EVALUATING THE EFFECTIVENESS OF BEHAVIORAL THREAT ASSESSMENT TEAMS IN STATE HOSPITALS: A MIXED-METHODS STUDY OF SAFETY OUTCOMES AND STAFF PERCEPTIONS

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Abstract

Workplace violence in the healthcare field continues to present significant challenges, especially when the patient population is in psychiatric and forensic hospital setting. This type of hospital settings is where staff face a continual intensified risk of verbal threats, physical assaults, and psychological harm. The Departmental of Behavioral Health and Developmental Disabilities (DBHDD) implemented a prevention program which requires each hospital to follow a Workplace Violence Prevention Program (Policy 03-115) led by a multidisciplinary team. A key factor in this program is the establishment of Behavioral Threat Assessment Teams (BTATs), designed to identify, assess, and mitigate threats before they escalate up the pathway of violence and violence erupts.

Despite this policy mandate, little empirical evidence exists regarding the effectiveness of the BTATs established in each hospital setting. Additionally, evidence is lacking on how staff perceive their role in promoting institutional safety and their understanding of the BTAT process operating within a violence prevention program. This study proposes a mixed-method program evaluation to examine the BTATs effectiveness by analyzing de-identified incident and injury data alongside anonymous staff surveys. Qualitative analysis will determine whether BTATs activity is associated with reductions in violent incidents and injuries, while survey data will assist in evaluating staff perceptions of awareness, employee confidence, and the process of reporting and communication related to the work prevention policy. Open-ended survey questions will assist in capturing staff insights and suggestions for improvement.

The findings will provide evidence-based recommendations for strengthening DBHDD's Workplace Violence Prevention Programs, improving staff confidence in violence prevention

strategies, and informing future policy decision, training ramifications, and legal implications. Lastly, this research will also contribute to the broader field of public safety by addressing a critical cap in evaluation and study of threat assessment in a psychiatric hospital setting.

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Chapter I: Introduction

Violence in any environment can be problematic, costly, and a morale killer for many reasons. Violence in hospitals whether they are private or state continually poses a great challenge for hospital administrators and staff alike. Hospital staff often face exposure to workplace violence ranging from verbal threats and intimidation to physical assaults. Psychiatric and forensic hospitals are especially vulnerable because of the population they serve, the legal obligations of involuntarily commitments, and the open campus structure of many facilities. This violence affects not only hospital employees but also visitors, patients, and family members as well. The impact of these actions creates an atmosphere of insecurity and stress for patients and staff which can lead to a number of issues including high staff turnover and mistreated patients.

The National data confirms the magnitude of the problem. The U.S. Bureau of Labor Statistics (BLS) and the US Department of Justice report that most workplace assaults are in the healthcare-related occupations (BLS,2007). Due to the nature of the job and the frequent direct contact with the public, workplace assaults in nursing homes are the major source of violence for staff, particularly nursing assistants. Healthcare, personal care, and community social service workers account for 55% of the total assaults (Wolf, 2008).

Ten years later, violence continues to plague healthcare settings. A 2018 study from U.S Bureau of Labor Statistics (BLS) reported that healthcare and social workers are five times more likely to experience workplace violence than workers in other industries (BLS, 2018). The rate of nonfatal intentional injures by another person in the healthcare and social assistance sector was 10.4 per 10,000 full time workers, compared to 2.1 per 10,000 workers in all private industries (BLS, 2020). The same report revealed that healthcare and social service employees represented 73% of all nonfatal workplace violence injuries.

To address these issues hospitals have lobbied legislators across the United States for the ability to create their own police departments and many have implemented BTATs designed to identity, evaluate, and manage potential threats before they can become an issue and/or problematic. The goal is to identify concerning behaviors early and intercede where appropriate to prevent or deter threatening and violent behaviors.

In Georgia for instance, hospitals have lobbied to pass the Safer Hospital Act, House Bill 383, which was signed into law by Governor Kemp in May 2023. This bill among other things enhanced the punishment for violence against healthcare professionals on the job (GA-HB383, 2023). One of the legislators (state Rep-Matt Reeves, R-Duluth) who brought this bill forward stated, "We've seen a dramatic spike in violent attacks in the health care settings, particularly since the pandemic. This has led to injures and to many nurses leaving the profession, worsening the shortage we already face" (The Center Square, 2023). Additionally, this bill allows private hospitals to create their own police departments to assist with maintaining peace and order on the hospital campus. This piece of legislation was originally requested by an Atlanta area hospital but was pushed statewide after hearing about similar incidents and concerns across the state of Georgia (The Center Square, 2023).

The passage of this bill confirms law makers have deemed that violence against healthcare workers in a hospital setting was indeed a problem. This passage of legislation was their response in assisting hospitals in addressing the issues around workplace violence by providing a mechanism where hospitals can continue to maintain a safe environment for healthcare workers and patients alike.

The DBHDD issued policy 03-115, Workplace Violence prevention Program, requiring all state hospitals under its jurisdiction to implement comprehensive violence prevention

programs. Within this program BTATs serve as multidisciplinary units tasked with identifying, assessing, and mitigating threats before they escalate into violence.

This evaluation examines the implementation of DBHDD policy 03-115 with a focus on staff perception of the workplace violence prevention program and BTATs. While the policy established clear mandates for prevention, there is little empirical evidence that BTATs are effective in reducing violent incidents or improving staff perceptions of safety. This introduction sets the background by reviewing policy, outlining objectives, asking an evaluation question, and describing the study's significance

Background of the Policy/Program

DBHDD policy 03-115, Workplace Violence Prevention Program was established in response to the growing recognition that hospitals face high rates of staff assaults, threats, and safety incidents. The policy aligns with federal and best industry standards from OSHA (Occupational Safety and Health Administration) and the Joint Commission, which emphasize the need for structured, system wide approach to violence prevention.

The policy requires each DBHDD hospital to:

- Establish a multidisciplinary team to oversee workplace violence prevention.
- Provide annual training for staff on recognizing, reporting, and responding to threats.
- Document and analyze incidents of workplace violence.
- Conduct annual program reviews and report findings to hospital leadership.

BTATs operate within this policy framework as a proactive mechanism to detect and address concerning and threatening behaviors before they escalate. By design, BTATs combine perspectives from several fields to include clinical, security, counseling, and administrative staff to assess threats holistically and develop intervention plans. However, the policy does

not specify how the BTATs effectiveness should be measured. Leaving an important gap for evaluation.

Problem Statement

Although policy 03-115 establishes requirements for workplace violence prevention, there is no systematic evaluation of whether BTATs are achieving their intended outcomes. While threat assessment models have been studied in many sectors to include schools, higher education, and corporate environments, limited empirical research exists in hospital settings. Hospitals face unique challenges. The hospital environment can include involuntary psychiatric admissions, high-risk forensic populations, and staff shortages. These factors can influence both the frequency of violent incidents and the effectiveness of the workplace prevention program.

Without an evaluation, administrators cannot effectively determine whether BTATs reduce violent incidents, minimize staff injuries, or improve staff perceptions of safety. Without an evaluation of the program DBHDD risks maintaining a program without knowing if this program is fulfilling policy objectives and the intended goal.

Purpose of the Evaluation

The purpose of this evaluation is to assess the effectiveness of BTATs in DBHDD hospitals as required by policy 03-115. Specifically, the study will analyze workplace violence outcomes and staff perceptions of safety to determine whether BTATs contribute to the policy's goals of reducing violence and fostering safer work environments.

Findings will be used to inform DBHDD leadership, hospital administrators, DBHDD Police Department command staff, and policymakers about whether BTATs are functioning as intended and where improvements, if any, are necessary.

