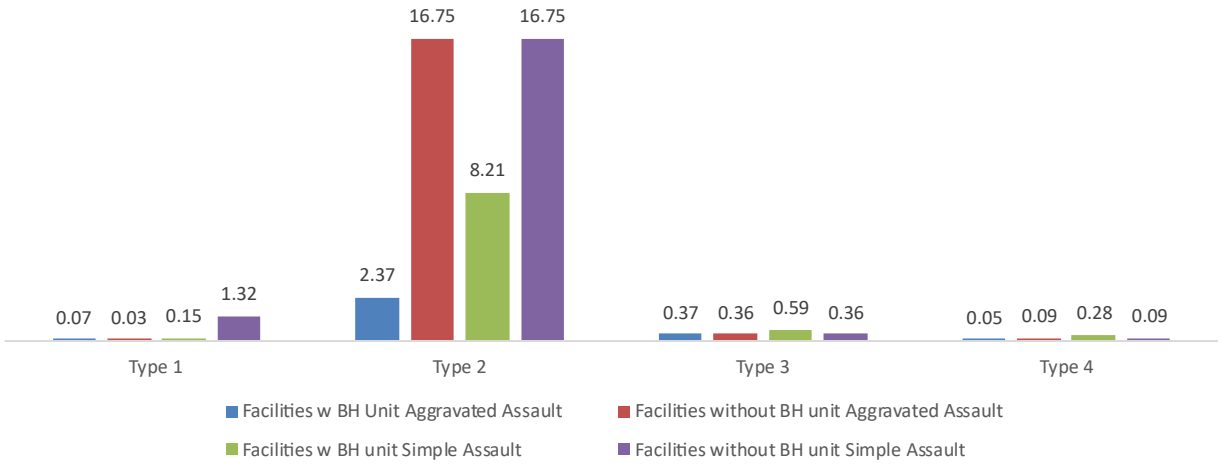
Overall, WPV Typology remains a critical analytic tool for healthcare security programs. Facilities that consistently apply typology-based classification are better positioned to monitor trends, allocate resources, justify staffing and training models, and advance formal WPV prevention and threat management initiatives. The continued stability of typology patterns across multiple years reinforces both the validity of the framework and its value in guiding data-driven mitigation strategies.

WPV Typology by Behavioral Health Facility Type

To further contextualize WPV exposure across healthcare environments, 2024 WPV typology results were examined separately for facilities with inpatient psychiatric/behavioral health units and facilities without BH units. Rates are expressed as incidents per 100 licensed beds, allowing for standardized comparison across facility types.

This analysis aligns with IAHSS Healthcare Security Industry Guidelines 01.05.02 Incident Categories and Data Analysis and 01.05.03 Security Metrics, which emphasize the use of normalized rates and stratified analysis to identify meaningful differences in WPV exposure and inform targeted prevention strategies.

Figure 5 *WPV typology by BH facility type (per 100 beds), 2024*



Type 2 (Patient- or Visitor-on-Worker) Assaults

In 2024, **Type 2 aggravated assault rates were lower in facilities with BH units**, averaging 2.37 incidents per 100 beds, compared with 16.7 incidents per 100 beds in facilities without BH units. A similar pattern was observed for Type 2 simple assaults, with facilities operating BH units averaging 8.21 incidents per 100 beds, compared with 16.75 incidents per 100 beds in facilities without BH units.

The higher concentration of Type 2 assaults in non-BH facilities highlights the operational challenges associated with managing behaviorally complex or psychiatric patients in environments not specifically designed for inpatient behavioral health care, such as emergency departments, medical-surgical units, and observation areas.

Type 3 (Worker-on-Worker) Assaults

Type 3 assault rates were comparable across facility types. Aggravated Type 3 assaults averaged 0.37 incidents per 100 beds in facilities with BH units and 0.36 incidents per 100 beds in facilities without BH units. Simple Type 3 assaults followed a similar pattern, averaging 0.59 incidents per 100 beds in facilities with BH units and 0.36 incidents per 100 beds in facilities without BH units.

These findings suggest that worker-on-worker WPV is influenced less by the presence of inpatient behavioral health services and more by universal factors such as operational stress, staffing pressures, and the high-intensity nature of healthcare work environments.

Type 1 (No Relationship to Facility) Assaults

Type 1 incidents remained infrequent across both facility types. Facilities with BH units reported slightly higher aggravated Type 1 assault rates at 1.09 incidents per 100 beds, compared with 0.07 incidents per 100 beds in facilities without BH units. Conversely, simple Type 1 assaults were marginally lower in facilities with BH units (2.31 incidents per 100 beds) compared with facilities without BH units (2.98 incidents per 100 beds).

Although these differences are modest, the overall low volumes reinforce that external criminal activity is not a primary driver of WPV in healthcare settings.

Type 4 (Personal or Domestic Relationship) Assaults

Type 4 incidents were more prevalent in facilities with BH units. Aggravated Type 4 assaults averaged 0.88 incidents per 100 beds in facilities with BH units, compared with 0.07 incidents per 100 beds in

facilities without BH units. Simple Type 4 assaults demonstrated a similar pattern, with facilities operating BH units averaging 4.65 incidents per 100 beds, compared with 0.20 incidents per 100 beds in facilities without BH units.

While Type 4 incidents remain rare overall, their elevated presence in facilities with BH units reflects added interpersonal, psychosocial, and situational complexity within these environments, including the intersection of personal relationships, behavioral health treatment, and workplace stressors.

Summary and Implications

Collectively, the 2024 WPV typology data demonstrate meaningful differences in WPV exposure based on the presence or absence of inpatient behavioral health services. Facilities without BH units experienced higher rates of Type 2 patient- or visitor-generated assaults, underscoring the risks associated with managing behaviorally complex patients in non-specialty settings. At the same time, facilities with BH units exhibited higher rates of Type 4 incidents and modestly higher Type 1 aggravated assaults, reflecting the broader interpersonal and psychosocial dynamics present in behavioral health environments.

Consistent with IAHSS Healthcare Security Industry Guideline 01.09 Violence in Healthcare, these findings reinforce that WPV is behavior-driven, clinically influenced, and structurally predictable, rather than random. The data highlight the importance of aligning staffing models, environmental design, de-escalation capabilities, and multidisciplinary threat management processes with the specific risk profile of each facility type.

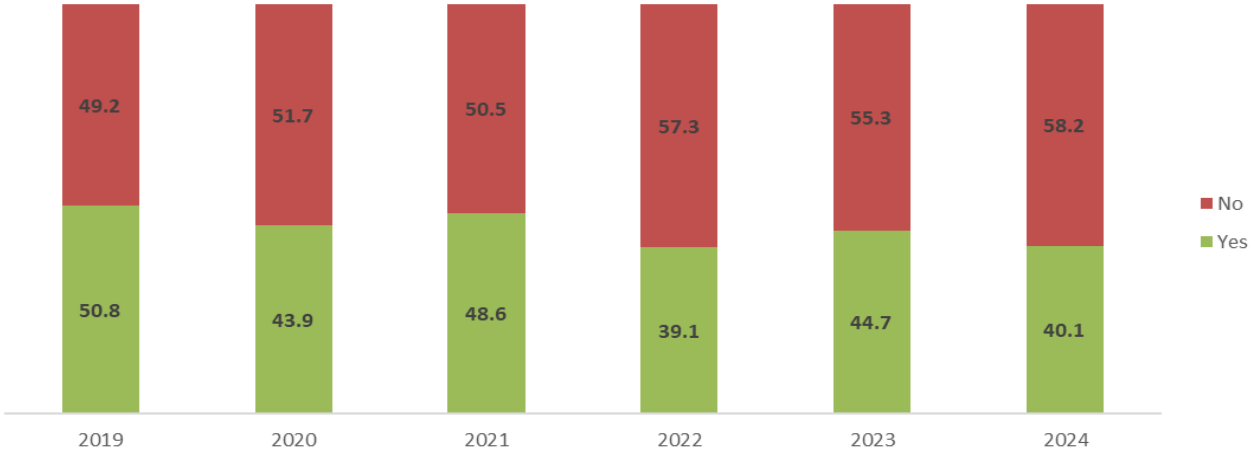
WPV typology remains an essential analytic tool for distinguishing these patterns and guiding targeted prevention strategies. Facilities that consistently apply typology-based analysis are better positioned to identify emerging risks, allocate resources appropriately, and advance comprehensive, data-driven WPV prevention programs.

