

## **II.B: OBSERVATION/ASSESSMENT SKILLS TO PREDICT CONFLICT (15–30 minutes)**

### **TRAINER NOTE: Group Exercise on Identifying Crisis Predictors**

Break the trainees into small groups of five or six depending on the number of trainees and instruct them to brainstorm about all of the factors that might predict or contribute to disruptive or violent behavior. Ask the groups to make two lists, one for factors within individual tenants, and another for factors within the program or social environment that could be predictive. You will probably need to give an example of each before they begin. After the small groups report back to the larger group, review the following together. See **HANDOUT #2: WARNING SIGNS OF IMPENDING VIOLENCE**.

**TRAINER STATES:** The purpose of this training is to equip you with the tools you need to intervene in crisis situations swiftly and effectively. One of the first skills you will need is knowing how to assess a crisis or conflict. While it often appears that crisis situations comes out of the blue, usually, at least in retrospect, there were clear signs that a problem might be brewing, particularly if you know what to look for. Let's look at some of the predictors of a crisis.

#### TENANT FACTORS

- Changes in Baseline Behavior (increase or decrease in ADL skills)
- Past History of Violence (#1 Predictor)
- Low Frustration Tolerance (knowing a person's triggers is useful)
- Change in psychiatric symptoms (increased paranoia, shift in baseline)
- Anniversary Reactions (e.g., anniversary of the death of someone special or a date that has particular significance, either positive or negative)
- Aggressive Body Language (pacing, hand wringing, agitation)
- Aggressive Verbal Content (provocative, inflammatory or paranoid statements)
- Change In Medications (noncompliance, lower dosage, new trial, new side effects, including insomnia, restlessness, agitation, sedation)
- Substance Abuse (Most drugs and alcohol increase the potential for violence by disinhibiting one's emotions, such as anger, and making it easier for people to act out aggressive impulses. Substances may also lower the Serotonin neurotransmitter in the brain, which correlates with anger and depression. There may be little warning if a tenant suddenly starts using again. Relapses can often be predicted. People in the recovery process should be closely monitored.)
- Unresolved Conflict
- HALT (AA motto—Hungry, Angry, Lonely, Tired)

### ENVIRONMENTAL FACTORS

- Tension Centers (every supportive housing building has tension centers, areas where it is known that arguments arise because of conflicts or obstacles in getting needs met: TV room, public phone, food lines)
- Climate (bad weather, snow or rain can increase tension if persons feels "cooped up;" hot weather can cause agitation)
- Changes in Normal Routine (therapist on vacation, change in schedule, visit from family, staff turn-over)
- Special Times of the Month ("Check day," visit with the psychiatrist or Medical Clinic day)
- Social/Political/Racial Tensions (persons may feel discriminated against, delusional material may get stirred up by current events)
- Unresolved Conflicts
- Unmet Needs (managed care denying access to services resulting in shorter hospitalizations, bad romance, recent disappointments)

**LEARNING POINTS:** If you can better tune into the predictors of crisis and learn what to assess for, you can become better prepared to intervene early and prevent a crisis from escalating.

**III.D: CRISIS PHASE AND CORRESPONDING INTERVENTIONS** (10–20 minutes)

**TRAINER STATES:** The “crisis phase” is characterized by the person becoming totally out of control and jeopardizing his or her own safety or the safety of others.

**CASE:** Bill continues to deny that he took John’s Walkman. John grows angrier and reaches behind the chair on which he was sitting. He stands up and pushes Bill. Bill falls to the ground with John standing above him. John strikes Bill with his fists stating that he wants his Walkman back.

**TRAINER ELICITS:** WHAT WOULD YOU DO NOW? [Expected responses include:]

**TEAMING:** If there are other staff around, the most effective intervention is to work as a team. Each person’s role on the team should be clear before the situation erupts. As new staff comes aboard, they should be trained about emergency response and their roles. The principal of teaming is to break up essential tasks. In this case, the following roles should be designated prior to a crisis encounter:

- Talking and “listening” the tenant down: An agitated person usually responds better to one person interacting with them rather than several staff. A person who knows the tenant best may be the natural choice here. Listening with empathy can help de-escalate an angry person. However, if you feel threatened, know how to back down/back out. (“I’ll be right back, what your saying is very important and I want someone else to hear as well.”)
- Crowd control: Someone should be responsible for clearing the area of onlookers and escorting the rest of the tenants to a safer place. This also may include asking tenants to wait in their apartments until the problem has been resolved.
- Calling 911: Someone should be designated to this task and should be clear about how to request help on the scene. We will go over these directions later in the training when we review how to involuntarily hospitalize a tenant. Sometimes it is helpful to have a code word so a worker does not have to shout “Call 911!” across the room, but instead says to other staff: “I’m thirsty, and want some water. Do either of you want some?” Most often, staff can indicate to other staff by conveying a “look” that indicates emergency services should be called.
- All staff should secure the area by removing sharp items such as scissors, three-hole punches and other potential weapons when there is indication that someone is escalating. This again can be communicated by a code word to diminish heightened anxiety.