Evaluation Objectives and Questions

Evaluation Objectives:

1. Assessing the impact of BTATs on workplace violence outcomes, including incidents and staff injuries.
2. Evaluate staff awareness of and confidence in BTATs as a violence prevention strategy.
3. Examine whether BTAT operations are consistent with the expectations of policy 03-115.

Evaluation Question:

To what extent are Behavioral Threat Assessment Teams effective in meeting the goals of DBHDD policy 03-115 by reducing workplace violence and improving staff perceptions of safety.

Significance of the Study

This evaluation contributes to three areas:

1. Public Safety and Practical Significance: Results will provide hospitals administrators with evidence-based insights into the effectiveness of BTATs in preventing workplace violence incidents, informing decisions around training, staffing, and incident management.
2. Policy Significance: Findings will inform DBHDD policymakers about the implementation of policy 03-115 and identify opportunities for improvement, standardization, and manpower allocation.
3. Research Significance: This study extends the literature on threat assessment by applying a program evaluation study in a state psychiatric hospital(s), where empirical evaluation remains limited.

Scope, Assumptions and Delimitations

Scope:

This evaluation will focus on the 5 state hospitals under the jurisdiction of DBHDD. Data sources will include de-identified incident and injury records, BTAT activity logs, training records, and anonymous staff survey results.

Assumptions:

- Staff will respond honestly to surveys.
- Hospitals will provide accurate and complete data.
- BTAT records will reflect actual BTAT activity.

Delimitations:

- The study examines associations between BTAT activity and outcomes, not casual relationships.
- Other factors such as staffing ratios, patient acuity, and external policy changes may influence workplace violence and are beyond this study.

Plan for Organization

This evaluation project will be organized into five sections: each section will provide insight and guidance on the systematic examination of the effectiveness of BTATs, in a state hospital setting. The plan of organization will follow a logical progression from identifying the problem, reviewing relevant literature, detailing the research methods, presenting the findings, and discussing implications for policy review and recommendations. Lastly, suggestions for future or expanded research on the topic.

Chapter II: Literature Review

This section reviews the literature and policy framework surrounding the evaluation of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) Policy 03-115: Workplace Violence Prevention Program, with emphasis on the role of BTATs. The review addresses 5 areas: (1) the theoretical foundations of threat assessment, (2) the policy and legislative context for hospital violence prevention, (3) theoretical and evaluation framework guiding the study, (4) previous research on threat assessment teams, violence in hospitals, and multidisciplinary safety practices, (5) gaps in the literature that justify this evaluation. The purpose of this review is twofold. The first is to summarize existing studies and secondly evaluate how the current body of research supports, contradicts, or leaves unanswered the following research question: To what extent are BTATs effective in fulfilling the goals of DBHDD policy 03-115 by reducing workplace violence and improving staff perceptions of safety?

Threat Assessment: Conceptual Foundations

Definitions and Origins

Threat assessment is a term coined by the United States Secret Service. If refers to a structured process of identifying, evaluating, and mitigating incidents of potential violence or threatening actions directed at individuals or group of individuals. The goal is to determine if an individual is on a pathway to violence (Fein et al., 1995) and whether the individual can be managed and redirected in a non-violent way. Unlike traditional risk-assessments, which primarily focus on the probability of future violence based on historical or actuarial data, threat assessment is dynamic and behavioral focusing on observable patterns or preparation for violence (Fein et al., 1995).

This idea of threat assessment and threat investigations are concepts that emerged from the 1990 exceptional case study project (ESCP) (Fein &Vossekuil, 1997) conducted by the United States Secret Service (USSS). The ESCP examined attacks on public officials and figures. The ESCP concluded that targeted violence is rarely spontaneous, often preceded by warning behaviors, and can be prevented through structured intervention (Fein & Vossekull, 1997).

The findings of the ECSP are lessons learned, and recommendations suggested by the Secret Service to the law enforcement community to deter and possibly prevent a targeted attack. The recommendations have become protocols and best industry standards and practices adopted by many federal, state, and local law enforcement on how to handle and possibly prevent targeted violence, such as assassinations and school shootings.

This early work created the field of protective intelligence, emphasizing the need for multidisciplinary collaboration, investigator thoroughness, and continuous monitoring of behaviors of concern (Fein et al, 1998). These foundations became industry standards in law enforcement and later spread into schools, universities, and workplaces as organizations sought mechanisms to prevent targeted violence in their own jurisdictions.

Protective Intelligence and Threat Investigations

This literature was produced by the USSS and discussed the ECSP in detail. The article explained the problem facing the USSS at the time and their work in trying to understand attack related behavior. The article continued by discussing threat assessment protocols and behaviors of individuals who had planned and attempted to carry out an attack or carried out an attack. The article elaborated about the threat assessment process and educating the reader on how to conduct threat investigations, myths concerning assassins, and how to evaluate and manage a threat case (Fein &Vossekuil, 1997). The USSS took the principles and refined them with the introduction of

BTATs. BTAT structured the investigation of threatening communication and behaviors, emphasizing appropriate analysis over static profiling. The most recent National Threat Assessment Center (NTAC) guidance outlined a six-step model: established a Behavioral Threat Assessment Unit and Policy, create operating procedures, identify and process reports of concerning behavior, gather information to assess for risk, develop risk management strategies, promote continuous improvement and a culture of prevention (USSS, 2024). This process-oriented model highlights that the strength of threat assessment lies not only in predicting violence with certainty but in creating systems of guardianship and intervention that reduce opportunities for escalation.

Key Models and Guidelines

Building on law enforcement foundations, researchers adapted threat assessments for educational and workplace environments. The Virginia Student Threat Assessment Guidelines (Cornel & Sheras, 2006) emphasized distinguishing between transient and substantive threats, encouraging de-escalation and conflict resolution over exclusion. Studies showed that schools implementing these guidelines experienced reductions in suspensions, expulsions, and law enforcement referrals while maintaining school safety (Cornell et al, 2018).

Similarly, the National Behavioral Intervention Team Association (NaBITA) developed models for higher education and workplace environments. These frameworks integrated clinical, legal, and administrative expertise reinforcing multidisciplinary teams' approach that characterizes effectible threat assessment (Van Brunt et al., 2015). Studies of behavioral intervention teams in universities show improvements in case management, earlier identification of concerning behavior, and reduced crises requiring emergency intervention (Sokolow et al., 2019).

Taken together these models establish that team-based, structured threat assessment is effective when organizations integrate multiple perspectives, follow organized protocols, and prioritize prevention over punishment. While much of this literature stems from schools and higher education, the principles are directly relevant to hospital settings where threats are complex, multidisciplinary, and context dependent.

Application in Institutional Settings

While there is plenty of research data on threat assessment in the private and public arena. There is not a lot of scholarly work on its application in a hospital setting. Hospitals and behavioral healthcare organizations face unique challenges, such as involuntary commitments, patients on constant care by medical professionals, psychiatric issues, patients with complex clinicals profile, and emotional family members (Caruso et al., 2022). These challenges require additional input and insight in the threat assessment approach. The approach will have to incorporate clinical judgement, legal considerations, patient rights, and a law enforcement approach that is sensitive to a medical setting (Stirling et al., 2001). While some hospitals have implemented BTATs documentation on their structure; training, and outcomes remains limited in the literature.

Additionally, hospitals that have implemented threat assessment teams, systematic evaluations are scarce, Arnetz et al. (2015) found that multidisciplinary violence prevention committees were associated with increased reporting and reductions in staff injuries. However, these studies are largely descriptive, focusing on implementation processes rather than outcome measures. This gap underscores the importance of evaluating BTATs within DBHDD Policy 03-115.

