The Bill Blackwood
Law Enforcement Management Institute of Texas

Threat Management at Academic Medical Centers

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ABSTRACT

Academic medical centers have a dual mission of education and patient care. These centers are highly charged environments with life or death decisions, circumstances, and situations occurring almost hourly. Following the mass killing on April 16, 2007 at Virginia Polytechnic Institute and State University (Virginia Tech), national attention was focused on the effective mitigation strategies to avoid future incidents. Many academic institutions made changes following this incident and the resulting studies and publications (IACLEA, 2008). A focus on prevention and threat management should be established because violence has occurred and will again. These attacks and incidents are preventable by early mitigation and prevention strategies. Academic medical centers should adopt the 2008 International Association of Campus Law Enforcement Administrators (IACLEA) blueprint for safer campuses in regards to the areas of prevention, education, planning, and preparation. The first steps are to adopt a formal education, early threat mitigation, and evaluation process to prevent work place violence. Through communication and collaboration, professionals can work toward safer hospitals for innovation in research, education, and patient care.

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INTRODUCTION

Through their teaching and health care missions, academic medical centers have a focus on education and patient care. These educational centers are highly charged environments with often life or death decisions, circumstances, and situations occurring almost hourly amidst a staff of varied levels of experience. Often bad news about a loved one's well-being is given inside the confines of these centers. On occasion, the staff does not meet family or patient expectations or adverse outcomes have occurred. At trauma medical centers, violence may carry over from the street either in retaliation or to complete attempted murders. The way these academic organizations function is slightly different from medical centers because they have to comply with the Department of Education Jeanne Clery Act requirements and often have a commissioned police staff.

Following the mass killing in 2007 at Virginia Tech, national attention was focused on prevention and the effective mitigation strategies to avoid these types of incidents. Many academic institutions made prevention changes as a result of lessons learned from this incident and the study of mass killings following the incident (IACLEA, 2008). In response, the 2008 International Association of Campus Law Enforcement Administrators (IACLEA) blueprint for safer campuses outlines specific recommendations in the areas of prevention, education, planning, and preparation. Primarily, these recommendations were based on the report of the review panel on the mass shootings at Virginia Tech (Virginia Tech Review Panel, 2007). Because most shooters in higher education have given some type of warning prior to the escalation to violence in hindsight, some of these incidents are preventable (Fein et al., 2004). When

considering the progression of an incident as a timeline where behaviors get increasingly alarming until violence occurs (see Figure 1), *left of boom* is the term the military has used for layered preventive measures put into place to prevent an improvised explosive device (IED) (Harwood, 2012). Military leaders first approached US Congress for heavily armored Humvees for protection of the troops when an IED explodes and then later returned for additional funding to prevent these attacks. A *focus left of boom* has become the terminology used to explain focus on preventive efforts. This terminology can be applied to this violence prevention and the focus on the prevention side while still preparing for the response or *right of boom*.

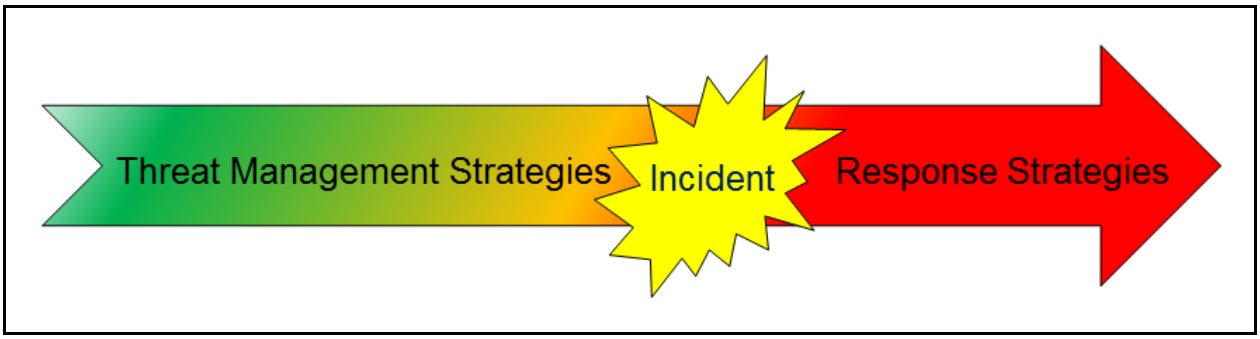

Figure 1. Timeline of threat through incident and response - Left and right of boom

