

VHA WORKPLACE VIOLENCE PREVENTION PROGRAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive provides policy and responsibilities for a VHA Workplace Violence Prevention Program (WVPP).

2. SUMMARY OF CONTENT:

a. Amendment dated February 22, 2022:

(1) Renumbers the directive as VHA Directive 1160.08. The rationale for this is that this policy falls under Clinical Services, Office of Mental Health and Suicide Prevention.

(2) Adds context to definition of Employee Threat Assessment Team in paragraph 3.g. (page 3).

(3) Clarifies paragraph 5.g.(2) (page 8)

(4) Clarifies paragraph 5.h.(3) and (8) (pages 8 and 9).

(5) Adds a clarifying note in paragraph 5.l.(1) (page 12).

(6) Updates Appendix C, Data Collection and Event Reporting in the Disruptive Behavior Reporting System and the Annual Workplace Behavioral Risk Assessment (page C-1).

(7) Removes the word independent from Appendix D, paragraph 1.b.(1) (page D-2).

b. As published August 23, 2021, this new directive established WVPP policy to promote a culture of safety and security for Veterans, patients, visitors, and employees in all VHA workplaces

3. RELATED ISSUES: VA Directive 7700, Occupational Safety and Health, dated February 11, 2009; VA Directive 5019, Employee Occupational Health Services, dated March 27, 2015; VHA Directive 2010-053, Patient Record Flags; VHA Directive 2012-026, Sexual Assaults and other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities, dated September 27, 2012; VHA Directive 7701, Comprehensive Occupational Safety and Health Program, dated May 05, 2017.

4. RESPONSIBLE OFFICE: The Office of Mental Health and Suicide Prevention (11MHSP) is responsible for the contents of this directive. Questions may be directed to WVPPActions@va.gov.

5. RESCISSION: None. **NOTE:** *The policy has been renumbered but the content has not changed.*

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of August 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

/s/ Kameron Matthews MD, JD
Assistant Under Secretary for Health for
Clinical Services

NOTE: All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

DISTRIBUTION: Emailed to the VHA Publications Distribution List on August 23, 2021.

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VHA WORKPLACE VIOLENCE PREVENTION PROGRAM

1. PURPOSE

This Veteran Health Administration (VHA) directive establishes policy and responsibilities for the development, management and administration of the VHA Workplace Violence Prevention Program (WVPP). It assigns workplace violence prevention responsibilities to all levels of management and provides for a VHA Central Office point of coordination for these activities within the organization. This purpose is consistent with VHA's longstanding commitment to a culture of safety and security, and to adherence to existing safety and security regulations and standards, in all places where VHA work is conducted. **AUTHORITY:** Title 38 United States Code (U.S.C.) §§ 1709, 7301(b); Title 38 Code of Federal Regulations (C.F.R.) § 17.107.

2. BACKGROUND

a. Many government and industry groups and publications require or recommend that organizations establish workplace violence prevention programs. Representative of these are the Federal Bureau of Investigation's Workplace Violence: Issues in Response; the Interagency Security Committee's Violence in the Federal Workplace: A Guide for Prevention and Response; the International Association for Healthcare Security and Safety's Guidelines on Threat Management and Violent Patient / Patient Visitor Management; The Joint Commission; and the Occupational Safety and Health Administration (OSHA).

b. VHA has demonstrated the feasibility of engaging multidisciplinary teams in evidence-based, data-driven behavioral threat assessment and management practices to prevent and reduce disruptive behaviors that contribute to incidents of workplace violence.

c. This directive addresses governance of the WVPP in VA medical facility workplaces. Although many VHA national or regional programs, such as call centers, manufacturing sites, and administrative units, etc., may be co-located in VA medical facility workplaces, the operating procedures addressing disruptive behavior at these locations are not covered by this directive.

3. DEFINITIONS

a. **Behavioral Code Team**. A Behavioral Code Team is comprised of personnel from any discipline, profession, or department who are available to respond to behavioral emergencies throughout the VA medical facility, and who have completed PMDB training requirements (see Appendix B).

b. **Behavioral Threat Assessment**. Behavioral threat assessment is the ongoing and iterative evidence-based use of available and relevant data to estimate the level of behavioral risk an individual poses in the health care environment. The assessment is conducted by either the Disruptive Behavior Committee (DBC) (see paragraph 3.e.) or

the Employee Threat Assessment Team (ETAT) (see 3.g.). **NOTE:** For further information on behavioral threat assessment, see Appendix D.

c. **Behavioral Threat Management.** Behavioral threat management is the ongoing and iterative process of managing a subject's threatening behavior through interventions and strategies designed to interrupt or prevent future acts of affective or predatory violence and disruptive behavior. **NOTE:** For further information on behavioral threat management, see Appendix E.

d. **Disruptive Behavior.** Disruptive behavior is verbal, non-verbal, written, or electronic behavior by any individual that: is intimidating, threatening, or dangerous; has jeopardized or could jeopardize the health, safety or security of patients, VA employees, or other individuals at the VA medical facility; would create fear in a reasonable person; interferes with the safe, secure and effective delivery of VA health care; compromises the ability of VA to engage in its mission of serving Veterans; or impedes the daily operation of the facility. Disruptive behavior does not depend upon the actor's stated intentionality or justification for the behavior, the presence of psychological or physical impairment, whether the person has decision-making capacity, or whether the person later expresses remorse or an apology.

(1) **Employee-Generated Disruptive Behavior.** Disruptive behavior committed by present or former VA employees, contractors, volunteers, health professions trainees (HPT), academic affiliates, locum tenens, without compensation appointees, personnel whose responsibilities bring them into VA medical facilities, and family members of these types of individuals. If a VA employee who is also a VA patient is disruptive in the workplace setting while in the employee role, the disruptive behavior is considered employee-generated.

(2) **Patient-Generated Disruptive Behavior.** Disruptive behavior by present or former VA patients; beneficiaries; patient visitors, guardians, companions, spouses, friends, family members, etc.; or individuals not otherwise affiliated with the VA whose behavior causes safety concerns. If a patient who is also a VA employee is disruptive in the health care setting while in a patient role, the disruptive behavior is considered patient-generated.

e. **Disruptive Behavior Committee.** The DBC is the VA medical facility multidisciplinary behavioral threat assessment and management team that operates under the authority of the Chief of Staff (COS) as the designee to address patient-generated disruptive behavior, threats, or violence that undermine a culture of safety within the VA medical facility, and to implement the requirements of 38 CFR 17.107. Although these clinical consultation teams historically have been called committees, they differ from traditional committees in that they do not require a quorum to conduct business; they do not vote on actions; attendance of required members is tracked by role, not individual; they are not required to produce formal minutes; and they do not require a charter (for more information, see the [Disruptive Behavior Committee \(DBC\) Guidebook](#)). **NOTE:** If the facility requires documentation of the DBC's roles and function, then it must be done in a way that acknowledges how it differs from a

traditional facility committee and is in keeping with safety-informed guidelines published by the WVPP national office. If the facility requires the DBC documentation of its activities, then such documentation will be generated from DBRS functionality in keeping with safety informed guidelines published by the WVPP national office.

f. **Disruptive Behavior Reporting System.** The Disruptive Behavior Reporting System (DBRS) is a VA-approved secure web-based reporting mechanism providing means for all VA employees to alert the DBC or the ETAT about behaviors that cause a safety concern, and about disruptive or violent events occurring within the health care setting.

g. **Employee Threat Assessment Team.** The ETAT is a VA medical facility level multidisciplinary behavioral threat assessment and management team that addresses employee-generated disruptive behavior, threats or violence that may undermine a culture of safety within the VA medical facility. This multidisciplinary behavioral threat assessment and management team is not a traditional committee in that it does not require a quorum to conduct business; it does not vote on actions; attendance of required members is tracked by role, not by named individual; it is not required to produce formal minutes; and it does not require a charter (for more information, refer to: [ETAT: Managing Risks Posed by Disruptive Employees](#)).

h. **Intimate Partner Violence.** Intimate partner violence (IPV) is physical, sexual or psychological harm or stalking behavior by a current or former partner that occurs on a continuum of frequency and severity, ranging from emotional abuse to chronic, severe battering or even death. IPV can occur in heterosexual or same-sex relationships and does not require sexual intimacy or cohabitation.

i. **Order of Behavioral Restriction.** An Order of Behavioral Restriction (OBR) is a restriction on the time, place, and/or manner of the provision of a patient's medical care. These restrictions are part of a behavioral threat management plan designed to enable the provision of safe health care to a patient who otherwise poses a threat to the health care milieu. ***NOTE: For further information on OBR, see Appendix E.***

j. **Patient Record Flag.** The Patient Record Flag (PRF) is a national communication tool used to immediately alert personnel to the presence of behavioral or clinical safety concerns, and to the actions, orders or treatment plans recommended to limit the impact of these concerns. A PRF is visible in the electronic medical record across all VA medical facilities. ***NOTE: A Behavioral PRF (BPRF) alerts personnel to patients who pose an immediate safety threat for seriously disruptive, threatening, or violent behavior. The BPRF permits VA health care providers to take appropriate measures to ensure that the patient may be safely treated within the VA health care system.***

k. **Personnel.** For the purpose of this directive, the term personnel includes those officers and employees of VHA; consultants and attending clinicians; without compensation (WOC) employees; Intergovernmental Personal Act (IPA) employees; contractors; others employed on a fee basis; medical students and other health professions trainees; and volunteer workers rendering uncompensated services,

excluding patient volunteers, providing a service at the direction of VA personnel.