Policy and Legislative Context

DBHDD Policy 03-115

The DBHDD issued policy 03-115: Workplace Violence Prevention Program in response to persistent violence in healthcare settings. The policy requires each hospital to establish a multidisciplinary violence prevention team, designate a coordinator, train staff annually, document and analyze incidents, and submit annual evaluations (DBHDD, 2023). The mission of the policy is to create safer environments for staff, patients, and visitors by embedding prevention practices into daily hospital operations.

Within this policy, BTATs function as specialized multidisciplinary units responsible for identifying assessing and managing threats. BTATs are the heartbeat of the policies proactive dimension, aiming to prevent escalation by addressing concerning behaviors early and collaboratively.

Federal and National Guidance

Policy 03-115 aligns with broader federal and accreditation frameworks. Occupational Health and Safety Administration (OSHA, 2016) issued guidelines for preventing workplace violence in healthcare and social service, urging organizations to develop comprehensive programs that include management commitment, staff training, incident reporting systems, and program evaluation. Similarly, the Joint Commission (2018) issued Sentient Event Alert 59, identifying workplace violence as a patient safety and quality issue. The alert requires accredited hospitals to adopt systematic reporting and prevention tools.

State Legislation

At the state level, Georgia passed the Safer Hospitals Act (HB 383, 2023), authoring hospitals to establish police departments and enhancing penalties for violence against healthcare

workers. While DBHDD obtains its legal authority from title 37, this legislation does assist DBHDD's prevention efforts, reinforcing that workplace violence is both a public safety and workforce issue.

Collectively, these frameworks situate DBHDD policy 03-115 within a strong policy environment that emphasized structured prevention, a multidisciplinary approach, and accountability. However, none of these frameworks provide empirically validated measures of effectiveness, leaving hospitals unaware whether their programs are meeting established policy goals.

Theoretical and Evaluation Framework

Integrated General Strain Theory (GST) – Routine Activity Theory (RAT)

This study draws on the combination of two theoretical frameworks and integrates GST and RAT. GST helps us understand the motivation for aggression, implying that individuals under stress or strain are more likely to lash out when constructive coping mechanisms are unavailable (Agnew, 1992). In psychiatric hospitals, strains could include involuntary commitment, loss of autonomy, mental illness, and stressful family circumstances, all of which may heighten aggression.

RAT complements this by explaining the opportunity for aggression, highlighting that violence occurs when a motivated offender encounters suitable targets in the absence of a capable guardian(s) (Cohen & Felson, 1979). In Hospitals, staff represent suitable targets, while guardianship may be compromised by staff shortages, lack of training, and/or lack of intervention systems.

By integrating GST and RAT, violence in hospitals is understood as the convergence of strain-driven motivation and situational opportunity. BTATs operate as capable guardians who

disrupt this union by identifying risks early, coordinating interventions, and reinforcing managerial guardianship. This integrated lens provides both a theoretical explanation for hospital violence and a rationale for evaluating BTAT effectiveness.

Review of Previous Evaluations and Research

Workplace Violence in Healthcare

Workplace violence is widely recognized as an inescapable problem in healthcare. The U.S Bureau of Labor Statistics (2020) reported that healthcare and social assistance workers experience workplace violence at rates five times higher than the national average with nearly three-quarters of all nonfatal workplace violence injuries occurring in this setting. Research consistently shows that psychiatric and emergency settings represent the highest-risk environments (Caruso et al., 2022)

The consequences extend well beyond physical harm. Violence contributes to staff burnout, mental distress, absenteeism, turnover, and reduced job satisfaction (Edward et al., 2014). Hospitals also face higher liability cost, decreased productivity, and compromised patient outcomes (Spector et al., 2014). The failure to report all incidents is a persistent problem. Phillips (2016) found that many healthcare workers refrain from reporting violence incidents because they perceive violence as a normal price of doing business or that reporting won't change anything. This underreporting complicates obtaining data and makes collecting information from staff data essential.

These studies demonstrate that workplace violence in healthcare is both widespread and costly. While data doesn't currently support the magnitude of the problem. The underreporting and inaccurate measurement creates challenges for evaluating prevention programs. This gap

highlights the need for standardized indicators in the healthcare settings, such as incidents per 1,000 patient days, that can ultimately provide valid and comparable metrics across hospitals.

Violence in Psychiatric and Forensic Hospitals

Violence in hospitals continues to be a persistent and complicated issue that weakens the safety of both staff and patients. Numerous studies have documented the high rates of assaults, verbal threats, and physical altercations in inpatient hospital and clinical settings. According to the Bureau of Labor Statistics (BLS, 2016), healthcare workers experience workplace violence five times higher than workers in other industries, with psychiatric units accounting for a disproportionate share (BLS, 2022). Involuntary commitments, simultaneous substance use, and patients with criminal charges create complex dynamics for staff. Lozzino et al. (2015) found that one in five psychiatric inpatients engaged in violent behavior during admission, with psychosis and hostility as significant predictors. Facilities with a forensics component, where patients have criminal charges, present even higher risk requiring staff to balance clinical responsibilities with security measures (Flannery et al., 2011).

The findings from this research indicate that psychiatric and forensic hospitals operate at a cross section between healthcare, clinical practice, and public safety and law enforcement measures. This cross section is where multidisciplinary violence systems are necessary and essential. This unique blend supports DBHDD's decision to require BTATs within the prevention policy as a proactive mechanism for managing threats in a high-risk patient/inmate environment.

Threat Assessment Teams in Other Contexts

The concept of BTATs originated in the field of law enforcement and protective intelligence and has been adapted to schools, universities, and corporate settings. The U.S Secret Service's National Threat Assessment Center (NTAC) has published researched demonstrating

that targeted acts of violence are often preceded by observable warning behaviors, and multidisciplinary teams are effective in identifying and mitigating threats before they escalate (U.S. Secret Service, 2019).

In educational settings, BTATs have been widely adopted and evaluated. Cornell and Sheras (2006) demonstrated that threat assessment protocols in K-12 schools reduced suspensions and expulsions while improving safety outcomes. Similarly, universities BTATs have been credited with preventing crisis by addressing concerning behaviors early and collaboratively (Van Brunt et al., 2015). Research shows multidisciplinary threat assessment teams work best with diverse expertise, a focus on prevention, and structured protocols for gathering information, assessing threats, and intervening.

Collectively, the research in this area implies that threat assessment teams are effective in structed settings such as schools and corporations. With this research, there is a limited focus on outcomes highlighting a research gap in the healthcare environment. This gap doesn't explain or explore the relationship in the reduction in violent incidents or the improvement in staff safety perceptions.

Threat Assessments in Hospitals

Compared to schools and workplaces, there is not a lot of research on hospital based BTATs. Stirling et al. (2001) documented staffs' perception of violence in general hospitals, highlighted the need for proactive interventions. Arnetz et al. (2015) found that multidisciplinary committees in hospitals improved reporting and may reduce violence, but their study emphasized underreporting rather than evaluating outcomes directly. Hogh and Viitasara (2005) reviewed longitudinal studies of workplace violence and concluded that program effectiveness is rarely measured in terms of long-term reductions in violence.

These findings confirm that hospital-based threat assessment is an emerging but underdeveloped field. While there is evidence that teams increase reporting and awareness, little research evaluates whether they reduce violence or improve staff confidence in general. This absence of information supports this study, which links BTAT activity to both incident data and staff perceptions.

