Mitigating Workplace Violence via De-Escalation Training

by Abigail Shulman

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1. Introduction

Healthcare organizations suffer from extremely high rates of workplace violence, a phenomenon that continues to grow worse.[1] Yet traditional methods of handling violence against healthcare staff—such as restraint and seclusion—are now framed by many researchers, healthcare workers, and healthcare managers as inflammatory and dangerous.[2] In response, de-escalation strategies have increasingly been recommended as effective and non-violent alternatives to restraint and seclusion. According to the Joint Commission, a U.S. based not-for-profit organization that accredits over 22,000 health care organizations in the United Sates,[3] de-escalation training teaches healthcare staff a "combination of strategies, techniques, and methods intended to reduce a patient's agitation and aggression," without having to resort to restraint or seclusion.[4] De-escalation training is lauded for its potential to prevent violent incidents, reduce injuries, and repair patient-staff relationships. Still, the field suffers from a lack of training program evaluation, which is the necessary next step in establishing a de-escalation training gold standard for widespread implementation in healthcare settings.

1.1. Workplace Violence in Healthcare

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "the threat or act of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty."[5] Between 2011 and 2013, it is estimated that between 70–74% of workplace assaults occurred in healthcare or social services settings, despite the sector comprising only 11% of the workforce.[6,7] The Occupational Safety and Health Administration (OSHA) states that workplace violence in healthcare is "vastly underreported,"[8] yet occupational injury records indicate that a workplace injury requiring days away from work is still 3.5 times more likely to be due to assault for a healthcare worker than for all other private sector employees.[9] This issue is not confined to the US. The International Labour Office in Switzerland reports that violence in the healthcare sector may account for almost a quarter of all workplace violence.[10] In the Western world, 61% of nurses in Canada reported abuse, harassment, or assault in 2018,[11] 26% of educational and health workers in Europe considered their health or safety to be at risk due to workplace violence in 2000,[12] and 36% of nurses and midwives in Australia experienced violence by patients or their midwives in 2007.[13] Unfortunately, this issue only continues to get worse. Over the nearly 10-year period between 2005 and 2014, violence against healthcare workers increased by 110% in US private industry hospitals.[14] Brous (2018) provides a diagnosis for this trend: "A vicious cycle is set up in which nurses leave the workforce in response to workplace violence. The exodus of providers compromises staffing, and inadequate staffing levels correlate with increased violence."[15] This hypothesis is validated in a global literature review by Ahmad (2015), who cites lengthy waiting times for patients and visitors as one of the most common risk factors for violence in healthcare.[16]

1.2. Historical Methods of Aggression Management

Restraint is any method, device, or drug that immobilizes or reduces the ability of a patient to move freely. Seclusion is the confinement of a patient alone in a room from which they are physically prevented from leaving.[17] Restraint and seclusion are both typically involuntary for the patient. For this reason, The Joint Commission states that "the use of

restraint and seclusion creates a negative response to the situation that can be humiliating to the patient, and physically and emotionally traumatizing to the staff involved."[18] In a survey of 142 patients, 48% of patients placed in seclusion, 52% of patients put in restraints, and 58% of patients forced to take medication found their experience to be severely distressing.[19] While there is not yet consensus that restraint and seclusion should not be used under any condition, these approaches are recommended largely as a last resort, only to prevent serious injury to the patient or staff.[20,21]

As part of the Nonviolent Crisis Intervention® Training Program, the Crisis Prevention Institute (CPI) outlines the Joint Commission's standards on seclusion and restraint. Using these guidelines, CPI offers recommendations on how to limit use of the practice, perform it safely when required, and report any resulting injuries or casualties.[22] Several other organizations, however, advocate for the full discontinuation of any restraint or seclusion practices.[23]

