

US DEPARTMENT OF VETERANS AFFAIRS



Implementing Multidisciplinary Behavioral Threat Assessment and Management Practice in Health Care:

Disruptive Behavior Committee (DBC) Guidebook

**Workplace Violence Prevention Program (WVPP)
Office of Mental Health and Suicide Prevention (11MHSP)
US Veterans Health Administration (VHA)**

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PREFACE

The incidence of violence in the United States has dropped by nearly 50% over the past two decades. There are two notable exceptions to this remarkable decline: mass shootings, which have increased in the past several years, and violence in the health care industry. (<https://www.iahss.org/>, <https://www.fbi.gov/resources/library>, https://www.osha.gov/dsg/hospitals/workplace_violence.html, [https://www.jointcommission.org/assets/1/18/SEA 59 Workplace violence 4 13 18 F INAL.pdf](https://www.jointcommission.org/assets/1/18/SEA_59_Workplace_violence_4_13_18_FINAL.pdf))

Mass shootings garner attention from the media and the public, although they are not a new phenomenon and remain rare in American workplaces. The term “active shooter,” scarcely heard ten years ago beyond law enforcement circles, has become part of the common vernacular. Video of terrified people fleeing an office building or school during a shooting has become a frightening cliché on the evening television news. Efforts to minimize the risk of these catastrophic events are essential, but must not cause costly neglect of the more common forms of violence that occur regularly in health care settings. The US Occupational Safety & Health Administration (OSHA) has shown that health care employees suffer more non-fatal incidents of violence than employees in any other industry, including employees in law enforcement, taxi drivers, and convenience store clerks.

When a nurse is shoved and slapped while performing rounds on a locked ward at night; when a patient, unhappy about wait times, threatens an ER doctor with a knife; when one patient bullies another; or when an employee is stalked by a former patient, the impact can be profound. Although these events are rarely fatal, their effects on the victims and their colleagues, family, and friends may be devastating. They cause employee recruitment and retention problems, lost time, Worker’s Compensation claims, litigation, and many other costs to VHA and its employees. Occasionally, non-fatal events such as threats and assaults precede more significant violence. All seriously disruptive behavior, threats, and assaults must be thoroughly evaluated. However, healthcare workers report violence less often than other workers. (<https://www.osha.gov/Publications/OSHA3826.pdf>)

Over the past 30 years, the U.S. Secret Service (USSS), the FBI, the U.S. Department of Education (DOE), state governments, and university researchers have conducted exhaustive reviews of mass workplace shootings. Recommendations from these reviews and studies underscore the importance of creating an organizational culture that strongly supports the importance of reporting behaviors that raise concern of violence risk. The FBI recommended the development and training of specialized multidisciplinary teams charged with gathering event reports, conducting threat assessments, and recommending risk mitigation actions to the organization’s leadership. ([Making Prevention a Reality, 2017 \(https://www.fbi.gov/file-repository/making-prevention-a-reality.pdf\)](https://www.fbi.gov/file-repository/making-prevention-a-reality.pdf))

Executive Summary

In August 2012 President Obama signed PL 112-154, section 106, which amends 38 USC § 1709, mandating that VA institute a comprehensive policy to address the prevention of sexual assaults and other safety incidents in health care work environments. The law mandates incident reporting, training of employees, and violence risk assessment. To conform with PL 112-154, section 106, VA issued Directive 2012-026, Sexual Assaults and other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities. This Directive mandates the development and deployment of evidence-based violence risk assessment instruments for use by VHA clinicians. VHA has responded by developing the Violence Risk Assessment Instrument for General Violence (VRAI-G) and the Violence Risk Assessment Instrument for Sexual Violence (VRAI-S), both based upon research with Veteran samples.

In 2003 VHA mandated the creation of multidisciplinary Disruptive Behavior Committees (DBC) to address the problem of patient-generated violence (VHA Directives 2003-028 and 2010-053, Patient Record Flags). DBCs are staffed by senior VHA clinicians and others. VHA established the Disruptive Behavior Reporting System (DBRS) for use across all facilities in 2015. VHA mandated use of the Prevention and Management of Disruptive Behavior (PMDB) training program for all employees in every health care facility (DUSHOM Memo, November 17, 2013: Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum).

VHA researchers have demonstrated the effectiveness of DBCs in significantly reducing the risk of patient-generated disruptive behavior while improving the quality of health care delivered to disruptive patients. VHA is recognized as a leader among health care organizations in mitigating violence risk posed by patients (Drummond *et al.*, 1989). Recently the International Association for Healthcare Security and Safety (IAHSS) released guidelines for dealing with patient and visitor violence which largely mirror the program VHA has developed. (IAHSS 2018 05.03 Violent Patient/Patient Visitor Management <https://www.iahss.org/page/guidelines?>)

VHA, through its Workplace Violence Prevention Program (WVPP), has begun to develop and train multidisciplinary Employee Threat Assessment Teams (ETAT), charged with reducing the risk of employee-generated disruptive behavior. DBCs and ETATs share scientific principles and strategies for behavioral threat assessment and management. However, there are critical differences in the legal, policy, and regulatory environments within which employee-generated disruptive behavior is managed (see ETAT Guidebook, and Appendices VI and VII).

<http://vaww.hefp.va.gov/guidebooks/etat-managing-risks-posed-disruptive-employees>

Many health care organizations simply expel a seriously disruptive, threatening, or violent patient from their health care (see IAHSS Guidelines on “Patient Violence/Patient Visitor Violence” cited above). Federal Regulation 38 CFR 17.107 (VA Response to Disruptive Behavior of Patients) affirms that even the most disruptive, threatening, and violent patients who are otherwise eligible for VA care must be

provided health care that is safe and appropriate for the disruptive patient, for other patients, and for employees.

A public health approach to workplace violence provides an opportunity to prevent violent events. This guidebook will describe primary violence prevention strategies, secondary prevention strategies that respond to violence as it unfolds, and tertiary prevention strategies for managing the aftermath of violence.

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A rich and extensive body of empirical research and a legacy of successful Veterans Health Administration (VHA) program implementation support the principles and processes underpinning this DBC Guidebook. While it is not possible to acknowledge all who have made substantive contributions to our efforts, VHA's WVPP deeply appreciates the work of the following extraordinary individuals and acknowledges that it is upon the foundation of their achievements that WVPP's current violence prevention initiatives are built:

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How to Use This Guidebook

This guidebook consists of five chapters.

Where appropriate, the reader may be directed to other guidebooks for selected content. Links are provided when relevant.

Chapter 1: Program Development

Chapter 1 provides background on the need and the authority for programs to address patient-generated disruptive, threatening, and violent behavior in VHA. Included are scientific support, legal and regulatory mandates, accreditation standards, and descriptions of VHA's past success in managing patient-centered violence.

Chapter 2: Prevention Strategies

Workplace violence prevention is the responsibility of all VHA employees. DBCs should expect all VHA employees to assist in this effort by maintaining a climate of civility and respect toward patients, their families, visitors, and other employees, and by reporting disruptive behavior. The DBC is the central advisory group and consultative body responsible for helping VHA employees assess the threat of patient-generated violence and develop appropriate threat mitigation interventions. The DBC, along with VA Police and other departments, advises executive leadership about locations in the facility that experience elevated levels of threats and assaults from patients, locations that would benefit from improved security surveillance and alarms, and areas that have specific staff training needs.

This chapter reviews evidence-based training to prepare employees to prevent and manage patient-generated violence. The Prevention and Management of Disruptive Behavior (PMDB) Program is mandated in all facilities for all employees. The amount of training employees must take is based upon the frequency and types of violence the employees experience in their workplaces, determined by the annual Workplace Behavioral Risk Assessment (WBRA). (**NOTE:** see *DUSHOM Memo, October 2012, "Workplace Violence Risk Assessment (WBRA)"*) at <https://dvagov.sharepoint.com/sites/VHAWVPP/Laws%20and%20Directives/Memorandum/DUSHOM%20Memo%20Workplace%20Behavioral%20Risk%20Assessment.pdf?web=1>) (see also *DUSHOM Memo, Nov 7, 2013, "Meeting New Mandatory Safety Training Requirements Using Veteran Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum,* "at <https://dvagov.sharepoint.com/sites/VHAWVPP/Laws%20and%20Directives/Memorandum/Memo%20Mandatory%20Safety%20Training%20Requirements%20using%20VHA%27s%20PMDB%20Curriculum.pdf>)

Chapter 3: Structure and Function of a Disruptive Behavior Committee (DBC)

Chapter 3 describes the recommended composition and function of the DBC. It describes the resources and qualities which characterize effective DBC leaders and members. DBC best practices are discussed.

Chapter 4: Threat Assessment

Chapter 4 addresses the core DBC role of identifying and assessing potential threats of patient-generated violence. It discusses the nature of violence, types of violence, conceptual and theoretical models of violence, and the use of structured professional judgment (SPJ) approaches to developing a risk assessment that can inform intervention.

Chapter 5: Using Therapeutic Limit-setting to Facilitate the Care of Disruptive Patients

Chapter 5 describes the use of therapeutic limit-setting to mitigate risk and ensure that disruptive and potentially violent patients receive appropriate care safely. The DBC works with the Chief of Staff in recommending ways to mitigate risk factors while enhancing protective factors, with as little inconvenience to the disruptive patient as possible. Mitigation opportunities may involve the disruptive patient's health care providers, who can help the patient address situational factors associated with elevated risks of violence among Veterans (e.g., homelessness, drug and alcohol abuse, other psychiatric problems, and other factors). (See Elbogen et al, 2010, at [Improving risk assessment of violence among military Veterans: An evidence-based approach for clinical decision-making \(sharepoint.com\)](#)).

1.1 Program Overview

The U.S. Occupational Safety and Health Administration (OSHA) classifies types of workplace violence based upon the relationship between the violent person and the organization where the violence occurs.

Health care workers experience more non-fatal violence than workers in any other occupation.

Employees in the health care industry, including those in VHA, are subjected to all four types of OSHA-defined violence. The four OSHA types are:

Type I: Violence perpetrated by criminal outsiders who likely have no formal relationship to the workplace.

Type II: Violence perpetrated by customers, patients or clients.

Type III: Violence perpetrated by an employee against another employee, or against customers, including patients

Type IV: Violence that emerges from relationships within the community, including that between intimate partners and family members, and spills into the workplace.

The fact that VA medical facilities are impacted by all four types of violence underscores the complexity and scope of the challenge the organization faces in meeting its obligation to create the safest possible environment for patients and employees.

Health care workers experience among the highest rates of non-fatal workplace violence (Peek-Asa et al., 1997; Janocha & Smith, 2010), more than police and security officers, cab drivers, and convenience store clerks. Violence in health care settings accounts for nearly 50% of all reported non-fatal workplace violence in the United States. According to recent research, violence against health care providers is a problem across the world (Spector, Zhou, & Che, 2014).

Homicide is the leading cause of job-related deaths for female employees in the U.S. Intimate partner violence is often a factor in such events. OSHA requires that health care facilities have policies and procedures in place to address the problem of workplace violence. The health care and convenience store industries are the only two for which OSHA has developed specialized guidelines for workplace violence prevention. The Joint Commission (TJC) has issued Leadership and Environment of Care standards designed to guide health care facilities in addressing aggression committed by patients and employees.

Studies of violent tragedies in recent years have challenged common assumptions about violence and its prevention. Violent individuals do not “just snap.” Precursors to behavioral incidents are often observable and interruptible when there is a strong

In VHA, banning or barring even seriously disruptive Veterans is prohibited by Federal regulation.

violence prevention policy; a well-trained workforce that knows what, how, and when to report behavior of concerns; and a specially trained multidisciplinary

team with the ability to evaluate and act upon violence risk.

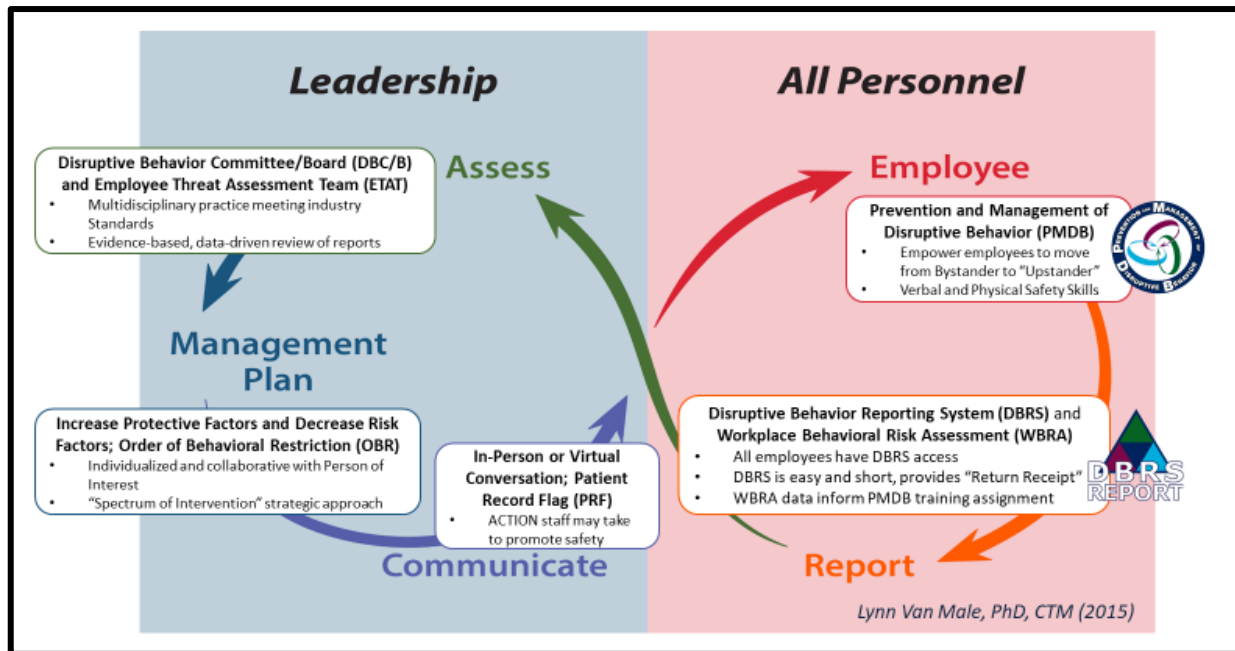
Several studies have found significant correlations between violence risk and certain psychiatric comorbidities in Veterans (Jakupcak, M., Conybeare, D., et al, 2007; Thomas, J.L., Wilk, J.D., et al 2010; and Marshall, A.D., Panuzio, J., et al 2005). One large study of combat Veterans who served in Iraq and Afghanistan suggests a strong relationship between violence risk and the presence of Post-Traumatic Stress Disorder (PTSD) with co-occurring alcohol abuse (Elbogen, et al 2014).

Only a small percentage of all VA patients are disruptive on VA property, and an even smaller group may be responsible for as much as 40% of the incidents that occur (Drummond, D.J. et. al.,1989). By identifying and understanding patterns and precipitants of disruptive behavior, VHA staff may reduce the risks of disruptive behavior and help the disruptive patient join with his/her providers in a mutually respectful and collaborative treatment plan. The importance of staff education and involvement cannot be overstated as a violence management strategy.

The standard of practice for many private and public health care systems and providers is to expel from their care any patient who is seriously disruptive, threatening, or violent. Such patients are usually not offered an opportunity to appeal these summary discharges. In contrast, VHA is committed to the highest standard of care, one that is patient-centered and consistent with its mission to provide health care to all eligible Veterans, including those who are disruptive. Federal Regulation 38 CFR, Part 17.107 specifically prohibits the practice of banning or barring eligible Veterans from VHA health care. VHA takes the position that prevention of violence requires an approach that is patient-centered, integrated, multidisciplinary, and transparent. Violence prevention promotes access to health care, and access to health care helps prevent violence.

1.1.1 VHA's Workplace Violence Prevention Model

Figure 1.1 VHA's Workplace Violence Prevention Model



Employees are the keys to a workplace free from disruptive and violent behavior. The Prevention and Management of Disruptive Behavior (PMDB) training program seeks to change bystanders into "upstanders" by providing education and awareness, combined with skills training.