It is incumbent upon the academic medical campus police authority (further referred to as police) to focus increasing efforts left of boom while at the same time having their staff prepared to respond right of boom. This is first accomplished by educating the public on identifying and promptly reporting behaviors of concerns and potential domestic violence spillover situations, as well as how to properly respond during an emerging threat. Secondly, a well-established and policy guided multidisciplinary behavioral intervention team (BIT) must be in place to centralize threat assessment, evaluation, and communication for the academic medical center. Third, a rapid threat assessment, mitigation, and management strategy must be in place to

mitigate the risk. Finally, proper planning, preparation, and training must be in place to respond to the right of boom. This takes efforts from all areas of the academic medical center as well as continued training for the police. Academic medical centers should adopt a formal education, early threat mitigation, and evaluation process to prevent work place violence.

POSITION

A focus on prevention and threat management should be established because violence has occurred and will again. In a study of hospital-based shootings in the United States from 2000 to 2011, it found that there were 154 hospital-related shootings with 235 injured or dead victims, which is roughly a third of what occurred in and around emergency centers (Kelen, Catlett, Kubit, & Hsieh, 2012). According to a April 2010 joint report by the United States Secret Service, the United States Department of Edcuation, and the Federal Bureau of Investigation, colleges and universities have been steadily increasing in number of attacks with increase in student population (Appendix A). For example, from 1950s to 1980s attacks doubled but student population tripled. A more recent study by Blair and Schweit (2013) on overall active shooters showed an increasing trend from 2000 where one incident occurred to 2013 where 17 incidents occurred in the United States (Appendix B). A 2015 Occupational Safety and Health Administration (OSHA) publication found that healthcare workers were at a “significant risk” of violence over that national average (Appendix C)

These attacks and incidents are preventable by early mitigation and prevention strategies. Behaviors of concern can be identified and then strategies put in place well before the situation escalates and a violent act occurs. The April 2010 campus attacks

study found several pre-incident behaviors of subjects, e.g., stalking/harassing behavior, verbal/written threats, or physically aggressive acts (Drysdale, Modzeleski, & Simons, 2010). These behaviors could have caused a notification, then an evaluation and a mitigation strategy to prevent violence. Fein, Vossekuil, & Holden (1995) stated "Careful analysis of violent incidents shows that violent acts often are the culmination of long-developing, identifiable trails of problems, conflicts, disputes and failures" (p. 3).

In 2009, the National Behavioral Intervention Team Association (NaBITA) described three levels of aggression: trigger phase, escalation phase & crisis phase (Sokolow et al., 2009). Each phase in this initial publication has behaviors that correspond to increasing aggression. In the 2014 NaBITA whitepaper on *Threat Assessment in the Campus Setting,* it outlines nine levels of hostility and violence on an escalating scale (Sokolow et al., 2014). If these behaviors can be identified and brought to the police for documentation and mitigation, then a potentially hazardous situation can be avoided. If an academic medical center has long term relationships with patients and family members, an upward trend of aggression of patients and family members can be documented and reviewed for risk.

According to Carnell (2010), "In 2007, the landscape of campus safety changed abruptly" (p. 8). Since the mass shooting at Virginia Tech, there has been a move toward prevention in higher education, including implementation of BITs and the formalization of assessments (Sokolow, 2009). These strategies are professionally accepted and failure to implement them may put institutions in a precarious situation or outside compliance of the Department of Education Jeanne Clery Act. In the Commonwealth of Virginia, Virginia Code 23-9.2-10, it requires each public college and

university have a violence prevention committee and a threat assessment team (Carnell, 2009).