NOTE: *Compensated Work Therapy (CWT) workers are not VHA personnel; they are patients receiving active treatment or therapy.*

l. **Prevention and Management of Disruptive Behavior Program.** The Prevention and Management of Disruptive Behavior (PMDB) program is the only approved curriculum to meet mandatory requirements to train all VA employees in concepts of workplace violence prevention.

m. **Structured Professional Judgment.** Structured professional judgment (SPJ) is an ongoing, iterative systematic process that uses existing evidence-derived risk and protective factors to inform clinical judgment in estimating current levels of risk, and identifying the conditions in which the risk is higher. Use of this approach affords the opportunity to develop strategies to reduce the impact of dynamic risk factors, and to enhance the number and influence of protective factors, in order to lower the overall threat of both affective and predatory violence.

m. **Violence Risk Assessment Instrument.** The Violence Risk Assessment Instrument (VRAI) is a structured professional judgment risk assessment guide developed specifically for VHA using Veteran-related data. **NOTE:** *For further information on VRAI, see:* <https://dvagov.sharepoint.com/:b:/r/sites/VHAWVPP/Tools%20Resources%20Strategies/VRAI-G%20User%27s%20Guide.pdf?csf=1&web=1&e=8R6eh9>. *This is an internal VA website and is not available to the public.*

n. **Workplace Behavioral Risk Assessment.** The Workplace Behavioral Risk Assessment (WBRA) is an annual report of all disruptive events occurring at a VA medical facility (and its components). It is submitted through the VA medical facility Director through the Veterans Integrated Service Network (VISN) Director to the WVPP national office (see paragraph 5.g.(7)).

o. **Workplace Behavioral Risk Level.** Workplace risk level is an estimate of the likelihood that employees working in that setting will be exposed to disruptive or violent behavior, based upon the WBRA results. The categories of workplace risk level identified by the WBRA are:

(1) **Minimal risk.** Data indicate that no workplace violence has occurred in the workplace and that employees who work here are at almost no risk of exposure to verbal, physical, sexual, criminal, or purposefully unsafe acts.

(2) **Low risk.** Data indicate that employees in this workplace are at risk for exposure to verbal (non-physical) disruptive behavior only.

(3) **Moderate risk.** Data indicate that employees in this workplace are at risk for exposure to physical and verbal disruptive behaviors, which may include sexual assault, criminal behavior, or other purposely unsafe acts.

(4) **High risk.** Data indicate that employees in this workplace are at risk for exposure to physical disruptive behavior severe enough to require physical containment of a patient in order to continue medical care safely.

p. **Workplace Violence.** For purposes of this directive VHA uses the National Institute for Occupational Safety and Health (NIOSH) definition that workplace violence consists of violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty. It can occur at or outside the workplace and can include, but is not limited to, interpersonal violence that enters into the workplace, stalking, threats, harassment, bullying, verbal abuse, emotional abuse, intimidation, physical assaults, homicide, disruptive behavior, or other forms of conduct that create anxiety, fear, and a climate of distrust in the workplace. **NOTE:** *The definition's exact wording and more information can be found on the NIOSH website at <http://www.cdc.gov/niosh/docs/96-100/introduction.html>.*

4. POLICY

It is VHA policy that each VA medical facility must have a comprehensive program to address all facets of workplace violence prevention, including both patient-generated and employee-generated disruptive behavior. The program must contain the following elements: employee education, data collection and analysis, behavioral threat assessment and management, and communication protocols.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for:

(1) Ensuring that the WVPP national office is appropriately resourced and funded to implement this directive.

(2) Supporting the WVPP national office with implementation and oversight of this directive.

(3) Identifying the offices and programs responsible for developing, implementing and monitoring physical security and environmental design requirements as they relate to workplace violence prevention, and ensuring their collaboration with the Office of Mental Health and Suicide Prevention (OMHSP).

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the VISNs.

(2) Assisting VISN Directors in resolving implementation and compliance challenges

in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive, relevant standards and applicable regulations.

d. **Executive Director, Office of Mental Health and Suicide Prevention.** The Executive Director, OMHSP, is responsible for:

(1) Ensuring that WVPP is funded adequately to meet all requirements of this directive and other mandates and regulations that may arise.

(2) Ensuring compliance with this directive through appropriate monitoring activities.

(3) Ensuring that WVPP is resourced adequately to fulfil its mission in VHA.

(4) Providing support and advocacy for the identification and promulgation of best practices in workplace violence prevention programming within VHA.

e. **National Director, Workplace Violence Prevention Program.** The National Director, WVPP is responsible for:

(1) Designing, implementing, overseeing and supporting the Workplace Violence Prevention Programming within VHA.

(2) Determining the content, implementation requirements and operational processes of the Disruptive Behavior Committee (DBC) and the Employment Threat Assessment Team (ETAT) to ensure that they meet respective published regulatory and statutory requirements and behavioral threat assessment and management best practice guidelines (See Appendix D, E, & F).

(3) Developing and updating this directive as delegated by the Executive Director, OMHSP.

(4) Ensuring that VA medical facility workplace violence prevention program personnel have access to tools and guidance for implementing:

(a) Multidisciplinary, evidence-based, data-driven behavioral threat assessment and management teams (i.e. Disruptive Behavior Committee (DBC) and Employee Threat Assessment Team (ETAT)).

(b) Disruptive behavior prevention.

(c) Violence prevention practices and initiatives within VHA.

(5) Ensuring that VA medical facility workplace violence prevention program personnel have access to WVPP-related procedures, curricula, training materials and regulatory guidelines on the WVPP SharePoint at

<https://dvagov.sharepoint.com/sites/VHAWVPP/sitepages/home.aspx> **NOTE:** This is an

internal VA website that is not available to the public.

(6) Ensuring that VA medical facility and VISN workplace violence prevention program personnel have access to consultation services related to:

(a) Behavioral threat assessment and management cases.

(b) Local VA medical facility WVPP operation and implementation issues.

(7) Serving as the business owner of the DBRS and determining its content and operational functionality requirements. (See Appendix C).

(8) Determining the content and operational processes of the WBRA and other reporting and data elements of the WVPP. (See Appendix C).

(9) Determining the content and operational processes of the Prevention and Management of Disruptive Behavior (PMDB) program to ensure that it meets published regulatory and statutory requirements (see Appendix B), and providing oversight, guidance, support and management of the PMDB program.

(10) Collaborating with Employee Education Service (EES) to implement the PMDB program in a manner consistent with the requirements set forth in Appendix B of this directive.

f. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Communicating the contents of this directive to each of the VA medical facilities in the VISN.

(2) Ensuring that each VA medical facility Director in the VISN has sufficient resources to fulfill the terms of this directive.

(3) Providing oversight to VA medical facilities in the VISN to ensure compliance with this directive.

(4) Reporting and summarizing implementation and compliance data regarding WVPP operations at VISN facilities when requested.

(5) Adhering to national guidance for workplace violence prevention, including this directive and future guidelines and processes provided by the WVPP and posted on the WVPP SharePoint at <https://dvagov.sharepoint.com/sites/VHAWVPP/sitepages/home.aspx>. **NOTE:** *This is an internal website that is not available to the public.*

(6) Issuing a final decision on a request for review of OBR in accordance with the timelines and procedures defined in Appendix E, paragraph 4.c.

