

Workplace Violence: Prevention & Intervention

GUIDELINES FOR
HOMELESS SERVICES
PROVIDERS

Brenda J. Proffitt, MHA, *editor*

HEALTH CARE FOR THE HOMELESS
CLINICIANS' NETWORK

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DEFINITION: WORKPLACE VIOLENCE

Violent acts (including physical assaults & threats of assaults) directed toward persons at work or on duty.

—CDC/NIOSH (2002)

This updated compilation of policies and protocols provides practical information for creating a safer environment for consumers and staff in Health Care for the Homeless Projects. It is an expanded and enhanced version of the 1996 document *Sample Safety Guidelines in Homeless Health Services Programs*, and would not have been possible without the essential and gracious support of many individuals.

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- The Mental Health Chaplaincy

These contributions have been gently edited for brevity, clarity, and editorial consistency. Any errors and omissions are my own.

—Brenda J. Proffitt, MHA, editor

2010 – 2011 HCH Clinicians' Network Communications Committee

Bob Donovan, MD; Sapna Bamrah, MD; Brian Colangelo, LCSW; Kent Forde, MPH; Kathleen Kelleghan; Bill LaRock, MS, ANP, RN; Michelle Nance, NP, RN; Rachel Rodriguez-Marzec, MS, FNP-C, PMHNP-C; James Williamson, MS, PA-C

Disclaimer

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Violence in the workplace is a serious health and safety issue. Homicide—the most extreme form of workplace violence—is the fourth-leading cause of fatal occupational injury in the United States according to the Occupational Safety and Health Administration. Although the majority of workplace homicides involve a person entering a small late-night retail establishment, nonfatal events involving assaults to service providers—especially health care providers—represent the most prevalent category of workplace violence that results in physical injury.¹

While there are no specific OSHA standards for workplace violence, a number of work settings—including agencies delivering services to individuals and families experiencing homelessness—have developed and implemented strategies for reducing exposure to risk factors for violence. The Health Care for the Homeless Clinicians' Network gathered the policies and protocols included in this publication to provide guidance to establishing a workplace violence prevention program. Six homeless services providers share their expertise in preventing and dealing with workplace violence in the documents included here. Others who are responsible for establishing workplace violence initiatives at their agencies are urged to use these resources to enhance workplace safety and to reduce and prevent disruption and violence.

These collected policies and protocols provide examples of:

- Practical measures to identify risk factors for violence at work
- Basic information about employer/employee roles in prevention and protections
- Recommendations for response to violent incidents
- A checklist of safety practices for workers who go out into the community

Resources at the end of the publication link to a variety of training and reference materials, including presentations, publications, sample forms, best practices, and successful methods of prevention. Appendices highlight additional information about two issues of particular concern, de-escalation of aggressive behavior and working with brain injury survivors. Our intent is to support homeless service providers in their efforts to maintain safe and healthful working conditions. ■

¹ Occupational Safety & Health Administration. (2007). *Safety and health topics: Workplace violence*. Retrieved from <http://www.osha.gov/SLTC/workplaceviolence>

Policy & Procedure: Behavioral Risk Management

Greater Cincinnati Behavioral Health Services (GCB) is the largest community-based mental health provider in Hamilton County, Ohio, serving adults who have the most severe forms of schizophrenia, bipolar disorder, and major depression. Through its PATH Program—Projects for Assistance in Transition from Homelessness—GCB is the largest local outreach provider to people who are experiencing homelessness. In 2010, GCB began a collaborative clinic with the Cincinnati Health Network’s Health Care for the Homeless Program. GCB updated and distributed these policies and procedures for behavioral risk management in 2010.

POLICY STATEMENT

- GCB will provide guidelines to staff to maximize client and staff safety in our facilities and in the community
- GCB will prohibit violence in the workplace and protect client safety through sound seclusion and restraint procedures
- GCB will provide training to staff on the risks associated with providing mental health services; the training will focus on crisis prevention, non-physical crisis intervention, and personal safety

PURPOSE

- *Behavior risks* are risks that result from the behavior of our staff, clients, or others. GCB will strive for a work environment that is safe for clients and staff.
- Since the nature of GCB’s business is such that risks to staff and clients are unavoidable, GCB will continue to develop strong policies and procedures to help safely manage these behavioral risks

GREATER CINCINNATI BEHAVIORAL HEALTH SERVICES

PROCEDURES

- Behavioral Risk Management in our Facilities and in the Community
- Clinical Risk Management
- Nonviolent Crisis Intervention
- Seclusion and Restraint
- Violence in the Workplace/Program/Settings
- Weapons

I. BEHAVIORAL RISK MANAGEMENT IN GCB FACILITIES & IN THE COMMUNITY

A. General

- Use Code Yellow Procedures when indicated
- Use the Clinical Officer of the Day as needed
- Use good judgment. Do not take risks. Consult with your supervisor when you have questions or concerns about your safety. If your supervisor is unavailable, contact your department director (or designee) and/or on-call system.
- Know your clients, learn their risks, and use the resources available to you
- When clients receive multiple services, the client coordinator manages services to assure consistency related to staff and client safety
- Knowing our clients and their behaviors can help staff avoid most situations of aggressive or violent behavior. Pay extra attention to clients who may present as anxious, agitated, or upset, and respond in a supportive and empathetic approach. Staff is responsible for close observation and early action.

B. Co-Treatment

- *Co-Treatment:* Two staff members deliver services to one client at the same time because of risk or safety concerns (either in the office or in the community). This applies to any two staff members including doctors and nurses.
- Use co-treatment when there is a safety risk that requires that two staff be present
- All co-treatment must have authorization by a GCB clinical supervisor
- Ongoing co-treatment for safety must be authorized in the ISP. A clinical supervisor must authorize a one-time service.
- A clinical supervisor must sign all progress notes documenting co-treatment

C. Contacting the Police

- For all calls requesting police assistance, staff provides the following information:
 - Caller's name
 - The specific location where the police are needed (generally, a street address; but when necessary, include the specific location within that street address)
 - The fact that you are calling from a mental health facility (if applicable)
 - The nature of the specific situation for which you are requesting assistance
- Provide a brief, clear, and factual description of the specific situation to the dispatcher:
 - Number of individuals involved
 - Type of weapons involved, if any
 - Nature and extent of any known injuries
 - Nature of individual: Depressed? Suicidal? Apparently responding to hallucinations? Intoxicated? Known to respond negatively to police officers?
- **If situation requires immediate police assistance, call 911**
- Staff should provide all information requested by the police and cooperate fully

D. Behavioral Risk Management & Quality Improvement

- The safety coordinator works with staff resources to include facility and community safety topics in the agency's orientation and annual training plan
- The safety coordinator ensures that the Safety Panel's quarterly and annual reports include information on facility safety and staff safety in the community
- Areas for improvement identified by the Safety Panel and Incident Review Panel will be included in agency strategic initiatives or in quality improvement plans
- GCB collaborates with local police to build an effective partnership to address crises

E. Resources for Managing Psychiatric Emergencies

- **GCB's Code Yellow Procedure** When a person is threatening to hurt themselves or others or is actively hurting someone else, a Code Yellow alert sounds through the phone paging system. A

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Crisis Team, comprising staff that completed eight hours of Crisis Prevention and Intervention training, will respond immediately. Staff already at the scene should continue attempts to de-escalate the agitated person and summon additional staff including the case manager, officer of the day, and security guard as needed. Initial responding staff or security guard can turn the situation over to the crisis team if indicated, but should continue to act in a supportive role.

If situation requires immediate police assistance, call 911. Provide all information requested by the police & cooperate fully.

- **Application for Emergency Admission** GCB will use our psychiatrists and advanced nurse practitioners to complete Statements of Belief and Observation for emergency admissions. If one of the above listed staff is unavailable, we will use one of our trained Health Officers to complete the statement of belief (*see Health Officer Guidelines below*).
- **Guidelines for GCB Health Officers** when considering signing a hold on an individual:
 - A GCB Health Officer can sign a hold only if the individual's treating psychiatrist or advanced practice nurse or another agency psychiatrist/APN is unavailable to sign the hold
 - If a Health Officer is needed to sign a hold, he or she must consult with a second Health Officer or another agency supervisory-level clinician (if a second health officer is unavailable) before completing the hold. These two clinicians must agree that a hold is required.
 - File a copy of the hold in the legal section of the individual's record. If a hold is signed in the field, keep the carbon copy for the client's record. The original hold must always accompany the client to the hospital.
 - Anytime a hold is signed, complete an incident report. The incident reporting committee will review every signed hold.
- **Psychiatric Emergency Service** PES is the "psychiatric emergency room" at University Hospital where many clients go for psychiatric treatment. PES provides the following services:
 - Psychiatric assessment
 - Administration of psychotropic medications to stabilize a person
 - Overnight observation

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- Admission to University Hospital's psychiatric units
- Referral to hospitals in the community
- Persons who have physical injuries as well (e.g., overdose of medications) will be seen in the Acute Care Section before being released to PES
- Any time a client is going to PES, staff should call first to provide the following information:
 - Client's name and other identifying information
 - Current prescribed medications
 - Time of last known dose(s)
 - Any information regarding suspected overdose or substance abuse (e.g., type, quantity, time ingested)
 - A staff member's name to contact regarding client's status
- **Mobile Crisis Team** Operated out of PES, MCT provides on-site response (e.g., assessment, evaluation, crisis counseling, referral to PES, authorization for involuntary admission) in certain situations. Factors that rule out MCT responding include situations where deadly weapons are involved or where the client is acting violently. In these situations, call 911. The client must voluntarily agree to talk with MCT. Note that the MCT cannot necessarily respond on short notice.
- **Life Squad & Police Emergency** For serious emergencies such as suicide or situations involving violence or deadly weapons, call 911.
- **Clinical Officer of the Day** GCB designates a supervisor as Clinical Officer of the Day to be available during business hours and gives all staff the Clinical Officer Coverage Schedule.
- **On-Call & Clinical Backup Services** GCB provides after-hours and on-call services to assist clients with emergencies when the office is closed. A clinician is on-call for consultation as needed.

F. Facility

- When providing services to a high-risk client within any GCB facility, plan so you are not meeting with the client in an isolated location. Meet in open surroundings in view of others. In nonresidential facilities, if someone is under the influence, we do not want him or her in the facility. In group homes, base decision making on the person's behavior and use the above resources as appropriate. Each GCB site conducts quarterly safety drills.
- Program rules or guidelines are posted in each staffed location

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- Each facility develops and posts “house rules” that address at least the following:
 - Threatening behavior
 - Respecting other’s space
 - Stealing
 - Fighting or violence
 - Weapon-free environment
 - Drugs or alcohol
 - Gambling

CRISIS INTERVENTION GOALS

- ▶ To protect potential victims, yourself & others
- ▶ De-escalate the situation
- ▶ Help the individual regain control

GENERAL PRINCIPLES

- ▶ Preventive techniques
- ▶ No physical intervention techniques
- ▶ Continually assess risk factors

G. Crisis Intervention Protocol for GCB Facilities

- Staff training will be provided
- The goals of any intervention should be to:
 - Protect potential victims, yourself, and others
 - De-escalate the situation
 - Help the individual regain control
- Each facility should have a process for notifying other staff that a crisis is occurring or about to occur. This is a call for help, and the Code Yellow Protocol outlines procedures.
- The first person on the scene should temporarily take the lead; the ideal lead person is someone who knows the individual well and already has good rapport
- Depending on the situation, no more than two staff should approach and work with the individual. Others responding should assist in clearing the area of onlookers, and take direction from the lead intervener.
- Any interventions should be progressive; i.e., do not under- or over-respond to the situation
- **Safety of GCB employees always comes first.** These are ways staff can increase safety in the workplace:
 - *Be aware:* Every work environment has a routine amount of noise and energy. The employee, however, needs to be aware of any changes, unfamiliar noises, or unfamiliar sounds, which could be an alert to a safety issue.
 - *There is safety in numbers.* If you or a client feels threatened, call for help and make noise.
 - If you are involved with a client who has reached the physical action stage, scan your environment for natural barriers to increase safety. For example, is there a table or chair that you can place between the employee and the client?

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- *Survey the area for potential weapons* that the client could use in the physical action stage, i.e., utensils taken from the kitchen area, broken glass
- *Always have an escape route in mind.* During any crisis management intervention, be aware of the safest exit route. Do not let a client position him or herself between you and the door.
- *Approach the individual slowly and calmly;* speak in a slow and normal voice tone; call the person by name
- *Do not approach the individual from behind* or directly head on; maintain a safe distance and have an escape route in mind
- If an external stimulus (e.g., another individual) is evident, other responders should assist in separating or removing the stimulus, as possible
- If individual is behaving in a verbally aggressive manner (e.g., shouting threats, cursing), firmly direct the individual to stop the behavior. If individual begins to de-escalate, continue to provide support and redirection. Help the individual to regain control.
- If situation escalates to physical violence—or if that has already occurred—call the police at 911
- **Never** position yourself between individuals who are fighting or appear ready to fight. In a firm voice, demand that the individuals stop immediately or that you will call the police. Other responders need to clear the area of bystanders. Do not attempt to physically intervene to separate two individuals who are fighting.
- After a crisis, the staff person in charge of the facility should see that an incident report is completed

H. Security Measures in GCB Facilities

- **Monitoring entrance and movement in GCB facilities** GCB's goal is to provide a safe and secure environment while still offering a warm and friendly atmosphere.
 - All staff and clients need to work together to provide a safe and secure facility
 - Entrance to any GCB facility is limited to active GCB clients, current staff, family members, Board of Directors, volunteers, referrals and their agents, business contacts, and other invited guests. Solicitation is prohibited.
 - For additional security, a few GCB facilities are equipped with a security guard, security cameras, security doors, outside lighting, and panic buttons

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- Each facility has an appropriate process to manage client and visitor movement within buildings
- Program Support Personnel will have access to client and staff rosters to allow status verification
- Program Support Personnel will notify the appropriate supervisor of staff or clients who repeatedly refuse to comply with facility security measures. Supervisors will counsel these individuals to ensure that they comply with procedures.
- Program staff will provide Program Support Personnel with a list of clients who are prohibited in the facility. Programs will also keep Program Staff and Safety Staff informed of situations that require locking the front door during business hours.
- Staff is strongly encouraged to inquire about anyone wandering about the building and assist him or her get where they need to be. Ask where they are supposed to be, whom they are here to see, and encourage them to wait in a designated waiting area. Clients and/or visitors are not permitted to be in the building unless they have official business. If it does not appear that the person belongs in the facility, ask them to leave. If they refuse, contact the clinical officer of the day, facility manager, and/or security guard.
- GCB expects staff to cooperate in keeping non-entrance doors locked. Staff should not disclose security codes. Never leave doors that are propped open unattended.
- Staff and clients should not leave personal items unattended in any GCB facility
- **Drugs & weapons** GCB does not permit drugs of any kind or weapons of any kind in any GCB facility. If staff becomes aware that drugs or weapons have been brought into the facility, and it is safe to confiscate them, give them to the highest-level supervisor on-site, who should work with the safety coordinator and other authorities as needed to determine what should be done with the item(s).

