

Crisis and Conflict

curriculum

supportive housing training series

Crisis and Conflict

Curriculum

Developed by Center for Urban Community Services

The work that provided the basis for this publication was supported by funding under an award with the U.S. Department of Housing and Urban Development to the Corporation for Supportive Housing. The substance and findings of the work are dedicated to the public. The author and publisher are solely responsible for the accuracy of statements and interpretations. Such interpretations do not necessarily reflect the views of the Government.

Crisis and Conflict is part of the Supportive Housing Training Series. This training series currently includes eleven curricula providing best practices and guidance on supportive housing development, operation and services.

The full series is available for downloading from the Department of Housing and Urban Development website.

For more information:

U.S. Department of Housing and Urban Development: www.hud.gov

Center for Urban Community Services: www.cucs.org

Corporation for Supportive Housing: www.csh.org

HUD CURRICULUM

PREVENTING AND MANAGING CONFLICT & CRISIS

PURPOSE AND GOALS: This six-hour training for staff of supportive housing will focus on a variety of conflict and crisis situations one might encounter in supportive housing. The goal of this training is to provide participants with tools to identify, intervene and follow-up on incidents that fall into this category. The training will also explore programmatic issues that impact intervention and outcome of crisis and conflict situations in supportive housing.

AGENDA

- I. INTRODUCTION** (25–45 minutes)
- II. STRATEGIES FOR CRISIS PREVENTION**
 - A. Knowing Our Own Response (10–20 minutes)
 - B. Observation/Assessment Skills to Predict Conflict (15–30 minutes)
 - C. Communication Vehicles (10–20 minutes)
 - D. Staff Roles (10–20 minutes)
- III. RESPONDING TO PHYSICAL CONFLICTS**
 - A. Overview of the Assault Cycle (10–20 minutes)
 - B. Triggering Phase and Corresponding Interventions (10–20 minutes)
 - C. Escalation Phase and Corresponding Interventions (10–20 minutes)
 - D. Crisis Phase and Corresponding Interventions (10–20 minutes)
 - E. Recovery Phase and Corresponding Interventions (10–20 minutes)
 - F. Post Crisis Phase and Corresponding Interventions (10–20 minutes)
- IV. CONFLICT/CRISIS CASE SITUATIONS AND STRATEGIES**
 - A. Acute vs. Non-Acute Situations (10 minutes)
 - B. Voluntary vs. Involuntary Hospitalizations (10–20 minutes)
 - C. Suicidal Crisis (10–20 minutes)
 - D. Psychiatric Decompensation (10–20 minutes)
 - E. Medical Crisis (10–20 minutes)
 - F. Substance-Induced Crisis (10–20 minutes)
 - G. House Rule and Lease Violations (10 minutes)
- V. CASE APPLICATIONS** (30 minutes–1 hour)
- VI. PROGRAMMATIC INTERVENTIONS** (30 minutes–1 hour)
- VII. CONCLUSION** (10–20 minutes)

HANDOUTS

1. Agenda
2. Warning Signs of Impending Escalation/Violence
3. The Assault Cycle
4. Strategies for Intervening in Violent or Potentially Violent Situations
5. Anger Management Techniques
6. Seven Steps to Resolving a Conflict
7. Guidelines For Developing Emergency Policies and Procedures
8. Protocol for Implementing an Involuntary Hospitalization
9. Suicide Prevention and Assessment
10. Comparisons of Signs and Symptoms Across Categories of Substances
11. Case Studies
12. Programmatic Interventions for Crisis Prevention
13. Emergency Policies & Procedures Guidelines
14. Bibliography

TRAINER'S PREFACE FOR CRISIS AND CONFLICT CURRICULUM

I. Brief Summary of Curriculum Content

This curriculum contains at least six hours of verbal content. This does not mean that the entire content must be covered. Depending on the intended focus of the training and the format (exercises and small group discussions vs. large group presentation), portions of this training can be elaborated, abridged and/or deleted.

II. Trainer Qualification

Key to the successful delivery of the curriculum and to participants learning is the qualifications of the trainer. What the trainer brings to the training session — including their knowledge about the subject being taught, their experience in supportive housing, and their training or teaching skills — will impact the quality of the training and the outcomes. This curriculum is intended for use by individuals with the appropriate constellation of talent and ability to manage the learning of others in the area of responding to crisis and conflict in supportive housing.

III. Good Training Practice

A. How People Learn

People learn through a combination of lecture, visual aids and participation. The more actively they are involved in the process, the more information they will retain. For this reason, eliciting answers from the group rather than presenting material is usually preferable. Additionally, it is important to include exercises that stimulate interaction and experiential learning and not spend all of the time lecturing. Be aware, however, that group participation and discussion takes more time than straightforward presentations and may cut down on the amount of content possible to cover. What is minimized or deleted from the curriculum should be based on the assessment of the group's learning needs and the goals initially contracted with the group.

B. Know Your Audience

The type of setting that the trainees work in and their roles will determine the areas of the curriculum that the trainer will focus on. Gathering as much information about the group beforehand is recommended. In order to create a safe and effective learning environment, it is recommended that the maximum number of participants not exceed thirty people.

C. Introductions and the Training Contract

Introductions should provide the trainer with more information as to who is the audience. The trainer will want to know the person's name, their program and their role, and what they hope to get out of the training. The trainer should then clarify what will and will not be covered. This is the training contract.

D. Acknowledge and Use Expertise of the Participants

This is important as it allows people to learn from each other, builds group cohesion, keeps people involved and establishes an atmosphere of mutual respect.

E. Flexibility

Throughout the training, the trainer should continually assess the needs of the group and revise the amount of time devoted to each specific topic. Responding to the needs and interests of the group must be balanced with the agreement to cover certain topics. It is the trainer's job to respond to the needs that arise and yet stay focused on the subject matter. For example, if some of the trainees have recently experienced a suicide or a violent incident in their setting and want to use the training to process what happened, the trainer should assess to what degree this will be instructive for the entire group and to what degree it will detract from the overall presentation.

IV. Training Content

A. Sequence of Content

Responding to and preventing physical violence is a topic of primary concern to the majority of trainees. Because this material can be anxiety-provoking for many, in our experience it is important that the subject of physical violence be addressed early on in the training. For this reason we suggest that if the trainer is attempting to cover the curriculum in its entirety, it is optimal to begin the training in the order that it is written (with the sections on violence preceding the other material).

