

“Zero Tolerance” for Violence and Violent Patients: Sound Policy or Sound Bite?

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Violence has risen to the forefront of concern in healthcare.¹ Two popular notions—at least in healthcare risk management forums—are that (1) even the sickest of patients understand the consequences of their actions (implying an ability to control behavior), and (2) all hospitals should have “no violence” policies. This article examines the validity of those propositions.

Are Even the Most Ill Patients Always Capable of Controlling Their Actions?

In December 2012, 26-year old Sainah Theodore, an emergency room clerk, purchased diet pills.² After taking them, she experienced insomnia, auditory hallucinations, and bizarre behavior including arguing with strangers, sending irrational and aggressive text messages, stopping her car in the middle of a busy intersection, tearing through her home’s screen door, and stabbing pillows and pictures. Ultimately, she was admitted to a psychiatric facility, where she spent five days until she recovered from the effects of unlisted ingredients in the pills, which lab tests reportedly confirmed to include phenolphthalein, sibutramine, and high levels of caffeine. Today, fully recovered, she has no memory of her bizarre and violent behavior.

In *Brain on Fire: My Month of Madness*, Susannah Cahalan recounts her experience in 2010 at age 24 with an acute manifestation of an initially unrecognized brain disease.³ She was a new writer for the *New York Post* when she went to work one day and told a colleague that she didn’t feel like herself. She felt numbness and tingling on the left side of her body, would cry hysterically one minute, and then was giddy the next. She became convinced she was bipolar and a consulting psychiatrist agreed. Over the course of weeks she experienced seizures, paranoid delusions, violent behavior, and catatonia. Another consultant told her she was probably experiencing alcohol withdrawal, although she rarely drank. She screamed all the way to the hospital, and once admitted, she tore at IVs and electrodes and ran uncontrollably up and down corridors. After two weeks, anti-anxiety drugs quieted her mind, but there was still no definitive diagnosis. Finally, Dr. Souhel Najjar, a neurologist, neuropathologist, and epileptologist, diagnosed her with anti-N-methyl-D-aspartic acid receptor encephalitis. Only in 2007 had University of Pennsylvania neuro-oncologist Josep Dalmau discovered and named the rare receptor antibodies responsible for attacking the brain in this syndrome, thought to be caused by a combination of genetics and some environmental trigger. Symptoms include psychosis and sometimes catatonia and seizures. At the time Cahalan was diagnosed, an estimated 90% of such cases were misdiagnosed. After undergoing treatment for about a year, Cahalan fully recovered.

In 1983, Dick Sem’s wife brought him to an emergency department because he wasn’t making sense and was acting out.⁴ Acting completely out of character, he struck the emergency room physician. He spent four days in a coma, and ultimately was diagnosed with Reye’s Syndrome. This had caused him to act violently—something over which he had no control and has no memory. Sem, who today is an independent security consultant, shares his story with healthcare organization clients to help them implement workplace violence policies.

Healthcare providers must sometimes interact with patients displaying violent behavior. While the scenarios just described may not be common (a 2014 survey found that nearly 50% of attacks on ED nurses came from patients and family members who were drunk or on drugs),⁵ it is precisely their infrequency that increases the risk of mishandling.

Says Dr. James McGee, a forensic psychologist, former FBI hostage negotiator, and director of forensic psychological services for Gavin de Becker & Associates⁶:

There are many psychiatric patients who, by virtue of the nature and severity of their condition, are not responsible for their actions. Examples include people who are experiencing “command auditory hallucinations” with voices of some “ultimate” authority (God, the President, etc.) ordering them to commit violent acts. Paranoid delusions are a common feature of many psychotic disorders such as schizophrenia, mania, psychotic depression, drug-induced psychosis, postpartum psychosis, dementia, delirium, Alzheimer’s, psychosis secondary to brain trauma or brain infections like encephalitis. Delusional paranoid patients often are convinced that they are in grave danger, being conspired against or about to be attacked or even murdered. In response, they may attack first as a purely defensive measure consistent with their delusional beliefs that they are in mortal peril. There is ample evidence that there are many medical/psychiatric conditions that render people incapable of making rational judgments and controlling their behavior including aggression and violence.⁷

In the face of such evidence that patients are sometimes incapable of controlling their violent behavior, why do messages to the contrary persist? One reason may be that if we can assign all responsibility to the patient, then we have no duty to act. In contrast, if we accept the fact that the sickest of brain-disordered or diseased patients are sometimes not in control of their actions, we then have some responsibility to plan for such occurrences and prevent harm where possible. But healthcare organizations aren’t alone in that duty. Others, such as law enforcement—often the first to respond to a person in mental health crisis—and lawmakers, share that responsibility.