I. Community

- GCB wants staff and clients to be safe. Use good judgment. Do not take risks, and consult with your supervisor when you have questions or concerns about your safety. If your supervisor is unavailable, contact your department director (or designee) and/or on-call system.
- GCB requires that all staff working in the community attend safety training annually. Each employee's Essential Learning profile tracks this training.

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- Consider your comfort level and relationship with the client. If a client is new, unknown, or has a concerning history (e.g., forensic or violent), consider safety precautions.
- When visiting a client's home, consider living arrangements (e.g., apartment, group home), and review safety issues with the neighborhood, isolation, weapons, pets, and other family members
- If the safety of a client's current living arrangement is in question, GCB staff can pursue solutions such as facilitating the client's move, involving the Board of Health or fire department, or other action as needed
- When the safety of a particular location is a concern, consider alternative visit locations, including a GCB office, a public setting (e.g., restaurant or library), or the client's family home when a trusted family member will be present
- Another option is to have additional team members or a supervisor accompany you to the appointment, with the appropriate documentation according to the Co-Treatment Policy & Procedures. When clinically appropriate, GCB staff may use other system resources such as Mobile Crisis to accompany them.
- When you are going into the community and anticipate that you may be isolated, discuss the situation with your supervisor in advance, carry a cell phone, give your travel plan to another person, plan to meet the client at GCB's main center, or take another person with you
- When you are visiting a community facility and there is a person or persons creating a disturbance that feels unsafe, immediately seek the assistance of the facility personnel, contact the police, or leave the area
- When you are visiting any community and you feel unsafe, leave the area immediately
- If you know that a client is in the possession of weapons, do not meet with them. Reschedule the meeting for another time and/or location. If someone the client lives with has a weapon, only meet with the client at an alternative location, as described above. **Inform your supervisor of any situation involving weapons.**
- Review safety factors when driving a client. If a client becomes threatening or intimidating, immediately pull your vehicle to the side of the

COMMUNITY SAFETY TIPS

- ▶ Use good judgment
- ▶ Always let someone else know your travel plans
- ▶ If you find yourself in a situation that feels unsafe, leave the area
- ▶ Know your client's history & any high-risk factors
- ▶ Call 911 when necessary

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street and ask the client to leave. If the client refuses to leave, take your keys and personal belongings, and leave the area. **Do not transport a client if you know they have a weapon in their possession.**

- If you know that a client lives with someone who may be dangerous, do not go to their home; meet at an alternative location as described above
- When visiting a client who has a visitor with whom you feel uncomfortable, let the client know that you will meet with him or her at another time and leave. If the visitor presents cause for extreme concern, contact your supervisor and/or call 911 if there is clear indication that the client may be at risk for harm.
- Be prepared. Be knowledgeable of client histories and appropriate clinical and Demographic Data Sheet information. Know which clients have high-risk issues.
- For the safety of the client who might be agitated in the community, it might be necessary to take additional steps. Consult a supervisor when possible; use police emergency 911 when necessary.
- When clients receive multiple services within the agency, a client coordinator manages services to assure consistency related to staff and client safety
- Regularly assess situations for safety. Complete a quick assessment of a client before entering their home for any signs of risk (e.g., agitation, hostility, substance use).
- Routinely evaluate the client's living arrangements for safety risks to the client or staff

NOTE: Even if a client is not identified as being high-risk for a history of homicidal behavior or thoughts, or a history of assault, leave the situation immediately and notify your supervisor if they begin to talk or act as if they could be dangerous.

II. CLINICAL RISK MANAGEMENT

The Clinical Guidelines for Recognizing and Responding to Critical Clinical Situations addresses the practice of staff throughout treatment identifying, assessing, and managing client clinical risk factors and staff interventions. Clients served at GCB are severely mentally ill and may have a history of violence to self or others. The practice of continual assessment of factors will aid staff in their ability to provide treatment in a safe and sensitive manner.

GREATER CINCINNATI BEHAVIORAL HEALTH SERVICES

A. At Intake

GCB's practice is to identify dynamic and static risk factors of clients who are being referred to GCB. *Dynamic factors* are risk factors that are subject to change by intervention or treatment. *Static risk factors* are not subject to change and are typically history.

- Staff will identify the dynamic and static risk factors using the Diagnostic Assessment Form (DAF) and the Historical Clinical Risk Assessment that is completed by Mental Health Access Point (MHAP) or other referring agency
- Staff will attempt to obtain any past and/or current clinical information from the referral source. A thorough review of past and current clinical assessments and records will help staff identify potential risk factors for the client. Seek information from criminal justice institutions, parole, and probation departments when indicated.
- Staff will access referred clients' legal history through the Hamilton County Clerk of Courts website (www.courtclerk.org). This practice may not be done for a few secondary services such as vocational and socialization.
- Staff will access clients' legal history through the Ohio Department of Rehabilitation and Corrections (www.drc.state.oh.us/OffenderSearch/Search.aspx). Information from this website will document any convictions and incarcerations throughout the state of Ohio. As necessary, staff will access other state websites and resources for legal history.

B. At Assessment

- It is GCB practice that staff will not enter the home of a newly referred client if there is documented evidence of violence. Based on information gathered at intake, staff may choose not to complete an assessment in the client's home and may elect to assess the client at a secure and public facility.
- If the client is known at GCB, the staff member may use other assessment means. For example, two GCB staff members may go to the home with discretion and approval of a team supervisor, or staff may arrange with another provider (e.g., parole or probation officer, transitional case manager from MHAP) or other collateral contact.
- It is GCB practice to continually assess client's dynamic and static risk factors. The staff member will confirm with the client the information in the DAF. In addition, staff will use client self-reported information to document past and current risk factors (see Assessment Policy). Refer to the Critical Clinical Indicator Guidelines to determine whether to implement and use a Safety Alert.

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C. At Treatment

- Staff will make every effort to identify ISP goals and interventions that will manage any identified risk. When necessary, staff will develop a Risk Management Safety Plan with the client. When dealing with a high-risk client, staff may need to review the ISP more frequently than once a year, as directed by the clinical supervisor. Staff will document the clinical review with the client on the ISP and progress note. The supervisor will assess the risk management goal and interventions for clinical appropriateness as they review the ISP before signing.
- Clinical risk review and management continues throughout the client's enrollment at GCB as a function of continuous review and assessment of the clinical risk factors, interventions, and client responses to those interventions. At any point in a client's treatment at GCB, staff may identify and assess client clinical risk to self and/or to others. Staff will then identify the necessary interventions and document them in the ISP and progress notes.
- When staff recognizes that they cannot safely serve a client in a particular setting or in certain situations, they will complete a Safety Alert and work with their supervisor to arrange for appropriate service delivery and treatment.
- This protocol is monitored through the chart review process. Cases are chosen randomly to ensure that risk issues are identified and documented, and that the interventions are appropriate and medically necessary. The agency's High-Risk Meeting and the team supervisors, directors, and doctor will regularly monitor Safety Alerts.

III. NONVIOLENT CRISIS INTERVENTION

All new GCB employees or those designated by their supervisors will attend the Behavioral Risk Management, GCB Safety, and Community Safety Trainings within three months of employment. This training focuses on crisis prevention, assessment, non-physical crisis intervention, and personal safety while providing services in the community or agency offices. GCB provides each employee with a copy of the Behavior Risk Management Policy. Staff should familiarize themselves with the policy and have it readily available during working hours. Code Yellow procedures are part of employee orientation.

GREATER CINCINNATI BEHAVIORAL HEALTH SERVICES

A. Essential Elements of Safety Training for New Employees

- **Prevention** By knowing our clients and their behaviors, staff can avoid most situations of aggressive or violent behavior. Staff should pay extra attention to clients who may present as anxious, agitated, or upset, and respond in a supportive and empathetic manner. All staff is responsible for close observation and early action.
- **Assessment** In situations of potential or actual violence or aggressive behavior, staff must make a rapid and accurate risk assessment of the situation. The GCB safety trainings teach how to identify potentially violent behavior.

B. Along with general training for all staff, GCB has a specially trained Crisis Intervention Team certified in Nonviolent Crisis Intervention. This team meets every two to four weeks for ongoing training and to review Code Yellow incidents. This team responds to all Code Yellow calls.

C. General Principles of Nonviolent Crisis Intervention:

- Preventive Techniques
- Nonviolent Crisis Intervention and Team Intervention
- Postvention

D. **Physical Intervention** GCB does not engage in physical intervention techniques

IV. SECLUSION & RESTRAINT

GCB works to promote a physically and psychologically safe environment, with calm surroundings and a focus on developing positive, trusting relationships. GCB promotes early identification of aggressive behavior and using de-escalation techniques to calm an agitated person. GCB will not use *seclusion* (placement in a segregated room with restricted freedom to leave) or *restraint* (physical intervention).

A. Emergency Intervention Procedures

- Contact law enforcement whenever physical aggression appears imminent. Clear others from the area.
- GCB does not use seclusion or restraint nor does the agency use emergency intervention procedures in response to assault or aggression. GCB trains staff in de-escalation techniques and to contact emergency personnel in response to threatening or violent behavior.
- GCB personnel must not use the following techniques and practices under any circumstances:

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- Face down restraint with back pressure
 - Aversive behavioral intervention
 - Techniques that obstructs the airways or impairs breathing
 - Aversive behavior management plans
 - Techniques that obstructs vision
 - Techniques that restrict the recipient's ability to communicate
 - Any form of mechanical restraint
 - Use of any object or weapon
 - Handcuffs or electronic devices such as stun guns
 - A drug or medication that is used as a restraint to control behavior or restrain the individual's freedom of movement that is not standard treatment for the individual's medical or psychiatric condition
 - Seclusion
- Individual programs may deny client access to programs or facilities based on their behavior and may refuse to transport clients. GCB may also suspend or terminate services if client behavior is inconsistent with program expectations. GCB may develop voluntary agreements or contracts with clients to address unacceptable behaviors. GCB does not consider these actions special treatments or restrictive procedures.
 - GCB will make every effort to have a debriefing session within 24 hours of any significant crisis. The department director, in consultation with the clinical director and Nonviolent Crisis Intervention Team, will conduct the debriefing. Depending on the situation, GCB may employ an outside consultant for stress debriefing.
 - GCB provides staff with training on its seclusion and restraint policy and in nonviolent crisis intervention, which focuses on de-escalating crises and training staff in personal safety. GCB staff should work to prevent and de-escalate any situation in which staff or other clients will be in danger from physical contact with one another.
 - Complete an incident report after all emergencies, including those during which a physical intervention is used. Incident reports are reviewed as part of GCB's quality assurance program.
 - GCB conducts a special review for any physical intervention, including the justification for the intervention, the length of time of the physical intervention, any injuries, etc.

V. VIOLENCE IN THE WORKPLACE

GCB believes that all employees and clients are entitled to a non-threatening workplace or program setting that promotes the basic safety of each person. Given the nature of our business, GCB is committed to providing as safe a workplace and program setting as possible.

■ This Violence in the Workplace Protocol addresses staff behavior and a safe workplace. Given the nature of our work with challenging clients, GCB has additional Critical Clinical Situation Guidelines and Safety Alerts that further address employee and client safety.

■ Any employee or client who threatens violence or engages in violence, engages in intimidating behavior, or violates regulations regarding dangerous materials at any GCB facility, is in serious violation of our Behavioral Risk Management Policy.

■ **GCB does not tolerate violence**—actual or perceived. This includes, but is not limited to:

- Threatening, hostile, or intimidating behavior
- Verbal abuse
- Physical abuse
- Fighting
- Violation of restraining orders
- Harassment
- Stalking
- Any behavior which is perceived as threatening by the recipient
- Disruptive activity in the workplace and program setting
- Possession of a dangerous weapon
- Being under the influence of alcohol or illicit drugs
- Sabotaging another employee’s work
- Harmful misuse of equipment or other company property

CONCEPT
Universal Precaution for Violence:
Violence should be expected but can be avoided or mitigated through preparation

■ Any employee or client who believes that he or she is or has been subjected to threatening or intimidating behavior by a fellow employee, client, family member, student, volunteer, or other individual should report such conduct as specified in the complaint procedure. Certain situations may require documentation in writing. Staff and clients are directed to use appropriate 911 assistance for situations needing emergency response. GCB will investigate complaints of intimidation or violence promptly and discreetly. Any employee who violates this directive will be subject to serious disciplinary action, up to and including termination of employment. Client behavior will be addressed through their treatment planning process. Depending on the situation,

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the client may be separated temporarily or permanently from the program.

- Former employees shall not have access to any GCB facility. They shall be required to remain at the designated waiting area for the receiving employee. If the former employee has reason to be at the facility, the receiving employee will escort him or her within the facility. If there is any concern, notify the Director of Personnel or Safety Coordinator.
- **Management Responsibility: Managers & Supervisors** Violence, or the threat of violence, whether committed by supervisory or non-supervisory personnel, is against agency policy and may be unlawful as well. It is management's responsibility to show employees and clients that the agency is serious about prohibiting and preventing violence at any GCB facility or program. In addition, management is responsible for taking action against threats or acts of violence by agency personnel or others (clients, outside vendors, family members, students, volunteers, or others), regardless of the manner in which the agency becomes aware of the conduct. If a supervisor becomes aware of any action, behavior, or perceived threat that may violate agency policy, she or he is responsible for immediately contacting a Department Director, Safety Coordinator, or Director of Personnel.
- **Complaint Procedures** Treat and investigate all complaints of violence or intimidating behavior as serious violations of the Violence in the Workplace Protocol. Bring complaints to the attention of the Supervisor, Department Director, Safety Coordinator, or Director of Personnel for investigation.
- **Non-retaliation** This protocol prohibits retaliation against any person who brings complaints of violent or intimidating behavior or who helps in investigating complaints. The person will not be adversely affected in terms and conditions of employment, program participation, nor discriminated against or terminated because of the complaint.
- Following the investigation, a determination will be made regarding the complaint's resolution. If an employee is found to be in violation of this directive, disciplinary action will be taken up to and including termination of employment.
- Clinical staff, under direction of the clinical director, will evaluate any client found to be in violation of this directive for appropriateness of program participation. Some situations may warrant an additional review by a quality improvement team with oversight from the Clinical Director, and documentation and review according to the agency's incident reporting and review policy.

