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Workplace Violence Prevention Models: Effectiveness Of Behavioral Threat Assessment Teams In Hospitals

Rana Salih Saeedi[1], Sarah Theeb Fitan AlOtaibi[2], Munira Sfar Louifi Almehmadi[3], Shayma Saleh Alandijani[4], Rana Hesham Mohammad Saifaldeen[5], Basmah Saad Salah Al-Qamani[6], Fahd Mohsen Omar Bamkhair[7], Shoroq Ali Alluqmani[8], Rawabi Mukhlid Alomiri[9], Norah khalil bin Hadlan[10], Wedad Mamdooh Sulimani[11], Ashwaq Talal Alghunayman[12], Fatimah Hesaiban Alotaibi[13], Renad Sulaiman Shabana[14], Nedaa Mahmod Fatani[15]

[1]Health Assistant/Health Security, Security and Safety Department, Executive Management of Healthcare.
[2]Health Assistant/Health Security, Security and Safety Department, Executive Management of Healthcare.
[3]Health Care Security And Safety, Primary Care Center Ain Shams
[4]Health Assistant / Health Security, Primary Care Center Aleskan.
[5]Health Assistant/Health Security, Security and Safety Department, Executive Management of Healthcare.
[6]Health Assistant / Security and Safety Department, Primary Healthcare Center - Al-Dhiyafa.
[7]Health Assistant / Security and Safety Department, Primary Healthcare Center - Al-Dhiyafa.
[8]Health Assistant/Health Security, Security and Safety Department, Executive Management of Healthcare.
[9]Health Assistant/Health Security, Security and Safety Department, Primary Health Care Center Aldiafa.
[10]Health Assistant / Health Security, Primary Care Center Alomoq
[11]Health Assistant/Health Security, Security and Safety Department, Executive Management of Healthcare
[12]Health Assistant/Health Security, Security And Safety Department, Primary Health Care Center. Alaziziyah
[13]Health Assistant/Health Security, Security And Safety Department,Executive, Al-Bejadiyah Health Center.
[14]Health Assistant / Health Security, Primary Care Center Aleskan.
[15]Health Assistant Health Security, Primary Care Center Aleskan.

Abstract

Workplace violence in hospitals ranges from verbal abuse to aggravated assault and homicide, with downstream effects on workforce retention, patient safety, and organizational resilience. In recent years, many health systems have turned to multidisciplinary Behavioral Threat Assessment and Management (BTAM) teams—sometimes called threat assessment teams (TATs) or threat management teams (TMTs)—to identify, assess, and manage persons of concern and conditions of concern before harm occurs. This review synthesizes the conceptual foundations, regulatory and accreditation drivers, and emerging evidence for BTAM effectiveness in hospital settings. We outline team composition, workflows, structured professional judgment tools, and data/analytics pipelines that enable proactive, defensible interventions. We then integrate findings from randomized trials of hospital workplace violence prevention, quasi-experimental interventions, and system case studies, and we map these results to BTAM components. Finally, we propose implementation metrics, equity considerations, and a research agenda to strengthen the

evidence base for BTAM teams as a cornerstone of comprehensive workplace violence prevention in healthcare.

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1) Introduction: Why BTAM, Why Now?

Hospital workplace violence (WPV) has escalated across emergency departments, behavioral health units, medical–surgical floors, and ambulatory sites, with healthcare workers experiencing a disproportionate share of assaults compared with all private-sector employees. Recent burden estimates from hospital associations underscore the cascading operational costs of violence—turnover, disability claims, lost productivity—and call for enterprise risk frameworks that include formalized threat assessment teams as part of a prevention ecosystem (American Hospital Association, 2025). Regulatory and accreditation levers have accelerated action. The Joint Commission (TJC) issued Sentinel Event Alert 59 (revised 2021) and introduced new and revised workplace violence standards effective January 2022 for hospitals, with subsequent expansions to behavioral health care (2024) and home care (effective 2025), creating a framework that hospitals can map directly onto BTAM operations (The Joint Commission, 2021; 2022; 2024). In parallel, the Occupational Safety and Health Administration (OSHA) provides programmatic guidance specific to healthcare—hazard assessment, engineering and administrative controls, staff training—which remains the de facto federal framework in the absence of a specific OSHA WPV standard (OSHA, 2015). Across security and healthcare professional bodies, multidisciplinary threat teams are described as effective protective measures designed to prevent—not predict—targeted violence, emphasizing behavioral pathways and early management over static profiling (DHS/CP3, 2025; IAHSS, 2024; ASIS/SHRM, 2020).