Fewer than a dozen states have laws requiring healthcare facilities to have workplace violence prevention programs.⁸ Five states still have not enacted legislation for involuntary outpatient commitment⁹; such legislation attempts to stop the revolving door pattern of emergency department visits, jail, and homelessness that is common among the seriously mentally ill. In the states that have enacted such laws, loopholes often frustrate the legislation’s purpose. “Kendra’s Law” in New York was enacted after Andrew Goldstein, who has schizophrenia, shoved Kendra Webdale to her death in front of a subway train in 1999. Goldstein admitted knowing it was wrong but said he was unable to overcome the urge to push. Webdale’s mother, Patricia, worked to ensure lawmakers passed the landmark mental health law giving judges more power to compel mentally ill people to comply with court-ordered psychiatric treatment. Goldstein was sentenced to 23 years in jail where, with medical treatment, his thoughts cleared. In 2012, after yet another person was pushed in front of a subway train, it was Goldstein calling for an even stricter Kendra’s law: “When I heard on the radio that someone else was pushed, I couldn’t believe it happened again. Should you let a mental patient like myself be in freedom so an incident like train-pushing can occur? . . . The court [should have] the right to hospitalize and medicate. There should be stricter regulations. They need to restructure Kendra’s Law.”¹⁰

Security consultant Sem notes that law enforcement and security are changing how they handle disruptive behavior calls by training

continued page 23

Zero Tolerance continued from p. 18

personnel to recognize signs of mental illness and respond with an understanding that the usual methods of deterring unwanted behavior may aggravate rather than deter those with serious mental illness. In 2009, the Houston Police Department was the first in the nation to devote an entire division to mental health. Reform efforts began in 2007 after two people with schizophrenia were shot and killed by police two months apart.¹¹ In Houston, all new officers undergo 40 hours of crisis intervention training, and Houston's mental health division is now considered the gold standard for the nation.

Origins of the Healthcare “Zero Tolerance” for Violence Policy

The Houston Police Department's mental health division would probably describe its reform efforts as the opposite of a “zero tolerance” policy. Yet, hospitals continually hear that they need a “no tolerance” or “zero tolerance” for violence policy. The source of that terminology in healthcare appears to be the Occupational Safety and Health Administration (OSHA). As recently as 2015, OSHA updated its Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, and reiterated its adherence to a “clear policy of zero tolerance for WPV (workplace violence).”¹²

The reason OSHA cites for adhering to the “no violence” terminology is that it “hear[s] from employees who fear they might lose their jobs or be blamed if they complain,” and “when nothing happens in response to an incident or a complaint, they stop complaining. That's why we say that management must communicate and enforce a policy of zero tolerance for violence . . . We're trying to change [the] culture and offer guidance.”¹³

OSHA recommends “[c]learly stating to patients, clients, visitors, and workers that violence is not permitted and will not be tolerated.”¹⁴ Certainly, communicating such a message can be a very important step toward curbing disruptive behavior. (Of course, this assumes recipients of the message are able to comprehend it and also control their behavior.) What OSHA means by “zero tolerance” is less clear. OSHA states that its new WPV guidelines “focus on particulars of the setting and how they relate to causes and controls,” and cites epidemiological studies demonstrating that “pain, devastating prognoses, unfamiliar surroundings, mind- and mood-altering medications, drugs, and disease progression can all cause agitation and violent behaviors.” OSHA also states that “zero tolerance should extend even to verbal and nonverbal threats,” without explaining what “zero tolerance” is in the context of patients in pain, those with a devastating prognosis, those in unfamiliar surroundings, or those whose medication or disease progression has caused them to behave violently.¹⁵