Even as far back as 2002, in a review of New Jersey hospital emergency departments, 82% stated that they had received training on workplace violence (Peek-Asa et al. 2002). Of these, 81% stated part of that training included aggression and violence predicting factors (Peek-Asa et al. 2002). In 2011, Sulkowski and Lazaus (2011) stated, “In instances in which students pose a danger to the campus community the threat assessment team should determine the degree to which the student is dangerous or the likelihood that this student will carry out a threat” (p. 344). Almost all of these studies and reports described the threat assessment team or BIT as a multidisiplinary team comprised of some combination of campus leadership, mental health practitioner, legal representative human resouces representative, and police or security representative. NaBITA published results of a 2014 BIT survey where the most common members were councelling, police/campus safety, the dean of students, student conduct, and residential life (Van Brunt, Reese, & Lewis, 2015).

An open line of communication needs to occur between nursing staff and police departments of the ongoing aggressive behaviors of patients and family members. Incidents seen by nursing staff from all areas need to be combined with all police reports on patients and family members to be sure an accurate picture is available. At this point, the risk can be assessed and a mitigation stategy put in place.

COUNTER POSITION

Some research has been conducted that shows people with mental illness are discriminated against in the workplace and often have a stigma attached to them

(Russinova et al., 2011). The stigma is that people believe these mentally ill persons are aggressive and uncontrollable. Many advocates believe that campus police looking into the mental illness of students or employees is a violation of medical privacy and can create discrimination against these students, employees or patients. These advocates have concerns about the employee assistance program (EAP) psychiatrists assigned to the behavioral intervention teams and the dissemination of private medical information by this staff (Russinova et al., 2011). The fear is that once these students, employees, or patients are labeled, they are treated differently in class, at work, and throughout the campus community. Under law, patients have an expectation of privacy and protection of their personal health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These patients could include patients or even employees or students who are attending EAP counseling sessions. In reality, most campus police officers have significant experience properly handling mentally ill persons and have specialized training in this area. For example, in Texas, all officers are required to have an in person course on de-escalation and crisis intervention training (Texas Commission on Law Enforcement, 2016).

As far as privacy is concerned, health care providers may disclose PHI if the patient presents a serious threat to themselves or others (U.S. Department of Health and Human Services, 2008). There has been a significant amount of cases where the care provider and or their employer has been held liable because they failed to disclose information prior to an attack occuring or failed to give warning and protect the potential victim. Enough of these cases have occurred that they are refered to as a psychiatrist's "Tarasoff Duty to Protect", named after the landmark Tarasoff V. Board of Regents case

(Greene, 2006). Further, guidance for a mental health professional's navigation of the legal realm of threat assessment has been published in the *Journal of College Student Psychotherapy* (Nolan & Moncure, 2012)

Drysdale et al.(2010) stated that students or former students did 60% of the attacks where the subjects' affiliation was identified in campus attacks 1909 to 2009. Because of this, students should expect as much scrutiny as anyone when preventing violence on campus. Patient and family member incidents involving security or incidents that threaten the safety and calm operation of a medical operation should be properly documented and tracked.

Encouraging reporting of domestic violence victims to police may be a violation of the employee or student's privacy. Many advocates believe that domestic violence victims have been victimized enough and to be further scrutinized by their university or workplace is repeating that pattern of victimization. They believe that their status as a victim and the fact that they may be currently going through marital issues is a private matter that should be separated from the workplace or their status as a professional student. Goodman and Leidholdt (2006) stated, "A job can provide a victim with the economic independence she needs to leave an abuser" (p. 330). Advocates believe that employers are being discriminatory if they hold their status as victim against an employee in any way, and employers may be required to make reasonable accommodations under law (state dependent).