Inpatient Psychiatric/Behavioral Health Units

To further examine the relationship between inpatient behavioral health capacity and security incident patterns, the 2024 survey asked facilities whether they operate an inpatient psychiatric or behavioral health unit. These units represent some of the highest-acuity environments in healthcare and are associated with unique clinical, behavioral, and security challenges that directly influence WPV exposure and overall incident volume.

This analysis aligns with IAHSS Healthcare Security Industry Guideline 05.07 Behavioral / Mental Health – General, which recognizes inpatient behavioral health environments as presenting elevated risks related to patient aggression, self-harm, interpersonal violence, and security resource utilization, as well as Guideline 01.04 Security Vulnerability Assessments, which emphasizes the importance of accounting for patient population complexity when evaluating security risk.

Figure 6 *Facilities operating Inpatient psych/ behavioral health units (%), 2019-2024*

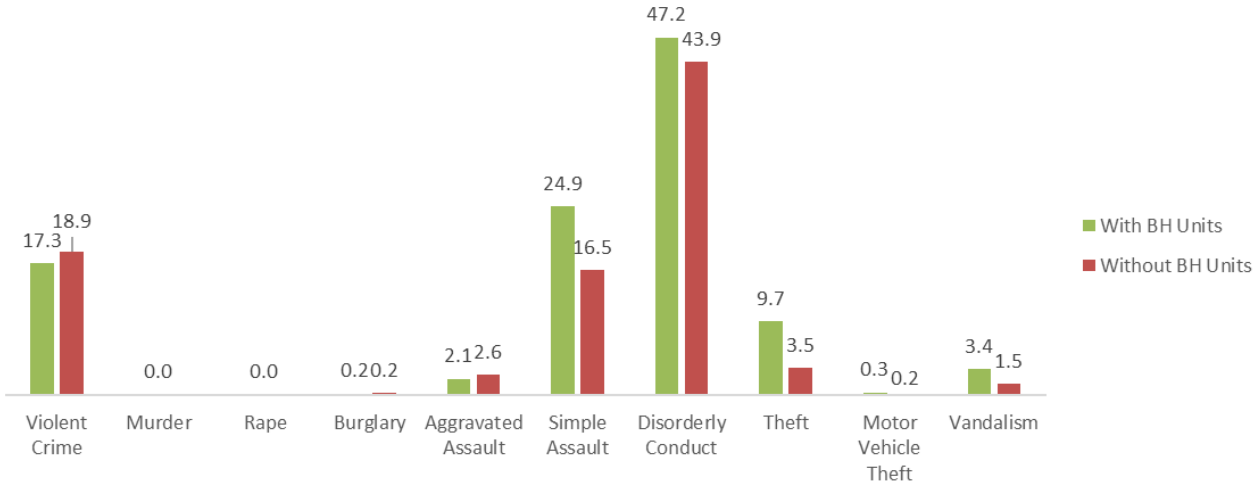


Of responding facilities in 2024, 40.1 percent reported operating an inpatient psychiatric or behavioral health unit. This proportion is consistent with historical survey results, which have typically ranged between approximately 39 and 50 percent across prior survey cycles, indicating stable representation of inpatient BH services among participating facilities.

Correlation analysis of the 2024 dataset indicates that facilities with inpatient BH units tend to operate within more complex clinical and operational environments. Facilities with BH units demonstrated a modest positive correlation with security staffing levels ($r = 0.29$) and licensed bed count ($r = 0.23$). While these correlations are not strong, they reinforce that facilities operating BH units often require expanded security resources to support higher behavioral acuity, increased incident exposure, and more frequent crisis-driven interactions.

Importantly, the relatively weak correlation with bed size confirms that elevated WPV and behavioral risk in BH-unit facilities is driven more by patient population complexity and service mix than by facility size alone. This finding is consistent with IAHSS guidance emphasizing that security risk in behavioral health environments is not adequately explained by census or square footage metrics in isolation.

Figure 7 *Incident rates comparing facilities with/without BH units (per 100 beds), 2024*



In 2024, facilities with inpatient BH units continued to demonstrate elevated rates of behavior-driven incidents across multiple categories. After excluding zero-bed facilities and adjusting for statistical outliers, violent crime rates averaged 17.3 incidents per 100 beds in facilities with BH units, compared with 18.9 incidents per 100 beds in facilities without BH units. Aggravated assault rates followed a similar pattern, with facilities without BH units reporting higher rates than facilities with BH units (2.6 versus 2.1 incidents per 100 beds, respectively).

A different pattern emerged across other behaviorally linked categories. Disorderly conduct was reported at higher rates in facilities with BH units, averaging 47.2 incidents per 100 beds, compared with 43.9 incidents per 100 beds in facilities without BH units. Simple assaults were also more prevalent in BH-unit facilities, averaging 24.9 incidents per 100 beds, compared with 16.5 incidents per 100 beds in facilities without BH units.

Adjusted rates for additional behaviorally associated categories remained higher in facilities with BH units. Theft averaged 9.7 incidents per 100 beds in facilities with BH units, compared with 3.5 incidents per 100 beds in facilities without BH units. Vandalism followed a similar pattern, with BH-unit facilities reporting 3.4 incidents per 100 beds, compared with 1.5 incidents per 100 beds in non-BH facilities.

These patterns suggest that while facilities without BH units may experience higher rates of certain violent outcomes—particularly aggravated assaults—facilities with BH units carry a consistently higher burden of behavioral escalation, interpersonal aggression, and ancillary crime categories tied to the intensity and volatility of behavioral health care environments.

Summary and Implications

The presence of an inpatient psychiatric or behavioral health unit remains one of the most consistent predictors of elevated behavioral incident exposure across healthcare facilities. Even after adjusting for zero-bed facilities, statistical outliers, and weighted bed distribution, facilities with BH units experience higher rates of simple assault, disorderly conduct, and other behaviorally linked incidents than facilities without such units.

Consistent with IAHSS Healthcare Security Industry Guidelines, these patterns reflect risks that are structural and clinically driven, rather than artifacts of reporting practices or facility size. While a small number of high-acuity facilities exert upward pressure on certain raw incident rates, adjusted analyses

confirm that underlying behavioral risk remains materially higher in environments providing inpatient psychiatric care.

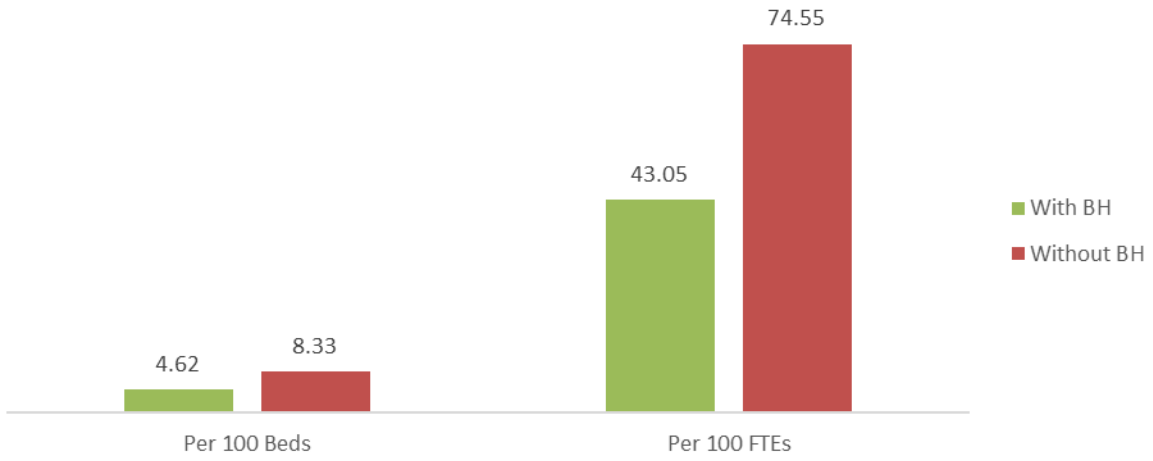
Taken together, the 2024 findings and historical survey data reinforce the need for enhanced security staffing models, interdisciplinary behavioral response strategies, advanced de-escalation capabilities, and targeted environmental controls in facilities operating inpatient behavioral health units. These facilities will continue to require elevated levels of operational readiness and tailored security resources to safely manage the complex behavioral dynamics inherent in this patient population.

