Security officers are an integral part in reducing disruptive behavior and assaults on behavioral health units, in Emergency Departments, and clinics by preventing patients from harming themselves and others. To better incorporate security services into the patient care team, hospitals should support inservice programs that foster collaborative working relationships for both security officials and hospital staff to improve the inpatient experience. These innovative programs and strategies are outlined within this document.

Presented by the **ASIS Healthcare Security Council**

STRATEGIES TO ENHANCE SECURITY'S ROLE IN REDUCING VIOLENCE ON BEHAVIORAL HEALTH UNITS

Written and developed by **Dan Yaross, CPP** *(MSM, CHPA);* **Nicholas Kane** *(MPA, BA);* **Bryan Warren**; **Drew Neckar, CPP** *(CHPA);* **Mike Hogan, CPP** *(MBA);* **Thomas Lynch** *(MPA);* **Robert W. Horton** *(MSN, BC);* **Elhadji A. Sarr, CPP**; **Bartholomew Bennett** *(CHPA);* **Terry L. Jones, CPP** *(CHPA, CHSP, CHEP);* **Marilyn Hollier, CPP** *(CHPA); and* **Bernard J. Scaglione, CPP** *(CHPA, CHSP)*

December 2015

The ASIS Healthcare Security Council provides resources and information on healthcare best security practices. Our mission is to provide credible and progressive sources of information and to lead on issues affecting healthcare security, which include forums that foster the exchange of information and ideas. To achieve this objective, the ASIS Healthcare Security Council establishes and promotes excellence in the healthcare profession by developing and delivering the highest quality educational programs in security and related disciplines in safety, emergency management, risk management, transportation, parking, and communications.

To this end the ASIS Healthcare Security Council publishes white papers on topics that are significant to the healthcare security industry. Because in the United States the health care industry has changed its financial perspective due to the Affordable Care Act, this white paper was created to provide supporting documentation on a topic for health care security professionals to create and sustain a cost-effective security program for the future.

This document was written by members of the ASIS Healthcare Security Council. A very special thanks to the council members who contributed and participated in its development. These members volunteered their time and hard work to create a credible and progressive document.

Ben Scaglione, CPP
Member Sponsor and Editor

ASIS INTERNATIONAL® | Healthcare Security Council

INTRODUCTION

Over the past decade, healthcare security professionals have seen a steady increase in violence occurring within their institutions. Contributing to this violence is an increase in the number of behavioral health patients seen with hospital emergency departments. This increase was caused by the slow decline in behavioral health funding throughout the United States over the past few decades. The lack of access to care for pyschological illnesses, substance abuse, and alcoholism has caused hospital emergency departments to bear the brunt of care decline. Emergency rooms today care for more behavioral health issues than ever before with very limited resources, training, and understanding of the care necessary for this specialized service.

In an article by the *Florida Courier Times/Herald-Tribune* published October 29, 2015 entitled, "Insane. Invisible. In Danger", by Leonora LaPeter Anton, Michael Braga, and Anthony Cormier, the authors indicated that years of neglect and $100 million in budget cuts for the State of Florida have turned state-funded mental hospitals into treacherous warehouses where violence is out of control and patients can't get the care they need. The article reports violent attacks at the state's six largest hospitals have doubled since 2009. Nearly 1,000 patients ordered to the hospitals for close supervision managed to injure themselves or someone else. State records and police reports show 23 acts of violence against patients or workers at the four hospitals that house people until they are fit to stand trial. In 2010, there were 47. The number increased to 72 by 2014.

The *Tampa Bay Times* and *Sarasota Herald-Tribune* spent more than a year chronicling life in these institutions, interviewing patients and their families, and examining thousands of pages of governement records. The newspapers found that over the past five years, at least 15 people died after they injured themselves or were attacked by other patients. One man with a history of suicide attempts jumped off the eighth floor of a parking garage. Another was stomped to death because no one separated him from rivals even though they had beaten him up the night before.

The authors cited this example:

> Daniel Lamar Mosley, a chronically homeless man, was sent to North Florida Evaluation and Treatment Center in Gainesville in June 2010 after he wandered naked outside a homeless shelter. Police found him standing in a daze in front of people, including children, and arrested him for exposing himself. Two months later, he argued with another patient in the TV room—one of the busiest parts of the hospital. Video cameras captured Errol Lyndon Lewis, 34, knocking Mosley to the ground and kneeling down to hammer his face with his fists, 18 times in all. Then Lewis stood up and stomped Mosley's head. Lewis walked away, leaving Mosley unconscious on the floor for 30 seconds. Still, no help came. Lewis had time to return, kneel over his victim and choke him until blood oozed from his nose. Mosley survived the beating after doctors treated his broken skull, face and jaw. Florida taxpayers were left with more than $60,000 in emergency room bills.

The *Denver Post* published a similar report on November 23, 2014 entitled, "A Broken Mental Health System", by Jennifer Brown. In her report, Brown indicated that the mental health care system in Denver was in crisis. More than 50 years after states began closing mental institutions, the system hasn't recovered—leaving emergency rooms, jails, and shelters as last-ditch stops to handle the most severe mental health cases. Violent events in Colorado have raised alarms over failures of the country's mental health system, even as Colorado's suicide rate has risen to the sixth highest in the nation. Brown pointed out that hospital emergency rooms are built to handle heart attacks and gunshot wounds, not mental breakdowns. Yet emergency departments in Denver are filled with patients having panic attacks or suicidal thoughts. People seeking mental health treatment in emergency departments are usually sent away with phone numbers of local therapists. The wait to see a psychiatrist in this city is about five months long. Colorado has only 15 psychiatrists per 100,000 people, compared with 92 primary-care physicians.

The *Denver Post* article goes on to cite an example of the mental health problems in Denver:

> Dee Fleming tried to protect her son from the voices in his head, the ones that told him he should die. She chased after him the night he ran toward the neighborhood church with a baseball bat in his hand. She worried to the point of exhaustion when he didn't come home at night, then returned beat-up and missing his watch. She thought she was holding it together, if barely. One day last April, when he was oddly quiet and confused, almost catatonic, Fleming took him to Swedish Medical Center's emergency room and told doctors he was suicidal. They sent him home. Two days later, Fleming's son downed dozens of prescription medications and household cleaning supplies, doused himself with gasoline and set himself on fire in her front yard. He lived only because a neighbor called 911 to report something smoldering on the lawn. A police officer who knew him kept him conscious until an ambulance arrived. What came next for the Fleming family was almost as shocking, a battle for treatment that epitomizes the massive breakdown in care for mental illness in Colorado and the nation. Doctors treated his burns but not his mind. Despite the family's pleas and a months-long battle, their 37-year-old son was released from Porter Adventist Hospital to a transitional shelter.

USA Today on May 12, 2015 outlined this longstanding problem in their series, "A Man-Made Disaster: A Mental Health System Drowning from Neglect", by Liz Szabo. According to the report, more than half a million Americans with serious mental illness are falling through the cracks of a system in tatters. The mentally ill have nowhere to go and often land hard in emergency rooms, county jails, and city streets. States have been reducing hospital beds for decades because of insurance pressures as well as a desire to provide more care outside of the hospital. Tight budgets during the recession forced some of the most devastating cuts in recent memory, says Robert Glover, executive director of the National Association of State Mental Health Program Directors. States cut $5 billion in mental health services from 2009 to 2012. In the same period, the country eliminated at least 4,500 public psychiatric hospital beds—nearly 10% of the total supply. The *USA Today* report included this example:

> A psychotic patient spent two weeks in the same ER, waiting for a psychiatric bed to open up, says Ray Keller, medical director of the emergency room at Burlington's Fletcher-Allen Healthcare, where Kelley was treated. "We've got patients living in our emergency department," he says. In some hospitals, psychiatric patients get private rooms in the emergency department. Elsewhere, they may "board" in hallways, surrounded by noise, trauma and bright lights 24 hours a day,

> says Mark Pearlmutter, vice president and chief of emergency network services at Steward Health Care in the Boston area. Some patients are physically restrained. The backups are so severe that they threaten the care given to all emergency patients, as those without mental illness are forced to wait longer for care, says John Bednar, medical director of Cone Health Emergency Services in Greensboro, N.C.

USA Today reported that mental illness sends nearly 5.5 million people to emergency rooms each year, accounting for 4% of all visits, according to the federal Agency for Healthcare Research and Quality. Because many of the mentally ill are uninsured, hospitals often are uncompensated for their care, according to Mark Pearlmutter. These visits increase the burden both on hospitals and taxpayers, who support emergency care through payments to medical centers that treat a "disproportionate share" of indigent patients. In fiscal year 2012, the USA spent $11.4 billion on these payments, about $456 million of that going to the care of the mentally ill.

U.S. News and World Report published an article on July 21, 2015 entitled, "What to Do During a Mental Health Crisis" by Anna Medaris Miller. In the article, Anna quotes the Center for Disease Control and Prevention who estimates that more than 4 million people visited the emergency room due to a mental health condition from 2009 to 2010. The CDC found during the same years that Americans made 63.3 million visits to doctor's offices, hospitals, and emergency rooms for what were eventually diagnosed as mental disorders. "The reality is, a mental health crisis is a common occurrence," says Paolo Del Vecchio, who directs the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services.

Jenny Gold published an article titled, "Mentally Ill Languish In Hospital Emergency Rooms," on April 13, 2011 for the NPR Partner, part of the Kaiser Health News. In the article, she stated mentally ill patients often languish in hospital emergency rooms for several days, sometimes longer, before they can be moved to a psychiatric unit or hospital. At most, they get drugs but little counseling, and the environment is often harsh. 70% of emergency department administrators report they hold mentally ill patients for 24 hours or longer, according to a 2010 survey by the Schumacher Group, a Louisiana firm that manages emergency departments across the country. 10% said they had boarded some patients for a week or more. Most administrators said delays compromise patient care in the ER, increasing waiting times for all patients, and cause overcrowding.

The problem has worsened during the economic downturn since 2009. 32 states have cut their mental health budgets, largely from outpatient services that keep people healthy and out of the ER, according to a study by the National Alliance on Mental Illness, a patient advocacy group. Since 2010, states have closed or planned to close nearly 4,000 state psychiatric beds (about 8% of capacity) according to the National Association of State Mental Health Program Directors Research Institute.

Gold cites several experts in the field like Dr. Gary Bubly, an emergency physician at Miriam Hospital and president of the Rhode Island Medical Society. He said, "The inside of the ER is kind of like Las Vegas [with a] 24/7, 365 day flow of activity. While the ER staff does its best to care for mentally ill patients, it's the wrong place for someone in the midst of a psychiatric crisis."

"Emergency rooms are for people with heart attacks and gunshot wounds, and it is just a disgrace that mentally ill people can be held two, three, five days, eating ham sandwiches in total chaos," said H. Reed Cosper, Rhode Island's mental health advocate.

"We're not cutting fat anymore," said Charles Ingoglia, vice president of public policy at the National Council for Community Behavioral Healthcare, a membership organization for mental health organizations that treat the uninsured and underinsured. "We're at the bone. All of the easy cuts have already been made over the years."

However, there is hope on the horizon. In an article published on May 11, 2015 in *Hospitals and Health Networks* titled, "Four Ways Hospitals are Improving Behavioral Health Care" by Geri Aston, health systems can create behavioral health strategies that improve access and care for behavioral health patients. These strategies can take the pressure off the emergency department. The hectic, stressful nature of the typical emergency department makes it a less than ideal setting for mental health care. Nevertheless, hospital EDs have become a major component of the nation's de facto behavioral health system.