VI. WEAPONS

- A. GCB does not permit weapons of any kind in any GCB facility. The following items are considered potentially dangerous weapons and are not permitted in GCB facilities or in the possession of staff, residents, or visitors
- Guns or other firearms
 - Explosives or items that may be explosive
 - Knives
 - Any other items that may be considered a dangerous weapon at the discretion of staff and based on an individual assessment
- B. **Procedure**
- At intake, every client will receive GCB's Safety and Participation Regulations, which outlines that GCB does not permit weapons of any kind in any GCB facility. Review these regulations with the client at intake, answer any questions, and ask the client to sign a copy acknowledging their understanding of the regulations.
 - If staff becomes aware that weapons have been brought into the facility, and it is safe to confiscate them, they should be given to the highest level supervisor on-site who will work with the Site Director and other internal and external authorities as needed to determine what should be done with the item(s)
 - Review GCB's weapons policy with clients at least annually and/or more often as indicated by a client's clinical state, risk history, and or potential for future risk-taking behaviors
 - If GCB staff knows a client is in the possession of weapons, he or she will not meet with them. Notify the client why you are cancelling the meeting, and that you will reschedule the meeting.
 - If a client lives with someone who has weapons in their possession, GCB staff will only meet with the client at an alternative location
 - GCB staff will inform their supervisor of any situation involving weapons
 - GCB prohibits staff from carrying or possessing weapons on their person, in their vehicles, or onto any GCB property
 - If a GCB staff person becomes aware that another staff person possesses a weapon, report this to his or her direct supervisor, who will notify their Director immediately ■

Community Safety Checklist

- I know the person's history of violence?
- I know their living situation? Who else lives in the home?
- I know their current mental status?
- I know if they are using substances?
- I know if they are experiencing current life stressors (e.g., divorce, fighting with relative)?
- I tell my supervisor or a teammate where I will be?
- I call before I go (whenever possible)?
- I know how to get where I am going?
- I take the safest route to my destination?
- I know about the community I am entering (drug area, high crime area, gang area, recent community violence)?
- I know the objective of my visit?
- I have my cell phone and it is charged and on my person?
- I have my keys ready before I walk to my car?
- I look around, under, and inside my car before getting in?
- I lock my doors when I drive?
- I do not place my purse or wallet on my front seat when I drive?
- I do not leave personal items of value in my car in view of others?
- I dress professionally, yet appropriately for the work I do?
- I wear shoes that I can run in?
- I do not wear showy or expensive jewelry, accessories, or clothes when working?
- I park in well-lit areas?
- I check my surroundings before I get out of my car (appearance of apartment building, people entering and exiting building, people around me, observable drug paraphernalia, security devices on doors, etc.)?
- I park so that I can enter and exit my car easily (not blocked in)?
- I carry only necessary items with me?
- I try to make appointments before dusk whenever possible?
- I look at everyone I pass and make eye contact?
- I use good body language?
- I ask permission before entering someone's home?
- I scan the environment before entering (e.g., potential weapons, drug paraphernalia, other people in the home, animals)?
- I always stay between my client and the door?
- I leave the front door cracked when visiting? I do not allow myself to be locked in? ■

Practice Guidelines for Violent or Aggressive Clients

Greater Cincinnati Behavioral Health Services (GCB) is the largest community-based mental health provider in Hamilton County, Ohio, serving adults who have the most severe forms of schizophrenia, bipolar disorder, and major depression. Through its PATH Program—Projects for Assistance in Transition from Homelessness—GCB is the largest local outreach provider to people who are experiencing homelessness. In 2010, GCB began a collaborative clinic with the Cincinnati Health Network’s Health Care for the Homeless Program. GCB updated and distributed these policies and procedures for behavioral risk management in 2010.

I. DEFINITION

Violence and aggression are acts or threats in which physical force or posturing is exerted to violate, damage, or abuse another person or property. As a population, individuals with mental illness are no more likely to exhibit violent behaviors than the general population. The exception is that individuals who have paranoid delusions, or who meet the criteria for antisocial personality disorder, have a small but significantly higher base rate for violence than the general population. Four categories of ‘at risk’ clients:

- Individuals with a history of violence against people, or property*
- Individuals with a history of threatening or intimidation*
- Individuals who are violent or threatening to a specific (or type of specific) target
- Substance abuse or dependency in combination with decompensated mental status

* *The best predictor of future acts is past behavior*

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II. GENERAL PRINCIPLES

- No one should ever accept or tolerate violence/aggression. Preventive measures are required for the safety of the clinical staff and the client.
- Trust your instinct and/or clinical judgment. If you feel threatened for any reason, leave the situation immediately.
- Take all threats seriously. Inform your supervisor.
- The clinician must continually assess his or her own feelings in the situation. Guard against taking the client's abusive statements personally or becoming defensive.
- Avoid responding in a disrespectful manner, no matter how threatened you might feel
- Pay attention to the client's angry and aggressive behavior. Do not minimize behavior in the hope that it will disappear. Minimization of angry behaviors and ineffective limit setting are the most frequent factors contributing to the escalation of violence.
- Set clear, consistent, and enforceable limits on behavior
- Emphasize to clients that they are responsible for all consequences of their aggressive behaviors, including legal charges
- Severity and effectiveness of past violent acts help determine outcomes of future violent acts
- Prediction of violence is difficult. Prevention is important.
- The level of risk for violence is not a static factor. Violent behavior is a product of the interaction between an individual and their environment.
- While individuals with severe mental disabilities have a small but significantly higher rate of violence than the general population, receiving support services decreases this risk
- The key to determining the focus of treatment is problem identification. Ongoing assessment and collaboration with internal and external providers should be the primary focus of interaction with the client so that providers may deliver treatment effectively and in theoretical contextual safety.
- Set clear limits and expectations of treatment
- Remember that you have a duty to warn potential victims
- Remember that you have a duty to protect identified victims or targets (*see Duty to Protect*)

Most frequent factors contributing to the escalation of violence:
Minimization of angry behavior & ineffective limit setting

III. ASSESSMENT GUIDELINES

A. **Presenting Signs and Symptoms for Assessing Current Potential for Violence** are factors that may indicate that client's behavior is escalating, and that behavior may become violent. The types of signs and symptoms that may increase risk:

- Command hallucinations (voices ordering particular acts, often violent or destructive ones)
- Homicidal ideation
- Paranoid ideation
- Delusional—especially those that precipitate fear of imminent harm
- Impulsivity
- Mania or agitated depression
- Co-occurrence of organicity (i.e., the mental disorder may likely have a known biological cause such as head trauma)
- Lack of empathy
- A pattern of disregard for, and violation of, the rights of others
- Substance abuse or dependency (co-occurring with another risk factor listed here)

While these disorders and symptoms of disorders may increase the risk of violence, be careful not to stigmatize the client based on these factors alone.

B. **Violence is usually (but not always) preceded by:**

- Hyperactivity, the most important predictor of imminent violence (e.g., pacing, restlessness)
- Increasing anxiety and signs of tension: clenched jaw or fist, rigid posture, fixed or tense facial expression, mumbling to self
- Verbal abuse: profanity, argumentative behavior
- Change of pitch of voice; either very loud (screaming) or very soft, forcing others to strain to hear
- Intense eye contact or avoidance of eye contact

C. **Additional signs and symptoms associated with the potential for violence:**

- Recent acts of violence, including property violence
- Stone silence
- Use or abuse of substances

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- Carrying a weapon or object that may be used as a weapon (e.g., fork, knife, rock); the existence and type of weapon also increases the lethality of a violent act
- Noncompliance with medications; unstable clinical symptoms
- History of violence
- Identifies a plan
- A lack of empathy for others, coupled with anger
- Identified violent wish or intention to harm another

D. Assessing client for risk or potential for future violence if past behavior has occurred:

- Obtain reasonably available records of recent treatment and carefully review current records
- Directly question the client and relevant others about violent acts and ideation
- Look for patterns of violence:
 - Violence may occur only when client is decompensated
 - Increased stressors present in the environment
 - Increased use or abuse of substances

E. Risk Factors Generally, the greater the number of risk factors, the greater the potential for violence.

The most significant identifiers are in *italic* and placed at the top of the list:

- *Identified history of violence: Assaultive, threatening, intimidating, menacing, stalking behavior; use of weapon*
- *Identified violent wish or intention to harm another*
- *Having availability or means to carry out plan*
- *Possesses a weapon or threatens to obtain one*
- *Homicidal ideation*
- *Use or abuse of substances*
- *Identifies a plan*
- *A lack of empathy for others coupled with anger*
- *Specific signs and symptoms:*
 - *Command hallucinations*
 - *Homicidal ideation*
 - *Paranoid ideation*
 - *Delusional—especially those that precipitate fear of imminent harm*

While these traits & symptoms may increase the likelihood of violence, be careful not to stigmatize the client based on these factors alone

- Certain demographics (i.e., male, 14 to 24 years old, low socioeconomic status, few support systems)
- Co-occurrence of organicity
- History of arrests
- Impulsivity
- Increased stressors
- Lack of empathy
- Lack of nonviolent problem-solving skills
- Mania or agitated depression
- Victim of sexual abuse
- Victim of physical abuse
- Greater than ten long-term psychiatric hospital admissions
- Past threats verbalized but not committed
- Noncompliance with medications; symptoms unstable
- A pattern of disregard for, and violation of, the rights of others
- Substance abuse or dependency (co-occurring with another risk factor listed here)

F. **Factors which increase likelihood of violence** and may determine specificity of target:

- Fixed delusions (subject of or person who interferes in)
- Persecutory, paranoid, systematized delusions (subject of)
- Past acts or the target's demographic similarities

G. **Understand research context of past violence:**

- *Affective Aggression*—either internally or externally stimulated—is aggression congruent with affect or mood, including insult-evoked violence, aggression secondary to psychosis, and aggression in the context of substance abuse
- *Predatory Aggression*—violence with non-congruent affect—is planned, purposeful, and a means to a perceived primary and secondary gain (i.e., ends)

H. **Classification of risk factors:**

- *Dynamic*—subject to change by intervention, treatment, or control of the situation (e.g., living situation, substance abuse, access to weapons)

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- *Static*—not subject to change by intervention (e.g., demographic information, history of violence, childhood abuse, antisocial traits)
- Use static risk factors to identify potential; use dynamic factors to drive treatment

- I. **Use and trust your feelings** If you feel threatened leave the situation and contact your supervisor
- J. **Assess client for violence towards self** (*see* Suicide Practice Guidelines)

IV. TREATMENT & REHABILITATION GUIDELINES

A. Service Planning

- If client is identified as high risk for violence, document the risk factors clearly in the ICR
- Try to identify what is causing the client to act in a violent manner, and create treatment goals to address these issues
- Document client's violent or aggressive acts and threats
- Clarification of case manager's role (compared to other service providers)
- Offer consistent consequences for acts and behavior related to the identified risk factors. This may help decrease the likelihood of some types of affective aggression.
- Ongoing clinical consultation with your supervisor, team members, psychiatrists, and other providers is essential
- Aim treatment or services at decreasing dynamic risk factors (e.g., substance abuse, environmental contexts, interpersonal deficits, communication skills, psychosis)
- Treatment or services should take into account static risk factors, including past violent acts, history of victimization, number of hospital admissions, specific target history
- Standardized means of tracking and identifying clients with risk factors must be developed and used within team
- Inform client that limits are being set on specific behaviors, not feelings (e.g., *"It is OK to be angry with Bill, but it is not all right to threaten or verbally abuse him."*)
- If a client's behavior is escalating, use a matter of fact, neutral approach. Remain calm and use a moderate, firm voice and calming hand gestures.

B. Safety

- If you have a client with a history of violence who is exhibiting risk factors:
 - Consider not doing home visits alone

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- Consider not driving with the client or have another staff person ride along
- Have a clear path to an exit always
- Be aware of your surroundings always
- Offer alternative means of connection or participation such as phone contact, contact with significant others, supervised setting contexts
- Carry the safety alarm
- Carry the agency cell phone
- Do not turn your back to the client. In the office, arrange furniture so that you have a clear path to the door. Do not situate client in front of door.
- Do not have 'weapons' on your desk, e.g., scissors, letter openers
- Give clients much space, staying at least one arm's length from them
- Set limits at the beginning of the relationship
- If the client starts to become abusive and behavior threatens to escalate, inform the client that you are leaving the situation. Leave for a period to give client a chance to calm down; set a time to re-meet if appropriate.
- Although dual staffing for community contacts is a routine practice, there is no evidence in the literature that suggests this decreases the likelihood of violence. Dual staffing serves the purpose of increasing the opportunity to assess risk factors and offer clarity around treatment planning, intervention strategy, and thinking.
- Dual staff if:
 - Client has recently threatened staff, but has not carried through with threat
 - Has numerous documented violent acts in the past, but none recently
- Meet client in secure public setting (such as probation office) if:
 - Client has repeatedly threatened agency staff. Threats are serious. Assume that they would be carried out if the opportunity is available.
 - Carries a weapon
 - Routinely refuses to accept responsibility for behavior and has one or more risk factors
 - Is actively psychotic with command hallucinations
 - Is exhibiting aggressive or threatening behavior
- See client in office only if:
 - Community setting is isolated
 - Your team considers the community setting dangerous

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C. Intervention

There are different types of violence, each differing in degree of seriousness (i.e., threatening tone, overt aggressive acts, actual verbal threat, assault). Individualize intervention based on the severity of violence. Base treatment on changeable–dynamic–risk factors (e.g., substance abuse or dependence, paranoid ideation).

- If the client’s behavior is escalating and several of the signs or symptoms of potential violence are present, staff and client safety must be immediately addressed

- Client Safety:

- Assess the client for need for hospitalization
- Assess potential for self-harm
- Remove other clients and bystanders from situation

- Clinical Staff Safety:

- Leave the situation immediately. Use a non-threatening excuse to leave the room.
- Inform your immediate supervisor
- Inform police if threats or actual violence occurred
- Document behavior in ICR

- If client threatens others:

- Assess degree of seriousness
- Assess client’s need for hospitalization
- Assess need for medication adjustment.
- Inform supervisor
- Inform client that you must warn other individual of threat
- Document threat in ICR

- If the client commits a violent act:

- Call the police
- Inform supervisor
- Assess physical well being
- Document violent act in ICR

- Goal Development:

- Anger management
 - ☐ Increasing client’s awareness, appreciation, and accountability for acts

Frequent training can reduce the likelihood of being assaulted

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- ❑ Enhancing client's ability to identify and manage the attitudes and emotions that are associated with violent behaviors. What factors provoke the behavior?
- ❑ Develop nonviolent and constructive conflict resolution skills
- Decrease social isolation
- Assertiveness training
- Increase problem-solving skills
- Increase skills for contending with difficulties
- Substance use/abuse/dependency
- Target identified risk factors
- Increase medication compliance
- Decrease threatening behavior

V. EVALUATION

- Decrease dynamic risk factors
- Increase in ability to handle difficult situations
- Decrease in threats or attempts

Victims of workplace violence suffer consequences in addition to their actual physical injuries:

- ▶ Short- & long-term psychological trauma
- ▶ Fear of returning to work
- ▶ Changes in relationships to coworkers & family
- ▶ Feelings of incompetence, guilt, powerlessness
- ▶ Fear of criticism by supervisors or managers

SOURCE: OSHA. (2004). Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers.