When employees are engaged in violence prevention, they need a way to report events and concerns to appropriate venues. The Disruptive Behavior Reporting System (DBRS) is available to all employees, is easy to use and takes little time, and notifies the employee that the report has been received and will be addressed. The Workplace Behavioral Risk Assessment is conducted annually to determine which work areas have higher risk levels and require higher levels of training.

Reports of disruptive events lead to behavioral threat assessments conducted by multidisciplinary teams (Disruptive Behavior Committees (DBC), Employee Threat Assessment Teams (ETAT)) using evidence-based, data-driven, structured professional judgment (SPJ) approaches to evaluate evidence and determine risk.

These structured threat assessments lead to threat management plans which seek a collaborative pathway to reducing risk of violence, using a variety of non-restrictive and restrictive strategies, and aimed at weakening risk factors and strengthening protective factors. Alerts placed in the electronic record inform staff "just in time" of the safety plan and actions needed to stay safe in an encounter.

1.2 Vision

To achieve a workplace that is free from disruptive and violent behavior and promotes the delivery of safe, effective, patient-centered health care.

1.3 Mission

To develop policies and supporting programs that disseminate and promote knowledge, skills, and appropriate use of evidence-based, data-driven processes for assessing, mitigating, and managing human behaviors that compromise the safety and effectiveness of VHA's health care workplaces.

Although it is not possible to eliminate all disruptive, threatening, and violent behavior from VHA facilities, it is possible to reduce its likelihood through a commitment to a culture that values civility and respect in all interactions, training, and incident reporting. This mission is most effective when employees and patients share the same vision of civility and safety.

Violence prevention promotes access to health care, and access to health care helps prevent violence.

1.3.1 Values

DBC's uphold VA's values of integrity, commitment, advocacy, respect, and excellence (I CARE). In addition, DBCs practice behaviors consistent with the values of safety, honesty, fairness, inclusion, equity, diversity, justice, intellectual integrity, and behavioral integrity.

DBC's practice behaviors consistent with the values of safety, honesty, fairness, inclusion, equity, diversity, justice, intellectual integrity, and behavioral integrity.

1.4 Goals

Each VHA facility will have a comprehensive program to reduce patient-generated disruptive, threatening, or violent behavior. This guidebook will assist VHA facilities to develop policies and procedures, training programs, and administrative structures to address patient-generated disruptive behavior.

1.5 Federal Laws

In January 2012, the United States Congress passed, and the President signed, Public Law (Pub. L.) 112-154. Section 106, which amended 38 USC § 1709. This law requires that VHA develop and implement at each medical facility a comprehensive policy on the reporting and tracking of sexual assaults and other public safety incidents.

1.6 VHA Regulations and Initiatives

VHA responded to Pub.L.112-154, Section 106 by issuing VHA Directive 2012-026, “Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities,” (<http://vaww.va.gov/vhapublications/publications.cfm?Pub=1>) requiring that any behavior undermining a safe and healing environment is appropriately reported, addressed, and monitored.

In 38 CFR Part §17.107, VHA is mandated to treat all eligible Veterans, even those with a history of threatening and physically violent behavior within VHA facilities. (http://www.ecfr.gov/cgi-bin/text-idx?SID=57de6a151189441b6e9605fd3edcb1ff&mc=true&node=se38.1.17_1107&rgn=div8). VHA may not ban or bar disruptive or violent patients. VHA has become a world leader in health care in creating innovative approaches for preventing and managing disruptive and threatening patients, employee violence prevention training programs, and policies to address patient-generated disruptive behavior.

VHA Directive 2010-053 (pending renewal as 1166), “Patient Record Flags,” (<http://vaww.va.gov/vhapublications/publications.cfm?Pub=1>) governs the use of electronic communication alerts that identify patients who, because of a history of violence or significant violence risk factors, require special accommodation to safely facilitate their health care. This Directive requires every VHA facility to have a Disruptive Behavior Committee (DBC), trained in threat assessment and management. Research has demonstrated the effectiveness of such teams in reducing patient-generated violence while enhancing the quality of health care delivered to patients with a history of disruptive behavior.

At the heart of a successful program for preventing disruptive and violent behavior is an interdisciplinary and well-trained team in each VHA facility that directly advises facility leadership.

1.7 VA Office of Occupational Safety and Health (VAOSH)

The Responsibilities of the VA Office of Occupational Safety and Health, facilities, and networks are spelled out in VHA Handbook 7701.01, “Occupational Safety and Health (OSH) Program Procedures.” ([VHA Directive 7701 | Healthcare Environment and Facilities Programs \(va.gov\)](#)). The Handbook is issued to assure conformity with VA

Directive 7700, “Occupational Safety and Health Program.” ([VHA Directive 7701 |](#)

[Healthcare Environment and Facilities Programs \(va.gov\)](#)). The Directive and Handbook require that facilities strive to reduce and/or eliminate work-related injuries.

1.8 U.S. Occupational Health and Safety (OSHA) Regulations

OSHA enforces 29 CFR 1960.8(a) which, like the General Duty Clause that applies to private workplaces, requires Federal Agencies to “furnish to each employee a place of employment which is free from . . . hazards that are likely to cause death or serious harm.”

OSHA publication, 3148-06R (2016) “Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers “ ([Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers \(sharepoint.com\)](#)), reflects findings from OSHA’s surveys and research that convenience stores and health care facilities have the highest rate of non-fatal workplace violence. OSHA’s interest in violence in health care facilities is strong. Since the original guidelines were issued in 2004, violence rates for convenience stores have decreased markedly, while they appear to have increased in health care facilities. In recent years, VHA facilities have been cited by OSHA for failing to take reasonable measures to prevent violent incidents.

1.9 The Joint Commission (TJC) Standards and Advisories

TJC has long promoted standards for health care institutions relating to managing safety, including the risk of workplace violence. These standards are disseminated through the TJC manual, primarily in the Environment of Care and Leadership chapters. As these standards change regularly, please contact your local accreditation specialist for the current standards. A copy of the current TJC manuals can be found here: <http://vaww.oqsv.med.va.gov/functions/integrity/accred/jointcommission.aspx>

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2.1 Rationale

In the United States, fifty percent of all workplace assaults are experienced by health care workers (Healthcare Crime Survey, 2016). Given that patient-generated violence is the most commonly reported violence risk in health care settings, a proactive and coherent program for assessing and managing patient violence risk is crucial. A public health framework is considered a best practice for violence prevention by many governmental agencies and professional associations. This guidebook recommends primary prevention strategies to prevent violence before it occurs, secondary prevention strategies to address violence as it unfolds, and tertiary prevention strategies to manage the aftermath of violence.

VHA facilities must plan for all types of potential violence, including uncommon events such as an mass shooting or a bombing. While planning for such high profile but extremely rare events is needed to ensure an adequate response and to enhance psychological safety, it is only one piece of a robust violence risk management program. Research on the assessment and management of violence has identified numerous commonly occurring risk factors that can inform preventative action in addressing the more common forms of disruption and violence occurring daily in health care facilities. This prevention is possible through the implementation of a coordinated program designed to identify, assess, and manage potential violence risk elements at the facility.

Prevention of workplace violence is built upon a culture of safety. Achieving a culture of safety demands effective leadership and management commitment. This commitment is demonstrated by having appropriate policies, training all employees, having resources to report and track disruptive events, utilizing evidence-based threat management strategies, and reviewing the program regularly.

A violence prevention program needs stakeholder support across the facility. Frontline personnel typically experience the greatest exposure to disruptive and violent behavior. All behaviors causing concern for safety should be reported and assessed. If employees believe their workplace violence prevention program will take effective action, they are more likely to report disruptive behavior. With timely and informative reporting, the chances of detecting vital cues to a potential escalation increase dramatically. Management of safety risks posed by a patient might include timely communication with staff regarding the threat, application of appropriate limits in the manner the patient receives care, and strategies to engage the patient in care for health challenges, substance use problems, domestic concerns, economic peril, and other stressors and risk factors. Outreach, relationship building, and communication with leadership at all levels and with employees throughout a facility are key to an effective program.

A public health policy framework is considered a best practice for violence prevention by NIOSH, OSHA, and many professional associations. This Guidebook describes “primary prevention strategies” to reduce violence before it occurs, “secondary prevention strategies” that respond to violence as it unfolds, and, “tertiary prevention strategies” for managing the aftermath of violence.

2.2 Primary Prevention Strategies

In VHA, primary prevention strategies emphasize employee training, event reporting, patient-centered safety planning, risk identification, and compassionate approaches to caring for disruptive and violent patients.

2.2.1 Review of Disruptive Patient Electronic Health Records (EHR)

Previous behavior is the best predictor of future behavior. When a patient has been disruptive or violent, a necessary but not sufficient part of an evidence-based structured professional judgment behavioral threat assessment is a thorough review of all available records, including the electronic health record. This review helps the DBC identify patterns of similar behavior, predisposing and precipitating factors, and factors that may mitigate future disruptive behavior. Information from the EHR will contribute heavily to the usefulness of the Violence Risk Assessment Instruments. This review facilitates the development of safety and clinical care plans to reduce identified risk and ensure the continued provision of VHA health care services in a safe environment.

***Note:** The DBC acts under the auspices of the Chief of Staff on behalf of the entire facility. The DBC's patient-related activities contribute to treatment planning and provision of services, and are considered clinical services. This affords the access to the EHR that is necessary to conduct behavioral threat assessment and to monitor and update the threat management plan as necessary.*

2.2.2 Leadership Safety Rounds

The Safety Officer, supervisors, senior leaders, and VA Police share responsibility for conducting regular safety assessments of VHA facilities and workplaces. Factors that may be examined include access control, visitor management, intrusion detection, and alarm monitoring. In addition, the effectiveness and operation of any closed-circuit television and other surveillance systems should be tested regularly as permitted by law. Panic alarms must be tested regularly to ensure they are functioning. One additional action that is encouraged during Environment of Care Rounds is for members of the inspection team to randomly ask employees what they would do in the event of threatening or dangerous behaviors of patients, visitors, or employees. This query reveals the degree of awareness that employees have of reporting requirements and training opportunities. The results of this query should be provided to the DBC and PMDB programs to assist with planning.

2.2.3 VA Police Pre-Incident Planning with Community Law Enforcement Partners

Because of the professionalization of VA police, VHA enjoys an enormous advantage over many other health care organizations. VA police are explicitly trained in verbal de-escalation – the art of calming a situation prior to an incident occurring. Being fully sworn and fully equipped gives VA police officers credibility with employees, visitors and patients, and other law enforcement agencies. Interagency relationships permit the

exchange of law enforcement intelligence, providing mutual benefit. The nurturing of interagency law enforcement relationships can prove valuable in the event of a major incident of violence.

2.2.4 Effective Collaboration with Local Labor Partners

VA labor union contracts and the Master Agreement require VHA facilities to have safe and healthy work environments, to ensure union representatives are kept informed of risks, and to involve union safety representatives actively in facility efforts to reduce workplace hazards and unsafe conditions, including behavioral threats. Formal inclusion of labor partners on workplace violence prevention teams, safety committees, and the annual WBRA helps ensure that local labor partners are an integral part of the workplace violence prevention program. Local labor leaders can communicate with employees, encourage event reporting and documentation, promote and facilitate training, and address myths, rumors, and staff anxiety. VHA endorses and recommends strong partnerships with labor.

Labor partners serving on the DBC may be particularly adept at responding to concerns of employees who filed disruptive behavior reports. After reporting, employees may worry that the patient will identify them and seek retribution. The labor representative can reassure the worried employee that a thorough risk assessment has been conducted, any identified risks addressed, and the reporting employee's identity protected. Of course, privacy rules still apply to what information can and cannot be released to concerned employees about patients or employees who have allegedly behaved disruptively. Not all the questions that a reporting employee has about threat management actions can be answered. But the practice of interacting in empathetic and transparent fashion with employees who have filed reports should solidify the working relationship between the violence prevention teams and their stakeholders. When such employees are concerned for their own safety, the labor partners on the DBC, often in cooperation with VA police, can help them identify ways they can enhance their own safety.

2.2.5 Employee Education in Prevention and Management of Disruptive Behavior

The Prevention and Management of Disruptive Behavior (PMDB) Program is VHA's employee education arm of the WVPP. The PMDB Level 1 Online Course in the Talent Management System is assigned to all VHA employees to introduce concepts of awareness, preparedness, and reporting of disruptive and violent behavior in VHA, including sexual assault prevention. The Level 1 course addresses the different types of workplace violence and provides the rationale for reporting disruptive behavior. PMDB Levels 2 and 3 increase the employees' skills in verbal de-escalation, limit setting, personal safety skills and therapeutic containment. More information about the PMDB program can be found on the PMDB SharePoint at <https://dvagov.sharepoint.com/sites/VHAPMDB/SitePages/Home.aspx>. New employees must complete all assigned levels of PMDB training within 90 days of hire to ensure they are prepared for workplace violence prevention.

In 2016 and 2017 the VA Office of the Inspector General (VA OIG) conducted Combined Assessment Program Surveys of workplace violence prevention efforts at several VHA facilities. (OIG Combined Assessment Program Summary [CAPS] Report, “Department of Veterans Affairs Health (VA) Health Care: Management of Disruptive and Violent Behavior in Veterans Health Administration Facilities” [OIG 17-04460-84] may be found at [Department of Veterans Affairs Office of Inspector General Combined Assessment Program Summary Report Management of Disruptive and Violent Behavior in VHA Facilities; Rpt #17-04460-84 \(sharepoint.com\)](#)). The OIG surveyed the implementation of violence prevention training in the facilities visited. The report stated “Leaders at each of the facilities visited had implemented security training plans that used the official Prevention and Management of Disruptive Behavior training curriculum and included basic (Level I) training to all employees and additional levels based on the type and severity of risk for exposure to disruptive behaviors. However, facilities need to improve in providing newly hired employees with Level I Prevention and Management of Disruptive Behavior training and additional levels as indicated.” The most compliant facilities included multiple levels of training in the formal New Employee Orientation, and OIG suggested that all facilities consider doing the same. In response to the recommendation, VHA agreed to “require facility senior managers to ensure all new employees complete Level 1 PMDB training, and all applicable additional levels of PMDB training based on the risk for exposure to disruptive/violent behaviors as determined by the Workplace Behavioral Risk Assessment (WBRA), within 90 days of hire.” The Deputy Under Secretary for Health for Operations and Management provided more direction in a Memorandum dated July 20, 2018. ([KM C554e-20180720140729 \(sharepoint.com\)](#))

2.2.6 Early Reporting and Intervention to Stop Disruptive and Threatening Behavior

The use of threatening, intimidating, harassing, disruptive, and/or violent behaviors is often a long-term pattern that will require active intervention to modify. A patient who engages in these behaviors may habitually attempt to deflect risk assessment or corrective action by claiming that the behavior was “just kidding around (minimizing),” was a function of a medical or psychiatric problem over which they have no control (avoidance of responsibility), or was caused by staff (externalizing blame). Repeated apologies by the disruptive patient, especially those unaccompanied by changes in behavior, do not relieve the DBC of its responsibility to conduct a thorough review of the incident.

Some people intentionally and repeatedly use harassment, intimidation, bullying and verbal threats to achieve desired goals. Such behavior is often rewarded by its effectiveness in achieving immediate goals. When interviewed by DBC after a disruptive event, patients have said such things as, “When you get in someone’s face you can get seen faster.” They can describe other payoffs for instrumental aggression. Generally, individuals who use such tactics will not commit serious physical violence against other persons. However, many individuals who do commit physical violence have histories of

bullying and harassment. Early intervention is warranted since behavior becomes more resistant to change as it continues and is reinforced by short term success.

The U.S. Equal Employment Opportunity Commission (EEOC) provides the following definitions for harassment in the workplace:

Harassment is unwelcome conduct that is based on race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability or genetic information. Harassment becomes unlawful where 1) enduring the offensive conduct becomes a condition of continued employment, or 2) the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile, or abusive. Anti-discrimination laws also prohibit harassment against individuals in retaliation for filing a discrimination charge; testifying or participating in any way in an investigation, proceeding, or lawsuit under these laws; or opposing employment practices that they reasonably believe discriminate against individuals, in violation of these laws. Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment.

