

Behavioral Health: How it can inform Workplace Violence

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Disclosure:

- I have no financial disclosures or conflicts of interest to report

Objectives:



Review behavioral health symptoms and diagnoses commonly encountered in healthcare settings



Describe strategies for incorporating Trauma Informed Care principles into healthcare



Discuss strategies for treatment of behavioral health issues and mitigation of workplace violence

How do we define Mental Illness?

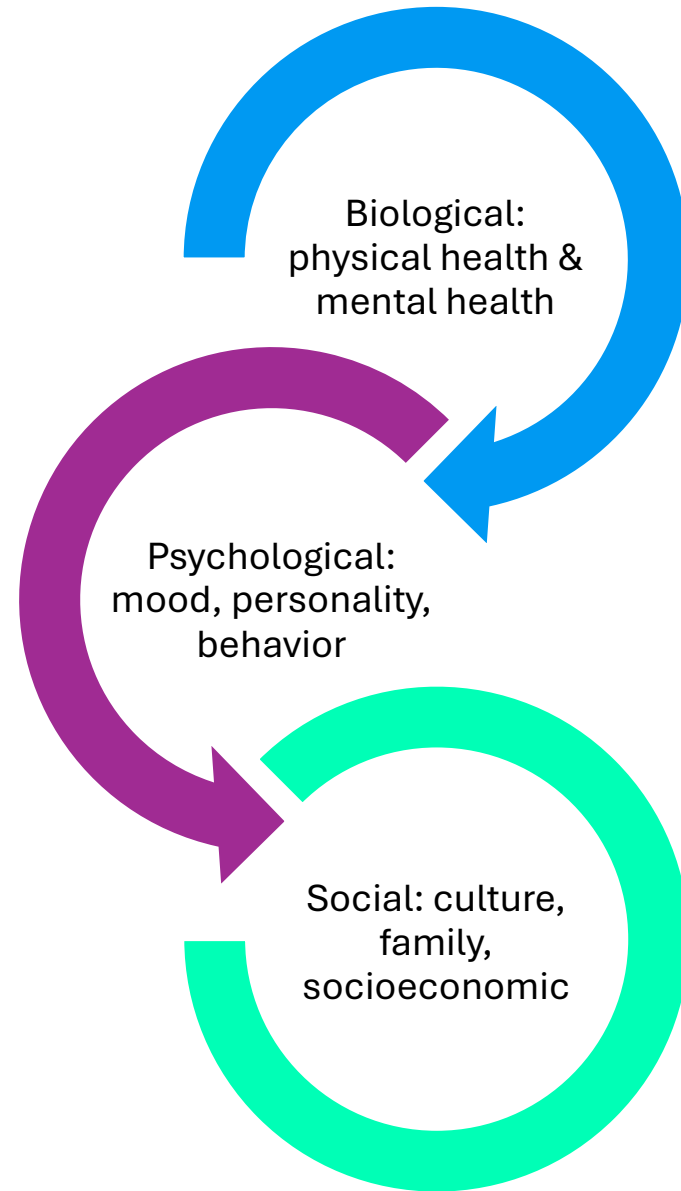
- A **health condition** featuring changes in emotion, thinking, and/or behavior.
- Impacts functioning in social, work and/or family activities.
- **Does not discriminate!** Can affect anyone regardless of your age, gender, geography, income, social status, race/ethnicity, religion/spirituality, sexual orientation, or background
- Mental illness is **treatable**. Most individuals with mental illness continue to function in their daily lives.

HOW COMMON IS MENTAL ILLNESS?

- Most common health conditions in the United States.
- More than 50% will be diagnosed with a mental illness at some point in their lifetime.
- 1 in 5 Americans will experience a mental illness in a given year.
- 1 in 5 children, either currently or at some point during their life, have had a seriously debilitating mental illness.
- 1 in 25 Americans lives with **a serious mental illness**, such as schizophrenia, bipolar disorder, or major depression.



Bio-Psycho-Social Model



Behavioral Health Diagnostic Categories

- Mood Disorders
 - Major Depressive Disorder, Bipolar Disorder
- Anxiety Disorders
 - Generalized Anxiety Disorder, Panic Disorder, Phobias
- Psychotic Disorders
 - Schizophrenia, Schizoaffective Disorder, Delusional Disorder
- Substance Use Disorders
 - Alcohol, Cannabis, Stimulant, Sedatives
- Developmental & Neurocognitive Disorders
 - Dementia, Autism, ADHD
- Personality Disorders
 - Cluster B personality disorders

Mood Disorders

Major Depressive Disorder

- 2 weeks or longer
- Marked sadness or lack of interest (anhedonia), impaired function
- Changes in sleep, appetite, energy, concentration
- +/- suicidality; +/- psychosis
- Medical comorbidity common

Bipolar Disorder

- Depression + Mania or Hypomania
- Mania:
 - 7 days, elevated or irritable mood, low need for sleep, rapid thoughts and speech, reckless behaviors
 - +/- psychosis; marked impairment
- Hypomania:
 - Milder, <7 days, no psychosis
- Bipolar Disorder ≠ mood swings

