Safety and Violence Education: SAVE

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WEBINAR

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## Safety

The door to safety swings on the hinges of common sense.
~Author unknown

To learn about eye protection, ask someone who has one.
~Author unknown

If you don't think it's safe, it probably isn't.
~Author unknown

Tupac was one of the biggest thugs I know, and he always wore his seat belt.
~Ice Cube, to Kevin Hart

## Safety:

## Purpose of SAVE Training:

Allow you all to be:

- More effective in your roles
- Safer and more prepared
- More efficient with challenging cases
- More satisfied with work
- Able to improve the environment for all!

## State of Individual within Forensic Setting: *What is it?*

- Lack of awareness re: legal forum
- One down (or more) to staff
- On the defense
- Expect to be done wrong
- Underrepresented
- Fighting *the system*
- Nothing to lose

## Workplace Violence Includes:

- Beatings
- Stabbings
- Suicides
- Shootings
- Rapes
- Near-suicides
- Psychological traumas
- Threats or obscene phone calls
- Intimidation
- Harassment of any nature
- Being followed, sworn or shouted at

## Training and Education

- Employees should understand concept of "Universal Precautions for Violence"
  - Violence should be expected but can be avoided or mitigated through proper preparation
  - "PPPPP"
  - limit physical interventions in workplace

Waiting Room and Office 1

Waiting Room and Office 2

## *Why* Safety Training?

- Violence towards providers by mentally ill individuals: *Infrequent*
- Inspires:
  - *Reactive responses*
  - *> Stigmatization*
- Goals:
  - *Reduce* : Provider fears, patient stigma
  - *Improve* : Provider knowledge, work satisfaction and safety

*ACCESS TO CARE FOR PATIENTS!*

## *Mental Health Trends* :

- Deinstitutionalization
- Reduced inpatient beds & L.O.S.
- > Substance use
- > Criminal Justice involvement

- *More acute patients with criminal justice involvement requiring community-based care*

Clients Requiring Outreach and Crisis Intervention *Characteristics:*

- High levels of disability and/or symptoms
- Substance Use Disorders
- Historically non-adherent to medications
- Historically have failed to engage in traditional treatment
- Multiple risk factors for violence
- Criminal justice involvement

## Team Staff:

- Part of multidisciplinary teams
- Typically have more frequent direct client contact
- Have variable levels of formal training
- Tend to receive most "difficult" and challenging clients
- Often work in unfamiliar settings

Incident

Consquences:

## Risk Factors for Future Violence:
*Past History*

"Past history of violence is the single best predictor of future violent behavior"
- 25% - 30% of male psychiatric patients with a violent history become violent again within 1 year

Klassen and O' Conner, 1988, 1990

MacArthur Study:
- All measures of prior violence:
  - Self-report, arrest records and hospital records were strongly related to future violence.

MacArthur Foundation, 2001

## Violence Risk Factors for SPMI/Co-occurring Individuals

- Treatment non-adherence
- Recent (6 months) history of violence
- Homelessness (survival mode)
- Active symptoms of mental disorder
- Limited coping skills
- Antisocial attitudes
- Substance use
- Limited intelligence

## Risk Factors for Future Violence:
*Past History*

<u>Violence History:</u>

- Most violent thing done?
- Type of violent behavior?
- Why violence occurred?
- Who was involved?
- Presence of intoxication?
- Degree of injury?

