Keeping Our Workers Safe: 
Developing a Comprehensive Program for 
Prevention and Management of Violence in 
the Workplace

Lynn M. Van Male, PhD 
Director, Veterans Health Administration (VHA) Workplace Violence Prevention Program 
VHA Office of Patient Care Services, Occupational Health (10P4Z) 
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To Veterans of ALL Conflicts and to Those Who Serve Them:

THANK YOU FOR YOUR SERVICE

Educational Objectives

1. Discuss the incidence of workplace violence in health care settings
2. Identify the common safety/security issues that arise in the population of your community that may contribute to incidents of workplace violence
3. Describe the five components of a systematic facility approach to reducing the risk of violence in the workplace
4. Explore tools that can be utilized to collect data to track and predict potential disruptive behavior incidents.
5. Explain the considerations necessary in education of staff regarding workplace violence, from “see something, say something” to the assessment of educational needs by risk area, up to and including active shooter training.
Agenda

- Workplace Violence Prevention Program Model: Implementation Essentials and Overcoming Challenges
- From Bystander to Upstander: Employees Are Our Key Asset
- Incident Reporting: Knowing What We Know and Finding Out What We Don’t Know
- Violence Risk and Threat Assessment in Health Care: Fundamentals of Multidisciplinary Practice for Employees and Patients
Extent and Characteristics of Workplace Violence in Health Care

- Approx. 24,000 assaults from 2010 - 2013
- Violent crime in US hospitals per 100 beds: 2.0 (2012) to 2.8 (2015)
- Emergency Department Assaults: 44% aggravated, 46% other
- Bureau of Labor: 50% of workplace-related assaults involve health care and/or social service workers
- Female nursing staff and psychiatric assistants most frequent “experiencers”
- Approx. 60% of reported threats and assaults occur between noon and midnight

Wyatt, Anderson-Drevs, & Van Male (2016)

International Association for Healthcare Security and Safety (IAHSS): 2016 Healthcare Crime Survey

NIOSH Type 2: Customer, Client, Patient, Student, Inmate, etc. on Employee
US Veterans Health Administration (VHA)

- 150+ Medical Centers
- 1000+ Community Based Outpatient Clinics
- 300,000+ Employees
US “Health Care Community Standard” vs. VHA

VHA **MUST** rise to a high standard of providing comprehensive workplace violence prevention programs and organizational infrastructure.

“What VHA **CAN** Do

Keep Veterans in VHA health care: The care VHA provides can address the 6 key protective domains.

Access to care is a violence risk mitigation strategy.
Protective Factors and Violence in Veterans

Protective factors indicate health and well-being in the following domains:

- Living
- Work
- Financial
- Psychological
- Physical
- Social

Eric Elbogen, DBC Chairs Conference, January 2014

VHA WVPP Model

- Employee-Generated
  - Employee Threat Assessment Team (ETAT)
  - Bullying, Mobbing

- Patient-Generated
  - Disruptive Behavior Committee (DBC)
  - Orders of Behavioral Restriction (OBR) + Patient Record Flags (PRF)

- Employee Education
  - Prevention & Management of Disruptive Behavior (PMDB)
  - PMDB Trainer Recalibration Conferences

- Reporting and Data
  - Disruptive Behavior Reporting System (DBRS)
  - Workplace Behavioral Risk Assessment (WBRA)

- Environmental Design
  - Facility-Based
  - Community-Based
Van Male, February 2016

- Bystander to “Upstander”
- Education and Awareness
- Skills

Van Male, February 2016

- All employees
- Easy and short
- “Return Receipt”
Leadership

Assess

Employee

Report

- Multi- and Interdisciplinary
- Evidence-based, Data-driven
- Structured Professional Judgment

Van Male, February 2016

Leadership

Assess

Management Plan

Employee

Report

- Collaborative with Patient
- Spectrum of “Confrontation”

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• What is the Safety/Treatment Plan?
• What ACTION should staff take to stay safe?
Violence Risk and Threat Assessment in Health Care

