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Healthcare Threat Management: What's Different & Why

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Unlike other industries, in healthcare, some potential victims have treating relationships with those who threaten them. This by itself creates a unique challenge, but healthcare has still more hurdles to offer the healthcare threat manager.

Street vs. Suite Violence

In John Monahan's seminal 1981 book *The Clinical Prediction of Violent Behavior,* he begins, quite logically, with a discussion of the definition of violence. "Corporate violence" he described as deliberate decision-making by corporate executives that results in unreasonable risk of physical harm.[i]

Recent examples of "corporate violence" include General Motors' ignition switch litigation, in which GM admitted it knew about ignition switch problems for more than a decade before issuing a recall. Reportedly for decades, Remington denied a trigger problem in its model 700 rifle. In 2015, a peanut company owner was sentenced to 28 years behind bars for salmonella poisoning linked to 9 deaths and about 300 hospitalizations. Toyota ultimately agreed to pay $1.2 billion for hiding its "unintended acceleration" problem ultimately linked to 89 deaths.

Monahan wrote that corporate violence "is responsible for more deaths and injuries than the more mundane forms of crime" and suggested that the "preoccupation of the law and the behavioral sciences with 'street' rather than 'suite' violence reflects, in part, political and economic biases operating in American society."

Nearly 40 years after the publication of Monahan's book, it's still *street*, not *suite*, violence that dominates workplace violence prevention efforts.

Broadly, *threat assessment* is the process of gathering information to make a decision regarding the potential for violence.[ii] *Management* refers to actions taken to gain control over a situation and *threat management* to "the actions that can be, should be, or have been taken to

prevent violence."[iii] Healthcare threat management strategies to prevent incidents of "street" violence range from least intrusive (e.g., actively monitoring a situation to detect change) to most intrusive (e.g., arrest, prosecution, involuntary commitment for treatment). In between are options such as behavioral contracts, physical environment modifications, security enhancements, warnings, dismissals (from a physician's practice, a clinic, or an organization), "no trespass" directives, and restraining orders. Threat management experts typically advise beginning with the least intrusive option available while still ensuring safety.[iv] While threat *assessment* does not differ in healthcare from other industries, threat *management* strategies do have some unique considerations.

Patients Who Threaten Providers

When a patient threatens a provider, the "knee-jerk" reaction may be to dismiss the patient. Of course, in any industry, whether or not such an action will promote safety should be considered: "[I]t is contrary to the practice of threat assessment to actually be responsible for further escalating a situation."[v] But in healthcare, there are additional concerns. Only in healthcare is there risk that the termination of the professional relationship with the threatening individual could result in harm and claims of medical abandonment.

Indeed, a full threat investigation may reveal the threatening behavior to be indicative of a new or undertreated medical or psychiatric problem that the provider or other providers in the organization are actually in a position to address. Maintaining a treating relationship with the patient can offer the ability to monitor for safety and intervene as warranted. Also, a thoughtful approach reduces concerns for claims of abandonment, and ensures strategies implemented are neither over- nor under-reactive, both of which can undermine the credibility of the healthcare threat manager. However, in healthcare there can be strong organizational influence reluctant *not* to dismiss patients who have acted in intimidating or threatening ways.

Healthcare Organizational Policies

OSHA's healthcare workplace violence (WPV) prevention recommendations aim to prevent all forms of WPV, including verbal and non-verbal threats.[vi] In keeping with OSHA's unending commitment to "zero tolerance for violence" policies,[vii] healthcare facilities may adopt organizational dismissal policies supportive of dismissing patients who have expressed threats. While the intent is to support staff, promote a safe workplace, and comply with OSHA recommendations, the organization may fail to recognize that dismissing such a patient may not enhance safety and in fact could worsen the potential for a violent outcome. Dismissal may also result in harm to the patient (unintended "suite violence") that far outweighs the patient's actions. Adhering to "zero tolerance" policies is generally not advised by threat management experts who avoid such language because it implies harsh justice without thorough investigation and carries with it baggage from the failed war on drugs; "by transferring a largely discredited brand name to violence prevention, the employer risks seeming more interested in appearances than in effectiveness."[viii]

Another organizational consideration[ix] is the healthcare facility's *mission* or *vision* statement, which may espouse commitment to the health of the community it serves. Our own does, and so did those of nine out of ten other facilities

that we randomly selected for review. Policies supporting the practice of dismissing patients from medical management do not seem consistent with efforts to promote community health. Moreover, in our experience, dismissal is simply not an effective violence prevention management tool. A significant percentage of dismissals end up being reversed, and patients can always return for care through our emergency department.