2. Departments Most at Risk

Some healthcare staff are more at risk for patient aggression than others. Workplace violence is most likely to occur in acute care settings, behavioral and mental health units, intensive care units, and geriatric care.[24] In terms of staff, mental health professionals and nurses—especially those working in emergency departments and behavioral health units—experience the most violence by patients and family members.[25] However, physicians, social service employees, hospital aides, reception aids, Human Resource employees, and security personnel are also at risk and require unique solutions to remain safe at work.[26] The International Association for Healthcare Security and Safety (IAHSS) provides safety training recommendations specifically for security personnel, given the direct relationship security officers have with workplace violence.[27]

2.1. Emergency Departments and Acute Care

Emergency departments (ED) are widely discussed as hotspots for workplace violence. IAHSS reports that in a survey of 81 hospitals in 2018, 46% of assaults against employees by patients or family occurred in emergency departments.[28] Surveys of ED staff corroborate this evidence. A cross-sectional study surveying 263 emergency medicine residents and attending physicians across the US found that 78% of respondents experienced at least one violent act at work in the past 12 months.[29] In another survey of 242 ED workers at five different hospitals, nearly half of those surveyed said they had been *physically* assaulted. Moreover, 65% of those assaulted said that they did not report the incident to hospital authorities.[30] Benham (2009) offers several contributing factors for these assaults, including patients coming to the ED in pain, experiencing long wait times, being more likely to be violent because of jail diversion or undiagnosed mental illness, being under the influence of drugs or alcohol, and requiring acute treatment for underlying psychosis or dementia.[31] Moreover, EDs are open 24 hours a day, presenting the opportunity for late-night incidents that would not occur in other departments.

2.2. Behavioral and Mental Health Units
Along with emergency departments, behavioral and mental health units are most at risk for incidents of workplace violence. The Department of Justice National Crime Victimization Survey reports that the victimization rate for mental health professionals was 21 per 1000 people between 2005 and 2009, around three times the rate of medical professionals and twice the rate of bus drivers.[32] This is largely because psychiatric conditions are often associated with increased aggression: people with diagnosable clinical psychiatric conditions are five times as likely to express violence as the general population, according to the National Institute of Mental Health Epidemiologic Catchment Area (NIMH) study.[33] Substance use compounds mental illness, with alcoholism and drug use increasing one's propensity to be violent to 12 times and 16 times more than the general population, respectively. As a result, the NIMH study reports that 31% of people identified in an initial survey as having both a mental illness diagnosis and substance use committed an act of violence within the following year.[34]

2.3. Geriatric Care Units
Staff working in nursing homes and geriatric care units report frequent verbal and physical assaults, likely due to the confusion, agitation, and aggression caused by age-related cognitive decline.[35] A cross-sectional study of 539 nursing home assistants found that 66% of respondents report experiencing daily physical assault resulting in minor soreness, abrasions, scratches, or bruises.[36] Elderly patients are a uniquely vulnerable population, and nuanced solutions are required to address the high rates of violence in long-term healthcare settings.

2.4. Intensive Care Units
For reasons that overlap with the issues facing emergency departments, intensive care units (ICUs) experience high levels of violence. Patients and their family members are under significant duress, resulting in increased aggression as compared to non-critical care wards. In a survey of intensive care senior nurses in England and Wales, the percentage of ICUs with reports of verbal abuse by patients or relatives was 87% and 74%, respectively. Physical abuse by patients was reported in 77% of ICUs.[37]

3. De-escalation Frameworks
De-escalation training is modeled on validated de-escalation frameworks, which develop a structure for how and when to assess aggression, use mitigating techniques to limit the possibility of aggressive action, and intervene during a violent episode. The Joint Commission (2019) endorses the Turnbull, et al. (1990), Dix and Page (2008), and Bowers Safewards (2014) models. However, some elements of those models are outdated.[38]

3.1. Turnbull et al.
Turnbull and Patterson (1990) do not discuss a theoretical model of de-escalation, but rather an actual training program characterized by a collection of learning objectives and verbal and non-verbal tips.[39] The Turnbull et al. (1990) model emphasizes flexibility, with the result that there is no "order" to their de-escalation framework. While some elements of the Turnbull training program have been validated and incorporated into more recent

de-escalation frameworks, the recommendations on restraint and seclusion tactics are largely outdated.

