

# Violence Prevention and Safety Training for Case Management Services

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## Introduction

This lesson provides a practical, prevention-based safety training for case managers. Within multidisciplinary mental healthcare settings, case managers typically have the most direct contact with patients despite often having the least formal training.<sup>1</sup> They also are more likely referred and tend to work with the most difficult and challenging patients. The danger of injury to case managers and patients alike can arise from symptom escalation, anger, fear, and unmet needs. It is known that individuals with mental illness are more likely to be victims rather than perpetrators of violence. Also, contrary to popular stereotypes, only a small subgroup of individuals with mental illness poses a higher risk for violence than the general population. Within this group are primarily those with past histories of violence or substance use disorders. The following lesson is

based on the Safety and Violence Education (SAVE) training curriculum that focuses on violent incident prevention and proactive safety strategies.<sup>1</sup> Case managers are trained to identify early warning signs of impending violence and learn methods to safely engage patients in community settings. The SAVE training objectives include understanding and assessing risk factors for violence, acquiring the necessary skills for preventing and deescalating crises, and providing patient transportation and home visit safety. In addition, the SAVE training reviews keys to communication and effective documentation for daily case management services. As with most training, effective results and mastery of skills will require ongoing review and repetition of fundamental program elements.

## Background Information

A variety of definitions exist describing violent behavior, yet no consensus exists on what constitutes a threat or act of violence in mental health services.<sup>2</sup> **For the sake of this lesson, violence committed by a patient against a mental health case manager is characterized by an actual physical assault, threat, or any other event the professional may consider as personally harmful.<sup>3</sup> Other types of violence include threat**

### Learning Objective

Understand and assess risk factors for violence; build skills to prevent and deescalate crises; review suggestions for talking with a potentially violent patient; ensure safe transportation and home visits; recall keys to communication and effective documentation.

**with a weapon, property damage, phone or e-mail harassment, stalking, and stolen property. The most prevalent form of violence described in the literature is a verbal threat, followed by physical assault.**<sup>4,5</sup> Bureau of Labor Statistics data support that health care and social services workers have a higher incidence of assault injuries than any other field.<sup>6</sup> Reports also maintain that younger and less experienced staff are at greatest risk of patient assault in community residential mental health programs.<sup>7,8</sup> In addition, the percentage of workers experiencing violence varies considerably, with estimates ranging from 50% to 88% prevalence.<sup>9</sup> Confounding the definition and accurate reporting of such behavior are professional's perceptions and the context in which the violent incident occurred.<sup>2,10</sup>

The location of mental health care delivery and potential for violent incidents by those with mental illness has changed dramatically over the last few decades. From the middle of the last century and continuing today, the focus of mental health care has shifted from large psychiatric facilities to community programs.<sup>11,12</sup> With the development of newer psychotropic medications, deinstitutionalization, and the ongoing trend toward reduced numbers of inpatient psychiatric beds and length of stay, patients with risk factors for violence are increasingly cared for in community settings. As a result, the need for case management services to understand and manage potential violent behavior by and against individuals with mental illness in the community has similarly escalated. This issue takes on further gravity in outpatient settings, as public-sector mental health systems face mandates to provide more cost-effective services in less restrictive environments.<sup>13,14</sup>

To qualify for case management services in the community setting, patients are usually required to have high levels of disability or psychiatric symptoms.<sup>15</sup> Many such patients have histories of nonadherence with medications, as well as of failure to engage with standard outpatient treatment. Such patients commonly have contributing risk factors for violence, including active psychosis, co-occurring substance use disorders, and limited education or employment. Fre-

quently, as the outreach arm of multidisciplinary teams, case managers are expected to serve these high-risk patients in unfamiliar settings and unpredictable circumstances. Many case managers provide services during evening and weekend hours when other mental health supportive services are closed. Combining these extended hours with high levels of patient contact in the face of limited training can place case management service providers at significant risk for verbal abuse, physical assault, and other forms of violence.

One strategy to reduce the risks associated with case management services is to improve the predictability of patient behaviors and therefore minimize violent incidents through staff participation in safety training.