Often domestic violence can spill over to the workplace. According to New York Courts, three studies have shown that between 35-55% of domestic violence victims are harassed at work by the abuser (Goodman & Leidholdt, 2006). The victim often moves

out of the co-habitation location to an undisclosed location, but that victim still needs to go to the same office or classroom, so this is where the abuser comes to confront the victim. The campus attacks study found that the number one factor of motivation (and occurred more than twice as often as that of the next factor) was related to intimate relationships, which was 33% of the cases (Drysdale et al., 2010). Employees and students should be shown to recognize signs of domestic violence, so that these victims can get the assistance they need before the situation escalates and puts everyone in the classroom or workplace at risk. These at risk employees or students can be directed to EAP for assistance and guidance.

RECOMMENDATION

Academic medical centers are highly charged environments that have to comply with the Department of Education Jeanne Clery Act requirements. These large centers often have a commissioned police staff to leverage for expertise, risk assessments and response strategies. Following the Virginia Tech event in 2007, the focus is on the left of boom mitigation strategies to avoid future incidents as well as ensuring institutions are well prepared right of boom if an unfortunate incident should occur.

Academic medical centers should adopt the 2008 International Association of Campus Law Enforcement Administrators (IACLEA) blueprint for safer campuses in regards to the areas of prevention, education, planning, and preparation. The first step is to adopt a formal education, early threat mitigation, and evaluation process to prevent work place violence. Violence has occurred and will again: 154 hospital-related shootings occurred from 2000 to 2011 (Kelen et al., 2012) and attacks at colleges and universities have been steadily increasing in number of attacks from 1909 to 2009

(Drysdale et al., 2010). Active shooter incidents appear with increasing frequency in the news. The difference here is that in 60% of the attacks where the subjects' affiliation was identified, it was carried out by a student or former student (Drysdale et al., 2010). Behaviors of concern can be identified and addressed making these attacks preventable. Strategies can be put in place well before the situation escalates (problems to disputes to increasing aggression) and a violent act occurs.

Failure to implement these professional accepted strategies will put institutions in a precarious situation and outside compliance of the Department of Education Jeanne Clery Act. Because of the historic discrimination against people with mental illness, police should be cognizant and ensure officers are properly trained to handle this special population and protect privacy where they can. Sufficient mental health peace officers should be on staff to limit escalation, work closely with the psychiatric staff, and get students and employees the help that they need. These officers are familiar with the laws concerning release of PHI if threats are present. On staff EAP psychiatrists should be sure that they are cognizant of requirements to protect under Tarasoff and law. Domestic violence can spill over to the workplace, and officers need to be sure to avoid re-victimization of victims.

Educating and preparing the public on identifying and promptly reporting behaviors of concerns and de-escalating in-justice collectors is important. Employees and students should be educated on recognizing signs of domestic violence so that these victims can get the assistance they need before the situation escalates and puts everyone in the classroom or workplace at risk. Employees and students should learn about the survival mindset and proper strategies to employ in an active shooter incident:

RUN, HIDE, FIGHT! Nurses should be reporting any aggressive or threatening behaviors by patients.

Secondary is an established and policy guided multidisciplinary behavioral intervention team (BIT) that must be in place to centralize threat assessment, evaluation, and communication. This should be a multidisiplinary team comprised of some combination of campus leadership, mental health practitioner, legal representative, human resouces representative, and police or security representative. This group could attend threat assessment training together and work closely and openly where policy and law permits.

Third, a rapid threat assessment, mitigation and management strategy must be in place to mitigate the risk. If an imminent risk is established, many processes should begin. In larger agencies with more resources, these tasks can be given to subject matter experts in each area. Officers need to inform the BIT and keep them updated. Officers need to gain intelligence and search all databases on the threatening party as well as the victim. If a criminal case can be made at this point, on or off property, this should be explored. A threat assessment of the work or educational area of the campus should be conducted and mitigation strategies put in place. If needed, patrol should step up patrols or help hand out crime alert bulletins. This procedure should be standardized where all areas know their responsibilities, escalation options, and de-escalation options depending on risk.