3.1.1. Learning Objectives

Turnbull's de-escalation training teaches 10 learning objectives: legal aspects (such as the "right to restrain"), theories of aggression, triggers of aggression, de-escalation skills, disengagement breakaways (strangle holds, disarming, bear hugs, etc.), basic control and restraint (wrist locks, bear hugs, etc.), advanced control and restraint (the three-arm team, removal, relocation, etc.), integration of de-escalation and control and restraint, guidelines for practice, and reporting incidents. These learning objectives are hands-on, with clear applications in clinical practice. Teaching restraint techniques in de-escalation training is beneficial in that it limits the incorrect use of potentially fatal techniques. It is important to note, however, that restraint mechanisms are now only recommended to prevent immediate injury to the patient or staff. It is therefore important to emphasize de-escalation strategies that prevent the requirement for restraint in the first place.

3.1.2. Verbal and Non-verbal Responses to Aggression

Turnbull's tips for de-escalation have largely been incorporated into more recent de-escalation frameworks, such as the Dix and Page model. The "responses to aggression" section includes seven skills: enlist colleagues for help, ask questions about the patient's feelings, give clear instructions, maintain friendly eye contact and body posture, be personable and separate yourself from "the system," show concern, and demonstrate empathy to match the patient's mood.

3.1.3. Efficacy

Turnbull et al. (1990) delivered their two-week de-escalation training program to nearly 150 nurses over a two-year period. The nurses who completed the course reported increased confidence in performing de-escalation techniques and avoiding the use of restraint and seclusion. However, there is no evidence regarding the efficacy of the Turnbull model for quantifiable outcomes, such as reduced violent events, reduced instances of restraint and seclusion, and reduced injuries to patients and staff.

3.2. Dix and Page

The Dix and Page (2008) model was originally developed for mental health units, though it since has been referenced as a validated de-escalation metric generally. It is comprised of three basic components: assessment, communication, and tactics (ACT).[40]

3.2.1. Assessment

Dix and Page emphasize that it is imperative that members of a treatment team share the same definition of an aggressive action, so that the assessment of a given incident is consistent. They recommend the seven-point Assaultive Rating Scale, developed by Lanza and Campbell (1991), which ranks potential consequences of an aggressive action, ranging from "threat of assault without physical contact" to "death."[41] With this scale in mind, Dix and Page describe how "situational analysis"—i.e., assessing the likelihood of violence using recent interactions as data points—is better suited to predicting aggression than psychopathology. Dix and Page use Frude's (1989)

progression of five factors—situation, appraisal, anger, inhibitions, and aggression—as the model by which to understand, and therefore assess, a patient's aggression.

1. Situation – the events that the patient focuses on immediately prior to his/her aggressive behavior
2. Appraisal – the patient's understanding of the situation
3. Anger – the emotional response to the appraisal
4. Inhibitions – the patient's attitude and general ability (or lack thereof) to manage aggression
5. Aggression – the behavioral result

3.2.2. Communication
The suggested communication techniques are only tools, intended for flexible use by the de-escalating practitioner. Communication, Dix and Page argue, must appear sincere and therefore cannot be taken verbatim from a fact sheet. Their communication strategies include both non-verbal and verbal principles, such as maintaining non-aggressive posture, avoiding touching the patient (even in a reassuring or gentle way), self-disclosing, avoiding using jargon, and bringing attention to the impact of the patient's behavior.

3.2.3. De-escalation Tactics
Dix and Page describe abstract models that offer a reimagining of the patient-staff relationship rather than specific de-escalation techniques. These include the "attitude and behavior cycle," the "win-lose equation," "debunking", "aligning goals," and "transactional analysis." Dix and Page's strategies are intentionally made vague so as to discourage practitioners from using a script, which is inflexible and presents as insincere. Generally, they suggest that the de-escalator shed assumptions about how processes "must be done," negotiate situations such that a perceived "win-win" is met, invalidate the need for aggression by fully empathizing with the patient's grievances, and frame staff goals to align with the patient's goals.