(7) Ensuring VA medical facilities in the VISN identify their offices and programs responsible for developing, implementing and monitoring physical security and environmental design requirements as they relate to workplace violence prevention in the facility, and ensuring that these offices collaborate with local WVPP personnel.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Establishing a comprehensive workplace violence prevention program and ensuring it is compliant with national program guidelines.

(2) Establishing an Employee Threat Assessment Team (ETAT), appointing a Chair skilled in team leadership and trained in the best practices of evidence-based and data-driven behavioral threat assessment and management, and ensuring that ETAT is appropriately resourced and in compliance with this directive. **NOTE:** *The ETAT Chair (and co-Chair) should not be selected from personnel whose role(s) may require their engagement in employee disciplinary actions (e.g., VA medical facility Director, Deputy Director, Associate Director, Assistant Director, Human Resources (HR), Union, etc.). A Chair who works remotely should do so within the local commuting area of the parent VA medical facility.*

(3) Appointing the VA medical facility Chief of Staff to be responsible for the Disruptive Behavior Committee (DBC). (See paragraph 5.h.(1))

(4) Ensuring all required members of the DBC and ETAT are trained in accordance with WVPP national office requirements that are found on the WVPP SharePoint: <https://dvagov.sharepoint.com/sites/VHAWVPP/sitepages/home.aspx>. **NOTE:** *This is an internal website that is not available to the public.*

(5) Ensuring all members of the DBC and ETAT are VA medical facility employees in good standing. **NOTE:** *An employee in good standing is regarded as having complied with all explicit obligations, while not being subject to any form of sanction, suspension, or disciplinary censure.*

(6) Ensuring that the DBRS is operational and available at the VA medical facility, including but not limited to unimpeded access for personnel to make reports regarding behaviors causing safety concerns.

(7) Ensuring that the WBRA process is adequately resourced, completed, and submitted to the WVPP national office by December 31 of each calendar year. (See Appendix C).

(8) Ensuring that the Prevention and Management of Disruptive Behavior (PMDB) program is adequately resourced to meet the VA medical facility workforce training requirements as determined by the WBRA (see Appendix B); and that the VA medical facility PMDB Coordinator has sufficient protected time to manage all elements of the facility program.

(9) Ensuring the annual PMDB Training Plan accurately reflects the VA medical

facility's training needs based upon the WBRA, records training completions, and is submitted to the WVPP national office by May 31 each year.

(10) Ensuring that all VA medical facility employees receive the elements of PMDB training required for the highest expected behavioral risk exposure for their job duties.

(11) Ensuring that supervisors/ managers develop alternate safety plans for any employees exempted from PMDB training due to physical or psychological limitations.

(12) Approving and implementing recommendations from the VA medical facility ETAT and maintaining unimpeded communication with the ETAT chair and co-chair, to include implementation status of recommendations.

h. **VA Medical Facility Chief of Staff**. The VA medical facility Chief of Staff (COS) is responsible for collaborating with the ADPCS to ensure the following:

(1) Establishing a Disruptive Behavior Committee (DBC).

(2) Ensuring that the DBC is appropriately resourced to operate within the full scope of its role as established in this directive.

(3) Selecting a DBC Chair who is a senior licensed clinician with knowledge of and experience in data-driven, evidence-based behavioral threat assessment and management best practices, in keeping with the guidance provided in Appendix D.

NOTE: A Chair who works remotely should do so within the local commuting area of the parent VA medical facility.

(4) Meeting regularly (at least quarterly) with the DBC Chair.

(5) Ensuring the VA medical facility Director receives training completion reports for all members of the DBC and is apprised of any DBC members who fail to fulfil training requirements.

(6) Developing a facility specific process to ensure that DBC is notified when a patient with a BPRF or OBR requests care at the VA medical facility or is admitted to inpatient care from another VA medical facility.

(7) Issuing OBRs when needed, based upon the evidence-based behavioral threat assessment and management plan recommended by the DBC, and ensuring notification of patients in accordance with the timelines and procedures defined in Appendix E.4.c. ***NOTE: The VA medical facility COS may designate the DBC or its leadership to act in this behalf as appropriate, but the COS remains responsible for the implementation and management of the OBR and of the request for review of restrictions process. (See Appendix E).***

(8) Ensuring that requests for review of OBRs are processed in accordance with the timelines and procedures defined in Appendix E, Paragraph 1.b.(1).(b) and that the DBC chair is engaged in the process of preparing the OBR review materials.

(9) Ensuring clinical and administrative support members of the DBC have access to the electronic health record (EHR), including functional access of DBRS templating features into the EHR.

i. **VA Medical Facility Associate Director for Patient Care Services.** The VA medical facility Associate Director for Patient Care Services (ADPCS) is responsible for collaborating with the COS to ensure the following:

(1) All required PMDB training as defined by the WBRA results is completed by all nursing personnel (see Appendix B).

(2) All new personnel complete all PMDB training required for their work area assignments within 90 days of hire.

(3) Personnel with behavioral emergency training are represented on all behavior code teams.

(4) High risk workplaces have assigned at all times a minimum of four clinical personnel fully trained to immediately implement patient containment safety procedures as described in Appendix B.

(5) At least one clinical registered nurse (RN) from a high risk workplace serves on the DBC (see Appendix D, paragraph 1 b) and thereby informs the content submitted in the annual WBRA (see Appendix C paragraph b).

(6) At least one clinical registered nurse serves on the ETAT.

j. **VA Medical Facility Chief of Police.** The VA medical facility Chief of Police is responsible for:

(1) Assigning senior ranking officers (e.g. Police Chief, Deputy Police Chief or a detective) to serve as members of the DBC and the ETAT, and ensuring that:

(a) These individuals are identified as recipients of DBRS event notifications.

(b) Alternate members are trained to fill in when any designated member of the DBC or ETAT is absent.

(c) There is police representation at every DBC meeting and ETAT meeting.

(d) All police members of DBC and ETAT have knowledge and training in behavioral threat assessment and management, physical security, and investigation of violent and criminal activity.

(e) All police members are able and willing to work as members of multidisciplinary teams.

(f) All police members provide their respective teams with information relevant to

behavioral threat assessment and threat management, including history of disruptive events, presence of protective orders, and criminal records as allowable.

(2) Ensuring that VA Police assist the DBC and ETAT in obtaining and providing behavioral and criminal data as appropriate to inform violence risk and protective factor identification.

(3) Implementing the DBC's behavioral threat management strategies and OBRs that require police action. Such strategies may include, but are not limited to, police escort (in rare and severe cases), police check-in, police standby, and talking with patients.

(4) Disseminating information that VA Police officers of any rank are eligible to serve as certified PMDB trainers in compliance with national PMDB program office standards.

(5) Ensuring VA Police officers complete Part 1 PMDB training that is required for all VHA employees.

(6) Ensuring VA Police officers are aware of the skills trained to VHA personnel in all elements of PMDB to improve their ability to collaborate with personnel during behavioral emergencies, including but not limited to maintaining the boundaries between clinical and law enforcement roles during hands-on engagement of patients.

(7) Ensuring VA Police officers do not use PMDB Personal Safety Skills or Therapeutic Containment techniques as part of their professional activities and actions, and do not serve as members of the four-person Therapeutic Containment team.

k. **VA Medical Facility Disruptive Behavior Committee Chair.** The VA medical facility Disruptive Behavior Committee (DBC) Chair is responsible for:

(1) Reporting to the VA medical facility Chief of Staff (COS) and the Associate Director for Patient Care Services (ADPCS) on the activities of the DBC, which operates as clinical care in the context of case consultation and treatment planning. These responsibilities include:

(a) Apprising the VA medical facility COS of DBC-specific training completion status for all members of the DBC, including both successful completions and failures to complete training.

(b) Apprising the VA medical facility COS and the ADPCS of the status of the facility PMDB program, including training requirements, resource needs and compliance as conveyed by the PMDB Coordinator.

(2) Acting on behalf of the VA medical facility COS to oversee, lead and conduct the activities and responsibilities of the DBC, including:

(a) Using a multidisciplinary team approach to conduct individualized behavioral threat assessments and to develop customized behavioral safety plans, following

evidence-based and data-driven practices that align with research and recommended strategies promulgated in the professional behavioral threat assessment and management community. (See Appendices D, E, and F.)