Psychotic Disorders

- Delusions +/-
- Hallucinations +/-
- Disorganized thought process
 - +/- Disorganized or Catatonic behavior
- Diagnoses differentiate by time & severity of impairment
 - + Mood Disorder -> Schizoaffective D/O
- Not uncommon in hospital setting to see psychosis symptoms related to SUD

Neurocognitive & Developmental Disorders

- Neurocognitive Disorder aka Dementia
 - Can experience delusions, behavioral changes
 - Often worse at night or when routine disrupted
 - Medical illness can increase symptoms, behavioral disturbances
- Intellectual Disability & Autism Spectrum
 - Can have difficulties with communication and processing
 - Behavioral disturbances can occur when ill or out of routine
 - Calming interventions and comfort can work better than Rx

Substance Use Disorders (SUD)

- All share common diagnostic criteria
 - Tolerance and withdrawal are inherent to the substance (physiologic)
- Both intoxication and withdrawal cause symptoms
 - Psychosis typically associated with stimulants, cannabis, PCP
 - Irritability and dysphoria are common in withdrawal
- Alcohol and Benzodiazepine withdrawal can cause delirium
- Assess interest in sobriety/treatment every time

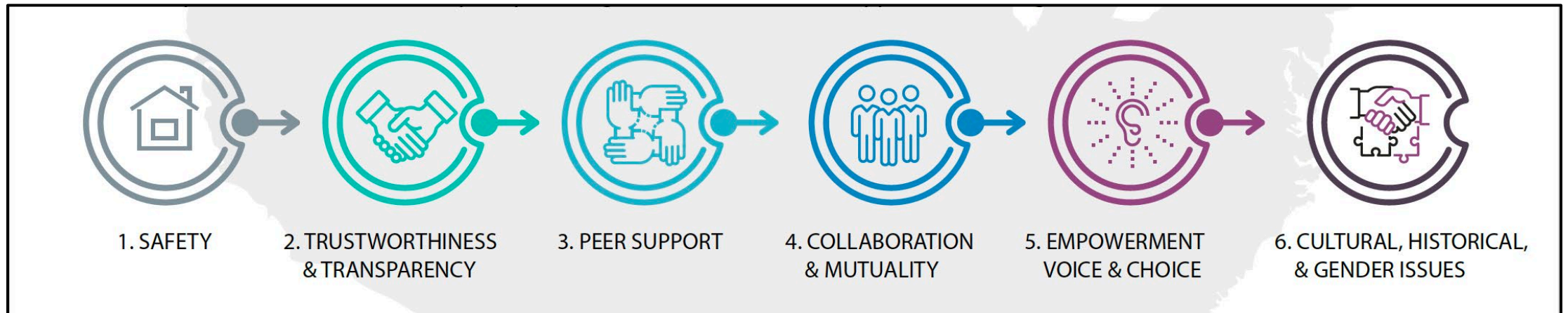
- Do not forget to think about nicotine withdrawal while hospitalized

SUD & WPV

- Surveys of medical staff have consistently shown a perceived link between SUD and acts of WPV
 - Of RNs: 88% believed EtOH & 79% believed drugs were a precipitating factor
 - Of ER staff: EtOH- 80%, drugs- 76% of physical assaults in prior 6 mo
 - 63% for all other "psych d/o" including neurocognitive
 - Of MH staff: hx SUD were 15x more likely though only 8% of patients
- Studies of dx/problem lists:
 - History of drug use d/o- 10%, Alcohol use d/o- 30%
 - SUD was primary or secondary diagnosis in 73% of cases
- None of these are definitive for cause

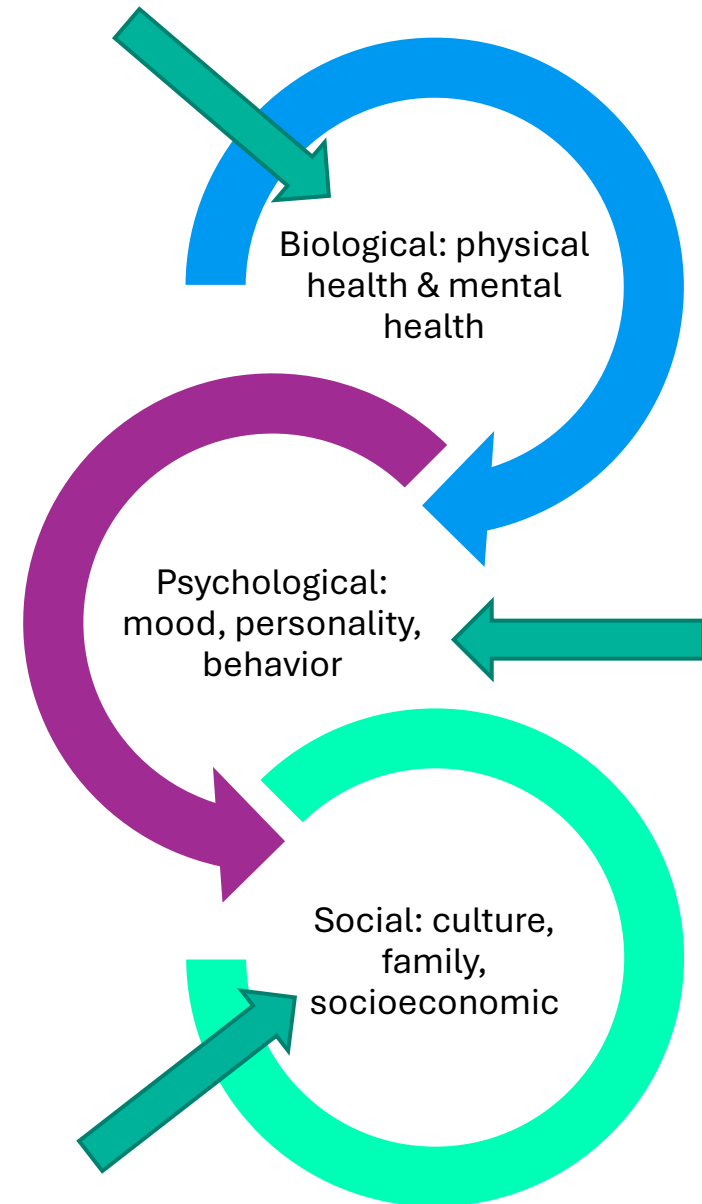
How do we define Trauma Informed Care?