Even when these behaviors do not escalate to physical violence, repeated threats of possible violence take a toll on employee morale and productivity. Timely assessment and intervention for this inappropriate behavior is effective for promoting a culture of safety. Organizations should train employees to recognize the value and importance of reporting *all* episodes of disruptive behavior.

The “see something, say something” awareness is invaluable in an employee culture of caring for patients, each other, and visitors. When this behavior is promoted as a way of ensuring excellent care in an environment safe and healthy for all, people may become less concerned about being a “snitch,” getting the disrupter in trouble, or receiving criticism because “it’s just part of your job to put up with bad behavior.” Employees may access any of the available channels to report concerning behaviors. These avenues may include supervisors, VA Police, Union representatives, the Disruptive Behavior Reporting System (DBRS), higher level executives, members of the DBC, the Harassment Prevention Program of ORM/EEO, or Employee Occupational Health. Employees must be assured that they will not suffer retaliation or other adverse consequences as a result of making reports. Those who receive reports must ensure that there will not be an overreaction to reporting and that the report will be handled professionally.

In summary, employees need an understanding of the value of reporting and of how and when to use the DBRS (see section 3.9 below). They need the confidence that they will not suffer retaliation or other adverse consequences from reporting in good faith, the belief that reporting is valuable, and the knowledge that their reports will be acted upon to make positive changes in the facility. Labor partner representatives serving on the DBC may be instrumental in developing this culture.

Employees should be trained to report anytime they see or hear anything that causes them to be concerned for anyone's safety—regardless of whether the behavior comes from fellow employees or patients.

2.3 Secondary Prevention Strategies

Secondary prevention strategies are responses to violent events as they are developing or occurring. These strategies de-escalate disruptive and violent behavior and prevent or minimize unwanted complications such as emotional or physical injury, psychological trauma, retaliatory violence, and damaged morale.

2.3.1 Trained Behavioral Code Responses

As with medical codes, behavioral codes enlist the assistance of trained experts capable of managing stressful, escalating, and crisis situations. Behavioral codes may include the full range of disruptive behaviors including verbal and/or physical violence toward self or others. The availability of trained professionals can prevent disruptive behavior from escalating to more severe forms of violence.

VA medical facilities deploy different strategies to ensure trained responders address behavioral codes. The best practice model is a blended approach that utilizes trained responders who work in high risk workplaces as well as trained responders from throughout the facility. These two teams are the Behavioral Emergency Response Team (BERT) and the Behavioral Rapid Response Team (BRRT), (see Table 3.1).

The BERT is composed of trained clinical staff members assigned to high risk workplaces. Typically, these will be inpatient psychiatric units, emergency departments, inpatient medical/surgical units, and community living centers (CLCs). BERT members are trained to safely and effectively stop physical violence by patients so that clinical care can continue in the high risk workplace.

Table 2.1 Comparison of Response Team Characteristics

Characteristics	BERT	BRRT
Full Name	Behavioral Emergency Response Team	Behavioral Rapid Response Team
Membership	Clinical employees only	May be multidisciplinary
Location	Members must be full-time staff in the high risk workplace they serve	May come from and serve different workplaces, work across settings/clinics/units
Availability	Team members must be available 24/7 in the high risk workplace (cannot work somewhere else and “respond to a code”)	May be determined locally
Training	Must be trained in all levels of PMDB and competent to safely perform therapeutic containment	Training in all levels of PMDB recommended but not required by current policy
Goal	To stop patient-generated violence immediately before anyone is injured.	To assist in de-escalation throughout the facility and act as back-up to support other de-escalation or containment efforts.

To use BERTs, high risk workplaces must also have ready access to physical and medical forms of restraint, seclusion rooms, emergency or rescue medications, and emergency medical care to ensure the safety of the patient requiring ongoing restraint to restore self-control. The BERT requires a minimum of four clinical staff members trained in all levels of PMDB. BERTs must be available in high risk workplaces 24 hours a day, 7 days a week per policy to ensure that clinical restraint interventions may be deployed immediately in the first moments of physical violence. High risk workplaces should train all clinical staff without physical limitations to be members of the BERT, while non-clinical staff and staff with physical limitations who work in high risk workplaces are required to train up through PMDB Level 2.

The Behavioral Rapid Response Team (BRRT) functions much like a medical rapid response team for behavioral events throughout the facility. In this model, employees trained in verbal de-escalation and limit-setting respond to behavioral codes in minimal risk, low risk, moderate risk, or even high risk workplaces to assist staff in managing disruptive behavior that threatens to escalate to violence. They can provide back-up and assistance to BERT Teams in high risk workplaces. Here, appropriately trained clinical members of the BRRT can assist in hands-on procedures, while non-clinical BRRT members may assist in managing environment factors contributing to the situation. For BERTs and BRRTs to work, the members must be quickly available, easily contacted, and well trained. Behavioral response team members should demonstrate patient-

centered attitudes and commitment to both I-CARE values and the safety of the health care and social services environment as a whole.

Additional considerations for behavioral response teams:

1. Regular drills are necessary to ensure the maintenance of skills for both BERTs and BRRTs responding to more severe forms of violence. Drill opportunities should be conducted at least quarterly, with all members refreshing knowledge and skills at least twice a year.
2. Teams and leadership should guard against misuse of the teams. Employees may become overly reliant on the response teams to provide patient care and management they themselves find uncomfortable or difficult. This form of “dumping” clinical responsibilities onto other staff can lead to burn-out and reduced responsiveness on the part of teams. Prevention involves early detection and redirection of this behavior by emphasizing regularly that violence prevention and management is everyone’s responsibility.
3. Team burn-out in BRRTs can also be avoided by establishing agreed upon service cycles. Leadership should determine an appropriate amount of time for team membership (e.g., terms of 1-3 years) and review members’ ability and willingness to continue service following the end of the term.

2.3.2 PMDB Program

PMDB is organized into 3 levels that can be tailored to meet the specific training needs of individual employees based on their assessed risk for exposure to workplace violence determined by the Workplace Behavioral Risk Assessment (WBRA). PMDB courses must be completed in the correct sequence as each module builds upon the material covered in its course prerequisite.

Level 1 PMDB training provides an overview of workplace violence and is required by all VHA employees. Additional training in Level 2 Low, required by employees in low risk areas, places an emphasis on early intervention to prevent the escalation to physical violence. This includes awareness and observation of self, others, and environment in all interactions. Staff are provided verbal de-escalation skills training and an opportunity for practice in the classroom. Proxemics, limit setting, and personal safety skills are taught in Level 2 High and required by employees in moderate risk areas. These techniques prevent or minimize injury during an assault, facilitate escape from immediate danger, and maximize safety of patients and employees. For employees working in high risk areas, Level 3 training provides an emphasis on working as a team to de-escalate and physically contain an individual at imminent risk of harm to self or others. Therapeutic containment is a clinical intervention allowing treatment to continue after the danger is contained and is used only as a last resort when all other interventions efforts have failed. When a weapon is involved the police must be the primary responders and this technique will not be used by staff.

2.3.3 Employee Annual Review Training on Workplace Violence

Annual training on workplace violence is considered best practice and recommended by agencies such as The Joint Commission and OSHA. Check local facility policy for further information.

2.4 Tertiary Prevention Strategies

Tertiary strategies are aimed at reducing the recurrence and impact after violence has occurred, and are often long-term interventions. Such strategies may involve fact-finding, root cause analysis, process review/evaluation, and threat assessment; will often address victim impact and rehabilitation of disruptive individuals; and may include target hardening, orders of restriction, VA police involvement, and mental health commitment.

2.4.1 Crisis Services for Patients Who Have Experienced Violent Behavior by other Patients.

The targets of disruptive patients are often other patients. They should be evaluated and offered crisis services as appropriate. For example, a staff member in the dental clinic might offer to accompany a frightened patient to the walk-in clinic in mental health after an altercation in the waiting room.

2.4.2 Services for Employees Who Have Experienced Violent Behavior

Employees who have experienced workplace violence deserve prompt and professional therapeutic intervention if they request it. If they are physically injured or emotionally traumatized, VA Emergency Department services should be made available as needed, until appropriate transfer is available. These interventions may not be mandated. Many facilities provide Employee Assistance Services (EAP) which can provide immediate assessment and care, and make referrals for employees who have experienced workplace violence. Most Federal employees have health insurance benefits that cover such interventions. Supervisors should ensure that these employees are given full access to needed services without fear of reprisal or loss of job status. There are other examples of ways support has been provided in VHA. A team from behavioral health might be available to employees from a work area where a difficult event, such as a suicide, has occurred. This team, with appropriate training, may be available to provide crisis intervention or debriefing. Some facilities have arranged for crisis support teams from the community to set up shop in or near a facility where there has been a traumatizing event.

2.4.3 When Intimate Partner Violence Enters the Workplace

Intimate Partner Violence (IPV) includes physical, sexual, or psychological harm or stalking behavior by a current or former partner that occurs on a continuum of frequency and severity, ranging from emotional abuse to chronic, severe battering or even

death. IPV can occur in heterosexual or same-sex relationships and does not require sexual intimacy or cohabitation. Apart from the obvious humanitarian concerns, it is in the interests of the facility to ensure employees have access to services that reduce the likelihood that IPV enters the workplace. It is not the employer's role to directly intervene in such situations, or to attempt to resolve the issues. However, supervisors, law enforcement, EAP, and Occupational Health need training in the issues related to these concerns and information on suitable referral sources within the community where a potential victim of such violence can receive guidance and support. The IPV Assistance Program Coordinator (IPVAP-C) serves as a resource for guidance in situations involving such violence. The mission of the IPVAP is to provide a comprehensive person-centered and recovery-oriented assistance program for patients, their families and caregivers, and VHA employees who use or experience intimate partner violence. The IPVAP-C may work with VA Police, the DBC and ETAT, and facility leadership to support legal restraints such as restraining orders, designed to provide protection when the potential victim is on the property. District Attorney offices and community law enforcement often have programs and trained counselors providing support for the experiencers of IPV. VHA Directive 1198 (January 2019) addresses access to services, including resources, assessment/intervention, and referrals. (https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=8192) .

2.5 References and Resources

Hesketh, K., Duncan, S., Estabrooks, C.A., Reimer, M., Giovannetti, P., Hyndman, KI, et al. (2003). Workplace violence in Alberta and British Columbia hospitals. *Health Policy*, 63, 311-321.

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Intimate Partner Violence Assistance Program, VHA Directive 1198, January 24, 2019. https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=8192

Chapter 3 Structure and Function of a Disruptive Behavior Committee (DBC)

Effective leadership at all levels of VHA is needed to create a culture of civility and safety. Operating under the authority of the facility Chief of Staff (COS), the DBC's mission is to reduce the risk of disruptive, threatening, or violent patient behavior while ensuring that disruptive patients receive the care they need.

In accordance with VHA Directive 2010-053 (pending updates contained in 5019.01), the COS selects DBC members based on the unique skills that each provides to the work of the DBC. This chapter describes the qualities of an effective DBC Chairperson, the skills, background, and temperament recommended for employees who serve on the DBC, and expectations for DBC members. The chapter concludes with an explanation of principles, processes, legal, and ethical considerations involved in DBC operations and record keeping.

Most health care organizations do not face the challenges VHA encounters in managing disruptive patients. Disruptive patients in most healthcare systems can be dismissed and prohibited from returning for treatment. However, all eligible Veterans are entitled to receive the full range of VHA health care services even when they pose a risk of violence or have been disruptive, threatening, or violent. The DBC evaluates the risk of violence and recommends a plan that creates a pathway for the disruptive patient to continue his/her health care in the least restrictive manner possible.

The DBC must balance safety and patient access to care by using the least restrictive interventions that ensure a safe and therapeutic environment.

3.1 Facility Leadership

Facility leaders must ensure that all components of the workplace violence prevention program operate successfully. Successful operation of a DBC requires adequate resourcing, including administrative support and protected time for the conduct of necessary business. In turn, a well-functioning DBC enhances the health care environment, improves patient care, and enhances satisfaction for patients and employees.

3.2 Naming a DBC

The name of the multidisciplinary committee formed to address disruptive, threatening, or violent behavior by patients is the "Disruptive Behavior Committee."

VHA Directive 5019.01 (VHA Workplace Violence Prevention Program) and VHA Directive 1166 (Patient Record Flags) require that all VHA medical facilities have a DBC. The responsibilities of the DBC go far beyond the management of Patient Record

To name the facility DBC the “Flagging Committee” or to consider the application of PRF as its primary mission reflects a profound misunderstanding of the DBC’s work.

Flags (PRF), and it should never be called “the Flagging Committee,” as has been the custom in some facilities.

3.3 DBC Leadership

The DBC Chairperson will be an experienced clinician provided with

protected time to manage the myriad duties involved in this key role. The selection of DBC leadership is among the most important decisions the COS will make about the management of disruptive patients and patient-related violence prevention. The well-managed DBC, having the confidence of the COS, will greatly reduce the burden which disruptive patients place on the facility’s resources.

The role of DBC chair is demanding. In more complex facilities it may require a full FTEE or more. An effective model used by many VHA facilities involves two qualified clinicians co-chairing the DBC, while another involves having a chair and co-chair. Either option offers the possibility of adequate resourcing for the responsibilities of managing the DBC. Either approach offers advantages and economies, including that:

- Both clinicians can maintain some clinical care responsibilities and their credentials/clinical privileges;
- They provide continuity of coverage during episodes of sick leave, annual leave, and training absences;
- There are more resources available during high utilization periods.

The following characteristics, qualifications, and personal qualities describe effective DBC chairs:

- a. DBC chairs report directly to, have ready access to, and have the confidence of, the COS.
- b. DBC chairs have demonstrated experience in leading a diverse and multidisciplinary team and have training in group dynamics and leadership. Ideally, the DBC chair will have experience in leadership and in managing stressful conditions.

- c. Effective DBC chairs encourage and respect divergent opinions and possess the skill to frame issues in a manner that encourages discussion and consensus building. The DBC chair garners input from diverse professionals with differing training and orientations. Skill is required to lead this diverse team to consensus about both the extent and nature of violence risk and recommendations to mitigate the risk.
- d. DBC chairs are individuals who strive toward a team mind-set that promotes openness, collegiality, continuous learning, self-awareness, and accountability.
- e. DBC chairs have knowledge of legal and ethical issues relating to privacy, informed consent, duty-of-care, duty-to-warn, and duty-to-protect, including relevant state and Federal laws and VHA policies related to these issues.
- f. DBC chairs will support and advocate for on-going training of the DBC. The field of violence risk assessment and management is rapidly evolving, and continued training is essential.
- g. DBC chairs will be senior clinicians with knowledge of, and experience in, evidence-based multi-disciplinary behavioral threat assessment (see VHA Directive 5019.01 VHA Workplace Violence Prevention Program).

Challenging situations arise when a DBC member's performance detracts from the work of the committee. Resolving such issues requires skill, sensitivity, and tact from the DBC chair, and may require support from the COS or the DBC member's supervisor. Some examples of problematic behaviors and situations include:

- consistently poor attendance
- lack of participation and failure to follow through on assignments
- failure to complete training needed for DBC participation
- violation of the trust required for teamwork
- personal attacks on other members
- sharing of confidential material outside appropriate boundaries
- poor grasp of the mission of the DBC
- difficulties engaging in the consensus building process of the DBC

Factors that contribute to these problems include the member's:

- being "voluntold" to the DBC rather than enjoying a sense of purpose
- joining for career advancement rather than to promote safety
- joining without understanding the nature and purpose of the activity

It can be useful to use the first six months of DBC membership as a probationary period during which the new member's goodness-of-fit can be evaluated, and during which the new member meets with the DBC chair/co-chair several times to discuss concerns, interests, questions, and progress.