Safety Protocol

Colorado-based Clinica Family Health Services developed these safety protocols for its People's Clinic Homeless Health Care Program in Boulder. Published in 2010, they are based on the safety manual and protocol developed by the Wasatch Homeless Health Care Program, which originally appeared in the HCH Clinicians' Network publication [Sample Safety Guidelines in Homeless Health Services Programs](#).

GOALS & PRIORITIES

- To interact with patients in such a manner that prevents the escalation of negative actions and potentially violent situations
- To persuade patients who act out to leave the premises willingly and quietly

Clinica Family Health Services established behavior guidelines to help staff and volunteers identify problem behaviors and deal with them effectively and appropriately before they escalate into a crisis. In order of priority, these personnel are involved with problem clients:

- Front desk personnel and staff who receive patients and make appointments are usually first to come across possible difficulties
- Medical assistants are second in this role
- Medical providers, other staff, and volunteers are usually last in this interaction process

Regardless of your role, you are responsible for your behavior and for protecting coworkers' security while serving patients.

PEOPLE'S CLINIC HOMELESS HEALTH CARE PROGRAM

GUIDELINES FOR INTERACTING WITH PATIENTS

To promote workable relationships, address patients with respect and kindness. Do not react to verbal abuse with anger or disrespect. Instead, remain calm and in control. Occasionally, patients try using aggressive and intimidating tactics to get what they want. Be aware of this type of behavior and respond appropriately:

- Answer patient questions assertively; assure them that they will be seen soon or according to their appointment
- Do not offer lengthy explanations or excuses. Responding in this manner may increase the patient's frustration level.
- Simply state the facts, repeating them if necessary
- When appropriate, refer the patient to other relevant resources

IF PROBLEM BEHAVIOR ESCALATES

- If a patient becomes verbally abusive or physically threatening, alert appropriate staff—the nurse team manager, the operations leader, and/or security—to assist in a supportive capacity. Other staff members should be present on a standby basis and prepared to intervene if needed. For example, if the designated staff person becomes ineffective with the patient, another staff person should take over giving the same message.
- Ask individuals whose behavior escalates beyond spoken communication to leave, informing them that it is not our policy to serve belligerent people. If they can remain calm and discuss the problem, however, we will attempt to serve them and devise a solution. If necessary, the nurse team manager, the operations leader, and/or security will escort them off the premises.
- In extreme situations, the police will be called to intervene and staff will stop further involvement unless it becomes necessary to restrain a patient for his or her own safety or for others' safety. Only designated, trained staff will perform the task of restraint. The intent is to serve patients and prevent escalation of a possible confrontation.
- If there is a traumatic encounter, all involved staff will meet to support each other through a debriefing process. They will document the encounter, file notations in the patient's chart, and make recommendations to the medical director and primary care provider, who will determine if services will be available to the patient in future. ■

Safety Manual

Colorado-based Clinica Family Health Services developed these safety protocols for its People's Clinic Homeless Health Care Program in Boulder. Published in 2010, they are based on the safety manual and protocol developed by the Wasatch Homeless Health Care Program, which originally appeared in the HCH Clinicians' Network publication [Sample Safety Guidelines in Homeless Health Services Programs](#).

PURPOSE

To outline procedures to prevent and handle situations with aggressive patients that have the potential to further escalate into violence. Staff safety is always the top priority. It is important to respond to aggressive or violent situations in a professional and sensitive manner. Individuals who are experiencing homelessness daily deal with grave physical and emotional difficulties, and staff or volunteer interactions should not cause further unnecessary suffering.

PATIENT STRESS & UNIQUE CIRCUMSTANCES OF HOMELESSNESS

- Keep in mind patients' extremely adverse living conditions and backgrounds. Stressful living situations erode morale and common social behaviors such as courtesy and patience. Under these circumstances, it can be challenging for staff to deal with such a person.
- If the patient is involved with drugs or alcohol, suffers from a mental illness, or has an antisocial background such as a history of criminal activity or prison, he or she can be especially difficult.
- Many homeless people interact with a multitude of private and public agencies to meet their basic needs, which can further exacerbate frustration. Consequently, during the process of waiting,

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answering personal questions, and applying for various types of assistance, frustration levels easily become elevated. By the time that they visit our clinic, they may be—understandably—in the mood to react negatively towards our requests or instructions.

- While the negative behavior may appear unwarranted, it may be a survival technique. Through hard living, some patients have learned that no matter how inappropriate, an aggressive, demanding behavior will help get their needs met.
- Some blame the system for everything that has happened to them. These patients may give up easily and leave the clinic in frustration.

GUIDELINES FOR ADDRESSING AGGRESSIVE PATIENTS

- Strategies for dealing with aggressive individuals are best formulated around the principle of least restrictive measure. This means starting with the least invasive tactic and not advancing to the next level of restriction unless necessary.
- Intervention levels:
 - Level 1: Prevention
 - Level 2: De-escalation of tension and action aimed toward safety for all individuals involved
- Preventing violent behavior can be achieved by effectively following four basic steps:
 - Observing
 - Skilled Listening
 - Talking
 - Actions

LEVEL 1: PREVENTION

- Anticipating and preventing are the best methods for managing physically or emotionally assaultive behavior
- Early assessment of the patient is key to managing assaultive behavior. For example, what are his or her needs? Can we satisfy them? If not, what options can we offer the patient, e.g., “*Would you like to speak to a supervisor?*” Consider if another facility can assist the patient; ask, “*Can we make a referral for you?*” or “*Would another time be more appropriate?*”
- Have and use clinic policy and environment to promote safety:
 - Identify an escape route convenient to you and the patient
 - Position yourself closest to the room exit

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- Keep furniture positioned with safety in mind
- Identify code words

Observation Pay attention to warning signals that may hint of escalating tensions:

- Defiant attitude
- Excessive swearing
- Aggressive motions
- Unusual demands
- Increase or decrease in voice volume
- Challenging demeanor
- Tightening of jaws
- Deep sighs
- Fidgety movements
- Rapid pacing
- Clenched fists
- Advance or retreat actions



HELPFUL TIPS

Listen carefully to what the patient is saying. Spending two or three minutes interacting with the patient may prevent an altercation. The more information you have, the better you will be able to develop a solution.

Listening The listening and attending skills of therapeutic communication are effective tools to avert violent behavior.

- Even though you may be having a busy, stressful day, clear your mind and pay attention to what the person is trying to tell you
- Don't rehearse your response; don't verbally defend yourself
- Practice reflective listening, which involves gathering information about what a person is thinking and feeling, and what may be done about a problem
- Don't assume that you know. Ask open-ended questions to elicit more informative responses than a simple yes or no answer.
- Listen carefully to what the patient is saying. Spending two or three minutes interacting may prevent an altercation. The more information you have, the easier it is to develop a solution.

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STEPS FOR EFFECTIVE LISTENING

- Notice your personal anxiety level. Assess your feelings and ask yourself if your feelings are interfering with your communication skills.
- Acknowledge the other person's feelings. Identify the anxiety or anger and acknowledge the potential for violence. You might say, "You seem very upset" or "I'm concerned that you might hurt yourself or others here."
- Try to elicit the real issues and determine what is behind the anger
- Demonstrate appropriate affect; be sincere and assertive
- Convey calmness, control, and a willingness to help

LEVEL 2: DE-ESCALATION OF TENSION & SAFE ACTION

Talking The ability to calm an angry, agitated patient is a valuable skill, and it is a skill dependent upon having and demonstrating a positive regard and respect for others.

- When speaking, be aware of your voice: Its tone has an immediate affect upon the patient. Maintain a calm and soft yet firm voice.
- If you become angry or aggressive, you are losing control of the situation. Simply state the facts and if necessary, repeat them.
- Avoid using your title or authority
- Do not offer lengthy explanations or excuses

THE DON'TS AND DOS OF THERAPEUTIC, EFFECTIVE TALKING

The Don'ts

- Don't threaten the patient or demand obedience
- Don't argue about the facts of the situation; this does not help ease the situation
- Don't tell the patient that she or he has no reason to be angry
- Don't become defensive and insist that you are right
- Don't offer placating responses such as "Everything will be OK" or "You're not the only one."
- Don't make promises that you cannot keep
- Never challenge the patient or call his or her bluff
- Never criticize the patient
- Never laugh at the patient

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The Dos

- Do ask, "What can I do to help?"
- Do use simple, direct statements
- Do ask opinions: "How can we serve you?" or "How would you like to see the situation resolved?"
- Do offer choices and alternatives: "If our services are inappropriate, may we refer you to another facility?" or "May we make another appointment for you at a more convenient time?" Try to provide patient options.
- Do encourage verbalization of anger rather than acting out. Express your limitation with this verbalization, however, such as expressions or language that is offensive and unnecessary.
- Do provide reassurance while setting limits and identifying behavioral expectations in a kind manner
- Do assume that patients have a real concern and that they are understandably upset
- Do recognize and acknowledge patients' right to their feelings.

IF THE SITUATION ESCALATES

Everything that we have learned so far about interacting with difficult patients becomes part of the process and culminates when we take physical action. A key idea in violence prevention is to try to decrease the person's sense of powerlessness or helplessness to minimize the person's frustrations. Communicate orally and behaviorally that the person is responsible for his or her own actions.

THE DON'TS AND DOS OF SUCCESSFUL INTERACTIONS

The Don'ts

- Don't ignore the patient
- Don't come too close to the patient or hover over him or her. Keep a comfortable, nonthreatening distance between you and the patient that still allows you to hear and be heard.
- Don't make threatening physical gestures
- Don't analyze or interpret the patient's motivation
- Don't personalize the patient's anger



HELPFUL TIPS

Do not take negative or aggressive behavior personally. Regardless of patient actions, staff reactions must not escalate negative behaviors. When a patient acts inappropriately, use intervention strategies.

PEOPLE'S CLINIC HOMELESS HEALTH CARE PROGRAM

The Dos

- Follow instincts, intuition, and use common sense
- Detect danger signals
- Keep everyone feeling safe
- Open the door to the room
- Assess the environment for potential weapons
- Identify a code word that will alert the need for help. Staff and volunteers should announce “*Security to the area*” across the intercom and provide their location. At that point, designated staff is to respond.
- Protect others in nearby surroundings
- Ask the patient to sit down
- Establish and maintain eye contact
- Observe social distance; don't touch the patient
- Decrease environmental stimuli by:
 - Minimizing the presence of staff and other patients
 - Turning down any loud music
 - Minimizing distractions
- Promote privacy
- Attempt to meet as many of the patient's reasonable requests or demands as possible
- Follow through with promises; do not make promises that you cannot keep
- Remember who you are and practice professional behavior

SUMMARY

The objectives of these guidelines are to assist in averting abusive and violent behavior while serving patients, and to protect staff and others from threatening and violent behavior. When put into practice, effectively observing, listening, talking, and action can help prevent violent behavior in the clinic. To enhance everyone's experience, staff and volunteers should use common sense and practice courtesy, concern, and compassion. Remember the adverse living conditions experienced by individuals who experience homelessness. Regardless of patient actions, staff reactions must not escalate negative behaviors. Use intervention strategies when a patient acts inappropriately. Be empathetic and treat others as you want to be treated, then we will be providing good health care and perhaps empowering patients to better manage of their lives. ■

Violence Policies & Procedures

These policies and procedures are from a medium-sized mental health agency in a downtown urban area. The agency includes an outpatient clinic and several types of client residences. Developed for clinical and support staff, the guidelines recommend specific responses tailored to the various agency settings. The guidelines are valuable because they clearly state the agency response to escalating and violent incidents. Having clear policies and procedures increases the confidence and security of staff and clients, thereby decreasing the number of potentially dangerous incidents.

I. DEFINITION

Violence is defined as any act or attempted act of physical aggression intended to hurt or harm oneself, another person, or property. Physical aggression includes assaultive physical contact such as slaps, kicks, punches, tripping, pushing, and shoving as well as throwing objects or destroying property. The Mental Health Center does not tolerate violence in agency-operated offices, homes, or apartments.

II. ASSESSMENT

Assessment of violent incidents must include the following considerations:

A. Assessment of the type, intent, and result of an act of violence:

- The *type* of violence includes the actual act or threat
- The *intent* of the violence includes the amount of control the person had over his or her behavior. For example, did drugs or alcohol influence the client? Is the individual psychotic? Was the aggression intentional or premeditated?

- The *results* of the violence include the consequences of the threat or action
- B. **Assessment of the milieu of the act or threat of violence:**
- Assess the involvement of other clients and/or staff. Was there provocation?
 - Assess the perceptions of clients and staff who were present. What did the others see and hear?
- C. **Using information collected during the assessment,** staff uses clinical judgment to address the situation

III. POLICIES FOR FACILITIES & PROGRAMS

Each program responds differently to perceived threats or incidences of violence due to its circumstances and limits.

A. Main offices

A *Crisis Resolution Team* consisting of four clinicians is assigned to each weekday. Each team is responsible for covering client crisis situations at the agency during its assigned day. All members of the Crisis Resolution Team are volunteers so that only staff members who feel that they can handle crises are called upon to do so. Each team member is aware of his or her assignment and who is to be that day's team leader. In the event more than four clinicians are needed to handle a crisis, the team leader may call for more staff support. An act or attempted act of overt physical aggression initiates the following staff response:

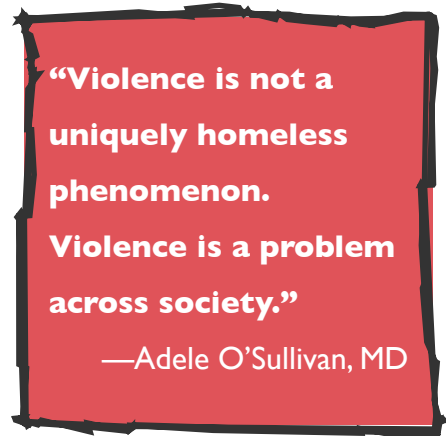
- The identifying staff person calls the Crisis Resolution Team into action by making a system-wide telephone page stating, "*We have a Code Strong,*" and providing the location. The Team Leader directs the intervention. The identifying staff person should not intervene alone.
- The Crisis Resolution Team directs other clients to clear the area. The Team then attempts to contain or remove persons from the room through verbal interventions. Do not attempt physical contact unless it is necessary to protect self, other clients, or the violent client.
- If verbal interventions are ineffective or if a physical intervention is necessary, the team leader will instruct a staff person to call for police assistance by dialing 911; the Leader may ask that a second Code Strong be called to alert general staff for needed assistance
- Staff should always obtain appropriate backup support. It is important to know who is available to help and what the group's limitations are regarding controlling an individual.
- Once the violent client is contained, the Crisis Resolution Team and other staff on the scene

need to process the incident. The client's case manager is informed so that appropriate follow-up interventions may be planned.