Patient Elopements

Patient elopement remains a critical safety and security concern due to the potential for patient harm, regulatory exposure, and resource-intensive response requirements. The 2024 survey examined patient elopement rates in facilities with and without BH units, using both bed-normalized and security staffing–normalized rates to support meaningful comparison.

This analysis aligns with IAHSS Healthcare Security Industry Guideline 05.05 Patient Elopement Prevention and Response, which emphasizes standardized definitions, consistent incident reporting, and the use of normalized metrics to evaluate elopement risk and prevention effectiveness.

Figure 8 *Patient elopement rates (adjusted), 2024*



In 2024, facilities with inpatient BH units reported lower elopement rates than facilities without BH units across both measurement methods. When normalized per 100 licensed beds, facilities with BH units reported 4.62 elopements per 100 beds, compared with 8.33 elopements per 100 beds in facilities without BH units.

A similar pattern was observed when rates were normalized per 100 security FTE personnel. Facilities with BH units reported 43.05 elopements per 100 security FTEs, compared with 74.55 elopements per 100 security FTEs in facilities without BH units. The consistency of this pattern across denominators reinforces the validity of the finding and minimizes the influence of facility size or staffing variability.

Despite caring for some of the highest-risk patient populations, facilities operating inpatient BH units consistently demonstrate lower elopement exposure. This outcome reflects the structural and operational characteristics of dedicated behavioral health environments, which commonly include secured or semi-secured unit design, controlled ingress and egress, ligature-resistant architecture, enhanced patient observation protocols, and staff competencies centered on behavioral risk recognition and crisis intervention.

In contrast, facilities without dedicated BH units frequently manage behaviorally complex or psychiatric patients in emergency departments, medical-surgical units, or temporary holding areas. These environments are often characterized by open layouts, competing clinical priorities, higher patient throughput, variable staffing levels, and limited environmental controls. Extended boarding of psychiatric patients while awaiting placement further elevates elopement risk in these settings.

Summary and Implications

Across multiple survey years, measurement methods, and denominators, the presence of inpatient behavioral health infrastructure functions as a reliable protective factor against patient elopement. Facilities with BH units consistently outperform facilities without such units, despite managing higher-acuity patient populations.

These findings reinforce the importance of purpose-built environments, trained staff, and structured behavioral care protocols in reducing unauthorized patient departures. Consistent with IAHSS guidance, effective elopement prevention is not driven solely by staffing levels or surveillance, but by the integration of environmental design, clinical collaboration, clear response procedures, and disciplined incident reporting.

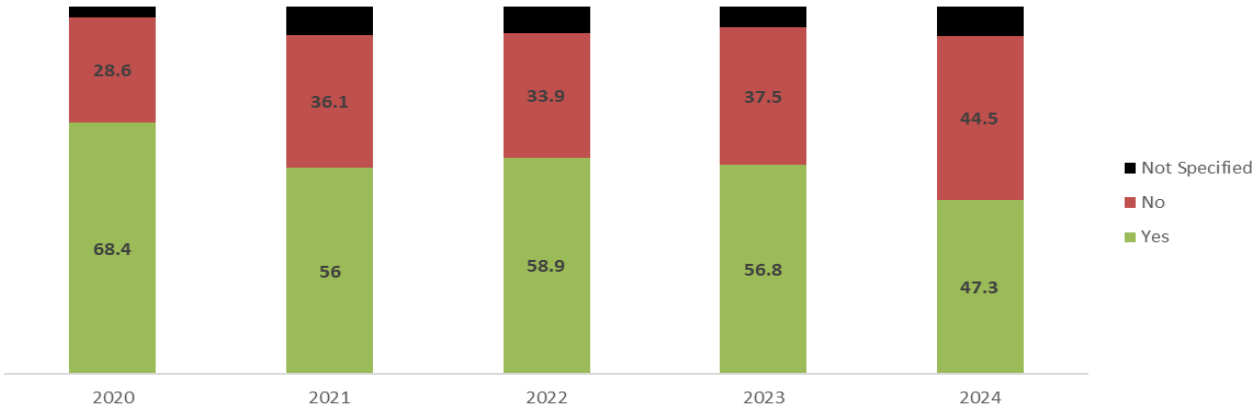
Taken together, the 2024 results and historical trend data confirm that investments in inpatient behavioral health infrastructure and elopement prevention programs produce measurable safety benefits. Facilities without BH units may need to prioritize interim mitigation strategies—such as enhanced observation, environmental controls, and multidisciplinary response protocols—when managing high-risk behavioral patients outside of dedicated behavioral health settings.

Threat Management Teams

Threat Management Teams (TMTs) represent a core organizational strategy for identifying, assessing, and managing threats of violence and other behaviors of concern within healthcare environments. The 2024 survey examined the prevalence of TMT adoption and compared incident rates between facilities with and without a formal Threat Management Team.

This analysis aligns with IAHSS Healthcare Security Industry Guideline 01.09.03 Threat Management, which emphasizes multidisciplinary threat assessment, early identification of concerning behaviors, and coordinated intervention, as well as Guideline 01.05 Program Measurement and Improvement, which supports the use of incident data to evaluate program effectiveness and guide resource allocation.

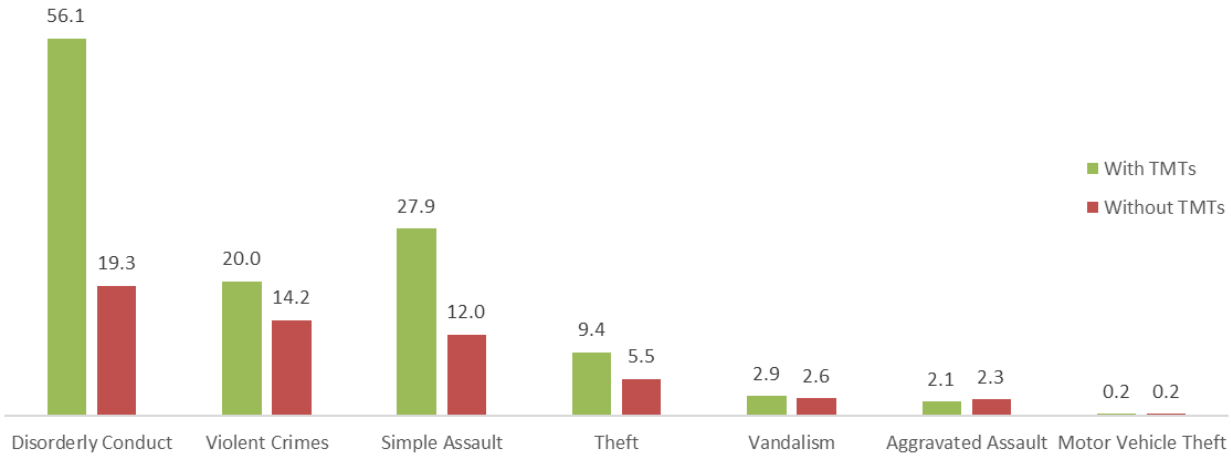
Figure 9 *Threat management team adoption (%), 2020-2024*



In 2024, 47.3 percent of responding facilities reported having a Threat Management Team in place. This represents a decline from 2023 (56.8 percent) but remains consistent with longer-term adoption patterns observed across prior survey cycles. As in previous years, TMT adoption was most common among facilities with larger campuses, higher behavioral acuity, and more complex operational environments.