## **A Review of Barriers and Central Issues**

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Unsafe working conditions and violence toward unprepared clinical case management staff can result in multiple negative consequences. According to various reviews, clinicians who have experienced violence report that it contributes to stress, role conflict, and demoralization.<sup>16,17</sup> Others reported effects including constricted thinking, restricted coping, and states of fear, anxiety, and depression.<sup>18</sup> Such concerns can impede the daily routine of afflicted case managers and contribute to significantly impaired performance and personal risk, especially for those without proper training. As a result, case managers involved with home visits may be less effective if they are afraid or find themselves in dangerous situations with little or no knowledge of what to do.<sup>19</sup> Witnessing episodes of violence, and the stress of observing such events directed toward colleagues, can additionally contribute to feelings of helplessness and loss of control and predictability for case managers. To provide effective and timely safety training to case managers, many barriers must be addressed.

Gathering together a large group of very busy and widely dispersed staff 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 man-

agers. Because few professional training programs offer safety training as part of their curricula, clinicians and other agency leaders may feel unprepared to conduct such training themselves.<sup>1</sup> The presence of such barriers may contribute to the tendency of staff and program heads alike to overlook the potential risks and safety issues faced each day by their case managers. Professional norms including client-centered perspectives may contribute to workers' belief that patient service supersedes worker safety.<sup>20</sup> Furthermore, the fiscal effect on agencies from direct and witnessed traumatic events like violence toward case managers may be considerable. Within agencies, a higher incidence of staff burnout, sick leave, medical and legal expenses, and turnover have been noted.<sup>18</sup> Ultimately, agencies may additionally be liable for injuries and loss of life suffered by victims of workplace violence.<sup>21</sup>

Training on violence prevention and workplace safety is an important area of skill development, and it is suggested that agency supervisors and administrators ensure that all staff receive safety training.<sup>22</sup> If safety training is provided, efforts to train case managers should be offered as early as possible, and should consider addressing risk factors for patient violence, providing environmental assessments, and teaching the essentials of communication along with crisis deescalation and exit strategies.

## **SAVE Program**

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### **Vignette:**

It's early Saturday morning, cold and overcast, and the rain just ended. You are notified by a phone message left by the clinic answering service to cover a home visit for your colleague who just called in sick. In fact, this was the case manager that picked up your caseload six months ago after your promotion to senior case manager. You hope to get this home visit out of the way, as there's a lot to do at your new apartment, and you reluctantly agreed to provide coverage on such short notice. You

leave straight from your home, avoiding the drive to the clinic to review the patient's clinical chart, and head straight to her apartment building. You plan to visit the clinic afterward to type up your progress note.

The patient, Jill, a 28-year-old, White female suffers from schizoaffective disorder and borderline personality. You remember Jill as variably compliant with her prescribed psychiatric medications. She didn't want to take them because they caused her to gain weight and feel sleepy. The phone message you received suggested that you deliver some money for food and check to see whether she has enough medications to carry her through the weekend. You recall she is about your height but definitely more stocky. She is a child of alcoholic parents. She has never been violent, at least not when you worked with her about a year ago, and she has to your knowledge no real serious criminal past. She now lives in a different rooming house in the city than when you last visited her. The streets seem deserted this morning—maybe from all the rain.

You park your car, walk along a bit, and realize you are on the wrong block. You decide to keep walking until you reach her reported apartment complex. The elevator reads "Out of Order," so you head into the dark stairwell and start climbing toward the third floor. You think about how you used to have to do this outreach work everyday and revel in the thought of your new desk job as case management supervisor. Your message from the clinic's after-hours service also mentioned that Jill has been keeping residents of her building up all night, frequently calling the emergency room to talk to others, pacing, and occasionally yelling out of the window, "Who took my money?" If she doesn't stop this

behavior, she may lose her housing. This is the same old Jill you remember.