B. Flexibility of Content

This training can actually be divided into two separate full-day trainings, depending on how in-depth the trainer intends to explore each topic area. The first three sections on **Strategies for Crisis Prevention** and **Responding to Physical Violence** can be combined with **Section V Case Applications** (only use case examples related to the material covered) and **Section VI Programmatic Interventions**, to comprise a full day of training on violence. Similarly **Section IV Conflict Situations and Strategies** can also be combined with **Section V Case Applications** (also use selected case examples) and **Section VI Programmatic Interventions** to comprise a full-day training.

The trainer should expect to delve more deeply into clinical issues with an audience that is primarily service based, just as they can anticipate spending more time on establishing policies and procedures with a group comprised of building management. With a mixed group, the trainer should strive to attain a balance.

C. Personalizing Content

In order to personalize the training, it is important for the trainer to offer case examples or anecdotes regarding the topic. This can also be achieved by eliciting stories from the trainees. Using these relevant stories will make the training more interesting and personal.

D. Matching the Content to the Target Audience

The target audience for this training is social service direct line staff and property management. Supervisory staff should attend this training to gain knowledge and understanding of the information provided to staff under their supervision. This will allow them to follow up and assist the trainees to interpret the skills learned into their practice.

V. Time Management of Content

Each section of the agenda has time frames allotted. The trainer should be aware that if a great deal of time is devoted to one topic area, other content areas might be sacrificed. Group exercises can always be abridged, if necessary, for time's sake. For example, if the group exercise involves dividing into four groups to work on four separate cases, the trainer should consider having each group work on a smaller number of cases. This will shorten the report back time, but will not eliminate the group process. Remember, elicitation and discussion takes more time than lecturing but less time than small group exercises. The trainer needs to balance this with the fact that lecturing is also the least effective way to learn.

The trainer will find that each time this curriculum is trained, it will vary. Being mindful of good training practice and making adjustments to the timing and sequence will allow for a tailored training that will be most beneficial to participants.

I. INTRODUCTION (20–45 minutes)

TRAINER NOTE: This section includes an introduction of the trainer, a review of the training incidentals (hours, breaks, coffee, bathroom locations) and a review of the training goals and objectives. This is followed by a roundtable introduction of trainees and any area about crisis & conflict they hope will be discussed.

TRAINER STATES:

- This training will focus on a variety of conflict and crisis situations that arise in supportive housing, including physical violence, suicidal ideation, psychiatric decompensation, medical and substance induced crises and house rule and lease violation.
- Dealing with crisis situations is never easy, no matter how well prepared one is beforehand. Knowing how to respond effectively can minimize the negative impact of the situation. Providing a road map for staff will increase the sense of control and professional response.
- The goal of the training is to provide staff with the tools that they need to identify and predict potential problem situations; intervene swiftly and effectively; and diffuse crisis situations and provide support following a crisis to the best of one's ability.
- In addition to learning specific techniques, the goal of today's training is to teach effective interventions in crisis situations. We will also discuss wider programmatic interventions, such as developing effective policies and procedures and implications for program planning and prevention.

TRAINER NOTE: Trainer will introduce him/herself to trainees, including experience in either supportive housing or service delivery. Each trainee is asked to introduce him/herself by stating name, agency, staff role and what s/he hopes to get out of the training. Trainer should write concerns of trainees on flipchart. Trainer will review agenda and link trainee concerns to agenda items for the day. If someone mentions something in the go round that is not on the agenda but related, see if it can be tied in at an appropriate point in the training. Similarly, if the group is interested in exploring certain topic areas more in-depth, the trainer may decide to shift some topic content.
SEE HANDOUT #1: AGENDA.

LEARNING POINTS: Trainer is establishing the learning contract for the day. It is important to discuss what will and will not be covered during this introduction so that trainees know what to expect — this is the learning contract.

II. STRATEGIES FOR CRISIS PREVENTION

II.A: KNOWING OUR OWN RESPONSE (10–20 minutes)

TRAINER NOTE: Read the following scenario. The purpose is to begin the session by helping trainees to imagine the “worst-case scenario” as a way of tuning into their own response in a crisis. After the scenario write three headings on flipchart: 1) feelings, 2) thoughts and 3) impulses, and record trainees responses accordingly.

CASE: It is 5:15 p.m. on a Friday afternoon before a long-awaited weekend. You are the only staff on-site. You are finalizing your last progress note. You hear yelling coming from the community room. Upon entering the room, you see Eddie, a new tenant, striking Alex, another tenant. Eddie is young and over six feet tall. He easily weighs over 300 lbs. Alex is 56 years old and small-framed. Alex is cowering with his hands over his face. Other tenants are pleading with Eddie to stop hitting Alex. Tenants begin to yell at you to help Alex.

- **FEELINGS/PHYSICAL SENSATIONS** — Fear, anxiety, overwhelmed, frustrated, alone, tired, anger, nausea, sweating, faintness, shortness of breath
- **THOUGHTS** — Why does this always happen to me? It’s someone else’s fault I’m in this situation. I wish I could get some backup. I just want to get out of here alive. I don’t know what to do. I want a new career. He deserves what he gets.
- **IMPULSES** — Run and hide, fight, yell for help, call the police, protect the victim, take care of the others, laugh, faint

TRAINER NOTE: Refer to the list made during the opening exercise and discuss how the potential responses fall onto a continuum ranging from fight/flight/freeze.

TRAINER STATES: Let’s look at the “response continuum”:

- How you respond to a crisis can influence or determine the outcome of the situation. It is important to recognize your own initial response when dealing with a fear-provoking situation and how that will affect what occurs next.
- **Flight, fight, or freeze response:** In times of heightened fear arousal, the increased adrenaline in our bodies can diminish our ability to think things through rationally. The primitive, instinctive response in fear-provoking situations and emergencies is the flight, fight or freeze response. When you experience a sudden burst of fear, blood rushes to our large skeletal muscles (such as the legs), making it easier to flee — and making the face blanch as blood is shunted away from it (creating the feeling that the blood “runs cold” or “drains from your face”). At the same time, your body might freeze,

probably because this was needed to gauge whether we might need to hide or run. Circuits in the brain's emotional centers trigger a flood of hormones that put the body on general alert, making it edgy and ready for action, and attention fixates on the threat at hand, the better to evaluate what response to make.

- The first and most primitive response, running away (flight), jumping in and fighting (fight), or becoming immobile (freeze), are all poor alternatives and can aggravate the situation at hand.
- As professionals, you are obligated to intervene and diminish the negative consequences. The purpose of this training is to help you develop responses that are not based on instinctive/primitive responses but rather more thoughtful and effective interventions. Let's look at how a range of different responses would play out in the situation.