Since 2020, TMT adoption has fluctuated but generally remained between 47 and 68 percent of responding facilities. The highest reported adoption occurred in 2020 (68.4 percent), followed by gradual declines through 2024. A small proportion of facilities each year continued to report TMT status as "Not Specified" (approximately 5–8 percent). These patterns suggest that while TMTs are now well-established in many organizations, sustained adoption may be influenced by staffing capacity, leadership turnover, and competing operational priorities.

Figure 10 *Comparison of weighted incident rates by TMT status (per 100 beds), 2024*



Weighted analysis of 2024 incident data indicates that facilities with Threat Management Teams reported higher overall incident rates than facilities without TMTs. Facilities with TMTs averaged 98.8 incidents per 100 beds, compared with 42.6 incidents per 100 beds in facilities without TMTs.

When incident rates were normalized by staffing levels, the same pattern persisted. Facilities with TMTs reported higher incidents per 100 security FTEs than facilities without TMTs, reflecting the combined effects of larger security departments, higher incident exposure, and more comprehensive reporting practices.

A more detailed review of 2024 incident categories further illustrates these differences. Facilities with TMTs reported higher rates of:

- Simple assault (27.9 per 100 beds, compared with 12.0 per 100 beds in non-TMT facilities)
- Disorderly conduct (56.1 versus 19.3 per 100 beds)
- Theft (9.4 versus 5.5 per 100 beds)
- Vandalism (2.9 versus 2.6 per 100 beds)

Overall violent crime rates were also higher in facilities with TMTs, averaging 20.0 incidents per 100 beds, compared with 14.2 incidents per 100 beds in facilities without TMTs.

These differences are consistent with patterns observed across multiple survey years and reflect the broader operational footprint of TMT-enabled facilities. Facilities with TMTs are more likely to be larger,

higher-acuity organizations with behavioral health services, elevated public interface, and mature security reporting infrastructures.

Summary and Implications

The presence of a TMT should not be interpreted as an indicator of increased violence. Rather, TMT adoption is a marker of organizational maturity, risk awareness, and reporting fidelity. Facilities with TMTs consistently document higher incident volumes because they operate in more complex environments and possess the governance structures necessary to identify, evaluate, and record behaviors of concern before they escalate into severe outcomes.

Consistent with IAHSS guidance, TMTs serve a critical role in healthcare environments by supporting multidisciplinary collaboration, structured threat assessment, early intervention, and coordinated response. Their prevalence among facilities with the highest behavioral and interpersonal risk reinforces their relevance as a foundational component of modern WPV prevention and behavioral risk management programs.

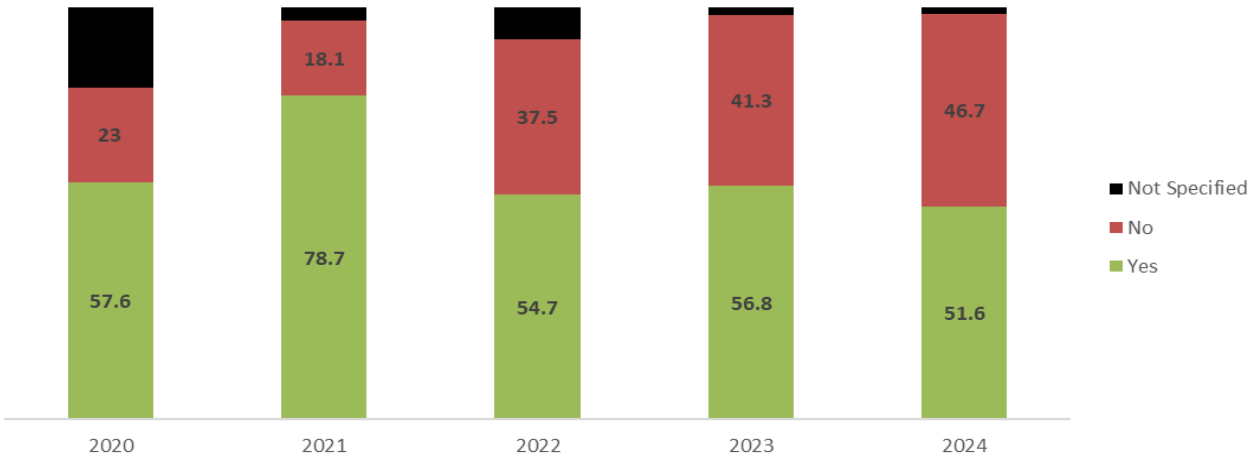
Taken together, the 2024 findings and historical survey data reaffirm that TMTs are most commonly implemented where they are needed most—within facilities facing elevated behavioral complexity, greater public exposure, and higher overall incident burden. Their continued adoption remains an essential strategy for improving threat visibility, strengthening prevention efforts, and supporting safer healthcare environments.

Visitor Management Programs

Visitor Management Programs (VMS) represent a foundational element of access control and public interface management within healthcare environments. The 2024 survey examined the prevalence of VMS adoption and compared incident rates between facilities with and without a formal visitor management system.

This analysis aligns with IAHSS Healthcare Security Industry Guidelines 04.03 Access Control and 01.05 Program Measurement and Improvement, which emphasize structured visitor control, credentialing, and the use of incident data to evaluate program effectiveness and inform risk mitigation strategies.

Figure 11 *Visitor management system adoption (%), 2020-2024*

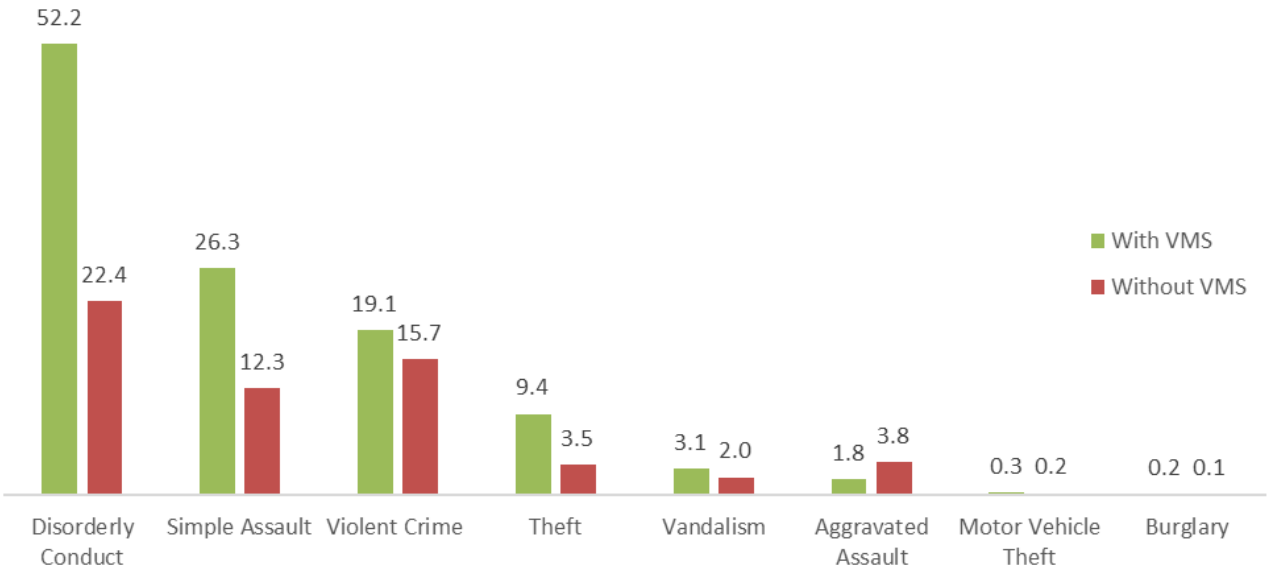


In 2024, 51.6 percent of responding facilities reported operating a formal Visitor Management Program, while 46.7 percent reported no such program in place. This represents a modest decline from 2023 (56.8

percent) but remains consistent with the stabilization observed following several years of adoption growth. VMS implementation continues to be most common among larger facilities, urban campuses, and regional health systems with high daily visitor volumes and complex access control requirements.

