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BUILDING RESILIENCY: THE ASSAULTED STAFF ACTION PROGRAM (ASAP) AT 35 YEARS

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Abstract: *The Assaulted Staff Action Program (ASAP) is a voluntary, system-wide, peer-to-peer help crisis intervention program to build resiliency when addressing the psychological aftermath of psychiatric patient assaults on staff. In its 35 years of continuous service, it has provided ASAP services for over 12,956 employee victims. During these years, it has also compiled the worldwide research findings on the characteristics of assaultive psychiatric patients and the staff victims of these assaults in five-year intervals to improve ASAP services as warranted and to provide a possible resource for interested researchers. This paper provides a retrospective state-of-the-art review of the field of patient assaults and ASAP's growth in its 35th year of service.*

Key Words: *assaults, Assaulted Staff Action Program (ASAP), psychiatric patients, resiliency, staff victims*

INTRODUCTION

It happened today. It will happen tomorrow. And the day after. Every day, somewhere in the world, a psychiatric patient assaults a healthcare provider in an unprovoked attack. Largely unknown by the general public, these assaults are a significant contribution to the world's sum of daily violence. However, these assaults are rarely reported by the media, politicians pay them little heed, and the courts, by and large, refuse to accept such cases for the docket. Thus, this violence continues, and healthcare providers are left to their own resources to address it. This includes nursing personnel who may be repeatedly assaulted during the course of their careers.

The Assaulted Staff Action Program (ASAP) (Flannery, 2012) is a voluntary, system-wide, peer-to-peer help and psychological crisis intervention program designed to provide both clinical support to

employee victims of patient assaults and to develop employee resiliency in the face of these assaults.

In recent years, Everly et al. (2015) and Everly and Athey (2023) have delineated five characteristics of resiliency: active optimism, decisive action, relentless tenacity, and interpersonal support, within the context of some form of moral compass. These skills have been found to strengthen managers and the general public in helpful ways. Here, the challenge was to design ASAP interventions that addressed the psychological needs of victims while also building resiliency in staff, as noted by Everly and Athey (2023).

During its thirty-five years of providing continuous service to employee victims, ASAP also monitored the characteristics of both patient assailants and employee victims to improve ASAP interventions as new research findings indicated and to provide an ongoing database for interested researchers on these topics. The purpose of the present paper is twofold: (1) to review the published data on patient assailants and staff victims to assess for any significant changes in assessed variables, and (2) to provide a current update on ASAP findings. It was hypothesized that there would be no significant changes in the characteristics of patient assailants or staff victims.

METHOD

Subjects:

Subjects were either patient assailants or staff victims, as designated in the research included in the two tables listed in the Appendix.

Procedure:

This study included articles drawn from medical records based on incident reports from two common databases: PubMed and PsycINFO. Key words included "assaults," "assaultive psychiatric patients," "psychiatric patients," "repeated assaults," "staff victims," and "employee victims." The criteria for study inclusion included: adult populations; the presence of raw data, including total assaults, basic demographic/ clinical assailant characteristics, or staff victim characteristics, inpatient, emergency room, or community settings; and studies of single assaults or repetitive assaults. All studies were in the English language from any country worldwide. Subjects were dichotomized by the presence or absence of assault. Articles not meeting the inclusion criteria included studies with repeated data entries, papers with subjects less than 10, special populations, papers validating scales, and studies of children. Operational definitions of assault included verbal abuse, racially derogatory comments, nonverbal intimidation, and various forms of unwanted physical contact. Demographic and clinical variables were based on previously published studies on assault and aggression. The demographic variables included duration of study in months, total physical assaults, total other assault types, diagnoses, setting, age, gender, years of experience, and country of study. Clinical variables included past history of violence, past history of personal victimization, and past history of substance use.

