THE BEAT
A MONTHLY PUBLICATION TO INFORM THE IAHSS COMMUNITY

Feature Article

July 2018

Understanding Violence: A Prerequisite to Prevention

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In the spring of 2009, a physician showed us an anonymous note that had been left on his car. It was a short note, handwritten on a child's "Little Mermaid" stationary:

> *Dear Doctor,*
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> *Now that spring is officially here, I thought I'd write you a note. My little friend loved spring what with Easter, and the tulips and daffodils, no more snow pants. But oh that's right, he will never enjoy this again – because remember you killed him. Hope you are having a good spring. I'll be watching you.*

This wasn't the first time a provider was concerned for his safety and uncertain whether to heed the advice of the police to seek a restraining order or take some other action of direct intervention – indeed, how *should* non-immediate indirect (or direct) threats be handled to best ensure providers' safety? While the majority of hostile patient/family interactions are usually managed safely by staff, providers and managers, what about the small percentage that depart from normal behavior and intimidate, threaten, or frighten? Can we avoid unintentionally escalating an unstable individual to violence?

That note launched our journey to find out, and thus began our study into the world of violence and these complex behavioral-sciences issues.

We first learned core principles and observed that many violence prevention experts refrained from using the health care profession's favored term of "best practice," yet there seemed to be one rule that is probably fairly described as just that:

Before taking any direct intervention, be certain the action under consideration is one that promotes safety, rather than one that risks escalating the concerning individual to violence.

If uncertain, opt instead for increasing security measures, implementing preventive strategies, and disengaging from the concerning individual -- what one renowned violence prevention expert calls "watchful waiting" rather than the approach more commonly taken, "engage & enrage." [i]

A common response to threats is to seek a civil restraining order which is an action brought against someone with whom contact is not wanted; thus, right from the outset, the logic of it seems inherently flawed. Despite decades of use, restraining orders continue to be a source of debate between camps in favor of (law enforcement) and camps against (safety authorities); nonetheless, there is no disputing the fact that in certain cases, restraining orders appear to have been the trigger to violence. Unless certain that you're not dealing with one of those cases, it would be wise to heed the words, "If a victim or a professional in the system gets a restraining order

to stop someone from committing murder, they have probably applied the wrong strategy."[ii]

In our own community several years ago, we heard the restraining order debate play out on front page news. On October 8, 2012, Zina Haughton walked into the courthouse and applied for a restraining order against her husband, who she feared would kill her for leaving him. She was right, and on October 21, 2012, (after purchasing a .40-caliber gun on-line the day before and three days after the court granted the restraining order) he did just that, also killing two of her colleagues and injuring three others at the spa where they worked.

In our experience, we observe that whenever the police are called to respond to disorderly conduct, they routinely provide information upon their departure on how to apply for a restraining order. Providers then rightly want to know – should they apply for a restraining order? We received such a call just a few weeks after what had become widely known as the "Spa Shooting." In this call, we learned that a few months prior, a clinic sent a patient a dismissal letter terminating him from medical care due to bigoted comments he had made; the patient had now unexpectedly shown up and asked to be seen. The clinic had called the police who responded; the police as well as the District Attorney's office advised the clinic to file for a restraining order and send the patient a "no trespass" letter so that were he to return, he could be arrested. Just a month earlier, this patient had made the local news when police responded to a domestic violence call at his home and a gun stand-off ensued (ultimately ending with no shots fired).

We recommended against applying for a restraining order, against sending (another) dismissal letter, and against sending a no trespass letter. We did, however, gather all available information, perform a threat assessment, and recommended increasing security at the clinic – a recommendation that we implemented for several months. Although we determined he did not pose a threat to the clinic when he first showed up after having been dismissed months earlier, the ensuing events that followed once the police were called were cause for concern that he would act out in retaliation.

Initially, our recommendation against direct intervention that was contrary to the advice of the police and district attorney's office was met with resistance, but the more time that went by while we increased security and vigilance in the clinic, the more the resistance to our management plan diminished, until ultimately all were on board with a plan that did not involve any sort of direct intervention with this erratic individual. What we knew and what others were coming to realize, is that "believing that others will react as we would is the single most dangerous myth of intervention."[iii] **The police and District Attorney recommendations of direct intervention were understandable – they were called upon to control the behavior of this unstable individual and they want to help.** Their tools for doing so (being able to arrest and prosecute for violations of restraining orders or no trespass orders) are often fine – just not in cases in which their contact exacerbates the unwanted behavior rather than deterring it.