Historical adoption trends between 2020 and 2024 demonstrate moderate variability. Adoption peaked in 2021 at 78.7 percent before stabilizing in a range of approximately 51 to 57 percent in subsequent years. A small proportion of facilities each year continued to report VMS status as “Not Specified” (approximately 5–8 percent), suggesting ongoing variability in program definition or reporting.

Figure 12 *Facility incident rates with and without VMS (per 100 beds), 2024*



Weighted analysis of 2024 incident data indicates that facilities with VMS reported higher overall incident rates than facilities without VMS. Facilities operating a Visitor Management Program averaged 56.7 incidents per 100 beds, compared with 42.3 incidents per 100 beds in facilities without VMS.

This pattern persisted across multiple crime and behavioral categories. Facilities with VMS reported higher rates of:

- **Simple assault** (26.3 per 100 beds, compared with 12.3 per 100 beds in facilities without VMS)
- **Disorderly conduct** (52.2 versus 22.4 per 100 beds)
- **Theft** (9.4 versus 3.5 per 100 beds)

Rates of vandalism and motor vehicle theft also trended higher in facilities with VMS. The one notable exception was aggravated assault, which occurred at a higher rate in facilities without VMS (3.8 per 100 beds) compared with facilities with VMS (1.8 per 100 beds). This pattern likely reflects the increased vulnerability of smaller or less controlled environments, where fewer formal access restrictions and visitor screening measures may be in place.

As observed in prior survey cycles, these differences reflect exposure, operational complexity, and reporting fidelity, rather than increased inherent violence. Facilities with VMS are typically larger, busier environments with higher public access, more behavioral health exposure, and more comprehensive incident reporting infrastructures.

Summary and Implications

The presence of a VMS Program should be understood as an indicator of organizational maturity, access control discipline, and risk visibility, not as a driver of increased crime or behavioral incidents. Facilities with VMS consistently report higher incident rates because they manage greater public interaction, operate more complex campuses, and possess the systems necessary to identify, document, and analyze security events.

Consistent with IAHSS guidance, effective visitor management supports early identification of unauthorized access, inappropriate behavior, and potential threats while reinforcing expectations for safe and appropriate conduct within healthcare environments. Facilities that deploy VMS are better positioned to manage visitor flow, protect vulnerable populations, and support coordinated response to disruptive or threatening behavior.

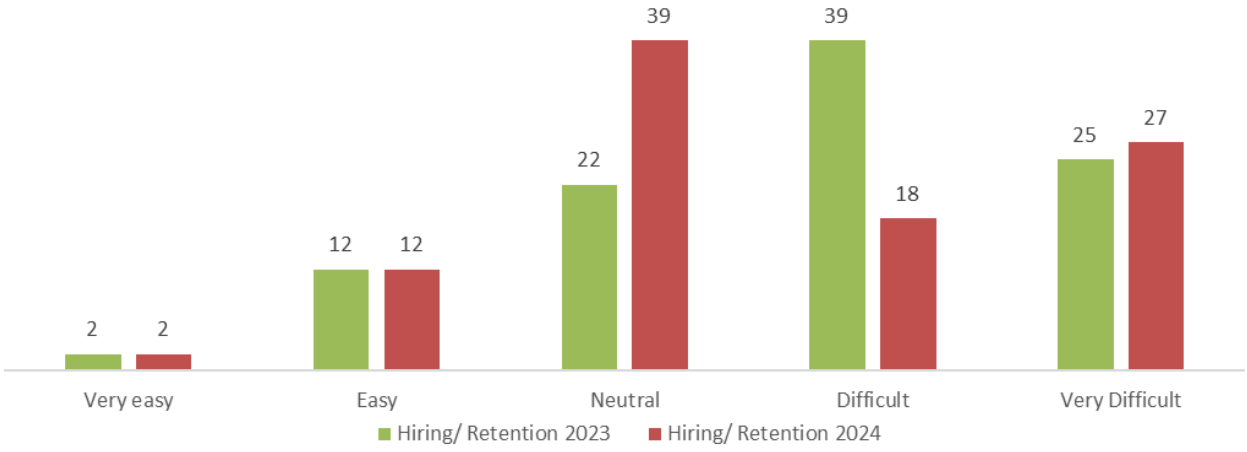
Taken together, the 2024 findings and historical data reinforce the role of Visitor Management Programs as a foundational component of modern healthcare security operations, particularly in facilities facing high visitor volume, elevated behavioral risk, and complex public interface challenges.

Recruiting and Retaining Security Staff

The ability to recruit and retain qualified security personnel remains a critical challenge for healthcare facilities and has direct implications for workforce resilience, incident response capability, and WPV prevention. The 2024 survey again assessed recruiting and retention conditions by asking facilities to rate the overall difficulty of hiring security staff using a five-point scale ranging from Very Easy to Very Difficult.

This analysis aligns with IAHSS Healthcare Security Industry Guideline 06 Security Personnel Recruiting and Selection, which emphasizes structured hiring processes, workforce competency, and alignment between staffing models and facility risk profiles, as well as Guideline 01.05 Program Measurement and Improvement, which supports the use of workforce and incident metrics to inform staffing strategies and resource planning.

Figure 13 *Hiring/ retention difficulty, 2023-2024*

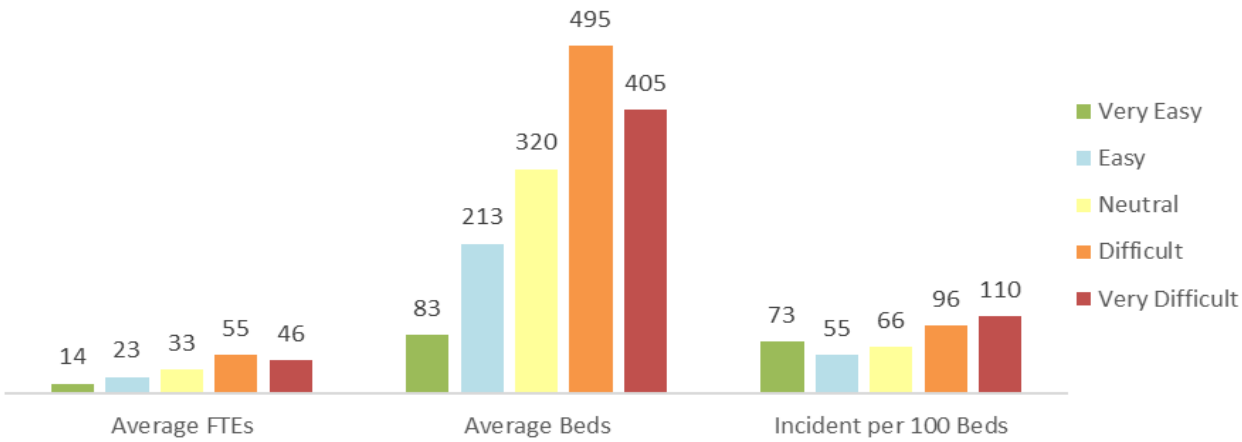


Consistent with 2023 findings, the majority of facilities in 2024 reported hiring conditions in the Neutral, Difficult, or Very Difficult categories. Very few facilities characterized recruitment as Easy or Very Easy.

These results reflect persistent national workforce shortages, competition for qualified personnel, wage pressure, and the increasing complexity of the healthcare security role.

Although earlier Crime Surveys did not capture recruitment difficulty, comparison of the 2023 and 2024 datasets reveals consistent patterns. Facilities reporting greater hiring difficulty tend to operate larger campuses, employ more security FTEs, and experience higher incident volumes than facilities reporting more favorable hiring conditions.

Figure 14 *Recruitment difficulty by average FTEs, average beds, and incident rates, 2024*



In 2024, facilities reporting Difficult or Very Difficult recruitment conditions operated at substantially greater scale than those reporting Easy or Very Easy conditions. Facilities in the most challenging hiring categories averaged approximately 400 to 495 licensed beds and 46 to 55 security FTEs, compared with 83 to 213 beds and 14 to 23 security FTEs in facilities reporting easier hiring conditions. In practical terms, facilities facing the greatest hiring challenges manage two to four times the staffing footprint and two to six times the bed capacity of facilities reporting the least difficulty.