Finally, proper planning, preparation, and training must be in place to respond to the right of boom. This takes efforts from all areas of the academic medical center as well as continued training for the police. It is important that departments of the

institution ask themselves what their role is in an active shooter incident, e.g., communications will have to help with media and patient affairs and nursing will have to help with patients. These areas need to make their plans accordingly. Academic medical centers should adopt a formal education, early threat mitigation, and evaluation process to prevent work place violence.

Force on force simulation is a preparation tool for the police response right of boom (if an event occurs). This training should be conducted as well as tabletops and full drills. Tabletops should include members of the campus community. Full drills should incorporate staged arrival, commanders, communication, team leadership, operator tactics, medical triage, and emergency medical care. Firearms and team movement drills should be trained on at firearms training time. Police officer shooting decision-making training can be conducted on simulators and in force on force training.

This effort of prevention cannot be owned by the police component of the academic medical center alone. It should be a holistic and team effort to confront this problem before it occurs. Prevention can only occur with honest communication and proper planning.

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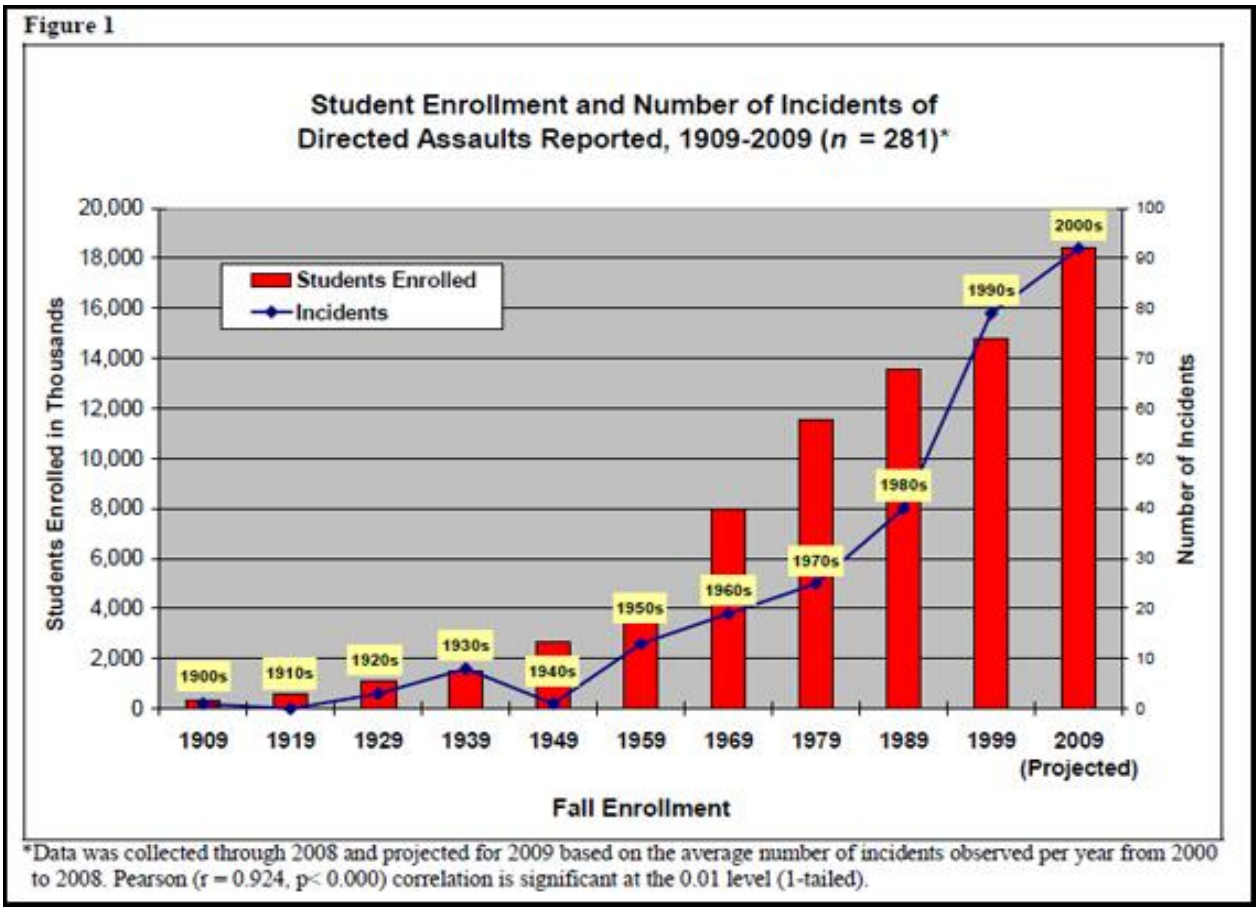
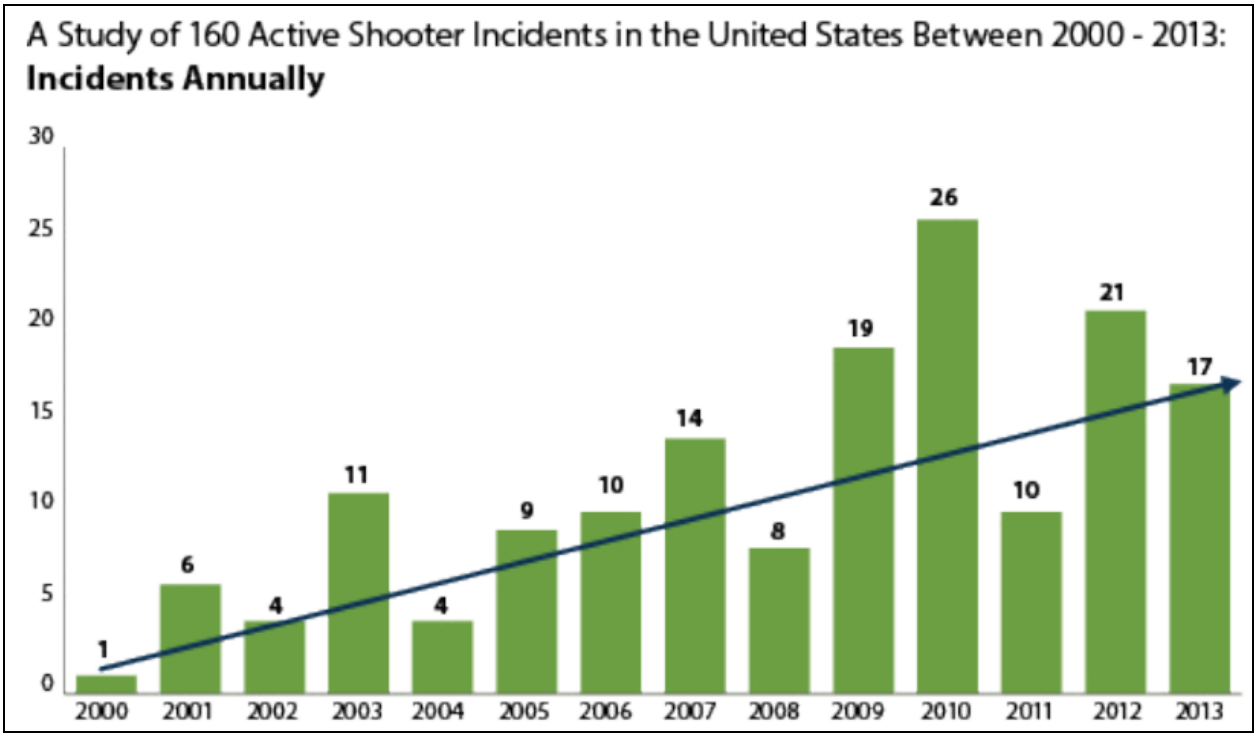
APPENDIX A