Prediction vs. Threat Assessment

Prediction: Yes or No

Threat Assessment

Risk Factors

Protective Factors
Evolution of Threat Assessment

Purely Clinical Approach
- Intent, plan, access, identified target, imminent?
- High(er) face validity
- Clinicians often barely as good a chance

Purely Actuarial Approach
- Increased predictive validity over purely clinical
- Low(er) face validity
- Does not inform risk mitigation strategies

Structured Clinical Judgment
- Combines the “best” of clinical and actuarial approaches
- Informed by empirical literature
- Standard items, often normed
- Increased predictive validity over actuarial alone
- Informs risk mitigation strategies
Sample Structured Clinical Judgment Guides

**WAVR 21**
- S.G. White and J.R. Meloy, 2007
- Workplace Assessment of Violence Risk

**HCR-20**
- Correctional, Forensic and Civil Psychiatric Assessment of Violence Risk

**VRAI**
- Incorporates Veteran-specific risk factors
- Evaluation and Implementation FY15-FY16

Violence Risk Assessment: How “Good” Are We?

- Flipping a Coin \(AUC=0.50\)
- Clinical Decision-making \(AUC=0.66\)
- Spousal Abuse Risk Assessment \(AUC=0.70\)
- History of Violence \(AUC=0.71\)
- Psychopathy Checklist \(AUC=0.75\)
- Violence Risk Appraisal Guide \(AUC=0.76\)
- **HCR-20** \(AUC=0.80\)
- **MacArthur Risk Assessment Study** \(AUC=0.82\)
- Perfect Accuracy \(AUC=1.0\)

*Eric Elbogen, 2014*
Bimodal Theory of Violence

Predatory vs. Affective

J. Reid Meloy (2006)

Pathway to Violence

Affective

Attacking
Breach
Ideation
Grievance

Predatory

Attacking
Breach
Preparation
Research & Planning
Ideation
Grievance

Calhoun and Weston (2003)
Threat Assessment and Management: Ongoing and Iterative

Personal Communication
Schouten, Van Male, & Meloy (2015)

From Bystander to Upstander: Employees Are Our Key Asset

August 2016
• Bystander to “Upstander”
• Education and Awareness
• Skills

PMDB Program Structure

PMDB Director
- Promotes, Trains, Recalibrates Master Trainers via
- Train The Trainer and Annual Recalibration

Master Trainers
- Train and Recertify Facility Trainers via
- Train The Trainer Course and FTRAs

Facility Trainers
- Train and Refresh Frontline Employees via
- Level II, III, and IV of PMDB In-Class Training

Front Line Employees
- Learn PMDB Skills through 4 Levels of PMDB Training

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PMDB Employee Curriculum

Level I
- Online
- Introduction to Violence Prevention Concepts

Level II
- In Class
- Customer Service, Observation, Assessment, and Verbal De-escalation Skills (Verbal Protection)

Level III
- In Class
- Limit Setting and Personal Safety Skills (Physical Protection)

Level IV
- In Class
- Therapeutic Containment (Patient intervention to control physically violent acts)

Matching PMDB Training Levels to Risk Definitions

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>DEFINITION</th>
<th>TRAINING NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>Exposure to physical disruptive behavior (DB) requiring therapeutic containment</td>
<td>Levels I, II, III, IV (Customer Service/Verbal, Physical Skills, Therapeutic Containment)</td>
</tr>
<tr>
<td>MODERATE</td>
<td>Exposure to both physical and verbal disruptive behavior (DB)</td>
<td>Levels I, II, III (Customer Service/Verbal, Physical Skills)</td>
</tr>
<tr>
<td>LOW</td>
<td>Exposure to only verbal disruptive behavior (DB)</td>
<td>Levels I, II (Customer Service and Verbal Skills)</td>
</tr>
<tr>
<td>MINIMAL</td>
<td>No exposure to any type of disruptive behavior (DB)</td>
<td>Levels I Only Intro. to WVP concepts</td>
</tr>
</tbody>
</table>
Percent Physically Violent Incidents Concentrated in Areas With and Without Mandatory PMDB Employee Training

Vance et al (2014)
Time Saved by Using WBRA and Reduced F2F Training

VHA reduced Face to Face (F2F) training hours 81% by using a data-driven process to inform training need and course assignment.