Just as every component of Dix and Page's de-escalation model is fluid, the three components together are interdependent. This means that assessment, communication, and negotiation tactics should consistently be revisited throughout the de-escalation process.

3.3. Bowers Safewards Model
Len Bowers' Safewards Model (2014) is a thorough depiction of sources of aggression and de-escalation strategies that can be used to prevent and defuse violent acts.[42,43] The model is founded on the principle that *conflict*, i.e. acts of aggression by patients, and *containment*, i.e., the methods healthcare staff use to control aggression by patients, exist in symbiosis. Aggressive patients who are contained (through seclusion, restraints, special observation, etc.) are likely to escalate violence in response to their containment.

3.3.1 Safewards Domains
The Safewards model, unlike other de-escalation frameworks that begin with the first signal of patient aggression, requires understanding potential sources of patient discomfort throughout the de-escalation process. In this way, the Safewards model has

an aerial view: its components comprise the entire healthcare ecosystem at all times. This is once again in contrast to other models that narrow their scope to the patient-staff member interaction. The model includes:

1. Originating Domains – elements of the ward that can lead to flashpoints. These elements are unalterable elements of hospital life and can be further broken down into six general categories: *patient community* (patient-patient interaction), *patient characteristics* (symptoms and demography), *regulatory framework* (legal framework and hospital policy), *staff team* (how staff manage feelings and interact with each other), *physical environment* (hospital layout and comfort), and *outside hospital environment* (what the patient's family and community is like outside the hospital).
2. Flashpoints – situations in which aggression could arise as a result of one of the originating domains.
3. Patient Modifiers – the ways in which patients respond toward originating domains and toward each other.
4. Staff Modifiers – the way that staff manage patients or the environment to reduce conflict and containment.
5. Conflict – any patient behavior that threatens their safety or the safety of others.
6. Containment – ways in which staff manage conflict, e.g. medication, seclusion, restraint, etc.

3.3.2. In Practice

The Safewards Model's de-escalation framework suggests that staff modifiers can affect all other domains to limit conflict and the resulting need for containment. It emphasizes consistent review and modification of all elements of a patient's experience. Through this holistic de-escalation process, Bowers (2014) implies that flashpoints can be mitigated, and the cycle of conflict and containment avoided.

An updated version of the model specifies 10 specific interventions for implementation in acute psychiatric wards: (1) staff and patients mutually agree upon, then publish, standards of behavior; (2) management hangs statements on using "soft words" during flashpoints in the nursing office; (3) the ward elects the best de-escalator; that person develops a de-escalation model to improve the skills of other staff; (4) management creates a requirement to say something good about each patient during nursing handover; (5) staff must scan for bad news a patient may receive from family or other staff, and speak with patient immediately; (6) staff creates a "know each other" folder that contains personal but non-private information about both patients and staff, such as music preferences or favorite sports teams; (7) staff members host a regular patient meeting to formalize support; (8) patient's room is equipped with a crate of distraction and sensory modulation toys; (9) staff provide reassuring explanations to all patients after potentially frightening incidents; and (10) hallways contain a board of positive messages from discharged patients.[44] These interventions are tailored for psychiatric wards. However, an evaluation of potential transferability to other departments is recommended.

3.3.3. Safewards Efficacy

In 2011, a collaboration between the Institute of Psychiatry, King's College London, Maudsley NHS Foundation Trust, and the National Institute for Health Research (NIHR) generated 298 de-escalation training intervention ideas based off the Safewards Model.[45]

Expert nurses and ward managers evaluated the interventions and selected 15 interventions for implementation in four wards in East London. Following implementation of the 15 interventions, the 10 most successful ideas were selected for a full trial in 2013.

The 10 interventions were implemented in generic acute wards and psychiatric intensive care units in 15 randomly chosen hospitals in South England. It is reported that, following the eight-week intervention, conflict decreased by 15%, and containment decreased by 24%.