- After the violent episode is resolved, the building coverage clinician or the crisis resolution team leader should take charge without the case manager or the case manager's supervisor. The clinician in charge should:
 - Provide follow-up attention to other clients and staff after resolution of the incident
 - Notify absent case managers and supervisors whose clients were affected by the incident
 - Obtain and/or provide supervision and support by appropriate personnel—supervisors, senior staff—or all staff immediately affected
 - If both the clinician and building coverage person are available, they should work together to attend to both the individual and the milieu

B. Supervised Group Homes

A violent act results in an immediate call to the police. House staff should notify the clinical coordinator and the client's case manager or on-call clinician. If before 5:00 PM, the clinical coordinator and case manager will evaluate the threat of violence and determine a course of action.



C. Crisis Residences

The Crisis Team initially screens incoming residents for potentially violent behavior. Any client who acts out violently is removed immediately.

D. Apartment Program

The Apartment Program has a policy of no violence. Each incident is separately evaluated and the clinical case manager in consultation with the residential team determines a plan of action.

E. Case Management

If a person becomes violent or appears to be at risk for violence, the case manager and supervisor develop a plan of action including options such as hospitalization, counseling, time out, or contracts. Communicate this plan clearly to appropriate agency staff. Unless the violent act is imminent, individualized treatment plans prevail. ■

Safety Protocols & Guidelines

These guidelines are from a mental health facility that specializes in providing outreach and housing placements to homeless individuals with psychiatric disabilities. Developed for clinicians, outreach teams, and support staff, the guidelines provide a foundation for understanding possible causes of violent and aggressive behavior, how to predict it, what signals or clues to look for when someone is about to act-out, and possible responses to de-escalate the behavior before clients or staff are injured. These guidelines have been especially useful in a classroom setting that includes participate discussion and role-playing.

I. THE ENVIRONMENT

The environment you create around your client can greatly affect the safety for you, your client, and others in the clinical setting. A client will feel less stressed, less nervous, and less confused in a situation where care and concern are constant and well organized.

II. GUIDELINES FOR PROVIDING A SAFER ENVIRONMENT

- Make change very slowly; prepare clients for any physical, emotional, personnel or geographic change
- Maintain a routine. It is important to create a dependable world and a structured existence and environment for your clients.
- Maintain communication through every channel. Provide social stimulation without overload.

STREET OUTREACH PROJECT

- Avoid sensory overload. Help clients avoid crowds or large spaces without boundaries.
- Keep instructions short and concrete. Clients may not have tolerance for complex activities or conversations.
- Provide positive reinforcement for any worthy act. This helps maintain the client's self-esteem and encourages participation in healthy activities.

III. THE CRISIS CYCLE

- A. **Crisis** A *crisis* is a turning point; it is the decisive or crucial time, stage, or event. It may be the actual event of aggression or assault. It is a situation that:
- Causes a sudden alteration in the individual's expectations of himself or his environment
 - Cannot be handled by the individual's usual patterns of contending with difficulties
 - Is an emergency or an "emerging situation"
- B. **Catastrophic reaction** A *catastrophic reaction* is an over reaction to minor stressors. Catastrophic reactions may occur out of distress when the person feels overwhelmed by high expectations and demands. People with brain impairment often become excessively upset and may experience rapid mood changes. Fear or misinterpretation of a person or a situation precipitates the reaction. The person may weep, blush, or become agitated, angry or stubborn, or may strike out at those trying to help them.
- C. **Trigger** Certain events or emotional stress can trigger crisis reactions. Triggers may be internal or external, and are different for different people.
- D. **Escalation** Once something triggers the crisis cycle, the client begins to escalate. *Escalation* is manifest by increasing levels of agitation or activity. This phase—which is generally longer than the crisis itself—is greatly variable in length, lasting anywhere from minutes to days to years.
- E. **Continued escalation** When escalation continues as evidenced by exaggerated behaviors and louder, more specific verbal threats such as "*I can't take it any more, I'm going to hit someone,*" move to the following interventions:
- Remember that attention is reinforcing. At whatever point you begin to attend to a client, you are giving reinforcement to that behavior.

- Talking does little good at this point. Verbal interaction should be matter-of-fact and directed in short sentences.
- Contract with the person, e.g., I will do something for you and you do something for me, “*I’ll get you some coffee and you come outside and sit down.*”
- Keep the person talking; this will help distract them from assaultive thoughts. Conversation is not usually compatible with assault.
- Set limits.
- Use “Please.” *Please* is a powerful word and gives the person control through providing an option.
- Help the person save face. Make it look more attractive not to assault than to assault.

F. **De-escalation** Decreasing levels of physical activity typically characterize the *de-escalation* stage. Behaviors in this phase can look the same as those presented during escalation. Take care to determine which phase it is.

IV. MANAGING THE DIFFICULT TO MANAGE CLIENT

Be aware of the Karpman Drama Triangle and counter transference, which can be dysfunctional. Tips for recognizing and avoiding triangulation:

- Triangulation typically involves parties assuming the classical roles of victim, rescuer, and persecutor
- When caught in triangulation, interactions tend to go round and round with no resolution and may lead to a power struggle
- Triangulation can also happen with only two parties
 - Keep interactions simple and visual
- Be aware of staff being manipulated by the client To avoid triangulation, provide much structure to maintain focus. *Contracting* is one way to structure interactions with clients:
 - The treatment plan, which is a type of contract, provides structure and focus
 - Contract for this session or meeting
 - Make the contract clear and concrete, including time, goals, and session content

STREET OUTREACH PROJECT

- Anti-harm contract
- It is important to engage difficult clients in treatment, especially clients who are mandated and non-voluntary. Getting agreement, contracting in small increments, and reducing goals and expectations to the smallest, acceptable steps are actions that can foster engagement.
- Make use of very specific steps, especially when the task is difficult for the client
- Do not accept passive agreements
- Clearly state the desired outcome when negotiating agreements. Be candid and clear about what is nonnegotiable.

NO-HARM CONTRACT

- ▶ Most clients view the contract as positive, thinking it communicates a sense of caring and helps build a strong therapeutic relationship
- ▶ While the contract has no legal bearing and cannot guarantee the client or anyone else's safety, practitioners find that clients rarely go back on their word when asked to commit to such a contract
- ▶ Contract wording is simple and to the point with no vagueness or wiggle room

SOURCE: James, RK. 2008. *Crisis intervention strategies*. © Thomson Learning, Inc.

V. AGITATED & AGGRESSIVE BEHAVIOR

A. Behaviors indicative of potential physical aggression:

- Loud or increased tone of voice: yelling
- Verbal threats
- Frowning
- Trembling
- Psychomotor restlessness (i.e., a feeling of restlessness associated with increased motor activity such as pacing, wringing hands, picking at skin, twisting hair, etc. This may occur as a manifestation of nervous system drug toxicity or other conditions).

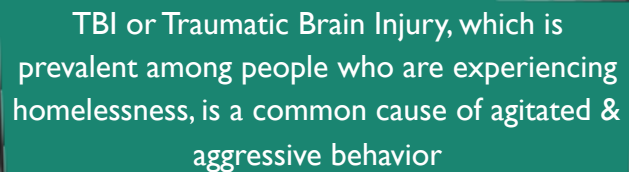
B. Overt physical aggression:

- Hitting
- Kicking
- Biting
- Pushing
- Throwing things
- Pinching
- Head banging
- Scratching

Verbal agitation & aggression can lead to violent & destructive physical behavior. Verbal aggression frequently occurs before or concomitant to physical violence.

C. Potential etiologies of agitated and aggressive behavior:

- Infection and fever
- Polymedicine, drug interaction, drug side effect, drug toxicity, or abrupt drug discontinuance
- Chronic psychosis
- Paranoid psychosis often presents as agitation
- Depression
- Bipolar disorder, manic phase
- Anxiety
- Constant pain
- Acute discomfort or pain related to unmet physical needs
- Lack of sufficient skills to handle life and environmental changes
- Fear of misinterpretation
- Trauma, especially head injury
- Malnutrition
- Anemia
- Dehydration
- Seizures—during or following a seizure
- Tumor—may present as confusion and/or agitation or aggression
- Cerebrovascular disease
- Hypothermia
- Hypothyroidism—known to be associated with psychological changes
- Hyperthyroidism—presenting as apathy, depression or a confused state
- Liver disease or failure
- Decreased cardiac output, secondary to congestive heart failure or pulmonary embolism
- Acute heart attack—may present mainly as confusion
- Respiratory disorders—pneumonia, hypoxia, chronic lung disease with hypoxemia and hypercapnia, pulmonary emboli
- Renal insufficiency (kidney)
- Azotemia—presence of excessive amounts of nitrogenous substances in the blood—secondary to obstructive uropathy or over zealous diuresis
- Hypoglycemia—low blood sugar—associated with hypoglycemic agents or over zealous attempts to control blood sugar with insulin



TBI or Traumatic Brain Injury, which is prevalent among people who are experiencing homelessness, is a common cause of agitated & aggressive behavior

STREET OUTREACH PROJECT

- Hyperglycemia—high blood sugar—associated with ketoacidosis, lactic acidosis or hyperosmolar states
- Electrolyte imbalance
- Substance abuse or withdrawal

D. Behaviors indicating agitation or aggression:

- Tears
- Eyes may widen
- Increased volume to voice
- Rate of speech may quicken
- Increased psychomotor behavior (pacing, grabbing, picking)
- Frowning
- Shaking or trembling
- Catastrophic reaction; over reaction to a minor stress; may exhibit escalating behaviors or lose control explosively

E. Environmental conditions contributing to agitation or aggression:

- Increased noise from the television, radio, or voices
- Crowded room
- Increased lighting
- Increased heat

VI. ASSESSING DISRUPTIVE & AGGRESSIVE PATIENTS

Any behavior that presents a danger to the patient or others or that delays or prevents appropriate care is disruptive and may lead to a crisis.

A. Assessing the situation

If you answer yes to three or more of the questions below, use extreme caution. If possible, try not to control or suppress the patient's behavior. Instead, allow him or her to express these feelings.

The most effective way to deal with a patient who exhibits aggressive or violent behavior is to reduce the crisis and prevent further disruptive behavior. The safest thing to do in these situations may be to call the police.

- Describe the information you have; what happened?

- Assess the environment—emotional, social, and physical; does it seem dangerous?
- Does the patient seem agitated, elated, depressed, or restless?
- Has he or she already demonstrated violent or aggressive behavior?
- Does the patient talk loudly and in a sarcastic way?
- Is he or she easily provoked to anger?
- Does the patient have a limited attention span?
- Does the patient seem to be out of control or disoriented?
- Does he or she seem to be afraid or panicky?
- Does he or she have a weapon?
- Is there evidence of alcohol or drug use?
- Is a domestic disturbance involved?
- Has criminal activity occurred?

B. Clinical assessment of agitation:

- Thorough assessment of behaviors and circumstances is needed before intervention
- Is the onset acute or chronic? Was there a precipitating event?
- Define specific behaviors being assessed
- Describe the physical changes being observed
- Assess environmental or recent life changes
- Complete a physical exam; include a mental stress exam
- Complete lab tests and review results
- Review medication

C. Guidelines for clinicians

- After checking to be sure that the patient is not injured, helping the patient feel safe and secure should be the focus of the intervention, not the agitated behavior itself. You may say, *“This is a safe place. You are safe here. There is no need to act that way here. I won’t let anyone hurt you.”*
- The goal is to help the patient regain control
- The clinician should not show fear or agitation

VII. INTERVENTION STRATEGIES

A. Behavioral strategies to reduce agitation:

- Speak in a soft, quiet voice

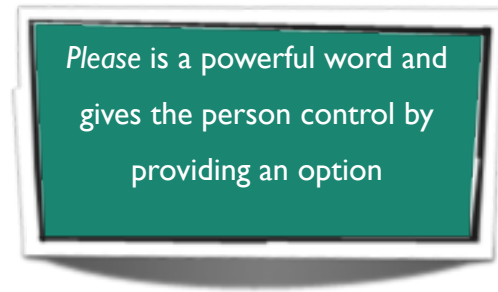
STREET OUTREACH PROJECT

- Use a calm, even tone of voice and calm manner
- Repeatedly call the patient by name
- Maintain appropriate eye contact
- Do not point
- Avoid folding arms or taking a “John Wayne” stance
- Calmly ask manner the patient needs. Allow time and space for a response. The goal is to help the patient regain control of his or her situation.
- Turn down the brightness of the lighting
- Turn down the volume of the television or radio
- Relocate to a less crowded or noisy area
- Try playing soft music
- Encourage the patient to sit down by sitting down yourself

B. Safety strategies with assaultive or potentially assaultive persons:

- Look for a door or an escape route
- Look for other people
- Scan the room for potential weapons
- Scan the area for obstacles
- Stand sideways
- Maintain appropriate eye contact; call the person by name
- Consider territory
- Change place, position
- Keep the person talking
- Help the person save face. Make it look more attractive to not be assaultive than to assault.
- Do not mistake anger for aggression
- Use “Please”
- Know methods of talking “to and through” the individual to let other staff know your plan
- Be aware of the usual progression of aggression:
 - Stance
 - Looks at you; looks away
 - Hits you

- If the person grabs you:
 - Say, “Please let go”
 - Make a fist; this will facilitate a release
 - Get out of their grip
 - If you cannot get out of the grip, get in
- If the person swings at you:
 - Do not let the blows land
 - Dodge toward the side of the attack and turn your back to person
 - If hit, use the momentum to push yourself off in a different direction



C. Medical management: Start low, go slow

- Try to use only one drug at a time
- Target specific symptoms to treat
- Consider half doses for younger persons
- Use multiple doses instead of one big dose
- Change dose in small increments
- Make changes slowly:
 - Consider drug half-life
 - Wait for a steady state
 - More aggressive dose changes may be indicated for violent or assaultive behavior
- Monitor risk for side effects, toxicities, and interactions
- It is sometimes helpful to increase the dose, and sometimes better to lower it
- Sometimes the best thing to do is to discontinue all medications, i.e., a drug vacation
- Give PRN medications during the escalation phase and before the crisis when behavioral interventions are ineffective to help the person regain control

VIII. DOCUMENTATION

Recording incidents that involve agitation or aggression must be specific and thorough. Essential elements include:

- **Biography:** Briefly describe who the person is and their history with the agency. Add relevant details about why the patient is here today.
- **Behavior (Problem)** State what the patient is doing that is a problem. Be specific with behavior

STREET OUTREACH PROJECT

descriptions. The note should include the first sign or signs of the trigger, escalation, and a systematic progression of events. Descriptive, direct quotations from clients are helpful. Include the specific time the incident began or occurred as well as the incident's location. A description of the environment is also important. Note the problem on the Problem List.