The research procedure was the same at each five-year interval. Each author conducted independent literature searches in each of the two common databases for possible relevant articles. Articles were compared and selected if all authors agreed that the inclusion criteria were met. Studies not meeting criteria were discarded. Each of the selected articles was then assessed for any additional relevant studies. Dissertation abstracts were excluded, and no attempt was made to secure unpublished data.

Statistical analysis.

Measures of means and standard deviations of descriptive statistics were computed. Pearson correlation coefficients for continuous variables were conducted.

FINDINGS

The Characteristics of Patient Assailants

Table 1 summarizes what 46 years of empirical research have taught us and displays the five literature reviews of assaultive psychiatric patients conducted by ASAP from 1978 to 2024. (Flannery, 2002; Flannery & Flannery, 2023; Flannery, Juliano, et al., 2006; Flannery & Flannery, 2023; Flannery, Wyshak, & Flannery, 2018; Flannery, Wyshak, Teece, et al., 2014). (see Appendix 1, Table 1: Characteristics of Patient Assailants)

These findings are based on 144 data-based peer-reviewed papers published in English. There were 97,316 primarily physical assaults that occurred in state or private inpatient units, emergency rooms, forensic settings, and community-based programs. There were 61,312 male and 39,394 female psychiatric assailants with an average age of 36 years. Most assailants were primarily diagnosed with schizophrenia, and many had histories of past violence, substance abuse, and personal victimization.

The Characteristics of Staff Victims

Table 2 displays the 27-year findings of five literature reviews of staff victims that were conducted from 1995-2022 (Flannery, 2004; Flannery & Flannery, 2018; Flannery & Flannery, 2023; Flannery, Farley, et al., 2007; Flannery, Wyshak, & Flannery, 2014). (See Appendix 2, Table 2: Characteristics of Staff Victims)

These findings are based on 96 data-based, peer-reviewed studies in English of staff victims in a variety of public/private inpatient, community, forensic, and emergency room settings.

The reported data included 108,526 primarily physical assaults and included 15,072 male and 47,161 female employee victims. These victims represented all staff disciplines but were primarily nursing personnel with an average age of 36.6 years and 8.7 years of experience.

As with the patient assailant data, victim data were also fairly uniform across time, across countries, and across cultures during these 29 years. Less experienced, female employees were most at risk, especially during restraint and seclusion procedures (Flannery & Flannery, 2018). Precipitants to these assaults were similar to those reported earlier for patient assailants. Assaults on female staff were at unacceptably high levels and reflect the levels of violence toward women found in many aspects of society at large. As with the patient assailants, staff victims were also subject to the instability of healthcare systems in constant change and mission expansion.

Many employees felt at increased risk of assault, and the research studies asked employee victims what further training or support would be helpful. Requests have included more training in nonviolent self-defense, restraint and seclusion procedures, patient-at-risk conferences, the early warning signs of patient loss of control, and requests for post-incident counseling and support.

DISCUSSION

With regard to the first purpose of this paper, the findings from these literature reviews support the study's hypothesis that there would be no significant changes in the characteristics of patient assailants or employee victims.

The most surprising finding was the uniformity of these findings across published research time (46 years), across countries, and across cultures. The high-risk patient in 1978 was a younger male patient diagnosed

with schizophrenia, substance abuse, and past violence. This was equally true of the high-risk patient in 2024. During these years, the assailant precipitants included acute psychosis, substance use, younger age, impulsivity, and denial of services. These precipitants have also remained consistent over time (Flannery & Flannery, 2018; Flannery, Staffieri, et al., 2011).

Further highlighting these findings was their stability in healthcare systems that were themselves in constant change. These changes included several agency fiscal shortfalls, downsizing, facility closures, and repeated staff reductions. These years also saw the inclusion of personality disorders around 1991, the shift to managed care in community settings around 1995, and the inclusion of forensic patients around 2002. Each of these shifts required the development of new protocols for patient care and staff safety. Add to this list the impact of COVID-19, which led to staff loss of life, retirements, serious burnout in remaining staff, and a continuing post-COVID staffing shortfall. Healthcare social system change was a constant.