You finally reach the third floor and stop to catch your breath. The hallways are quite long, but they are divided by several blind turns. You hear a large dog barking somewhere down the hallway. You walk down to the first turn and look around the corner, then turn two corners right and one left before you find the apartment. You listen for Jill as you approach, and knock on apartment 347, the number given to you by the after-hours team. No response. You knock again, and hear many glass bottles clinking as if they are being moved in a hurry. You call out, "Jill, are you in there?" You hear someone move inside right up next to the thin wooden door. You move directly in front of the door so that she can see you through the peephole. After a long minute, she screams, "Did you take my money?" You speak through the door and tell her that you would like to come in. She says, "No not now," but opens the door a little so you can see into the apartment. With the door ajar, you notice the familiar stale smell of burnt cocaine and see empty bottles on the coffee table and a pair of large men's boots near the bedroom entrance. This, you realize, is not the same Jill that you remember!

Now all of a sudden, she yells at you to come in: "Just do it, you're the damn police anyway!" You have a funny feeling that you shouldn't, so you decline. You say that you'll catch up later, but you worry that she isn't doing well and may be at risk for harm. She then runs up and slams the door closed on you. You hear the lock catch, then another, and then a third. All of a sudden you hear a low man's voice yell, "Did you get the damn money?" You'd better get some backup, as this situation should not be handled alone. You then become aware

that you left your cellular phone on the front seat of the car, along with your clinic identification badge. You proceed back down the stairs and try to remember whether there was a pay phone in the lobby. As you enter the lobby, you see a group of unsavory characters monopolizing the single pay phone. You avoid eye contact and quickly walk past, toward the exit. You head back to your car with a purpose; the rain has started up again and it's a long cold walk. Time is of the essence, and you need to make your call for assistance right away.

This hypothetical vignette demonstrates a number of overt and veiled potential pitfalls into which even an experienced case manager may stumble. The following key points illustrated within this scenario from the SAVE curriculum should be considered as fundamental prevention toward safe case management work.<sup>1</sup> Above and beyond the following details, it is critical to always maintain a key sense of awareness of your environment and ever-changing situation. This ongoing appreciation relative to the uncertainty of daily community work will assist you in practicing safely and effectively as a case manager. Furthermore, developing the necessary competence and expertise for safe practice requires experience combined with the spirit of teamwork and openness toward communication between you, your patients, your colleagues, and your supervisors alike.

## Understanding and Assessing Risk Factors

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In the above vignette, the number of real and potential risk factors for violence far exceeds the factors protecting against such risk. There are at least 20 risk factors that could compromise this case manager's safety and only a handful of details that minimize risk in this particular case.

A thorough patient assessment is essential to case managers, as it affords a level of predictability in addition to early identification of potential risks before and

during an encounter. This assessment can come from many sources, including past clinical records, discussion with other service providers, and direct observation and evaluation of the patient. Risk factors can also be obtained from a number of other sources including school and criminal records, caretakers, and questioning of friends and family. Following a comprehensive review of available information, the case manager can consider appropriate precautions or responses for each patient.

Clinical factors relating to acute symptoms of a patient's mental illness should be reviewed. These symptoms may be expressed through changes in behaviors or baseline habits. Jill, as described in the above vignette, had changed drastically in her case manager's opinion through her current involvement in drug use. Misperceptions or paranoid thoughts can manifest as unpredictable or atypical behaviors by your patient during a visit. Medication noncompliance or variable compliance can lead to unpredictable circumstances. A patient who has changed prescribed medication patterns or discontinued recommended treatment completely should raise the case manager's suspicion about potential behavioral instability. Patients may miss their medication as a consequence of active symptoms of their illness, substance abuse, and stigma related to having such impairment. Table 1 offers a number of possible reasons for medication noncompliance for patients with mental illness.

The saying "nothing predicts the future like the past" is highly relevant to violence assessment for patients requiring case management. According to the literature, a history of aggression in young psychotic men who have been hospitalized in the past is an excellent predictor of future outbursts.<sup>23</sup> In addition, a patient's behavior in the immediate past and the clinical presentation at the time of evaluation are better predictors of imminent violence than are the diagnosis and chronic characteristics.<sup>24</sup> Consideration should be given to the facts related to prior violent episodes and to the frequency of violent acts for each patient. Precipitants to the violence, situational factors, and identified stressors should be noted for future reference. In addition, risk

factors can be broken down into those forces acting internally or externally on the individual patient receiving case management services.