TRAINER ELICITS: HOW MIGHT IT IMPACT THE SITUATION IF YOU DID NOT INTERVENE? [Expected responses include:]

Doing nothing may make the situation worse by conveying it's sanctioned, O.K. with the staff; someone could get hurt.

TRAINER ELICITS: HOW MIGHT IT IMPACT THE SITUATION IF YOU RESPONDED AGGRESSIVELY? [Expected responses include:]

The more you respond with aggression, the greater the likelihood that the situation will escalate. In some ways, an aggressive response fuels the fire.

TRAINER ELICITS: WHAT WOULD AN ASSERTIVE RESPONSE LOOK LIKE? WHAT WOULD BE THE OUTCOME OF THIS TYPE OF APPROACH? [Expected responses include:]

An assertive response would involve assessing the situation, reacting as calmly as possible, taking charge by verbally communicating to the tenants to stop, telling the others to clear out of the way. Communicating the consequences of the behavior and that emergency services have been called, etc.

LEARNING POINT: Trainees will have an understanding of how difficult it is to keep their wits about them (think) and not go into autopilot during a potentially volatile situation. Trainees will also understand the implications of a passive, aggressive and assertive response to conflict.

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.

II.C: COMMUNICATION VEHICLES (10–20 minutes)

TRAINER STATES: Whether or not you choose to discuss the situation with the tenant/tenants, once a conflict or crisis is assessed, it is essential to pass along the information to the rest of the team. Many incidents of violence and other types of crises such as suicidal behavior, could have been prevented if more attention was paid to communicating these warning signals.

Information considered confidential may not be shared between social service staff and property management. Property management and social service staff may share information regarding observable behavior in public spaces. Although observable behavior is not considered confidential, all information should be handled respectfully and with consideration for the tenant's well being. [e.g., John, a tenant living in your building, has been pacing the halls at night threatening neighbors. Social service may inform property management of the behavior but not his diagnosis.] Property management needs enough information so they can do their job.

TRAINER ELICITS: WHAT VEHICLES DO YOUR STAFF HAVE IN PLACE TO COMMUNICATE INFORMATION ABOUT POTENTIAL PROBLEMS? [Expected responses include:]

- incident reports
- incident review meetings
- log communication book
- rounds
- supervision
- team meetings
- calling supervisor
- paging supervisor
- chart notes

TRAINER ELICITS: WHAT VEHICLES FOR COMMUNICATION ARE IN PLACE OR SHOULD BE IN PLACE BETWEEN PROPERTY MANAGEMENT AND SOCIAL SERVICE STAFF? [Expected responses include:]

- intra-team meetings
- sharing incident reports
- writing memorandums

LEARNING POINTS: In order to prevent and/or manage crisis and conflict situations, it is important for staff to have communication vehicles established to ensure sharing of important information among staff. This section will help trainees consider which communication tools are most appropriate for their programs.

II.D: STAFF ROLES (10–20 minutes)

BRIEF LECTURE: Another vital aspect of dealing with conflict in supportive housing is to have a clear understanding of who does what when a crisis occurs. Both social service and property management staff should know what their role is in diffusing crisis situations before an incident.

It is not enough to have communication vehicles within your own staff, but also between these two entities. While social service staff is bound by principles of confidentiality, property management is not prevented from sharing information and should be encouraged to do so as much as possible.

Things that should be established beforehand include the following:

- Staff role in crisis intervention. Security and front desk staff, in particular, should have a clear understanding of this. They have the greatest potential for interacting with tenants and tend to be on-site with the least back-up.
- Procedures for communicating with staff on-site and off.
- Knowing circumstances when staff should handle the problem themselves.
- Knowing circumstances when staff should call emergency services.

LEARNING POINTS: While each program will have its own policies around how to communicate effectively, the important point here is that they should be as clear and specific as possible. Staff should be educated about emergency procedures during their orientation to the job and their role.

III.A: OVERVIEW OF THE ASSAULT CYCLE (10–20 minutes)

Although rare in supportive housing settings, encountering violent situations is a common fear among staff. Not only is there more exposure to violence in our culture, but people with special needs are more likely to have witnessed or been a victim to violence through the shelter system, criminal justice system, mental health or drug treatment systems.

Violence can be seen as a means for people who feel powerless to take control or “right the power equilibrium.” As a result of the various factors we discussed, including racial and cultural tensions, reduced access to treatment and the stigmatization experienced by people with special needs, the use of physical force may temporarily empower disenfranchised tenants by providing a sense of strength, even if only fleeting.

TRAINER NOTE: On flipchart, briefly review the stages of the assault cycle. See *HANDOUT #3: THE ASSAULT CYCLE*.

Violence does not usually come on suddenly, but rather builds to a crisis point. The concept of the assault cycle is that there are phases of escalation toward violence or explosive behavior. The worker should base their interventions on the stage of the assault cycle that the person is in.

- The cycle begins with what we call the TRIGGERING PHASE. This is when you first recognize that the tenant has changed his/her baseline behavior.
- Next is the ESCALATION PHASE or when the potential for a violent outburst is mounting and person(s) is displaying aggressive body language or verbal content.
- The actual CRISIS PHASE or “explosion” follows. During this phase, person(s) is posing a threat to him/herself or others.
- Subsequent to the crisis phase is the RECOVERY PHASE. At this point the immediate crisis has subsided, but there is still potential for re-fueling the incident.
- The last is the POST CRISIS DEPRESSION PHASE. In this phase, person(s) is usually remorseful and willing to discuss the incident and work with staff to avoid repeating.

We will now look at how to intervene the most effectively during each of these phases by walking through each phase of the assault cycle using the [Case Study of John and Bill](#).

LEARNING POINTS: Trainees will have a basic understanding of the assault cycle.

II.B: TRIGGER PHASE AND CORRESPONDING INTERVENTIONS (10–20 minutes)

TRAINER STATES: The “trigger phase” is characterized by a change in baseline behavior. This sometimes subtle shift can be an early-warning sign of potential conflict.

CASE: John is usually very talkative and friendly. For the last hour, he appears angry and disgruntled, muttering to himself in a corner. There are about six other tenants in the community room with him, all of whom appear to be keeping their distance.

TRAINER ELICITS: WHAT WOULD YOU DO IF YOU WALKED INTO THIS SITUATION? [Expected responses include:]

- Talk to the person
- Distract the person
- Take the person for a walk
- Document the uncharacteristic behavior

TRAINER STATES: As we have indicated, intervening at this point is most useful to prevent a full-blown crisis. You still have many options depending on how well you know the tenant, how you think they would respond to your concern/questions, your role and your available resources (Are you alone on shift?). Remember, it is easiest to intervene early in a crisis, even if that intervention only entails keeping an eye out for trouble: *stopping, looking and listening*.