(b) Including data from the patient's electronic health record (EHR) in conducting behavioral threat assessments and developing behavioral safety plans.

(c) Scheduling regular live (i.e., in-person or videoconference) meetings occurring at least monthly (see Appendix D, Part 1 Disruptive Behavior Committee for more information).

(d) Receiving and reviewing within one business day of receipt every DBC-relevant DBRS event report and other reports raising behavioral safety concerns. The DBC chair may take emergency safety action upon review of the report if indicated (see Appendix D), including the placement of a temporary BPRF to communicate urgently needed safety actions (see Appendix E). Regardless of whether emergency safety actions are taken, the DBC will continue its multidisciplinary process (per 5.k.(2)(a) and Appendix E) as soon as possible but within 30 calendar days after receipt of the report.

(e) Ensuring that individualized behavioral threat management plans address risk and protective factors and are modified as needed based upon ongoing and iterative reassessments on active cases. (See Appendix D.)

(f) Using the minutes function of DBRS to standardize documentation of DBC meetings and other activities, if such documentation is required by the VA medical facility, or to support requests for documentation of DBC activities from other entities within the VA medical facility. **NOTE:** *This directive does not require the DBC to routinely produce minutes.*

(g) Ensuring the completion and submission of the annual VA medical facility WBRA to the WVPP national office by December 31 of each calendar year; and reviewing WBRA data annually to monitor for trends and identifiable behavioral threat-related violence hazard changes. (See Appendix C.)

(h) Ensuring interfacility collaboration when a patient with an OBR or BPRF transfers care between facilities.

(i) Immediately notifying VA medical facility Police when a report of sexual assault is received.

I. VA Medical Facility Prevention and Management of Disruptive Behavior Coordinator. The VA medical facility Prevention and Management of Disruptive Behavior (PMDB) Coordinator is responsible for:

(1) Serving on the DBC to incorporate as part of the behavioral threat assessment and management planning any information about employee training or need for training that may contribute to or reduce severity of workplace violence events. **NOTE:** *A PMDB Coordinator who works remotely should do so within the local commuting area of the*

parent VA medical facility.

(2) Participating in the completion of the annual WBRA. (See Appendices B and C.)

(3) Apprising the DBC of the current status of the facility PMDB training program at least quarterly, including updates on unmet training requirements, current and anticipated resource needs, and level of training compliance.

(4) Working with VA medical facility Education Service and Talent Management System (TMS) administrator to ensure that:

(a) All employees are assigned to and complete appropriate elements of training based upon their individual workplace risk as determined by the WBRA.

(b) Any contractors, health professions trainees, fee-basis, or part-time personnel employed in workplaces with known risks as determined by the WBRA will be offered the opportunity to complete commensurate in-person training in PMDB and will at a minimum complete online introductory training.

(c) Employees receive requested additional elements of training in disruptive behavior and workplace violence prevention.

(d) Employee training is assigned, completed, tracked and reported correctly in TMS.

(5) Ensuring the facility PMDB training program meets the following standards:

(a) All courses are taught by teams of at least two WVPP-certified PMDB trainers.

(b) All trainers are certified by completion of an approved Train the Trainer (TTT) course, are recertified no less than every 4 years, and maintain certification by completing a minimum of 4 classes per year in each PMDB course they are certified to train.

(c) All trainers submit required EES documentation annually.

(d) All courses remain within the approved participant range of six to sixteen per class.

(e) At a minimum, PMDB courses in awareness and preparedness, reporting, verbal de-escalation skills, limit setting and physical safety are made available for all new employees to take during new employee orientation before they enter their workplace.

(f) All new employees are assigned the required PMDB courses as identified by WBRA data and that completion status within 90 days of hire is monitored and reported to the DBC Chair.

(g) Following completion of initial PMDB training, employees demonstrate

competency in the skills in which they trained at least every 2 years, either by successfully completing a formal skills assessment or by returning to class for retraining.

(h) Employees in clinical areas that require annual training in management of disruptive behavior (e.g. VA medical facility Emergency Departments, many inpatient psychiatric units) receive PMDB skills assessments annually or return to class for retraining.

(i) Quarterly drills are provided for all employees trained in PMDB patient containment techniques, and employees qualified to use these techniques must participate in at least 2 drills every 12 months, which satisfies the employee's required skills assessment found above in 5.I.(5).(g).

(6) Collecting and providing upon request training completion data, in aggregate, for reporting and accountability.

(7) Attending monthly PMDB conference calls for program updates, guidance and continuing education and training in the role of PMDB Coordinator.

(8) Adhering to the guidelines established by the national PMDB program office as published on the PMDB SharePoint site (<https://dvagov.sharepoint.com/sites/VHAPMDB/SitePages/Home.aspx>). **NOTE:** *This is an internal VA website and is not available to the public.*

m. **VA Medical Facility Employee Threat Assessment Team Chair.** The Employee Threat Assessment Team (ETAT) Chair is responsible for:

(1) Reporting to the VA medical facility Director on the activities of the ETAT. These responsibilities include:

(a) Apprising the VA medical facility Director of ETAT-specific training completion status for all members of the ETAT, including both successful completions and failures to complete training.

(b) Communicating to the VA medical facility Director recommendations for supporting the facility's culture of safety arising from tracking and trending ETAT-related behavioral threat assessment and management data.

(2) Acting on behalf of the VA medical facility Director to oversee, lead and conduct the activities and responsibilities of the ETAT, including:

(a) Using a multidisciplinary team to conduct behavioral threat assessments and to develop individualized behavioral safety plans, following evidence-based and data-driven practices that align with research and recommended strategies promulgated in the professional threat assessment and management community (See Appendices B, E, and F).

(b) Providing the VA medical facility Director with individualized case-specific recommendations for risk mitigation and protective factor enhancement based upon the results of the ETAT's behavioral threat assessments (See Appendix F).

(c) Scheduling regular in-person meetings occurring at least monthly (see Appendix D, Part 2 Employee Threat Assessment Team for more information).

(3) Receiving and reviewing within one business day of receipt every ETAT-relevant DBRS event report and other reports raising behavioral safety concerns.

(4) Triaging reports to determine the level of action required and ensuring that the ETAT addresses reports that create safety concerns during the first available ETAT meeting but no later than 30 days after receiving each report.

(5) Ensuring that individualized behavioral threat management plans address case-specific risk and protective factors and are modified as needed based upon ongoing and iterative reassessments on active cases (See Appendix D).

(6) Ensuring reports of harassment (sexual or otherwise) that come to the ETAT's attention are also properly reported to the facility Harassment Prevention Program (HPP)/Office of Resolution Management (ORM) in accordance with regulatory and statutory requirements.

(7) Informing individuals who report experiencing sexual harassment, harassment or sexual assault of the option to report their experiences to the Harassment Prevention Program (HPP) for intervention, and of the time window for reporting.

(8) Immediately notifying VA medical facility Police when a report of sexual assault is received.

(9) Reporting information contained in DBRS reports regarding injuries in compliance with facility injury reporting protocol.

6. PRIVACY REQUIREMENTS

a. The DBRS must not be modified to become a System of Records as defined by the 1974 Privacy Act.

b. The ETAT must not become the keeper of records for documents rightly held by Human Resources, VA Police, employee unions or other sources, but information from these records may be used in conducting behavioral threat assessments and management. The DBC must not become a keeper of VA Police reports but may use information provided from those reports by VA Police in the conduct of threat assessment and management.

c. The DBC must have access to the electronic health record (EHR) of a patient in the course of performing its duties; the ETAT must have a release of information to access the EHR.

7. TRAINING

All training requirements are located on the WVPP SharePoint at: <https://dvagov.sharepoint.com/sites/VHAWVPP/sitepages/home.aspx> and the PMDB SharePoint site at: <https://dvagov.sharepoint.com/sites/VHAPMDB/SitePages/Home.aspx>). **NOTE:** *These are internal VA websites and are not available to the public.*

8. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive must be managed per the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule (RCS) 10-1. Any questions regarding any aspect of records management should be directed to the VA medical facility Records Officer.