At New York's Montefiore Health System, requests by primary care physicians for help in treating patients with behavioral health issues sparked an initiative that embedded social workers and psychiatrists in each of its 23 primary care sites. The new care model includes universal depression screening for patients at the primary care clinics at least once annually, but ideally at each visit. The self-administered screening starts with a two-question tool. Patients who screen positive then get a nine-question tool. Primary care physicians refer patients who again score positive to the social worker who, in some cases, is able to see the patient in the same visit. After a full psychosocial evaluation of the patient, the social worker consults with the psychiatrist and they decide whether the patient needs a referral to the psychiatrist. Having social workers and psychiatrists on the care team provides relief for primary care physicians.

Over the years, Atlantic Health System in New Jersey has built a continuum of behavioral health care that reaches from inpatient mental health and emergency department services to outpatient therapy and even partial hospitalization and residential care. Now it is working to fold behavioral health into its hospital-owned, community-based practices. Atlantic has embedded psychologists in many departments, such as diabetes, pain management, oncology, cardiology and bariatrics. Integrating behavioral health into those departments removes the stigma associated with mental health care and improves patient compliance with treatment according to Lori Ann Rizzuto, the director of behavioral and integrative health services. Take for example behavioral health integrated into the diabetes curriculum. "You have the nutritionist, the diabetes educator and the psychologist. It doesn't seem to be odd in any way because they're part of the team," she said.

The 2010 closure of a state mental health hospital caused alarm in the St. Louis-area health care community over the increased demand it would have on an already overburdened system. To come up with solutions to the problem, local hospitals and community mental health centers partnered to create the Behavioral Health Network of Greater St. Louis. The organization developed the Hospital-Community Linkages Project that facil-

itates referrals from hospitals to community mental health centers and improves care coordination between them. The project is funded primarily by the state and by an annual fee paid by participating hospitals. It target patients who are uninsured or on traditional Medicaid, who aren't already linked with a service provider, and who have a serious mental illness. On the inpatient side, each of the 11 participating hospitals and seven CMHCs has a dedicated liaison. When a hospital is discharging a patient from its inpatient psychiatric unit, the liaisons participate in discharge planning, schedules an outpatient appointment and transfer medical information, says Wendy Orson, the network's CEO. The initiative is expected to generate 700 or more referrals from inpatient units this year.

In the project's ED component, emergency department staff or the hospital liaison calls Behavioral Health Response, a nonprofit mental health crisis response provider with 24/7 mobile outreach services. If the mobile outreach team is available, it goes to the ED to meet the patient and schedule an outpatient appointment. If the patient leaves before the team gets there, it follows up within 24 hours. The program generates about 540 referrals from EDs each year.

Florida's Lee Memorial Health System is taking several approaches to connecting ED patients with mental health and/or substance abuse problems to the outpatient care. The system is part of a multiagency collaboration supporting the Bob Janes Triage Center & Low Demand Shelter, which serves homeless people with mental health or substance abuse disorders. The voluntary shelter, opened in 2008, provides an alternative to jail for people whose behavioral health condition or substance abuse puts them at risk of being arrested for low-level, nonviolent offenses. The bulk of shelter admissions, 71%, are pre-arrest diversions by law enforcement. But the second largest admission source, at 19%, is Lee Memorial. The 58-bed shelter is housed on the Fort Myers campus of SalusCare, a mental health and substance abuse service provider that offers treatment and social services to shelter patients. Emergency patients who would benefit from the triage center are identified by ED nurses or physicians who alert a social worker or case manager, explains Heidi A. Shoriak, R.N., Lee Memorial's director of care management. After eligible patients are medically evaluated and cleared, the social worker or case manager checks whether a shelter bed is open and arranges patient transportation. "You're doing the right thing by helping someone to get off the streets," said Chris Nesheim, R.N., vice president of care management. "It can be life-changing."

Many hospitals are trying to better care for behavioral health patients. Within any behavioral health care model security plays a significant role. Often security officers are assigned to provide patient watches—sitting next to or in close proximity to the patient—in order to keep behavioral health patients from harming themselves or others. The officers respond to situations where patients are in crisis, acting out, or struggling to keep their composure. Patients do become violent, lash out and strike staff or other patients, try to run out of the hospital or clinic, and attempt to commit suicide. Several hospitals have developed programs and strategies that incorporate security services as part of the patient care team to effectively reduce disruptive behavior and assaults. These innovative programs and strategies are outlined within this white paper.

REFERENCES

"Insane. Invisible. In Danger." by Leonora LaPeter Anton, Michael Braga, and Anthony Cormier. *Florida Courier Times/ Herald-Tribune.* Published October 29, 2015.

"Special Report: A Broken Mental Health System" by Jennifer Brown. *Denver Post.* November 23, 2014.

"Cost of Not Caring: Nowhere to Go. The financial and human toll for neglecting the mentally ill" by Liz Szabo. *USA TODAY.* May 12, 2014.

"What to Do During a Mental Health Crisis" by Anna Medaris Miller. *U.S. News and World Report.* July 21, 2015.

"Mentally Ill Languish in Hospital Emergency Rooms" by Jenny Gold. NPR Partner, part of the Kasier Health News. Published April 13, 2011.

"Four Ways Hospitals Are Improving Behavioral Health Care" by Geri Aston. *Hospitals and Health Networks.* May 11, 2015.

ASIS INTERNATIONAL
Advancing Security Worldwide®

1625 Prince Street
Alexandria, VA 22314
+1.703.519.6200
asisonline.org

Presented by the **ASIS Healthcare Security Council**

STRATEGIES TO ENHANCE SECURITY'S ROLE IN REDUCING VIOLENCE ON BEHAVIORAL HEALTH UNITS

CASE STUDIES

CONTENTS

ASIS INTERNATIONAL® | Healthcare Security Council

ENHANCING THE BEHAVIORAL HEALTH SERVICES SECURITY ENVIRONMENT

by **Dan Yaross, CPP,** *(MSM, CHPA)*

Dan Yaross, CPP has over 30 years leadership experience and is currently the Director of Security at Nationwide Children's Hospital, Columbus OH. He previously served as Director, Cincinnati Children's Hospital Medical Center.

He holds a Bachelor's Degree from Ohio State University and a Master's of Science in Management Degree from Troy State University. He retired from the U.S. Army in 1995. He continued his management career in a private security company and over the past 14 years in the healthcare security field. He has held a variety of leadership positions throughout his military and civilian careers. He has been a speaker at a number of National Security and Nursing seminars. Dan can be reached at (614) 722-2126 or by e-mail: Dan.Yaross@nationswidechildrens.org.

Abstract

In addition to servicing behavioral health patients in clinical and inpatient settings, the department's community-based section treats many patients at the patients' homes. This service can represent a significant risk to the hospitals, as they are working in some cases with potentially physically violent patients to include some Autistic children. In geographic areas in which they work or drive through Central Ohio, there are risk concerns due to higher crime rates than other portions of the city. Currently behavioral health unit averages over 40,000 visits to patients' homes and schools. Some of these homes and schools are in economically and/or crime challenged areas, which has made safety a concern for some staff. Each of these visits represent various types and levels of risk to not only the clinicians, but to the hospital overall. To address these risks, the security department provides behavioral health unit with "Safety in the Field" (personal safety) training as well as assisting them in reviewing and selecting appropriate technology, such as an appropriate cellular smart phone app or GPS/mobile duress technology option for the clinicians. This equipment need has been placed in the operating budget for approval.

Background

Nationwide Children's Hospital (NCH Behavioral Health) in Columbus, Ohio, provides a comprehensive service line dedicated to children and adolescents suffering from problems of emotional, behavior, development, thought, and adaptation to life challenges, including those associated with physical illness and trauma.

Objective

Behavioral health and psychiatry staff are committed to partnering with patients, families, as well as referring primary care clinicians and specialists to deliver services and achieve the best possible clinical outcomes. Services to the patient population are provided through an array of services to include inpatient stays, outpatient clinics, as well as a significant community-based practice.

Methodology

The hospital has provided behavioral health services in both the community-based and outpatient clinic environments for several years. However, a large segment of the patient population were not being serviced well in Central Ohio. Therefore the hospital decided on creating and opening the Inpatient Psychiatric Unit in November of 2014 and now provides service across the entire spectrum of the pediatric/adolescence patient population. The security department recognizes different risks and risk levels for each of these environments and provides mitigation strategies to enhance staff's personal safety.

Results

Outpatient Clinic Program. In 2014, the security department received approval to place an officer at two different areas that have clinics solely providing services to behavioral health patients. One site is about 12 miles away from the main campus at two leased facilities. The buildings are separated by approximately the distance of a city block. The officer services both locations and responds to requests for assistance in addition to conducting random patrols of the buildings and parking lots. Less than a mile away from campus, there are behavioral health clinics in three different leased buildings near downtown Columbus. Security has placed an officer to patrol and respond to those locations. The service has been frequently used and much appreciated by the clinics' staff.

Additionally, Nationwide Children's Hospital (NCH) has several other off-site locations that operate Urgent Care and Primary Care clinics. At some of these locations, behavioral health patients are provided services. NCH security officers or officers from a private security company provides coverage at these locations to assist. Since the behavioral health patient population represents a higher risk than most others, the security department works collaboratively with behavioral health staff to enhance the security environment at these locations. Members of the security management staff conducted security assessments of every facility and compiled a report outlining areas of vulnerability, along with offering various mitigation strategies to improve the safety/security issues. It concluded security officer staffing is sufficient to safely manage behavioral health patient incidents at the main campus, but not at the off-site locations. The behavioral health department selected a nationally recognized de-escalation and crisis intervention training program that will be discussed below. All security officers, along with the behavioral health department and selected nursing units, participated in the training together.

Inpatient Psychiatry Unit. NCH opened a sixteen-bed, inpatient psychiatry unit in November of 2015. In preparation for the opening, all security officers and the behavioral health department and nursing staff were trained in the Western Pennsylvania Medical Center, Western Psychiatric

Institute and Clinic's Comprehensive Crisis Management Program (Safe Hold techniques).

Soon after the opening of the psychiatric unit, the hospital realized there was an urgent need for an inpatient unit based on the growing waiting list that quickly formed to place patients there. The hospital collaborated with architects, engineers, and multiple departments within the hospital including Security in order to design and build a safe and secure environment for the patients and staff. The lengthy design and construction project for this specialty unit was quite interesting and with all of the safety topics discussed during the period, could comprise an article on its own. When the unit opened and the hospital began experiencing a growth in behavioral health patients presenting at the emergency department (ED), the hospital responded to the concerns expressed by the nursing staff. A new protocol was created through a multi-disciplinary approach, which immediately enhanced employee and patient safety in the ED. Once a behavioral health patient is presented in the ED, a security officer would be assigned as a Security Constant Attendant if the patient exhibited physical or violent behavior. Otherwise, another employee would be assigned to serve as a Constant Attendant to watch the patient. A special training program must be successfully completed by employees who serve as Constant Attendant. Security officers serving as Security Constant Attendant are exempt from that training because they've received specialized training to handle violent situations.

Due to the quickly increasing number of behavioral health patients brought to the hospital, the ED converted five exam rooms into "safe rooms" in a short hallway. Additionally, locking doors were installed at both ends of the hallway to provide a secure environment for this patient population. When the patients were admitted from the ED, a security officer would escort the patient and a patient transport employee to the psychiatry unit. A security officer will also provide an escort for the more severely-behaved behavioral health patients when they would need to be taken to MRI, a lab, or elsewhere for treatment that could not be conducted within the unit.