Multidisciplinary Safety Practices and Safety Climate

A growing body of literature highlights the importance of understanding organizational safety climate. Neal and Griffin (2006) found that safety climate predicts safety motivation, behaviors, and accident outcomes. Clarke (2010) integrated multiple models, showing that an organizations' safety climate influenced compliance and discretionary safety behaviors. Singer et al. (2009) demonstrated that a positive climate directly correlates with better safety performance and patient outcomes.

Research around workplace violence, Arnetz et al. (2017) found that staff trust in coworkers and leadership influenced the reporting of unsafe conditions. When organizations make safety a priority, staff are more willing to report incidents, comply with procedures, and engage in proactive behaviors. The same is true concerning leadership they perceive is indifferent to their safety. Reporting declines, when staff don't trust leadership which in turns impacts the safety climate of the institution (Phillips, 2016).

These studies suggest that BTAT effectiveness cannot be measured by outcomes alone. Staff perceptions, their awareness of BTATs, confidence in their abilities, and feelings of safety are fundamental to whether violence prevention programs can succeed. With the incorporation of staff surveys, this evaluation captures both the objective and subjective dimensions of safety, aligning with best practices in safety climate research.

Gaps and Justification for the Study

Despite the extensive literature on workplace violence and threat assessment, several gaps persist:

1. Hospital-specific evaluations are infrequent. Most studies describe implementation but do not measure BTAT effectiveness in reducing violence or injuries.
2. Outcome measures are underused. Research often emphasizes team existence or process metrics but fail to develop measurable outcomes such as incident rates per 1,000 patient days, which is a metric used by hospitals.
3. Staff perceptions are overlooked. Safety climate literature establishes that perceptions matter, yet most evaluations of hospital prevention programs exclude staff experiences.
4. Psychiatric/forensic hospitals are underrepresented. These setting pose significant risk but lack targeted program evaluation.
5. Policy Benchmarks are undefined. DBHDD policy 03-115 mandates BTATs but does not establish empirically validated performance standards.

Justification

This study speaks to these gaps by evaluating the BTATs through both quantitative data (incident and injury rates, BTAT activity logs, patient-days) and qualitative perceptions (anonymous staff surveys and open-ended responses). By incorporating this mixed – method design the evaluation provides DBHDD leadership with evidence-based recommendations for refining policy 03-115, ensures accountability for policy outcomes, and contributes to the broader literature on violence prevention in psychiatric hospitals.

Chapter 3: Methodology

Evaluation Design

This evaluation proposal will utilize a mixed-method sequential explanatory design to examine the effectiveness of BTATs implemented under DBHDD policy 03-115: Workplace Violence Prevention Program.

The mixed-method approach is designed to collect both quantitative data, representing objective measures of workplace violence incidents, and the qualitative data, reflecting staff experiences and perceptions. The quantitative data will be collected from DBHDD's Hospital Incident Management System (HIMS), which includes agency wide standardized incident reporting codes across all hospitals. Quantitative data will be obtained through an anonymous staff survey administered through Qualtrics.

This design supports a comprehensive evaluation by allowing numerical results to be interpreted alongside appropriate insights from staff who are involved directly with BTAT operations. The overall purpose is to assess how effectively BTATs function as a violence prevention mechanism within the framework and scope of policy 03-115.

Evaluation Criteria

The evaluation will assess BTAT effectiveness based on these five key outcome criteria as follows:

Criterion 1 – Violence Reduction: Incident rate per 1,000 patient days.

Criterion 2- Staff Injury reductions: Number/severity of injuries.

Criterion 3- BTAT operational activity: referrals, meetings, interventions

Criterion 4- Staff Perception and Awareness: survey score.

Criterion 5- Policy Implementation Fidelity- alignment with DBHDD policy 03-115 procedures.

By evaluating BTATs against these five criteria, this program evaluation will set the criteria for examining the effectiveness of the workplace prevention program.

Population and Sampling

The population for this evaluation consists of all state operated hospitals under the purview of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). Each state hospital is mandated to follow policy 03-115, which mandates the operation of a multidisciplinary workplace violence prevention program that includes a BTAT.

The sample for this study will include:

Qualitative Data- All workplace violence incidents and related staff injuries reported during a 12-month period across DBHDD hospitals.

Qualitative Data- Voluntary participation from DBHDD staff who agree to complete an anonymous Qualtrics survey distributed to all hospital employees, including clinical, security, administrative, and support staff.

Data Sources and Instruments

Quantitative Data Source: DBHDD HIMS

Quantitative Data will be obtained from DBHDD's Hospital Incident Management Systems, which is used to document and categorize all incidents of workplace violence, staff injuries, and related events in accordance with policy 03-115. The evaluation will use standardized incidents codes and definitions (Attachment A, Revised May 2024) to ensure consistency in identifying workplace violence incidents.

The following codes will define the scope of workplace violence for this evaluation:

- A-3: Aggressive Physical Act individual to individual.
- A-6: Verbal Assault individual to individual.

- A-7: Criminal Act by an individual
- A47: Physical Aggression individual to staff
- W01: Bullying Staff
- W02: Verbal Aggression
- W03: Threat of individual to staff.
- W08: Physical Aggression individual to staff.

These codes represent the official DBHDD definitions of workplace violence and are consistently used across all hospitals for tracking purposes.

Qualitative Data Source: Staff Survey (Qualtrics)

Qualitative data will be collected using an anonymous online survey administered through Qualtrics, DBHDD's approved institutional survey platform. The survey is designed to measure employee perceptions related to BTAT operations and workplace safety. It will include:

- Likert-scale items measuring awareness of BTATs, perceived safety, and confidence in BTAT effectiveness.
- Two open-ended questions allowing respondents to provide narrative comments about BTAT performance, strength weakness, and recommendations for improvement.

The survey instrument will be pre-tested by a small group of non-evaluated staff to endure clarity, reliability, and suitability for the hospital environment.

Data Collections Procedures

Data collection will occur over a six-week period, with quantitative and qualitative data collected concurrently to ensure completeness and consistency.

Step 1- Quantitative Data Request and Approval

Prior to data collection, written authorization will be obtained from DBHDD leadership and hospital administrators to access de-identified data from the HIMS system. A site permission letter will be obtained before information is collected. Once approved, each facility's designated data coordinator will extract 12 months of incident data corresponding to the specified codes (A3, A47, etc.). Data will include the date, type, incident, location, severity, and whether staff injury occurred.

Step 2- Data Verification and Standardization

Once received, all quantitative data will be verified for completeness and accuracy. Incident totals will be standardized per 1,000 patient-days to allow valid comparisons between hospitals of different sizes. Only de-identified facility -level data will be used; no names or personal identifiers will be collected.

Step 3- Survey Distribution

The Qualtrics staff survey will be distributed electronically through the internal hospital email system, with a brief explanation of the evaluation's purpose and a link to the survey. Participation will be voluntary and anonymous. The survey will remain open for three weeks, and one reminder will be sent midway through the collection period to encourage participation.

Step 4- Data Integration

After both datasets are collected, quantitative and qualitative data will be integrated for comparative analysis. The data will be entered into a free statistical software to assist with analysis. Quantitative results will reveal patters and correlations in incident data, while qualitative responses will provide narrative insights explaining the results.

Variables and Measures

This program evaluation will examine both quantitative and qualitative variables to assess the effectiveness of BTATs in reducing workplace violence and improving staff perceptions within DBHDD hospitals. The inclusion of both numerical indicators and staff perceptions allows for a balanced understanding of program performance.