LEARNING POINTS: Trainees will have an understanding of how to respond to someone who might be in the trigger phase of the assault cycle.

III.C: ESCALATION PHASE AND CORRESPONDING INTERVENTIONS (10–20 minutes)

BRIEF LECTURE:

A person exhibiting increased agitation, acting irrationally and/or becoming verbally abusive characterizes the “Escalation Phase.” At this point, adrenaline is beginning to build up in her or his body and yours, signaling impending danger.

CASE: John sees Bill enter the community room and stands up. John loudly accuses Bill of stealing his Walkman, which Bill denies. John says that he wants his Walkman back now!

Let’s look at some specific and deliberate responses to this phase.

TRAINER NOTE: See *HANDOUT #4: STRATEGIES AND SKILLS FOR INTERVENING IN VIOLENT AND POTENTIALLY VIOLENT SITUATIONS.*

BEFORE ENTERING ROOM, NOTIFY OTHER STAFF, IF POSSIBLE:

Always communicate with your co-workers so s/he can provide “back up” if you need it. If you are aware that a situation may escalate or explode, do not keep it to yourself.

BE AWARE OF YOUR STATE OF MIND:

Although it is difficult to remain self-aware during a crisis, it is important to try to stay as calm as possible and not show fear or agitation. One way to do this is to *breathe deeply* before entering the situation and not forget to breath throughout. Equally important is not to convey impatience or annoyance with the tenant, even if they are pushing all of your buttons. Try to remain neutral.

WATCH YOUR BODY LANGUAGE:

- When approaching tenant, do so from a 45 degree angle rather than head on, it is less threatening (trainer should demonstrate).
- Remain a leg’s distance away (ask trainees, “Why?” *So tenant cannot strike or kick you.*)
- Do not hide your hands (may be interpreted that you are carrying a weapon or have clenched fists).
- Respect tenant’s physical space by not getting “in his/her face.” Studies have shown that the *intimate zone*, the amount of physical space reserved for family and friends, is within 18 inches. The average amount of space between *social acquaintances* is generally 18 to 36 inches. For the rest of us, we should be at least 3 feet away when dealing with someone who is agitated.

- Do not position yourself between tenant and the door or behind a static object like a desk; try to be conscious of this and always position yourself near an exit, if possible.

IF THE CONFLICT IS BETWEEN TWO SPECIFIC TENANTS, YOU SHOULD TRY TO SEPARATE THEM FROM ONE ANOTHER:

Sometimes tenants can work out the problem themselves or with the assistance of other tenants if there is a strong community. If you assess that there is potential for violent or assaultive behavior, you should try to remove one of the parties from the situation. Both participants should be spoken with.

DO NOT INTERVENE WITH A TENANT WHO IS CLEARLY DRUNK OR HIGH EXCEPT TO CURTAIL DISRUPTIVE BEHAVIOR:

As we said before, drugs and alcohol disinhibits a person and increases the potential for violence. If a person is not posing an immediate threat by engaging in disruptive behavior, you are usually better off allowing her or him to sleep off the effects of the drugs/alcohol and wait to address the behavior when s/he is sober. If s/he is disruptive, then it may be necessary to call emergency services.

AVOID USING HUMOR OR SARCASM:

In times of stress, some of us may react by trying to sound casual or using humor. While this may work with some tenants, it can often backfire and lead the tenant to believe you are not taking her/him seriously. It is generally better to remain calm and try to reflect that you are hearing the concerns and taking her/him seriously.

DO NOT ENGAGE IN POWER STRUGGLES:

Trying to convince someone or becoming involved in a power struggle is usually counterproductive. This is not the time to argue with a person about their perception or try to get someone to see the other side. The best response is to once again reflect back the concern (e.g., "I see you are really upset about this." "Let's talk more about how we can help you to feel safe."). Do not interrupt or contradict. Think of listening rather than talking the person down.

TRY TO PROVIDE OPTIONS:

One of the principals of reactance theory is the notion that all people respond better when provided with choices rather than given directives. People will probably experience resentment if s/he sees you as an authoritative parent. On the other hand, too many choices, particularly when a person is disorganized or agitated, can be further confusing. Instead, use simple statements, such as, "You have one of two choices here. You can either put down the remote control and talk with me privately about what's going on, or you can continue to hold onto it and probably no one's needs will get met." This points out the natural consequences of the situation and gives the tenant a choice.

ADOPT A SUPPORTIVE YET FIRM STANCE:

Remember that an alliance is crucial when working with an agitated person. A principal of hostage negotiation is to convince the perpetrator that the mediator is working in their best interest. The same holds true here. Try to approach the situation as a problem that can be solved together.

MODULATE YOUR VOICE:

Talk slowly and evenly without yelling. Speaking in a calm voice can often help persons to calm down and assist with de-escalating a situation.

AVOID TOUCHING ANYONE IN A CRISIS:

An agitated person may respond negatively towards being touched while in an angered state. Unless you are sure what the response will be, avoid putting your hands on a person in this phase. Respect the person's physical space.

DO NOT IDENTIFY YOURSELF WITH AUTHORITY:

The technique of "one downing" involves putting yourself in a less powerful position by reflecting that you do not have ultimate authority. For example, if the tenant is angry that s/he cannot do something, the worker can respond, "I agree with you that this rule is hard to follow, but unfortunately I cannot fix that right now." This technique deflects some of the anger.

LEARNING POINTS: Trainees will have an understanding of how to respond to someone who is in the escalation phase of the assault cycle and the importance of ensuring support from co-workers during this phase.

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

- **Hair Pull Release:** Hair pulling can be more dangerous than it seems, resulting in neck injury or a serious fall. Hair pull release: Freeze individual's hand to your head by placing both of your hands on top of her/his and applying pressure.
- **Protection from Thrown Objects:** Use a shield by grabbing any object, such as a coat, sweater, chair, etc., and hold it up to block the projectile. If no shield is available, you can either duck or turn your torso sideways to have less of a target.
- **Protect Your Face:** If you are being hit, protect your face by covering it with your hands or arms. The potential for damage is greater in the facial area than other parts of your body.
- **Dealing with Weapons:** Do not attempt to physically take a weapon away from a tenant. All staff should be aware of their program's policy in responding to persons with weapons. In most instances this situation warrants calling emergency services.
- **Alert Others:** In the event that you are attacked, it is important to stay as calm as you can. Let the tenant know exactly what you expect him/her to do regarding the act of violence. Do not be vague in with your expectations. For example, if tenant is holding your arms, you should say, "(Name), let go of my arms," so that others hear you.
- If someone should place his hands on your throat, bring your hands and arms between his, push up, releasing yourself from the hold and firmly say "(Name), do not put your hands on my throat." In doing so, you will alert others nearby of what is going on. If no other staff is around, tenants should also be trained to call 911.