Repeatedly absent members, even those who have served for a long time, may not appreciate their importance to the overall process. Supportive chairs might be able to re-engage them in contributing more, offer them a graceful exit strategy when interest lags or burnout is present, or work with their supervisor to resolve the attendance problems.

Conduct issues addressed early are generally more easily solved. Very occasionally a DBC member's conduct could rise to the level of requiring supervisory or HR intervention, and documentation by the chair will be essential in following through with corrective actions.

3.4 Qualifications for DBC Members

VHA facilities vary greatly in size, complexity, and structure. All the required positions described in section 3.5, or their functional equivalents, will be present in all facilities, and are essential to an effective DBC. It may seem daunting for the COS and supervisors to identify staff members who possess both the requisite professional and personal qualifications to serve effectively on a DBC and the desired interest. This search is important, however, as there are two primary reasons that DBCs are ineffective: lack of executive leadership support and poorly selected DBC leadership and membership.

In most cases, the Chief of Staff, in consultation with the DBC Chair or Co-chairs and service level leadership, will appoint the DBC membership. The following should weigh heavily in this selection process:

- a. The prospective DBC member has demonstrated professional expertise and adequate job experience in the facility. Trainees or newly hired employees will usually not serve a primary role on a DBC.
- b. The prospective DBC member understands the importance of keeping sensitive information and deliberations confidential and is aware of the harm that may result from the inappropriate release of information. DBC members should be experienced in handling highly sensitive written, electronic, and oral information within VHA.
- c. The prospective DBC member has demonstrated the ability to work collaboratively with colleagues from other departments and disciplines.
- d. The prospective member has credibility, the respect of others, strong interpersonal skills, and the ability to manage conflict in a constructive manner.
- e. The prospective member possesses emotional maturity. DBC membership is not appropriate for someone who has anger or authority problems. Effective members understand that the function of a DBC is to address behavioral threat in a patient-centered approach which allows the provision of safe and effective health care. They

embrace the DBC's role as a clinical care operation which is not designed to determine guilt, assign blame, or mete out punishment.

- f. The prospective member possesses high tolerance for ambiguity. Behavioral threat assessment is a complex process. Risk factors are difficult to assess, and it is hard to measure the success of prevention efforts. A DBC member must appreciate the delicate balance between interventions that could potentially harm versus those that may help reduce risk in a DBC case.
- g. The prospective DBC member should expect to serve at least two years, although this cannot be enforced. The importance of continuity in DBC membership, the length of the learning curve, and the investment in training that the facility will make in each member are compelling arguments for selecting members who agree to serve at least two years. Facilities should develop effective strategies to allow DBC members to account for their workload activities.

Even when the DBC does its work well, others in the facility are sometimes disappointed in the outcome. Individuals who have experienced threats or violence are often angry and frightened, and demand swift and public resolution of their concerns in a manner that is not permitted under VA regulations, not consistent with accepted clinical ethics, and not likely to reduce risk. Employees may desire punishment for a disruptive patient and become incensed when they learn that the disruptive patient will continue to receive VA care. Individuals who have experienced violent behavior may resent the DBC's threat assessment because it reveals their own deficiencies in training, interpersonal skills, and/or inappropriate responses. Supervisors may resent the implication that they have failed to provide appropriate training or supervision on issues related to disruptive patients. Patients who have engaged in disruptive behavior often become defensive and blame others when their behavior is questioned. They sometimes threaten litigation or violence.

Sometimes a DBC will receive direct requests from other employees to take actions that are not consistent with the work the DBC has done. For example, a physician called a DBC requesting the removal of a PRF because the "patient was psychotic" when he assaulted the night charge nurse on the inpatient unit, and he is "usually as harmless as a lamb." On another occasion, a clinic manager called the DBC chair demanding a "red flag" on a patient who used a particularly vulgar word when told her doctor had left for the day. Such events can be intimidating, especially when they involve someone in supervisory or even leadership roles. However, these occasions afford the opportunity for education around the risk assessment process, the use of risk and protective factors to inform an evidence-based process, and the fact that many brains are better than one when it comes to threat assessment and management. It is always important to honor the concern and insight offered by the requestor, and to indicate that the information provided will be integrated into the iterative threat assessment process. The requestor might be gently reminded that the use of PRF and other strategies is derived from the threat assessment with the expectation of enhancing future safety, and is not at all a punishment for undesirable behavior. For example, the physician mentioned above

might agree that the patient's psychosis still poses a threat for further injury to nursing staff, and that preventing future events is the purpose of the interventions. After a chance to talk, the manager offended by bad language might agree that the patient was understandably frustrated after a long and fruitless drive, and did not present a threat of harm that would justify a PRF. Other means of heading off such behavior in the future might then be cooperatively developed.

The gratification for serving on a DBC comes from knowing that one's work has reduced stressful working conditions for employees and may have prevented violence against other patients and employees. Effective DBC members will be gratified when their efforts result in a patient's finally receiving the health care that s/he needs.

DBC members require reasonable flexibility in their duties to accommodate DBC case reviews and other assignments associated with membership, including occasionally urgent matters. Sometimes DBC members will want or need to have time to attend training opportunities related to their work, to keep up with advances in the field of behavioral threat management.

DBC members may work in CBOCs or other distant facilities that are administratively part of the facility, since teleconferencing and videoconferencing resources enable a DBC member to participate remotely.

Effective DBC members keep abreast of the latest science in the rapidly changing field of threat assessment. A questioning, analytical, and skeptical mindset is useful for conducting behavioral threat assessments. A high degree of sensitivity to clinical ethics is very important. To be effective, DBC members, including those with a background in behavioral science or even forensics, will need training on evidence-based structured professional judgment behavioral threat assessment. This work cannot rely solely upon "clinical judgment."

Effective DBC members monitor their own stress levels and practice effective stress management and healthy work-life balance. While the work of DBC membership can be rewarding, it is also stressful, given its ambiguity, uncertainty, conflicting interests, and the sense of responsibility without control that often exists.

3.5 DBC Membership

The DBC will be comprised of the following required members or their functional equivalents:

1. The chair, who is a senior clinician and licensed independent provider with knowledge of and experience in structured professional judgment approaches to assessment and management of violent behavior in health care. While the DBC chair will generally be trained in the behavioral sciences, providers from other clinical service lines may serve as chair, provided that they possess or acquire the requisite training and knowledge in the theory and practice of behavioral threat assessment

and management. The chair must have demonstrated leadership skills and experience in working with multi- and interdisciplinary teams. Many facilities will find value in having a co-chair to assist in DBC leadership and workload management. These requirements would apply to co-chairs as well.

In situations where the chair or co-chair is not aligned in behavioral health, there needs to be at least one DBC member who has graduate training, licensure, and experience in behavioral science. Such members must have knowledge of the scientific literature pertaining to behavioral threat assessment and threat management. At least one member must be conversant with psychiatric nomenclature, diagnosis, and pharmacological and psychotherapeutic treatments for psychological disorders, although being a prescriber or medically trained is not necessary.

2. A representative from the PMDB Program in the facility, to facilitate the DBC's oversight and support of the program. This close coordination between PMDB and DBC enhances efforts to keep PMDB relevant to the needs of the facility. This member keeps the DBC updated on training progress. The PMDB representative provides status updates regarding the completion of PMDB training plans that are crafted around the needs identified from the annual WBRA data. Information garnered during PMDB classes about areas of high conflict within the facility can be brought back to the DBC through the representative, and information gleaned from DBC meetings can help the PMDB assess the impact of the training program.
3. Representatives of local bargaining units, preferably the safety representatives. Labor provides invaluable support in the implementation of VHA's violence prevention initiatives, and national Labor leaders help to keep the issue high on the list of safety priorities for VHA.

It is important to remember that DBC represents the safety interests of all patients and employees in the facility. Union members can provide insights into workplace-related contributing risk factors that may not be apparent to others working on a case. For example, the bargaining units may have information about patient experience, patient care, employee morale, or leadership challenges in the job site where alleged disruptive behavior events occur. They may have observations about workload issues, staffing levels, training needs, and other factors that will enhance the assessment and inform a plan for reducing the risk of violence.

Bargaining unit DBC members also serve an essential role in educating employees about the purpose and process of the DBC, the importance of reporting behaviors of concern, and the value of participating in employee training opportunities, such as PMDB training. They can support employee access to the EAP.

4. A senior ranking VA police officer or detective with knowledge and training in the practice of behavioral threat assessment and management. The presence of a

professional police force is a resource VHA has that most health care systems lack. VA police officers set a high standard for community policing and bring substantial training and experience to bear when assessing threatening behavior. Since past violent behavior is the single most important risk factor for future risk, VA Police can play a vital role in providing critical information regarding past criminal history.

Threat management strategies may involve ongoing police involvement, as when a patient is required to check in with police upon arrival at the facility. Therefore, VA Police need to participate in the development of behavioral management plans and in reviewing the viability and resourcing of recommended actions.

5. The Patient Safety Officer and/or the Risk Manager brings broad knowledge of safety issues related to patients and staff concerns, has a close working relationship with Regional Counsel, and provides insight on facility risk related to actions planned by DBC.
6. Patient Advocates (a.k.a. Veterans Experience office) deal constantly with patient concerns and bring needed perspective to DBC deliberations. Patient Advocates can help DBC identify employees who might need more customer service or PMDB training, work areas which may need primary prevention training based upon the number of complaints, and sometimes a quick understanding of a patient's perspective in a disruptive event.
7. At least one member representing community-based programs such as Home Based Primary Care (HBPC), HUD-VASH, Homeless Programs, Mental Health Intensive Case Management (MHICM), Caregiver Support, or Transitional Care Management. Best practice would also include a member representing the Community-based Outpatient Clinics (CBOCs) program.
8. A representative from each workplace designated as high risk in the most recent WBRA. It is considered best practice for these representatives to be Nurse Managers or other nursing professionals.
9. Sufficient clerical and administrative support staff to accomplish the required tasks.

In addition to the required members already described, many DBCs will add members who represent other work areas of particular concern or who have work experience and interests that strongly support the DBC's mission. Some examples include the following:

1. Members that provide diverse and comprehensive representation of the VA medical facility's workplace violence prevention needs. Some areas to consider include Community Based Outpatient Clinics (CBOCs), nursing home/community living centers (CLC), residential treatment programs (RRTP), substance abuse treatment programs (SARRTP), inpatient psychiatry, Veterans Justice Outreach (VJO), and

mental health/psychology. V-Tel is an acceptable medium for off-site committee members to attend meetings.

2. Some facilities have included the DBC as a training rotation for psychology, psychiatry, social work, or other behavioral health interns and fellows.

Finally, ad hoc members bring specialized expertise to bear on specific problems that arise occasionally in the DBC's work. It is best practice for those willing to serve ad hoc to be trained in the mission and operation of the DBC and on the essentials of behavioral threat management. There are other specialists in a facility, such as the Secure Messaging coordinator, who have focused expertise or skills and will gladly consult with the DBC as needed, without being assigned an ad hoc membership.

1. Ad hoc access to an attorney from the VA Office of General Counsel or a local VA Office of Regional Counsel (OGC/RC) is essential in the operation of the DBC. OGC/RC may become involved in DBC cases regarding adherence to 38 CFR 17.107 and in clarifying issues regarding information sharing, privacy, and HIPAA.
2. The IPVAP-C may serve as a regular or ad hoc member to provide guidance on cases involving IPV. The IPVAP provides a comprehensive, person-centered, and recovery oriented assistance program for patients, their families and caregivers, and for VHA employees who use or experience intimate partner violence. When DBC cases involve reported or suspected IPV, the IPVAP-C can provide perspective and information that informs the development of risk estimates and threat management planning. The IPVAP-C may assist with resources to enhance protective factors and reduce violence risk.
3. With the implementation of the DBRS and issues related to documentation, privacy, and information access, Health Information Management Service (HIMS), Privacy Office (PO), and Freedom of Information Act (FOIA) Office can provide guidance to the DBC in challenging cases, whether or not serving as ad hoc members.
 - HIMS: Provides guidance regarding technical aspects of placing and electronically managing PRFs, as well as informing the infrastructure that permits DBC workload captured in the DBRS to be documented in the electronic health record.
 - PO: Provides guidance regarding adherence to the 1974 Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA), especially with respect to situations involving duty to warn, and for requests to modify or amend a PRF.
 - FOIA: With increasing regularity, DBCs are being asked to provide case-specific information from the DBRS. The FOIA Officer will work closely with the DBC Chair to ensure that information required to respond to a FOIA request is released with appropriate attention to safety and threat management issues (see Fact Sheet 2016-02-01 "DBRS FOIA Report" in Section 3.11, "Enclosures").

NOTE: Current policy requires the national FOIA office to review responses to FOIA requests for DBRS reports.

4. Given the close relationship between self- and other-directed violence, the facility's Suicide Prevention Coordinator may provide valuable insight and information to the DBC on occasion, and sometimes serves on the DBC as a full member or ad hoc.
5. Others whose expertise and role can support and inform the DBC's process include:
 - The Office of Community Care
 - The Minority Veterans Program Coordinator
 - The LGBT Program Coordinator
 - The Women Veterans Program Coordinator
 - The Integrated Ethics Program Coordinator
 - The Veterans Justice Outreach Coordinator (if not a member of DBC)

3.6 Training of DBC Members

Ongoing training for DBC members is essential. In their study of subjects conducting threat assessments, Teo, Holly, Leary, and McNiel (2012) found that assessment accuracy improved with training and experience. Facility directors should make DBC training a priority, and facility managers supervising DBC members should support their participation. DBC chairs can identify the training needs of DBC members and seek experts who can enhance their knowledge of threat assessment. Nationally, there are highly respected experts in workplace violence prevention who provide training for community threat assessment programs, and several VHA facilities have taken advantage of these at their expense. However, the national WVPP office provides excellent training resources available to all involved in violence prevention in VHA (see SharePoint link below for comprehensive information and contact information):

- A DBC Community of Practice call at 12:00 Eastern time on the 4th Thursday of each month, offering a combination of information exchange and occasional case consultation.
- A monthly behavioral threat assessment training call at 12:00 Eastern on the 3rd Tuesday of each month, focusing particularly on the use of the Violence Risk Assessment Instruments (VRAI-G and VRAI-S).
- A consultation service, available by email (WVPPConsultation@va.gov) to address specific questions on general practice issues and specific case management.
- Weekly Virtual Office Hours (VOH) staffed by WVPP Consultation Team members and available to all on an as-needed drop-in basis.
- On-site DBC training at a facility's expense provided by WVPP staff may be arranged.

- There are regional and national organizations for threat assessment professionals, and several DBC members have joined one or more of these and attend their national conferences and training programs.
- Other resources available from WVPP (see SharePoint link below) include:
 - training videos with case studies,
 - intensive new-chair mini-residencies,
 - DBC regional or all-chair conferences,
 - copies of articles and references,
 - copies of policies governing workplace violence prevention.
- The WVPP SharePoint site containing these resources is reached at: <https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/Home.aspx>.
- The appendices of this guidebook contain examples of material also found on the SharePoint.

When DBCs train as a group, it affords the opportunity to strengthen cooperative relationships among members. “Table-top exercises” are effective and cost-effective training tools. In these exercises, a threat assessment on an actual or facsimile case is completed by the entire team. The team develops a risk estimate, identifies risk and protective factors, writes a summary, and develops a set of strategies designed to mitigate identified risk factors and enhance available protective factors. Team members can actively discuss items where there is disagreement and share perspectives on resolving the discrepancies.

3.7 DBC Processes

The safety of patients, employees, and other members of the facility community depends on the skilled work of the DBC. Even though the science of behavioral threat assessment and management has advanced rapidly over the past twenty years, under the best circumstances the DBC will rarely have all the information needed to achieve a definitive threat assessment. Many factors are dynamic and change while the DBC performs its assessment. Sometimes the ebb and flow of dynamic risk factors will be rapid, while at other times static factors will predominate. Group problem solving brings its own challenges, and it is important that DBC members are chosen for their ability to work well with ambiguity and with others in cooperative and collaborative fashion.