Quantitative Variables

Dependent Variables:

1. Workplace Violence Incidents: Total number of incidents recorded under DBHDD incident codes A3, A6, A7, A47, W01. W02, W03, and W08.
2. Staff Injury Rate: Number of reported staff injuries resulting from violent or aggressive events.
3. Incident Rate per 1,000 Patient Days: Calculated by dividing total incidents by total patient-days, then multiplying by 1,000 to allow comparison between facilities of different census levels.
4. Injury Severity Rating: Each reported incident is coded for injury severity within the HIMS using the official DBHDD incident codes and Definitions (Attachment A, Revised May 2024). The standard ratings across all hospitals are:
    a. Level 1- No Injury: Incident occurred but no physical injury sustained.
    b. Level 2- Minor Injury: First-aid treatment only; no medical care beyond on-site intervention.
    c. Level 3- Moderate Injury: Requires off-site medical evaluation or treatment without hospitalization.

d. Level 4- Serious Injury- Requires hospitalization, surgery, or long-term medical care.
e. Level 5- Death: Fatal injury to staff resulting from a workplace violence incident.

For quantitative analysis these categories will be converted to a numeric value (1-5). A mean injury severity score (ISS) will be calculated for each hospital. Including this measure will provide insight into the seriousness of violence incidents, the frequency, and aligns directly with the staff injury reduction goals established in policy 03-115.

Independent Variables:

1. BTAT Activity Level: Total number of referrals, meetings, or interventions documented by each hospital's BTAT.
2. Staffing and Census Variables: Average daily census and staff to patient ratio, used as contextual controls to interpret variations in incident and injury rates.

Qualitative Variables

- Staff Awareness of BTATs: Knowledge of BTAT existence, function, and reporting process.
- Perceived Effectiveness: Confidence in BTAT's ability to identity, assess, and manage threats.
- Perceived Safety Climate: Overall employee sense of personal safety and organizational commitment to prevention.
- Narrative Feedback: Open ended comments describing experiences, challenges, or recommendations related to BTAT operations.

Together, these variables will demonstrate whether BTAT operations under policy 03-115 have achieved their intended outcomes of violence prevention, safety, and staff confidence in the program.

Data Analysis Plan

Quantitative data will be analyzed using descriptive and inferential statistics to evaluate the relationship between BTAT activity and workplace violence outcomes.

1. Descriptive Statistics will summarize incident frequencies, staff injuries, and BTAT activity levels.
2. Standardization will express incident counts as rates per 1,000 patient data for cross facility comparison.
3. Comparative Analysis (ANOVA or t-test) will examine differences in incident and injury rates between hospitals with high versus low BTAT engagement.
4. Correlation Analysis (Pearson's r) will measure relationships between BTAT activity and violence or injury rates.
5. Regression Modeling will assess the predictive value of BTAT activity and staffing variables on incident and injury outcomes.

Injury Severity Analysis

Descriptive statistics will summarize the distribution of injury severity ratings across hospitals. Mean severity scores will be calculated for each facility and compared using one way ANOVA to determine whether significant differences exist based on BTAT activity levels. A multiple regression model will include average injury severity as a dependent variable to test whether hospitals with higher BTAT engagement exhibit lower severity levels after controlling for incident volume and census size. Incorporating injury severity provides a more nuanced

measure of BTAT effectiveness by determining whether the program reduces not only the frequency but also the seriousness of workplace violence incidents.

Qualitative Analysis

Qualitative survey data will undergo thematic analysis following Braun and Clarke's (2006) six phase process: familiarization, coding, theme development, review, definition, and reporting. Emergent themes will be triangulated with quantitative findings to clarify how staff perceptions and experiences relate to the observed statistical patterns in incident frequency and injury severity.

Ethical Considerations

Ethical integrity is central to this evaluation. Approval will be obtained from the University's Institutional Review Board (IRB) before any data collections begins. Additionally, the research project must be approved by the Department of Public Health's (DPH) IRB to conduct research within any DBHDD hospitals. This project will use only de-identified and aggregated data from DBHDD's system and anonymous survey responses, it presents minimal risk to participants.

- Confidentiality: all quantitative data will be stripped of identifying information prior to analysis. Data will be aggregated at the hospital level, and no facility, will be individually named in published results.
- Survey Anonymity: The Qualtrics survey will not request names or any personally identifying information. Participation will be completely voluntarily, and consent will be implied through survey completion.

- Data Security: All electronics files will be stored on a secure, password-protected One-Drive account accessible only to the principal investigator and the academic chair. Data will be deleted 12 months after project completion.
- Conflict of Interest: The researcher holds a professional role within DBHDD but will not obtain any identifiable information or request any identifiable regarding any location or incident. The researcher will not contact any person who is responsible for obtaining data directly to prevent the investigators' position from influencing information gathering. All contact will be made with the Reginal Hospital Administrator, and they will coordinate information retrieval on this investigator behalf.

The next chapter will present the results of data analysis, comparing quantitative trends with qualitative matters to determine how effectively BTATs fulfill DBHDD's mission of maintaining a safe and secure hospital environment.

Chapter 4: Results and Findings

Presentation of Data

This evaluation will examine both quantitative and qualitative data to assess the effectiveness of BTATs as implemented under DBHDD workplace violence prevention policy 03-115. The analysis will explore how BTAT activity correlates with workplace violence incidents, staff injuries, injury severity, and staff perceptions of safety across all DBHDD state operated facilities.

Quantitative data will include de-identified records extracts from HIMS for a 12-month period. Each incident has been classified using the standardize DBHDD incident code definition (Attachment A, Revised May 2024). The following codes will serve as indicators of workplace violence and abuse: A3, A6, A7, A27, A47, W01, W02, W03, and W08. These codes capture the full range of aggressive, threatening, or assaultive behaviors directed towards staff, patients, or property.

Variables analyzed will include total workplace violence incidents (A3-W08 combined), incident rate per 1,000 patient days. Number of staff injuries, average injury severity score (Levels 1-5 per DBHDD scale), and BTAT activity levels (referrals, meetings, and interventions). Facility level comparisons will identify whether higher BTAT activity corresponds to reductions in incident frequency or severity.

Qualitative data will be collected from the staff survey, including both Likert-scale responses and two open ended questions (Q18-Q19). The survey will assess BTAT awareness, perceived responsiveness, and confidence in workplace safety.

The central evaluation question is, to what extent are BTATs effective in meeting the goals of DBHDD policy 03-115 by reducing workplace violence and improving staff perceptions of safety?

Corresponding hypothesis are:

H_1 - Hospitals with higher BTAT activity will report lower rates of violent incidents per 1,000 patient days.

H_2 -Hospitals with higher BTATs will report higher confidence in workplace safety.

H_3 – Staff with greater awareness of BTATs will report higher confidence in workplace safety.

This program evaluation will use simulated data to assist in interpreting the results in chapter 4. The simulated data is for illustrative purposes only and is not designed or created for statistical analysis.

Table 1. Illustrative Example of Anticipated Quantitative Results by Facilities (Simulated Data)

Hospital	Average Daily Census	Total Incidents (A3- W08)	Incident Rate Per 1,000 PD	Av. Injury Severity (1-5)	Staff Injuries	BTAT Referrals	Notable Characteristics
Hospital A	500	120	1.8	2	25	145	Large Urban facility, Strong BTAT engagement, and proactive prevention
Hospital B	650	210	2.1	2.3	35	120	Forensic population; High acuity but improving injury severity outcomes.
Hospital C	300	190	2.5	2.6	40	95	Medium acuity: consistent BTAT coordination and stable safety climate.
Hospital D	250	220	2.7	2.9	45	75	Small regional facility; moderate engagement and low incident frequency.
Hospital E	200	260	3.0	3.2	50	60	Low Acuity facility; lowest incident and injury severity averages.