Conclusion

NCH has provided over 30,000 community-based visits throughout 2014, and are easily on pace to match this volume in 2015. The NCH Security Department (as well as Legal, Risk Management, and Safety departments) have worked collaboratively with Behavioral Health in enhancing their clinical staff's personal safety while working in the field. The hospital continues to provide personal safety training for staff working independently in the field as well as investigating various GPS tracking panic devices and smart phone apps to increase their level of safety.

The same departments in conjuction with the Engineering Department have teamed up to provide a safe and secure environment for the Inpatient Psychiatric Unit on the main campus.

UNIVERSITY OF MICHIGAN HOSPITALS AND HEALTH CENTERS BEHAVIORAL HEALTH SECURITY PROGRAM

by **Nicholas Kane,** *(MPA, BA)*

Nicholas Kane works at the Hospitals and Health Centers Security Services at the University of Michigan. He has almost seven years of experience in the healthcare security field with three years specializing in security for psychiatric and behavioral patients. Nick has a Bachelor's Degree in Criminal Justice and a Master's Degree in Public Administration from the University of Michigan – Dearborn. Nick also works on an Autism Focus Group that provides training and awareness for hospital staff. Nicholas Kane can be reached at (734) 936-7890 or by e-mail at nkane@umich.edu.

Abstract

As the level of violence demostrated by behavior health patients continue to increase in recent years, our department has recognized the need to modify our interactions with this patient population. Our department has always put an emphasis on training for our officers, however, now we offer training for hospital staff as well. Each officer receives Non-Violent Crisis Intervention training taught by a certified CPI instructor. Non-violent crisis intervention focuses on acting out individuals and ways to verbally de-escalate the situation. We now provide CPI training as a service to the rest of the health system for departments who find they are dealing with increasingly aggressive patient behavior. Other departments have been receptive to the training, and are finding that it is helping their staff in dealing with difficult situations.

In addition to training, we have found building a working relationship with nursing staff to be most effective. For example, we created a lead officer position to work closely with management from the psychiatric units to unify our goals and protocols. Furthermore, we have been encouraging staff to call security personnel sooner rather than later in an attempt to stop escalating behavior. When we do have to interact with a patient in an escalated situation, we have developed a process to work with nursing staff. When we arrive to the unit, we conduct what we call a "pre-brief". During that time, nursing staff gives us a quick background on the patient, discusses what has been tried, and what limits have been set. Additionally, we identify who the team leaders are and determine what the plan of action will be to ensure that security and medical staff work in conjunction with each other for the safety of the patient and staff.

Background

Over the last several years, the amount of calls for security assistance for behavioral and violent patients has been increasing. The majority of calls for service for these patients occur in the medical/surgical inpatient units of the hospital and within inpatient and emergency psychiatric services. On those units, most of the behavioral and violent patients that

we interact with have some sort of psychiatric condition or are developmentally delayed. In recent history, we have also noticed that many of the patients that we encounter have traumatic brain injuries. Even more concerning however is the increased interaction of patients who are on the autism spectrum. The increase in the number of patients with one or more of these conditions has increased the frequency of violence and injury towards nursing, medical staff, and security officers within the University of Michigan Health System.

Objective

Ultimately, our objective as a department was simple. We needed to safely manage, sometimes physically, our increasing number of behavioral patients and keep our nursing staff safe from injury. We recognized the need to build better working relationships between our department and the clinical staff who deal with the behavioral patients on a daily basis. We realized if we wanted to meet our objective of improving our physical managements of behavioral patients, we needed more continuity between department and staff.

Methodology

One way we believed we could help keep our staff safe was to offer Nonviolent Crisis Intervention Training developed by the Crisis Prevention Institute (CPI). As a department, we have always trained our new officers in CPI and recur training annually. Nevertheless, we thought that CPI training would be valuable to staff members throughout the health system to increase awareness and to decrease injury from not only behavioral patients but anyone who has the potential to act out. Therefore we did just that and increased the number of CPI instructors in our department and offered to train staff members throughout the entire health system.

During the training to our staff members, we emphasize the interactions between staff and our patients before a situation ever becomes physical. We teach them to recognize the signs of anxiety and agitation, the different ways in which people act out, and, if a situation does become physical, they learn how to safely remove themselves from the situation without injuring the patient while keeping themselves safe. For the safety of the patient, we emphasize restraint related positional asphyxia when put into situations of physically managing patients, especially for security officers. Furthermore, we use the training to emphasize the importance of calling security early. Although this has resulted in an increase in calls for service for our department, we have found that early security intervention with our behavioral patients helps keep the situation under control longer allowing us to plan as a multidisciplinary care team how to best interact with the patient.

Another crucial implementation we made was to create a Lead Officer position dedicated to the psychiatric units. Out of that decision, better working relationships were fostered between our department and nursing staff on the psychiatric units. Both our security department and nursing had the same goals of providing the best care possible but the ways in which we sought to reach that objective did not always align.

I was fortunate enough to accept that position. I was able to immerse myself into the nursing culture and learn why nursing practiced the way they did, such as setting limits and timing of medications. In turn, I was able to relay the information to the rest of our department, which gave everyone a deeper understanding of nursing procedures. In return, I was able to provide information on our department's practices and procedures to the psychiatric units, which gave them an understanding as to why we operate in the manner that we do.

Ultimately, the position allowed us to partner better with nursing staff. We jointly developed protocols for security response to the psychiatric units. For example, when we arrive to assist nursing staff with a behavioral patient, as long as no one is in immediate danger, our responding officers and staff will meet to do a "pre-brief". During the pre-brief, nursing staff gives the responding officers a brief history of the patient, such as the types of behavior they have exhibited and what may be causing that behavior. Additionally, nursing staff will advise what they have done prior to our arrival. Nursing may, for example, say that they offered the patient oral medications and they have tried to set limits but have been unsuccessful. Now they are at a point in which medication must be administered but oral medication may no longer be an option. Therefore they will tell us what is negotiable, such as what medications can be negotiated with the patient or if they are setting limits, whether an injection might be the only alternative.

Once the pre-brief is over, both nursing staff and responding officers determine team leaders from each group to ensure a streamlined communication between departments and limit any type of unforeseen confusion. Both team leaders will develop a plan appropriate and safe for not only the patient but staff as well. Once the plan is developed, it is relayed to everyone involved. At any time during the interaction with the patient, we give each other an option to pull out of the situation if it becomes unsafe or not going as planned. We can then readdress the plan or create a new one.

When the situation is over, we have a debrief process between our officers and the nursing staff handling the situation. Primarily we want to ensure that there were no injuries to anyone, especially the patient. The debriefing allows us to have an outlook on what future contacts with the patient may look like and we pass that information to oncoming shifts. We talk through what happened and come to a consensus as to how the incident went. If the incident went well, no further action is required. However, if the situation went poorly we will then set up a formal debriefing for evaluation.

Results

The working relationships between our department and nursing staff have vastly improved. We now have a simple, standard process that allows for necessary communication to pass between staff. Staff feel more comfortable calling for se-

curity assistance while security officers have learned a great deal in regards to the coordinated care that nursing needs in order to provide exceptional patient care. The misunderstandings and complaints between officers and nursing staff have decreased dramatically. Better communication between the departments at the front line level equated to building better working relationships. Nursing now views security as part of the patient care team and they frequently request our expertise.

As an added benefit, we have found that the security officers are taking the procedures developed on the psychiatric units to the other units within the health system that they are responding to. Granted, not every nurse in our extremely large health system is familiar with the psychiatric procedure guidelines. Our officers guide the nurses by asking the appropriate questions:

- What is the background of the patient?
- What types of behavior are they displaying?
- What type of plan can we come up with to handle the situation?
- These questions help keep everyone aligned and working towards the same goal.

As a consequence, creating a better working environment between security and nursing staff has paved the way for reaching our primary goal of providing exceptional patient care. Instead of spending time critiquing and working against each other, security and nursing now has a formal process in which they can work conjunctively together. Consequently everyone can focus all of their attention towards providing optimal patient care. Although providing the best patient care has always been a priority for both departments, we now do have a process for everyone to be on the same page and be aware of each other's needs.

Conclusion

Dealing with behavioral patients cannot be handled solely by one discipline. Nursing is well equipped to handle patients medically but can at times struggle with anxious, aggressive, or violent behavior. On the other hand, security has adapted quite well to handling situations where these behaviors are presented. It is extremely important that nursing and security partner together, draw from each other's expertise, and find the best possible solution to navigate difficult behavioral patients.

Lastly, the importance of having a set system in place for the partnership should not be underestimated. Without the set of formal procedures in place, there is no guarantee that staff members from either nursing or security will follow through with them. At times you may have some coherence. At other times there may be a loss of support. Having the formal procedures in place has undoubtedly changed the cultural relationships between security officers and nursing staff in a most positive fashion.

INTEGRATING SECURITY AND BEHAVIORAL HEALTH SERVICES FOR IMPROVED STRATEGIC OUTCOMES

by **Bryan Warren**

Bryan Warren is Director of Corporate Security for Carolinas HealthCare System, based in Charlotte, NC. He holds a bachelor's degree in Criminal Justice, an MBA with a focus on legal foundations of healthcare and has over 27 years of healthcare security experience. He is a former President of the IAHSS, a member of ASIS, and participates in a number of professional associations and national taskforces. In 2013 Bryan was named as one of the Top 20 Most Influential People in Security in the US and in 2015 as one of the Top 30 Voices in Healthcare Security by Forbes magazine and currently serves as sector chief for emergency services for the FBI's InfraGard public/private sector information sharing program. Bryan can be reached at (704) 667-9252 or by e-mail at bryan.warren@carolinas.org

Abstract

At Carolinas HealthCare System (CHS) Corporate Security, we have taken an integrated approach to the way security interacts and assists our behavioral health patient population at our facilities. By creating a structure of innovative, progressive, and mutually supporting processes, we realized significant success in tangible and intangible outcomes. (Such as direct cost savings, increased revenue opportunities, and higher patient and staff satisfaction scores.) The primary programs that we have successfully implemented are three-fold:

1) additional in-house education opportunities for teammates (both direct patient care and support divisions);
2) efficient and safe proprietary transport of behavioral health patients between treatment facilities without the use of local law enforcement agencies; and
3) the concurrent employment of existing highly trained healthcare security officers as patient sitters when such services are required for extended times within our facilities.

Background

Carolinas HealthCare System (CHS) is a large and complex healthcare organization providing a variety of comprehensive healthcare related services to the populace that it serves, including a number of behavioral health related services. With tens of thousands of patient encounters involving this potentially high risk group, our Corporate Security Department realized several years ago that we needed to become more proactive in our approach in assisting these patients and their caregivers, particularly since the long term boarding of behavioral health patients in our Emergency Departments and acute care facilities has become commonplace. These extended boarding times, the result of a reduction of dedicated psychiatric beds with a coinciding increase in the number of patients requiring these specialized services have

created the "perfect storm" of opportunities for negative outcomes such as an increased potential for workplace violence, elopement attempts, and self-harm or suicide attempts. With these types of issues being recognized on a national scale by the caregivers as well as a variety of regulatory agencies such as The Joint Commission and OSHA, CHS Security decided to take a holistic approach to detecting, deterring and mitigating the effects that long term boarding of behavioral health patients has on their safety and security as well as that of our facilities and teammates.

Objective

The first of three processes we interlinked was a credible, nationally recognized and certified conflict resolution and de-escalation training for clinical staff that would be taught by CHS Corporate Security personnel. By providing training in-house—with our own security instructors—we not only enabled an increase in teamwork and a collaborative atmosphere with clinical and non-clinical staff who participate in educational sessions and practice scenario-based techniques together (as they would do in real-life situations), we potentially realize savings of hundreds of thousands of dollars versus that of engaging a consultant or third party to provide this training.