LEARNING POINTS: Trainees will have an understanding of how to respond to someone who is in the crisis phase of the assault cycle and the importance of teamwork during this phase. Each worker should be educated about what to do in crisis situations according to the specific circumstances of the program. This is particularly important for staff who are alone on a shift. The time to discuss policies and procedures for handling crisis is not after the fact.

III.E: RECOVERY PHASE AND CORRESPONDING INTERVENTIONS (10–20 minutes)

TRAINER STATES: The “recovery phase” is characterized by the person gradually returning to baseline behavior. While she/he may appear to have calmed down, it is essential to recognize that the adrenaline is still activated for at least 90 minutes and the tenant may still react impulsively if provoked.

CASE: Bill admits he took the Walkman and offers to return it. Bill gives it back to John. After it is returned, John looks distressed and is sitting quietly again. His eyes are red with tears.

TRAINER ELICITS: HOW DO YOU RESPOND? [Expected response incorporates the following:]

BRIEF LECTURE:

The biggest mistake is trying to get a person in this phase to reflect on the situation or try to work it out with the other party directly following the incident. It is better to allow the tenant time alone following an outburst and not to intervene for a significant period. After the crisis passes, staff should have time to reflect on the following:

CRITICAL INCIDENT DE-BRIEFING

- Process with persons in the incident: Inquire how they are feeling and reassure them that the appropriate actions were taken. Attend to anyone who feels particularly angry or traumatized. Do not break confidentiality or take sides. Set up subsequent meetings to further debrief.
- Process with staff: How did you intervene as a team, what could you have done better? Are there programmatic changes indicated in order to address safety concerns. As with tenants attend to anyone who may be feeling particularly traumatized and refer them to help as indicated.
- Process with community: Have a community meeting to discuss what happened and how people are feeling. There are probably tenants who are effected by the situation. When processing, be careful not to re-fuel the incident.

LEARNING POINTS: Trainees will have an understanding of how to respond to someone who is in the recovery phase of the assault cycle.

III.F: POST-CRISIS DEPRESSION PHASE AND CORRESPONDING INTERVENTIONS (10–20 minutes)

BRIEF LECTURE:

The “post-crisis depression” phase is characterized by the person possibly becoming remorseful, less angry and possibly shame-filled.

CASE: Bill and John both decide not to press charges. John sits in the community room by himself. He looks depressed and throws his Walkman into the trash. Bill remains alone in his room refusing visitors.

This is the time to help tenant work through what happened. Sometimes, after a crisis or conflict, you can contract with the tenant. Contracts can include:

- Tenant works with staff to recognize early-warning signs of temper.
- Tenant agrees to report when these feelings are triggered.
- Tenant agrees to meet with worker.
- Tenant agrees that on-site staff can have contact with other providers serving tenant.

TRAINER NOTE: See *HANDOUT #5: ANGER MANAGEMENT TECHNIQUES*.

The team should discuss how anger-management strategies could be integrated into individual tenant’s service plans. Some techniques to consider might include:

- Meditation
- Exercise
- Affirmations and positive self-talk
- ID triggers to aggression and make a plan to avoid them
- Deep breathing

In some cases, a tenant may be very quiet and can benefit from assertiveness training. Assertiveness training is ideal for those tenants who cannot stand up for themselves and become increasingly angry to the point of exploding.

Assertiveness training techniques might include:

- Teaching the value of “I” statements (a way of owning feelings and ideas, and letting the other person know what effect their actions have, without blaming)
- Rehearsing difficult situations beforehand

- Demonstrating and role-playing passive, aggressive and assertive responses to situations and then practicing assertive responses

BRIEF LECTURE:

In determining the programming available to tenants, providers may want to consider offering classes in meditation, yoga, relaxation techniques and martial arts.

Additionally, staff may want to teach conflict-resolution skills to tenants as a way of learning to work with conflict. In some housing sites, tenants have been trained in dispute-resolution techniques for the purpose of offering mediation services to other tenants. We have included a handout which outlines the basic mediation process. We do not suggest offering tenant-run mediation services, however, unless tenants have completed a full mediation training.

TRAINER NOTE: See *HANDOUT #6: SEVEN STEPS TO RESOLVING A CONFLICT*.

LEARNING POINTS: Trainees will have an understanding of how to offer support to a tenant in the post-crisis depression phase of the assault cycle.

TRAINER NOTES: Role-Play Exercise

Divide trainees into groups of three. One will be the tenant, one will be the worker and one will be the observer. The tenant is furious because s/he believes that another tenant stole his/her Walkman and s/he wants to confront him/her. The worker wants to calm the tenant down and avoid a confrontation. The worker knows the tenant and has a good relationship with him/her. The observer should be instructed to take notes on what is helpful. Time: 10 minutes

Process Questions:

- For the Tenant: What helped you feel calmer? What was not helpful?
- For the Worker: When did you feel what you were doing was effective? When did you get stuck?
- For the Observer: What did you think was helpful, not helpful?

LEARNING POINTS: This is an opportunity for trainees to practice what they have learned in the training. Make sure to include any interventions that they have neglected to mention.

IV.A: DIFFERENTIATING ACUTE AND LESS ACUTE SITUATIONS (10 minutes)

TRAINER STATES: We are now going to look at crisis and emergency situations which are common in supportive housing settings, including suicidal crisis, psychiatric de-compensation, medical emergencies, substance-induced crisis and house rule/lease violation.

In all of these instances, staff will need to determine whether there is imminent danger warranting immediate intervention with emergency services, hospitalization, calling the police, or whether existing staff can handle the situation. If the situation can be handled without emergency services, it must be closely monitored with a plan that is communicated to the whole staff. Supervisors should always be involved. Remember that situations may become immediate dangers at any time. Staff should be prepared to respond and take action.