Vance et al (2014)

Active Threat/Shooter: Considerations in Health Care

- Patient Abandonment
- Sterile Environments
- Chemicals, Biohazards
- Realistic Expectations of Police Response
- Federal Bureau of Investigation, Behavioral Analytics Unit: Targeted Violence in Health Care (Amman, 2015)
Incident Reporting: Knowing What We Know and Finding Out What We Don’t Know

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- All employees
- Easy and short
- “Return Receipt”
Disruptive and Violent Behavior Incident Reporting

Challenge

20% Reporting Rate
- Similar rate internationally, across health care systems
- Multiple probable causes:
  - Competing demands—reporting takes time
  - Not want to “label” patients
  - Concern for own reputation
  - Beliefs as to whether reporting will do any good

Solution

Successful Reporting Systems:
- Accessible
- Short and Simple
- Trusted and Secure
- Optional Anonymity
- Result in Identifiable Outcomes
- Labor and Management Support

Voice for Concerns

Disruptive Behavior Reporting System (DBRS)

Incident Collection
Email Notification
Incident Management
Management Reporting
Documentation in CPRS

Mario Scalora, PhD
Association of Threat Assessment Professionals, 2014

Shawn Loftus and Gregory Roth
DBC Chairs Conference, January 2014
How does access to DBRS work?

- Secure website within VA intranet
- Accessible to any VHA employee
- VA log on (network username)

Incident Collection

- Access limited based on network username
- Facility determined

DBRS Management

Incident Collection: Reporting an Incident

**Location & Time**
- Facility
- Date and time

**Who is Reporting?**
- Contact information

**Who Experienced?**
- Who experienced the disruptive behavior

**Who was the Disruptor?**
- Brief information about the disruptive individual

**Incident Details**
- Description of the incident and other related details

Shawn Loftus and Gregory Roth
DBC Chairs Conference, January 2014
Data Capture

Data Capture: Patient and Employee Generated Behavior

employee: *no*, disruptive individual was not an employee

*yes*, the disruptive individual was an employee
Email Notification

Only DBC/ETAT Committee members can access this web page.
**DBRS Management: Tracking Incidents**

- **Status and Assessment**: Documentation of findings and interventions
- **External Reporting**: WBRA Data Collection, CPRS (patient generated)

**Documentation of Findings: CPRS Notes**

[Image of a CPRS note interface]
Violence Risk and Threat Assessment in Health Care: Fundamentals of Multidisciplinary Practice for Employees and Patients

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Leadership

- Multi- and Interdisciplinary
- Evidence-based, Data-driven
- Structured Professional Judgment

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Multidisciplinary Teams Matter

Van Male, July 2015

Multidisciplinary Teams Matter

Van Male, July 2015
Multidisciplinary Teams Matter

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Van Male, July 2015

Multidisciplinary Teams Matter

Van Male, July 2015
Multidisciplinary Teams Matter

Van Male, July 2015

Multidisciplinary Teams Matter

Van Male, July 2015
Disruptive Behavior Committee

- Operates under the authority of, and reports to, the Chief of Staff: **DBCs are Clinical Care**
- Is an **inter- and multidisciplinary team**:
  - Senior Clinician (Chair)
  - Union Safety Representative
  - Training Program Rep.
  - Quality Management
  - Legal Counsel (ad hoc)
  - Support/Clerical staff
  - Law Enforcement or Security
  - Rep.s from High Risk Areas
  - Patient Advocate
  - Privacy Officer (ad hoc)
  - Patient Safety or Risk Mgmt
  - Clinical Trainees

**DBCs Fulfill Critical Functions**

- Consultation
- Education
- Threat Assessment
- Safety Risk Management
Disruptive Behavior Committee

- Advises clinicians, clinic managers, and the Medical Director on a coordinated approach for addressing patient disruptive behavior; promotes the safe and effective delivery of health care
- Encourages disruptive behavior reporting
- Trends disruptive behavior data
- Completes violence risk assessments
- Develops risk mitigation recommendations