**Internal risk factors for potential patient violence such as age, gender, medical concerns, intellect, and degree of mental impairment or personality disorder should be considered as part of a comprehensive review by a case manager.** Being young, male, and demonstrating violent behavior at an early age bodes poorly for future high-risk behaviors. The prognosis is even more ominous for individuals who continue with a chronic course of such aggressive behaviors following an early first episode. As described in the case of Jill, the presence of internal forces, including active symptoms of mental illness and paranoia, and misperceptions such as disturbing auditory hallucinations, may result in fearful or defensive patient responses. Patients with delusional beliefs about being controlled by outside forces may act unpredictably or escalate rapidly into hostile behavior as a result of their illness. Your patients may misperceive your good intentions and exhibit uncharacteristic responses to your presence or benevolent offers of assistance. This was demonstrated in the above vignette, when Jill's response to a request from the case manager was, "You're the police anyway." A paranoid and inappropriate response like this should alert the case manager to the potential risk of proceeding without assistance.

In addition to psychotic mental illness, mood disorders, such as major depression, may dispose an individual to angry or hopeless emotions. These emotions should be taken seriously and respected. Such disorders are not uncommon precipitants to impulsive or aggressive behavior, and in extreme cases they have factored into murder-suicide attempts.

The presence of a personality disorder, primarily those disorders described as overcontrolled, may predict higher rates of violence toward the self and others. **Antisocial, narcissistic, and borderline personality disordered patients often lack the necessary interpersonal skills to stop aggressive thoughts and feelings from becoming actions.** Patients diagnosed with these disorders may develop significant emotional

intolerance and hostility, fueling potential escalation to violence when stressed.

The vignette above describes a patient with borderline personality as well as psychotic illness. Combinations of risk factors should increase the case manager's index of suspicion accordingly. Case managers should also assess the limits of intelligence or coping ability that their patients possess. In general, individuals with lower intellectual capacity represent a higher risk of impulsivity and impaired self-control compared with those with average or above average intelligence. Information pertaining to a patient's IQ is frequently reported or estimated within their mental health record. A patient with a low IQ may have impaired coping skills and lose control during periods of duress or even when faced with relatively minor changes in routine.

Community service providers frequently are called on to work with individuals with co-occurring substance use disorders and mental illness. **External forces influencing violent behaviors like the presence of drugs or alcohol are important to ascertain as part of a violence history and prevention plan.** The combination of the use of prescription medications with substances must also be considered in the case manager's risk assessment. **Substances that initially disinhibit and then depress emotions, such as alcohol, can lead not only to unpredictable case manager-patient interactions but also to dangerous postintoxication states.** The individual's mental state following intoxication can often manifest as highly irritable or confused behavior. In the case of alcohol withdrawal, these signs and symptoms may represent an acute medical emergency: delirium. Use of activating drugs, such as cocaine or amphetamines, create a twofold risk. The first reaction may include hyperactivity and overreactivity that may further impair a patient's judgment. Second, the level of risk to an intervening case manager can increase in parallel with the individual's craving to acquire more of the drug. This can be considerably menacing if a patient's expectation for money or other support differs from that delivered by a case manager.

Owning and possessing knowledge of weapons use can also contribute as an external risk factor. As case management services are often provided in high-risk urban areas, the presence of weapons obtained legally or illegally for protection by patients, their roommates, or family members may pose a substantial risk. The risk of violence and lethality to both self and others can rise substantially in the presence of firearms in concert with other known risk factors, primarily drugs and alcohol. Individuals with special expertise with weapons, such as law enforcement and military personnel, should be questioned about their possession of weapons and ammunition and intention for use. A review of their beliefs and potential for use of weapons when angry or stressed should, if possible, be obtained by the case manager.

Another predisposing external risk factor for violence can include witnessing family violence during developing stages of life. A history of violent physical or emotional trauma to patients by their caretakers may reinforce destructive responses during periods of routine conflict. Learned or sanctioned violence present during family conflict may also increase the likelihood of similar behaviors by dependents. Disagreements and differences of expectations occur regularly between patients and their caretakers. Aggressive or hostile learned responses, if not managed adeptly, can predispose case managers to dangerous patient interactions.