3.4. Utilizing Security Personnel

The previously described de-escalation frameworks describe de-escalation and violence control in a one-on-one context, generally. While it is important to teach skills that medical practitioners can use as individuals, it is also imperative that security personnel be trained in violence management and that hospital staff learn protocols for contacting security personnel. IAHSS details the expectations that should be established by healthcare facilities, in this regard.[46]

4. Assessing Aggression

An integral part of all de-escalation models is assessment. Knowing when a patient is likely to become violent is imperative to enacting de-escalation strategies, but often, the details of aggression assessment are left out of the broader context of a de-escalation framework. Berg, Bell, and Tupin (2001) propose a linear de-escalation framework that contains assessments for "potential violence" and "imminent violence."[47] They argue that, prior to diagnosing aggression, it is important to determine the immediacy of the threat.[48] In a literature review regarding risk assessment tools in emergency department settings, Calow et al. (2016) discusses nine different tools, the three most commonly used being the STAMP violence assessment framework, the Brøset Violence Checklist, and the M55 Violence Risk Assessment Tool.[49] Calow et al. organizes the tools according to their intended setting – emergency department or inpatient.

4.1. Berg, Bell, and Tupin

Berg, Bell, and Tupin (2001) identify three stages of aggression: potential violence, imminent violence, and emergent violence.[50] The authors quip, "Clearly, while one is being choked is not the time to gather data about why one is being choked."[51] For this reason, only potential and imminent violence require assessment protocols.

4.1.1. Potential Violence

Berg, Bell, and Tupin emphasize the need for staff consultation with colleagues, in order to prevent denial of aggression symptoms, identify unintentionally provocative behavior on the part of staff, and keep a de-escalation team informed. Consistent consultation should occur simultaneous to the identification of potentially violent patients via background checks, and violence histories. Historical data not only provides information on who is likely to be aggressive, but what their potential triggers might be.

The authors list the following as additional risk factors for aggression in the healthcare setting: alcohol or substance abuse, low staffing, untrained security personnel, lack of

emergency devices, and environmental concerns (e.g., unpleasant conditions, furniture that can be used as a weapon).

4.1.2. Imminent Violence
Certain behavioral warning signs signal to staff that violence may be imminent. This includes agitated behavior (e.g., pacing), use of threats, aggressive body language (e.g., opening and closing of fists), pupil dilation, standing too close, impulsiveness, an immediately recent episode of violent behavior, and demonstrations of fear and apprehension. Berg, Bell, and Tupin (2001) state that spoken threats in the form of yelling, name calling, or cursing are the most common precursors to physical violence.

4.2. Calow et. al
Calow et al. (2016) conducted a 13-paper literature review on aggression assessments. They identify themes from assessments used in both ED and inpatient settings.[52]

4.2.1. Emergency Department
The authors identified three risk assessment tools used in the ED setting: the STAMP violence assessment framework, Assessment, Behavioral Indicators, and Conversation (ABC), and the five attributes of caring to avert violence (be safe, available, respectful, supportive, and responsive). Collectively, these tools identified high-risk behaviors as staring/glaring at the caregiver, increased volume or hostile tone, anxiety, mumbling, pacing, aggressive statements, belligerence, clenched fists, demanding attention, irritability, and general hostility. The STAMP tool was used most often in the ED setting, and has been validated as an effective tool.

4.2.2. Inpatient Care
Calow et al. identified six risk assessment tools used in the inpatient setting that cover a range of possible risk factors, including patient behavior, history of violence, psychopathology and current demonstrations of psychosis, and intoxication and substance abuse. The behaviors identified as possible precursors to violence in the inpatient setting were consistent with those described for the ED. The Brøset Violence Checklist, a six-item tool that includes confusion, irritability, boisterousness, verbal threat, physical threat, and attack on objects, was the most commonly used aggression risk assessment tool. It demonstrates the best validity and reliability. The M55 Violence Risk Assessment, the third most commonly used assessment alongside STAMP and Brøset, has mixed validity results.

5. Evaluating De-escalation Training
Research on the efficacy of de-escalation training programs is somewhat limited, partially because of a lack of validated evaluation metrics.[53] Evaluation frameworks are important to healthcare organization decisions on whether or not to implement de-escalation training, and if so, which one. Three frameworks were identified in the literature: De-escalating Aggressive Behavior Scale, Confidence in Managing Patient Aggression Scale, and Kirkpatrick's Training Evaluation Model.