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 place of employment.¹⁶ In type 1 violence, there is no relationship between the perpetrator and the workplace (e.g., a healthcare provider injured during a burglary); 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. Unfortunately, type 2 violence is not further divided between intentional (“targeted”) violence and spontaneous (“affective” or “reactive”) violence. Thus, the aggrieved patient who makes a decision to take a violent action against a provider with whom he is angry is grouped with the geriatric Alzheimer's patient who grabs at her caregiver's hair while being helped with bathing or dressing. Similarly, in recommending a zero tolerance policy, OSHA does not distinguish between these two very different types of violence.

Indeed, healthcare facilities trying to enforce a “zero tolerance” policy soon find that it is like the “don't talk to strangers” rule: as soon as the mandate is out of our mouths, our children observe us talking to store clerks, the person standing next to us in line, and the bank teller—all of whom are strangers.¹⁷ Similarly, as soon as we publish the “zero tolerance” for violence policy, we're likely to make exceptions to it. That is true because both situations (child safety and workplace violence) are more complex than can be summarized in a soundbite. The name belies the complexity of the problem and could lead an employee to believe that no matter the circumstances, “zero tolerance” requires police to be called (or dismissal or a restraining order or similar action demonstrating “zero tolerance”). Additionally, leadership may be lulled into the belief that with a “zero tolerance” for violence policy in place, the organization has no need for staff de-escalation training, a risk assessment survey, or any of the other multiple layers of prevention and response plans that comprise a comprehensive WPV program in the healthcare setting today. It may make sense to have a subsection within a broader WPV policy that designates certain incidents as “zero tolerance,” for which a particular response is prescribed, but a healthcare organization's overall WPV policy and efforts are probably not served well by such nomenclature.

Sem recalls the early stages of overly broad “no tolerance” policies introduced in workplaces regarding sexual harassment and in schools regarding violence. He remembers when, as a security director for a company, he was absorbed for some time investigating a complaint about an employee's arm tattoo depicting a swimsuit model; the employee, it turned out, had been a sailor during World War II. Similarly, the early days of school “no tolerance” policies resulted in student expulsions for such things as bringing art scissors to school. Sem encourages his clients who use “zero tolerance” language to clearly define it in a way that makes sense—for example, that the organization will thoroughly investigate and fairly resolve each incident, taking into consideration whether the violence is the result of an uncontrollable act or instead is purposeful.

Efforts Vary

After Hurricane Katrina in 2005, Ochsner Medical Center began experiencing an increase in agitated and combative patients and family members, and recognized the need for healthcare providers and staff to receive de-escalation training and be able to call a “code green” for additional staff support.¹⁸ With the implementation of that training and program, incidents defuse more quickly and staff members feel more secure in their work environment, helping employee retention and recruitment.¹⁹

Clearly, more needs to be done at some facilities. Dr. Stephen Seager has been an outspoken critic of his administration at Napa State Hospital, a psychiatric hospital run by California's Department of State Hospitals, where more than 80% of the patients (some having committed unspeakable crimes) are referred by the criminal justice system.²⁰ In 2014, Napa State Hospital patients committed more than 1,800 physical assaults. On October 23, 2010, psychiatric technician Donna Gross was killed by a patient outside the buildings, where staff alarms did not function. (Now they function both inside buildings and outside on the grounds, thanks in large part to the efforts of Michael Jarschke, psychiatric technician at Napa State Hospital for over 30 years.) How did Napa State Hospital become such a dangerous place? The hospital opened in 1875 and until about 20 years ago, most of its patients were there due to civil commitments that did not involve crimes.²¹ The fairly recent shift to the current population coming from the criminal justice system required greatly enhanced safety measures that weren't implemented.²²

Zero Tolerance continued from p. 23

OSHA's updated healthcare WPV policy is not a "one-size fits all" model. Instead, it encompasses prevention strategies based on epidemiological studies that include physical site assessment to identify high-risk areas (e.g., high volume areas, unrestricted access points, poor lighting, isolated areas), identification of hazards and other risk factors (e.g., inadequate healthcare staffing, inadequate security staffing, inadequate staff training, long wait times, increased use of emergency departments for psychiatric treatment, increased presence of gangs, increased presence of armed private citizens), and implementation of well thought-out policies that consider the broad range of patients and others entering the doors. It is probably time for OSHA to let go of the "zero tolerance" description.