The second of our processes (built upon the first) would be the safe and efficient transport of behavioral health patients between CHS facilities through the use of proprietary or contract security personnel. By creating the legal framework with local authorities and providing this service, CHS Corporate Security would be able to reduce the wait times that behavioral health patients often face while waiting for law enforcement to arrive at the facility. This process would also have the added benefit of reducing the stigma associated with our behavioral health patients being placed in the back of a police car and would also hopefully improve the already outstanding relationship that our organization and security division had with local law enforcement (since they would then not have to invest finite and valuable resources on time-consuming calls for service, which detract on other important duties and responsibilities in the community).

The third process to support and enhance the previous processes would be that of using off duty security personnel in concurrent job roles as patient sitters. By working with human resources and our clinical teammates, we would seek to provide concurrent job classifications for high performing security personnel who might be seeking additional employment opportunities. This would allow a certain number of our officers a method for receiving additional compensation without impacting our own departmental overtime budgets while simultaneously providing a well-trained and professional sitter for our clinical staff's behavioral health patient needs.

Methodology

We researched the initial investment for certifying a small number of our existing security personnel as certified instructors in a nationally recognized de-escalation and behavior management program, and we calculated the overall cost per student that a wide scale certification of direct patient care providers would cost if a third party or vendor was used (to include travel, lodging, and other accommodations aside from the tuition of each student). We then determined that the cost savings by using an in-house program would offer a return on investment within just a few months of its inception.

This was only the direct tangible benefit, and our theory was that once we began certifying care givers in high risk areas (such as Emergency Departments) on methods of recognizing warning signs of potentially violent behavior and how to defuse them, we would see an overall decrease in the number of reported workplace violence incidents as well as a reduction of injuries to both patients and teammates resulting from such behaviors.

Similarly, we researched our patient transport proposition and determined, in tangible terms, that for every hour where we reduce the wait time of a behavioral health patient in an Emergency Department bed (by efficiently providing transportation to another facility), it would result in a revenue generation potential of approximately $500 per hour, per bed. There would be the added benefit of a reduction in the total time the behavioral health patient had to go without appropriate psychiatric specific care (hopefully reducing violent outbursts and elopement attempts), shorter wait times for others who were at the Emergency Department seeking medical attention (increasing throughput of the department), and an increase in satisfaction scores from patients and teammates. Lastly, regarding using existing security personnel as patient sitters, our prediction was that by utilizing healthcare security professionals who were already certified in a variety of de-escalation and conflict resolution techniques and were well versed in regulatory issues regarding patient restraint and seclusion, we could simultaneously avoid potential issues with CMS Conditions of Participation complaints when dealing with this specialized patient population while providing our direct patient caregivers assistance from those teammates who they had already trained with side by side and shared a working relationship and similar culture regarding patient treatment and core values of service.

Results

After initially certifying six of our security personnel as trainers and beginning the education of direct care givers in the de-escalation and intervention program, we have created a much more flexible and realistic training opportunity and now certify hundreds of our teammates each year in ways to recognize potentially violent behavior and the verbal and physical skills to safely de-escalate and control our behavioral health patients when aggressive conduct occurs. In the

first six months of 2015, we have recognized a cost avoidance of over $658,000 in this program (versus utilizing outside vendors). A comparative study of assaults against staff that occurred during patient restraints over a one year period showed a direct correlation between the number of teammates being certified in de-escalation techniques and the resultant reduction in assaultive behaviors by patients.

Regarding the patient transport process, we have demonstrated an increase in revenue generation potential for our Emergency Departments of over $304,000 in the first six months of 2015 thanks to over 152 transports being completed without excessive delays or the use of local law enforcement. More intangibly this process has improved the overall patient experience by reducing wait times and providing a more dignified transportation option for the patient. Another noticed benefit is freeing up the acute care bed so that wait times for others in our Emergency Department are shortened and they can receive treatment in a timely fashion.

Regarding the utilization of existing security personnel as patient sitters, we have seen an increase in employee satisfaction scores—not only to our own security teammates (who are receiving additional compensation without seeking a secondary place of employment) but also with our direct care givers who know and trust our security personnel who are providing this important service in a concurrent role. We are enjoying a continued lack of issues with patient restraint and seclusion complaints, although we do not have sufficient data from the use of third party patient sitters with which to create a comparative study.

Conclusion

Through a three pronged approach in how we deal with behavioral health patients upon their arrival, during their initial assessment and how we assist them during their extended stay at our facilities, the CHS Corporate Security Department has been able to teach our direct patient care teammates how to better identify and prevent behavioral health patient's "high risk" conduct, to offer a safe and timely method for transporting behavioral patients so they may receive the help that they need while freeing up valuable resources for the facility and to then provide a safe and professional presence while these behavioral health patients are being treated in our facilities. This integrated, systematic program has helped us in reducing the number of negative outcomes such as workplace violence and elopement incidents while supporting the overall strategic goals of the organization to include cost savings, improved satisfaction scores and better patient care outcomes.

IMPROVING STAFF SAFETY AND THE PATIENT EXPERIENCE THROUGH REDESIGN OF SECURITY'S ROLE IN THE EMERGENCY DEPARTMENT

by **Drew Neckar, CPP,** *(CHPA)*

Drew Neckar, CPP is the Director of Security Services at Mayo Clinic Health System in Eau Claire, Wisconsin. Drew has been in the healthcare security field for the past 11 years where he managed all aspects of security systems design and operation, security force operations, and investigations for multiple hospitals, stand-alone clinics, retail pharmacies, and long-term care facilities.

The Emergency Department at Mayo Clinic Health System in Eau Claire is the only Level II trauma center in northwestern Wisconsin and it treats over thirty thousand patients each year. A significant number of these patients present due to symptoms from mental illness that will result in their admission into the hospital's inpatient behavioral health unit.

A survey of staff in the Emergency Department revealed that many of the staff clamored for an increased security presence in their department to deal with a perceived problem with patient on staff violence. After thorough analysis of the problem, a solution was found that improved staff perceptions of safety and the patient experience by redesigning the way care was provided to mental health patients in the emergency department rather than increasing security staffing levels and involvement.

Healthcare Failure Modes and Effects Analysis

Based on the survey responses, a multi-disciplinary team was formed with membership made up of front line employees and leaders from the Emergency Department, Behavioral Health, Security, Social Services, Nursing, and Quality Improvement departments. This team used a Healthcare Failures Modes and Effects Analysis (HFMEA) methodology to quantify and isolate what issues could be driving the staff's concerns.

The HFMEA methodology began with identifying and mapping twenty-two high level process steps for providing care in the Emergency Department for a patient who would be admitted to the inpatient Behavioral Health Department. Once process steps were identified, each was evaluated for potential failure modes, or ways that the process step could result in a less than optimal situation. Each of the 322 failure modes identified was then evaluated for potential causes and rated on severity and probability to assign an overall hazard score to the failure mode. Those failure modes with a hazard score over a set threshold were then further evaluated for action.

Analysis

The initial results of the HFMEA showed that the medical staff felt in order to assure their safety in their working environment, additional security staffing should be deployed to the Emergency Department. Appropriate levels would include one-to-one security officer observation with any patient deemed to present a risk of violence and around-the-clock security officer presence in the emergency waiting area.

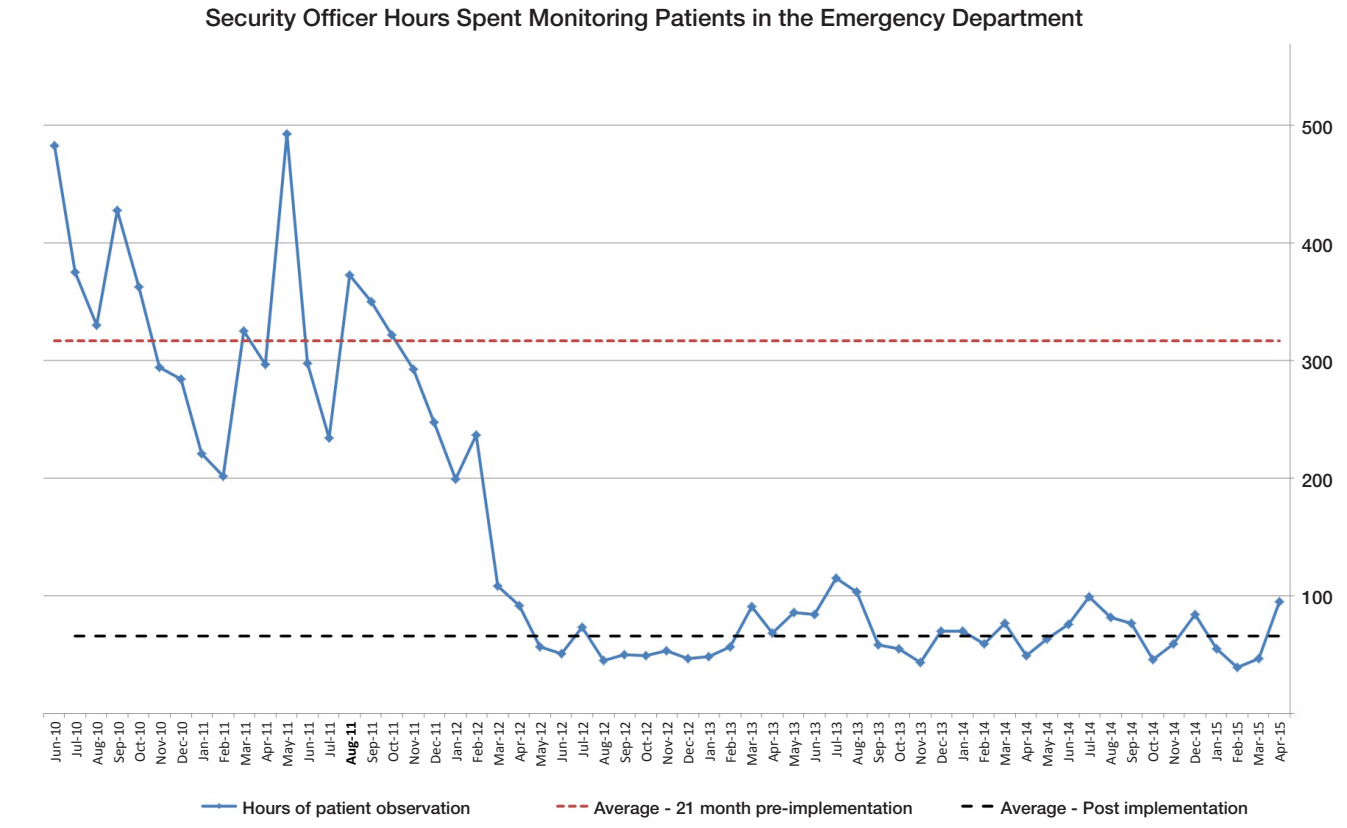
Further analysis by leadership from the multi-disciplinary team (Emergency, Behavioral Health, and Security) indicated that a possible root cause of the problem could be related not to having too few security officers but to the comfort level of the staff in managing mental illness instead. While 27% of patients presenting to the emergency department had a behavioral health disorder as either their primary or a contributing secondary diagnosis, few of the emergency department staff felt they had the necessary comfort level or training to deal with this type of illness. In fact less than 40% of the staff surveyed responded positively to the question, "how do you feel about your skill level in dealing with BH patients?"

A multi-pronged approach was developed that would be implemented to provide training to ED staff so they would be more comfortable in dealing with emotionally disturbed patients.