Incident exposure followed a similar gradient. Facilities reporting Very Difficult recruitment conditions experienced weighted incident rates exceeding 110 incidents per 100 beds, compared with approximately 55 to 75 incidents per 100 beds among facilities reporting Easy or Neutral conditions. This pattern reflects predictable differences in operational intensity: larger facilities, particularly those with behavioral health units, high-volume emergency departments, or regional referral roles, encounter substantially higher levels of disruptive, violent, and behavior-driven incidents.

Importantly, these relationships persisted even after adjusting incident rates to exclude zero-bed facilities and statistical outliers. The continued alignment between recruitment difficulty, facility scale, and incident burden confirms that these differences reflect genuine operational realities rather than artifacts of data distribution or reporting variability.

Summary and Implications

The 2023–2024 findings demonstrate that recruiting and retention challenges in healthcare security are structurally linked to facility size, behavioral acuity, and operational complexity, rather than isolated workforce management issues. Facilities reporting the greatest hiring difficulty are consistently those managing the most demanding environments—large campuses, high-acuity patient populations, elevated WPV exposure, and extensive public interface.

Rather than signaling organizational weakness, recruitment difficulty functions as a leading indicator of operational intensity and security risk. Facilities facing higher incident volumes require larger, more skilled security teams, which in turn face greater competition, burnout risk, and training demands.

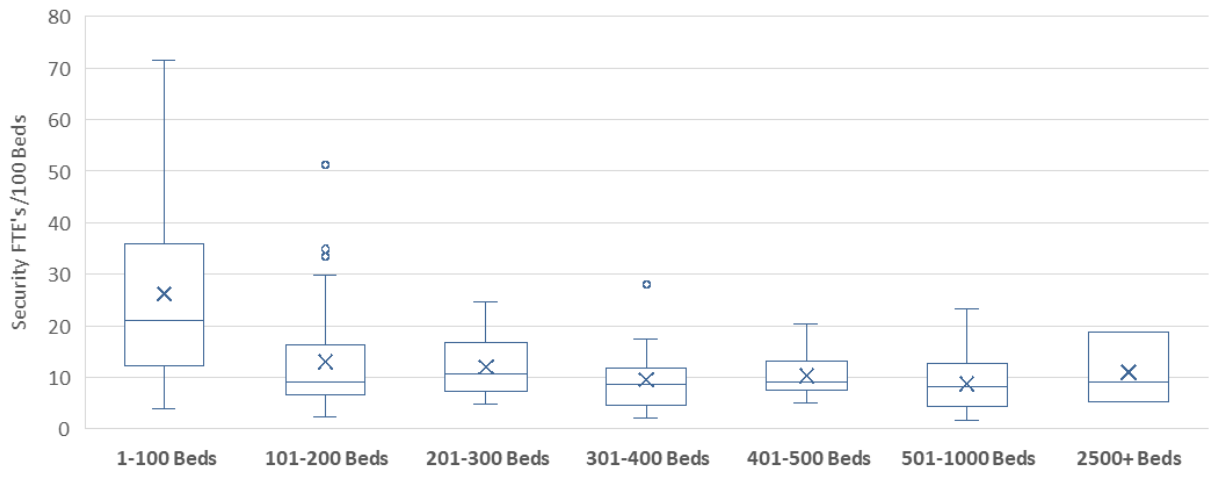
These findings reinforce the need for deliberate workforce strategies, including expanded recruitment pipelines, competitive compensation and benefits, professional development pathways, role clarity, and staff wellness initiatives. Facilities can use these benchmarks to contextualize their staffing challenges, assess whether recruitment difficulty aligns with expected patterns for similar organizations, and support data-driven decisions related to staffing models, resource allocation, and long-term workforce sustainability.

Security Staffing per 100 Beds Distribution

Security staffing levels remain a critical indicator of a facility's ability to respond effectively to crime, WPV, and behavioral risk. The 2024 survey examined the relationship between licensed bed count and budgeted security FTE positions to better understand how staffing scales across healthcare facilities of varying size and complexity.

This analysis aligns with IAHSS Healthcare Security Industry Guideline 02.01 Security Staffing and Deployment, which emphasizes that no single staffing formula is appropriate for all facilities and that staffing decisions should be informed by security vulnerability assessments, patient acuity, service mix, and operational demands. It also aligns with Guideline 01.05 Program Measurement and Improvement, which supports the use of normalized staffing metrics to benchmark and justify resource allocation.

Figure 15 *Security FTEs per 100 beds, 2024*



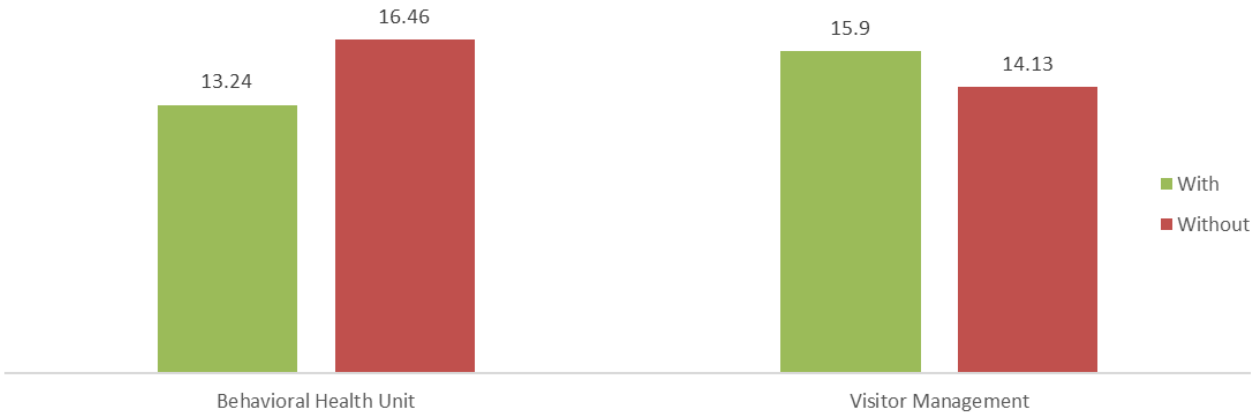
Analysis of the 2024 dataset demonstrates a strong positive relationship between facility size and security staffing levels. The correlation between licensed bed count and budgeted security FTEs was r = 0.901**,** indicating that staffing expands consistently as facilities increase in size. This finding mirrors results from every IAHSS Foundation Crime Survey since 2016, all of which have reported correlations exceeding r = 0.85**.**

Across all responding facilities, the average staffing level was 8.4 security FTEs per 100 beds, while the median staffing level was 18 FTEs per 100 beds. The divergence between the mean and median reflects a skewed distribution driven by the wide diversity of facility size, mission, and operational complexity.

When stratified by bed count, three distinct staffing patterns emerged:

1. **Minimum-Staffing Facilities (1–100 beds)**
   Small facilities exhibited the highest staffing ratios, averaging 24.6 FTEs per 100 beds. This elevated ratio reflects minimum 24/7 coverage requirements rather than increased incident exposure. Regardless of bed count, these facilities must maintain baseline staffing to support continuous operations, emergency response, and after-hours coverage.
2. **Efficiency-Band Facilities (101–1,000 beds)**
   Mid-sized facilities demonstrated the most consistent staffing ratios, typically ranging between 8 and 13 FTEs per 100 beds. These facilities often benefit from stable workflows, fewer specialty units, and efficient deployment models that allow staffing to scale proportionally with size.
3. **Complexity-Driven Facilities (1,000+ beds)**
   Very large facilities reported the highest absolute staffing levels, with total security FTEs ranging from approximately 126 to 476. Staffing ratios increased again to an average of 11 to 12 FTEs per 100 beds, reflecting the operational demands of behavioral health units, trauma centers, high-volume emergency departments, extensive visitor traffic, and multi-campus environments.

Figure 16 *BH units and VMS staffing averages per 100 beds, 2024*



Additional stratification by facility characteristics further illustrates the influence of operational complexity on staffing ratios. Facilities with inpatient behavioral health units reported an average of 13.24 FTEs per 100 beds, compared with 16.46 FTEs per 100 beds in facilities without BH units. This difference is influenced by a small number of very large non-BH facilities with exceptionally high staffing totals, which elevate the average. In practice, facilities with BH units continue to maintain substantial absolute staffing levels to support heightened behavioral acuity, continuous observation, and crisis response demands.