### TIPS FOR WHEN YOU ARE ALONE:

- Discuss policies and procedures beforehand with supervisor so you are prepared to intervene
- Maintain good communication between shifts (use shift logs and reports)
- Notify someone to “check in” by calling you throughout your shift
- Use tenants you feel can assist you in the situation (calling emergency services)

**TRAINER STATES:** PHYSICAL RESTRAINT — When we are talking about how to intervene in violent situations, we recognize that your possibilities for intervention are determined by the setting you work in.

**TRAINER ELICITS:** HOW MANY OF YOU WORK IN AGENCIES THAT ALLOW STAFF TO PHYSICALLY INTERVENE OR RESTRAIN AN AGITATED TENANT? [Expected responses include: Most agencies do not sanction this.]

### BRIEF LECTURE:

Because of liability issues, most housing sites do not allow, teach or sanction employees to lay hands on tenants, even if it is to protect a tenant from physical harm or in self-defense. This clearly is frustrating to some who feel they have a moral obligation to step in and protect another tenant or staff from physical harm, particularly when they feel qualified to exercise physical restraint. While we cannot present you with techniques of physical restraint or even tell you how you should handle a situation if the policy says one thing and your gut says another, we can ask you to consider the following questions when determining how you should intervene:

1. What is my relationship with the tenant/tenants involved? How might they respond to physical intervention? Are there other tactics I could use?
2. What is my agency policy about physical intervention? How supportive would my supervisor/agency be, given my choice of physical intervention, in this situation? Is someone’s life in danger? Is there a potential for serious physical harm?
3. What level of jeopardy exists for others nearby?

Given the above suggestions, there are still many other intervention tactics aside from physical restraint that can diminish the potential for the escalation of violence. Let us review them now.

## PERSONAL SAFETY AND SELF-PROTECTION SKILLS

## **PROTOCOL FOR IMPLEMENTING AN INVOLUNTARY HOSPITALIZATION**

The issue of hospitalization should be raised with the tenant, if possible. For hospitalizations done on a voluntary basis, admissions can be arranged beforehand with the hospital or the managed care/insurance plan.

If you suspect that such a discussion could result in violence, then the tenant should not be informed of the hospitalization until after the police or EMS have arrived.

1. Notify all staff and security of impending action, assign roles and coordinate plans.
2. Move tenant to private space, or, if necessary, ask other tenants to clear the area. All potential weapons and sharps should be removed beforehand. A staff member should be with the tenant at all times.
3. Designate a signal for staff communications around calling emergency services. For example, if two staff are with the tenant, one may say, "I'm thirsty, and want some water. Do either of you want some?" This would alert staff that the designated person will call emergency services. When staff has worked together for some time, a certain "look" from one person to the other will indicate calling emergency services.
4. Call emergency services requesting a transport for someone who is dangerous to self or others. Be prepared to give tenant information: name, age, address, type of residence, Medicaid #, medications.
5. Gather documentation. This can be a form letter which is kept for psychiatric hospitalizations. It should include:
  - name
  - date of birth
  - dx (psychiatric and medical)
  - meds
  - hx of psychiatric illness (last hospitalization, doctor's name, etc.)
  - reason for current need for inpatient stay detailing homicidal or suicidal ideation/behavior.

Make three copies, one for the EMS team, one for the ER and one to accompany the tenant to the unit.

6. When emergency services arrive, speak to the person in charge. Be specific when emphasizing behaviors or statements indicating need for psychiatric evaluation.
7. Attend to the fears/concerns of tenants who may be witnessing the events.
8. Accompany tenant to hospital in the ambulance, if possible.
9. Present ER staff with documentation, and request to speak to the attending doctor and the social worker.
10. Remain at the ER until the tenant is admitted.
11. Exchange names and numbers with the ER staff or the floor staff, if tenant has been moved already.
12. Reassure tenant that you will be in close contact, and make sure s/he knows how to reach you. Offer quarters for the phone and food or cigarettes, if allowed.
13. Call tenant's outpatient psychiatrist and inform them of the hospitalization.

**IV.D: PSYCHIATRIC DECOMPENSATION** (10–20 minutes)

**TRAINER STATES:** Psychiatric decompensation is something that is often very upsetting for the staff and tenants involved, but it is to be expected in buildings housing people with special needs. Decompensation can occur for many reasons but sometimes is related to stress, such as moving in, or even successes, like graduating from a program.

As we discussed earlier, the most important thing to look for is change in baseline behavior, such as deteriorating ADL skills, isolation or change in socialization. Psychosis can be managed if the person is receiving treatment and is closely monitored. Hospitalization is necessary when the person is a danger to themselves/others.