Re-Alignment of Security's Role

During the HFMEA process, it was identified that security officers were already spending nearly four thousand hours each year in the ED conducting one-to-one observation of patients. It had become so common for ED staff to see a security officer with a patient that some of them had begun to refer to patients who had presented in need of care for mental illness as "security's patients." This was also reflected in complaints from patients who mentioned the perception that they were being "arrested" or that they feared that assumptions were being made about them due to having a uniformed security officer posted outside their room, not based on their behavior but only on their diagnosis.

In addition to these issues, it was determined in order to provide the level of security that the ED staff felt was needed to keep them safe while treating their patients, the security department would need three additional security officer positions to around the clock duties, which would add over $630,000 annually to operating costs. It was determined very early in the review process that adding more security officers was neither sustainable or desirable. Alternatives were researched such as shifting some of the responsibilities away from the Emergency Department Technicians, who were all licensed EMTs, onto nurses so that time could be freed up to shift the one-to-one observation duties onto the technicians.



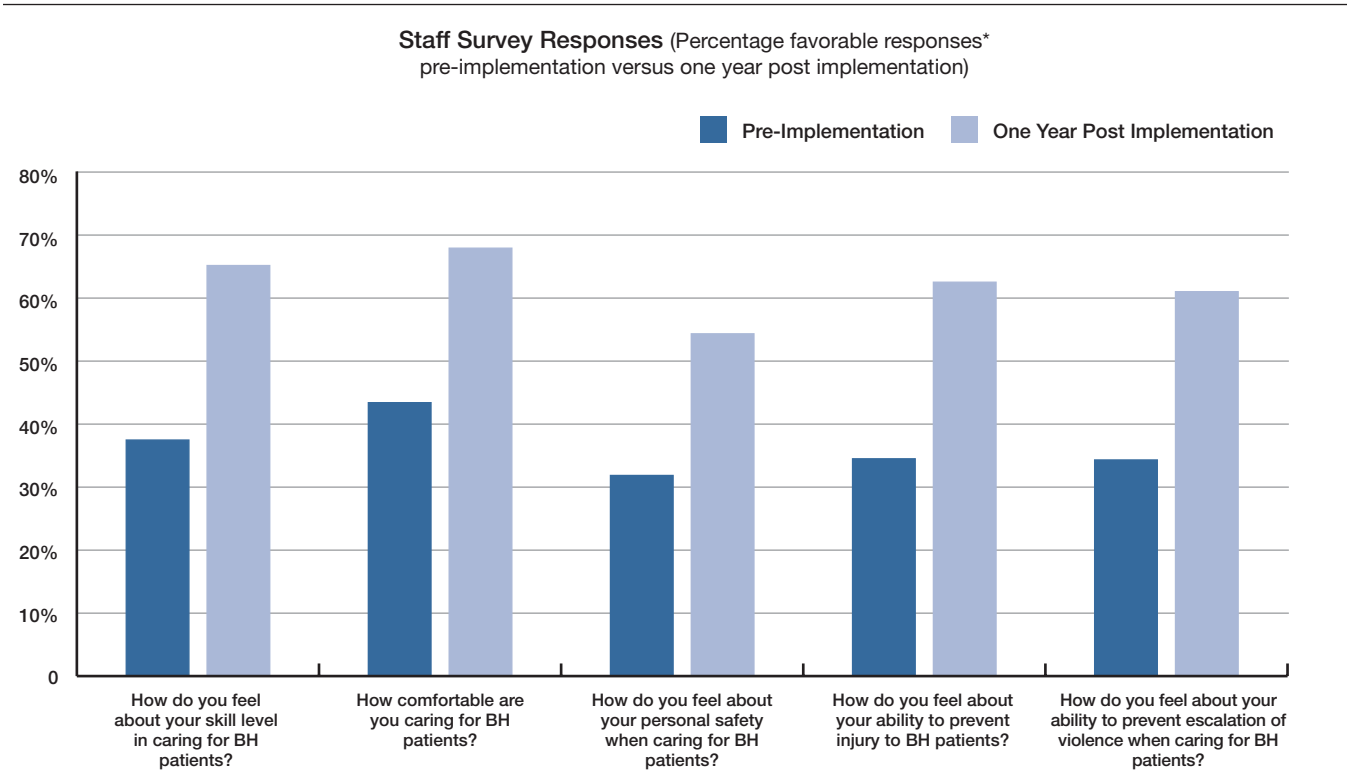
Prior to implementation of this project in August 2011, security officers spent on average 333 hours per month in the Emergency Department engaged in patient observation. The project was completed in May 2012 and three years post implementation, that average has been reduced to 66 hours per month, a reduction of over 80%.

This allowed security officers more freedom to respond where needed to de-escalate and manage potentially violent incidents both within the emergency department and in surrounding areas. To ensure appropriate response ability of the security officers who were no longer tied down performing patient observation, systems were put in place to allow emergency department staff to quickly notify Security Officers of developing situations. These systems included a personal duress alarm for each emergency department staff member and placing a handheld radio at the emergency department nurses' station to allow for direct communication from the staff to the security control center as well as to the responding security officers. The personal alarm system that was chosen for the project utilizes infrared technology. It consists of Personal Infrared Transmitter (PIT) devices that all staff wear attached to their clothing, and infrared receivers throughout the area. Once a staff member either presses a button on their PIT or pulls it off of its lanyard, a signal is sent to the receiver and activates audio and visual alarms in the department notifying other staff and Security of the issue.

Training

While all Emergency Department staff felt fully confident in their ability to deal with someone suffering from a heart attack or broken leg, many were not nearly as confident in dealing with non-physical symptoms of a patient suffering from mental illness. In fact, when surveyed nearly sixty percent of Emergency Department staff said that they did not feel comfortable in their abilities to care for these patients. During staff interviews and group discussions it became evident that staff did not feel fully comfortable in recognizing early signs of behavior that could lead to violence if not properly addressed. Because of this staff were often categorizing all patients suffering from behavioral health disorders as having a high potential for violence.

To address these concerns and ensure that the Emergency Department Technicians were adequately prepared to take on the duties of one-to-one observation of the patients, the Security and Behavioral Health departments collaborated to provide training to Emergency Department staff. Training included the basics of mental health diagnosis and appropriate strategies for working with patients who are affected by them, appropriate use of restraint and seclusion and the rules governing both, identification and de-escalation of potentially violent behavior, and self-defense techniques to prevent injury to themselves or others in case a situation were to turn violent. Once they were equipped with these tools, emergency department staff were much better prepared to make risk based assessments of what, if any, preventative measures should be put in place with an individual patient.



* "Positive response" is classified as the percentage answering "good/very good," "comfortable/very comfortable," or "unconcerned/very unconcerned."

Prior to project kick-off a survey was given to Emergency Department staff to judge their perception of their personal safety and the perception of their skill level when treating patients who suffer from behavioral related disorders. The survey indicated there was significant room for improvement. One year after completing the project, a second survey of ED staff indicated on average a 26% positive effect on the scores of questions regarding perception of personal safety and feelings of competence in caring for patients suffering from a behavioral health diagnosis.

Behavioral Health Liaison Nurse Program

Even with the additional training that was being provided to the Emergency Department staff it was deemed that it would be beneficial to have a subject matter expert with experience in mental health present in the emergency department during times when peak volumes of patients were being seen.

At the beginning of the project the emergency department was staffed with a social worker between the hours of eight o'clock in the morning and four o'clock in the afternoon. Interviews with staff showed that these social workers played a critical role in assisting with patients who were being admitted for treatment of a mental illness, and emergency department nursing staff relied on them heavily for their subject matter expertise. Unfortunately an analysis of volumes of patients being admitted for treatment of a mental illness showed that peak volumes of admissions were consistently presenting to the emergency department between the hours of two o'clock in the afternoon and two o'clock in the morning, during the hours where there was no social worker coverage available in the emergency department.

It was decided that based on patient volumes, a subject matter expert in mental health was needed in the emergency department from when the social workers ended their day at four o'clock in the afternoon until at least two o'clock in the morning. After significant discussion it was determined that this coverage would be provided utilizing a nurse with significant experience working with mental health patients. This nurse would be able to assist the emergency department nurses not only by providing mental health expertise, but also by beginning specialized mental health care earlier and working to facilitate the patient's transfer to the inpatient behavioral health unit if appropriate.

Results

Two years after implementation, the project has resulted in significant improvements in staff's perception of personal safety, real monetary savings, and in the perception of care by the patients themselves.

The project has resulted in a decrease in security officer time spent performing patient observation, from an average of three hundred and seventeen hours per month to a post implementation average of sixty-six hours per month, which is an eighty-one percent decrease. The project also achieved significant decrease in the number of incidents of assaults on staff perpetrated by patients, and resulted in speeding the throughput of patients from the emergency department to the inpatient behavioral health department, decreasing the average time a patient requires observation in the ED from an average of more than three hours to slightly less than two hours, or a thirty-nine percent reduction.

A secondary, yet more important, benefit was a significant rise in patient satisfaction scores for patients admitted to the inpatient behavioral health unit through the emergency department. Within one year of project implementation, patient satisfaction scores rose from the 70th percentile to the 90th percentile nationally.

After completion of the project, a re-survey of ED staff also indicated an average twenty-six percentage point positive effect on the scores of questions regarding perception of personal safety and feelings of competence in caring for patients suffering from a behavioral health diagnosis.

Example of a HFMEA Worksheet

			Scoring			Decision Tree Analysis				
Process Step	Failure Mode	Potential Cause	Severity	Probability	Hazard Score	Control? (HS>8)	Single Point Weakness?	Existing Control Measure?	Detect-ability?	Proceed?
Patient arrives in the Emergency Department	No Security Officer present	Security Officers busy with other ED patients	2	4	8	Y	N	Y	Y	N
		Security Officers busy within other areas of facility	2	4	8	Y	N	Y	Y	N
		Security Officers not notified of patient arrival	2	4	8	Y	N	Y	Y	Y
		Security Officers responding, but not yet arrived due to large physical footprint of facility.	2	4	8	Y	N	Y	N	N
	No appropriate room available	Only two rooms designed for high risk patients	2	4	8	Y	Y	N	Y	Y
		All ED rooms are full	2	4	8	Y	Y	N	N	N

The HFMEA methodology begins with mapping each step in the process that is being evaluated. Once process steps are identified, each is evaluated for potential causes, and each potential cause is scored as to the severity if it were to occur and the probability that it will occur on a 1 to 4 scale. Probabilities and severity are then combined to create a hazard score for each potential cause. Causes with a hazard score over a set threshold are further evaluated for action.

SUPPORT, GUARDIANSHIP, AND TRANSPORT OF MENTAL HEALTH PATIENTS

by **Bernard J. Scaglione, CPP,** *(CHPA, CHSP)*

Bernard J. Scaglione, CPP is the Director of Healthcare Security Services for G4S Secure Solutions. He has 30 years of experience in the healthcare security field including a Master's Degree from Rutgers University School of Criminal Justice in New Jersey. Ben currently serves as a Secretary on the Board of the International Association for Healthcare Security and Safety (IAHSS). He served on IAHSS Education Council from 2005 until 2011. Ben is past Chairman of the ASIS International Healthcare Council and the Past President of the New York City Metropolitan Healthcare Safety and Security Directors Association. Ben can be reached at (561) 691-6714 or by e-mail at bscaglio@gmail.com.

Abstract

The goal was to implement an efficient system that provides security for behavioral health patients without infringing on already limited clinical and law enforcement staffing. To do so, an alternative infrastructure for support and transport would be established. The resulting program provides benefits that include reduced costs, increased efficiencies, and a greater focus on more dignified, compassionate treatment for voluntary and involuntary committed patients. This process improves the flow of mental health patients through Emergency Departments and inpatient units into appropriate settings while improving patient satisfaction, quality of care, and reduced hospital costs.