3.7.1 DBC Operating Principles

The success of multidisciplinary behavioral threat assessment and management practice relies upon the ability to “collect the dots” in order to successfully “connect the dots.” It is critically important that all people feel the “dots” they bring to the DBC are valuable and taken seriously. The DBC is best able to engage in data-driven, evidence-based best practices when it embraces and creates a space where all people are valued and treated with dignity and respect. DBC composition itself should reflect the diversity of its health care community. Equity of practice across all forms of diversity represented in the patients we serve is a value DBCs uphold. The “dots” brought to the DBC are treated inclusively and with respect from all reporters.

Specific DBC operating principles will be discussed in this sub-section.

- a. The DBC reports directly to the COS and operates under the functional category of direct care. Its activities are considered treatment. DBC members must obtain clinical information from the electronic health record while conducting individualized multidisciplinary evidence-based behavioral threat assessments, developing management plans to reduce threat and increase protective factors, and monitoring the results of previous DBC actions.
- b. Emergently dangerous situations require immediate police response rather than the immediate involvement of the DBC. Occasionally there are situations in which the unique access and skill set of DBC leadership can enhance safety on an urgent and provisional basis, pending further assessment and action by the DBC. An example might be the immediate placement of a temporary BPRF to warn staff of an imminent and significant risk while a more complete threat assessment is pending. However, individual DBC members should not offer risk judgments and risk mitigation recommendations to employees before the team has done a behavioral risk assessment. Typically, there is time to gather data, cross-check its validity, and evaluate future risk. Research indicates that complex risk assessments are superior when conducted by members of a multidisciplinary group whose members are trained in threat assessment/management. When risk assessments or recommendations are made outside the consensus DBC process, they may produce confusion or exacerbate risk.

DBC members do not offer risk judgments and recommend mitigation strategies to employees before the team has done a behavioral risk assessment.
- c. Effective DBCs will avoid rushing to reach a unanimous assessment of risk or make recommendations without first considering the quality of risk data, all possible actions, and the potential beneficial and adverse effects of the actions under consideration. Well-functioning DBCs avoid “groupthink,” which occurs when superficial concord and agreement are prized more than candor” (Buller, 2010). Effective DBC members share differing viewpoints and attend to “gut feelings.” The goal of DBC deliberations is to develop a threat assessment and mitigation plan based upon consensus, not unanimity. DBC members do not vote on risk assessments or follow the principle of “majority rule.” Misgivings need to be heard. Failure to reach consensus often indicates the need to gather more information, consider alternate pathways, or establish first steps while giving time for the larger picture to develop and provide additional options.
- d. An effective DBC will develop contingency plans for adverse and unexpected outcomes of the intervention plan.

- e. DBC members must feel free to acknowledge their biases. This allows frank disclosure and discussion of issues that may influence a member’s opinions in each case. A non-judgmental atmosphere in the DBC helps to ensure that biases do not distort the risk assessment process. For example, a DBC member might recuse herself from working on the case of her former patient, because of concerns about her own objectivity and the risk of unnecessary and inappropriate divulgence of protected information that is not a part of the record.
- f. The validity of risk factor information is important to the DBC’s risk assessment. DBRS reports entered in the emotional aftermath of a violent or disruptive event may be especially subject to distortion by witnesses and victims (Van Der Meer and Diekhuis, 2014; Phelps and Sharot, 2008). Rumors are common. Witnesses are sometimes driven by fear to exaggeration. “He looks just like those guys in the news who later come back to the hospital to shoot the doctors who refused to give him narcotics” is an example of data that needs a great deal of clarification – at the very least. The DBC should respond in a neutral, concerned, and calming tone; “Thank you for contacting us. We are very interested in your observations and any information that may help us prevent a future incident. What is it about this person’s behavior that causes you concern? What do you know about this person that we need to know? What is the source of that information? Please be specific.”

Interviews with the disruptive patient’s care providers, reviews of electronic health records, military service records (when available), criminal history, and any other legally available records will help cross-check the accuracy of information that informs the risk assessment. The DBC makes its assessment as a good faith effort to ensure completeness and validity of the totality of risk-relevant information, while recognizing that any behavioral threat assessment is a snapshot in time, and is subject to change with additional information (refer also to section 4.5.5.e).

- g. All employees should be aware of the limited scope of DBC responsibility. A DBC’s violence risk assessment can be likened to a clinical consultation. The DBC is not a court or tribunal determining guilt or innocence, or imposing a just sanction for a patient’s disruptive behavior. An evidence-based behavioral risk assessment and threat management plan are not intended to establish moral blame. DBC’s focus is on describing future threat and preventing violence.

A DBC’s violence risk assessment can be likened to a clinical consultation.

h. Members of the DBC should remember the “intervention dilemma.” DeBecker (1997) notes that each action intended to prevent violence may have one of three effects: lower, not affect, or increase the risk of violence. The latter is more likely if the DBC’s recommendations and the resulting actions increase the patient’s sense of grievance, alienation, or loss of dignity. Every intervention must strive to preserve the disruptive patient’s dignity, hope, and privacy. The DBC must take care to avoid unduly stigmatizing the patient.

- i. As discussed earlier (section 2.1.4), the DBC provides appropriate feedback to employees who have reported behaviors of concern. This feedback may be limited. For example, DBRS generates a templated email to the reporter indicating that the report was received and will be processed. It provides contact information for the DBC. DBRS can also generate a note in the electronic health record providing similar information. Facilities have the option to modify the verbiage in the response email and the EHR note to meet local needs and practices. Individual contact with the reporting and affected employees in follow up to the report is a best practice.
- j. Employees affected by a violent event may be encouraged to consider services in Occupational Health or Employee Assistance Program (EAP), but may not be required to do so.

3.7.2 DBC Operating Practices

DBC's must meet at least monthly. Many facilities have discovered that more frequent meetings are necessary to keep up with the demands of the work. Large complex facility DBC's often meet weekly. There is a basic conflict between meeting as infrequently as possible and conducting comprehensive structured professional judgment behavioral threat assessments using the collective wisdom of the membership. Effective DBC's establish meeting schedules based on what is required to conduct best practice and comprehensive threat assessments at their facilities, understanding that other facilities may have different demands requiring different schedules. Assessments should be completed within 30 days of a DBRS report's receipt, and there is a 24-hour turnaround time on entering a PRF after the implementation decision has been made. Meeting length will vary by complexity and workload, and to some extent by how much work has been done in preparation for the meeting by those with more time to devote to the process. While some DBC's may manage on hour-long meetings, many run closer to two hours.

Attendance at all DBC meetings by the permanent members is expected. Ad hoc members may be available by phone, by electronic medium, or in between meetings on a prn basis. There is generally no need for ad hoc members to attend every meeting, but they may attend when there is an appropriate occasion such as training, or when consideration is planned for a specific case needing the insight of the ad hoc subject matter expert. To cover vacations and other attendance conflicts, both planned and unplanned, it is advisable to have backups for DBC members who fill specific roles, such as VA Police, Patient Advocates, and Patient Safety/Risk Management. These staff who provide backup will benefit from training, and from occasional attendance to enhance their familiarity with the process.

DBCs do not vote on threat assessments. The effective DBC leader promotes open and healthy discussion of case particulars and leads the group toward consensus. When there are differences of opinion and insight, these are shared and discussed. When there are misgivings about a course of action, these are heard and considered, and alternatives explored. Sharp disagreements regarding a threat assessment or management plan likely mean that there is vital information yet to be uncovered, which when identified will lead toward convergence. It is far better to develop a temporary course of action as an interim measure that the group can support than to run roughshod over objections by using majority rule.

DBCs do not vote on behavioral threat assessments.

DBC

s vary in how work is assigned. When substantial resources in FTEE are assigned to DBC, these individuals can do a great deal of the work in between the meetings in gathering data and completing parts of the VRAI. When no one has protected time, a DBC may spread the work around amongst the members, playing to their expertise, so that no one feels overwhelmed. Some facilities have established “teamlets” that meet in between DBC meetings to do data collection, initiate the rendering of the VRAI, conduct interviews, and prepare summaries for the main DBC to use at their meetings. There may be no single correct way to conduct the daily business of the DBC, as long as the outcome is patient-centered, comprehensive and thorough, and is based upon the science of threat assessment and the best practices developed over the years.

DBC

s support the referral of patient care into the community. Information regarding Orders of Behavioral Restriction and PRFs may be disclosed to community providers as with other pertinent medical record information. There are no known prohibitions to the release of treatment recommendations specific to behavioral management. HIPAA

DBCs support the referral of patient care into the community, and provide behavioral safety information to community providers as allowed by HIPAA guidelines for continuity of care.

allows a covered entity to disclose PHI to another provider for the treatment activities of that provider, without needing patient consent or authorization. Treatment under HIPAA is broadly defined as the provision, coordination, or management of health care and related services by one or more providers, including the coordination or management of health care by a provider with a third party;

consultation between providers relating to a patient; or the referral of a patient for care from one provider to another. Activities of the DBC related to behavior management are clinical in nature, and are a crucial part of both treatment planning and provision of care. To withhold critical safety-related treatment plan information could place the patient and community provider in harm’s way. The Office of Community Care (OCC) Field Guide Chapter 3 contains descriptions of ways DBC will support the referral process, and is available at <https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/Chapter>

Documents/Chapter 3.docx. DBCs will be contacted earlier in the referral consult process to provide recommendations when referred patients have PRF or OBR. DBC may also consult with interested providers who have accepted a patient regarded as possibly posing a behavioral safety risk within VA.

3.8 Record Keeping for DBC Case Material

DBC's must document its activities. It is important for each DBC to seek the guidance of OGC/RC and HIMS on this matter. Information regarding a threat assessment should be preserved in the DBRS report. Risk-relevant information from outside documents such as medical records and police reports can be summarized into the DBRS report text boxes, and any physical copies of the original records returned to their keeper. The DBRS contains an interactive copy of the VRAI with descriptors of each item and checkboxes to record the presence of risk and protective factors. The DBC places summaries of each VRAI section and of the overall threat assessment in DBRS, and these can be ported into the EHR.

Information informing a threat assessment is preserved in the DBRS report.

DBC members should be extremely careful in creating records. This includes hard copy records as well as electronic reports and email. If entire documents must be preserved outside of DBRS, they should be placed behind the VA firewall in a secure location with access limited to those with need to know. Language should be factual and brief. It is often appropriate to signify exact quotations and the exact language of any hostile or threatening comments. Any speculation should be labeled as such and stated in terms of probabilities. Highly judgmental, stigmatizing or prejudicial comments should be avoided.

Although information from VA Police reports is essential to a comprehensive threat assessment, the police record itself remains in the custody of the Police Department, not the DBC. The same is true for other official records used in the threat assessment, such as patient health records.

E-mail subject headings will avoid identifiers that would reveal the identity of anyone involved in a threat assessment. As with other PHI and PII, encryption must always be used in emails containing sensitive information about a patient associated with disruptive behaviors.

Case status reports to the COS's office and any other summary reports are written with the awareness that all documentation which can be located by personally identifiable information (PII) is likely discoverable in a legal proceeding, or releasable with a simple Release of Information. DBRS provides a mechanism for producing DBC meeting minutes which meet appropriate standards and do not

contain PHI or PII. (See the WVPP SharePoint at <https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/Home.aspx>)

3.9 Disruptive Behavior Reporting System (DBRS)

The DBRS was created and deployed across VHA to improve reporting of disruptive, threatening and violent behaviors within VHA. The Maryland Health Care System created DBRS as a secure web-based electronic disruptive behavior reporting program. WVPP recognized the value of the reporting mechanism as a best practice model and expanded it into a nationwide rollout to all VHA facilities.

The DBRS simplifies the DBC's process of collecting, triaging, reviewing, and assessing disruptive behavior. Using the DBRS for reporting all disruptive behavior events is a critical step forward for VHA in addressing the phenomenon of underreporting found in health care settings. This heightened reporting serves a vital role in creating a safer healthcare environment for all.

DBRS Administrators have the privileges required to customize DBRS to meet an entity's needs. Each VISN must have at least one DBRS network administrator, and each facility more than one, to provide redundancy and continuity. Likely facility-level candidates for administrative privileges include DBC and ETAT leadership. The day-to-day management of the DBRS falls to certain members of the DBC, often the chair or administrative support person. These members possess knowledge, skills and abilities to assist in the triage process for incoming reports. DBC leadership often designates additional personnel that will receive notification of new reports. Such individuals could include a police officer, patient safety, union safety representative, and others with a need to know.

The following highlights the four levels of access in the DBRS:

- a. **VISN Administrator(s)** – can access the VISN and facility system setup portions of DBRS and can review and manage reported incidents. Specifically, these user roles within DBRS are to:
 1. Activate facilities within the VISN.
 2. Add/manage Facility Administrators for each facility.

- b. **Facility Administrator(s)** – can access the facility system setup portion of the site and can review and manage reported incidents. Specifically, these user roles within DBRS are to:
 1. Identify and activate facility locations and settings which appear for selection during incident data collection.
 2. Activate the electronic health record note function.

3. Designate which DBC members and others will receive event notification alerts, and provide access privilege to those who will help in managing reports and recording data.
 4. Manage incidents and document interventions and follow-up.
 5. Enter DBRS notes into the electronic health record.
 6. Use the Utilities function to populate WBRA's and generate other reports.
 7. Activate and deactivate other facility administrators.
- c. **Facility DBC Team Members** – can review and manage event reports. Specifically, these DBRS users:
1. Are identified as DBC members.
 2. Have the option to be notified via email when an event occurs.
 3. Add data to event reports in the Review mode section of the site.
 4. Enter electronic health record notes from DBRS when authorized.
 5. May enter new event reports in the Report mode section.
- d. **Staff Reporters** - may use Report mode to enter new disruptive behavior event reports. This level of access is granted to all VHA employees who have access to the VA intranet.

A link to the DBRS User Guide (ver. 3) is available in the “Enclosures” (3.11) section below. This guide provides specific and detailed technical information on the implementation, maintenance, and operation of the DBRS. Links to DBRS-related fact sheets are also available on the SharePoint.

3.10 REFERENCES

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4 Threat Assessment

A core responsibility of the DBC is to evaluate concerns that a patient poses a risk of workplace violence. Every report of patient-related threatening, disruptive, or violent behavior requires attention. To perform its mission, the multidisciplinary DBC functions as a facility repository to which all relevant information regarding an alleged patient event is funneled. This function prevents the phenomenon in threat assessment known as “stove-piping” or “siloing.” These conditions, which exist when different individuals and groups possess separate pieces of information about a possible threat, inhibit full awareness of the mosaic of the threat. By collecting and integrating information from these disparate sources, the DBC can conduct an evidence-based and comprehensive behavioral threat assessment, advise the COS of the extent and nature of any identified threat, highlight the at-risk situations and people, and initiate actions that might mitigate that threat.

4.1 Violence Prediction vs. Behavioral Threat Assessment

Accurate prediction of a violent act remains virtually impossible. The prediction that a patient will not be violent in a specific situation and time is most likely to be correct, because incidents of violence are rare compared to the numbers of patients being treated. Efforts to make such predictions are typically based upon static characteristics of a possibly disruptive individual, such as gender, age, and a history of violence. While this sort of historical factor “profiling” may be useful to law enforcement in narrowing the search for an individual who has already committed an act of violence, it is virtually useless in determining who among a universe of individuals (e.g., all patients cared for in a VHA facility) will commit violence in the future. Behavioral threat assessment is a proactive, preventative approach aimed at identifying observable behaviors which indicate an individual’s progress on the pathway to violence, and at intervening to lower the risk.

Dynamic factors associated with the disruptive individual, the potential victim or victims, and the context and situation are important in determining whether there is currently a low, medium, or high level of threat. These dynamic factors include the subject’s current mental state and health, grievances, recent losses and other personal stress, recent acquisition of weapons, and similar factors. Estimating the level of threat is not the same as making a prediction. In their 2012 article, entitled “The Role of Warning

There is no useful ‘profile’ of the patient who will commit violence against others.