Facilities operating a formal Visitor Management Program reported higher staffing ratios than those without. Facilities with VMS averaged 15.9 FTEs per 100 beds, compared with 14.1 FTEs per 100 beds in facilities without VMS. This pattern reflects the increased access control requirements, public interface management, and operational complexity associated with high visitor volume environments.

Summary and Implications

The 2024 findings reinforce that security staffing levels are best understood through the combined lenses of facility scale, behavioral acuity, and operational intensity, rather than bed count alone. While no national benchmark exists for “appropriate” security staffing per 100 beds, consistent patterns emerge across the dataset. Most U.S. healthcare facilities fall within a range of approximately 8 to 13 security FTEs per 100 beds, with ratios increasing at both ends of the size spectrum due to minimum staffing requirements in small facilities and complexity-driven demands in very large facilities.

Facilities can use these data to compare their staffing levels against similarly sized and similarly structured organizations, identify gaps relative to behavioral and public interface risk, and support evidence-based justification for staffing enhancements. When integrated with incident data, WPV exposure, and facility-specific vulnerability assessments, staffing metrics provide a powerful tool for aligning security resources with clinical realities and organizational mission.

LIMITATIONS

There were several limitations associated with the 2025 Healthcare Crime Survey, including, but not necessarily limited to, the following:

- **Sample size and representativeness:** The 182 survey responses received represent approximately three percent of hospitals in the United States, leaving roughly 97 percent unaccounted for. While the response volume was consistent with recent years (down slightly from 192 in 2023 and more than 220 in the two years prior), the sample remains self-selected, creating the possibility of sampling bias. As a result, participating hospitals may not be fully representative of the national hospital population.
- **Participant recruitment:** Survey outreach primarily targeted IAHSS member hospitals. Healthcare facilities without IAHSS-affiliated security leaders or members on staff are therefore less likely to have been included, further limiting sample diversity.
- **Data quality and outlier management:** Several responses required judgment-based data validation to identify and exclude implausible or incomplete entries. For example, records lacking a licensed bed count or security FTE count were excluded from rate calculations, and one response with implausible incident totals was flagged and removed. These decisions, while made conservatively, introduce the potential for both Type I (exclusion of valid data) and Type II (retention of invalid data) errors.
- **Rounding, estimation, and range reporting:** Some responses used qualifiers such as “approximately,” “about,” or “+,” suggesting estimation. Where numeric ranges were provided (e.g., “10–16 security employees”), the midpoint was used for calculations. In cases where estimates were clearly provided, the submitted numbers were used as if exact to preserve continuity with prior survey methods. This introduces potential rounding and estimation variance.
- **Partial-year program responses:** For questions regarding the presence of behavioral health units, threat management teams, or visitor management programs, respondents sometimes indicated partial-year operation. Consistent with prior years, programs in place for six months or longer were counted as “Yes,” while those in place for less than six months were counted as “No.” Responses that indicated operation in “certain areas” were also treated as “Yes.”
- **Duplicate representation of systems:** Because responses were collected at the individual hospital level, some multi-hospital systems may have been represented more than once. This could potentially inflate or dilute results in certain regions or categories.
- **Use of bed counts as denominator:** Bed counts remain the primary size metric for calculating crime rates, ensuring continuity with prior IAHSS Foundation Crime Surveys. However, bed count may not be the ideal indicator of facility size or exposure. Other denominators—such as emergency department visits, hospital square footage, average daily census, or adjusted patient days—could offer additional precision if consistently reported. Bed count remains the most widely available and reliable denominator.
- **Data entry and definitional inconsistencies:** Some data may have been mis-entered or derived using non-standard definitions of crimes. Despite providing Uniform Crime Reporting (UCR) definitions within the survey, respondents may have applied internal definitions or classification

systems. Variability in how terms such as “elopement” or “threat management” were interpreted could influence data consistency.

- **Outlier influence:** A small number of hospitals reporting unusually high incident volumes can significantly affect rate calculations. For instance, a handful of large urban facilities accounted for a disproportionate share of behavioral incidents—consistent with patterns seen in previous survey years. Although data were weighted by bed count and FTE to mitigate this effect, extreme outliers continue to influence aggregate rates for some categories, particularly assaults and disorderly conduct.

Table 1 *Descriptive Characteristics, 2020-2024*

	2020	2021	2022	2023	2024
Security Incidents					
Violent crimes	1.7	2.5	1.9	2.0	2.29
Other Assaults	14.2	17.7	22	23.3	23.2
Disorderly Conduct	36.7	56.8	52.2	59.5	41.6
Vandalism	2.4	2.6	2.8	2.3	2.8
Motor Vehicle Theft	0.4	0.4	0.6	0.6	0.3
Theft	4.9	5.7	5.6	5.8	8.1
Elopements	--	--	6.1	5.6	4.7
Have Behavioral Health Unit					
Yes	43.9	48.6	39.1	44.7	40.1
No	51.7	50.5	57.3	55.3	58.2
Use Threat Management Teams					
Yes	68.4	56	58.9	56.8	47.3
No	28.6	36.1	33.9	37.5	44.5
Use Visitor Management					
Yes	57.6	78.7	54.7	56.8	51.6
No	23	18.1	37.5	41.3	46.7
Licensed Beds					
1 - 100 Beds	23	17.6	19.3	24.6	26.5
101 - 200 Beds	20.4	24.1	22.4	20.1	21.7
201 - 300 Beds	20.8	19	17.2	15.5	14.3
301 - 400 Beds	13	13.9	12	12.1	10.6
401 - 500 Beds	5.9	9.3	7.8	6.4	5.3
501 - 1000 Beds	14.1	13.9	12.5	18.9	14.8
1001 - 1500 Beds	1.9	1.4	4.7	1.9	1.6
1501 - 2500 Beds	0.7	0.9	2.1	0.4	0
2500+ Beds	--	--	0.5	--	2
Not Specified	--	--	1.6	--	3.2
Budgeted Security FTEs					
1 - 25 Employees	--	55.1	56.8	59.5	58.2
26 - 50 Employees	--	21.8	22.4	22	21.2
51 - 75 Employees	--	7.4	6.8	9.8	6.9
76 - 100 Employees	--	5.1	2.6	1.5	5.3
101 - 150 Employees	--	5.1	5.2	3.4	2.1
151 - 200 Employees	--	1.9	1	2.3	0
201 - 300 Employees	--	--	--	--	1.6
301 - 400 Employees	--	--	0.5	--	0
400+ Employees	--	2.3	1.6	0.4	1
Not Specified	--	1.4	3.1	1.1	3.7
Maintain full qualified staff					
Very easy	--	--	--	2	2
Easy	--	--	--	12	12
Neutral	--	--	--	22	39

	2020	2021	2022	2023	2024
Difficult	--	--	--	39	18
Very Difficult	--	--	--	25	27
No Response	--	--	--	0	2
Use WPV Typology					
Yes	61.3	72.7	62.5	69.7	67.8
No	18.6	15.7	26.6	24.6	23
Aggravated Assaults by Type					
Type 1	--	2	17	7	2.2
Type 2	--	82	73	83	84.2
Type 3	--	7	7	4	11.9
Type 4	--	9	3	6	1.8
Other Assaults by Type					
Type 1	--	6	10	3	3.4
Type 2	--	81	86	93	89.5
Type 3	--	5	3	2	4.9
Type 4	--	8	1	2	2.2