Many thanks to Dick Sem, CPP CSC, and Dr. James McGee for their willingness to be interviewed for this article; and to Rachael Wolfe, Marquette University Law School student and MCW risk management intern, for the legal research.

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Sheridan and **Jonathan Wertz, J.D., R.N., jwertz@mcw.edu, Director of Clinical Risk Management at the Medical College of Wisconsin, will join Robert J. Martin (Senior Advisor at Gavin de Becker & Associates and Principal at RJM Training & Consulting) and James McGee, Ph.D. (Director of Forensic Psychological Services for Gavin de Becker & Associates) to present "Threat Assessment and Management with a Healthcare Focus," an in-depth seminar, November 2-4, 2016 (13.5 WI CLE hours, 2 CHPA credits, 11.5 CPHRM credits, 11 MN POST credits; the HR Certification Institute has pre-approved this activity for recertification credit towards the aPHR®, PHR®, PHRca®, SPHR®, GPHR®, PHRI® and SPHRI® certifications). More details can be found at <http://www.mcw.edu/FileLibrary/Groups/Compliance/KohlerTAMSeminarBrochure2016.pdf>.**

¹Busby, Gary, "Incidence and Cost of Workplace Violence," Letter to the Editor, *Journal of Emergency Nursing*, Vol. 41, Issue 1 (January 2015), p. 5.

Crilly, J., Chaboyer, W., Creedy, D., "Violence Towards Emergency Department Nurses by Patients," *Accident & Emergency Nursing*, 12 (2004), pp. 67-73.

Gacki-Smith, J., Juarez, A., Boyett, L., "Violence Against Nurses Working in U.S. Emergency Departments," *The Journal of Nursing Administration*, 39 (2009), pp. 340-49.

Gillespie, et. al, "Implementation of a Comprehensive Intervention to Reduce Physical Assaults and Threats in the Emergency Department," *Journal of Emergency Nursing*, Vol. 40, Issue 6 (November 2014), pp. 586-91.

Howard, P., Gilboy, N., "Workplace Violence," *Advanced Emergency Nursing Journal*, 31 (2009), pp. 94-100.

Jacobson, Roni, "Epidemic of Violence Against Health Care Workers Plagues Hospitals," *Scientific American* (December 31, 2014).

Luck, L., Jackson, D., Usher, K., "Innocent or Culpable? Meanings That Emergency Department Nurses Ascribe to Individual Acts of Violence," *The Journal of Clinical Nursing*, 17 (2007), pp. 1071-78.

Speroni, et al., "Incidence and Cost of Nurse Workplace Violence Perpetrated by Hospital Patients or Patient Visitors," *Journal of Emergency Nursing*, Vol. 40, Issue 3 (May 2014), pp. 218-28.

Ventura-Madangeng, J., Wilson, D., "Workplace Violence Experienced by Registered Nurses: A Concept Analysis," *Nursing Praxis in New Zealand*, 25 (2009), pp. 37-50.

Wilkes, L., Mohan, S., Luck, L., Jackson, D., "Development of a Violence Tool in the Emergency Hospital Setting," *Nurse Researcher*, 17 (2010), pp. 70-82.

²Oren Yaniv, "Diet Pills Gave Queens Woman Insomnia, Put Her in Mental Hospital: Lawsuit," *New York Daily News* (January 9, 2014).

³Susan Cahalan, *Brain on Fire: My Month of Madness* (New York, Simon & Schuster, 2012).

⁴Personal Interview with Dick Sem, CPP CSC, President of Sem Security Management, an independent security and workplace violence consulting firm (March 2016).

⁵Speroni, et al., *supra* n.1.

⁶Gavin de Becker & Associates is a firm that protects people who are at risk, advises on the assessment and management of situations that might escalate to violence, and develops strategies for improving safety and privacy.