Disruptive Behavior Committee

- Recommends whether an electronic medical record alert would help reduce risk
- Oversees training in Prevention and Management of Disruptive Behavior (PMDB)
- Brokers debriefing as requested for individuals traumatized in violent incidents
- Advises the COS and the Facility Director about systems issues that may be contributing to disruptive patient behavior
Employee Threat Assessment Team: Addressing Employee-Generated Disruptive Behavior

Defining the ETAT

- ETATs are interdisciplinary and multi-departmental teams whose specially trained members are appointed by, responsible to, and offer advice to the agency CEO.
- The ETAT addresses matters in which there is concern about possible workplace aggression or violence involving employees, trainees, or volunteers.
Mission of the ETAT

- To assess whether the employee *poses* a safety threat—now, near future, distant future
- To develop recommendations for reducing the risk of violence to all employees
- To protect the dignity and privacy of *all* employees
- To refer supervisors to resources available to employees who may have been traumatized by workplace violence

Priority Hierarchy

1. Law Enforcement
2. Threat Management
3. Disciplinary Action

*Hart et al (2016)*
ETAT Does NOT Make Disciplinary Recommendations or Decisions

Employee Behavior may trigger simultaneous pathways of possible action.

ETAT and HR are separate entities with different responsibilities and roles.

Employee Behavior may result in Safety Recommendations and/or Disciplinary Actions—and separate processes lead to outcomes.

Membership: DBC vs. ETAT

DBC
- Behavioral Science Professional
- Medical Director
- Law Enforcement
- Patient Advocate
- Labor Partner(s)
- PMDB Trainers
- Reps from high-risk areas (e.g., Nursing Home, ED, inpt. psych)
- Legal Counsel (ad hoc)

ETAT
- Behavioral Science Professional
- Labor Partner(s)
- Chief Executive Office Support
- Law Enforcement
- Human Resources
- Safety Office
- Nursing Professional Service
- Legal Counsel (ad hoc)

Common Membership
- Behavioral Science Professional
- Law Enforcement
- Labor Partner(s)
- Legal Counsel
Be Careful of Boundaries Between the Missions of the ETAT & the DBC

For a DBC to attempt to assess and recommend management of violence risk in employees is to invite violations of employee rights (HIPPA, Privacy Act, ADA, EEO, and Fair Credit Reporting Act, etc).

2-Tiered Approach

1. Screening, Consultation, Disposition

VS.

2. Full Threat Assessment/Management Intervention
ETAT Incident Review Algorithm
Tier #1: Triage

- Employee
- Fellow Employee
- Supervisor
- Union
- Police

Employee TAT Member is contacted about a possible incident, notifies ETAT triage

**Acute?**
- Contact Police and others as appropriate

ETAT triage gathers ROC, Police reports, HR Information, etc.

ETAT Triage partners with Union and at least one other TAT member to decide:
1. Need to gather more information
2. Does not meet definition of WPV
3. Supervisory issue (partner with HR as needed)
4. TAT needs to meet

Case closed, file; consider memo to supervisor and/or parties involved

Modeled upon the work of Lt. David Okada and John van Dreal, MA

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ETAT Incident Review Algorithm
Tier #2: ETAT Review

- ETAT needs to meet
- Gather information as needed

**Meet**

**Conclusion?**

- Write up, send figures and conclusions to CEO, distributed to supervisors
- Case Management
- File

Yes

No

Modeled upon the work of Lt. David Okada and John van Dreal, MA
Recommended Threat Management Strategies: Non-Confrontational

- Take no action at this time
- Watch and wait
- Third party control or monitoring
- Subject interview

Passive
- Watch and wait
- Information gathering
- Refocus or assist
- Warn or confront

Active Monitoring
- Information gathering
- Refocus or assist
- Warn or confront
Recommended Threat Management Strategies: Confrontational

- Arrest
- Mental Health Hold
- Civil Order
- Clinical / Administrative Restrictions

What is the Safety/Treatment Plan?
- What ACTION should staff take to stay safe?