- **Intervention** (Method) Describe what you are doing to solve the problem and why you are doing it. The note should reflect step-by-step interventions in cases where the first intervention or interventions are ineffective. Note these interventions as “methods” on the Treatment Plan.
- **Outcome** (Response) Describe the patient's response to the intervention and what the patient does when you intervene (i.e., is the plan working). The outcome should relate to the goal on the Treatment Plan. Outcome charting involves the patient's immediate response to an intervention as well as a longer-term response (e.g., follow-up notes indicating effectiveness or lack thereof from PRN—as needed—medication, time-out, diversional activity, etc.). In addition, the note should contain recommendations regarding further treatment (i.e., whether current interventions helpful or not or can a new method be added to the treatment plan).

IX. POST-CRISIS DEPRESSION

A. Behaviors

- May be sleepy
- May attempt to harm self
- May refuse to care for self, e.g., eating, grooming

B. Intervention strategies

- Provide support one-to-one. Ask “*Can I do anything to help you feel better?*” or say “*I’ll sit with you.*”
- Watch closely
- Reassuring touch
- Attempt to elicit information regarding the nature of the trigger
- Generally patients have a lowered resistance and are receptive one-to-one
- Allow the person to rest. Failure to allow the body time to rest may serve as another stressor

X. OTHER PROBLEMATIC BEHAVIORS

A. Sundowning or sundown syndrome

Sundowning is increased confusion and/or agitation in the late afternoon, evening, and night, hence

the name. The person may exhibit mood swings, become abnormally demanding, suspicious, upset or disoriented. Interventions include:

- Plan the day so that fewer things are expected in the evening
- Reduce the number of things going on around the person
- Plan a walk or a car ride in the late evening
- See that the person has gone to the bathroom before going to bed
- A night-light may help
- Check room temperature for comfort
- Is the bed comfortable?
- Sit with the person or allow them to sit with you; offer quiet reassurance
- If they get up, allow them to stay up; provide a safe environment and a chair for napping
- Consider medications and be alert to side effects

B. Paranoia

- Do not argue or confront
- Give the person as much control as possible, for example, in decision making
- Provide calm, consistent support



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Safety Guidelines for Outreach

Outreach workers in Skid Row, Los Angeles, developed these guidelines to help staff avoid trouble on the street. The strength of these guidelines is that they address the specific needs of the street outreach worker who has a very different work environment than staff who are agency-based. The guidelines are only one part of the agency's overall safety policies and procedures.

- Your supervisor always needs to know where you will be
- Learn much about the situation before setting out to do outreach
- Do not plan outreach for areas in which you have good reason to believe are inherently dangerous
- Be aware of gang areas and their colors. To be safe, do not wear red, blue, or purple while conducting outreach.
- Always carry business cards and California identification with you
- Inform collaborating agencies of your presence
- Introduce yourself and inform people of what you are doing and why
- Do not stand and argue with someone who does not agree with what you are doing
- Preferably, conduct outreach in two-person teams. No team member shall conduct outreach activities alone unless receiving prior approval from their supervisor.
- Never approach those who are giving “signs” that they do not want to be bothered
- Do not be critical of your partner in public; always present yourselves as a team.
- Wear comfortable clothes and shoes. Do not overdress.

HOMELESS HEALTH CARE LOS ANGELES

- Do not carry valuables or other personal possessions such as jewelry, large amounts of money, radios, etc. If carrying incentives, arrange to hold these in a secure place.
- Do not remain in a spot where you are privy to a drug deal in progress or being set up to “go down.” Leave the area immediately without drawing attention to yourself or others.
- Do not linger with a person who you know is holding illicit drugs
- Do not interrupt the sale of sex or drugs for money. Leave the area immediately without drawing attention to yourself or others.
- Do not counsel or play the role of a social worker on the streets
- Maintain confidentiality of all clients you meet
- Do not accept gifts, food, or buy any merchandise from clients
- Do not give or lend money to clients
- Do not accept or hold any type of controlled substance
- Never enter clients’ cars, homes, or any enclosed area
- Tell clients approximately when you will be back and where you can be reached. Give clients your business card.
- Develop a contingency plan for worst-case scenarios or dangerous situations with your partner and supervisor
- Keep your supervisor informed of any unusual developments
- In an emergency, call—or have another person call—911. Do not separate from your partner unless you feel that staying would increase your danger.

EMPLOYEE STATEMENT

I acknowledge that I have received a copy of the safety guidelines for performing outreach. I certify that I have read and understand these guidelines, and I agree to comply with agency guidelines related to this issue to the best of my ability.

Print Name

Signature

Date

Supervisor Signature

Date

Policy & Procedure: Management of Violent or Disruptive Behavior

The San Francisco Department of Public Health administers a number of special projects and contracts with community-based organizations to deliver a variety of services to homeless persons, including the Tom Waddell Health Center. These policies and procedures, which were reviewed and revised in 2008, are adapted from the document, Management of Violence in the Emergency Department, produced by the San Francisco Community Health Network.

I. PURPOSE

To provide health center staff with a standardized approach when confronted with disruptive and/or violent behavior

II. PRINCIPLES

- A. The Tom Waddell Health Center Safety Committee is committed to providing leadership and direction in the promotion of the safety and security of all staff, clients, and visitors of the clinic. The procedures in this document are designed to provide a standardized approach for staff to follow when faced with verbal abuse, disruptive behavior, threat to cause bodily harm, and physical assault. The premise of these procedures is that violence is not tolerated at TWHC and while not all incidents of violence are preventable, impending violence can be predicted and thus de-escalation and evasive maneuvers are effective tools to be used to protect staff and clients from harm.

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- B. It is the responsibility of all staff to be familiar with and follow DPH/TWHC policies and procedures. An essential component of our safety practice is to easily identify DPH and TWHC staff. You are required to always wear your identification badge when at work.

III. DEFINITIONS

- **Assault:** An unlawful threat, coupled with the ability to inflict an injury on another person
- **Battery:** Any willful or unlawful use of force or violence upon another person
- **Disruptive behavior:** Any behavior that interrupts the ability of health care providers to provide care to patients at TWHC. This can involve—but is not limited to—verbal abuse, provocative statements made to staff or other clients, excessively loud tone of voice, obtrusive presence in unauthorized areas, and loitering.
- **Service animal:** Any animal individually trained to do work or perform tasks for the benefit of a person with a disability
- **Support or companion animal:** An animal that primarily provides assistance for people with psychiatric disabilities. Service and support animals are not pets. The service and support animal should not be disruptive, must be under the owner’s control, and cannot present a danger to others through aggressive behavior. There is no legal requirement for service and support animals to be visibly identifiable or documented. Any animal in Tom Waddell Health Center must be leashed, licensed (with visible license on the collar), and always under the owner’s control.

IV. MANAGEMENT OF DISRUPTIVE BEHAVIOR

A. Defining Characteristics

- Excessively loud tone of voice
- Unauthorized presence in clinical areas
- Wandering corridors
- Interrupting clinical providers involved in patient care or related activities
- Harassing other clients
- Any animal which is blocking aisles or hallways, interrupting the normal flow of patient care, or does not obey its owner’s commands

GOAL

Patients, staff & visitors will be safe & undisturbed while in the clinic

B. Goals

- The disruptive person or animal owner will stop the disruptive behavior
- Patients, staff, and visitors will be safe and undisturbed while in the clinic

C. Immediate Actions

- Staff Member
 - Recognize that the behavior is interfering with patient care
 - Maintain calm demeanor
 - Ask the person if you can help them, i.e., “*What do you need?*”
 - Deal with their needs, if possible
 - Be simple and direct with words
 - Set clear limits on behavior
 - If an animal’s behavior is disruptive, determine who is the owner; ask the owner to get the animal under control
- If behavior continues:
 - Elicit assistance from client’s medical provider as needed
 - Make it clear to client that if the animal’s behavior continues to be out of the owner’s control, the owner will need to take the animal outside. The patient is responsible for ensuring that the animal is attended and under another person’s control.
 - If the owner refuses to cooperate or is unable to control the animal’s behavior, they will have to leave the premises with the animal
 - Elicit assistance from SFSD Deputy as needed
 - Clinicians will communicate with the Deputy about the desired response, which can include:
 - Standing-by (in case of potential departure or escalation)
 - Clearing the area (to ensure safety and ease of transport)
 - Facilitating the detention (preventing departure or intervening with patient unable to de-escalate)
 - Arranging transportation (coordinating transfer, waiting until patient leaves the clinic)
 - Patient behavior can change rapidly, so it is imperative the Deputy and clinical staff communicate directly regarding the desired response
 - Summarize the incident to the SFSD Deputy upon arrival, privately, if possible
- In the case of repetitive disruptive behaviors, i.e., the client or client’s animal causes more than two disturbances in a month:
 - A referral will be made to the Chair of the Safety Committee who will facilitate a meeting of the client’s primary provider or a pertinent urgent care provider and other health care

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providers involved in the client's care. This group could include RN, NP, MSW, HW, or MEA. The group will write a behavioral agreement outlining behavioral limitations for the client and clearly state what the clinic can and cannot do for the client. A copy of this behavioral agreement will be given to the Nurse Manager/Safety Committee Chair. A meeting will be held with the client to elicit cooperation with the agreement as evidenced by his or her signature.

- The Medical Director will review and approve client agreements
- Client agreements will be kept in their medical records and flagged by a notation in the problem list
- The Safety Committee Chair will review agreements every six months
- Clients who refuse agreements will be referred to the Medical Director for disposition
- If SFSD Deputy is needed:
 - Call 560-6666 for assistance and enter the number to reach staff. When the deputy responds, give your name, location, and the nature of the incident. Provide the number of suspects, their description(s), and any other relevant information.
 - Staff should look for the SFSD Deputy and direct him or her to the incident location
 - If unable to use phone for assistance, call out for help in a loud but calm voice. When another staff member hears a call for help, notify the SFSD Deputy immediately.
- SFSD Deputy
 - Maintain eye contact with affected staff person
 - Standby, but within disruptive person's vision
 - Remove bystanders
 - Take over management of incident:
 - If requested by the staff member or
 - If incident is escalating out of control and communicate with staff
 - Separate disruptive person and the staff member
- Other Staff Member, if present
 - Standby, back away, and do not interrupt
 - Never rush the disruptive person
 - Observe the interaction
 - Call for SFSD Deputy if the situation escalates out of control

D. Reporting the Incident, if Needed

- Staff person will file an Unusual Occurrence online and inform his or her supervisor
- Safety Committee Chair or designee will place a clinical alert in the LCR

V. MANAGEMENT OF VERBAL ABUSE

A. Defining Characteristics

- Repeated complaints or demands towards staff
- Hostile, provocative, or vulgar statements
- Loud, sharp, aggressive voice (yelling)
- Increased motor activity (pacing, arms flailing)
- Rapid, irregular breathing
- Muscles tense and active (banging fists on counter, kicking walls, throwing objects)
- Angry facial expression (lips pursed, flared nostrils, frown)

B. Goals

- The abusive person will stop the verbal assault, and not progress to or use threats to cause bodily harm or battery
- Patients, staff, and visitors will be safe in the clinic

C. Immediate Actions

- Staff Member
 - Recognize signs of impending danger
 - Maintain calm demeanor and self-control
 - Appear calm and interested
 - Do not respond or react to abusive language
 - Avoid engaging in verbal altercation with the abusive person
 - Avoid screaming, shouting, or threatening tones; do not sound harsh or sarcastic
 - Follow your instincts
 - Use de-escalation techniques:
 - Be simple, direct, and brief with words
 - Use calm, low voice tones

HELPFUL TIPS

- ▶ Be alert to impending danger
- ▶ Stay calm & maintain self-control
- ▶ Do not respond to abusive language
- ▶ Follow your gut instincts

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- Avoid loaded words like “never”
- Be observational, comment on behavior not motivation
- Listen to what the person is saying
- Do not interrupt
- Deal with the present situation
- Use evasive techniques:
 - Stay out of striking range, about three to four feet away
 - Stand slightly to the side with weight on balls of feet
 - Be ready to move quickly, hands unclenched and at waist level
 - Consider using environmental factors—desk, door—to maintain a physical barrier while trying to get to the closest exit
- Make and maintain eye contact with SFSD Deputy or other staff member if possible
- Clinicians will communicate with the Deputy about the desired response which can include:
 - Standing-by (in case of potential departure or escalation)
 - Clearing the area (to ensure safety and ease of transport)
 - Facilitating the detention (preventing departure or intervening with patient unable to de-escalate), or
 - Arranging transportation (coordinating transfer, waiting until patient leaves the clinic)
- Patient behavior can change rapidly, so it is imperative the Deputy and clinical staff communicate directly regarding the desired response.
- Summarize the incident to the SFSD Deputy upon arrival, privately, if possible
- If SFSD Deputy’s intervention is needed:
 - Call 560-6666 for assistance and enter the number to reach staff. When the deputy responds, give your name, location, and the nature of the incident. Provide the number of suspects, their description(s), and any other relevant information.
 - Staff should look for the SFSD Deputy and direct him or her to the incident location
 - If unable to use phone for assistance, call out for help in a loud but calm voice. When another staff member hears a call for help, notify the SFSD Deputy immediately.
- SFSD Deputy:
 - Maintain eye contact with affected staff person

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- Standby, but within the abusive person's vision
- Remove bystanders
- Take over management of incident:
 - If requested by the staff member or
 - If incident is escalating out of control and communicate with staff
- Separate abusive person and the staff member
- Other Staff Member, if present:
 - Standby, back away, and do not interrupt
 - Never rush the abusive person
 - Observe the interaction
 - Call for SFSD Deputy if situation escalates out of control