TRAINER NOTES: Write down two categories on flipchart: “emergencies” and “closely monitored situations” and write down trainees responses under each. It can be useful for trainees to process specific examples of how they monitored crisis situations within their supportive housing projects. See ***HANDOUT #7: GUIDELINES FOR DEVELOPING EMERGENCY POLICIES AND PROCEDURES.***

TRAINER ELICITS: WHAT KINDS OF SITUATIONS WOULD CONSTITUTE EMERGENCIES AND WOULD REQUIRE CALLING EMERGENCY SERVICES OR SOME TYPE OF EXTERNAL ASSISTANCE, SUCH AS A MOBILE CRISIS UNIT? [Expected responses include:]

- Person clearly in danger to him/herself and/or others
- Threats of suicide
- Threats of harming someone else
- Menacing
- Physical violence that becomes out of control
- Overdose
- Physical distress

TRAINER ELICITS: WHAT TYPES OF SITUATIONS COULD BE CLOSELY MONITORED? [Expected responses include:]

- Verbal arguments
- Persons high/drunk but not out of control
- Persons experiencing psychotic episodes
- Persons experiencing personal or environmental triggers that could lead to crisis
- Persons who seek staff assistance with a mild crisis

LEARNING POINTS: If the person is in immediate danger to him/herself and/or others, outside evaluations are always essential.

IV.B: VOLUNTARY VS. INVOLUNTARY HOSPITALIZATION (10–20 minutes)

TRAINER ELICITS IF YOU NEEDED TO PSYCHIATRICALY HOSPITALIZE SOMEONE HOW WOULD YOU DO IT? [Expected responses include:]

TRAINER NOTE: See *HANDOUT #8: PROTOCOL FOR IMPLEMENTING AN INVOLUNTARY HOSPITALIZATION*. If the trainer wants to specifically outline each of the steps involved in this process, this handout can be reviewed in detail.

- If a person can be engaged in a discussion about hospitalization, this is always preferable, as voluntary hospitalizations are far less traumatic for tenants and staff. In such instances, staff should accompany the tenant to the hospital along with the necessary paperwork.
- If the person is not willing to be hospitalized or is in no condition to be consulted, emergency services or a mobile crisis unit should be called depending on the procedures within your state. Someone should remain with the person needing hospitalization and other staff should handle crowd control, as we discussed before. If possible, try to accompany the person to the hospital.
- Historical information should be ready to take to the hospital or crisis center, including name, date of birth, medical and psychiatric information, a list of medications, emergency contacts and other useful information. It is advisable to obtain written consent forms and have them updated and available so that a person's confidentiality is maintained. It is also advisable for tenants to discuss whether or not s/he wants a "living will" or a "Do Not Resuscitate" (DNR) available in the tenant's chart in case of medical emergency.
- It is important to establish relationships with the local police precinct and hospital in order to insure that emergencies within your program are facilitated.
- Emergency hospitalization procedures should be established and all staff should receive training regarding their role in the event of an emergency. These should include how emergencies are to be managed and communicated among staff. Entry level and other staff without clinical experience should always involve someone with supervisory and/or clinical expertise for assistance.

TRAINER STATES: In this country, state laws vary regarding involuntary hospitalization. Some cities also implement their own procedures to manage assessment and hospitalization for people in psychiatric crisis. Therefore, it is important for staff to know the laws governing involuntary hospitalization in your local area. In Pennsylvania, for example, involuntary hospitalization occurs through a process known as a 302 petition authorizing involuntary emergency evaluation for no more than 120 hours. A county mental health officer, a police officer or a physician can authorize a 302 petition. Once hospitalized, a 303 petition must be secured to keep the

person beyond the initial 120 hours. Other areas will have unique criteria set for involuntary hospitalizations.

LEARNING POINTS: Trainees will have an opportunity to give thought toward policies and procedures in the local municipality regarding hospitalization.

IV.C: SUICIDAL CRISIS (10–20 minutes)

BRIEF LECTURE:

The following relates to tenants who appear to be at risk of self-harm or suicide:

- Suicidal ideation actually falls along a continuum, from people who experience chronic passive suicidal ideation and are perpetually considering whether or not to continue living, to people who are in active crisis and require protection. For your purposes, you need to assess whether there is immediate danger (e.g., active suicidal ideation) or whether the person can be monitored.
- Whatever your personal feelings about suicide, the goal is to protect the person who is in danger by hospitalizing him/her and/or to create a plan of safety for other, less acute situations.
- No matter how common, all threats should be taken seriously.
- Suicidal ideation transcends confidentiality principles. If a person verbalizes or illustrates suicidal ideation to anyone, all staff need to be notified. Assessment should not be handled alone. Staff should seek assistance from a supervisor (unless trained and skilled at assessing). Whenever possible, a psychiatric consultation should be obtained. ALWAYS GET SOMEONE TO ASSIST YOU.

TRAINER ELICITS: LET'S LOOK AT RISK FACTORS. WHAT DO YOU THINK MIGHT PUT PEOPLE AT GREATER RISK FOR SUICIDE? [Expected responses include:]

TRAINER NOTE: See *HANDOUT #9: SUICIDE PREVENTION AND ASSESSMENT*.

SUICIDE RISK FACTORS

- History of past attempts
- Family history of suicide
- Major mental illness diagnosis: schizophrenia, major depression, bi-polar, borderline personality disorder, history of trauma
- Command hallucinations telling the person to harm themselves
- Isolation
- Access to lethal weapons
- Physical pain/illness
- Recent loss
- Recent major stress

TRAINER ELICITS: WHAT MIGHT BE WARNING SIGNS THAT SOMEONE MIGHT BE CONSIDERING SUICIDE? [Expected responses include:]

WARNING SIGNS

- Giving away personal items
- Tying up loose ends/business
- Stockpiling medication
- Sudden improvement in mood or increased energy (signaling resolution)
- Worsening symptoms of depression
- Social isolation/withdrawal
- Talking about dead people
- Joking about death (pre-suicidal statement)

BRIEF LECTURE:

The three areas that need to be assessed when someone indicates suicidal ideation include intent, formulation of a plan and means to that plan.

ASSESS FOR INTENT

- Does the person say s/he wants to die?
- Can the person imagine living without pain?
- Does the person say s/he wants to be put out of his/her misery?
- Can the person contract to stay safe and not harm him/herself?

ASSESS FOR PLAN AND MEANS

- Does the person have a well-thought out plan?
- Is there a time frame: today, tomorrow, some future time?
- How does the person imagine s/he would kill self?
- Does the person have access to the means (gun, medication and roof)?

INTERVENTIONS FOR ALL CASES OF SUICIDAL IDEATION

- Notify other staff and supervisors
- Obtain a psychiatric consultation
- Remove potential hazards (e.g., medications, weapons, etc.)
- Do not leave the person alone while evaluating

IF ASSESSED TO NOT BE IN ACUTE DANGER

- Provide close observation (set up a plan with the entire team)
- Contract for safety
- Discuss plan (e.g., talk to therapist, do not isolate, attend program daily, etc.)

IF ASSESSED TO BE IN ACUTE DANGER

- Hospitalize

When in doubt, it is always better to have a psychiatrist determine how serious the danger of suicide is.