- TIC is a strengths-based service delivery approach “that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment” - SAMHSA TIP 57



Bio-Psycho-Social model

- Adverse Childhood Experiences (ACE) Study in 1998 found strong graded relationship between breadth of ACEs and risk factors for adult morbidity & mortality
 - Surveyed 9500 patients
 - **52% had 1 ACE, 25% >2**
 - Most prevalent SUD in household



Trauma Informed Care & WPV

- Trauma Informed Care (TIC) emphasized physical, psychological, and emotional safety for **both** care providers/staff and recipients
- TIC model requires review of assumptions about who and why perpetrate WPV
 - “What happens to recipients that causes them to instigate WPV?”
 - Are there factors about the environment or care that are traumatizing for patients? visitors? staff?
- TIC models aim to prevent adverse outcomes by acknowledging root causes and prior experiences

Trauma Informed Care & WPV

- “Safety”
 - It’s more than elimination of dangers and the absence of violent event or injuries
 - 2 dimensional: objective & subjective
- Polyvagal Theory:
 - Nervous system interprets environment, input, people to determine safety
 - Poses organized hierarchy of social interaction-> fight/flight -> freeze
 - Safety = parasympathetic system -> social engagement attempts
 - Perceived or real threat = recruit sympathetic system - > fight or flight



1. SAFETY



2. TRUSTWORTHINESS
& TRANSPARENCY



3. PEER SUPPORT



4. COLLABORATION
& MUTUALITY



5. EMPOWERMENT
VOICE & CHOICE



6. CULTURAL, HISTORICAL,
& GENDER ISSUES

How do we treat Behavioral Health Illnesses?

- Identification of diagnosis(es)
 - Comorbid illnesses are common
 - Sobriety &/or medication assisted therapy
- Therapy
 - Individual and group
 - Talk therapy and behavioral therapy
- Family Interventions & Wrap around services
 - Assertive Community Treatment (ACT)
 - First Break Programs

Classes of Medications

- **Antidepressants** – used to treat depression, panic disorder, PTSD, anxiety, obsessive-compulsive disorder, borderline personality disorder and eating disorders.
- **Antipsychotic medications** – used to treat psychotic symptoms (delusions and hallucinations), schizophrenia, bipolar disorder.
- **Sedatives and anxiolytics** – used to treat anxiety and insomnia.
- **Hypnotics** – used to induce and maintain sleep.
- **Mood stabilizers** – used to treat bipolar disorder.
- **Stimulants** – used to treat ADHD.

Management of aggression

- #1 is verbal deescalation and behavior modification
 - Acknowledge and offer safe options, give back some power
- Management with psychoactive medications is "off label" use
 - Antipsychotics and Anxiolytics are common
 - Oral medications work as fast as injections
- Seclusion and restraint should be last resort

Can we mitigate risks?

- Studies on patient perspectives in WPV:
 - Poor communication and environmental factors = significant precursors
 - Moment of “Self-empowerment”
 - Over reliance on control through restrictions and rules
- Screening for risk with structured risk assessments
 - Support decision tools for interventions
 - Avoid “static” screening
 - Study: -41% in severe aggression events, - 27% use of coercive measures
 - Study: - 68% aggressive acts, -45% time in seclusion

Mitigation continued...

- Workforce Training
 - Teaching evidence-based communication techniques is crucial
 - 2022 scoping review: training staff in relationship-based approach might be more useful than attempting to predict events
 - Teach confidence, critical thinking, and flexibility
 - One of the most powerful techniques is positive reinforcement
 - Training significantly increases confidence of staff to address WPV
- Organization Culture
 - Arguably the most critical platform for prevention
 - Awareness, reporting, & support

Questions?

Thank you!