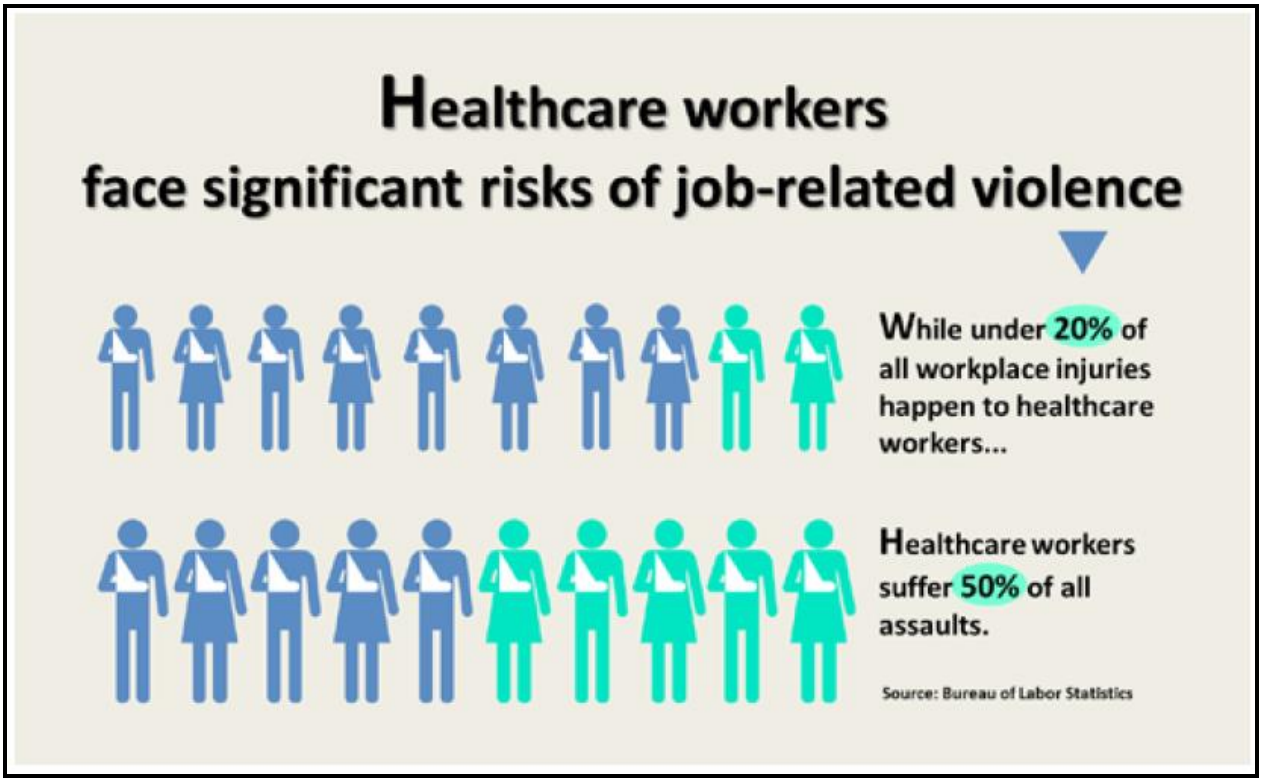
Appendix A - Campus Attacks 1909-2009 (Drysdale, Modzeleski, & Simons, 2010)

APPENDIX B



Appendix B – A Study of 160 Active Shooter Incidents in the United States Between 2000 – 2013 (Blair, J. Pete, and Schweit, Katherine W., 2014)

APPENDIX C



Appendix C – OSHA review of Bureau of Labor Statistics (Blair, J. Pete, and Schweit, Katherine W., 2014)