Note: Values are simulated for illustration only and do not represent actual DBHDD hospital results. Census figures are included to demonstrate normalization for incident rate calculations. The numbers are not meant for analysis.

Table 1.5 continued

Hospital	BTAT Meetings	BTAT Interventions	Dept type 1= clinical/ 2= nonclinical	BTAT awareness)1-5)	Safety Confidence (1-5)
Hospital A	12	22	1	4	4
Hospital B	10	20	2	4	4
Hospital C	9	18	1	3	3
Hospital D	7	15	2	3	3
Hospital E	6	12	1	2	2

Findings by Evaluation Questions or Themes

*Evaluation Question 1***:** To what extent have BTATs reduced the frequency and severity of workplace violence incidents as defined in DBHDD Policy 03-115?

The anticipated results directly relate to $H_1$and H_2, which suggest that higher BTAT activity corresponds with lower incident and injury rates. The quantitative examination is expected to show that hospitals with more active BTATs experience lower incidents and severity and staff injury rates. It is anticipated that total reported threats may increase due to stronger reporting culture, the frequency of serious physical assaults and high severity injuries is expected to decline.

Evaluation Question 2: How do staff perceive the presence and effectiveness of BTATs in promoting a safe workplace environment. This section addresses H_3, examining whether greater awareness of BTATs is associated with stronger perceptions of workplace safety. Based upon prior research it is anticipated that staff who are aware of the BTAT process and have observed its interventions will express a generally positive perception of the program. Employees who understand that potential threats are investigated, monitored, and resolved through a multidisciplinary process are expected to report feeling safer and more supported in the workplace.

Equally, facilities where BTATs are less visible or communication about their actions is inconsistent may report neutral or mixed perceptions. The overall expectations is that the

presence and visibility of BTAT operations will have a positive psychological effect on staff, reinforcing the feeling of a safe workplace and knowing there is a process to deal with concerning behaviors. Quantitative data from the Likert-scale portion of the staff survey will provide insight into the overall perceptions of BTAT effectiveness.

Table 2. Sample simulated responses of Staff Perceptions from Likert-Scale items (n=250)

Survey Item	Strongly Disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly Agree (%)	Mean Score
I am aware of the existence of the Hospital BTAT Team	2	4	8	56	30	4.1
I know how to make a BTAT referral.	3	6	14	52	25	3.9
I understand what steps the BTAT takes after a report.	5	10	24	45	16	3.6
I have received training on BTATs in the past 12 months.	8	14	28	36	14	3.3
The BTAT helps prevent incidents of violence.	3	7	20	48	22	3.8
The BTAT responds in a timely manner to reported concerns.	4	10	22	44	20	3.7
I feel safer at work because of the BTAT.	2	7	18	50	23	3.9
Reporting threats or concerns is encouraged in my workplace.	3	6	16	52	23	3.9

Note: Mean scores are based on a 5-point Likert scale (1=Strongly Disagree, 5 = Strongly Agree). Simulated results show generally positive perceptions of BTAT visibility, responsiveness, and safety impact. The Highest means scores appear in the areas related to awareness and safety perceptions., supporting H_3

It is expected that BTAT performances will vary according to hospital size, patient population, team maturity, and communication culture. Facilities with a higher forensic population (e.g. Hospital B) may continue to experience more violent events, while smaller or mental health facilities only will exhibit lower rates. Qualitative analysis of open-ended

responses (Q18-Q19) will identify patterns explaining these contextual differences, using Braun and Clarke's (2006) six phase thematic analysis. Simulated anticipated themes are provided in Table 2

Table 3 Simulated Example of Anticipated Qualitative Themes and Codes

Theme	Source Questions	Sample Codes/ Keywords	Expected Interpretations	Policy 03-115 Alignment
Training and awareness Gaps	Q18, Q19	Need more refreshers; Want annual training; more feedback after reports.	Staff emphasize ongoing education and BTAT visibility.	Supports annual training requirement.
Confidence and Responsiveness	Q18, Q19	They respond quickly; We feel supported; They take concerns seriously.	Reflect positive perception of BTAT's role in violence prevention.	Reinforces prevention goal.
Communication and Feedback loops	Q18, Q19	Don't know what happens after reporting;	Indicates desire for improved follow-up communications.	Aligns with policy emphasis on transparency and reporting culture.
Reporting Barriers	Q18, Q19	Fear of retaliation; Unclear reporting process.	Reveals persistent procedural and cultural barriers.	Highlights area for policy improvements.

Note: Themes and codes are simulated. Actual categories will be determined through qualitative analysis.

Evaluation Criteria Findings

This section evaluates the simulated data based upon 5 principles to evaluate the effectiveness of BTATs. The chart below focuses on the criterion, area of focus, the method in which the section was analyzed.

Quantitative results are drawn from the sample dataset described in table 1 and table 1.5 continued. This sample data would normally be calculated by entering the info into a statistical database. For this evaluation the data collected would have then been entered into Jeffrey's Amazing Statistics Program (JASP), a free open-source statistical software for data analysis.

Descriptive statistics, correlation analysis, and regression modeling would be used to explore relationships among BTAT activity, workplace violence incidents, and staff safety outcomes.

Table 4

Section	**Focus**	**Data Source/Analysis**
Violence Reduction	Descriptive incident data and incident rate.	Quantitative (JASP descriptive+ correlation
Staff Injury Reduction	Injury counts & Severity	Quantitative (Correlation + regression
BTAT Operational Activity	Referrals, meetings, interventions	Quantitative (descriptive trends)
Staff Perceptions and Awareness	Awareness/ Confidence survey	Quantitative (Likert means+ Chi-Square)
Policy Implementation Fidelity	Whether team practices align with the policy.	Qualitative /document review summary

Criterion 1: Violence Reduction

Criterion 1 examined whether BTATs are helping to reduce violence incident across hospitals. The two main numbers used for analysis are:

- The number of violent incidents (A3-W08). (For this examination, total incidents were calculated and not the type. Future research can examine the different types.)
- Incident rate per 1,000 patient days, which adjust for hospital size.

Hospitals with more BTAT referrals in general showed fewer violent incidents when compared by rate. For example, using the simulated data, the hospital with the highest number of referrals (145) also had a lower incident rate (1.8), while the hospital with fewer referrals (60) had a higher rate (3.0).

This researcher would expect that if the data was entered into JASP would show a correlation analysis demonstrating a strong negative relationship between BTATS referrals and incident

rates. Similarity, we would expect the regression model would confirm that BTAT activity would predict violence rates.

The expected results would uphold that the violence reduction criterion supports the idea that greater BTAT involvement would contribute to a safer hospital environment by identifying concerning and threatening behaviors before they escalate into violence.

Criterion 2: Staff Injury Reduction

The next criterion measures whether BTAT activity corresponds to fewer and less severe staff injuries. The analysis would use two key indicators: the number of staff injuries and average injury severity (on a 1-5 scale).

The researcher would expect the descriptive data to show that hospitals with greater BTAT engagement had fewer and less severe injuries. In the simulated data, Hospital A reported 25 injuries with an average severity of 2.0, while Hospital E reported 50 injuries with an average severity of 3.2.

These results fulfill the staff injury reduction criterion, supporting the idea that BTATs not only reduce violence events but also mitigate the harm caused when such incidents occur.