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Repeat Offenders Account for 40% of All Incidents

Incident Types for Patients with Patient Record Flags

<table>
<thead>
<tr>
<th>Incident</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Assault</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>Assault with weapon</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>Repeat Verbal threat</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Weapons/explosive</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Suicide attempt at VA</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Hostage Taking</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Repeated disruption</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Drummond et al (1989)
### Change in Disruptive Behavior for Patients with Patient Record Flags (N=36)

<table>
<thead>
<tr>
<th></th>
<th>12 Mos Pre-Flag</th>
<th>12 Mos Post-Flag</th>
<th>Change</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Outpt Incidents</td>
<td>44</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Inpt Incidents</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.31</td>
<td>0.11</td>
<td>Decrease 91.6%</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Incident/Visit</td>
<td>0.18</td>
<td>0.03</td>
<td>Decrease 85.4%</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*Drummond et al (1989)*

### Change in Disruptive Behavior for Patients with Patient Record Flags (N=36)

![Graph showing change in disruptive behavior](image)

*Drummond et al (1989)*
### Healthcare Utilization for Patients with Patient Record Flags (N=36)

<table>
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<tr>
<th></th>
<th>12 Mos Pre-Flag</th>
<th>12 Mos Post-Flag</th>
<th>Change</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Outpt Visits</td>
<td>226</td>
<td>137</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Inpt Visits</td>
<td>28</td>
<td>10*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Visits</td>
<td>254</td>
<td>147</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>7.6**</td>
<td>4.08***</td>
<td>Decrease 42.2%</td>
<td>&lt;.05</td>
</tr>
</tbody>
</table>

*One patient had six admits for radiation therapy

**The medical center mean for that year was 6.24 visits per veteran

***The medical center mean for the following year was 5.9 visits

*Drummond et al (1989)*

### Healthcare Utilization for Patients with Patient Record Flags (N=36)

![Bar chart showing healthcare utilization pre- and post-flag](#)

*Drummond et al (1989)*
Patient Record Flags Are Road Signs, NOT the Road Itself

CHALLENGES AHEAD

WARNING

Patient Record Flags as “Eyes On”

• Must reflect an organizational commitment to violence reduction
• Must be available to all ‘front line’ users
• **Must have signal value above the usual din**
• False negatives must be minimized
• False positives must not be overly costly
• Depend upon an infrastructure of incident reporting, incident review and threat assessment and policies
• Those responding to the alarm must be well-trained
Patient Record Flags Are NOT...

- A Panacea
- An intervention in and of themselves
- A Law Enforcement tool
- An Administrative tool
- A list of “bad apples”
- *Punishment or payback...EVER*
- A substitute for clinical decision making

Patient Record Flags: Standards

1. Flags are authorized *only* by the COS
2. Flags are confidential
3. Flags should *only* be used in VHA facilities that are in full compliance with VHA Programs for violence prevention
4. Established by multi- and interdisciplinary clinically-directed groups
Patient Record Flags: Standards

5. Secure supporting documentation for each flag
6. Periodic review of flags (2 yr max.)
7. Training
8. Criteria

What Are Appropriate Uses of Patient Record Flags?

“PRF were...Developed for the specific purpose of improving safety in providing health care to patients who are identified as posing an unusual risk for violence.”

“...Patient Record Flags (PRF) immediately alert [employees] to the presence of risk that must be known in the initial moments of a patient encounter.”

VHA Directive 2010-053, Patient Record Flags
PROBLEM

1-2 sentences describing the problem determined to pose a safety threat:

“Patient has a history of concealing firearms on his person while on VHA property.”

“Patient has a history of violence toward staff, resulting in injury, particularly while intoxicated.”

PLAN

1-2 sentences describing action to take to promote safety:

“Patient must check-in with VA Police when on VHA property. Police may search if there is probable cause.”

“Staff should have a low threshold for notifying VA Police when Patient presents for care under the influence of substances.”
Questions?

Lynn M. Van Male, PhD
Director, Veterans Health Administration (VHA) Workplace Violence Prevention Program
VHA Office of Patient Care Services, Occupational Health (10P4Z)
Washington DC