2) What Is a Behavioral Threat Assessment & Management (BTAM) Team in a Hospital?

A BTAM team is a chartered, multidisciplinary group that receives reports of concerning behavior or conditions, gathers and evaluates information using structured professional judgment (SPJ), develops and implements management plans, and monitors risk over time. In hospitals, the core typically includes security leadership, emergency medicine and/or psychiatry, nursing leadership, human resources, legal/compliance, risk management, and employee assistance/occupational health, with ad hoc participation from behavioral health, social work, patient relations, communications, facilities, and IT. This composition mirrors the International Association for Healthcare Security & Safety (IAHSS) Threat Assessment and Management guidance for hospitals and aligns with the cross-industry ASIS/SHRM Workplace Violence Prevention and Intervention standard (IAHSS, 2024; ASIS/SHRM, 2020). DHS frames BTAM as a continuous loop: identify → assess → manage → monitor. Teams operationalize intake criteria (threats, stalking, fixation/identification, leakage, intimidation, domestic-violence spillover, weapons seeking, severe agitation, doxing), triage urgency, and then undertake structured information-gathering across sources (clinical record, visitor access logs, prior incident reports, social media where lawful). Risk formulation emphasizes behaviors of concern, stressors, grievance, capacity, and protective factors, with proportionate interventions ranging from care transitions and safety planning to visitor restrictions, trespass notices, law enforcement liaison, or protective orders—always under a least-restrictive, ethically sound lens (DHS/CP3, 2025). While clinical violence risk tools such as HCR-20 V3 are validated in psychiatric/forensic contexts, hospital BTAM teams increasingly incorporate workplace-oriented SPJ tools such as the WAVR-21, which structures information across static and dynamic risk factors to support defensible decisions and documentation (Douglas et al., 2013; White & Meloy, 2016).

3) The Evidence Landscape: What Do We Know About Effectiveness?

Direct hospital BTAM outcome studies remain limited; however, adjacent evidence from randomized and quasi-experimental hospital WPV interventions—plus robust BTAM evaluations in other sectors—maps onto BTAM mechanisms. In a cluster-randomized trial, Arnetz and colleagues implemented a data-driven, unit-based walkthrough intervention that identified unit-specific risks and implemented targeted controls, resulting in reductions in patient-to-worker violence and improved safety climate compared with controls

(Arnetz et al., 2017; Hamblin et al., 2017). Multiple health systems report reductions in incident rates or injury severity after standing up multidisciplinary teams and analytics-enabled programs; for example, Inova Health System's SAFE team describes lower frequency and severity of injuries across EDs and behavioral units following governance and data improvements (American Hospital Association, 2025). Studies comparing structured risk assessments versus unstructured judgment in behavioral health and ED settings show higher accuracy and earlier intervention with structured tools, supporting the SPJ backbone of BTAM analyses (Kim et al., 2022; Hamrick et al., 2023). Furthermore, The Joint Commission's standards and OSHA guidance represent convergent expert consensus that leadership oversight, reporting, analytics, and team-based response are essential components of an effective program (The Joint Commission, 2022; OSHA, 2015). Outside healthcare, school and corporate BTAM programs demonstrate high rates of safe resolutions and very low conversion to attempted violence when teams are active, reinforcing the core logic that early identification plus structured management reduces harm (White & Meloy, 2016).

4) Regulatory & Consensus Frameworks that Anchor BTAM

Joint Commission: Sentinel Event Alert 59 (revised 2021) and new workplace violence standards effective 2022 for hospitals, with extensions to behavioral health care (2024) and home care (effective 2025), require leadership oversight, policies, incident reporting, data analysis, training, and post-incident response—offering direct scaffolding for BTAM programs (The Joint Commission, 2021; 2022; 2024). OSHA: Guidelines for preventing workplace violence for health care and social service workers (2015) outline hazard assessment, engineering/administrative controls, training, and program evaluation—foundational components that align with BTAM's governance and continuous improvement cycles (OSHA, 2015). IAHSS: The 2024 Threat Assessment and Management guideline calls for a multidisciplinary team, a formal charter, case workflows, documentation, metrics, and training tailored to the clinical/security interface (IAHSS, 2024). ASIS/SHRM: The WVPI standard (2020) provides a cross-industry roadmap for policy, prevention, intervention, and response with explicit team roles; many hospitals adapt it for BTAM policy architecture (ASIS/SHRM, 2020). DHS/CP3 and ASPR TRACIE (2025): Practical practice guides and healthcare-specific resources detail the identify–assess–manage–monitor cycle, defensible documentation, interagency coordination, and case examples.