⁷Personal interview with James McGee, Ph.D. (March 2016).

⁸OSHA, *Workplace Violence Prevention and Related Goals* (December 2015), p. 2.

⁹The five states are Connecticut, Maryland, Massachusetts, New Mexico, and Tennessee.

¹⁰Jennifer Bain, "Kendra Webdale's Infamous Subway-Push Killer Says Mental-Health Law Needs to Be Restructured," *New York Post* (December 29, 2012).

¹¹Meg Kissinger, "Houston's Solution to Mental Health System Problems Offers a Case Study for Milwaukee," *Milwaukee Journal Sentinel* (June 8, 2013).

¹²OSHA & Worker Safety, "Guidelines for Zero Tolerance," *Environment of Care News*, Vol. 18, Issue 8 (August 2015), p. 8.

¹³*Id.*, p. 11.

¹⁴*Id.*, p. 10.

¹⁵*Id.*, p. 8.

¹⁶Mark A. Lies, II, ed., *Preventing and Managing Workplace Violence* (Chicago, ABA Publishing, 2009).

¹⁷Gavin de Becker, *Protecting the Gift* (New York, Dell Publishing, 1999) (see Ch. 5, "Talk to Strangers," where the author discusses the importance of parents teaching children how to select a stranger to talk to, should they ever find themselves alone and in need of help).

¹⁸Edward Doyle, "A 'Code Green' Initiative Boosts Safety and Satisfaction of Staff," *Today's Hospitalist* (June 2008).

¹⁹*Id.*

²⁰Scott Shafer, "Five Years After a Murder, California Hospital Still Struggles With Violence," KQED (October 20, 2015).

²¹*Id.*

²²*Id.*

Property Tax continued from p. 9

(adjusted to the subject property).

- A property owner will be barred from having a hearing or contesting an assessment if the owner refused the assessor the right to inspect the property after reasonable request was made by certified mail.
- If a property owner presents a written appraisal as evidence of value, the property owner should have the appraiser present sworn testimony in support of the appraisal. A property owner should present an appraisal for value—not an appraisal for financing or an estimate of value.
- It is essential that all forms are completely and accurately filled out.
- The BOR has the authority, usually invoked for complex appeals, to waive a BOR hearing and allow a property owner an appeal directly to the circuit court. The property owner may seek this bypass by timely filing a Request for Waiver form.

Property assessments are meant to be fair to all property owners. Objectors can enhance their chances of success by understanding and adhering to the rules, and by arming themselves with convincing evidence.

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¹City of Milwaukee residents must go through an intermediate step: filing an objection with the Board of Assessors. This body serves as a first level of appeal and screens cases for the BOR. A board of assessors normally does not hold a formal hearing.

²For an excellent and comprehensive discussion of the appeals process, see McAdams, "Over Assessed? Appealing Home Tax Assessments," *Wisconsin Lawyer* (July 2011).



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Sheridan Ryan Wins 2017 MBA Messenger Award



Sheridan Ryan

Statement of the panel of judges:

The *Messenger* Award Panel selects Sheridan Ryan of the Medical College of Wisconsin as the winner of the 2017 MBA *Messenger* Award for her article, “Zero Tolerance’ for Violence and Violent Patients: Sound Policy or Sound Bite?,” appearing in the Fall 2016 issue. At the outset, we three award judges note that the four issues over the past year offer a particularly rich array of well-written articles covering new case law, user-friendly help with various legislative mazes, timely public policy updates, and fascinating historical studies. Ultimately, we had to make a choice. We chose the “Zero Tolerance” article for several reasons.

The article describes the uneasy fit of the workplace violence “zero tolerance” OSHA guideline in the context of hospital settings. The “zero tolerance” guideline presupposes that an individual understands the consequences of his actions and has an ability to control his behavior. Using stories of people who, while suffering from medication errors, undiagnosed brain disease, or Alzheimer’s, engaged in discrete acts of violence in a health care setting, the author questioned whether those acts truly were within the person’s control. The author then suggested that state and national legislation should require more targeted training for healthcare workers to anticipate and prevent violence by persons who might not be able to control their own behavior. Zero tolerance, in the author’s opinion, puts the onus on the ill person and unduly relieves healthcare workers from any duty to protect or prevent.