9. REFERENCES

- a. 38 U.S.C. § 1709.
- b. 38 C.F.R. 0.735–12, 1.201, 1.203, 1.218 and 17.107.
- c. VA Directive 7700, Occupational Safety and Health, dated February 11, 2009.
- d. VHA Directive 2010-053, Patient Record Flags, dated December 2, 2010.
- e. The Joint Commission Standards: Environment of Care (EC.02.01.01 & EC.04.01.01), Human Resources (HR.04.01.01) and Leadership (LD.03.01.01).

RESOURCES

- a. 5 U.S.C. § 552a (Privacy Act).
- b. Workplace Violence Prevention Program SharePoint, <https://dvagov.sharepoint.com/sites/VHAWVPP/sitepages/home.aspx>
- c. [Disruptive Behavior Committee \(DBC\) Guidebook.](#)
- d. [ETAT: Managing Risks Posed by Disruptive Employees.](#)
- e. VHA Directive 1101.05(2), Emergency Medicine, dated September 2, 2016, amended March 7, 2017.
- f. VHA Directive 1093, Delegations of Authority to Process Tort Claims, dated July 17, 2014.
- g. Association of Threat Assessment Professionals <http://www.atapworldwide.org/>.
- h. Elbogen, EB; Beckham, JC; Butterfield, MI; Swartz, M; Swanson, J. "Assessing Risk of Violent Behavior Among Veterans with Severe Mental Illness." Journal of Traumatic Stress Vol. 21. February 2008, pp. 113-117.
- i. Farber, N.J., Jordan, M.E., et. al. "Primary Care Physicians' Decisions about Discharging Patients from Their Practices," J General Internal Medicine, 23(3):283-7, 2008.
- j. "General Duty Clause," Section 5, Occupational Safety Health Act, 1970. https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=3359&p_table=OSHACT.
- k. "Guidance for Agency-Specific Domestic Violence, Sexual Assault, and Stalking Policies", OPM 2013 <https://www.opm.gov/policy-data-oversight/worklife/reference-materials/guidance-for-agency-specific-dvsas-policies.pdf>.
- l. "Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers," Occupational Safety & Health Administration (OSHA 3148-01R 2004).
- m. "Healthcare Inspection-Management of Disruptive Patient Behavior at VA Medical Facilities" (Report No. 11-02585-129), VA OIG, 2013. <https://www.va.gov/oig/pubs/VAOIG-11-02585-129.pdf>.
- n. "Healthcare Program Evaluation-VHA's Management of Violent Patients" (Report No. 6HI-A28-038), VA OIG, 2004. <https://www.va.gov/oig/54/reports/VAOIG-02-01747-139.pdf>.
- o. "Interagency Security Committee Policies, Standards, and Best Practices."

<https://www.dhs.gov/isc-policies-standards-best-practices>.

p. Interagency Security Committee *Violence in the Federal Workplace: A Guide for Prevention and Response*.

q. The Joint Commission Standards.
https://www.jointcommission.org/standards_information/standards.aspx.

r. National Institute of Occupational Safety and Health
<http://www.cdc.gov/niosh/docs/96-100/introduction.html>).

s. OSHA WVP Guidelines.
<https://www.osha.gov/SLTC/workplaceviolence/standards.html>.

t. "Workplace Violence: Issues in Response." FBI, 2004. <https://www.fbi.gov/file-repository/stats-services-publications-workplace-violence-workplace-violence/view>.

u. International Association for Healthcare Security and Safety (IAHSS) *Guidelines on Threat Management 01.09.03* (February 2018). <http://www.iahss.org/>.

v. International Association for Healthcare Security and Safety (IAHSS) *Violent Patient / Patient Visitor Management 05.03* (April 2018). <http://www.iahss.org/>.

w. VHA Directive 1198, Intimate Partner Violence Assistance Program, January 28, 2019.

APPENDIX B

**PREVENTION AND MANAGEMENT OF DISRUPTIVE BEHAVIOR (PMDB)
PROGRAM**

a. The Prevention and Management of Disruptive Behavior (PMDB) program is the only curriculum approved for mandatory training of all VHA personnel in concepts of workplace violence prevention. The PMDB Program fulfills the requirements of:

(1) Title 38 United States Code (U.S.C.) § 1709, and

(2) The behavioral safety training requirements of The Joint Commission (TJC), the Commission on Accreditation for Rehabilitation Facilities (CARF) and the Occupational Safety and Health Act (OSHA).

b. The PMDB program meets these requirements by addressing the following:

(1) Providing content to ensure that every worker understands the concept of “universal precautions for violence,” and specifically that violence can be expected and avoided or mitigated through preparation.

(2) Improving customer experience as an essential violence risk reduction strategy.

(3) Teaching warning signs of behavioral escalation and verbal de-escalation techniques.

(4) Teaching underlying causes of disruptive and violent behavior.

(5) Informing employees how one’s behavior affects the behavior of others.

(6) Teaching disruptive behavior and violent incident reporting procedures.

(7) Providing a physical skills curriculum scientifically researched and biomechanically evaluated for safety and effectiveness

(8) Teaching physical safety skills and physical holding techniques that do not use pain or tissue damage to prevent and manage behavioral violence that threatens the delivery of safe, secure and effective care and service.

c. PMDB training is assigned to VHA personnel based upon the risk of violence in their physical workplace location as determined by the WBRA. Alignment of risk to training is as follows:

(1) All employees must receive basic education in the universal precautions for violence through the completion of online training in awareness, preparedness, response and reporting. This is the only training required of employees in minimal risk workplaces.

(2) Employees in low risk workplaces must also be assigned and complete training

in customer service and verbal de-escalation skills.

(3) Employees in moderate risk workplaces must also be assigned and complete training in customer service skills, verbal de-escalation skills, limit-setting skills, and physical safety skills.

(4) Employees in high risk workplaces must also be assigned and complete training in customer service skills, verbal de-escalation skills, limit-setting skills, physical safety skills and safe patient containment techniques.

d. All high risk workplaces must be equipped to provide all levels of health care to patients in behavioral crisis, which is a medical emergency. All high risk workplaces, therefore, must have:

(1) A minimum of four (4) personnel available at all times in the workplace to use PMDB patient containment techniques. These personnel must be:

- (a) clinical personnel;
- (b) proficient in all elements of PMDB training;
- (c) available in the workplace 24 hours a day, 7 days a week, 365 days a year; and
- (d) refreshed through drill participation a minimum of twice per year.

(2) Facilities have the option of developing Behavioral Code Teams available to respond to behavioral emergencies throughout the VHA medical facility. Members of a code team can come from any discipline, profession, or department, and must be:

(a) Trained and highly skilled in PMDB elements of ongoing interactive assessment, customer service, verbal de-escalation, and limit setting techniques, at a minimum;

(b) Trained and prepared to escape and evade physical violence safely and effectively using PMDB skills and techniques;

(c) Trained and capable of acting as either an alternate in PMDB containment techniques and as ancillary assistance to safely manage the environment in which PMDB containment techniques are being used; and

(d) Readily available to respond to behavioral emergency codes both within and outside of their workplaces.

(3) Employees in high risk workplaces are required to cover their own high risk workplace, therefore their participation in Behavioral Code Teams should be limited to only the highest risk behavioral codes. Facilities should limit the participation of employees from high risk workplaces to behavioral codes occurring in inpatient care settings, intensive care or post-operative units, Emergency Departments, Urgent Care Centers, or Community Living Centers. Behavioral Code Team members from other

workplaces should respond to behavioral codes occurring in less acute workplaces (e.g., outpatient or ambulatory care, administrative workplaces, radiology, etc.) where the use of therapeutic containment is prohibited.

