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BRIEF REPORT

Violence Prevention and Safety Training for Case Management Services

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ABSTRACT: Violence inflicted by individuals with mental illness towards healthcare workers has received significant media attention. Though such incidents are relatively infrequent, they inspire reactive responses and contribute to further stigmatization of the mentally ill. Prevention of violence is an important challenge for those who train and supervise mental health workers. Project Link is an outpatient treatment program designed to reduce jail and hospital recidivism among severely mentally ill adults with histories of criminal justice system involvement. Utilizing a Safety and Violence Education (SAVE) curriculum, Project Link has successfully transitioned high-risk mentally ill individuals from the criminal justice system into the community since 1995. The SAVE curriculum uses a preventative strategy to train case managers to identify warning signs of impending violence, and to safely engage patients in community settings. This paper will present an overview of the SAVE curriculum and its development, as well as results from a preliminary evaluation of trainee satisfaction.

KEY WORDS: violence; Project Link; severe mental illness; safety training.

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INTRODUCTION

During the spring of 1998 in Buffalo, New York, a woman with severe mental illness bludgeoned her intensive case manager to death with a hammer during a routine home visit. The patient, a mother of three, had grown suspicious that she was about to lose custody of one of her children (Gryta, 2000). A similar incident occurred in 1988 in Glen Falls, New York, when a 23-year old female case worker died of injuries sustained after being physically and sexually assaulted by a male patient. The attack occurred during an outreach visit to the patient's apartment, a residence that was part of a program aimed at integrating individuals with mental illness into local neighborhoods (Mahoney & Silverman, 1988).

Although such tragic events are probably rare, these cases illustrate that potentially lethal violence can occur. The actual frequency of serious assaults against mental health case managers by patients is not currently known. Studies of violence in the severely mentally ill suggest that only a small percentage of individuals become violent, although the true rate of violent behaviors may be underreported (Zitrin et al., 1976). Given the relatively infrequent occurrence of violence, predicting which disturbed patient might follow through on a threat or unexpectedly become violent is often difficult (Torrey, 1997). This difficulty may lead some mental health professionals to deny the potential dangers involved in treating such patients. In reference to a recent murder of a psychiatrist by his patient in Southfield, Michigan, Dr. Alan Berman, a psychologist in Washington, D.C. remarked, "things like this are an occupational hazard that most mental health professionals don't think about" (Detroit News, 1999).

A variety of beliefs exist regarding the danger individuals with severe mental illness pose to the general population. In a review of public perceptions by Monahan, the idea that mental disorder bears some moderate association with violent behavior is noted to be both historically invariant and culturally universal (Monahan, 1992). Recent studies support a moderate but reliable association between mental illness and violence. Considerable evidence suggests that much of the violent behavior observed in the mentally ill is not random but is motivated and directed by psychotic symptoms. In many cases, the behavior appears to be a predictable and in some ways rational response to irrational beliefs (delusions) and perceptions (hallucinations) (Junginger, 1996).

Using data from the National Institute of Mental Health Epidemiologic Catchment Area project and the Triangle Mental Health Survey,

Swanson and colleagues examined the links between violent behavior and a variety of factors. These variables included type and severity of psychopathology, comorbid substance abuse, and community mental health treatment. Their study found a curvilinear relationship of violence risk to psychoticism/agitation, a significant violence association with substance abuse comorbidity, and the absence of recent contact with a community mental health provider (Swanson, 1997).

Despite the difficulty involved in predicting violence among patients with severe mental illness, certain general clinical and demographic variables have been associated with such behavior in certain populations. Risk factors for violence in schizophrenia includes a history of prior arrests, use of illicit drugs and alcohol, and active psychosis (Bartels et al., 1991). The presence of neurologic and cognitive impairment has also been associated with violence (Volavka & Krakowski, 1989). According to Glancy et al., additional risk factors include being male, poor, unskilled and uneducated (Glancy & Regehr, 1992).

With deinstitutionalization and continuing trends toward reduced numbers of inpatient psychiatric beds and lengths of stay, patients with risk factors for violence are increasingly cared for in outpatient programs. As a result, the need to understand and manage risk of violent behavior among people with severe mental illness in community care settings is increasingly being recognized. This issue takes on further import in community settings, as public-sector mental health systems face mandates to provide more cost-effective services in less restrictive environments (Swanson, 1998, 1999).

Case managers are often the "front line" in providing treatment and supportive services to high risk patients in community settings. While a variety of models of case management exist (Mueser et al., 1998), most case managers function as members of multidisciplinary teams. Team members may include psychiatrists, nurses, social workers, psychologists, rehabilitation counselors, or other professionals. Within these teams, case managers typically have the most direct contact with patients despite often having the least formal training. Case managers also tend to work with the most difficult and challenging patients. In order to qualify for case management services, patients are usually required to have high levels of disability and/or symptomatology (Mueser et al., 1998). Many have histories of non-adherence with medications, and of failure to engage with standard outpatient treatment. Such patients commonly have additional risk factors for violence, including active psychosis, co-occurring substance disorders, and lack of education or employment. As the outreach arm of the multidisciplinary team, case

managers are expected to serve these high-risk patients in community settings that are sometimes unfamiliar. Many are required to serve patients during evening and weekend hours. These combined factors can place case managers at significant risk for verbal abuse, physical assault, and other forms of violence.