This article merits an award because it broaches a topic affecting all *Messenger* readers as consumers and citizens, and not simply one particular practice group. The article is effective, as is good legislation, because it illustrates its policy position with compelling human stories of difficult situations. Most of the stories have happy endings. The article is heavily footnoted, providing a good bibliography for further study. Thanks to Sheridan Ryan for provoking us to think beyond the “sound bite.”

Each year a contributor is selected to receive the MBA *Messenger* award for the best article. Our panel of three reviews all four issues and chooses the article that is most interesting, timely, and clearly written.

Honorable Margaret D. McGarity
Honorable Beth E. Hanan
Attorney Kelly L. Centofanti

CLE Calendar

July 2017

All CLEs are at the MBA unless otherwise noted.

Monday, July 10
Grow Your Practice Institute: Effectively Managing Your Time
 4:00 - 5:15 p.m.
 Thomas M. Olejniczak, *Conway, Olejniczak & Jerry*
 Aaron T. Olejniczak, *Andrus Intellectual Property Law*
 1.0 CLE credit

Wednesday, July 26
Grow Your Practice Institute: Maximizing and Leveraging Your Online Presence
 4:00 - 5:15 p.m. with networking reception to follow
 Steve Ryan, *Founder & CEO, RyTech*
 Tim Pierce, *State Bar of Wisconsin*
 1.0 CLE credit

Wisconsin-accredited MBA Live Webcasts are available online through

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Thank you to our April, May, and June CLE presenters!

Annual ERISA Litigation Update
 Charles P. Stevens, *Michael Best & Friedrich*

CERCLA Litigation: The Basics
 Dillon J. Ambrose, *Davis & Kuelthau*
 Elizabeth K. Miles, *Davis & Kuelthau*

The Milwaukee County Children’s Court Unified Court—the Nexus Between Children’s and Family Courts
 Hon. Mary Triggiano, *Milwaukee County Circuit Court, Children’s Division*
 Susan Medina, *Milwaukee County Children’s Court, Children’s Division*
 Jane E. Probst, *Probst Law Offices*

Health Care Worker Protection
 James A. Schacht, *Wisconsin Department of Workforce Development*

How to Win Cases Under the Defend Trade Secrets Act
 Patrick Huston, *The Huston Law Firm*
 (San Diego, CA)

Westlaw Wednesday—Tax Research With Checkpoint
 David Wolak, *Thomson Reuters*

Understanding & Calculating Lost Profits for Litigation
 Benjamin Wilner, *Alvarez & Marsal*
 (Chicago office)

Startup Intellectual Property Issues
 Louis Condon, *gener8tor*

Recent Trends in False Claims Act Enforcement and Whistleblower Suits
 Doris E. Brosnan, *von Briesen & Roper*
 Stacy C. Gerber Ward, *von Briesen & Roper*

Family Court Judges Live and in Concert!
 Hon. Michael J. Dwyer, *Milwaukee County Circuit Court*
 Hon. Paul R. Van Grunsven, *Milwaukee County Circuit Court*
 Hon. Mary M. Kuhnmuench, *Milwaukee County Circuit Court*
 Hon. Kevin E. Martens, *Milwaukee County Circuit Court*
 Hon. Richard J. Sankovitz, *Milwaukee County Circuit Court*

Comm. Ana Berrios-Schroeder, *Milwaukee County Family Court Commissioner’s Office*
 Comm. David Pruhs, *Milwaukee County Family Court Commissioner’s Office*
 Susan A. Hansen, *Hansen & Hildebrand*
 Richard H. Hart, *Hart Law Office*
 Paul Stenzel, *Hansen & Hildebrand*

Westlaw: Practical Law Basics for New Attorneys and Summer Associates
 Steven Silverstein, *Thomson Reuters*

DNR Procedures for WEPA Compliance: The Revised Wisconsin Administrative Code NR 150
 David Siebert, *Wisconsin Department of Natural Resources*