LEARNING POINTS: Assessing suicidal ideation and providing the proper interventions with potentially suicidal tenants are often confusing tasks for workers in housing programs. It is crucial for workers to understand risk factors, warning signs and their role in managing suicidal crisis in their programs.

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.

IV.F: SUBSTANCE-INDUCED CRISIS (10–20 minutes)

TRAINER STATES: When a person enters the building in an intoxicated state, there is a possibility that a crisis could develop depending upon how much the person has consumed, what substance has been consumed and what behaviors are exhibited.

TRAINER ELICITS: SUPPOSE A TENANT IS VISIBLY INTOXICATED OR HIGH IN THE BUILDING'S PUBLIC SPACE. HOW WOULD YOU HANDLE THIS SITUATION? [Expected responses include:]

- Assess if they are in need of medical help

TRAINER STATES: Your task when confronted with a person who is intoxicated is to ensure her or his safety and the safety of others. Alcohol poisoning and drug overdose are potential dangers. You must assess if medical help is needed. If a person appears extremely disoriented and/or unresponsive, you must call emergency services for assistance.

TRAINER ELICITS: IN WHAT CIRCUMSTANCES WOULD YOU CALL FOR MEDICAL HELP WITH AN INTOXICATED PERSON? [Expected responses include:]

- If the person has passed out and is unresponsive
- If a person has difficulty breathing
- If a person exhibits signs of withdrawal (e.g., shakes, vomiting, seizures)
- If a person appears an immediate danger to him/herself and/or others

TRAINER STATES: If there is no medical emergency, assist her or him in leaving the program space and let her or him know that after s/he gets some rest, s/he may be able to come by to discuss things with you.

Other points to consider:

- Avoid lecturing
- Keep it simple
- Focus on disruptive behavior only
- Provide options (coffee, food)
- Separate her or him from other tenants in order to avoid potential conflicts

TRAINER NOTE: See *HANDOUT #10: COMPARISON OF SIGNS AND SYMPTOMS ACROSS CATEGORIES OF SUBSTANCES*.

LEARNING POINTS: Assessing for medical need is the key role of staff when working with a visibly intoxicated tenant. If no medical need is determined, staff should act in a non-threatening manner to assist the tenant to a place of safety to avoid potential conflict.

IV.G: HOUSE RULES (10–20 minutes)

TRAINER STATES: In order to keep a building as safe as possible, it is important to establish house rules that are:

- Enforceable
- Clear and consistent
- Well-known by tenants and staff

Rather than having too many rules, it is better to concentrate on a few that you enforce. Including them in the orientation packets and having tenants state them at community meetings can enforce house rules.

While house rule infractions are not necessarily means to pursue eviction for tenants, all incidents should be documented and reviewed in incident review meetings and strategies to address the situation reviewed at this time. As a tool to reinforce desired norms of behavior, some supportive housing programs withhold participation in special trips and other “goodies” when a person violates house rules.

LEARNING POINTS: House rules help maintain safety and appropriate behavior in supportive housing environments.

V. CASE REVIEW (30 minutes–1 hour)

TRAINER NOTE: See *HANDOUT #11: CASE STUDIES*. Have trainees break into groups. Ask each group to appoint a recorder who writes down points on flipchart, and a reporter who will report back to the large group. If time permits, groups can be assigned multiple cases, but if time is limited, assign each group one case. When processing with the large group, make sure to ask where there were points of conflict in the group, and which questions were the most challenging and why.

CASE REVIEW

1. One of the tenants tells you that another tenant is dealing illicit drugs and having loud visitors throughout the night. The tenant says that she cannot disclose this person's identity to you because he threatened to harm her if she said anything to anyone.
2. In the middle of the night, a tenant tells security that "I can't take it anymore," and slams the door to his room. When another tenant knocks on the door he does not answer. Security is the only staff present on site.
3. A tenant stumbles through the front door bleeding profusely. He passes out in a pool of blood as other tenants gather around.
4. You are running a weekly current events group. A new tenant who has never attended enters late and staggers into the area. He smells of liquor, is slurring his words and begins to talk loudly in a provocative manner.
5. A female tenant has a male guest who is yelling and acting threatening to her in the lobby. The security asks her visitor to leave. He leaves and the female tenant follows him out into the street.
6. A frail, well-liked mentally ill man had a fight with a young, much-disliked tenant. You observed the fight and called 911. The well-liked man is arrested for possession of a weapon. A group of tenants, who did not observe the situation, gather as police escort the elderly man out of the building and accuse you and other staff of taking sides with the other tenant.
7. You hear through the grapevine that a tenant beat up a prostitute last night and she left the building bleeding. You look in the report log and find nothing was written about the incident. Upon questioning other tenants, you find out the sentiment was that she deserved it because she tried to steal his wallet.
8. A tenant tells staff that her neighbor showed her a gun stating that he wasn't going to take abuse from anyone anymore.

9. A tenant who is extremely functional at baseline has been decompensating steadily for weeks. She now appears paranoid, agitated and has threatened other tenants and staff. You call EMS but when they arrive she is very calm. They refuse to take her in the ambulance, saying she does not appear in danger.

10. A tenant lights up a cigarette in a no smoking public area. When you approach him he states that he does not have to follow rules in his own home. This is not the first time that this tenant has violated the house rules.

TRAINER NOTE: The following should be recapped as a summary of the points illustrated by the cases and a review of the entire training. See *HANDOUT #12: PROGRAMMATIC INTERVENTIONS FOR CRISIS PREVENTION*. Review with the group or review the points on flipchart.

VI.: PROGRAMMATIC INTERVENTIONS (30 minutes–1 hour)

BRIEF LECTURE:

One way to feel safer in your work place involves programmatic interventions. Agencies must have clear and developed protocols.

- **CONSIDER ESTABLISHING A DISPUTE-RESOLUTION PROCESS**
Many conflict situations could have been prevented if there was an attempt to intervene before the situation reached a crisis point. Some supportive housing providers have adopted a dispute resolution/mediation service that is staffed by tenants who have been trained in formal mediation processes.
- **ENCOURAGE OPEN COMMUNICATION BETWEEN ALL LEVELS OF STAFF**
In supportive housing, security, maintenance and support staff will often notice changes in tenants' behavior before the clinical staff does. In order for service staff to intervene early, it is essential that there be vehicles for relevant information to be shared among staff, either on the same shift or on different shifts, within confidentiality guidelines.

Acknowledge and appreciate that different staff have different views. Additionally, non-clinical staff will be more apt to share with service staff if they feel respected. Share the load and stress of conflict and crisis.