D. Further Actions

- If the verbal abuse stops:
 - Determine the cause of the outburst
 - Address the abusive person's request directly
 - State the limits on unacceptable behavior
 - Respond calmly and objectively to the behavior
- If the verbal abuse continues and the person is not a patient:
 - Those involved will make a collaborative decision whether to continue contact with the abusive person or have the individual removed from the clinic
- If the verbal abuse continues and the person is a patient:
 - Continue using de-escalation and defusing techniques
 - The patient's physician (i.e., physician on duty in urgent care or the primary care provider if in PC clinic) will be responsible for making the medical decision of continued treatment or discharge from the clinic
 - For patients who repetitively present to the clinic with verbal abuse, follow the procedures for developing a client contract as outlined in the previous section, Management of Disruptive Behavior

E. Post-Incident Management

- Orally assaulted people are vulnerable to additional harmful trauma and the interventions

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delivered during the four hours immediately following a violent incident are the most helpful:

- Reassign the orally assaulted person to a different task for the remainder of the shift
- Allow the assaulted person a break to get away from patients and release tension privately
- Allow verbally assaulted person to ventilate feelings in a private space
- Affirm that their stress reaction is normal

F. Reporting the Incident

- Staff person will file an Unusual Occurrence online and inform his or her supervisor
- Safety Committee Chairperson or designee will place a clinical alert in the LCR

VI. MANAGEMENT OF THREAT TO CAUSE BODILY HARM (ASSAULT)

A. Defining Characteristics

- Verbal threats of violence
- Threatening gestures (raised, clenched fist)
- Intense, direct stare
- History of assaultive behavior in the clinic
- Any animal that stiffens, growls, shows aggression, or lunges at people or other animals

B. Goals

- The assaultive person will stop the threat to cause bodily harm, and not progress to or use physical assault
- The owner of the assaultive animal will stop the animal's threatening behavior and prevent the animal from progressing to physical assault
- The threatened person, patients, visitors, and staff will be safe while in the clinic

C. Immediate Actions

- Staff Member
 - Recognize signs of impending danger
 - Maintain calm demeanor and self-control
 - Firmly but calmly, inform person that dangerous behavior is not acceptable
 - If an animal's behavior is out of control, determine who the owner is and:

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- Make it clear to client that if the animal's behavior continues to be out of the owner's control, the owner will need to take the animal outside. The patient is responsible for ensuring that the animal is attended and under another person's control.
- If the owner refuses to cooperate or is unable to control the animal's behavior, he or she will have to leave the premises with the animal
- Do not respond or react to abusive language
- Avoid engaging in verbal altercation with the assaultive person
- Avoid screaming, shouting, or threatening tones; do not sound harsh or sarcastic
- Follow your instincts
- Use de-escalation techniques:
 - Be simple, direct, and brief with words
 - Use calm, low voice tones
 - Avoid loaded words like "never"
 - Be observational, comment on behavior not motivation; set limits on violent actions
 - Do not cajole, threaten, challenge, or touch the person
 - Talk quietly, yet firmly when person is loud and belligerent
- Use evasive techniques:
 - Never turn your back to assaultive person or animal
 - Do not block assaultive person's or animal's exit, unless to protect yourself
 - Stay out of striking range, about three to four feet away
 - Stand slightly to the side with weight on balls of feet
 - Be ready to move quickly, hands unclenched and at waist level
 - Consider using environmental factors—desk, door—to maintain a physical barrier while trying to get to the closest exit
- Make and maintain eye contact with SFSD Deputy or other staff member, if possible
- Clinicians will communicate with the Deputy about the desired response, which can include:
 - Standing-by (in case of potential departure or escalation)
 - Clearing the area (to ensure safety and ease of transport)

DE-ESCALATION TECHNIQUES

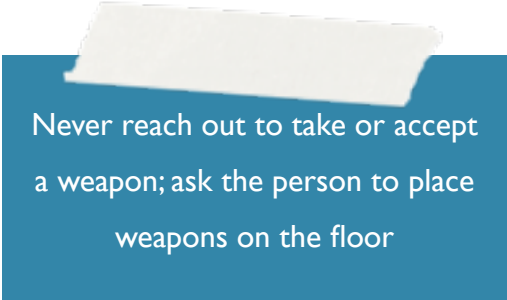
- ▶ Speak in calm, low voice
- ▶ Be simple, direct & brief
- ▶ Comment on behavior not motivation
- ▶ Set limits on violent actions
- ▶ Do not threaten, challenge or cajole

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- ❑ Facilitating the detention (preventing departure or intervening with patient unable to de-escalate)
- ❑ Arranging transportation (coordinating transfer, waiting until patient leaves the clinic)
- Patient behavior can change rapidly, so it is imperative that the Deputy and clinical staff communicate directly regarding the desired response
- Summarize the incident to the SFSD Deputy upon arrival, privately, if possible
- If SFSD Deputy is not immediately present:
 - Call 560-6666 for assistance and enter the number to reach staff. When the deputy responds, give your name, location, and the nature of the incident. Provide the number of suspects, their description(s), and any other relevant information.
 - Staff should look for the SFSD Deputy and direct him or her to the incident location
 - If unable to phone for assistance, call out for help in a loud but calm voice. When another staff member hears a call for help, notify the SFSD Deputy immediately.
- SFSD Deputy:
 - Maintain eye contact with the threatened person
 - Remove bystanders
 - Take over management of incident and communicate with staff
 - Separate threatening person or animal and threatened person or animal
- Other Staff Member, if present:
 - Standby, back away, and do not interrupt
 - Maintain eye contact with staff member if possible
 - Assist in clearing the immediate area
 - Never rush the threatening person or animal
 - Call for SFSD Deputy if situation escalates out of control
 - Assist SFSD Deputy as instructed

D. Additional Actions When a Weapon is Present

- Assume a defensive posture, keeping clear of the assaultive person
- Never reach out to take or accept the weapon from the assaultive person; ask the person to place weapons on the floor



Never reach out to take or accept a weapon; ask the person to place weapons on the floor

E. Further Actions

- If the assault stops:
 - Determine the cause of the threat
 - Address the threatening person's or assaultive animal owner's request directly
 - State the unacceptability of dangerous behavior
 - Respond calmly and objectively to the behavior
 - Consider pressing charges; *see* Pressing Charges, below
- If the threat continues and the assaultive person or the assaultive animal's owner is not a patient:
 - The SFSD Deputy will instruct the threatening person to leave the clinic, unless charges are being pressed. In the case of a threatening animal, the owner must leave the animal outside. The patient is responsible for ensuring that the animal is attended and under another person's control.
- If the threat continues, and the threatening person or the threatening animal's owner is a patient:
 - The primary provider responsible for the threatening patient or owner of threatening animal will be responsible for making the medical decision of continued treatment or discharge from the clinic. If the patient's treatment is to continue, he or she will need to leave the animal outside. The patient is responsible for ensuring that the animal is attended and under another person's control.
 - The Medical Director will review the case to determine whether to write a Denial of Services letter to the client
 - For patients who repetitively present to the clinic with threatening behavior or owners of assaultive animals that repetitively display threatening behavior in the clinic, if the decision is made to continue services to the client, follow the procedure for developing a client agreement as outlined in the Management of Disruptive Behavior section.

F. Pressing Charges

- The SFSD Deputy will advise the assaulted person of their legal rights
- The staff member has the right to press charges, taking into account the clinical and legal ramifications of such action
- The SFSD Deputy's advisement is intended to assist in the procedure and not interfere with the staff member's right to press charges

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G. Post-Assault Management

- Speed is of the essence. Assaulted people are vulnerable to additional harmful trauma and the interventions delivered during the four hours immediately following a violent incident are the most helpful.
- The immediate supervisor or designee will:
 - Remove the assaulted person from duty; take them to a private, comfortable location
 - Allow assaulted person to ventilate feelings in a private space
 - Do not analyze their role or behavior at this time
 - Affirm that their stress reaction is normal
 - Assess their level of stress related symptoms. Determine if they would like to, or if they should or should not remain at work. If the staff member remains at work, consider reassigning him or her to a different task for the remainder of the shift.
 - Ask them what would help right now
 - Offer them some time alone to regain their composure

H. Reporting the Incident

- The SFSD Deputy will complete a report of the incident per procedure
- The immediate supervisor will ensure that the orally assaulted staff or witness files an Unusual Occurrence report
- Safety Committee Chairperson or designee will place a clinical alert in the LCR

VII. MANAGEMENT OF PHYSICAL ASSAULT

A. Defining Characteristics

- Physical contact such as biting, hair pulling, punching, scratching, slapping, fondling, and/or spitting
- Use of a weapon resulting in physical contact
- Any animal which bites and/or scratches patients, visitors, staff, or other animals

B. Goals

- The assaultive person will stop the use of physical assault and not physically assault another person

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- The owner of the assaultive animal will stop the assault and prevent the animal from physically assaulting any person or another animal
- Patients, visitors, and staff will be safe while in the clinic

C. Immediate Actions

- Staff Member
 - Maintain calm demeanor and self-control
 - Firmly shout “No” or “Stop”
 - If an animal’s behavior is out of control, determine who the owner is
 - The owner will need to follow the Deputy Sheriff’s orders regarding containment of the animal. The deputy may order the owner to take the animal outside or have other commands for the owner. The patient is responsible for ensuring that the animal is attended and under another person’s control.
 - If the owner refuses to cooperate, he or she will be subject to an intervention by the Deputy Sheriff
 - Do not cajole, threaten, challenge, or touch the person
 - Follow your instincts
 - Use evasive techniques:
 - Assume a defensive posture
 - Move away quickly, if possible
 - Do not block assaultive person’s or animal’s exit, unless to protect self
 - Consider using environmental factors (desk or door) to maintain a physical barrier while trying to get to the closest exit
 - Call out for help, if safe to do so
 - Make and maintain eye contact with SFSD Deputy and/or staff member
 - Clinicians will communicate with the Deputy about the desired response, which can include:
 - Standing-by (in case of potential departure or escalation)
 - Clearing the area (to ensure safety and ease of transport)

EVASIVE TECHNIQUES

- ▶ Assume defensive posture
- ▶ Move away quickly, if possible
- ▶ Do not block assaultive person’s or animal’s exit, unless to protect self
- ▶ Use environmental factors to maintain a physical barrier while trying to get to the closest exit

TOM WADDELL HEALTH CENTER/HOMELESS PROGRAMS

- ❑ Facilitating the detention (preventing departure or intervening with patient unable to de-escalate) or
- ❑ Arranging transportation (coordinating transfer, waiting until patient leaves the clinic)
- Patient behavior can change rapidly, so it is imperative the Deputy and clinical staff communicate directly regarding the desired response
- Summarize the incident to the SFSD Deputy upon arrival, privately, if possible
- SFSD Deputy
 - Maintain eye contact with assaulted person
 - Remove bystanders
 - Take over management of incident and communicate with staff
 - Separate assaultive person or animal and assaulted person
 - Physically restrain assaultive person, according to departmental policy
- If SFSD Deputy is not immediately present:
 - Call 560-6666 for assistance and enter the number to reach staff. When the deputy responds, give your name, location, and the nature of the incident. Provide the number of suspects, their description(s), and any other relevant information.
 - Staff should look for the SFSD Deputy and direct him or her to the incident location
 - If unable to phone for assistance, call out for help in a loud but calm voice. When another staff member hears a call for help, notify the SFSD Deputy immediately.
 - If assaultive person is armed, call 911
- Other Staff Member
 - Call for help if SFSD Deputy not present
 - Request staff calls SFSD Deputy
 - Assist SFSD Deputy as instructed
 - Assist in clearing immediate area
 - Do not rush the assaultive person or animal
 - Provide witness statement to SFSD Deputy after the incident is over

D. Additional Actions When a Weapon is Present

- Assume a defensive posture, keeping clear of the assaultive person or animal
- Never reach out to take or accept the weapon from the assaultive person; ask the person to place weapons on the floor

E. Further Actions

- If the assault stops:
 - Determine the cause of the assault
 - Address the assaultive person's or assaultive animal owner's request directly
 - State the unacceptability of dangerous behavior
 - Respond calmly and objectively to the behavior
 - Press charges, if the assaulted person requests
- If the assault continues and the assaultive person or owner of assaultive animal is not a patient:
 - If the assaultive person or owner of assaultive animal is injured, medical care will be provided. The SFSD Deputy will escort the assaultive person or owner of assaultive animal out of the clinic, unless charges are being pressed.
 - If a person is bitten, the SFSD Deputy will report the incident to Animal Care and Control and isolate the animal. He/she will write the report and fax it to ACC, which will verify the owner's home and quarantine the animal. ACC Staff determines quarantine location.
 - The person who has been bitten will complete the Complaint of Vicious and Dangerous Dog form. If he or she refuses to do so, the Safety Committee Chairperson or his or her designee will do so. Staff will give the bitten person the Vicious and Dangerous Dog Hearing Information Sheet (located in UC Nurse's Station).
- If the assault continues and assaultive person or owner of assaultive animal is a patient:
 - The primary provider or provider caring for the patient or owner of assaultive animal will determine if there is a life-threatening emergency present. If not, the patient or owner of assaultive animal will be released to the SFSD Deputy and escorted from the clinic, unless charges are being pressed.
 - If a person is bitten, the SFSD Deputy will report the incident to Animal Care and Control and isolate the animal. He/she will write the report and fax it to ACC, which will verify the owner's residence and quarantine the animal. ACC Staff determines quarantine location.
 - The person who has been bitten will complete the Complaint of Vicious and Dangerous Dog form. If the person refuses to do so, the Safety Committee Chairperson or his or her designee will do so. Staff will give the bitten person the Vicious and Dangerous Dog Hearing Information Sheet (located in Nurse's Station).

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- The Medical Director and discipline supervisor will review the case to determine whether to terminate clinic services for the assailant or owner of assaultive animal.
- If the decision is made to serve the client who repetitively presents to the clinic with assaultive behavior or owners of assaultive animals that repetitively display assaultive behavior in the clinic, follow the procedure for developing a client agreement as outlined in the Management of Disruptive Behavior section.