One strategy to reduce the risks associated with case management is to improve the foreseeability and prevention of violence through safety training. Despite the potential importance of safety training, surprisingly little has been written related to the role of case managers on this subject. Review of citations on the MEDLINE electronic database combining key words "case management," "violence," "safety" and "training" reveal no articles published since 1966. This paper will present an overview of a training curriculum developed as part of a new program to treat high risk mentally ill adults in urban upstate New York.

LOCAL NEEDS

Project Link was initiated in 1995 in Rochester, New York, after a survey by the Monroe County Office of Mental Health revealed a significant number of mentally ill persons cycling through the local jail. These high risk individuals were found to be primarily young men with comorbid schizophrenia and addiction who had histories of non-compliance with outpatient treatment and lacked stable housing. Project Link was subsequently designed with the goals of reducing jail and hospital recidivism, and of promoting community adjustment among this population. It is a university-led consortium of five community agencies that spans healthcare, social service and criminal justice systems. General descriptions of the program and preliminary data about its effectiveness have been presented previously (Gold Award, 1999-Lamberti, 2001-Lamberti, in press). Project Link consists of a mobile treatment team of five case advocates, a forensic psychiatrist, and a nurse practitioner. The project's case advocates are five bachelor's-level staff with a primary responsibility of linking "at risk" patients to psychiatric, medical, social and residential services in the community. Emphases is placed on assessing client needs, linking clients to necessary healthcare and social services, coordinating service activities, and monitoring ongoing treatment. Assigned duties include securing financial resources, visiting clients in the county jail and local hospitals, transporting clients to appointments, and providing outreach services at the client's residence.

Project Link's admission criteria are presence of a serious mental

illness such as schizophrenia or bipolar disorder, a history of involvement with the criminal justice system, and an age of 18 or older. This group of clients is predominately male, has a high prevalence of psychosis and co-occurring substance disorders and other general risk factors for violence. The majority of clients had prior felony convictions, had failed to complete High School, and were unemployed at the time of enrollment. Taken together, historical data about violent crimes and the presence of clinical and demographic risk factors suggests that Project Link's clients are at substantial risk for future violent behaviors. Their criminal histories and behaviors, including homicide, require careful attention and can create significant angst for Project Link and other community providers.

TRAINING PROCESS

Applicants for the project's case advocacy positions have presented from a variety of backgrounds, including drug counseling, residential counseling and interpreter services. At the time of hiring, none of Project Link's first five case advocates reported having received any prior formal training about mental illness and its treatment, or about assessment and prevention of violence. In addition, they reported having received no training about how to interface with the criminal justice system. In order to prepare new case advocates for work in Project Link, they receive a series of general introductory lectures by the team's forensic psychiatrist. The lectures cover a variety of fundamental topics including causes of mental illness, psychiatric diagnoses, common symptoms, and psychiatric medications. Case advocates also receive ongoing clinical supervision from the project's coordinator, a master's level nurse with substantial mental health and criminal justice experience. In addition to these basic training activities, Project Link's directors instituted a safety training curriculum early in the program's inception because of the high-risk nature of the clients served. Entitled the Safety and Violence Education (SAVE) curriculum, its goal is to promote the safe and effective practice of case management in the community.

The SAVE curriculum consists of 10 topics listed in Table 1. The topics are presented in succession, within two separate ninety-minute sessions. Each session begins with a 60-minute didactic presentation, including time for questions, discussion, and sharing of relevant experiences. Sessions are conducted in a group format to promote active participation. Each didactic presentation is followed by a 30-minute role-play

TABLE 1

Safety and Violence Education (SAVE) Curriculum

1. Causes of human violence.
2. Epidemiology of violence against mental health practitioners.
3. Risk factors for violence among the severely mentally ill.
4. Identifying warning signs of violent behavior.
5. Techniques for communicating with an agitated patient.
6. Strategies for safety and violence prevention in community settings.
7. Communicating with co-workers as a primary preventative strategy.
8. Pharmacotherapy and behavioral management strategies for aggression.
9. Debriefing following an incident.
10. Risk management: Confidentiality, informed consent and documentation.

involving the case advocates. Case advocates are instructed to choose from a list of "real life situations" that involve making home visits, transporting clients, and other common activities. Volunteers are then selected to play the depicted roles, and are provided with basic role-play instructions. After the role-play is completed, the group is led in conducting a critical review of each situation, examining the possible pitfalls and risks that might jeopardize safe case management. Discussion is followed by a detailed review of safety tips to be considered when making home visits (Table 2). This list was compiled from a review of existing training materials, with a goal of providing clear and practical guidelines for use by case managers in community settings (Dvoskin, 1995).