Over time managing numerous threatening situations, we learned to adapt core threat assessment and management principles and practices to the healthcare setting, where management strategies require consideration of factors not present in other industries. Due to aspects unique to healthcare (e.g., the patient-provider relationship, EMTALA, medical treatment needs), while the *assessment* process is the same, *management* of threats in healthcare can be very different compared to other industries.[iv] Had we been consulted for input prior to that clinic

patient's dismissal, we would have advised against it, offering other recommendations instead such as transferring to another provider and addressing his comments as well as expectations for behavior. Our open medical campus is simply not conducive to effectuating no contact, as demonstrated by his appearance after dismissal from care.

Won't my organization's "Zero Tolerance" Policy toward violence prevent any problems?

To be effective, zero tolerance policies, like restraining orders, require cooperation from the very individuals who show themselves to be most uncooperative. While OSHA and Joint Commission continue to use this outdated terminology, violence prevention experts do not, in part because research shows zero tolerance policies deter reporting of incidents.[v] If your organization has a Zero Tolerance/Incidents/Harm Policy, extra educational effort may be needed in order to convey the message to employees that reporting incidents is encouraged, and that "zero tolerance" does not necessarily in every circumstance contemplate the harsh justice it implies, such as when patients behave inappropriately due to a temporary or permanent brain condition.

Moreover, "zero" as relates to human interactional violence is almost certainly an unachievable goal, the continued adherence to which reflects these organizations' lack of understanding of violence. If one realizes no more than the fact that acts of violence can be unintentional or intentional, instrumental or reactive, perceived as the only alternative or one of many, and that healthcare facilities cannot realistically intervene to affect all possible contributing factors to violence in the lives of all people who enter their facilities or come onto their premises, than this should be apparent.

However, the recent Joint Commission Sentinel Event Alert mentions many different acts of violence committed against healthcare personnel yet also notes, **"The most common characteristic exhibited by perpetrators of workplace violence is altered mental status associated with dementia, delirium, substance intoxication, or decompensated mental illness."**[vi] Seven recommendations then follow that begin with a call to leadership to establish a goal of zero harm.

Healthcare organizations that more fully comprehend such concepts as the differences in types of violence (general, affective or reactive, and targeted) and the different approaches they call for **are better positioned to allocate resources in a way to ensure all violence types are being addressed to the extent possible.**

Healthcare security professionals are usually the primary resource for dealing with incidents of **general violence**, and have a significant role, ideally alongside behavioral health team members, in addressing incidents involving **affective or reactive violence**. Acts of serious **targeted violence** are rare by comparison, but are the most feared by clinicians and can have devastating consequences, so ensuring everything possible is being done to prevent such violence is a hugely worthwhile albeit time-consuming endeavor requiring a **team** approach. For this reason, the study of threat assessment and management for the prevention of targeted violence in healthcare is **perfectly suited for collaboration among a healthcare organization's security professionals, risk managers, clinic managers, providers, human resources and others.**[vii] Working collaboratively, healthcare organizations can commit to an achievable goal of doing everything possible to prevent harm to providers, staff, patients and visitors.

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annual seminar focusing on prevention of targeted violence in healthcare: *https://www.mcw.edu/departments/risk-management*

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[i] Gavin de Becker, *The Gift of Fear*, New York: Dell Publishing (1997), p. 132.
[ii] *Id*., p. 200.
[iii] *Id*. p. 146.
[iv] Sheridan Ryan, *Healthcare Threat Management: What's Different & Why* (IAHSS The Beat May 2017).
[v] Federal Bureau of Investigation Behavioral Analysis Unit, *Making Prevention a Reality: Identifying, Assessing, and Managing the Threat of Targeted Attacks*, at p. 64 (Feb. 2017).
[vi] Joint Commission Sentinel Event Alert Issue 59 at p. 3, April 17, 2018.
[vii] https://www.mcw.edu/departments/risk-management