Similarly, over time, no single efficacious patient-assault treatment approach has emerged. Advances in psychopharmacology, behavioral consults, patient-at-risk conferences, skills-based rehabilitation efforts, substance abuse programs, community placements, trauma-informed care initiatives for restraint and seclusion have helped many patients, but no one treatment has emerged as a basic paradigm for recovery.

As with the patient assailant data, victim data were also fairly uniform across time, across countries, and across cultures during these 29 years. Less experienced, female employees were most at risk, especially during restraint and seclusion procedures [Flannery & Flannery, 2018]. Precipitants to these assaults were similar to those reported earlier for patient assailants. Assaults on female staff were at unacceptably high levels and reflect the levels of violence toward women found in many aspects of society at large. As with the patient assailants, staff victims were also subject to the instability of a healthcare system in constant change and mission expansion.

The uniformity of patient assailants and staff victims is likely due to the biological nature of serious mental illnesses and the required medical services and personnel needed to address the needs of these patients properly.

The Assaulted Staff Action Program (ASAP)

The second purpose of this manuscript was to provide an ASAP update. As noted earlier, the Assaulted Staff Action Program [1] is a system-wide, voluntary, peer-to-peer crisis intervention program to assist employee victims in addressing the psychological aftermath of psychiatric patient assaults. Voluntary in that employee victims are free to decline ASAP services; system-wide in that ASAP responds to every assault incident; and peer help in that fellow agency employees volunteer to staff ASAP teams. ASAP is the only program of its type in the published literature and addresses one of the oft-repeated requests of staff victims for post-incident support.

ASAP basic services include individual counseling, group (e.g., ward) counseling, weekly support groups for employees in need, employee victim family counseling, and referrals to private therapists who have been vetted for skills in psychological trauma counseling. Agencies sponsoring an ASAP team provide two team beepers and access to the facility's email system. All other ASAP services are provided at no cost by ASAP team members with the exception of referrals to private therapists, when insurance is

utilized, unless the agency already has a designated, contracted in-house mental health provider. These referrals are made when the staff victim's trauma issues go beyond the specific patient's assault.

COVID-19 continues to impact ASAP as the virus has still not been eradicated. The COVID-19 quarantine also resulted in less commerce overall and reduced state tax incomes, thus reducing state budgeting for a variety of public and private health services. This shortfall has impacted ASAP. Many healthcare providers, including ASAP team members, were worn out from direct care responsibilities and retired. This has resulted in a major staffing shortage and fewer new hires within a framework of a national shortage of employees willing to work in many differing types of work settings. Remaining ASAP team members encountered ASAP time being assigned to other projects, repeated mandated overtime shifts, and continuing budget shortfalls that further depleted resources. Although the economy has generally recovered, budget shortfalls still hamper many healthcare agencies.

Although ASAP remains somewhat constricted due to COVID-19 staffing and fiscal shortages, in its 35-year history, ASAP has fielded 49 teams in nine states and trained 2,500 facility employees to provide ASAP services to their peers; they have treated 12,956 employee victims and volunteered 2.5 million hours of service to their agencies. ASAP has been shown to result in less injury, less medical expense, less utilization of sick leave, fewer industrial accident claims, less legal expense, reductions in patient violence, less staff turnover, and increased productivity. ASAP teams literally pay for themselves. In regard to resiliency, ASAP team members in their work with assaulted staff were taught to implement ASAP interventions with decisive action, tenacity, and interpersonal support that has resulted in improved optimism, morale, and productivity. All of which has been done within the moral compass of helping others, both patients and staff. The ASAP data offer additional support for the concept of resiliency.