OUTCOMES AND ISSUES

The SAVE curriculum has been presented by Project Link's forensic psychiatrist to all case advocates in the program since 1996. While the curriculum was originally developed and implemented for Project Link case advocates, it has subsequently been used to train case managers and nurses outside of the program. Between 2/15/99 and 3/2/00, seven

TABLE 2

Safety Guidelines When Making Home Visits

1. Always inform colleagues of your destination. Include a sign out sheet, telephone numbers, visit length and clients name and address.
2. Utilize cellular phones with programmable emergency numbers. Phones must be charged and on at all times.
3. If possible, make initial home visits in the company of a co-worker.
4. Wear loose comfortable clothing that is non-restrictive allowing quick movement. If a tie is to be worn a clip on style is preferable.
5. Limit the wearing of jewelry, including necklaces and earrings.
6. Large purses should be locked in an office or trunk of vehicle.
7. Know buildings, dwellings and other areas that present a high risk for crime and violence, and avoid parking in front of high-risk locations.
8. Always lock your vehicle, and have your keys readily available.
9. Use all your senses when approaching a home. Look, listen and smell for anything that could compromise your safety. Shouting and unfamiliar individuals may herald danger.
10. Be alert to the presence of pets. If the client has a large pet, request that it be contained in another room during the visit.
11. When arriving at a client's home stand at the side of the door when knocking or ringing the bell.
12. When inside the residence always inquire if anybody else is home.
13. Always attempt to position yourself near the doorway you entered or a conspicuous window.
14. Never attempt to interview an intoxicated client.
15. Avoid mediating a domestic quarrel.
16. Be careful to avoid invading a client's personal space. Avoid potentially perceived threats to a client or his family, and confront judiciously.

safety training programs were attended and rated by a variety of trainees. Of the seven training programs, four were provided to case managers and three were provided to nurses from local residential and mental health agencies. Surveys were administered to attendees during the last training period. Using a 1–10 scale with 10 being the most satisfied with the training, out of a total of 150 attendees 90% responded. Of the 135 respondents, 104 were mental health case managers and 31 were nurses who assisted the elderly in a community access program. The average (SD) score provided by case managers was 9.7 (0.6), and the average (SD) score provided by the nurses was 8.4 (1.4). Additionally, according to these surveys, the most frequent suggestion for program improvement was a request for yearly refresher training. This recommendation was supported by survey responses suggesting the importance vigilance in this area that ongoing regular programming could provide. Results suggest that the SAVE curriculum was well received by the audiences and relevant to their day-to-day work.

While all case advocates in Project Link have participated in the SAVE curriculum, it is unclear whether this training has contributed to the overall level of safety and effectiveness of the program. A preliminary evaluation of Project Link has demonstrated a significant reduction in average numbers of incarcerations and hospitalizations per patient in the program (Gold Award, 1999). From a safety perspective, no assaults, suicide attempts or other reportable incidents have occurred among patients treated by the mobile treatment team since admission. Controlled studies are needed to evaluate the effectiveness of the SAVE curriculum at promoting safe case management of persons with severe mental illness.

In order to provide effective and timely safety training to case managers and other mental health workers, many barriers must be addressed. Gathering together a large group of often very busy and widely dispersed staff members can be a monumental task. This difficulty may be compounded by a lack of financial resources and by productivity pressures that exist within agencies employing mental health case managers. Since few professional training programs offer safety training as part of their curriculums, clinicians and other agency leaders may feel unprepared to conduct such training themselves. The presence of such barriers may contribute to the tendency of staff members and program heads alike to overlook the potential risks and safety issues faced each day by case managers.

DISCUSSION

Violence prevention and safety training requires time and effort on the part of those who direct and supervise mental health workers. In light of the need for outreach programs to assist high-risk individuals previously institutionalized, proper education and safety training may be a key investment. Similar to Cardio-Pulmonary Resuscitation (CPR), effective safety training requires ongoing review and practice. As suggested by training recipients, a single seminar may not be enough, and refresher courses should be made available to provide a review of basic safety principles at regular intervals. As noted above, Project Link's current level of safety cannot be directly related to the SAVE curriculum. However, it seems likely that safe and effective case management high risk patients may be promoted via a structured program of violence prevention and safety training. Work is currently underway to develop the SAVE curriculum into a series of transportable instructional materials that may be utilized by any experienced case management supervisor. This curriculum can be adapted and applied for use with other front-line staff including group therapists, residential program workers, counselors and mental health technicians. It is hoped that the this curriculum will be helpful in overcoming barriers to providing safety training to case mangers and other direct care staff.

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