5.1. De-escalating Aggressive Behavior Scale

The De-escalating Aggressive Behavior Scale (DABS) is a seven-item Likert Scale assessment developed by Nau et al. (2009).[54] It requires that a clinician directly evaluate a de-escalator handling a tense situation or use a simulation patient for evaluation purposes. Nau (2011) validates this metric as reliable but acknowledges that it is not the most accessible due to its requirement of direct evaluation.[55]

5.2. Confidence in Managing Patient Aggression Scale

Thackery's (1987) Confidence in Managing Patient Aggression Scale[56] assesses de-escalation training efficacy via de-escalator confidence metrics. Nau (2011) found that it had fairly high sensitivity (84%), specificity (79%), and positive and negative predictive values (0.87 and 0.76, respectively).[57] However, the model did a poor job of assessing de-escalation competency on an individual basis, and is thus not suited to fully replace the DABS.

5.3. Kirkpatrick's Training Evaluation Model

The Kirkpatrick Training Evaluation Model (1959, 1975, 1993) is used for evaluation training generally, and is not designed specifically for de-escalation training.[58,59,60] However, it is mentioned in this review for its repeated validation over several decades. The model consists of four levels of evaluation, adapted to a de-escalation framework in this description: reaction (do trainees like the course), learning (did trainees learn the material), behavior (are trainees able to practice de-escalating behaviors), and results (impact of the training on workplace violence in a healthcare setting). While somewhat dated, Kirkpatrick's model benefits from including a "results" section; ultimately, the goal of de-escalation training is to reduce incidents of violence, injuries, and restraint and seclusion practices in healthcare settings.

5.4. Evaluation Going Forward

Several evaluation metrics, including the Confidence in Managing Patient Aggression Scale, evaluate de-escalation training approaches using metrics of gained knowledge and self-confidence. While these measures are important to gather following the implementation training, they do not answer the question of greatest priority: does de-escalation work in on-the-ground clinical practice? Proper evaluation of de-escalation training efficacy must occur case-by-case, in all units in which a new de-escalation intervention is implemented. It is imperative that healthcare organizations emphasize reporting violent incidents, and that they publish data regarding aggressive incidents, instances of restraint, instances of seclusion, and injuries to patient and staff.

6. Conclusion

Solutions to the epidemic levels of violence in healthcare settings are in dire need. De-escalation training has promise for its potential to prevent violent incidents and defuse incidents as they occur, limiting the need for last-resort techniques like restraint and seclusion. However, the field of de-escalation lacks widespread testing, validation, and improvement of clear de-escalation frameworks. The non-profit research institute RAND Europe conducted a review of 19 studies on de-escalation training, for which they found consistent reports of gained knowledge and self-efficacy following training interventions.[61]

Yet the group was unable to find any measure showing that de-escalation training actually reduces violent incidents. De-escalation training deserves, by RAND's recommendation, "well-designed studies to confirm preliminary results."[62] This criticism of de-escalation in the literature was echoed by Hallett (2017), Beech (2006), and Anderson (2010), who went so far as to describe de-escalation recommendations in the literature as "weak or dubious" given the lack of validating studies.[63,64,65] As this body of work continues to grow, however, violence in healthcare settings will likely be mitigated. Growth, though, can only be achieved through concerted efforts by researchers, healthcare staff, and hospital administrators to investigate, report, and publish data regarding the efficacy of de-escalation training.

AUTHOR

Abigail Shulman received a B.A. from Rice University in Cognitive Sciences and Religion, specializing in the impact of policy, religion, and culture on health outcomes. She is currently pursuing a Masters in Public Health at the University of Texas School of Public Health, with a major in Epidemiology and particular experience studying sexual health and HIV. With her continued interest in the political and societal bearing on health behaviors, Abigail hopes to contribute to a culturally invested intervention programs aimed at improving community health.

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