F. Pressing Charges

- The SFSD Deputy will advise the assaulted person of their legal rights
- The staff member has the right to press charges, taking into account the clinical and legal ramifications of such action
- The SFSD Deputy's advisement is intended to assist in the procedure and not interfere with the staff member's right to press charges

G. Post-Assault Management

- Medical Care
 - For life-threatening injuries:
 - Anyone sustaining life- or limb-threatening injuries will be taken to SFGH Emergency Department for immediate treatment
 - For non-life-threatening injuries:
 - UCSF employees and students will follow UCSF procedures for injuries related to work

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FOR INJURIES OCCURRING DURING NORMAL BUSINESS HOURS:

Kaiser Occupational Health Clinic

601 Van Ness Avenue, Suite 2008

Hours: 8:30 AM - 5 PM, Monday - Friday

Telephone: (415) 674-7000

Saint Francis Treatment Room

1199 Bush Street, Suite 160

Hours: 7:30 AM - 5:30 PM, Monday - Friday

Telephone: (415) 353-6305

AT&T Clinic | Saint Francis Health Center

24 Willie Mays Plaza

Hours: 8:30 AM - 3:30 PM, Monday - Friday

Telephone: (415) 972-2249

California Pacific Medical Center, Davies

Campus, Occupational Health Services

Castro & Duboce Streets

Hours: 8 AM - 5 PM, Monday - Friday

Telephone: (415) 600-6600

San Francisco Airport Medical Clinic

Terminal 2, Boarding Area D, Ground Floor

Hours: 8:30 AM - 7 PM, Monday - Friday

Telephone: (650) 821-5600

US Healthworks

1893 Monterey Road, Suite 200, San Jose, CA

Hours: 7 AM - 7 PM, Monday - Friday

Telephone: (408) 288-3800

Valley Care Occupational Health Clinic

5565 West Los Positas Blvd., Suite 150

Pleasanton, CA

Hours: 8 AM - 5 PM, Monday - Friday

Telephone: (925) 416-3562

FOR INJURIES OCCURRING AFTER NORMAL BUSINESS HOURS:

San Francisco General Hospital Emergency

Department

1001 Potrero

Telephone: (415) 206-8111

California Pacific Medical Center Davies

Campus | Emergency Department

Castro & Duboce Streets

Telephone: (415) 600-0600

Kaiser Permanente Medical Center

Urgent Care Clinic

2238 Geary Blvd., Eighth Floor, SE

Hours: 5 PM - 9 PM

Telephone: (415) 833-2000

Kaiser Permanente Emergency Department

2200 O'Farrell Street at Baker

Hours: 9 PM - 8 AM

Telephone: (415) 202-2000

Saint Francis Memorial Hospital Emergency

Department

1150 Bush Street, between Hyde and

Leavenworth Streets

Telephone: (415) 353-6300

TOM WADDELL HEALTH CENTER/HOMELESS PROGRAMS

- Defusing and staff support
 - *Speed is of the essence.* Assaulted people are vulnerable to additional harmful trauma, and interventions delivered during the four hours immediately following a violent incident are the most helpful.
 - Immediate supervisor or designee:
 - Take the staff member away from the incident location to reduce the sights associated with the assault. If possible, move to a private, comfortable location.

Interventions delivered during the four hours immediately following a violent incident are the most helpful

H. Explore the incident

- Allow assaulted person to ventilate feelings privately
- Do not evaluate their role or behavior at this time
- Ask, “What was the worst part?”
- Affirm that their stress reaction is normal
- Assess their level of stress related symptoms. Determine if they would like to, or if they should or should not remain at work. If the staff member remains at work, consider reassigning him or her to a different task for the remainder of the shift.
- Ask them what would help right now
- Offer them some time alone to regain their composure

I. Reporting the Incident

- The SFSD Deputy will report the incident to the SFPD per procedure
- Quickly notify the following people using the appropriate forms:
 - SFSD Deputy
 - SFPD Incident Report Form
 - SFPD Witness Statement Form
 - Citizen’s Arrest Form
 - Immediate Supervisor
 - Ensures that assaulted staff or witness files Unusual Occurrence
 - Employee’s Claim for Workers’ Compensation Benefits
 - Employer’s Report of Occupational Injury or Illness

TOM WADDELL HEALTH CENTER/HOMELESS PROGRAMS

- Supervisor's Incident Investigation Report
- Assault Pay Request, if applicable; *see below*
- Chair of the Safety Committee
 - The Chair or designee will place a clinical alert in the LCR

J. Battery Leave with Pay

- Administrative Code Section 16.170 states that CCSF staff shall receive leave with pay for any absences caused by bodily injury or illness arising out of and during employment and resulting from an act of violence
- The immediate supervisor shall send a memo to Personnel requesting assault pay
- The assaulted staff member shall receive sick leave until assault pay is approved and be reimbursed for any other paid leave used in the interim

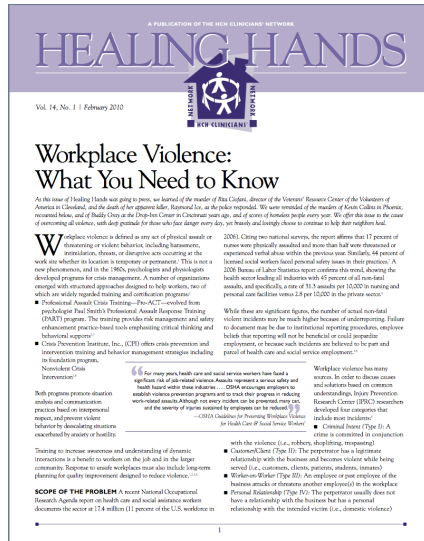
Approved:

Date:

Medical Director, Primary & Urgent Care

Medical Director, Homeless & Community Services





Title: Workplace Violence: What You Need To Know

Author: Health Care for the Homeless Clinicians' Network

Link: www.nhchc.org/Network/HealingHands/2010/

Link: [FebHHandsweb.pdf](http://www.nhchc.org/Network/HealingHands/2010/FebHHandsweb.pdf)

Year published/updated: 2010

Resource type: Newsletter

Teaser: This issue examines workplace violence in the homeless health care setting, covering statistics, training, using contracts with clients & other consumer-centered collaborative approaches. Interviews with clinicians working on the frontline provide valuable insight & strategies ■

Title: Health Care Wide Hazards: Workplace Violence

Author: Occupational Safety & Health Administration

Link: www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/viol.html

Year published/updated: 2008

Resource type: Website

Teaser: This site provides comprehensive resources on health care facility safety. Perhaps most useful is the workplace violence prevention program outline, including samples of a written plan, checklists & forms. Other content addresses staff & management commitment; work-site analysis, hazard prevention & control; training; post-incident response; evaluation & record-keeping ■

Title: Pro-ACT® Professional Assault Crisis Training & Certification

Author: Pro-ACT

Link: <http://parttraining.com>

Year published/updated: 2010

Resource type: Website

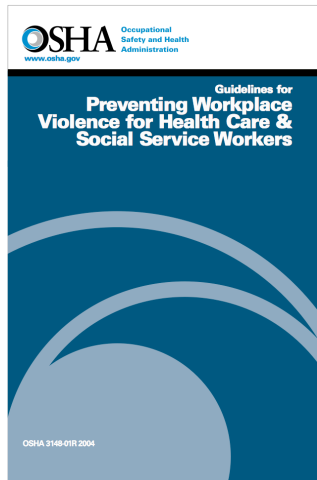
Teaser: Pro-ACT provides training & education for creating safer work environments ■



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Websites accessed August 2011

RESOURCES



Title: Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers

Author: Occupational Safety & Health Administration

Link: www.osha.gov/Publications/osh3148.pdf

Year published/updated: 2004

Resource type: PDF

Teaser: Health care & social service workers face a significant risk of job-related violence, accounting for 48% of nonfatal assaults & violent acts at work. These guidelines specifically address violence inflicted by patients & clients against staff, offering policy recommendations, practical preventive strategies, sample forms & checklists ■

Title: Workplace Violence & Health Centers

Part I: Assessing Security Risks | Part II: Effective Management of Aggression

Author: National Association of Community Health Centers

Links: www.softconference.com/nachc/sessionDetail.asp?SID=258026

www.softconference.com/nachc/sessionDetail.asp?SID=258120

Year published/updated: 2011

Resource type: Webinar

Teaser: This two-part webinar covers best practice techniques to safeguard health centers & engage clinic staff in protection efforts. Part I presents workplace design considerations, an assessment tool to promote safety, plus policies, procedures & practices to reduce risk. Part II discusses escalation stages, the aggression cycle, and managing difficult patients or visitors. Speakers provide communication strategies to recognize, understand & react to aggression ■

Title: Reducing Workplace Violence Through Positive Behavior Supports

Author: The Mandt System®

Link: www.mandtsystem.com

Year published/updated: 2011

Resource type: Website

Teaser: The Mandt System uses a train-the-trainer approach to help organizations reduce & eliminate workplace violence. Reducing workplace violence results in significant savings in workers compensation & other costs. Staff feel safer at work, staff injuries are reduced, staff turnover decreases & consumer satisfaction increases ■

Websites accessed August 2011

Title: Violence: Occupational Hazards in Hospitals**Author:** National Institute for Occupational Safety & Health**Link:** <http://www.cdc.gov/niosh/docs/2002-101/pdfs/2002-101.pdf>**Year published/updated:** 2002**Resource type:** PDF**Teaser:** This brief publication covers the effects of violence, risk factors for violence, prevention strategies & dealing with the consequences of violence. A one-page list of safety tips & case reports are featured. The information is applicable to other health care settings as well as hospitals ■
.....**Title: Violence on the Job****Author:** National Institute for Occupational Safety & Health**Link:** www.cdc.gov/niosh/docs/video/violence.html**Year published/updated:** 2004**Resource type:** DVD/Video**Teaser:** Based on NIOSH research & supplemented with information from other authoritative sources, this video discusses practical measures for identifying risk factors for violence at work & taking strategic action to keep employees safe. Audience: Human resources, health care & social services managers ■
.....**Title: Workplace Violence: Awareness & Prevention for Employers & Employees****Author:** Washington State Department of Labor & Industries**Link:** www.lni.wa.gov/IPUB/417-140-000.pdf**Year published/updated:** 2000**Resource type:** PDF**Teaser:** This brief guide contains samples of policies, forms, checklists & more to help agencies develop an effective violence prevention program ■
.....**Title: Preventing Violence & Reducing Injury****Author:** Prevention Institute**Link:** www.preventioninstitute.org**Year published/updated:** 2011**Resource type:** Website**Teaser:** PI offers training, presentations, TA & strategy development, policy research & analysis. This site provides many tools & publications; look into Prevention is Primary: Strategies for Community Wellbeing ■

Websites accessed August 2011

Listen & Communicate to Help Stop a Crisis

De-escalation techniques are a method of preventing violence. An essential factor in de-escalating any crisis is communication. Listening with empathy—trying to understand where the person is coming from—is an important skill that can be learned. The five principles of empathic listening are

- Give the person undivided attention
- Be nonjudgmental
- Focus on the person’s feelings, not just the facts
- Allow silence
- Use restatement to clarify

One of the most important actions that you can take in any crisis is to remain in control of yourself, a crucial aspect in whether you help de-escalate or escalate the situation. To rationally detach yourself from the situation, verbal de-escalation training programs teach these five ways to remain in control of any situation:

- Develop a plan
- Use a team approach whenever possible
- Use positive self-talk
- Recognize personal limits
- Debrief

SOURCE: Adapted from Dufresne, J. (2003). Verbal de-escalation training. Communication is the key to crisis de-escalation. *Law & Order Magazine*. Retrieved from http://educate.crisisprevention.com/De-escalation-Tips.html?code=ITG030ORR&src=Pay-Per-Click&gclid=COX_lC__6oCFQVrgwodzysJ5Q

To learn more about de-escalation techniques and crisis prevention, investigate these practical resources:

- Crisis Prevention Institute | www.crisisprevention.com
- Universal Behavioral Precautions: Techniques of Verbal De-Escalation (PPT) | [www.mc.vanderbilt.edu/.../files/Workplace%20Violence%20PP%20\(2\).ppt](http://www.mc.vanderbilt.edu/.../files/Workplace%20Violence%20PP%20(2).ppt)
- Assertive Communication: De-Escalation (PDF) | www.thousandwaves.org/docs/VPResources/De-Escalation.pdf
- Specific procedures to help de-escalate violence (PDF) | www.ta-tutor.com/webpdf/ram079.pdf
- The Center for Nonviolent Communication (website) | www.cnvc.org
- QBS, Inc. | Quality Behavioral Solutions (website) | www.qbscompanies.com
- De-escalation (PPT) | www.nhchc.org/deescalationtraining.pdf

Homelessness & Brain Injury

People who experience a traumatic brain injury (TBI) may have cognitive deficits and behavioral problems that can make it extremely difficult for them to function independently in society. Studies on how many homeless people suffer from TBI report numbers ranging from at least 50 percent to 98 percent, and practitioners working in homeless health care think that TBI is under-identified in the homeless population. In patients with TBI, explosive behavior can be set off by minimal provocation and occur without warning. Episodes range in severity from irritability to outbursts resulting in property damage or assaults on others.

Here are strategies and techniques that clinicians can apply when working with homeless individuals with brain injury or cognitive deficits:

- Meet with people one-on-one, not in a room with others
- Eliminate distractions such as background music
- Refrain from answering email and taking telephone calls while meeting with people
- Limit communication to one mode at a time; i.e., do not show people something new while talking to them about it
- Accompany people to their appointments
- Do not assume that people can read, write, read a map, or do math
- Do not assume that people can negotiate public transportation
- When prescribing, use monotherapy whenever possible, and use a QD drug over BID, TID, and QID medications whenever possible
- Label medications for people who cannot read in a way that they can understand
- Screen and test all homeless persons for deficits in cognitive functioning
- Use neuropsychological test results to justify SSI/SSD and/or VA disability claims

SOURCE: Highley, J. L. (2008). *Traumatic brain injury among homeless persons: Etiology, prevalence & severity* (B. J. Proffitt, ed.). Nashville, TN: National Health Care for the Homeless Council. Retrieved from <http://www.nhchc.org/TBIJune08final.pdf>

Resources & Additional Readings

Brain Injury Association of America | www.biausa.org

Brain Injury Association of Minnesota | www.braininjurymn.org

Brainline.org | preventing, treating, and living with TBI | www.brainline.org

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APPENDIX B | VIOLENCE AS A CONSEQUENCE OF TBI

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“Coming Home:

Rejoining Other Humans in Ways We Have Been Unable to Accomplish”

“The problem of aggression and violence among brain injury survivors is huge. It keeps us from being able to access the help that we need to escape the streets, get medical care, and find employment. It erodes our self-image and self-confidence; it destroys our sense of competency and being able to effect change in our own lives.

The source of our [continued] wounding is our inability to manage impulsivity and aggression, and [maintain] emotional stability because we haven’t had access to rehab or treatment or people who cared enough with the skills to teach us. So if HCH staff could help heal one of the things that’s often been a factor leading to our becoming and remaining homeless, it would certainly help protect the safety of HCH staff, other HCH consumers and the community.

Part of the solution lies within the people we turn to for help in our everyday lives on the streets. Brain injury survivors often need to relearn social skills such as how to be in a group of people. HCH frontline staff can model and teach these things to us. When that happens, all of our lives become more whole, both the “helped” and the “helpers.” If we can find our right place in the community and rejoin others in ways we had previously been unable to, that will be our coming home.”

—Miki K.

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