Behaviors in Threat Assessment: An Exploration and Suggested Typology,” Meloy and his colleagues state:

“Typing someone as high risk is not a probability estimate that s/he will behave in a violent way; rather, it is a statement that the subject shares important statistical associations with that group of people from which the few individuals who will go on to commit the behavior are most likely to emanate.”

Fig. 4.1 The Shift from Prediction or Profiling to Risk Assessment

Violence Prediction Model	Behavioral Threat Assessment Model
<p>Dangerousness resides within the individual.</p> <p>Dangerousness is viewed as static and constant.</p> <p>The risk of violence is dichotomous (present or not present).</p>	<p>Dangerousness depends upon interacting variables involving the subject, the target, and the setting.</p> <p>Dangerousness (risk of violence) is viewed as dynamic and shifting.</p> <p>The risk of violence ranges along a continuum from low to high.</p>

4.2 Types of Violence

There are several ways to categorize violence. Violence may be defined by the nature of the violent act itself, using terms such as physical assault, verbal assault, sexual assault, harassment, and threats.

Violence may be categorized by the degree of planning and intent present. Predatory (targeted) violence may occur after months of contemplation, planning, and preparation, all going on “under the radar.” When the attack finally occurs, people may be surprised and say things like, “He just snapped,” when nothing is further from the truth. The purpose of predatory violence may be to right a perceived grievance, exact revenge, or obtain a desired outcome not otherwise available.

Affective (spontaneous, emotional) violence occurs in response to anger, mental illness, pain, substance intoxication, confusion, or other situations internal or external to the disruptive individual, is driven by high levels of emotion, and may surprise the disruptive individual as much as it does those around him/her. This distinction between predatory and affective violence is imperfect, because even the affectively disruptive individual may be uncertain of the extent to which s/he consciously planned an outburst. Still, most incidents can be placed on a continuum ranging from clear-cut predatory violence to impromptu unplanned affective violence. Health care facilities, including VHA, are recognized by OSHA as suffering from high rates of patient-driven violence, most of which is impromptu and affective. (see Calhoun and Weston, (2004), *Preventing*

Violence in Healthcare, at:

<https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/DBC.aspx>.

Violence risk factors are often dynamic. Risk assessment must be ongoing.

This guidebook will use the terms “affective” and “predatory” (Meloy, 2006) in discussing violence prevention within VHA. The reader of the literature on threat assessment will encounter other roughly equivalent terms for these types of violence. These also are not “clean” categories, and acts of violence often incorporate features of both types (similar dichotomies found in the research literature include:

opportunistic vs targeted, hostile vs proactive, reactive vs instrumental,

primal vs cognitive, impromptu vs intended, and affective vs predatory).

Violence may also be described by the relationships between the people involved. In this approach, Type I violence occurs between strangers and involves criminal intent; Type II violence is customer-related; Type III violence occurs between co-workers or former co-workers, and Type IV violence is intimate partner or domestic violence which spills into the workplace.

4.3 Types of Violence Risk Factors

Violence risk factors also fall along a continuum. Researchers have noted a distinction between those factors that are relatively static and those that are dynamic or modifiable. An example of a static risk factor is age. An example of a dynamic risk factor is a recent or pending major loss, such as a job, a relationship, or incarceration. In this guidebook, we use the terms “static” and “dynamic” to distinguish between factors that are fixed and those that are modifiable or subject to changing.

The fluid nature of dynamic risk factors necessitates ongoing evaluation to appreciate current level of risk. The timing of reassessment of the risk factors will depend upon the specifics of the case; some will require infrequent reexamination (e.g. 2-year review) while others need weekly or even daily assessment (e.g. substance detoxification, acute mental illness, intoxication), (Van der Meer and Deikhuis, 2014).

Static and dynamic factors may characterize features of the context in which violence may emerge, or they may describe characteristics of the potentially disruptive patient. These distinctions clarify which factors are most readily addressed. While we cannot change a person’s age, we may assist the him/her toward sobriety, if substance abuse contributes to the risk of violence.

4.4 Conceptual Models in Threat Assessment

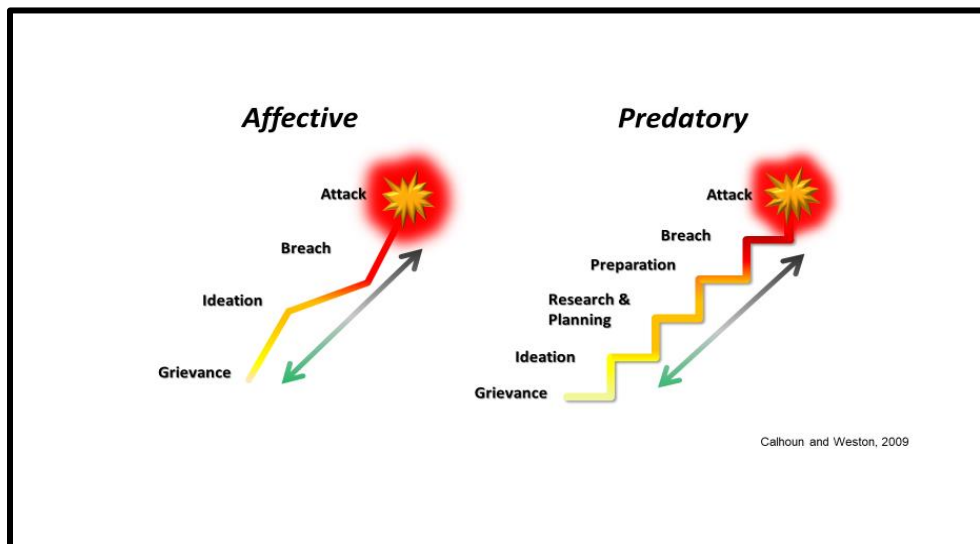
It is worth taking a brief look at a few of the conceptual models derived from research into behavioral threat assessment, including “The Pathway to Violence,” “The Venn of Violence,” and the concept of “Expressed Threats.”

4.4.1 The Pathway to Violence

After workplace violence events, media reports often characterize the perpetrator as having “snapped.” Research on predatory violence events by the US Secret Service and others has found that predatory violence is largely the closing act of a subject’s journey down a discernible “pathway” (Calhoun & Weston, 2003). This important concept addresses the interaction of the subject’s grievances and motivations, the speed of movement up the path, target characteristics, and presence of other risk factors. Understanding the pathway provides opportunities for the threat manager to interrupt or reverse the trajectory toward a violent act (See Figure 4.2).

Although there is a similar pathway for affective violence, it is usually shorter. It lacks research, planning and preparation, moving quickly from grievance, to ideation, to breach, and to attack. The pure predatory and affective pathways form the endpoints of a continuum of violence, and there may be elements of planning and preparation found in what was largely an affective outburst.

Figure 4.2 The Pathways to Affective and Predatory Violence



A patient might say, for example, “If I see Dr. XYZ, I don’t know what I might do, but I have my trusty cane if he gets close enough!” Most disruptive behavior in health care lies toward the affective end of the continuum and moves quickly up the pathway. Even so, this affective pathway can be interrupted. For example, when an experienced ED nurse notices a patient’s increasing agitation (“ideation to breaching”) and moves

quickly to calm and de-escalate the patient, the threat is reduced, and the likelihood of future violent events reduced because the development of another grievance has been averted.

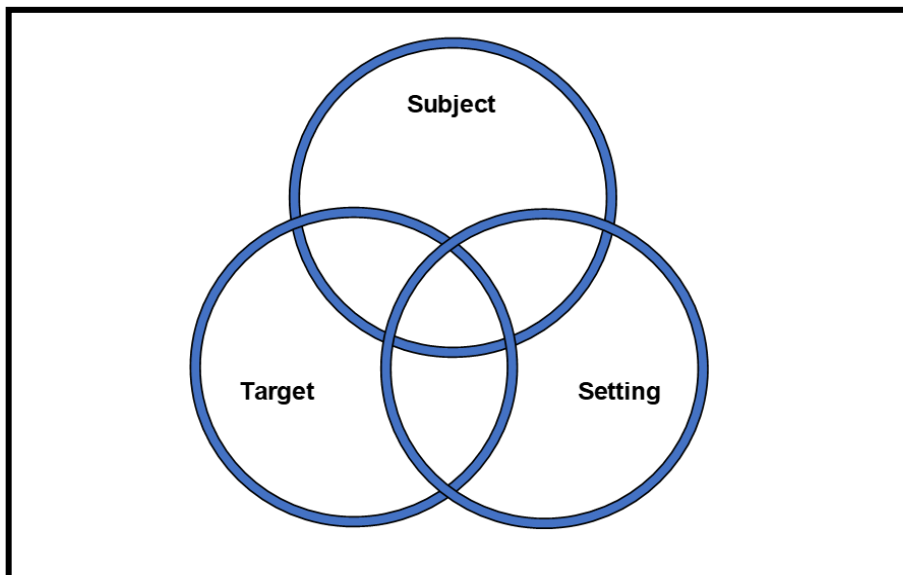
Although a patient may race up the affective pathway to a violent act without preplanning, seeming to erupt without warning, there is often an identifiable history of perceived grievances which served to lower the threshold for entering the pathway in future visits. When events and situations have caused notable stress for a patient in prior visits, the patient may come to future appointments “primed and ready” for something to go wrong and provide an excuse for acting out. As is taught in VHA’s PMDB training courses, “Today’s precipitating event can become tomorrow’s predisposing factor!” This issue highlights the importance of good customer service at each interaction, and encourages appropriate service recovery efforts when things have not gone well. Otherwise, each unpleasant or dissatisfying interaction lowers the elevation of the violence pathway portal and heightens risks of affective outbursts.

The observable and modifiable nature of this pathway is the foundation of the rationale for having a DBC. It is the DBC’s job to identify individuals who are on this trajectory and devise means of interrupting the patient’s progression along the pathway.

4.4.2 The “Venn” of Violence

The U.S. Secret Service conducted studies of a spate of school shootings in the 1990s. Their findings revealed that most predatory attacks, whether against school children, government officials, intimates, or coworkers, could be understood as the intersection of three separate domains: characteristics of the subject; characteristics of the target (s); and characteristics of the setting in which the attack occurred (Borum et al., 1999), (see Figure 4.3).

Figure 4.3 Violence as a Systems Problem: The Secret Service Model



Conceptualizing violence as a systems problem allows more complete analysis of the factors that contribute to violence risk and mitigation. In this model, it is insufficient to look only at the alleged subject, his/her history, psychological makeup, stressors, and grievances. Target(s) characteristics are important as well, including: how vulnerable is the target, how able or willing is the target to act for self-protection, could the target benefit from PMDB training, and what other individual characteristics, attitudes and behaviors are increasing the target's risk? These questions do not seek to "blame the victim," but to ensure consideration of all contributing factors in the pursuit of safety. The setting for the alleged threat is also considered: Is there an effective workplace violence prevention program in place, is there a workplace violence prevention policy that is understood by employees, are there workload, training, or supervisory issues that may be contributing to the problem, are there safeguards in place, is the security adequate, are there any aspects of the organization that encourage or allow violence and victimization?

The DBC explores all three domains and their interactions as it evaluates threats of workplace violence. The full picture of risk involves a threat, the presence of assets endangered by the threat, and the vulnerability of the context. This exploration allows a more robust understanding of the violence gestalt and informs the tailoring of individualized interventions for mitigating the risk of violence.

4.4.3 Expressed Threats

Another conceptual issue relates to the nature of a threat. When weighing threats, it is common for people to ask, "Did the subject actually make a threat?" This questioning implies that, lacking an articulated threat, someone's frightening behavior should be of less concern. This misguided reasoning can lead to tragedy. Certainly, a patient's direct or indirect threat is a cue for the DBC to initiate a risk evaluation. However, studies of violent attacks reveal more complex relationships between expressed threats and violence risk. Articulated threats have been associated with increased violence risk (e.g., violence between intimates), reduced risk (e.g., violence against public officials), or no association with risk of violence (e.g., a psychotic patient in a custodial institution). In a series of studies ("Exceptional Case Study Project," Fein, R., & Vossekuil, B., 1999) the Secret Service found that very few attacks on Secret Service-protected government officials were preceded by expressed threats. Threat assessment should focus upon any behavior suggesting the existence of a threat, not just upon whether a threat was expressed.

“. . . it is important to distinguish between someone who makes a threat . . . and someone who poses a threat . . .”

Calhoun and Weston (2016) address this concept in their discussion of "Hunters and Howlers." Hunters intend to commit violence and will follow the pathway all the way to

the violent act unless interrupted. Howlers go partway up the pathway without ever intending a violent act. This howling itself is the act, designed to cause fear and achieve goals. The authors describe the use of the pathway to violence as a way of determining if a subject is moving toward a violent act. Hunters may be unlikely to directly express threats, knowing that doing so could lead to discovery and interventions to block them. A successful threat assessment team will look for evidence of leakage. Leakage consists of behaviors and indirect statements that show where on the pathway a person is when not directly expressing intention to harm. Many people who pose a significant threat never make a threat, while most who make threats never act on them. Expressed threats are one of many subject behaviors to include in a threat assessment, important but insufficient in identifying risk.

4.5 Approaches to Violence Risk Assessment

Assessment of violence risk has taken different forms over the years. Mental health and law enforcement professionals in the past often relied upon the “clinical judgment” or “professional experience” approaches to assess the risk of violence in non-custodial situations. These types of unstructured and often quick approaches were based upon the confidence the professional placed in his/her wisdom resulting from previous experience, interviews with the subject, intuition, and so forth. They have been shown little better than chance in identifying risk in non-custodial subjects (Elbogen, Fuller, et al. 2010). From this time-honored but inadequate approach to violence prediction, scientist-practitioners from varying disciplines have developed more structured and evidence-based approaches to threat assessment and management. The two best-supported approaches are discussed in the following sections.

4.5.1 Actuarial Approach

The “actuarial” approach uses statistically weighted static risk factors to generate a risk score. The identification of the salient risk factors and their relative contribution to overall risk arose principally from retrospective studies of forensic patients discharged into the community. For forensic patients and inmates, actuarial approaches offer a modest improvement over the clinical judgment and professional experience approaches. However, these approaches have limitations. The use of group derived formulae to draw conclusions about an individual’s risk do not account for dynamic factors in the individual, the target, or the threat context. Risk levels frequently vary according to context. For example, VA treats many patients who pose high risk for criminal violence in the community, but who never cause problems during medical visits. In contrast, for some patients the health care setting may provide risk enhancing features that are not encountered in the community, such as loss of freedom, fear, pain, and long wait times.

4.5.2 Structured Professional Judgment Approach

The current best practice approach to addressing violence risk in non-custodial settings is referred to as structured professional judgment (SPJ) (Douglas, Cox & Webster,

1999). In this approach, evidence-derived factors are used to inform clinical judgment in a manner that incorporates the strengths of the two older approaches.

The SPJ approach has resulted in the development of several decision support tools. SPJ decision support tools are not psychological tests, do not offer cutting scores, and are not normed on specific settings and specific populations, as are the actuarial tools. SPJ tools have been developed for use with specific types of cases, such as those involving IPV, psychiatric inpatients released into the community, correctional releases, adolescents in juvenile corrections, and threats of violence in the workplace. Storey, Gibas, Reeves, and Hart (2011) found that police and correctional officers, untrained in formal psychological assessment, could be trained to use SPJ instruments quite reliably.

Of particular interest to VA readers is the development of the Veteran-specific Violence Risk Assessment Inventory for General Violence (VRAI-G) and the Violence Risk Assessment Inventory for Sexual Violence (VRAI-S) by a VA workgroup established in response to *Public Law 112-154, Section 106 (2015)* as directed by the Deputy Undersecretary for Health for Operations and Management (DUSHOM). Extensive discussion of these innovative instruments is found below in paragraphs 4.5.4 and 4.5.5, and in Appendices II and III.

Ongoing research has identified a consistent group of risk and mitigating factors more frequently associated with violence of any kind. An SPJ instrument provides an array containing the most important evidence-based violence risk and protective factors likely to be at play in a non-custodial setting such as a VA facility. While most research in threat assessment and management has studied predatory violence with potentially identifiable targets, the SPJ approach effectively addresses affective violence as well.