Background

Nearly 60 million Americans experience a mental health condition each year. Regardless of race, age, religion, or economic status, mental illness affects the lives of at least one in four adults and one in 10 children across the United States. The need for efficient support and movement of behavioral health patients through the current health care system is growing and becoming increasingly problematic for healthcare providers, law enforcement agencies, and the patients themselves. Ensuring adequate service delivery can be difficult when there is generally not enough service capacity to fulfill existing needs. A 2011 study released by the National Alliance on Mental Illness (NAMI) estimated emergency department cost for mental health patients awaiting placement at $1,000 per day.

Involuntary Commitments

Involuntary commitment patients are typically diagnosed in one facility, then transferred to an appropriate, available treatment facility that may be hours away. According to the 2010 Involuntary Commitments North Carolina Sherriff's Impact released by NAMI.

The median average transport time for the counties of North Carolina is 8.0 hours per trip. All counties expressed that there were some trips that were at least double the average length with some extreme trips taking days, not hours. Counties also reported deputies who experienced wait times of 48 hours or more while providing guardianship for a patient in the ED who was awaiting placement.

Voluntary Commitments

Although the voluntary and involuntary commitment patients may be vying for the same limited number of psychiatric beds, there are some significant legal and regulatory differences. Often, when transportation is unavailable for the voluntary commitment patient, the patient's status is changed to involuntary in order to activate the requirement of law enforcement to transport the patient to an appropriate treatment facility. The conversion to an involuntary commitment could have a lasting impact on the patient's personal rights, such as their ability to secure employment, obtain a commercial driver's license, or to possess a weapon.

Inpatient Discharge

In many cases, behavioral health patients have discharge orders from physicians but no means of transportation. Some patients can wait as much as 48 hours in an inpatient unit with a discharge order because they have no transportation. This results in the continued hospital costs to care for the patient and the lack of payment from third party insurance, Medicare and Medicaid. Furthermore, the hospital realizes an opportunity cost of not being able to utilize the bed for another patient.

Methodology

Before suggesting a solution, the security contracting service G4S developed a comprehensive understanding of the mental health guardianship and transport process to include the logistical challenges, financial implications to hospitals and law enforcement agencies, legal and regulatory framework, and the unique requirements of the patient-customer. Additionally, G4S became educated on the rights of the patient and the state's responsibility to treat them with dignity and respect under the law. Within this learning process, G4S invested over two years working with the relevant stakeholders to identify the issues and concerns with the current process, and then began to develop a solution that could remedy these shortcomings. G4S first met with the National Alliance on Mental Illness (NAMI), and then began working with the government agencies, Sheriffs Association and Chiefs of Police Association. Next, G4S met with county commissioners and other local government associations, and finally involved the state hospital associations, local management entities (LMEs)/managed care organizations (MCOs), emer-

gency department directors, chief nursing officers and heads of psychiatric services. These meetings also educated G4S on the critical need for patient support and transfer staff to be certified in crisis intervention training and possess a working knowledge and overall understanding of the difficulties that mental health patients encounter.

Once G4S had a holistic understanding of the situational requirements, a solution was created to address the growing concern for the safe and deferential guardianship and transport of behavioral health patients. G4S Patient Support Services was initially implemented in 2012 in Western North Carolina and is now supporting many patient care facilities. G4S Patient Support Services assists facilities by improving the flow of behavioral health patients out of emergency departments and inpatient units into appropriate settings, resulting in improved patient satisfaction, quality of care, and a reduction in costs.

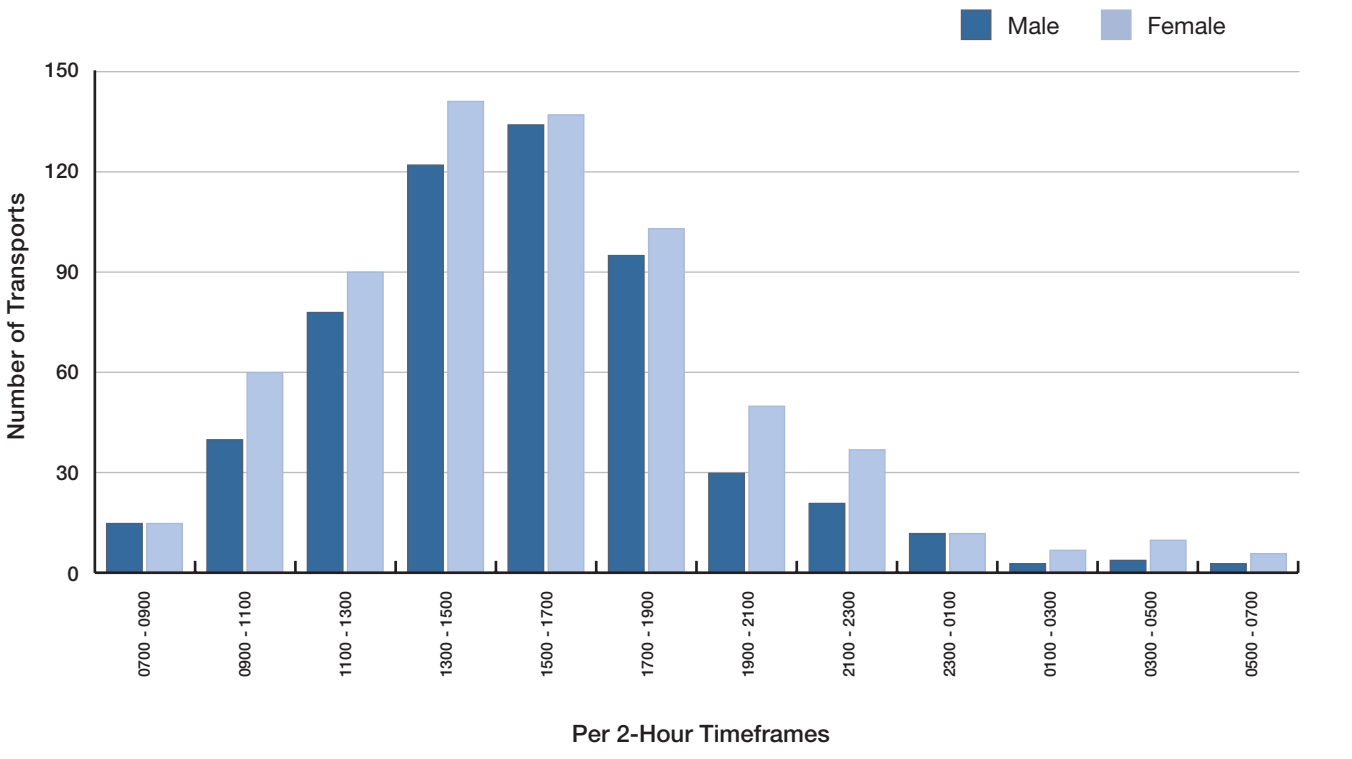
The G4S Behavioral Health program focuses on:

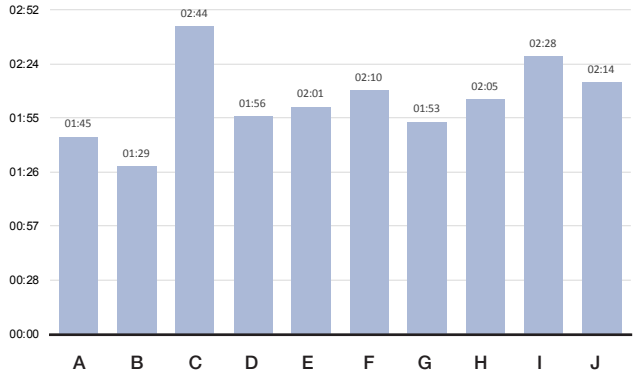
- Treating patients with compassion, respect and dignity
- Providing patients and providers with a positive experience and provide support with empathy and understanding
- Understanding behavioral health issues and their effect on patients
- Providing their staff with crisis intervention training as well as training in behavioral health issues and patient behavior
- Employing staff members that are trained in statutes governing the state and hospital's commitment and responsibilities to the patients
- Customizing staff training, based on requirements of LME/MCO, NAMI and hospital staff

Results

The use of a contracted service has several advantages over law enforcement and in-house security. Contracted services provide pick-ups, transports, and sitting services faster and more cost efficiently. Utilizing an experienced and proven service reduces overtime for security and law enforcement personnel, allowing them to focus on their core business. The implementation of this program has reduced wait times and reduced costs to both law enforcement and hospital budgets. Between November 2013 (program inception) until January 2014, the G4S Behavioral Health Guardianship program provided 2,500 transports and logged 128,000 miles—all accomplished without a single incident. The program has allowed hospitals to plan events because of the gathered data and provided to clients.

The chart below displays the times of the day most transports occur, allowing hospitals to staff services more efficiently.





Average Response Time

Average wait times were calculated for clients to see their savings comparing the cost associated with bed occupation and staff costs caring for the patient while awaiting transport. The average cost per ride averages $230.00. This fee saves clients thousands of dollars each year when compared to the loss of usable emergency department beds, inpatient beds, and staff costs for care.

Conclusion

The G4S solution frees up the law enforcement agencies to focus on their primary duties, re-establishes the flow of patients through ED, generating beds for individuals who truly need them, and enables the payment of third party insurance, Medicare, and Medicaid. Furthermore, the G4S transport program frees up hospital security personnel by reducing patient watches. The Patient Support Service program and its components are scalable in order to provide for the needs of many different clients and react in a timely manner to the needs of mental health providers.

STAFF TRAINING FOR THE BEHAVIORAL HEALTH SETTING: LATERAL VIOLENCE AND BULLYING

by **Tom Lynch,** *(MPA)*

Tom Lynch is the Director of Security at Baystate Health, a five hospital system based in Springfield, MA. He has over 30 years of experience in healthcare security, including 11 years as the assistant director of security at Mount Sinai Medical Center in Manhattan. He currently serves as the Chairman of the Central/Western MA chapter of the International Association for Healthcare Security and Safety (IAHSS). He is a former Chairman of the Western MA chapter of ASIS International. He can be reached at (413) 794-4463 or by e-mail at Thomas.lynch@baystatehealth.org.

Abstract

The problem of incivility is significant in the workplace. This program is a multi-discipline approach to addressing the problem in work groups. Led by the director of security and the director of employee assistance and supported by human resources and unit leadership, a one hour program, co presented by the director of security and the director of employee assistance, discusses common language and definitions, identification of the issues, personalizes the experience through employees describing incidents and how the experience felt. Finally, techniques and resources are discussed. Follow-up sessions are conducted, as needed, three months later that focus of staff ability to identify instances of lateral violence and bullying and to determine what has worked to reduce the frequency of occurrences.

Background

Seven years ago a manager in an operative area approached security for support. She had noticed that graffiti was appearing in the locker room with inappropriate comments towards various members of the department. She was concerned about the vandalism and wanted to know what might be done. After getting the background information, the director asked for time to consider an approach. He reached out to the director of the employee assistance program and after agreeing that this went beyond a security issue they met. They developed an outline of a program that they brought to the manager, human resources and ultimately to the vice president of the division.

Objective

The objective of the program was to highlight the underlying violence in lateral violence and bullying and to demonstrate what these two behaviors are and are not. By raising the awareness in a focused way staff would engage in conversation about their own cultural blindness to potentially destructive behaviors and look for ways to eliminate them from their work area.

Methodology

There is always a pre meeting with the leadership of the work group in advance of the training. This meeting also includes the human resources person assigned to support that work unit. The session is information gathering for the presenters about the concerns that prompted the request for training. Specific concerns are incorporated into the presentation. The presenters also review the content and process of the training. Normally leadership is not present during the training. The point can be made to staff, however, that the leadership is aware of the details of the program and support it. One leader is asked to kick off the session.