Table 2 *Incidents per 100 beds and security FTE analysis, 2024*

	Per 100 Beds			Per 100 Security FTE		
Incident Type	**Mean**	**Std Dev**	**Min – Max Incidents**	**Mean**	**Std Dev**	**Min – Max Incidents**
Murder	0.12	0.11	0.00 - 1.01	0.13	0.98	0.0 - 8
Rape	0.01	0.07	0.0 - 0.48	0.15	0.93	0.0-10
Robbery	0.09	0.56	0.0 - 7.14	0.73	3.59	0.0 – 40
Aggravated Assault	2.84	10.58	0.0–1,697	3.89	131.62	0.0–1,154
Other Assaults	24.54	41.59	0.0-17,926	33.99	397.91	0.0–3,353
Burglary	0.22	0.79	0.0 – 131	0.65	5.81	0.0 – 58
Theft	3.99	4.86	0.0 – 24	39.33	65.80	0.0- 567
Motor Vehicle Theft	0.24	0.64	0.0 - 4.29	2.52	7.09	0.0 – 59
Vandalism	2.55	4.61	0.0 – 29	26.65	71.54	0.0 – 805
Disorderly Conduct	45.68	119.10	0.0–1,305	394.35	1027.7	0.0–10,423

Table 3 *Pearson correlation*

	Violent Crimes	Murder	Aggravated Assault	Rape	Burglary	Other Assaults	Disorderly Conduct	Vandalism	Motor Vehicle Theft	Theft	Elopements	BH Unit	Threat Mgmt. Teams	Visitor Mgmt.	Licensed Beds	Budgeted FTE	Maintain Staff	Aggr. Assault Type 2	Other Assault Type 2
Violent Crimes	1	0.002	0.713	0.371	0.202	0.993	0.521	0.401	0.254	0.461	0.541	0.211	0.174	0.192	0.742	0.574	-0.059	0.372	0.980
Murder		1	0.285	0.196	0.012	0.418	0.449	0.550	-0.003	0.490	0.012	0.184	-0.086	-0.085	0.426	-0.042	0.075	0.045	-0.025
Aggravated Assault			1	0.146	0.287	0.482	0.370	0.325	0.095	0.242	0.364	0.151	0.091	0.055	0.493	0.602	-0.105	0.460	0.782
Rape				1	0.031	0.387	0.456	0.644	0.366	0.277	0.066	0.228	0.040	0.093	0.093	0.101	-0.157	0.012	0.414
Burglary					1	0.164	0.380	0.337	0.064	0.658	0.119	0.133	0.038	0.162	0.540	0.648	-0.118	0.223	0.190
Other Assaults						1	0.895	0.881	0.267	0.892	0.541	0.181	0.154	0.162	0.934	0.530	-0.114	0.346	0.986
Disorderly Conduct							1	0.904	0.273	0.922	0.168	0.144	0.149	0.153	0.913	0.619	-0.167	0.268	0.531
Vandalism								1	0.457	0.936	0.189	0.200	0.092	0.137	0.887	0.383	-0.157	0.107	0.426
Motor Vehicle Theft									1	0.125	0.113	0.222	0.094	0.145	0.516	0.239	-0.090	0.003	0.223
Theft										1	0.374	0.126	0.079	0.101	0.897	0.606	-0.120	0.241	0.576
Elopements											1	0.128	0.107	0.213	0.422	0.329	0.001	0.232	0.573
BH Unit												1	0.117	0.241	0.227	0.292	-0.125	0.293	0.200
Threat Mgmt Teams													1	0.151	0.138	0.162	-0.070	-0.032	0.156
Visitor Mgmt														1	0.180	0.243	0.048	0.144	0.142
Licensed Beds															1	0.852	-0.172	0.493	0.737
Budgeted FTE																1	-0.167	0.349	0.544
Maintain Staff																	1	0.111	-0.044
Aggr. Assault Type 2																		1	0.340
Other Assault Type 2																			1

Strength of correlation

0.00 – 0.19	Very weak/ Negligible
0.20 – 0.39	Weak/ Low
0.40 – 0.59	Moderate
0.60 – 0.79	Strong
0.80 – 1.00	Very Strong/ Robust

Appendix A: 2024 IAHSS Foundation Crime Survey Questions

1. How many licensed beds did your hospital have in 2024?
2. How many budgeted full-time security employees did your hospital have in 2024?
3. How many Murders occurred at your hospital in 2024? *(UCR Definition: Murder and nonnegligent manslaughter (criminal homicide) – The willful (nonnegligent) killing of one human being by another.)*
4. How many Rapes occurred at your hospital in 2024? *(UCR Definition: Rape - The carnal knowledge of a male or female forcibly and against his/her will. Note: Sexual intercourse or other forms of sexual penetration is an essential element of carnal knowledge. Do not include any sexual assaults that do not include intercourse or other penetration.)*
5. How many Robberies occurred at your hospital in 2024? *(UCR Definition: Robbery - The taking or attempting to take anything of value from the care, custody, or control of a person or persons by force or threat of force or violence and/or by putting the victim in fear. Examples: carjacking, purse snatching from a person. Note: Robbery should not be confused with larceny-theft or burglary as defined below.)*
6. How many Aggravated Assaults occurred at your hospital in 2024? *(UCR Definition: Aggravated Assault - An unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury. This type of assault usually is accompanied by the use of a weapon or by means likely to produce death or great bodily harm.)*
7. How many Other Assaults occurred at your hospital in 2024? *(UCR Definition: Other Assaults - An unlawful physical attack by one person upon another where neither the offender displays a weapon, nor the victim suffers obvious severe or aggravated bodily injury involving apparent broken bones, loss of teeth, possible internal injury, severe laceration, or loss of consciousness. To unlawfully place another person in reasonable fear of bodily harm through the use of threatening words and/or other conduct, but without displaying a weapon or subjecting the victim to actual physical attack (e.g., intimidation).)*
8. How many Burglaries occurred at your hospital in 2024? *(UCR Definition: Burglary - The unlawful entry of a structure to commit a felony or a theft. Examples: burglary of the pharmacy after-hours; burglary of a physician's office or clinic. Note: This does not include burglaries of vehicles (vehicles are not structures).)*
9. How many Thefts occurred at your hospital in 2024? *(UCR Definition: Theft (except motor vehicle theft) - The unlawful taking, carrying, leading, or riding away of property from the possession or constructive possession of another. Example: shoplifting from the gift shop. Note: Include all thefts from motor vehicles, but not thefts of vehicles themselves.)*
10. How many Motor Vehicle Thefts occurred at your hospital in 2024? *(UCR Definition: Motor Vehicle Theft - The theft or attempted theft of a motor vehicle. Note: Do not include thefts from motor vehicles, only thefts of vehicle themselves.)*
11. How many Vandalism events occurred at your hospital in 2024? *(UCR Definition: Vandalism - To willfully or maliciously destroy, injure, disfigure, or deface any public or private property, real or personal, without the consent of the owner or person having custody or control by cutting, tearing, breaking, marking, painting, drawing, covering with filth, or any other such means as may be specified by local law.)*
12. How many Disorderly Conducts occurred at your hospital in 2024? *(UCR Definition: Disorderly Conduct - Any behavior that tends to disturb the public peace or decorum, scandalize the community, or shock the public sense of morality. The FBI includes disturbing the peace, blasphemy, profanity, and obscene language with Disorderly Conduct. Examples: public intoxication, disturbing the peace, loitering, foul language, obscene gestures, unreasonably loud commotion or noise.)*
13. Did your hospital have an inpatient psychiatric/behavioral health unit in 2024? (Y/N)
14. How many patient elopements occurred at your hospital in 2024?
15. Did your hospital use threat management teams in 2024?

16. Did your hospital have a visitor management program in 2024? (Y/N)
17. How easy or difficult was it for your hospital to recruit and retain a full, qualified security staff in 2024?
18. Does your hospital maintain statistics using the Workplace Violence Typology? (Y/N)
19. How many Type 1 Aggravated Assaults occurred at your hospital in 2024?
20. How many Type 2 Aggravated Assaults occurred at your hospital in 2024?
21. How many Type 3 Aggravated Assaults occurred at your hospital in 2024?
22. How many Type 4 Aggravated Assaults occurred at your hospital in 2024?
23. How many Type 1 Other Assaults occurred at your hospital in 2024?
24. How many Type 2 Other Assaults occurred at your hospital in 2024?
25. How many Type 3 Other Assaults occurred at your hospital in 2024?
26. How many Type 4 Other Assaults occurred at your hospital in 2024?