Criterion 3- BTAT Operational Activity

This criterion examined the extent of BTAT engagement in preventative operations, including referrals, meetings, and interventions. The ability of the BTATs to come together and assess potential threats creates an environment of safety within the hospital settings. Table 1.5 (continued) shows BTATs across the 5 hospitals conducted between 6 and 12 meetings annually and 12-22 interventions. This suggest that Hospitals with higher referral volumes held more meetings and completed more interventions, suggesting a strong alignment between workload and team activity.

Criterion 4- Staff Awareness and Confidence

This criterion examined how staff perceived the BTAT program. It examined their awareness of how the team function and their confidence in the BTATs ability to promote safety. Responses were measured on a 5-point Likert scale (1= Strongly Disagree to 5=Strongly Agree). The simulated data shows the average scores across the hospitals showed the following:

- BTAT awareness= 3.2
- Safety Confidence= 3.2

These averages would suggest that most staff members are familiar with BTAT operations and generally believe the program makes their work environment safer. This research believes that the data would show a strong positive correlation between awareness and confidence indicating that as staff understanding of BTAT processes increase, their perception of workplace safety also improves. These results would confirm the awareness and confidence criterion, reflecting a positive organizational culture of safety tied to BTAT visibility.

Criterion 5- Policy Implementation Fidelity

The fifth criterion evaluates whether BTATs are operating in accordance with DBHDD Policy 03-115, which outlines the structure, reporting procedures, and multidisciplinary team requirements for the violence prevention programs. Across all five hospitals, BTATs demonstrated moderate to high procedural alignment. Each hospital:

- Conducted routine meetings,
- Documented threats evaluations,
- Implanted some form of interventions,
- And involved representatives from clinical, administration, and security.

The consistency shows strong fidelity to Policy 03-115 and reinforces DBHDD's

commitment to the workplace violence prevention program. The simulated results would support the policy implementation fidelity criterion, confirming that the BTAT practices adhere to agency expectations and best practice standards.

Comparative Analysis

This researcher expects the comparative analysis of staff injury rates revealed that hospitals demonstrating high levels of BTAT activity engagement experienced substantially lower staff injuries than those with limited engagements. These finding support the hypothesis that effective, consistent threat assessment operations contribute to a safer institutional climate.

Correlation Analysis

This researcher expects the correlation analysis would show a very strong relationship between how active a hospital's BTAT is and the amount of workplace violence that occurs. Hospitals that used their BTATs more often became more involved therefore made more referrals, met regularly, and followed through on cases had much lower levels of violent incidents.

The researcher would expect that as BTAT activity went up, reports of violence would go down. When looking at the simulated data and all five hospitals, there was a clear pattern, hospitals that had a BTAT were more engaged had fewer incidents.

Regression

The researcher would expect the regression to explain if hospitals that use BTATs more often, or have stronger staffing coverage, tend to have fewer staff injuries. The researcher would expect that the data would support that staff injury outcomes across the hospitals would be congruence with such an expectation. Both variables would be significant predictors indicating that:

- Hospitals with higher staffing rations also had fewer incidents.
- Hospitals with more active BTATs had fewer staff injuries.

Summary of Key Outcomes

The anticipated results suggest that higher BTAT activity correlates with lower injury severity, improved staff perceptions of safety, and a stronger safety culture. Hospitals with BTAT processes demonstrate proactive prevention and reduced violence severity, while forensic facilities showed continued improvement despite a greater baseline risk. Likert- scale findings indicate a strong awareness and confidence in BTAT performance, supporting H_3. Qualitative findings reinforce that communication, transparency, and consistent training remain central to the program success.

The simulated data presented in Tables 1,2, and 3 collectively support the central evaluation question and hypothesis. Facilities with a higher BTAT involvement demonstrate lower incident rates and staff injuries (H_1 and H_2), while staff expressing greater awareness and confidence in BTAT operations report stronger perceptions of workplace safety (H_3)

When we examine the 5 criterions against the simulated data we would find the following:

Table 5

Evaluation Criterion	Key Finding
Violence Reduction	Higher BTAT activity is linked to lower incident rates.
Staff injury reduction	More BTAT engagement corresponds to fewer and less severe staff injuries.
BTAT Operational Activity	All hospitals demonstrate regular meetings and interventions.
Staff Awareness & Confidence	Staff generally know about BTAT and feel safer because of it.
Policy Implementation Fidelity	BTAT operations are consistent with DBHDD policy 03-115.

Collectively, these findings indicate that BTATs are functioning effectively withing DBHDD hospitals. And supports and affirms the primary evaluation question, to what extent are BTATs effective in meeting the goals of DBHDD policy 03-115. The combination of quantitative and qualitative results supports the conclusion that BTATs are a valuable component of DBHDD's workplace violence prevention program strategy; meeting or exceeding evaluations across all five-evaluation criterion.

Chapter 5: Discussion and Recommendations

This chapter interprets the findings presented in Chapter 4 and discusses their broader meaning for public safety policy and practice within the DBHDD. The discussion explores the five evaluations criteria and integrated both the quantitative and qualitative results drawn from the sample data. Also, the implications for public safety leadership. Policy, and operations, followed by recommendations for program improvement and acknowledgement of evaluation limitations, and suggestions for future research.

Interpretation of Findings

The results presented in Chapter 4 from the simulated data, collectively indicate that the BTATs are an effective tool for promoting safety and reducing violence in DBHDD hospitals. Quantitative analysis revealed a strong opposite relationship between BTAT activity and violent incident frequency suggesting that as BTAT engagement increased, incidents per 1,000 patient days decreased. Similarly, staff injury counts, and severity were lower in hospitals with higher levels of BTAT activity. The findings would support the violence and injury reduction criteria of the evaluation and demonstrate alignment with the DBHDD objectives of Policy 03-115.

The simulated data further showed that BTATs are functioning consistently, holding regular meetings, reviewing referrals, and implementing interventions across hospitals of varying size and complexity. These operational patterns confirm that the BTAT model has been successfully institutionalized within DBHDD and are operating with success. Staff perceptions data revealed generally positive attitudes toward BTATs, with the mean score of 3.2 for both awareness and confidence, indicating that employees view BTATs as credible and valuable components of the workplace safety plan.

In review of the simulated and expected results, the findings suggest that BTATs fulfill their intended purpose as a multidisciplinary violence prevention program. Even though the dataset was simulated for this evaluation, the relationship modeled expected outcomes from prior research on threat assessment effectiveness. As such, the research data supports the primary evaluation question: BTATs appear effective in meeting the goals of DBHDD policy 03-115 by reducing workplace violence and enhancing staff perceptions of safety.

Implications for Public Safety Policy and Practice

The outcome for public safety is highlighted in three areas. First the findings validate DBHDD policy on workplace violence as a solid policy that has been implemented and is being carried out in practice and operations. The policy integrates clinical, administrative, and security perspectives in managing behavioral threats. Second, the results reinforce the importance of proactive threat assessment as a complement to traditional security measures, emphasizing how early intervention and case management can prevent incidents from escalating to violence. Third, the operational model implemented and simulated data suggest that this model may be able to be used and replicated in other similar situated facilities across Georgia and other states.

From a public safety standpoint, these finding emphasize the need for data driven oversight and accountability. The use of 1,000 patient days, referral counts, and other measured data in this study can provide objective metrics that can inform future policy improvements, resource allocation, staffing models, and performance evaluation.

In essence, the BTAT model bridges the gap between clinical care and security by creating a structured, evidence-based process for identifying, assessing, and managing threats which can lead to enhanced safety.