Characteristics	High Risk Workplace Employees engaging in Patient Containment	Behavioral Code Team
Membership	Clinical employees only	Can be multidisciplinary
Location	Members must be assigned to the high risk workplace full-time	Can come from other workplaces, work across settings/clinics/units
Availability	Required to be present 24/7 in the high risk workplace	Can be determined locally
Training	Must be trained in all elements of PMDB and competent to safely perform therapeutic containment	Training in all elements of PMDB recommended but not required; at a minimum should be highly competent in verbal de-escalation, limit setting, and physical safety skills.
Goal	To stop patient-generated violence immediately before anyone is injured	To assist in de-escalation throughout the facility and act as back-up to support other de-escalation or containment efforts

APPENDIX C

DATA COLLECTION AND EVENT REPORTING IN THE DISRUPTIVE BEHAVIOR REPORTING SYSTEM AND THE ANNUAL WORKPLACE BEHAVIORAL RISK ASSESSMENT

The Disruptive Behavior Reporting System (DBRS) is an approved disruptive event reporting mechanism that must be readily accessible to all VA medical center employees, and to others who have authorized access to VA computer systems, including VA contractors, health professions trainees (HPT), and Without Compensation (WOC) providers. All personnel with access are encouraged to use DBRS to alert the Disruptive Behavior Committee (DBC) or Employee Threat Assessment Team (ETAT) of disruptive or violent events. **NOTE:** *A DBRS event report is used in conducting and documenting threat assessments, but the information contained within a report must be vetted against data obtained from a variety of sources during the threat assessment. A DBRS event report is not: a legal, forensic, or medical record document; a sworn witness statement; or a record of fact. It is a person's subjective report of what they heard, saw, thought, or experienced. Such reports are, by their nature, subject to being incomplete, contextually anchored, and possibly biased.*

The Workplace Behavioral Risk Assessment (WBRA) is an annual compilation of all disruptive events occurring at a VA medical facility and its components that must be submitted to the WVPP national Office. The WBRA provides local workplace violence prevention programs with facility-specific estimates of violence risk exposure for the workforce, from which the facility will assess its violence prevention training needs and develop its PMDB training plans. It also allows the national WVP office to compile risk related data and trends for VHA at the national, network, and facility levels.

a. The Disruptive Behavior Reporting System has the following functionality requirements:

(1) Must provide electronic confirmation to VA employees who submit a DBRS report that the appropriate behavioral threat assessment team, DBC or ETAT, received the report, except when the reporting employee chooses to remain anonymous. This automated notification must be modifiable so that it can be tailored to the specific needs of the facility. **NOTE:** *For more information, see the [DBRS User's Guide](#). This is an internal VA website that is not available to the public.*

(2) Must provide the option for anonymous reporting.

(3) Must provide contact information for the DBC or ETAT to employees submitting a DBRS report who have chosen not to report anonymously.

(4) Must provide means to generate data reports and aggregate summaries of disruptive and violent behavior events, patterns, and trends at VA medical facilities and across VHA, to inform all levels of workplace violence prevention planning and preparation in VHA, including the Workplace Behavioral Risk Assessment (WBRA).

(5) Must provide the technology for DBC to place a templated note from DBRS into the Electronic Health Record (EHR) to document the receipt of the event report and to track such reports in the EHR across time. This provides for the EHR, a System of Records (as defined by 5 U.S.C. § 552a (Privacy Act)), to contain appropriate information regarding the history of disruptive behavior event reports.

(6) Must not function in a manner that would render it a System of Records as defined by the 1974 Privacy Act.

(7) Must provide a summary report mechanism for responding to Freedom of Information Act (FOIA) requests. **NOTE:** *Completed FOIA requests for DBRS-related material must be routed through the national FOIA office for review and determination of final content before being released.*

(8) Must contain the structured professional judgment (SPJ) tools (e.g. Violence Risk Assessment Instrument (VRAI)) used by DBC and ETAT to conduct the evidence-based behavioral threat assessment(s), provide a repository for the summaries and recommendations resulting from this process, and generate the DBC standardized minutes report.

(9) Must provide disruptive event data transfer to support each facility's requirement to submit an annual Workplace Behavioral Risk Assessment (WBRA).

(10) Must enable VA employees to meet the requirements of 38 C.F.R. § 1.201 with respect to the mandatory reporting of acts of violence in the workplace.

b. The Workplace Behavioral Risk Assessment has the following requirements (for related responsibilities, see paragraph 5.d. Director, Workplace Violence Prevention Program Office):

(1) Must be submitted electronically and successfully to the WVPP national office no later than December 31 each calendar year, and must include all behavioral safety data from the prior Fiscal Year (FY) ending September 30 of that year. For specific guidance regarding the completion and submission of the WBRA, see <https://dvagov.sharepoint.com/sites/VHAWVPP/sitepages/home.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

(2) Must not contain personally identifiable information (PII).

(3) Must be completed in accordance with processes identified by WVPP national office.

(4) Must collect and analyze behavioral safety data drawn from DBC and ETAT DBRS reports; other DBC and ETAT records; VA Police data relevant to disruptive behavior, including sexual assaults; Patient Safety Reports; Occupational Health and Safety Reports; and other sources when identified and if appropriate.

BEHAVIORAL THREAT ASSESSMENT

VHA's evidence-based behavioral threat assessment approach uses all available and relevant data to estimate the behavioral risk of targeted and affective violence an individual poses in the health care environment. The assessment process identifies violence-relevant static and dynamic risk factors, and protective factors, that characterize the individual of concern. It seeks to identify the situations and conditions that might raise or lower the estimated risk. Whether conducted by the DBC or the ETAT, behavioral threat assessment is an ongoing and iterative process.

The use of Structured Professional Judgment (SPJ) approaches to behavioral threat assessment is considered a best practice within VHA. These approaches rely upon data collection to identify the presence or absence of factors that have been scientifically shown to be related to future violence. The estimates of risk are rendered from the array of risk and protective factors through the professional judgment of multidisciplinary teams trained in this approach to risk assessment.

In VA medical facilities, the behavioral threat assessment teams are the Disruptive Behavior Committee (DBC), which addresses patient-generated disruptive behavior and violence, and the Employee Threat Assessment Team (ETAT), which addresses employee-generated disruptive behavior and violence. Further information about and training on behavioral threat assessment is available on the WVPP SharePoint at <https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/Home.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

1. Disruptive Behavior Committee (DBC). Each VA medical facility must have a DBC. The DBC conducts thorough review and assessment of reported patient-generated disruptive behavior or violent events (see Definitions in paragraph 3 of this directive). DBC should be convened in-person. Required members of the DBC are expected to attend all meetings. Virtual attendance that supports real-time interaction is acceptable for DBC members for whom attendance in-person would place undue burden on their other job responsibilities, when they work remotely, or when they have physically limiting conditions making in-person attendance difficult or challenging. Although encrypted email may augment between-meeting communications, DBC activities are not conducted solely via email. Comprehensive guidance for the activities of the DBC may be found in the [Disruptive Behavior Committee \(DBC\) Guidebook](#). **NOTE:** *This is an internal VA website that is not available to the public.*

a. The behavioral threat assessment is guided by use of the Violence Risk Assessment Instrument (VRAI-G or VRAI-S), a structured professional judgement tool developed for use with Veterans in VHA. An interactive version of the VRAI-G is embedded in each patient-related DBRS report. The VRAI-G Users guide may be found on the WVPP SharePoint at <https://dvagov.sharepoint.com/:b:/r/sites/VHAWVPP/Tools%20Resources%20Strategies/VRAI-G%20User%27s%20Guide.pdf?csf=1&web=1&e=BgFX3z>, and the VRAI-S User's Guide at

<https://dvagov.sharepoint.com/:b:/r/sites/VHAWVPP/Tools%20Resources%20Strategies/VRAI-S%20User%27s%20Guide.pdf?csf=1&web=1&e=7r24ca>. **NOTE:** These are internal VA websites that are not available to the public.

b. The DBC is comprised, at a minimum, of the following VA medical facility personnel in good standing, who are to be trained in accordance with the requirements of the WVPP national office as per this directive:

(1) A Chair, appointed by the VA medical facility Chief of Staff, who is a senior clinician and licensed provider, with knowledge of and experience in structured professional judgment approaches to behavioral threat assessment and management. The DBC chair will usually be a mental health provider, but it is acceptable for the chair to be a senior clinician from another professional service line with the appropriate training and expertise in behavioral threat assessment and management. The chair must have demonstrated leadership skills and experience in working with multidisciplinary teams. Many facilities will find value in having a co-chair from a different discipline from the chair to co-lead the DBC.

(2) A representative of the facility's PMDB Program, to support the DBC's oversight and facilitation of the PMDB program.

(3) A senior ranking VA police officer or detective.

(4) A representative from Patient Safety or Risk Management.

(5) At least one member representing community-based programs such as Home-based Primary Care (HBPC), U.S. Department of Housing and Urban Development-VA Supportive Housing Program (HUD-VASH), Homeless Programs, Mental Health Intensive Case Management (MHICM), Caregiver Support, or Transitional Care Management (TCM).

(6) A representative from the Patient Advocate's office.

(7) A delegate from each labor union to represent the workplace violence prevention interests of the bargaining unit employees. **NOTE:** VHA is responsible for inviting labor partner participation on the DBC, but cannot mandate participation.