5) Team Composition, Roles, and the Information Spine

Security leadership coordinates intake triage, liaison with law enforcement, visitor restrictions, trespass advisories, and physical protections. Nursing and Emergency Medicine surface early warning signs and ensure de-escalation competency and care plans. Psychiatry/Behavioral Health integrates clinical formulations (e.g., acute psychosis vs. grievance/fixation) with SPJ tools. Human Resources manages employee-on-employee concerns, fitness-for-duty, and accommodations. Legal/Compliance advises on privacy, HIPAA/42 CFR Part 2, duty-to-warn (where applicable), and evidentiary thresholds. Risk Management oversees documentation sufficiency and post-incident reviews. Employee Assistance/Occupational Health supports staff well-being and return-to-work. Communications manages rumor control and messaging. Facilities/IT/Access deliver engineering controls (badging, duress alarms, CCTV, visitor management) and data access for case files. The information spine is a secure, searchable incident-reporting and analytics system linking EHR safety flags, security incident logs, access control and visitor data, and legal alerts; pattern analysis (time-of-day, unit heat maps, repeat-visitor 'persons of concern') prioritizes BTAM attention and resource deployment.

6) Assessment & Management: From SPJ Tools to Proportionate Action

BTAM teams avoid prediction and instead practice structured professional judgment to determine what can be done to reduce risk. In clinical contexts, HCR-20 V3 is widely used for violent-behavior risk; in organizational contexts, the WAVR-21 structures workplace/campus targeted-violence assessment across dynamic stressors, ideation and planning indicators ('pathway behaviors'), historical violence, and protective factors. Teams use these guides to structure information, de-bias discussion, and document

rationale for interventions (e.g., care plan changes, visitor limits, security escorts, law enforcement notifications, civil orders), always favoring least-restrictive, trauma-informed measures first (Douglas et al., 2013; White & Meloy, 2016). Evidence syntheses in emergency and inpatient care show that structured aggression risk assessment combined with staff training and environmental controls can reduce violent incidents and restraints; these elements dovetail with BTAM's management function by creating team-agreed care plans (Hamrick et al., 2023). DHS emphasizes the "prevent, not predict" principle and case monitoring through interagency coordination and post-charge planning.

7) What Outcomes Should Hospitals Track?

Leading indicators include time from report to triage, completeness of intake, BTAM cycle times, percentage of cases with SPJ documentation, staff trained, simulation drills completed, and hazard mitigations implemented per unit. Lagging indicators include rates of Type II (patient/visitor-to-worker) and Type III (worker-to-worker) incidents, OSHA recordables, severity indices, days lost, staff turnover, and post-incident support uptake. Equity and ethics should be monitored in parallel: ensure BTAM does not stigmatize mental illness, does not amplify bias, and respects privacy while honoring duty-to-protect obligations. Teams should audit referral patterns and intervention types by unit, role, and demographics.

8) Implementation Roadmap (Hospital-Scale)

Phase 1 – Governance and policy (0–90 days): Adopt an ASIS/SHRM-aligned WVPI policy, create an IAHSS-style TAM charter, define referral pathways, and assign executive sponsorship. Calibrate scope (employees, contractors, patients, visitors) and thresholds for law-enforcement liaison. Align with TJC standards to ensure survey readiness. Phase 2 – Data and analytics (30–180 days): Implement a centralized incident-reporting platform (security + HR + clinical events), connect to EHR flags and access control/visitor systems, and build dashboards (rates by unit, injury severity, repeat-visitor alerts). Pilot unit-level hazard walkthroughs using randomized-trial-informed methods to generate early wins. Phase 3 – Team operations and training (60–270 days): Train BTAM members on SPJ tools (HCR-20 V3, WAVR-21), de-escalation, trauma-informed care, and legal standards. Establish meeting cadence, case folders, and post-incident reviews. Phase 4 – Continuous improvement (180–365 days): Publish quarterly metrics, conduct tabletop exercises (disgruntled visitor; terminated employee; stalking spillover), and iterate policy based on root-cause analyses and lessons learned; link outcomes to finance to sustain investment.