Reviewing the circumstances surrounding past and recent violent incidents can further enhance risk assessment. Determining whether the violent behavior was in self-defense, the result of a mental illness, or more of a predatory-type behavior is important. Such detail may provide clues to how a patient with a violent history may react under similar circumstances. This information can also provide clues to a patient's respect for social limits and the law and may allow a general appraisal of their appreciation for consequences of their behavior.

Transporting patient funds and medications in public areas poses a particularly high risk to case managers. As in the scenario above, it was the case manager's role to deliver prescriptions, if necessary, and money to Jill.

**Table 1**  
**Medication Compliance Risk (Patient)**

- Has trouble remembering to take medication every day
- Living circumstance may lead to loss of medication
- Problems with thinking and processing
- Substance abuse
- Limited insight into illness
- Irregular routine
- Embarrassed to take medication (afraid of stigma)
- Complains of medication side effects that may lead to discontinuation
- Stops medication when feeling better
- Paranoid thoughts regarding medication (poisoning, etc.)

In this example, this initially would have taken place in an isolated area on a weekend. On leaving the patient's apartment, the surroundings changed quickly in the residence lobby. The unfamiliar individuals gathered there may not necessarily recognize or appreciate the case manager's benevolence. Providing case management services in notorious high-crime areas must be given strict attention by staff and supervisors. Serving these locations may dictate pairing up or similar proactive strategies for home visitation, discussed later in this lesson. Finally, the level of maturity, available oversight, and professionalism inherent to the case manager must be considered.

The literature indicates that younger mental health workers have a higher rate of assault than their older colleagues. This may be a factor of professional experience, training, hours of work, and level of enthusiasm. Moreover, for a case manager, time spent with highly impaired patients may contribute to burnout and low frustration tolerance, often in the face of inadequate professional reimbursement and stature. Such pressures without adequate supervision and consultation can place the case manager at substantially more risk for a violent encounter or other unfortunate event.

## Skills for Preventing and Deescalating Crises

Case managers in their role as front-line professionals may be able to dictate the tenor of an interaction with their patient. Keys to initiating and maintaining a safe and effective patient encounter stem from strong preparation and maintaining a respectful demeanor. Prevention of violence against case managers is a two-way street. Patients will perceive quickly if a case manager is in a hurry, not paying attention, or dismissive. There is usually nothing to gain but a poorer outcome following a demonstration of disdain, disrespect, or nonsensical confrontation with your patient. On review, most violent interactions between mental health care workers and their patients reveal several overt signs of escalation before the incident itself. To execute safe delivery of case management services, the role of the professional is not only to avoid being party to contributing factors of violence but also to be vigilant for signs of impending violence in their patients.

Most violent behavior committed by patients has a prodrome; these are typically warning signs that imminent interpersonal danger is lurking. Examples of prodromes are commonly apparent, yet they require constant vigilance, mental preparation, and observation by the case manager. During the early escalation phase toward violence, individuals typically show physical and verbal cues such as muscle tension, clenching of fists or teeth, and statements related to fear of losing control. Progression from this stage may include the patient being loud and verbally abusive, boasting of prior violence, and making a mess of surroundings or throwing items. The final phase before actual violent behavior often constitutes pacing, threatening gestures, and cursing, along with property destruction. The most significant portion of this stage is determined by pointed and clear threats to others. Case managers faced with this level of agitation should always take such threats seriously. They must also consider immediate termination of the encounter, an exit strategy, and a plan of action to then assist the patient in distress.

Exiting a situation in which a patient poses a threat to safety or demonstrates a high level of agitation is critical to safety in the community setting. By virtue of such nonsecure environments being essentially unpredictable and uncontrolled, and of working with unscreened patients, removing yourself from potential danger is the most important step. Further discussion or planned interventions should be put on hold, and attention to your safety and avoiding further escalation toward violence should be made a priority. If you encounter your patient at an early stage of preaggression, a number of verbal and nonverbal techniques can be employed to avoid or reduce the probability of a crisis.<sup>25</sup>

Methods to minimize the risk of an upset patient escalating into violence require practice and confidence. It should be mentioned up-front that these verbal and nonverbal techniques should never be a substitute for exiting a near-out-of-control situation. The following measures, suggesting methods to safely talk with a potentially violent patient, should only be applied once you have carefully determined that your safety and that of others are not at risk.