(8) A representative from each workplace designated as high risk in the most recent Workplace Behavioral Risk Assessment (WBRA). At least one of these representatives must be a nurse manager or other nursing professional.

(9) Clerical and administrative support personnel to accomplish the required tasks.

(10) In addition to the above required DBC membership, additional members may be selected to ensure diverse and comprehensive representation of the VA medical facility's workplace violence prevention needs. Some areas appropriate to consider, if not already required per 8 above, include Community Based Outpatient Clinics (CBOCs), the emergency department, inpatient mental health, outpatient behavioral

health clinics, primary care clinics, Geriatrics and Extended Care programs (e.g. community living centers), residential treatment programs, and substance abuse treatment programs.

c. The DBC is expected to work collaboratively within the VA medical facility in its mission to facilitate a safe health care environment. There are a number of program offices whose representatives can provide expertise and resources in collaborating with DBCs. These representatives may be invited to serve as ad hoc or full members of the DBC, or as subject matter experts who may be called upon when the need arises.

(1) Office of General Counsel (ad hoc).

(2) Health professions trainees (HPT) may serve as regular members or as time-limited rotational members to gain professional expertise in behavioral threat assessment and management in health care workplaces.

(3) Privacy Officer or Health Information Management Service.

(4) Ethics representative (from the local Integrated Ethics Program, e.g., Ethics consultation or Preventive Ethics).

(5) Intimate Partner Violence Assistance Program Coordinator (IPVAP-C).

(6) Veterans Justice Outreach (VJO) program(s) representative.

(7) Suicide Prevention Program (SPP) Coordinator.

(8) Community Care Office (CCO) representative.

(9) Minority Veterans Program Coordinator.

(10) LGBT Program Coordinator.

(11) Women Veterans Program Coordinator.

2. Employee Threat Assessment Team (ETAT). Each VA medical facility must have an Employee Threat Assessment Team (ETAT). The ETAT conducts thorough review and assessment of reported employee-generated disruptive behavior or violent events (see Definitions in paragraph 3 of this directive). ETAT should be convened in-person. Virtual attendance that supports real-time interaction is acceptable for ETAT members for whom attendance in-person would place undue burden on their other job responsibilities, when they work remotely, or when they have physically limiting conditions making in-person attendance difficult or challenging. Although encrypted email may augment between-meeting communications, ETAT activities are not conducted solely via email. Comprehensive guidance for the activities of the ETAT may be found in the ETAT Guidebook, [ETAT: Managing Risks Posed by Disruptive Employees](#). **NOTE:** *This is an internal VA website that is not available to the public.*

a. The behavioral threat assessment is guided by use of the structured professional judgement tool available electronically in the Disruptive Behavior Reporting System (DBRS). More information about behavioral threat assessment using a structured professional judgment approach can be found in the ETAT Guidebook referenced above.

b. Each primary member of the ETAT must have an identified backup person who can adequately fill in when that member is absent. The ETAT is comprised, at a minimum, of the following VA medical facility personnel in good standing, who are to be trained in accordance with the requirements of the WVPP national office as per this directive:

(1) A chair who has demonstrated ability to lead multidisciplinary teams. This role is generally assigned to a senior mental health clinician. Many facilities will find value in having a co-chair to assist in ETAT leadership and workload management, and who may be a senior VA police officer, safety office representative, or other ETAT member with proven leadership skill. This will help to maintain leadership continuity during vacations, illness, or when role conflicts necessitate that the chair be recused.

(2) At least one member with behavioral health expertise and experience in behavioral threat management, if the ETAT chair or co-chair does not fill this role.

(3) Representatives from the local union and labor bargaining units must be invited to work on the ETAT, although their participation cannot be required. These members represent the workplace violence prevention, safety, and security interests of all employees, rather than the interest of an employee who reportedly engaged in the behavior being reviewed or assessed. Union representatives serving on the ETAT do not serve as chair or co-chair.

(4) A representative from the Executive Office with direct access to the VA medical facility Director and other VA medical facility leadership and who has knowledge of the workings of VA medical facility management. This role might be filled by an executive assistant, an administrative officer, or others in leadership support roles. This member will facilitate the ability of the VA medical facility Director to receive and act upon the threat mitigation recommendations from the ETAT. It is not best practice for a member of the facility's executive leadership team (e.g., Facility Director, Associate Director, Deputy Director, Chief of Staff COS), etc.) to chair, co-chair, or serve on the ETAT.

(5) A consistent representative(s) from Human Resources (HR). The HR representative(s) will have knowledge of issues related to employee rights, privacy, and confidentiality. This representative(s) will inform ETAT of behavioral risk-relevant information about the employee's history of prior issues, interventions, and responses. The HR representative does not serve as chair or co-chair.

(6) A VA Police representative. This role may be filled by the Police Chief or designee, or by a senior officer who is responsible for investigations. This representative(s) will inform ETAT of behavioral threat-relevant information about the

employee's law enforcement and criminal history, and known current threat-relevant behaviors and communications.

(7) A clinical registered nurse (RN) representative from nursing service.

(8) In addition to the above required members, the ETAT may include other members to ensure diverse and comprehensive representation of the VA medical facility's workplace violence prevention needs. Examples include the following:

(a) The Intimate Partner Violence Assistance Program Coordinator (IPVAP-C) and the Harassment Prevention Program Coordinator can provide guidance and assistance as ad hoc or full members for cases involving intimate partner violence, sexual harassment, and workplace harassment.

(b) An ad hoc VA medical facility Safety Office representative may facilitate a collaborative response to Occupational Safety and Health Administration (OSHA) inquiries and investigations regarding allegations of workplace violence at the facility.

(c) Attorney(s) from the Office of General Counsel serve on an ad hoc basis.

APPENDIX E

BEHAVIORAL THREAT MANAGEMENT

Based upon the findings of an individualized behavioral threat assessment, the VA medical facility Disruptive Behavior Committee (DBC) or facility Employee Threat Assessment Team (ETAT) develops customized recommendations designed to reduce the impact of violence risk factors and enhance the presence of protective factors. Use of the multidisciplinary team approach provides the opportunity to integrate a variety of perspectives regarding risk management into a comprehensive and cohesive plan. Threat assessment and management strives to achieve consensus, being neither conducted by a sole individual nor determined by a majority vote.

Behavioral threat management recommendations may involve assisting the individual to resolve psychosocial challenges, obtain needed treatment for behavioral problems, or develop new coping strategies. For both patient- and employee-generated disruptive behavior, behavioral threat management recommendations should be the least restrictive possible while promoting the safety of VHA workplaces.

Every effort should be made to engage the person of concern in collaborative behavioral safety planning.

1. Behavioral Threat Management for Patient-Generated Behaviors

Recommendations made by the DBC are considered part of clinical care delivery and are aligned with treatment planning. As such, they are documented in the electronic health record (EHR), unless so doing raises safety concerns. The DBC's recommendations maintain VA's provision or resourcing of patients' medically necessary health care, and may be categorized as non-restrictive and restrictive interventions. More information is available in the DBRS User's Guide found on the WVPP SharePoint at <https://dvagov.sharepoint.com/sites/VHAWVPP/Shared%20Documents/DBRS%20Presentations%20and%20Materials/DBRS%20Manual%20V3.pdf?web=1>. **NOTE:** *This is an internal VA website that is not available to the public.*

a. Non-restrictive recommended interventions may include, but are not limited to:

(1) Referral for medically necessary care.

(2) Counseling by the patient's providers, the DBC, the Patient Advocate, VA Police, VJO representative, or others as appropriate regarding behavioral expectations in the health care facility.

(3) Behavioral agreements that describe acceptable behavior but do not place restrictions to "time, place, and/or manner of the provision of a patient's medical care." (38 C.F.R. § 17.107).

(4) Letters from providers, DBC, or clinic administrators regarding needed behavior change.

(5) Communication of information that is needed in the initial moments of an encounter to provide for safe and effective health care that otherwise is not restrictive (see 5.c. below) may be achieved with judicious use of a Behavioral Patient Record Flag.

b. Restrictive recommended interventions may include, but are not limited to:

(1) Orders of Behavioral Restriction (OBR), which are issued by the VA medical facility Chief of Staff or designee at the recommendation of the DBC. An OBR must be narrowly tailored to address the disruptive behavior while avoiding unnecessary inconvenience to the patient. An OBR must be entered into the patient's electronic health record and the patient must be notified of the effective date and conditions of the restriction(s), of the right to request a review of the restriction(s), and of the process for submitting a request for the Network Director's review of the OBR. When an OBR is issued, a Behavioral PRF (BPRF) providing essential alerting information regarding the OBR must be placed in the EHR.