## Risk Factors
*External*

- Presence of:
  - Gang members, drug/alcohol abusers, distraught family/friends
  - Criminal/Forensic matters
    - End dates, new charges…
- Low staffing levels:
  - during times of increased activity such as in session or visiting times
  - Transporting/escorting individuals

## Risk Factors for Future Violence:
*Environmental Factors:*

- Social supports
  - More support = less violence
  - Family as central support
- Employment
  - Negatively correlated with violence
- Domestic Violence
  - Common for mentally ill individuals
  - Uncertain as to perpetrator / victim

Estroff, 1994, Monahan et al 2000, Dvoskin, 1994

## Risk Factors for Future Violence:
*Life Events:*

- Loss of significant others
  - Death, breakup, protective services
- Conditional Oversight/Controls
  - Parole, Probation, Release, CPS
    - *If not balanced with proper treatment!*
- Loss of stability
  - Legal status, job, residence, transportation
  - Entitlements or ***finances***

Risk Factors for Future Violence:
*Life Adjustments:*

- Re-entry to community from
  - Incarceration
  - Hospital stay
- Moving
  - Alternative location
  - From family or supportive residence to independent living

Massaro et al, 2002, Rotter et al, 1999

## Risk Factors for Future Violence:
*Personality Disorders*

- Personality types:
  - Borderline and Sadistic PDs associated with increased violence
    Tardiff, 1999; Tardiff ,Sweillam, 1980; Meloy, 1992
  - Antisocial
    - Most commonly associated with violence
      MacArthur Foundation, 2001
    - Motivated by revenge or during periods of heavy drinking
    - Cold and calculated, lacking in emotionality
      Williamson et al., 1987
  - Low I.Q. and Antisocial P.D. = Ominous combination
    Heilbrun, 1990

## Risk Factors for Future Violence:
*Depression*

- Circumstances for violence:
  - Despair
  - Most common diagnosis in murder-suicide
    Coid, 1983; Marzuk et al., 1992
  - Depressed or psychotic patient
    - Mothers who take the lives of their very young children
      Resnick, 1969
    - Couples – feelings of jealousy and possessiveness
      Rosenbaum, 1990
    - Homicide-suicide:
      - Individual cannot bear life without vital element, or others carrying on without them.

## Tips on Evaluating Dangerousness:

- All threats should be taken seriously
- All details should be elucidated
- Inform individual and assess his ability to appreciate the consequences
- Grudge lists
- Investigate fantasies of violence
- Assessment of future victim if identified
- Assess for suicidal risk in any homicidal patient
  - High correlation (attempts and ideation)
- *Your experience does not always save you!*
- *Each situation is new and unique!*

## Proactive Team Approach:

- Roles of team staff
  - Who brings what to the team?
- Synergy:
  - Experience + Education = Proactive Collaboration
- Communication skills for safety
  - Team approach
  - ***Information must flow freely among ALL staff on team***
- Unified front for Universal Violence Precautions
- Maintaining trust and boundaries

## Team Work:

- Can be used in new and difficult situations
- Team up with co-worker
- Team up with others
  - parole, probation, security, law enforcement
- Allow teammates the discretion to ask for assistance or to discontinue a visit

Scenario:
*Outreach Preparation*

*Outreach Safety*

Safety Guidelines During Outreach Visits:

- When approaching a residence look, listen and smell for anything that could compromise your safety
- Be alert to the presence of pets
- Stand to the side of the door when knocking or ringing the bell.
- Inquire if anybody else is around upon arrival
- Position yourself near the doorway you entered or a conspicuous window
- Never attempt to interview an intoxicated individual
- Avoid mediating a domestic quarrel
- Be careful to avoid invading personal space
- Avoid perceived threats to an individual or his family, and confront judiciously

## Assessing the Situation:
*A.W.A.R.E.*

- Assess from a safe space / Approach with caution
  - Make first observation from a distance
  - Face to face
    - Maintain appropriate social space
  - Approach
    - Assessment informs approach
    - Rate
    - Proximity
    - Posture and body language

## Assessing the Situation:
*A.W.A.R.E.*

- W's: Where, What, Who, When?
  - Where are the exits?
  - Where is help?
  - What are potential weapons?
  - What is my relationship with this person?
  - What is the intensity of verbal/physical behaviors?