## Steps to Take When Talking With an Upset or Potentially Violent Patient

*Always approach the patient in a calm manner.* Walk slowly, speak softly, and avoid direct eye contact at first.

*Attempt to maintain a sense of “passive control.”* You may be fearful and should be cautious. **It is appropriate to admit this to a patient, as you are not attempting to confront, but rather to appreciate their level of distress.** Focus on presenting a level of professionalism, control, and confidence that you are there to assist the patient.

*Speak in soft, slow manner; speaking briefly is best.* Avoid passing judgement or discussing provocative topics, and aim to further reduce the agitation of the patient. Be respectful, but appreciate your limits for abusive interactions and exit if basic boundaries are breached.

*Offer to listen and allow the patient to vent.* Initially avoid interruptions or interpretations of patient statements. Do not begin or continue your visit during physical hostility or destructive behaviors.

*Use connecting or alliance building emphatic statements, such as, “You appear to be very upset/angry/sad,” etc.*

*Provide adequate space between yourself and the patient.* Offer the patient a place to sit, a cold beverage, or a moment to calm down. Inquire whether your patient requires any other immediate needs. Attempt to satisfy them if they are reasonable, practical, and sensible. Speak only to a sitting patient—and you should be seated as well. This posture is disarming and presents a nonconfrontational posture to your patient.

*Consider requesting security, a coworker, or other trained staff to be present during your encounter.* If you have assistance, introduce this person to the patient and explain why you have requested him or her (safety, teamwork, protection, etc.)

*Never promise what you cannot deliver.* Offers of money, passes, and/or entitlements that cannot be provided may set you up for acts of retribution and can destroy any alliance that may have been developed.

*In the interview environment, preparation is your best defense.* If you are concerned, request a pat search of the patient by trained personnel. Consider your surroundings for objects that could be destroyed or used to harm you or others. If in an office setting, know the location of panic buttons, alarms, or emergency numbers at your disposal. Post these numbers conspicuously. Allow a clear visual and physical exit for your patient from you during an interview. Blocking a door or exit can heighten paranoia or increase agitation in a frustrated patient. Allow for a clear exit for you from your patient in case an urgent escape is needed. Never chase a fleeing patient; call for law enforcement assistance if retrieval is necessary.

## Safe Home Visits and Environmental Assessment

Like a surgeon in the operating room, it is best for the case manager to prepare and plan accordingly for unex-



**Table 2**  
**Safety Guidelines when Making Home Visits**

1. Always inform colleagues of your destination. Include a sign out sheet, telephone numbers, anticipated visit length, patient's name and address.
2. Use 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 coworker.
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 patient's home stand at the side of the door when knocking or ringing the bell.
12. When entering inside a 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 patient.
15. Avoid mediating a domestic quarrel or disturbance.
16. Be careful to avoid invading a patient's personal space. Avoid potentially perceived threats to a patient or his/her family, and confront judiciously.

pected outcomes for each home visit. The case manager should consider and attempt to answer "What if" at any point during an encounter if a component of his or her plan falls through or changes.

In the above vignette, the case manager parked and realized that he or she was on the wrong block. At this point, a decision was made to walk the rest of the way, as opposed to the potentially safer option of returning to the vehicle and moving closer to the patients address. In this case, during the weekend, in unknown sur-

roundings, and with a potential crisis visit at hand, the prudent decision for the case manager would be to keep the vehicle close to the destination. Table 2 represents some practical guidelines for performing residential visits, including working in pairs during initial patient visits and for high-risk cases or locations thereafter.<sup>1</sup> In the case of Jill, a review of these guidelines would have suggested having a sign-out protocol for all case management services. The case manager in this vignette was notified by an answering service message. No definition of a meeting time was delivered or confirmation of the visit communicated. The case manager also failed to take a cell phone into the residence as a useful precaution. A dog was heard barking in the hallway, indicating additional risk to the case manager's safety. On arrival, the case manager stood directly in front of the door. If a patient or another resident misperceives your visit or intentions, you have become a direct impediment to their exit and potentially a target of a quickly opened door or a projectile. As an experienced case manager in the above vignette, recognition of the presence of empty alcoholic drinks and the odor of illicit drugs provided another signal of considerable risk. Interaction with an intoxicated individual should be avoided if at all possible. In cases like this, the case manager should plan for another time to meet and avoid a potentially disastrous outcome.