**TRAINER ELICITS:** WHAT KINDS OF THINGS WOULD YOU NEED TO ASSESS IN DETERMINING WHETHER THE PERSON IS IN IMMEDIATE DANGER? [Expected responses include:]

- Is the person experiencing command hallucinations?
- Are the voices saying derogatory things to her or him?
- Are the voices telling her or him to harm someone?
- Is the person taking care of him/herself: eating, sleeping and functioning?
- Is the person able to keep outpatient appointments?
- Is the person acutely paranoid, agitated, incoherent, non-responsive, completely out of touch with reality?
- Is the person's disorganization/actions posing a threat to him/herself and/or others?

**TRAINER STATES:** Just like with suicidal crisis, communication is vital. Social service staff can communicate with property management without violating confidentiality. For example: "I am really worried about Joe. Could you page me if you observe anything strange in his behavior?" Remember, observed behavior is never confidential. It is possible to alert staff to a tenant's behavior without discussing confidential matters.

**LEARNING POINTS:** Early intervention with tenants experiencing psychiatric decompensation may prevent or reduce hospitalization and disruption of living routines. Workers will learn to assess for changes in baseline behavior and signs of decompensation.

**IV.E: MEDICAL CRISIS** (10–20 minutes)

**TRAINER STATES:** There will be times when a medical emergency occurs in your program. All staff should be prepared. Knowing CPR, the number for poison control, universal precautions practice, etc. should be part of training. Security and front desk staff should be informed of all protocols since s/he will most likely play an active role in many interventions.

As mentioned before, staff should discuss living wills, health care proxies, advance directives and “Do Not Resuscitate” (DNR) documents with tenants *before* a crisis occurs. Staff should also be knowledgeable about how to access medical support services such as transportation, home health aide, hospital beds and other supports. Establishing a good relationship with the local hospital, emergency crisis teams and area community support services is important. These relationships can facilitate communication during a crisis.

**LEARNING POINTS:** All staff must know their agency’s policies on management of medical crisis. Additionally, tenants should have any advance directives clearly identified in a place where they can be easily retrieved in the event of a medical crisis.

Murdach, A.: "Working with Potentially Assaultive Clients." *Health and Social Work*, (18/4): 307–312, 1993

This article discusses a variety of reasons why violence occurs, how clinicians and other social service professionals can recognize clues to impending danger and various clinical approaches for intervening.

Rooney, R.: *Strategies for Work with Involuntary Clients*. Columbia University Press, 1992

This book discusses techniques to engage difficult clients and work effectively with treatment resistance.

Yeates, C.; Cholette, J.; Duberstein, P.: "Suicide and Schizophrenia: Identifying Risk Factors and Preventative Strategies." *Medscape Mental Health*, 3(3), Medscape, Inc., 1998

This article discusses the prevalence of suicide and suicide attempts among different groups of people diagnosed with schizophrenia and outlines risk factors and implications for preventive strategies

#### Internet Sites:

Center for Urban Community Services

<http://www.cucs.org>

Center for Urban Community Services (CUCS) provides a continuum of supportive services for homeless and formerly homeless people, including street outreach, a drop-in center, transitional and permanent housing programs, and vocational and educational programs. Particular emphasis is placed on specialized services for people with mental illness, HIV/AIDS and chemical dependency. This website provides information and links to a variety of resources regarding transitional and permanent housing.

Corporation for Supportive Housing

<http://www.csh.org>

CSH's mission is to help communities create permanent housing with services to prevent and end homelessness. CSH works through collaborations with private, nonprofit and government partners, and strives to address the needs of tenants of supportive housing. CSH's website includes a Resource Library with downloadable reports, studies, guides and manuals aimed at developing new and better supportive housing; policy and advocacy updates; and a calendar of events.

### Guidelines for Workplace Violence Prevention Programs

[nsi.org/library/work/violence1.html](http://nsi.org/library/work/violence1.html)

This website offers visitors both an outline and text on recommended guidelines for workplace violence prevention.

### National Alliance to End Homelessness (NAEH)

<http://www.naeh.org>

The National Alliance to End Homelessness (NAEH), a nationwide federation of public, private and nonprofit organizations, demonstrates that homelessness can be ended. NAEH offers key facts on homelessness, affordable housing, roots of homelessness, best practice and profiles, publications and resources, fact sheets and comprehensive links to national organizations and government agencies that address homelessness.

### National Resource Center on Homelessness and Mental Illness

<http://www.prainc.com/nrc/>

The National Resource Center on Homelessness and Mental Illness provides technical assistance, identifies and synthesizes knowledge, and disseminates information. Users can be linked to findings from Federal demonstration and Knowledge Development and Application (KDA) projects, research on homelessness and mental illness, and information on federal projects.

### Training Institute for Suicide and Clinical Interviewing

[www.suicideassessment.com](http://www.suicideassessment.com)

This website is designed specifically for mental health professionals, substance abuse counselors, school counselors, primary care physicians, and psychiatric nurses who are looking for information on the development of suicide-prevention skills, crisis-intervention skills and advanced clinical interviewing skills.