(a) The OBR may restrict the time (e.g. identify specific clinic hours, identify pre- and post-appointment intervals for presence at facility, etc.), place (e.g. specify precise facility for care delivery, provide care through community referral, etc.), and manner (e.g. identify specific provider demographics or numbers of providers; require police check-in, standby, or escort during visits; recommend telehealth appointments; etc.) of the provision of medical care to a patient posing a significant risk to safety.

(b) When an OBR is issued, there must be documentation in DBRS that the patient was notified of the OBR by certified mail or by hand delivery. The patient's OBR notification must include the following:

1. The terms of the OBR.
2. The timeframe of the OBR, including effective date and the review date.
3. The process of requesting a review of the OBR, including the following information:
 - a. Within 30 days of the OBR effective date the patient may request a review of the restrictions by stating objections in writing to the VA medical facility Chief of Staff (COS).
 - b. The VISN Director's final decision on the request for review will be provided to the patient within 30 days of the receipt of the patient's request by the VA medical facility Chief of Staff.
 - c. As provided in 38 CFR § 17.107, there is no additional review process for an OBR.

(c) The process for completing a request for review of an OBR is as follows (**NOTE:** *the process for responding to requests for review of restrictions that complies with 38*

CFR 17.107 is available on the WVPP SharePoint at [OBR Fact Sheet – 2021 Order of Behavioral Restriction \(OBR\) Request for Review Process](#).):

1. The patient submits the request for review in writing to the COS at the facility where the OBR is active within 30 days of the OBR's effective date.

2. The VA medical facility COS ensures that the DBC chair is engaged in the process of preparing the OBR review materials. The COS sends the patient's request for review, the OBR itself, and the DBC's OBR review materials to the VISN Director for review and final decision. As a best practice, the VISN Director may engage the expertise and assistance of the Chief Mental Health Officer (CMHO) or the Chief Medical Officer (CMO) in conducting the review.

3. The VISN Director conveys the final decision regarding the request for review to the VA medical facility COS.

4. The VA medical facility COS then notifies the patient in writing of the Network Director's decision.

5. Steps 2-4 must occur within 30 days of receipt of patient's request for review of the OBR.

(2) Civil sanctions. VHA may not prohibit employees from pursuing civil sanctions that are their inherent right as citizens of the United States. VHA must comply with mandatory reporting and psychiatric civil commitment requirements of the jurisdiction within which it operates.

(3) Criminal sanctions. VHA may not prohibit employees from pursuing criminal sanctions that are their inherent right as citizens of the United States.

2. Behavioral Threat Management for Employee-Generated Behaviors

Findings and recommendations made by the VA medical facility Employee Threat Assessment Team (ETAT) are provided in writing to the VA medical facility Director for action (See Appendix F). The ETAT:

a. Determines whether reported behavior poses a safety threat to the workplace and provides behavioral safety-related recommendations to the VA medical facility Director. It is the role of the VA medical facility Director to consider and implement the ETAT's recommendations.

b. Evaluates the risk relevant effects of actions being considered by leadership or HR in response to disruptive behaviors by an employee and provides this feedback to leadership.

c. Does not make disciplinary or employment termination recommendations or recommend criminal prosecution or civil litigation of employees.

d. Must obtain an appropriate release of information in order to view an employee's health care records, regardless of whether the employee is a VHA beneficiary. Accessing an employee's health care record without appropriate authorization is a violation.

e. Does not replace the roles and responsibilities of other entities in the VA medical facility such as the VA Police, Human Resources, Safety, supervisors, Labor Partners, EEO, ORM, and others.

More extensive discussion of the management of employee-generated violence is available in chapter 5 of the ETAT Guidebook: [ETAT: Managing Risks Posed by Disruptive Employees](#). **NOTE:** *This is an internal VA website that is not available to the public.*

APPENDIX F

**NOTIFICATION AND COMMUNICATION OF BEHAVIORAL SAFETY
RECOMMENDATIONS**

The development of evidence-based threat management recommendations is useless unless the strategies for behavioral threat management are communicated to those who are expected to implement them. The pathways for communication differ for patient-generated and employee-generated behavioral threat management and are addressed separately.

1. Communication of Behavioral Threat Management Recommendations for Patient-Generated Behaviors. VA medical facility Disruptive Behavior Committees (DBC) communicate behavioral threat management plans through written DBRS and EHR documentation, through Behavioral Patient Record Flags (BPRF) and through in-person communication with referral sources, treatment teams, work teams, patients, and caregivers. Detailed guidance for communicating threat management strategies arising from the DBC process are found in the [DBC Guidebook at Disruptive Behavior Committee \(DBC\) Guidebook](#). **NOTE:** *This is an internal VA website that is not available to the public.*

- a. DBC plans and actions are documented in the status and assessment section of the DBRS.
- b. The DBC should document clinically relevant treatment and safety plan information from DBRS into the electronic health record (EHR) when needed to promote the delivery of safe and effective health care for the patient-of-interest, other patients in the milieu, and the personnel providing such care. This documentation may include a templated note recording the receipt of the DBRS event report.
- c. When the DBC uses the Violence Risk Assessment Instrument for General Violence (VRAI-G) or Sexual Violence (VRAI-S), the DBC may place in the patient's EHR a DBRS templated note containing the narrative fields of the VRAI, provided that so doing documents clinically relevant information in the medical record.
- d. When the behavioral threat management recommendations include the need to convey safety information in the initial moments of a patient's encounter, the DBC must place a BPRF in the EHR.
- e. Behavioral PRF must be used to inform VA medical facility personnel of the presence and terms of an Order of Behavioral Restriction (OBR). An accompanying note in the EHR must contain a copy of the OBR letter sent to the patient.
- f. The Behavioral PRF is not a threat management strategy in and of itself, but rather is a tool used to communicate the strategy.
- g. The text of the BPRF must include:
 - (1) PROBLEM: (1-2 sentence summary of behavior of concern and its context)

(2) PLAN: (1-2 sentences describing specific actions personnel may take to promote safety)

(3) A reminder that future events of disruptive and violent behavior should be reported to the DBC.

2. Communication of Behavioral Threat Management Recommendations for Employee-Generated Behaviors. The VA medical facility Employee Threat Assessment Team (ETAT) will provide the VA medical facility Director with a case status report. Detailed guidance for communicating threat management strategies arising from the ETAT process are found in the ETAT Guidebook, [ETAT: Managing Risks Posed by Disruptive Employees](#). **NOTE:** *These are internal VA websites and are not available to the public.*

a. The case status report must:

(1) State that the ETAT convened to determine whether a reported employee-generated violent or disruptive behavior indicates an ongoing or continued behavioral safety threat to the VA medical facility.

(2) Document the ETAT's utilization of the behavioral threat assessment and management best practice of employing a structured professional judgment approach to assess the reported behavior.

(3) State whether the assessed behavior poses a safety threat within the workplace, and the level of threat posed.

(4) Provide individualized safety and threat management recommendations that are informed by the findings of the data-driven, evidence-based, individualized behavioral threat assessment.

(5) Provide information on reasonably foreseeable circumstances that may increase or lower the behavioral safety threat.

(6) Request the ETAT be informed of any next actions or steps the agency takes or plans on taking so the ETAT may continue the iterative process of monitoring threat management strategies.

(7) Address the safety implications of disciplinary, criminal, or civil actions being considered by executive leadership, supervisors, or VA Police.

(8) Specify the limitation of behavioral threat assessments as being only as effective as the information upon which they are based and subject to change with new information (i.e. it is an ongoing process based on additional reported behavior).

b. The case status report must not:

(1) Make recommendations whether to pursue disciplinary actions (e.g. counseling, performance plans, termination, etc.), criminal prosecution, or civil litigation.

(2) Include personally identifiable information of individuals other than the employee about whom the case status report is written.

c. Case status report samples may be found on the WVPP SharePoint at <https://dvagov.sharepoint.com/sites/VHAWVPP/sitepages/home.aspx> and in [ETAT: Managing Risks Posed by Disruptive Employees](#).