The points below are a representative sample of common suggestions for case managers performing outreach services. These points should be adjusted according to your particular circumstances. Examples of such variables include the use of public transportation, location of service delivery, availability of communication devices, and staffing patterns dictated by your agency.

## Keys to Transportation Safety<sup>26,27</sup>

Case managers are often responsible for transporting patients to services. Personal transportation of patients can present one of the most significant areas for dangerous events and deserves an equivalent level of attention. Clear guidelines should be set out and followed by the case manager and his or her agency and communicated clearly to the patient to be transported. The preferred method for transporting patients is public use of buses, trains, and taxis. In many communities, public transportation is limited, and in some cases, patients' impairments resulting from mental illness may preclude their solo use. When practical, patients should be encouraged to travel independently or should work toward development of that daily living skill. Benefits derived from accompanying the patient include opportunity for advocacy and other necessary assistance. As a general rule, if there are safety concerns, it is recommended that mental health case managers should be given discretion as to whether they transport an individual or not. Other arrangements should be sought based on the level of concern. This may include the use of trained mobile crisis or law enforcement personnel.

### High-Risk Transport Situations

Case managers should not transport individuals in the following circumstances: the patient is agitated, suicidal, or threatening; the patient appears intoxicated; the patient is in medical distress; or the patient is experiencing a psychiatric crisis.

Case managers may transport patients via an agency vehicle or use their own car. As with safety concerns during residential visits, working in pairs is the preferred approach during transport. It is not recommended that case managers transport a patient's family member, friend, or significant other. Conversely, case managers should never transport other nonprofessional staff like family or friends during patient encounters. Direct services during assigned work hours provided by case managers are for the patient only. Alternate transportation should be found for additional passengers to avoid any further risk or potential liability. If a case

manager is transporting a patient in a vehicle, a sound policy to maintain is that all riders sit in the rear passenger seat. It is also important to remind all riders that they must wear a seatbelt while in transport. All patients should be notified in a respectful manner of this policy before entering your vehicle. As a rule, transporting a patient should not proceed until these standard requirements are met.

When picking up a patient, the case manager should always meet and greet him or her outside of the vehicle. It is important to follow this simple set of steps to improve your ability to assess the patient and to determine whether or not your safety may be in jeopardy. On arrival at the patient's location, park the vehicle, remove your keys, and lock the vehicle. When you greet the patient, pay particular attention to his or her emotional state, his or her responses to your inquiries, and other warning signs for risk, such as intoxication. Reminding your patient of where and what the purpose of the visit will be before transporting is essential. Any misperceptions, different expectations, or confusion should be handled before entry into your vehicle.

Before transport, remind your patient that your agency's policy is for riders to be situated and belted in the rear passenger seat. Placing a soft article like a gym bag in the driver's side rear seat will force your patient to sit toward the safer, rear passenger side position. Having the patient in this location provides the driver a clear view of the patient and naturally creates the most distance between the patient and the driver and the vehicle steering wheel. This precaution minimizes the likelihood of physical interruption of the driver by the passenger. Moreover, driving with a preference for the right lane of traffic can augment the safety between the case manager and patient. If a patient is intent on exiting the vehicle, he or she can do this away from direct traffic, plus, this gives the driver the option of pulling over rapidly to the shoulder if the need arises.

An additional safety measure is to let your patient know early on that they can change their mind and refuse travel at any point before or during transport. The patient should be afforded the choice to request the driver to stop and allow their exit or to return them

to their place of origin at any reasonable time. Also, planning ample time to pick up and transport your patient will minimize stress related to excessive haste or tardiness.