The director of security leads off the program with a discussion of violence in general demonstrating with a chart that simply shows the limits of violent behavior from non-verbal to homicide. Focusing on the lower limit of non-verbal and verbal behaviors the point is made that since this is all violence, wherever you fall on the line of violence you are a victim and feel as any other victim does.

Definitions of lateral violence and bullying and examples are provided. Important points of emphasis are that each is a pattern of behavior over time. In the case of lateral violence the behavior is generally peer to peer and involves everything from ignoring someone to withholding information, backstabbing and other overt and covert behaviors designed to make the victim feel humiliation or inferiority. Bullying involves power in the relationship either formal as exists between a supervisor and staff member or informal power as when two or more gang up on a single person. The role of security in the discussion is because ordinarily dysfunction in the workplace is a human resources or employee assistance matter. In some of the cases, however, progressive behavior crosses the line and threats are made, property is stolen or vehicles damaged that make it a case for security involvement. There are deep cultural issues involved and many see these behaviors as part of the culture that they work in. We have to change and learn to identify and address these behaviors.

The second part of the program is led by the Director of Employee Assistance and focuses on three questions.

- *Can you provide examples of either lateral violence or bullying in your current workplace or in a previous environment?*
- *How does the experience of these two behaviors feel?*
- *What have you seen that is effective is countering these behaviors?*

This section begins with establishing ground rules around respectful comments and behavior in the group and no sharing of names or identifying characteristics when citing examples. Techniques are then provided that can assist in the management of these behaviors and examples of assertive statements that can be used. Of particular emphasis is the role of the bystander who can provide important intervention or identification of the problem to others rather that standing silent.

The final part of the program deals with resources. Having opened the conversation, it is important that staff know where to go if they have further questions or concerns. A one-page handout is reviewed that lists organizational policies that deal with these behaviors. Contact numbers for HR, EAP, and security are provided, as is the corporate compliance hotline. The goal is always to resolve issues at the lowest level; however, sometimes it is a leader who is the problem and so the numbers are provided.

Results

Over the last seven years, the program has been offered over 150 times. Presentations have been made to senior leadership and in every campus of the system at all levels. Presentations have been made to all staff, including physicians. There has been no formal advertising. But after the first several presentations, the program is now a regular referral by human resources consultants as they look at issues that come up in various departments. Post presentation surveys indicate a clear understanding of definitions. The comment most frequently received from managers is they find that once the sessions are completed in their area they find it much easier to hold people accountable for behaviors. Staff provided feedback that they feel more empowered to bring issues forward and to hold one another accountable for behaviors. The one caveat is since this is seen as an opportunity to reset expectations, staff pay particular attention to how leaders respond to ongoing bad behavior and, if it is without a clear plan of action, the loss of credibility in the manager is virtually permanent.

Conclusion

This program has significantly raised the awareness of two very problematic expressions of violence in the workplace. The program has been extremely well received and is now core training for use by human resources in addressing incivility issues. This program is also now in the orientation schedule for all new human resources consultants. The program can serve as a lead into other trainings, such as diversity, boundary setting, and stress management. The security and employee assistance departments have added other facilitators to meet the needs of the program. One other positive impact of the program is that it shows the activity of the security department in a different role than is normally seen.

BEHAVIORAL HEALTH SECURITY FORCE SHADOWING PROGRAM

by **Tom Lynch,** *(MPA) and* **Robert W. Horton,** *(MSN, BC)*

Tom Lynch is the Director of Security at Baystate Health, a five hospital system based in Springfield, MA. He has over 30 years of experience in healthcare security, including 11 years as the assistant director of security at Mount Sinai Medical Center in Manhattan. He currently serves as the Chairman of the Central/Western MA chapter of the International Association for Healthcare Security and Safety (IAHSS). He is a former Chairman of the Western MA chapter of ASIS International. Tom can be reached at (413)794-4463 or by e-mail at thomas.lynch@baystatehealth.org.

Robert W. Horton, MSN, BC, is the Nurse Manager for the Adult Psychiatric Treatment Unit at Baystate Medical Center.

Abstract

A measurable violence reduction process. Security cross-trains with psychiatry in a shadowing program promoting understanding, teamwork, and safety while reducing the need for coercive treatment and restraint.

Violence in high risk areas is always a challenge. The presence of uniformed officers is often disruptive and traumatic. This program describes how a partnership between security and psychiatry led to ongoing cross- training of security and psychiatry staff to reduce violence on an inpatient behavioral health unit.

Background

Over time the Department of Psychiatry had moved to a trauma informed care model of treatment for acutely ill behavioral health patients. This model recognizes the often traumatic backgrounds of this patient population and addresses treatment by avoiding occasions where the underlying trauma resurfaces and inhibits the improvement in the patient's condition. As this program was introduced, the communication about what this would mean in terms of security response to the unit did not keep pace.

As officers responded, they did so with the expectation that staff needed an immediate show of strength and potentially would require a physical intervention in the form of assistance with a restraint. When officers arrived, however, there was no intervention. In many cases they were called upon to remain in the background while the patient ate some soup or had a snack. After a period of time they were cleared from the scene by staff without explanation. This caused a significant issue for officers who did not understand why they had to rapidly respond, only to do nothing.

Objective

The objective was to find a way that would in the long term align closely the clinical approach to management of difficult patient behaviors on the inpatient unit with appropriate security response when additional support was required. To further that, in this pursuit of alignment, immediate attention could be given to concerns regarding response by both unit staff and security staff.

Methodology

A working team was formed with leadership from both behavioral health and security. Representatives visited at each other's staff meetings to get input on approach and concerns staff had about what had been going on.

A program was developed from these meetings, where security staff would shadow clinical staff on the unit. Each security staff member would spend a total of eight hours shadowing behavioral staff. Officers would be on the unit in two 4-hour blocks. Security staff would be in civilian clothes and would only be on the unit when the patient population was calm for security staff to observe the environment when there was no crisis. After consultation with risk management, security staff was given access to most of the activity on the unit so that they could get as complete an orientation to issues that staff, patients, and families face. The shadowing was to promote conversation and questions on the part of the working team to:

- Improve understanding of the role of security including the background of officers and their training
- Improve understanding of trauma survivors
- Reduce the perception of security response as "muscle"
- Gain knowledge of diagnosis, legal issues, regulations, and privacy and treatment protocols
- Reduce restraints and improve safety for all

What has been most important about the process is when security is called to the unit, they now recognize that it can be for a show of support. The crisis the patient is experiencing is managed by a team with physical or chemical intervention as a last resort. What has also been a key practice is in each instance, security does not leave the unit until all those involved in the incident have the opportunity to meet and discuss what went well and what could have been done better. No one leaves with a question or unresolved concern.

Results

- patient restraints reduced 24%, episodes reduced 13%
- medication restraints reduced 41%, episodes reduced 54%
- the vocabulary that officers use in discussing behavioral health patients has changed, reflecting their clinical exposure and a greater underlying understanding of the illnesses of the patients and the trauma they may have suffered
- officer discussion reflects understanding of problems of staff, patients, and families on psychiatry units
- officer approach on other units and areas has been similarly affected

Conclusion

This program achieved its original objective and exceeded it. Relationships between security and behavioral staff are close and based on mutual respect for what each can provide in caring for patients. The trauma informed care model has been easy to understand and incorporated into overall security training. The added benefit of this program has been that officers use experience gained through the closer relationship with behavioral health staff on other units. This has better equipped them to handle other crisis patients and family situations across the medical center.

Recently, this program has been introduced to other nursing units in a modified format. Officers are selected from each shift to be primary liaisons to the unit and spend two hours in civilian clothes shadowing staff on these units. There has been an immediate, positive impact on staff engagement surveys and on the way in which officers are greeted when they arrive on units.

HOSPITAL WORKPLACE VIOLENCE: BEHAVIOR HEALTH PATIENTS

by **Elhadji Sarr, CPP**

Elhadji Sarr, CPP is the Director of Security for multiple area hospitals in the CHI- St. Luke's Health System based in Houston TX. Throughout his career, he has successfully overseen the security programs of large hospitals with trauma designations and/or behavioral health centers. Hadji currently serves as Vice-chair of the ASIS Healthcare Security Council. Elhadji Sarr can be reached at (832) 875-9842 or esarr@stlukeshealth.org.

Abstract

Workplace violence continues to be a concern across the spectrum of different industries. In the healthcare setting, which has a high assault rate compared to other sectors, behavioral health patients are one of the elements associated with workplace violence. In fact, a 2004 publication by OSHA made it clear that one of the risk factors responsible for an increase in healthcare worker assaults by patients is an increasing number of acute and chronic mentally ill patients being released without follow-up care. (OSHA, 2014.)

Background

Behavioral health related violence has been an ongoing issue for hospital security and emergency departments. This is due to several factors that are contingent to politico-economical strains and socio-metamorphosis. The reduction in mental health facilities, increase in substance abuse and increase in life expectancy along with other socially related factors all have a contributive role. As a result, behavioral health patient visits have increased as well as their length of stay in emergency departments. In an article published by the Journal of Emergency Nursing, Dr. Anne Manton mentioned that one out of every eight emergency department patients are related to behavioral health or substance abuse. (Manton, 2014.)

Problem

Given the factors named above and the lack of resources in particular, behavioral health patients are utilizing hospital emergency departments as a primary venue to seek mental health care. Dr. Alex Rosenau, president of the American College of Emergency Physicians (ACEP) echoed this when he said that the failures of other parts of the healthcare system have led people in mental health crisis to seek care in emergency rooms. (Glatter, 2014.) In addition, Dr. Robet Glatter, MD cited in the same Forbes journal that "nearly 91% of emergency physicians participating in the SCEP survey explained that boarding has led violent behavior by distressed psychiatric patients, distracted staff or bed shortages, all of which may harm patients." Hospital emergency rooms have been therefore experiencing an increase in workplace violence and a significant part of it is specifically attributed to behavioral health.

Solution

It is imperative hospitals have an adequate plan and preventive program. Behavioral health patients typically end up in emergency rooms by checking themselves in or being checked-in by a family member, ambulance, or by police. Once registered, they are categorized in two types: Voluntary or Involuntary. Regardless of the category, each has a potential for violence, thus the same below measures are taken:

1. Upon admission, the patient should immediately be placed in a distinguishable gown that would differentiate them from other patients. This enables staff to visually identify and address the patient accordingly.
2. All belongings should be removed from the room and tagged. The patient should also be screened to ensure that no weapons or contraband is present. This can be done by pat down or with the use of a hand held metal detector.
3. The patient's room should be cleared for any moveable equipment in order to eliminate the possibility of using any object as a weapon. This includes telephones, carts, poles, and other medical supplies, like syringes.
4. A sitter should always be assigned to a behavioral health patient regardless of their current level of violence. The sitters are usually Patient Care Assistants (PCA), however if the patient is in an active state of violence Security must be assigned and stay with the patient.
5. The restrictions on visitors depends on the circumstances and the current state of the patient. In some instances, a family member may be a resource for keeping the patient calm. In others, family members could be the source of agitation. Depending on the situation, family members will be allowed at bedside or restricted from visiting.
6. For hospitals that do not have Behavioral Health Centers (BHC), the goal is to medically assess and stabilize the patient prior to transferring them to a BHC. For that reason it is important to collaboratively work with the physician, the nurse and the Mental Assessment Team (MAT) in order to expedite the transfer and reduce the length of stay. This will minimize risk because the longer the patient stays in the emergency department, the more the possibility of violence.
7. If the patient is:
    a. Involuntarily committed and is threatening to leave, Security will keep the patient from leaving by any means necessary, including physical restraint. Involuntary commitment includes a motion signed by a judge, a peace officer or a physician.
    b. Voluntary committed and is threatening to leave, all efforts will be made to keep the patient at the hospital, however there will not be any physical contact.
8. In all situations dealing with violent patients, an Emergency Response Team (ERT) should always be notified to respond prior to the event if possible and during and after an event.
9. A part of the prevention program, staff education is crucial, especially to prevent incidents of workplace violence. All staff, including security and clinical should be mandated to attend de-escalation courses as well as mental health reinforcement training.
10. The patient's history is an important factor to take into consideration. More proactive measures should be taken if the patient has a history of violence. This is confirmed by Anderson and West when they concluded that the history of past violence is the most consistent static variable to predict future violence for behavioral health patients. (Anderson, West 2011.)