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APPENDIX 1

Table 1: *Characteristics Patient Assailants*

Study	Research Duration in Years	Total Assaults Physical	Total Other Assaults	Setting	Age	Gender M/F	Diagnosis	Past Violence	Past Victim	Past Substance Abuse	Manuscripts Reviewed
1978-2001 Flannery, 2002	62.25	9412		State, Private Psych Units	34.94	2549/ 604	Schizophrenia (85%)				28
1990-2005 Flannery et al., 2006	15	1857		Psych Inpatient, Community	35.04	1047/ 1056	Schizophrenia (47.5%) Affective (18%) Pers. Disorder (18%)	1161 90%	849 66%	686 53%	13
2000-2012 Flannery et al., 2014	247.6	24,666		Inpatient, Community	36.78	16,282/ 13,867	Schizophrenia (45%) Affective (20%) Pers. Disorder (10%)	3%		5%	69
2013-2017 Flannery et al., 2018	31.17	521,378		Inpatient, Forensic, ER	37.2	19,105/ 6,044	Schizophrenia (45%) Affective (20%) Pers. Disorder (10%)				14
2017-2022 Flannery & Flannery 2023	75.17	6,172	2931	State, Private Psych Units	36.33	22,329/ 17,818	Schizophrenia (65%) Affective (60%) Pers. Disorder (20%)	38,235 95%	30,166 25%	30,186 25%	20

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APPENDIX 2

Table 2: *Characteristics of Staff Victims*

Study	Duration in months	N	Total Assaults	Discipline	Average Age In Reporting Studies	Gender M/F	Years Experience	Setting	Training Needs	Papers reviewed
1995-2001 Flannery, 2004	362	4,252	4,302 physical/ verbal	Primarily All Staff	35.44	1,349/ 2,903	9.3	ER, Inpt, Community	NVSD, Post incident crisis counseling, Behavioral consults, Restraint & seclusion	18
1990-2005 Flannery et al., 2007	120	2,152	2,152	All Nursing Staff	20-35 years	1,071/ 1,049		Inpt, Community	NVSD, Restraint, Crisis support	6
2000-2012 Flannery et al., 2014	801	16,769	17,220 all types	All Staff, esp. Nurses	37	7,284/ 9,485	7	Varied Inpt, Community	Warning signs of violence, Coping strategies, Post incident crisis support	28
2013-2017 Flannery, 2018	658.56	4,774	45,818	Mainly Nursing	37.87	1,327/ 3,447		ER, Varied Inpt, OPD,	Manage Pt Aggression, Post incident crisis counseling	20
2017-2022 Flannery & Flannery, 2023	198.36	34,679	39.034 all types	All Nursing Staff	36.2	4,046/ 30,277	10.3	ER, Inpt, Community	Ways to manage Pts. Post incident support	24

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Compliance with Ethical Standards

Disclosure of Potential Conflicts of Interest Summary Statement

Declarations:

Conflicts of Interest: The authors declare no conflicts of interest.

Consent: The corresponding author, writing on behalf of all authors, states that there are no potential conflicts of interest of any kind in this submission. No funding of any kind was involved and there was no AI involvement. This review of published findings involved no direct research for this manuscript that involved human or animal participants. Thus, there was no need for an IRB review or informed consent. This submission is solely a review of the extant published literature.

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Data Availability Statement

This is a review article and no data availability notice is necessary. Since this review is in the area of clinical psychology, it could be stored in 10.25504/Fairsharing.f9e697.

Contribution Declaration

Dr. Raymond Flannery, Jr. created the original idea and prepared the first draft. Thomas Greenhalgh, LICSW, a senior experienced crisis intervention specialist with 20 years of providing support and training of hospital personnel was asked to read the first draft to be sure that all cited reviews included all relevant papers, that papers were reported accurately, that no relevant study had been overlooked, and that conclusions drawn in this review were correct and supported by the data in the reviewed articles. Katy Klick, LCSW, and Stacie Adrian, LCSW have been team ASAP team leaders at Fulton State Hospital in Fulton, MO, USA for several years. All authors viewed the various copies of the draft, and approved the final draft for submission.