The SPJ approach does not yield a single numerical indicator of violence risk. Applied to a specific subject, the SPJ approach will consider static and dynamic risk factors, risk mitigation or protective factors, and organizational or other contextual factors to determine whether the risk is high, medium, or low. This assessment further describes the risk: for what type of violence, with what likely experiencers, in what situations, under what conditions, during what time frame. This context driven risk description is far more useful in mitigation and prevention planning than one overall risk rating that is non-specific. For example, knowing that a patient is likely to be violent when intoxicated in the ER, but not in other situations, may lead to strategies such as having police available when he checks in the ER until a safety check can be completed. This awareness saves resources by not requiring a police escort for all appointments. It also supports efforts to engage the patient in treatment for his substance abuse issues.

Risk categories of “high, medium, or low” are about as refined as the measure of risk can be described, given current scientific knowledge and the dynamic nature of risk and risk mitigating factors. Moreover, because SPJ is a blending of clinical judgment with knowledge of evidence-based static and dynamic risk and mitigating factors, it would be statistically unsound to establish “cut-off scores” for “low vs moderate risk” or “moderate

vs high risk.” Dynamic factors can and often do quickly change. Due to the risk posed over time, assessment should be an ongoing process. The frequency of re-evaluation will vary with the needs of a case, but cases are often not “closed” in a traditional sense. They remain open for periodic review of the evolving risk factors and adjustment of the management strategies as necessary to meet the current level of risk posed in the least restrictive means possible.

4.5.3 A Summary of Research Findings on Structured Professional Judgment

- There is consensus that decision making should be more systematic.
- Research has confirmed that use of SPJ violence risk assessment is associated with higher levels of accuracy than clinical or actuarial assessments alone, and thus improves risk management planning in the health care setting.
- Violence risk assessment instruments (VRAI) using SPJ are shown to enhance managing risk of violence.
- VRAIs do not guarantee perfect accuracy and should not be used alone, but as part of a clinician-led DBC’s evidence-based process.
- Extensive research has led to identification of robust static and dynamic risk and protective factors applicable to a wide range of workplace settings. Over decades, in dozens of studies of scores of workplace attacks in diverse settings, including elementary and secondary schools, universities, hospitals, elected officials’ offices, corporate offices, factories, and public spaces, many of the same risk and protective factors emerge as important. It is reasonable to extrapolate this body of knowledge to violence risk assessment and mitigation in VHA.

***NOTE:** Appendix VIII contains an in-depth review and discussion of the literature on structured professional judgment in the practice of behavioral threat assessment and management*

4.5.4 VHA’s SPJ Violence Risk Assessment Instruments (VRAI-G & VRAI-S)

Concerned about incidents of sexual assault and other violence in VHA, Congress created, and the President signed, Section 1709 of title 38, United States Code, requiring VHA to develop violence risk assessment tools. In implementing section 1709, VA issued VHA Directive 2012-026, which directs the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to develop and use:

“... evidence-based, data-driven risk assessment tools to examine any risks related to sexual assault that a Veteran may pose while being treated at a VHA facility to include as appropriate the legal history of the Veteran and the medical record of the Veteran, within the limitation of the law and policies.”

Pursuant to direction from the DUSHOM, the Violence Risk Assessment Workgroup (VRA) produced *Violence Risk Assessment of Veterans: Fulfilling the Requirements of Public Law 112-154, Section 106 (2015)*:

(<https://dvagov.sharepoint.com/:b:/r/sites/VHAWVPP/Tools%20Resources%20Strategies/Violence%20Risk%20Assessment%20Instrument%20Work%20Group%20Report%205%2026%2015%20FINAL.pdf?csf=1&web=1&e=ngEuLx>). The contributors to this plan conducted an extensive review of the scientific literature for both general and sexual violence risk assessment, and for violence risk assessment and Veterans. From that review, the VRA constructed two SPJ instruments: VHA's VRAI-G and the VRAI-S. The use of these instruments constitutes current best practice for conducting threat assessment with Veteran populations within VHA (see Appendices II & III).

4.5.5 Integrating Risk and Protective factors using SPJ to Assess Violence Risk for Veterans

Use of VHA's VRAI-G and VRAI-S is integral to the DBC's threat assessment process.

- a. These tools include clear descriptions of risk and protective factors. The inclusion of examples illustrates the relevance and scope of the factors, enhancing the reliability of the assessment. Training of DBC members in the use of the VRAs is essential to achieve reliability and confidence in the outcomes. DBC members should keep current on the latest research on behavioral threat management to render scientifically defensible risk assessments (see Section 3.6 for DBC member training resources).
- b. By using the VRAI, the DBC can determine which risk and protective factors are already known, and focus its efforts on gathering information needed to flesh out a comprehensive assessment and plan. The VRAI may help in identifying signs of imminent risk in some situations.
- c. The DBC should administer the VRAI consistently from case to case, as well as over time with a specific case.
- d. The DBRS provides a platform for the DBC to document, organize, and prioritize its VRAI assessments, risk mitigation plans, recommendations to the COS, recommendations to the disruptive patient's health care providers, and other DBC actions.
- e. Critical sources of information about both risk and protective factors include the following:
 - Notes from the electronic health record, discharge summaries, C&P exams, other local clinical records.
 - Remote records from Joint Legacy Viewer (JLV).
 - Email about the patient from concerned providers and employees.
 - DBRS event reports, reports of contact, ASISTS reports (if available), and other incident reports.
 - Criminal background checks when available.
 - Investigative Reports (formerly Uniform Offense Report) from VA police.

- Telephone contacts.
- Community medical records if available.
- Communication directly from disruptor and family (i.e., letters, phone messages, etc.).
- Interviews with the experiencers of the violence.
- Interviews with the disruptor.

It is best-practice and patient-centered to gather information directly from the disruptive patient and/or his/her family (with appropriate consent) when possible. An open-minded and non-judgmental approach serves several purposes. It informs the patient that concerns were raised regarding his/her behavior, and allows the DBC to hear the patient's perspective on the event. The DBC has opportunity to gather firsthand information from the patient and to elicit additional pertinent information about protective and precipitating factors. There is the opportunity for the DBC to gather information about the patient's insight into the concerning behaviors and to identify factors that may impact the risk (e.g., mental health symptoms, substance abuse, stressors, weapons possession, etc.).

The information gained in this contact may contribute to a more complete assessment and help the DBC develop a better risk management plan, individualized to the patient's needs. Interviews of the allegedly disruptive patient should be conducted by clinical members of the DBC in keeping with the health care aspects of DBC operations.

Risk factors in the VRAI-G and the VRAI-S do not come with specific statistical "weights." They are marked as "Absent/No," "Present/Yes," or "Unknown." Generally, the more risk factors present, the higher the risk. However, violence risk factors are not additive in a statistical sense and not equal in a functional sense. For example, in considering the risk posed by a disruptive patient, the presence of one or two high risk factors alone, expressed in the context of a rapidly changing and unstable context, might elevate the DBC's violence risk assessment to "high." Conversely, a patient who exhibits many violence risk factors may pose a low violence risk if committed long-term to a secure psychiatric or forensic facility (Scalora et.al., 2002). The dimensions of

Developing and maintaining relationships with care teams in areas prone to disruptive behaviors can open lines of communication when those teams are needed to help intervene with a disruptive patient.

frequency, recency, and severity of the risk factor behaviors are important considerations in determining risk levels. To assess risk level and to develop an intervention strategy, DBCs consider static and dynamic risk factors. Static risk factors (e.g. age, gender, criminal history) change very slowly, if at all. Dynamic factors (e.g. mood stability, substance use, financial situation, family

support) may change through intervention, or may shift on their own. The patient's care providers and social support programs can intervene to lower some of these dynamic factors. Leveraging existing care relationships in this way is often an effective way to move a dangerous patient off the pathway to violence. An example of this would be hospitalizing a patient with paranoid delusions that escalate the risk that s/he will strike out at another individual. Prevention of violence is part of delivering quality health care to a patient. At its core, behavioral threat assessment is a problem-solving process. Active mitigation of the situation or stressor causing a grievance can gain the cooperation of the disruptive patient, leading him/her to return to acting in an appropriate manner without further incident or intervention.

In the SPJ model, some risk factors are situational or contextual, rather than being individual traits. Understanding this helps the DBC avoid the error of overlooking important environmental and interactional variables which can elevate a patient's risk or precipitate a violent episode. It also supports consideration of facility factors that might contribute to ongoing violence risk for other patients as well. Examples of facility-related risk factors include long wait times, insufficient staffing, inadequate employee training, failures in patient-centered care, and inadequate policies and procedures.

A patient's risk of engaging in violence may fluctuate significantly in response to life circumstances, necessitating ongoing assessment. Research has documented that situational variables are just as strongly associated with future violence as individual variables (Elbogen & Johnson, 2009). Mulvey and Lidz (1995) discuss the concept of conditional prediction of violence, stating, "Clinicians' predictions about the occurrence of violence are based upon an assessment of what types of violence the patient might commit and the circumstances under which it will be done." VHA best practice involves the use of SPJ instruments such as the VRAI-G and VRAI-S by a multidisciplinary group of trained professionals to conduct behavioral threat assessments which meet community standards. These evidence-based, thorough, and ethical assessments are the necessary foundation for the risk mitigation recommendations that follow. Deficiencies in the risk assessment process can lead to an

Clinicians who are not trained to use an SPJ approach to risk assessment tend to over predict the risk of violence.

understatement of risk (Type II statistical error -- "false negative") and a failure to detect a dangerous situation. The most serious consequence of deficient risk assessments is injury or death. The fear of missing dangerousness may create bias toward overstating risk (Type I statistical error-"false positive"), a bias which might be called the "better safe than sorry" approach we were taught as children. This error may lead to the injustice of falsely labeling a patient as dangerous.

Prospective DBC members and facility leaders occasionally express concern about the legal risks inherent in conducting threat assessments. Litigation is sometimes brought against VHA facilities after a violent event, especially if the violence was lethal. In these rare cases, the allegation of negligence will focus less upon the failure of the outcome and more on the quality of the assessment process itself. Investigators can raise many questions. Was the case evaluated using the latest research and guidelines available from OSHA, the Secret Service, the FBI and the VA? Did the DBC follow best practices in evaluating and addressing the threat? Was the assessment itself unduly influenced by employees who are angry or fearful, particularly high-status employees or supervisors? Did the threat assessment meet the community standard for violence risk assessment?

The most effective response to concerns about the liability inherent in threat management endeavors is to point out the greater hazards posed by having no process at all. Situational factors in the event may lead to allegations that the facility was negligent. Described earlier, these factors may include long wait times, insufficient staffing, inadequate employee training, insufficient police availability, inadequate policies and procedures, and other such factors under facility control. Having the facility practices and procedures line up with national guidance and community best practice can be a solid prevention strategy and defense if the worst happens.

4.5.6 A Summary of Research Findings on Violence Risk in Civilians and Veterans

- Most violence risk factors are common to civilians and Veterans.
- Interpersonal violence is a problem for a very small subset of patients; researchers have identified factors statistically related to violence in Veteran and military populations.
- Examples of factors consistently related to violence in Veteran and civilian populations include younger age, history of childhood abuse, history of arrests and/or violence, and financial instability, but not traumatic brain injury or dementia.
- Clinical factors consistently related to violence in Veterans and civilians include substance abuse, depression and certain personality disorders.
- VA clinicians can confidently adopt the conceptual framework which underlies effective risk assessment. This approach discourages categorizing a Patient as violent or nonviolent but encourages describing the conditions which would increase an individual's risk of violence.
- Combat exposure and PTSD are Veteran-specific factors which have shown a statistical association with violence in some studies. The link between PTSD and violence is complex, largely mediated by co-existing alcohol or drug abuse. Specific PTSD symptoms like frequent anger, rather than a diagnosis of PTSD, are also critical for understanding this link. There are limitations in the research linking PTSD

with violence. These include the use of overwhelmingly male samples, the measurement of violence and PTSD by self-report, and varying definitions of violence.

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Chapter 5

Using Therapeutic Limit-setting to Manage the Care of Disruptive Patients: Non-Restrictive and Restrictive Approaches

VHA uses therapeutic limit-setting to address disruptive patient behavior, with the following goals:

1. Maintain the patient's access to high quality VA health care.
2. Increase safety for patients, employees, and others.
3. Assist the disruptive patient develop better behavioral management.
4. Facilitate the provision of care in the least restrictive manner possible.

Therapeutic limit-setting requires a thorough threat assessment to identify factors contributing to the disruptive behavior. The development of interventional strategies includes:

- a. Evaluation of incidents of disruptive behavior and any contributing situational factors through the behavioral threat assessment process. The evaluation considers all dimensions of the event: whether there were contextual contributors, employee skill or training deficits, or other precipitating and exacerbating factors present; whether the patient's medical or psychiatric condition contributed to the behavior; whether the needs, fears, and aspirations of the patient have been heard; and identification of resources and strategies available to the patient and to other parties to reduce the threat of violence.
- b. Identifying interventions to improve the medical facility's ability to provide health care services in a manner that does not frustrate or anger patients or staff, and to decrease incidents of disruptive or non-adherent behavior.
- c. Determining appropriate interventions to enhance the patient's ability to interact safely while obtaining care at the medical facility.

5.1 Therapeutic Strategies

Calhoun and Weston (2016) emphasize the importance of applying threat management strategies flexibly and intelligently. They position management strategies along a continuum ranging from non-confrontational to confrontational. We will use similar terms which are consistent with language in 38 CFR 17.107 and other VHA policy describing the DBC mission: Non-restrictive and Restrictive. Calhoun and Weston note that every threat management strategy has advantages and disadvantages. Each case requires an individualized strategy based upon the facts of the case, the nature of the threat, and the level of threat. The reasoning behind the choice of interventional strategies should be documented in the case records. The DBC should remain mindful that the deployment of a strategy may unexpectedly increase rather than decrease the level and nature of the threat (DeBecker, 1997). For example, moving a patient's care from a

CBOC to a facility where VA Police are present may exacerbate the patient's grievances. This issue highlights the importance of ongoing assessment after interventions are in place.

As noted, with Federal Regulation 38 CFR 17.107, VHA has established a high standard, one that is patient-centered and consistent with its mission to provide health care to all eligible Veterans, even those who are disruptive. 38 CFR 17.107 specifically prohibits the practice of banning or barring patients from care. Prevention of violence requires an approach that is patient-centered, integrated, multidisciplinary, and transparent. Table 5.1 below describes the range of restrictive and non-restrictive therapeutic limit setting strategies that may be appropriate depending upon the facts of a given case.

Development of a threat management strategy will often require ingenuity and continued assessment on the part of the DBC. The appendices at the end of this guidebook provide additional examples in the form of case studies.

5.1.1 Non-Restrictive Strategies

Several non-restrictive strategies may be most usefully employed outside the DBC, when the patient first begins to exhibit disruptive or problematic behavior. Other approaches may fall in the bailiwick of the DBC after a report is received and a threat assessment is conducted. It is desirable for the DBC to provide consultation with services, workgroups, and treatment programs around the facility in supporting the implementation of some of these strategies, before a case has escalated to the point where the DBC has to take more official actions.

Counseling addresses behaviors that interfere with the delivery of safe and appropriate care but pose low risk of significant threat to the patient or others. Examples of patient behavior which might call for counseling include: excessive or inappropriate use of call center resources; repeated scheduling of unnecessary appointments; verbal abuse of others; inappropriate, vulgar, demeaning and/or loud language; and repeatedly missing appointments without advance notification. Counseling is a conversation that may occur between patient and his/her provider or other appropriate personnel in the medical center (e.g. Patient Advocate, service line supervisor, therapist, social worker). It may be helpful to involve a mental health professional in the counseling process. Sometimes a conversation with a VA Police Officer may have a salutary outcome with a disruptive patient. Communicating directly and in person with the patient can improve the provider/patient relationship, elicit information about the patient's concerns over unmet needs, and help develop collaborative plans to mitigate the behavioral issues. Counseling should be documented in the patient's electronic health record.