## Assessing the Situation:
*A.W.A.R.E.*

- Who:
  - Else is there (friends and family…)?
    - Avoid being drawn into family issues
  - Needs to leave?
    - Removing instigators
    - Person involved with escalated behavior
    - Diminish stimulation

## Assessing the Situation:
*A.W.A.R.E.*

- Ask
  - Ask for help
    - Plan ahead for sources of help (partner, supervisor…)
  - Ask yourself
    - Do I feel afraid?
    - Do I feel angry?
    - Should I enter the situation?

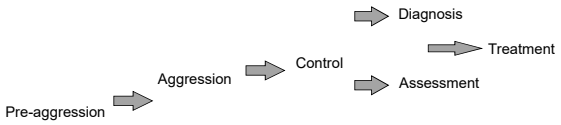
## Assessing the Situation:
*A.W.A.R.E.*

- Respond
  - Use knowledge and skills
    - Safe space
    - Verbal defusing
    - Personal safety
  - Use Crisis Plans
    - Agency
    - Team
    - Individual
  - Use Self
    - Relationship
    - Respect

## Assessing the Situation:
*A.W.A.R.E.*

- Evaluate
  - Damage
    - Property
    - Personal injury
    - Psychological injury
  - To whom
    - Staff, recipients, others
  - Skills
    - What went well?
    - What could have been done differently?
    - Do plans need reevaluation?
  - Restoration
    - Safety, health, control of arena (Court)?

## Linear Aggression Sequence:




Maier, Stava, Morrow, et al (1987)

## Preaggression:

- Most violence has a prodrome
- Not necessarily step wise
- Progression is usually obvious

**OBSERVATION IS ESSENTIAL**

## Preaggression - Phase 1 (early)

- Tenseness of muscles
- Rigid posture
- Clenching of fists and teeth
- Statements of fear of losing control

## Response:
Phase 1

- Utilize empathy
- Include the person's input

## Preaggression - Phase 2

- Verbally abusive - **LOUD**
- Boasting of prior violence
- Makes a mess, scatters clothes or objects
- Engenders most negative staff reactions

## Response:
Phase 2

- Safe Space
- Safe Place
- Limit setting / Directive Statement (cautious)
- Offer choices & consequences
- Include person's input

## Preaggression - Phase 3

- Extreme hyperactivity (fight or flight)
  -Pacing -red flag of impending violence
- Threatening gestures
- Throws objects down, banging, kicking walls or furniture
- Vicious cursing
- Makes clear threats to others

## Response:
### Phase 3

- *Crisis Plan*
- Exit strategy – Back off
- Call for assistance (911, local security…)
- Attempt to minimize collateral damage
- Do not attempt physical control or pursuit unless properly trained to do so!

## COMMON MISTAKES:

- Arguing

- Lose Composure
- Resort to power

- Move in too closely

- Minimize potential for danger

## Talking with person in crisis:

- Calm Approach
- Appear to be in control:
  - "Passive Control"
- Lower voice – Keep it S&S
- Comment on obvious neutral items:
  - empathy
- Provide adequate space
  - speak only to a sitting person
  - difficult in jail/forensic settings

## Limit Setting:
Strategy for deescalating behavior

- Polite Requests
  - "Please and thank you"
  - Avoid authoritative stances initially:
    - Parental responses may fuel or escalate situation
- Save Face
  - Allow person to do so if limits are being set
  - Avoid anger/arrogance that may impede this
- Communicate Respect

  It's not about you
  - Avoid personalizing person's behavior
  - Back off and get assistance if necessary!!

## Situational Awareness Model:
*Chain of Events - Air force*

Interpreting Incoming Data

- Forward Posture

  Flying ahead of the plane
- Spatial Orientation

  Where am I in relation to what is important at this moment?

## Talking with person in crisis:

- **Respect** patient and avoid direct eye contact at first
  - Challenging?
- **Listen** to person initially and avoid interpretations or interruptions.
- **NEVER PROMISE WHAT YOU CAN'T DELIVER**
  - $, Housing, Special favors... It may come to haunt you.