Recommendations for Policy and Program Improvement

The following suggestions are intended to provide recommendations for policy improvements. They include the following:

1. Standardize BTAT training: Develop and implement a standardized BTAT training curriculum across all hospitals to ensure consistent understanding of best practices in threat assessment procedures, concerning and threatening behaviors, documentation standards, and intervention strategies.
2. Enhance Intervention Protocols: Evaluate existing intervention types to identify which methods yield the best outcomes and incorporate these into a whitepaper for statewide guidance.
3. Establish Clear Performance Metrics: Introduce measurable performance indicators such as number of mitigated threats, time from referral to BTAT meeting, referral to resolution time, and repeat incident rate to measure BTAT effectiveness over time. Especially, at the hospitals who had lower referral numbers but higher incident rates and injuries.
4. Expand Staff Awareness and Education: Increase outreach, communication and training sessions for all employees to ensure they are aware and understand BTATs role, how to submit referrals, and what to expect after, during, and at the conclusion of a threat referral.
5. Integrate Data and Reporting Systems: Incorporate DBHDD incident reporting data with BTAT tracking tools to streamline documentation and enhance data accuracy.

Limitations of the Evaluation

Several limitations should be addressed. First, this evaluation utilized simulated data for illustration purposes. The data used modeled research outcomes from previous studies on BTATs

in other sectors to show the relationship between BTAT activity and safety outcomes. While this approach demonstrated how analysis would be conducted, the results cannot be generalized to actual DBHDD population data.

Second, Policy 03-115 is an actual policy that can be found on the DBHDD website. DBHDD policy dictates a workplace prevention policy however, the numbers used are for demonstrative purposes and this research cannot produce any actual recommendation of the effectiveness of the current policy. This program evaluation leaves room for the investigator to conduct an actual assessment of the program for future research.

Third, the analysis of aggregated violence related to incidents codes (A3-W08) were counted as a single incident variable representing total incidents rather than disaggregating by each incident type. This method provided a clear overall measure of violence but did not engage in variations of among physical, verbal, or sexual aggression.

Fourth, the evaluation relied on a 12-month staff perception data rather than a long-term employee study, limiting insight into how perceptions evolve over time. Despite these constraints the evaluation provides a valid framework for the understanding of how BTAT activity can be analyzed, measured, and improved within DBHDD's public safety context.

Suggestions for Future Research and Evaluation

1. Disaggregate Incident Codes: Examine each DBHDD code (A3- W08) individually to determine whether BTAT interventions are more effective for certain types of incidents, such as physical assaults versus verbal aggression.
2. Longitudinal Evaluation: Collect and analyze data across multiple years to determine whether the positive trends identified in this illustrative program evaluation persist over time.

3. Comparative Analyses: Compare outcomes across hospitals with varying BTAT staffing levels, team composition, team training, team experience, or intervention practices to identify the most effective structures.
4. Qualitative Inquiry: Conduct interviews with BTAT members and hospital staff to better understand barriers to reporting, decision making processes, and team dynamics.
5. Cost Effectiveness and Resource Study: Evaluate whether reductions in incidents and injuries corresponds to financial savings through decreased staff injuries, reducing staff turnovers, and overtime cost.
6. Examine BTAT team make up and compare teams among the different hospitals metrics such as occupation, years of experience, and training level. Does any of these factors affect response, case management, or intervention recommendations.
7. Compare intervention strategies at each hospital. Is there any standardization among the hospitals. Does one intervention method work better than others.

This chapter provided a comprehensive discussion of the evaluation's findings its implications for DBHDD workplace violence prevention program. The next and final chapter offers a conclusion of the evaluation, reiterating its purpose and central problem, summarizing the major outcomes, and highlighting the significance of this program evaluation for both policy and operational insights.

Chapter 6- Conclusion

The purpose of this evaluation was to assess the effectiveness of BTATs within DBHDD in fulfilling the intent of their workplace violence prevention program. The program evaluation examined the process and evaluated whether BTAT operations contribute to violence reduction, staff safety, and compliance with overall workplace violence prevention programs across all the state hospitals.

The problem addressed in this evaluation centered on the challenges faced by hospitals more specifically psychiatric hospitals dealing with elevated risk of physical assaults, verbal aggression, and other disruptive behaviors. Although DBHDD initiated a workplace violence prevention program, limited evaluation of BTAT in clinical settings have been conducted. This evaluation sough to close this gap by examining quantitative indicators of safety outcomes and staff perceptions, thereby determining the degree to which BTAT support DBHDD's primary safety mission.

Summary of Key Findings

The results of this evaluation were based upon simulated but representative data, suggesting that BTAT's are successfully achieving their intended objectives:

1. Violence Reduction: Hospitals with higher BTAT referral activity consistently showed lower rates of violent incidents per 1,000 patient-days, demonstrates that proactive threat management correlates with fewer workplace assaults.
2. Staff Injury Reduction: Facilities with more engaged BTATs reported fewer and less severe staff injuries, underscoring the protective value of early intervention and case management.

3. Operational Effectiveness: BTAT met regularly, reviewed cases, and implemented interventions, indicating a stable institutionalized process rather than an unstructured response.
4. Staff Awareness and Confidence: Employees who were more aware of BTAT processes expressed higher confidence in workplace safety, reflecting the positive cultural influence of a transparent threat management process.
5. Policy Implementation Fidelity: All hospitals have shown knowledge and usage of the workplace prevention policy as established in policy 03-115. This suggest that the policy is in use and is working across all 5 hospitals.

Collectively these findings support the primary evaluation question by showing that BTAT continue meaningfully to both safety outcomes and staff perceptions.

Significance of the Evaluation

If the simulated data was real, the evaluation would have provided several significant implications for public safety policy. First, it would provide empirical support for multidisciplinary BTATs, validating its relevance in a clinical setting.

Second, it would have demonstrated that policy structure and implementations matter. Policy 03-115 effectively has been implemented and being followed within all 5 hospitals. Each hospital has had threat referrals, BTAT meetings, Intervention strategies, and effective case management.

Third, the evaluation demonstrated the value added of conducting research and obtaining measurable data. Using quantifiable data such as incident rates, injury counts, and BTAT referrals enables leadership to monitor progress, identify needs, and allocate resources strategically.

Forth, obtaining qualitative data, allows for feedback from employees to gain insight on the safety culture of a hospital and how employees perceive the process and what areas may need enhancing per the employee perspective.

Fifth, for DBHDD leadership, the findings emphasize that proactive identification, assessment, and intervention are central to maintaining safe treatment environments. For DBHDD, this program evaluation would give leadership great insight into the culture and support the efficacy of the DBHDD workplace prevention program.

Closing Statement

This evaluation concluded that the BTATs are a vital, effective, and sustainable component of DBHDD's approach to workplace violence prevention, through structured collaboration and contant policy adherence, BTATs enhance the safety culture within the DBHDD hospital setting and serve as a model for other public institution confronting similar challenges.

This researcher plans to continue the IRB approval process for DBHDD to conduct the actual research and obtain real data. Obtaining real data can be used to strengthen the empirical base for these conclusions and provide DBHDD leadership real information to access. The simulated study would have affirmed that DBHDD commitment to proactive, multidisciplinary threat assessment is well founded and impactful in many settings including a psychiatric setting.

Based upon the simulated data continued investment in training, technology integration, and longitudinal monitoring will ensure the BTAT remain a cornerstone of institutional safety and a benchmark for best practices in a psychiatric and forensic hospital setting.

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Appendix-DBHDD Policy 03-115

Appendix- Incident Codes and Definitions

Appendix- Institutional Review Approval

Appendix- Protection of Human Subjects and institutional Review Board

Appendix -Survey Instrument

Appendix- Data request letter to Hospital