Table 5.1 Therapeutic Limit-Setting Strategies to Reduce Disruptive Behavior¹

THERAPEUTIC LIMIT-SETTING STRATEGIES	Non-Restrictive Therapeutic Tools and Strategies	Restrictive Therapeutic Limit-setting Strategies
	Counseling by providers, DBC, Patient Advocate, VA Police, Veterans Justice Outreach point-of-contact, or others as appropriate, regarding expectations for behavior ²	
	Behavioral Agreement with providers to address behavior & treatment plan adherence ²	
	Certified Letter from providers, clinic supervisors, or DBC regarding needed behavior change. ² Other suggestions for non-restrictive strategies are provided in the DBRS Status and Assessment section	
	Behavioral PRF placed by DBC. Used to alert staff in first moments of an encounter to specific safety issues and to provide brief guidance on appropriate actions.	Order of Behavioral Restriction (OBR) ³ Document OBR in certified letter to patient, + EHR note (copy of letter) + Copy of letter scanned into Vista Apps + PRF linked to OBR by EHR note, provides brief safety instructions to staff
	Patients may request an amendment to a PRF containing erroneous information. There is no appeal of a PRF	Patients may request a review of an OBR by the Network Director within 30 days of issuance ¹

¹38 CFR, Part 17.107
²May be authorized by clinician, clinic manager, program manager, Patientcare line manager, etc.
³Only authorized by the COS or designee.

A letter of concern may be useful when counseling is not possible or has been unsuccessful in gaining the cooperation of the disruptive patient. Such a letter may also be useful when the patient’s behavior has escalated to a level at which adverse outcomes are likely. It describes the disruptive behaviors and why they cause concern.

The letter should include a summary of prior efforts to assist the patient and recommendations for how the patient can most effectively contribute to his/her receiving appropriate and safe healthcare. Ideally the letter is provided to the patient during a counseling session.

A letter of concern may be generated and presented by the provider or treatment team, or by someone else involved in the patient's care with whom the patient has a trusting relationship. It might notify the patient that a consultation from the DBC has been requested. Letters written by providers should be entered into the patient's health care record, and should always include a statement of intent to provide the best healthcare possible (see Appendix IV for sample letters and documents related to intervention strategies).

Behavioral agreements are used by the patient's provider or treatment team to establish limits on a patient's disruptive behavior. A behavioral agreement describes the patient's behavioral obligations in accessing needed care and the provider's obligations in providing treatment. It can also describe the negative outcomes that are likely to result from continued disruption of the health care process. The behavioral agreement should be copied into a progress note, and the patient must receive a copy, whether or not s/he agrees to abide by the agreement.

NOTE: *Sometimes Behavioral Agreements have been called "Behavioral Contracts." VA Attorneys advise that the use of this term be avoided. The use of "contract" implies that both parties have essentially equal power, a condition which does not describe the relationship between a VHA provider and patient. The term "agreement" is more appropriate.*

Non-restrictive strategies are frequently employed by the DBC. For example, the DBC may issue a variant of the letter of concern that could be called a "warning letter." A warning letter can inform the patient that the DBC has received reports of disruptive behavior and has identified concerning behaviors that need to stop. It can restate the parameters of appropriate behavior, identify policies that the patient may have violated, suggest resources for the patient to consider, and outline next steps if the behavior continues.

The DBC may place a Behavioral Patient Record Flag (BPRF) (see Section 5.2 below for more information) on the patient's chart. This communication tool instantly pops up when the chart is opened. It provides a brief description of the safety risk, and describes appropriate actions to ensure safety.

**Use of Counseling
or Letters of
Concern for
punishment or
retribution is
prohibited.**

The DBC may consult with the disruptive patient’s providers about referrals designed to mitigate risk factors or enhance protective factors, such as treatment for problematic substance use or interventions for homelessness. The chair might offer to consult with an inpatient setting around strategies to manage the risks posed by a patient.

Finally, an oft-used strategy of the DBC could be called “watch and wait.” In such cases the threat assessment might not generate strong evidence for serious or immediate threat, but does suggest that problems could develop in the future. Additional DBRS reports, follow up by providers, and information from VA police could lead to additional assessment and development of more active strategies.

It is important to note that decisions made by the DBC to address behavioral concerns will be based upon the outcome of evidence-based, data-driven, structured professional judgment behavioral risk assessments, and the recommendations tied to the nature and context of the assessed threats. In threat management, many heads are better than one, and there is always room for creativity (see Appendix IV and the WVPP SharePoint for samples of letters and other documents used for limit setting).

5.1.2 Restrictive Strategies

Orders for Behavioral Restriction (OBR) are restrictive forms of therapeutic limit-setting (see Appendix V). They may be appropriate when other interventions fail or when the threat is significant. An OBR may restrict the time, place, and/or manner of the provision of a patient’s medical care (38 CFR Part 17.107). It must be narrowly tailored to address the patient’s disruptive behavior while avoiding undue inconvenience or interference with care. An OBR is issued in the form of a letter from the COS or designee (e.g. DBC) after a thorough, evidence-based multidisciplinary behavioral threat assessment by the DBC. Ideally, the letter is delivered to the disruptive patient during a face-to-face meeting, but it may be sent by certified mail or other reliable delivery method in keeping with policy. Mechanisms for documenting delivery efforts are available in the Status and Assessment Section of the DBRS (Appendix V contains flow charts of the OBR process).

Although a patient may consider an OBR as “coercive,” use of an OBR as punishment or retribution is prohibited.

Note: *An OBR is used to reduce risk resulting from disruptive or aggressive behavior. It is not used for non-adherent behaviors that do not pose a safety threat to others, no matter how challenging or costly the non-adherence may be to the patient or to the facility.*

The OBR may include, but is not limited to:

1. Specifying the hours in which non-emergent health care will be provided.
2. Specifying a specific patient care area (e.g., private exam room near an exit) for the patient to receive care.
3. Specifying a specific site for the patient's care (e.g., at the main facility rather than CBOC).
4. Specifying the specific healthcare provider and related personnel who will be involved with the patient's care.
5. Requiring police check-in or escort when the patient comes for an appointment.

The OBR sets therapeutic limits intended to increase the likelihood that the patient will engage in health care in a safe and appropriate manner, or will return for a future appointment when an encounter has been terminated due to the patient's disruptive or threatening behavior. A disruptive patient may experience an OBR as coercive, but intentional use of an OBR as punishment or retribution is prohibited.

a. The OBR will contain:

1. A summary of the pertinent facts and the bases for the determination that restrictions are necessary.
2. The effective date of the restrictions, which will usually be immediately upon issuance by the COS or designee.
3. The duration of the restrictions, or of the time before the restrictions are reviewed (not more than two years), if there is no end date established.
4. The criteria for loosening or termination of restrictions.

b. Documenting the OBR:

1. The letter sent to the patient documenting the OBR will advise the patient of the right to request a review of the OBR, and of the process for doing so. It should remind the patient of the availability of emergency services, and of the intent of VHA to provide the patient with high quality healthcare.
2. For all OBRs, there will be a Behavioral Patient Record Flag (BPRF) (see below) placed in the patient's record. The flag narrative itself should conform to Directive 1166 and should be a brief statement of the "Problem" and the "Plan."
3. Accompanying this OBR-related PRF will be a Progress Note in the health

record. A copy of the OBR letter may serve as the TIU progress note.

c. **Request for review of the OBR** (See Appendix V OBR Implementation Flowchart).

1. The patient must submit a written request for review of the OBR to the COS within 30 days of the effective date of the OBR.
2. The COS shall quickly forward the OBR, supporting documentation, and the patient's written request to the network director for a review and a final decision. The facility will work with the network office to determine the documentation needed for the review. This will generally include the VRAI and the VRAI summary, an accounting of other DBRS reports and known events leading to the OBR, information from VA police as appropriate, and other strategies tried before implementation of the OBR, but may vary by network and facility.
3. The network director shall issue a final decision on this request within 30 days of when the COS received the request and will notify the COS of the decision.
4. The COS will provide written notice of the network director's final decision to the patient.
5. VHA will enforce the OBR while it is under review by the network director.

Note: *The OBR review process is established by 38 CFR 17.107 as follows:*

“Review of restrictions. The patient may request the Network Director's review of any order issued under this section within 30 days of the effective date of the order by submitting a written request to the Chief of Staff. The Chief of Staff shall forward the order and the patient's request to the Network Director for a final decision. The Network Director shall issue a final decision on this matter within 30 days. VA will enforce the order while it is under review by the Network Director. The Chief of Staff will provide the patient who made the request written notice of the Network Director's final decision.”

The regulation maintains a patient-centered stance even as it describes the placement of restrictions to the manner of care in the interest of safety. There will undoubtedly be times when an individualized patient-centered approach will be required in addressing issues such as a late request for review, difficulty in notifying a patient of an OBR, and redirecting patients who have taken the wrong track in seeking to have restrictions lifted. The goal of an OBR is to provide treatment safely, not to punish or embarrass a patient.

When the patient fails to comply with an OBR, the encounter may be terminated as soon as the patient is medically stable. If necessary, VA Police will escort the patient from facility grounds. The patient will be rescheduled in accordance with VHA guidelines. Repeated failure to abide by an OBR may result in progressive

restrictions short of denying access to care. In some cases, violation of an OBR may lead to citations or criminal charges for trespass, disorderly conduct, or other appropriate actions by VA police.

NOTE: *In implementing Regulation 38 CFR, Part 17.107, it is understood that VHA restrictions on the time, place, or manner of care may inconvenience a patient. For example, a patient who poses a threat at a community-based outpatient clinic (CBOC), where there are no VA Police, may be restricted from care at all CBOCs and required to travel to the closest VA facility where adequate security is present. Placing an OBR may challenge the facility's resources, as when an OBR requiring "police officer escort" throughout the course of a patient's visit places a demand on valuable police resources. The facility may elect to provide purchased-care services to the patient and will follow usual policy in determining whether the patient is eligible for beneficiary travel to the new treatment location, which will be considered the closest facility available to provide needed care.*

When the OBR requires a patient to receive care at a non-VA health care facility, local policy, practice and procedure will address the following considerations:

1. The patient must be able to get to appointments at the receiving facility. Beneficiary travel will be provided if the patient meets eligibility requirements. The VA Veteran Transportation Program has issued guidance directing that the presence of an OBR requiring the Veteran to travel outside the local area will meet the requirements for beneficiary travel if the patient is otherwise eligible.
2. Any relevant health conditions that might be exacerbated by travel to the receiving facility must be considered and accommodated by the sending facility.
3. The patient under an OBR should be provided with information about assigned providers and appointments at the receiving facility prior to his/her first visit there.
4. The patient should also receive prescription refills from the sending facility to bridge any delays before his/her first appointments at the receiving facility.
5. The disruptive patient should be provided all transfer information in writing prior to his/her first visit to the receiving facility.
6. It is best practice for the patient to have a point-of-contact at the sending facility to be liaison for future healthcare needs and to facilitate communication with other facility-based staff as needed. This POC may be a social worker, patient advocate, someone from the executive office staff, or other appropriate person.
7. The receiving facility or office should receive information regarding the threat posed by the patient to facilitate planning for the safe provision of healthcare.

5.2 Behavioral Patient Record Flags (PRF)

The PRF is a tool developed specifically for VHA's electronic health record. National PRFs appear anytime the patient's record is opened across VHA, while legacy Category II local PRFs (see note below) appear only in the record at the facility which placed the PRF. The PRF provides a highly visible alert to a range of specific safety issues which require consideration and possible action in the initial moments of an encounter (examples of PRF are found in Appendix IV).

NOTE: *Category II PRF will be discontinued when the new PRF directive 1166 is published. The use of Behavioral Category II PRF should not be occurring at any VA medical facility.*

There are three types of (national) PRFs commonly used in VHA. One identifies patients deemed at high risk for suicide (HRS-PRF), while a second alerts staff when an "at-risk" patient is missing (MPRF).

The third type of flag is the Behavioral PRF (BPRF), used by DBC to identify those patients whose threat of disruptive, threatening, or assaultive behavior is high enough that staff need awareness and guidance in the first moments of an encounter. VHA Directive 1166, Patient Record Flags, will detail the functionality of national PRF and discontinue the use of Category II PRF. The directive describes the appropriate uses of all PRF.

Behavioral PRF must be reviewed every two years at a minimum, and sooner when appropriate. As threat management is an iterative process, the strategies being used to prevent disruptive behavior will be reviewed in accordance with the changing environment. It is generally appropriate to review a PRF when the patient requests it, unless the request is part of an ongoing pattern of disruptive behavior which appears designed to interfere with operations of the healthcare system. A review can also be appropriate when requested by a provider who offers new or additional information about and insight into a patient's behavior and its management, or even questions its utility in light of other treatment considerations.

There is a Text Integrated Utility (TIU) progress note which provides more information about the PRF. This TIU note is linked to the PRF so that it can open directly from the PRF pop-up page. While the TIU note was required in earlier directives for all PRF, its use is now discretionary for Behavioral PRFs without OBRs, based upon the DBC's assessment of its relative value in providing more detail versus any exacerbation of risk it might generate. The TIU note may be used to provide more background information underlying the placement of the PRF, and more details about the threat management plan which are applicable

The mere presence of a PRF may not be used preemptively or as the sole reason to deny access to clinically indicated services for which patients are otherwise eligible.

in the first moments of the encounter. If there is an OBR, the TIU note is required and contains the details of the OBR.

Note: The mere presence of a PRF may not be used preemptively or as the sole reason to deny access to clinically indicated services for which patients are otherwise eligible. This prohibition extends to programs as well as individual treatments. However, the behavioral reasons for the PRF may inform the admission process, and the potential for disruptive or violent behaviors in certain settings can preclude admission pending resolution of the identified risks. More information regarding the management of Patient Record Flags may be found on the WVPP SharePoint, located at <https://dvagov.sharepoint.com/sites/VHAWVPP/sitepages/home.aspx>

5.3 Case Management and Monitoring

Once interventions to reduce risk are implemented, a case is stabilized, and the current threat is minimized, the DBC monitor the case for changes that could rekindle the threat. A well-developed threat management plan will include a schedule for review and contingency plans to address unexpected issues that might exacerbate risk in the future. The following are some questions which can guide the monitoring efforts:

1. What could go wrong in the future?
2. What are the potential hazards in the current action plan?
3. What action plans are in place if untoward events threaten the management plan?
4. What future events, situations, or conditions might move the patient up the pathway to violence?
5. What changes have been noted in the patient's behavior?
6. What changes in risk or protective factors occurred since the last review?
7. What new events have occurred in the patient's healthcare services or other areas of his/her life?
8. What key people involved with the patient can provide updated information for evaluating the management plan?

5.4 Closing Remarks

Patient Record Flags must be reviewed at least every two years. However, a robust threat management process will require more frequent reviews in many cases, as dynamic risk and protective factors can change. Modifying these factors is a major intent of effective threat management. When the recommended interventions enhance protective factors and reduce risk factors, there may be a significant reduction in risk, and the threat management strategies can be relaxed and/or removed. There are many considerations at play in the decision to reduce restrictions, remove OBRs, or inactivate a PRF. During a review, the DBC will update the information captured in the VRAI.

Some of the evidence that risk is lower and that interventions could be modified include:

- The absence of any new DBRS reports in a substantial time frame;
- Evidence that the patient has successfully completed treatment for a substance use disorder and remains sober;
- Evidence of improved adherence to medical and mental health treatment options;
- Evidence that the patient has successfully completed a treatment regimen that addressed risk factors such as anger and PTSD;
- Evidence from the health record that the patient's interactions with providers has improved;
- Establishment of stable housing, income, and/or meaningful work;
- Development of a social support system;
- Engagement with family members who are positive factors in the patient's life;
- Resolution of other destabilizing factors in the patient's environment, including stressful relationships;
- Evidence of improved coping skills.

One of the great satisfactions in doing this work comes from seeing progress which allows restrictions and warnings to be lifted. While it is undesirable from a patient-centered perspective to keep alerts and restrictions in place longer than is necessary, it is also problematic to remove them too soon. Achieving this balance is the goal of the DBC.

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