Unlike what might be expected of other industries, healthcare should recognize that mental health can fluctuate just as physical health does, and healthcare often presents frustrations sufficient to test even the most resilient among us. While most patients behave within generally accepted social norms despite what may be very stressful conditions, it should not be a surprise that some people - those in a mentally fragile state for whatever reason – who are in the midst of a health crisis, navigating healthcare system obstacles, and experiencing concurrent social stressors (e.g., divorce, job loss, mortgage foreclosure), are pushed beyond their limits and act out. OSHA, as anyone working in healthcare arguably should, recognizes the high stress atmosphere healthcare can be: "Pain, devastating prognoses, unfamiliar surroundings, mind- and mood-altering medications, drugs, and disease progression can all cause agitation and violent behaviors."[x] Such awareness is necessary to direct WPV prevention efforts where they are likely to have greatest effect.

Healthcare Workplace Violence Statistics

"Every year, OSHA staffers are 'shocked' by the number of workplace injuries and fatalities in [healthcare]."[xi] And almost every year, healthcare organizations receive annual reports showing a rise in violence. The threat manager can benefit from understanding what makes up the violence statistics because for many in healthcare, what comes to mind is an increase in instances of the "street" type of violence – intentional assaults, batteries, and homicides committed by aggrieved patients or their angry family members against healthcare providers. In reality, the reason healthcare is consistently at the top of the WPV statistics is because we're where violent patients are brought for care.[xii]

Ever since WPV statistics began being tracked by the Society for Human Resource Management in 1996[xiii], workplace violence has been a concern for both employees and employers. For research and data reporting purposes, OSHA has adopted the California Division of Occupational Safety and Health's description of four workplace violence categories, which are based on the relationship of the perpetrator to the victim-employee's workplace[xiv]. In type 1 violence, there is no relationship between the perpetrator and the workplace (e.g., a healthcare provider injured during a burglary at a hospital); in type 2, the perpetrator of violence is a customer/client of the employer business; type 3 involves employee on employee violence, and type 4 is domestic violence brought into the workplace. Violence by patients or their family members directed toward healthcare staff is type 2 violence, which is typically not further divided between acts of intentional (*targeted*) violence and spontaneous (*unintended, affective,* or *reactive*) violence. Thus, for statistics purposes, the aggrieved patient who makes a decision to take a violent action against a provider is grouped along with the geriatric patient with dementia who grabs at her caregiver's hair while being helped with bathing. This broad grouping of Type II violence accounts for healthcare consistently being at the top of

the statistics. When Type II violence statistics are reported to have risen, it can be helpful to know if the rising violence is of an intentional or unintentional type, as well as whether or not the increase reflects an increase in reporting or instead is truly reflective of rising incidents, not just reporting. Many reports on WPV to healthcare facilities rely on voluntary reporting and do not account for increased reporting efforts that have been undertaken.[xv] Recognizing potential contributing factors for violence as well as the basis for reported statistics can aid healthcare WPV prevention policy-making as well as threat management decision-making.

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[i] John Monahan, *The Clinical Prediction of Violent Behavior*, p. 10 (NJ, Aronson Publishing, 1995 edition).
[ii] Meloy, Hart, Hoffmann, *International Handbook of Threat Assessment*, Meloy & Hoffmann, Eds., Ch. 1, pp. 3-4, (NY, Oxford University Press 2014)
[iii] *Int'l Handbook of Threat Assessment*, p. 4.
[iv] See e.g., Gavin de Becker, *The Gift of Fear,* pp. 132, 139-147 (NY, Dell Publishing, 1997).
[v] Van der Meer and Diekhuis, "Collecting and Assessing Information for Threat Assessment," Ch. 4, p. 58, *Int'l Handbook of Threat Assessment*.
[vi] OSHA & Worker Safety, "Guidelines for Zero Tolerance," *Environment of Care News*, Volume 18, Issue 8 (August 2015), p. 8.
[vii] OSHA & Worker Safety, Vol 18, pp. 8, 10.
[viii] Mark A. Lies, II, Ed., *Preventing and Managing Workplace Violence*, pp. 29, 217 (Chicago, ABA Publishing, 2009).
[ix] For an excellent discussion of organizational influences in threat assessment, see Cawood & Corcoran, *Violence Assessment and Intervention,* chapter 7, (FL, CRC Press 2009).
[x] OSHA & Worker Safety, Vol 18, p. 8.
[xi] Gloria Gonzalez, *Business Insurance*, 1/11/2017.
[xii] Besides violent patients brought to healthcare facilities for treatment, social services and healthcare providers deliver care to patients in private settings and are included in healthcare WPV statistics.
[xiii] *Preventing and Managing Workplace Violence,* p. 4.
[xiv] *Preventing and Managing Workplace Violence*, p. 39.
[xv] OSHA & Worker Safety, p. 10 (encouraging tracking not only incidents, but also near-misses because "Some serious cases are preceded by threats that went uninvestigated and undocumented.")