Conclusion

The best scenario would be for States and Local authorities to fund enough facilities that would accommodate the needs of the behavioral health patient population. This is unfortunately just an ideal perspective at this moment of time while the issue is emergent and cannot wait years of legislative argumentation. For now, hospitals must utilize their own resources in order to adequately protect both the patients and staff by observing security and clinical procedures specifically designed to address the issue.

SERVICE AS A MECHANISM OF CONTROLLING BEHAVIOR IN HEALTHCARE FACILITIES

by **Bartholomew Bennett,** *(CHPA) and*
Terry L. Jones, CPP, *(CHPA, CHSP, CHEP)*

Bartholomew Bennett is the Senior Healthcare Services Manager for Teachout Security Solutions. He has worked in healthcare security management since 2012. He earned a Masters of Business Administration from Saginaw Valley State University. He is an active member of the Greatlakes Chapter of IAHSS. Bart can be reached at (800) 747-0755 or bbennett@teachoutsecurity.com

Terry L. Jones, CPP is the Vice President of Operations for Teachout Security Solutions. He has 36 years of security experience, 27 of those years in healthcare safety, security, and emergency management. He is a member of the Executive Board of the Greatlakes Chapter of IAHSS. He is a member of the ASIS International Healthcare Council. Terry can be reached at (800)747-0755 or tjones@teachoutsecurity.com

Abstract

At a 400-bed regional medical center in central Michigan with a 22-bed behavioral health unit, "hands-on" incidents in the Emergency Department were reduced by more than 60% after applying a program model focused on "pre-escalation." At the foundation of the program is the concept behavior should be managed before there is any indication behavior will be an issue. A recurring phrase in the training program is, "It is easier to keep positive behavior positive than to manage negative behavior."

The basics of the program are:

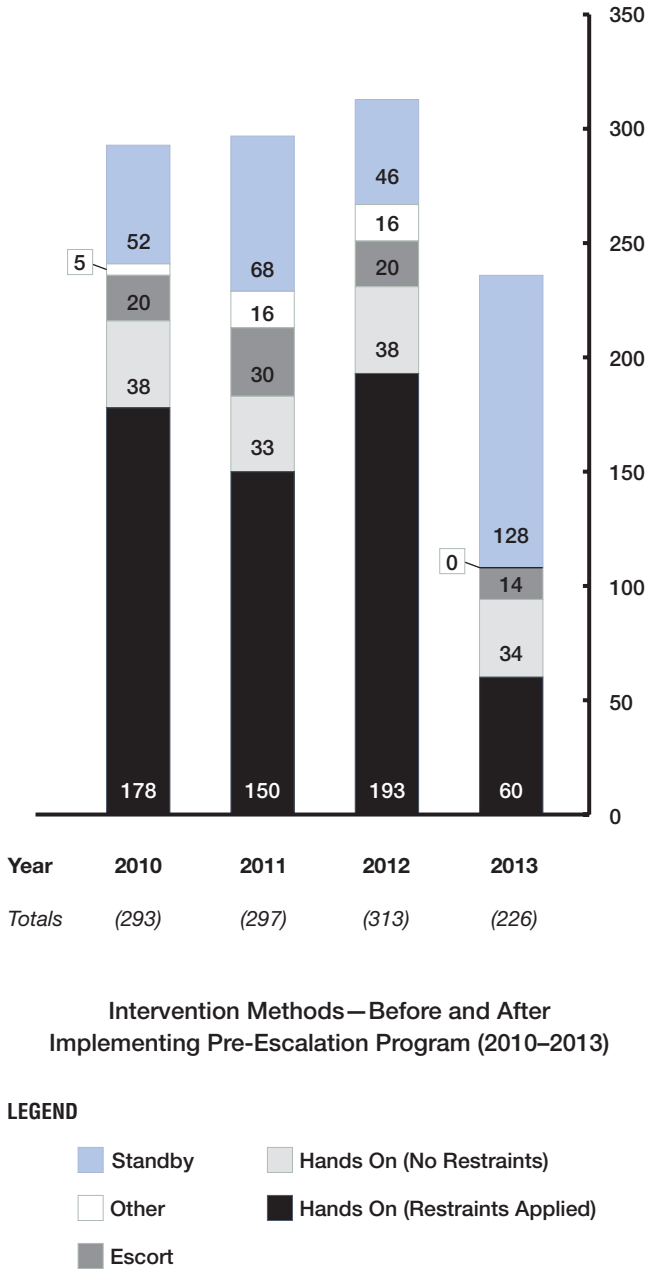
1. Initiate positive contact with every person approaching the emergency entrance.
2. Maintain a high profile presence with an extreme service orientation.
3. Training is provided to all ED and Behavioral personnel, and delivered to groups including security, clinical, and support staff together.
4. An interdisciplinary operations committee meets regularly; effective planning does not occur during an incident.

Background

In early 2013, a contract security provider specializing in healthcare security began operations to replace an in-house security team at a 400-bed regional medical center in central Michigan.

Objective

A primary stated objective of the hospital's administration was to reduce incidents in general and use of force incidents in particular. The objective was not specific to behavioral health patients although they represent a significant number of incidents. For this reason efforts to reduce incidents had to take into consideration that patient population.



Intervention Methods—Before and After Implementing Pre-Escalation Program (2010–2013)

Methodology

The new security program includes a dedicated security manager employed by the contract security provider, which the program lacked in the past. The manager had the benefit of managing within the contractor's structured program which was developed specifically to reduce incidents and has the added benefits of increasing the perception of safety, improving customer service and perceived quality of care. From the colors and style of the uniform designed to be authoritative rather than authoritarian, to the selection of officers and managers, to the training program, controlling behavior is the primary driver.

The cornerstone of training for the officers is a proprietary program called Managing Agitated Persons (MAP). The name of the program is somewhat misleading as MAP has evolved since its creation in 1998 to include a pre-escalation component proven to reduce incidents, which makes it unique in the marketplace. When the process works, there is no agitation to manage.

While MAP includes a de-escalation model and physical management component, it is the pre-escalation component that delivers the reduction in incidents. The premise is simple: It is easier to keep positive behavior positive than to manage negative behavior. Interactions that begin positively are more likely to end positively than those which begin negatively. Thus the security staff is trained to initiate positive contact with everyone they encounter.

The program does not differentiate between behavioral patients and other patients. It does not even differentiate between patients, visitors, and staff—officers are charged with greeting everyone in a positive manner before they enter the hospital. Clinicians and support staff are trained by the security provider to greet every patient and visitor warmly before the other party can choose to start the interaction negatively.

Another component of the program is actively seeking an opportunity to serve. Security personnel are required to perform constant high profile patrols and actively seek out ways they can help someone—anyone. When seeking opportunities to serve, external customers (patients, visitors, and guests) are given a higher priority than internal customers (staff).

The pre-escalation component is nothing more than providing great customer service to everyone. The emotionally charged environment of a hospital requires a level of compassion and consideration beyond those of other environments. Staff members who complete the program know that they could be the most important person in the world—to someone who is having the worst day in their life.

The last piece of the program is a joint operations committee made up of security personnel, Emergency Department staff, and Behavioral Health staff. The group meets regularly to debrief incidents, develop response models, and create scripts to use during incidents. Process improvements cannot be made during an active incident but they must be made. Beyond the improved processes that come from these meetings, the participants and groups that they represent are able to get clear expectations from everyone else.

The data (see chart) highlights the security intervention data from January 1, 2010 until December 31, 2013. It clearly shows a reduction in calls overall and a dramatic reduction in restraints.

Conclusion

Proactively applying an intensive customer service orientation decreases incidents in general, and reduces the number and intensity of interventions. Adding a "pre-escalation" component to de-escalation training is advisable. Initiating positive contact with a facility's users is a viable strategy to improve customer service and reduce incidents.

2015 ASIS Healthcare Committee Members

Daniel B. Yaross, CPP
Director of Security
Nationwide Children's Hospital
(CHAIRPERSON)

Steven C. Dettman
Director-Security/Visitor Support
Mayo Clinic
(VICE-CHAIR)

Elhadji A. Sarr, CPP
Safety/Security Director
St. Lukes The Woodlands Hospital
(VICE-CHAIR)

Dennis R. Blass, CPP, PSP
Director
Children's of Alabama

Michael S. D'Angelo, CPP
Security Manager
Baptist Health South Florida

Anton Doerig
Head of Corporate Security/CSO (ISHSSE)
Kontonsspital St. Gallen (State/Cantonal Hospital)

Michael V. Hogan, CPP
Director of Security and Transportation
City of Hope National Medical Centre

Marilyn W. Hollier, CPP
Consultant
SRMC

Lexiel L. Holloway, CPP
Director of Security & Safety
Caris Life Sciences

Marilyn W. Hollier, CPP
Director
UM HHC Security & Entrance Services

Lex Holloway, CPP
Director, Safety & Security
Caris Life Sciences

Terry L. Jones, CPP
Vice President of Operations
Teachout Security Solutions

Terry L. Jones, CPP
Manager, Security Systems
University of Arkansas for Medical Sciences

Steve C. Kaufer, CPP
President
Inter/Action Associates

Ronald Lander, CPP
Chief Specialist
Ultrasafe Security Solutions

David G. LaRose, CPP
Director of Safety and Security
Lakeland Regional Health System

Myron Q. Love, CPP, PSP
Director of Security Services
Ann & Robert H. Lurie Children's Hospital of Chicago

Thomas F. Lynch
Director of Security
Baystate Health

William S. Marcisz, CPP
Administrative Security Director
Florida Hospital Orlando

Keith McGlen, CPP
Regional Security Director
Memorial Hermann Healthcare System

Bonnie S. Michelman, CPP
Director Police/Security Outside Services
Massachusetts General Hospital

Ryan M. Nelson
Security Manager
Providence Health & Services

William H. Nesbitt, CPP
President
Security Management Services, Intl

Anthony Notaroberta, PCI
Police Director
New York City Hospital Police

Michael D. Potter, CPP
Vice President, Operations
Apex3 Security, Premier Security

Michael C. Preece, PSP
Principal
Smith Seckman Reid

Morgan H. Saunders
Director of Security
Holzer Health System

Bernard J. Scaglione, CPP
Director Healthcare Security Services
G4S Secure Solutions (USA)

Thomas Arthur Smith, CPP
President
Healthcare Security Consultants

Dean R. Sobcoviak, CPP
Vice President
HSS

Larry J. Spicer
Aurora Health Care

Michael T. Spicer, CPP
CEO
The Outzen-Spicer Group

Lisa Pryse Terry, CPP
Director, Hospital Police & Transportation
UNC Healthcare

John M. White, CPP
President/CEO
Protection Management

ASIS INTERNATIONAL
Advancing Security Worldwide®

1625 Prince Street
Alexandria, VA 22314
+1.703.519.6200
asisonline.org