## "When in Doubt - Get Out and Shout!"

## Prepare Your Area:

- A surgeon has a predictable place to work
  - Create safe practice and work areas
- Identify a go-to person in case of emergency
- Have a backup plan (Code, 911, Alarm…)
- DON'T BE A HERO –
  - Avoid confrontation
  - Recognize when to exit and call for backup!

## Avoiding Road Rage


- Avoid setting off other drivers by:
  - Do not cut people off.
  - Do not tailgate.
  - Do not make obscene gestures.
- Avoid use of high beams to prompt passing in a lane
- Do not escalate minor disputes by arguing with other drivers
  - Slow drivers should always use the right hand lane
  - Take deep breaths and keep your emotions calm
- Maintain safe distance from other drivers
- If someone chases or makes threatening gestures and you feel you are in danger, call 911 and stay inside vehicle

## Requesting Emergency Assistance: *Steps*

- Don't panic – Adrenaline is flowing
  - Obtain space from the emergency - if possible
- Find a phone and ID your number
- Dial 9-1-1:
  - **Do *not* hang up if you do not connect immediately!!**
- Plan what you will say to the dispatcher
- Know what you will be asked:
  - Where is the emergency?
  - What is the nature of the emergency?
  - What happened or is happening?
  - Where you are located?
  - Listen to dispatch and follow orders
  - Do not hang up until instructed to

## Self Defense Techniques:

- Non-confrontational interview
- Self defense is to reduce harm
- *Never* to injure patient or others
- Know your surroundings:
  - Escape routes "*When in doubt…"*
  - Panic buttons
  - Emergency contacts

## Debriefing Basics

- 24-48 hours
- Invite all affected staff
- Set ground rules:
  - What is said in the room, and by whom, stays and is confidential;
  - This is about support - not an incident review.

## Debriefing Process

- Walk through the facts: what happened first, next, etc.
- What do individual remember?
- What did they feel?
- What was the worst part of it?
- Acknowledge the fear; anxiety; anger…
- What is staying with them?
- What is helping them to cope?

## 10 Rules for Staying Safe:

1. Offer Space
2. Respect
3. Be Aware
4. Trust Instincts
5. Try Not To Make Things Worse
6. Communicate Desire to Help
7. Defuse – Verbally
8. Use Safety Plan
9. Evaluate and Process All Incidents
10. Use Your Own Good Judgment

## Incident Review:
*Reactions to Trauma*

- Individual Responses
- Emotional /Psychological
  - Anger, guilt, vulnerability, loss of trust in team
  - Anxiety, irritability, depression, shock, disbelief, apathy, self-blame, fear
- Psychosomatic
  - Insomnia, substance abuse, absenteeism
- PTSD

Engle, 1986 and Warshaw, 1996

## Incident Review:
*Response*

- Medical attention immediately if needed
- Process all incidents!
  - Involve victim/s and client if appropriate
  - Avoid denial by team members or leaders
  - Administrational support
  - Informal supports
- Utilize Trauma Preparation or trained individuals
- Referral to EAP or similar counseling services
- Planned time off and return to work

## Team Mental Health:

It is up to all staff to recognize signs and symptoms of burnout
  - *Apathy and lethargy may lead to poor judgment and bad outcomes*

- Offer assistance to overworked staff:
  - "mental health" days and extra supports
- Consider educational retreats or team building events to reduce burden
  - Outings and collective recreational activities can ease work related burnout, while improving staff relations and team morale!!

Know where you are,
and where your going at all times!


## Violence Prevention:
*Summary*

- Unique Case

- Safety First
- Assess Risks
- Violence Escalates
- Escape if Necessary
- Do No Harm

- Inform Each Other
- Take All Precautions

Better put a strong fence 'round the top of the cliff'
Than an ambulance down in the valley.

*John Milins*