Maintaining a casual conversation with your passenger and discussing nonclinical topics are recommended when transporting patients. This practice avoids raising or responding to emotionally charged clinical issues that may lead to escalated and unpredictable behaviors. Such material is best avoided or delayed until after transport has been completed.

### **Communication and Documentation:**

The foundation for dispensing and gathering relevant information for case managers is based on communication. This can take the form of record review, discussion, or consultation with colleagues and team members as well as direct interview of the patient. The safe practice of case management is also established on clear and proactive communication skills. Identifying a case manager's whereabouts or notifying your agency of a change in plan, location, or patient status requires coordinated, predictable, and routine patterns of communication.

Use of a sign-out system can improve tracking and identification of a case manager's whereabouts. Maintaining a simple sign-out sheet reflecting the case manager's name, time leaving the home agency, expected time of return, and location of intended visit can provide a significant level of information during an emergency situation. If necessary, additional staff can be dispatched to the intended site and law enforcement or other emergency services can be notified of a case manager's intended destination. This proactive, basic, and inexpensive method of communication provides supervisors, colleagues, and administration with a certain degree of confidence for locating a staff member if necessary. Attention to sign-outs allows early monitoring of a case manager's status and their whereabouts and signals who is available or when they might be expected to return to their home base.

More mental health agencies are supplying case management staff with cellular phones and similar commu-

nication devices to improve safe service delivery. Effective use of these devices requires knowledge of special features, such as one-touch dialing and quick access to emergency services. Some phones are equipped with Global Positioning Systems that give emergency services a method of locating the owner holding that device. The utility of mobile communication device like a cellular phone is maximized if the phone is always on, in working order, charged, and carried by the case manager during all working hours. In the vignette above, the on-call case manager realized too late that the cell phone had been left behind in his or her car. This simple lack of preparation could make the difference between a safe patient encounter and one with no chance of establishing emergency contact if necessary.

### **Documentation**

Documenting your case management services serves many important safety functions. Clear and clinically relevant documentation of services can support the efforts of a case manager and effectively complete the picture drawn by the treatment team of the status of their patient. Adequate documentation does not have to be exhaustive in length, but it is best when it legibly describes the services delivered, the rationale why or why not services were delivered, and the general state of the patient during an encounter. This form of ongoing communication in a record form offers multiple snapshots that can inform colleagues about safe and productive ways to work with each individual patient. Providing details of successful as well as unsuccessful interactions can potentially not only save your colleague excess time and effort but also improve their safety by creating a coherent review of risk factors for violence and successful techniques to manage them.

### **Summary**

This lesson offers a review of proactive and preventative approaches to safe case management practice. As case management service providers continue to face more acute and potentially unpredictable patients in uncertain circumstances, safety training is warranted as a primary prevention tool. Focusing case managers on

maintaining an awareness of the assessment of risk factors for violent behavior, predicting volatile surroundings, and learning interview techniques to prevent and deescalate crises is crucial to this training. Critical issues surrounding safe patient transportation, home visits, and methods to improve communication skills and documentation should also be considered. In addition to benefiting case management staff, the SAVE curriculum can be adapted and applied for use with other front-line staff including group therapists, residential

program staff, counselors, and mental health technicians. Violence prevention and safety training requires a commitment of time and effort on the part of those who supervise as well as those who provide case management. **Making this important investment in safety training may pay substantial dividends, including more effective delivery of services to patients, fewer incidents of violence, and improved case manager morale and job satisfaction.**

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## Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

45. Which of the following is/are included in the definition of violent behavior?
- A. Physical assault
  - B. Verbal threat
  - C. Stalking behavior
  - D. All of the above
46. In the vignette, all of following are risk factors for potential violence, *except*:
- A. Substance abuse
  - B. Other individuals in the apartment
  - C. Size of the patient
  - D. Borderline personality
47. Appropriate methods to deescalate a crisis situation include:
- A. Approaching the patient calmly
  - B. Announcing your own fear to the patient
  - C. Avoiding physical contact
  - D. All of the above
48. Potential outcomes of ongoing safety training and violence prevention for case managers include all of the following, *except*:
- A. Reduced violent incidents
  - B. Improved delivery of services
  - C. Higher job satisfaction
  - D. Less need for case managers

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