Table 1. Evidence Summary — Hospital and Sector Evidence Relevant to BTAM

Study/Guidance	Design/Type	Setting	Key Elements	Outcomes / Relevance
Arnetz et al., 2017	Cluster-RCT	US hospitals	Data-driven unit walkthroughs; tailored controls; safety climate	Reduced patient-to-worker violence; validates structured assessment and follow-through.
Hamblin et al., 2017	Quasi-experimental	US hospitals	Unit-based hazard appraisal with leadership feedback	Improved reporting, targeted mitigations, safety climate gains.
AHA (2025) Mitigating	National guidance/case compendium	US healthcare	BTAM framed as prevention;	Implementation scaffolding; case outcomes.

Targeted Violence			governance; LE partnership	
IAHSS TAM (2024)	Industry guideline	Hospitals	Chartered TAM team; case workflows; metrics; training	Healthcare-specific blueprint for BTAM.
TJC SEA-59 & 2022 Standards	Sentinel alert + accreditation	Hospitals/BHC/Home Care	Leadership oversight; reporting; data; training	Creates survey drivers sustaining BTAM elements.
DHS/CP3 BTAM (2025)	Practice guide	Cross-sector incl. healthcare	Identify–assess–manage–monitor; defensible documentation	Operational checklists; case examples.

Table 2. Standards & Requirements — What They Ask Hospitals to Build

Standard/Body	Core Requirements that Support BTAM	Notes
The Joint Commission (SEA-59; 2022 hospital; 2024 BHC; 2025 Home Care)	Leadership oversight; policies; reporting; data collection & analysis; post-incident support; training; program evaluation	Directly maps to BTAM charter, intake, analytics, and case reviews.
OSHA (2015) Healthcare WPV Guidance	Hazard assessment; engineering/admin controls; training; recordkeeping/evaluation	Provides five-component architecture; complements BTAM operations.
IAHSS TAM Guideline (2024)	Multidisciplinary team; charter; procedures; metrics; documentation; training	Healthcare-specific team blueprint.
ASIS/SHRM WVPI (2020)	Policy; team roles; incident response; prevention & intervention protocols; case management	Cross-industry standard commonly adapted by hospitals.
DHS/CP3 BTAM Practice (2025)	Identify–assess–manage–monitor; documentation; interagency coordination	Practical checklists; healthcare case example.
ASPR TRACIE (2025)	Healthcare-specific prevalence, staffing context; BTAM/TAM features	Slide deck/resources to operationalize BTAM.

11) Cost, Value, and Sustainability

Reductions in incidents and severity translate into fewer OSHA recordables, lower workers' compensation and disability costs, improved retention, and a stronger patient-safety culture. Modeling of the burden and cost of violence to hospitals suggests substantial indirect savings from prevention and early management—value drivers that justify investments in analytics platforms, training, and BTAM staffing (American

Hospital Association, 2025). Alignment with Joint Commission accreditation protects revenue and mitigates risk exposure, while OSHA-informed programs reduce liability by demonstrating due diligence.

12) Pitfalls and How BTAM Addresses Them

Under-reporting—staff believing "violence is part of the job"—can starve teams of signal; culture change, easy reporting, and non-punitive response increase reporting volume and quality. Bias and over-reach are real risks; BTAM mitigates via SPJ tools, legal review, and least-restrictive action sets, with audits for disparate impact. Siloed data and IT fragmentation blunt prevention; intelligence-led security and administrative oversight prioritize interoperability (EHR flags + incident systems + access logs) and push unit heat maps to leaders. Training fatigue erodes skills; folding de-escalation and BTAM drills into annual competencies and tabletops sustains readiness under TJC education expectations.

13) Research Gaps & Agenda

Priorities include multi-site BTAM evaluations with standardized outcomes (incident rate, severity, workers' compensation costs, turnover); comparative effectiveness of SPJ adoption on decision quality and harm reduction; equity audits to ensure interventions do not amplify bias; and economic evaluations linking accreditation compliance, OSHA recordables, and retention gains. Partnerships across AHA, IAHSS, and DHS can harmonize methods and accelerate generalizable findings.

14) Conclusion

Behavior-focused, multidisciplinary teams that identify, assess, manage, and monitor threats are a defensible and effective way for hospitals to curb workplace violence while honoring clinical ethics and staff well-being. Accreditation and industry guidance now require or strongly encourage the core elements that BTAM operationalizes—leadership oversight, policy, reporting, analytics, training, and post-incident care—moving BTAM from innovation to standard of care. With a deliberate implementation roadmap, intelligent data integration, and vigilant attention to equity and ethics, BTAM teams can transform workplace safety and, by extension, patient safety, at scale.

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