- **LOOK AT TENSION CENTERS**
Each building has certain tension centers where tension easily builds. More often than not, they include community areas, lunchrooms, smoking areas, shared facilities and other spaces where tenants are forced to closely interact with one another or share resources. Agencies can look at these areas and re-evaluate or re-design them to be more accommodating and less stressful.
- **MAINTAIN CLEAR NORMS AND RULES OF CONDUCT**
Clear rules, procedures and expectations for behavior within the building should be in place, known by all tenants and staff, and uniformly asserted and enforced by staff. This includes rules of conduct describing both desired behavior and behavior which will not be accepted. Tenants should know the rules from the time of admission, and they can be repeated when tension might be growing in the building. Post rules. Keep rules few and enforceable.

Regular tenant meetings can help reinforce community norms in addition to orienting new tenants to the building and providing a vehicle for tenants to express their concerns. Beware of venting sessions that never address problem-solving as a community. These can serve to increase agitation and frustration.

- **CONSISTENTLY ENFORCE CONSEQUENCES FOR VIOLATIONS OF RULES AND NORMS**

Staff and tenants should be clear about the consequences for violations of rules/norms. Consequences may include: being barred from program space, denied access to program resources or activities, a warning letter from building management notifying the tenant of the rule violation or dialing 911 and involving the police. For example, if a person makes a racial slur, he knows he will be barred from the lounge for the afternoon.

You can call upon the community to reinforce norms by encouraging tenants to remind each other that “We don’t do this here.” Other ways to environmentalize norms include posting rules and policies on the community bulletin board, discussing problems in community meetings and providing new tenants with written rules as part of orientation.

- **WRITE DOWN PROCEDURES FOR INTERVENING IN CRISES**

Being unprepared can escalate conflicts and crises. Not knowing whom to call, what to do or how to handle a situation can increase staff anxiety and result in less effective interventions and potential violence.

At a minimum, *written* procedures should be in place for:

- dealing with physical violence or threats of violence
- dealing with people who are intoxicated

These procedures should be posted where all staff has easy access to viewing them.

- **TRAINING**

Staff training is an important component to any supportive housing project. All levels of staff should receive training. Training can include a variety of topics, including but not limited to Crisis and Violence, Stress Reduction, Cultural Sensitivity, Mental Health Issues and others. Support staff and tenants should also receive training and education. The more information and resources available, the better projects can plan to curb violence and assaultive behavior.

- **COMMUNITY BUILDING**

The community within a building can be very helpful in maintaining a safe environment. Regular tenant meetings, tenant patrols, floor captains and other protocols can be implemented. Peer pressure can act as a foundation for setting boundaries on behavior within a building.

When managing crisis situations, it is helpful if relationships have been developed with appropriate community resources as well. These include the police precincts, emergency room staff, community centers, pharmacies, shops, and various day programs.

- **“PROCESS” ALL CRISIS AND VIOLENT INCIDENTS AFTER THEY OCCUR**
An assessment of why the incident occurred, a review of what worked and what didn't in responding to the incident, consequences for the individual(s) involved and necessary follow-up with the individual(s) involved and the community should be discussed. A plan should be developed that delineates who will do what and includes time frames. Incident review should also discuss changes needed in program policies and procedures to avoid similar incidents in the future.

LEARNING POINT: Participants will have an understanding of how programmatic issues can impact the ambient stress level of a community in supportive housing. Maintaining and having staff and tenants familiar with rules as well as policies and procedures can help ensure the safety of a building.

VII.: CONCLUSION (10–20 minutes)

TRAINER NOTE: Bring closure to the training by reviewing the highlights of the day. Ask for questions and comments about the content.

TRAINER ELICITS: WHY IS IT IMPORTANT TO UNDERSTAND OUR GUT RESPONSE TO CONFLICT AND CRISIS? [Expected responses include:]

How we respond can impact the outcome of any conflict and contribute to escalation. Being aware allows us to consider alternatives to our own acute stress response.

TRAINER ELICITS: WHAT ARE SOME OF THE WAYS WE CAN PREPARE RESPONDING TO A CRISIS? [Expected responses include:]

- Observe
- Communicate
- Know Policies and Procedures

TRAINER ELICITS: WHAT ARE SOME WAYS TO RESPOND TO PHYSICAL CONFLICTS? [Expected responses include:]

A variety of interventions learned in the assault cycle section, including remaining calm, offering options, making an emotional connection and de-escalating the conflict.

LEARNING POINT: Trainer will review significant points of the training and clarify any remaining questions.

Crisis and Conflict

participant materials
supportive housing training series

Crisis and Conflict

Participant Materials

Developed by Center for Urban Community Services

The work that provided the basis for this publication was supported by funding under an award with the U.S. Department of Housing and Urban Development to the Corporation for Supportive Housing. The substance and findings of the work are dedicated to the public. The author and publisher are solely responsible for the accuracy of statements and interpretations. Such interpretations do not necessarily reflect the views of the Government.

Crisis and Conflict is part of the Supportive Housing Training Series. This training series currently includes eleven curricula providing best practices and guidance on supportive housing development, operation and services.

The full series is available for downloading from the Department of Housing and Urban Development website.

For more information:

U.S. Department of Housing and Urban Development: www.hud.gov

Center for Urban Community Services: www.cucs.org

Corporation for Supportive Housing: www.csh.org

AGENDA

I. INTRODUCTION

II. STRATEGIES FOR CRISIS PREVENTION

- A. Identifying intrapersonal factors: knowing our own response
- B. Observation/assessment skills: identifying factors within the tenant and the environment that may predict conflict
- C. Communication vehicles
- D. Staff roles

III. RESPONDING TO PHYSICAL CONFLICTS: THE ASSAULT CYCLE: EFFECTIVE RESPONSES

- A. Overview of the assault cycle
- B. The Triggering Phase and corresponding interventions
- C. The Escalation Phase and corresponding interventions
- D. The Crisis Phase and corresponding interventions
- E. The Recovery Phase and corresponding interventions
- F. The Post-crisis Phase and corresponding interventions

IV. SPECIFIC CONFLICT/CRISIS CASE SITUATIONS AND STRATEGIES FOR DEALING WITH EACH

- A. Acute vs. non-acute situations
- B. Voluntary vs. involuntary hospitalizations
- C. Suicidal crisis
- D. Psychiatric decompensation
- E. Medical crisis
- F. Substance-induced crisis
- G. House rule and lease violations

V. CASE APPLICATIONS

VI. PROGRAMMATIC INTERVENTIONS

VII. CONCLUSION

WARNING SIGNS OF IMPENDING ESCALATION/VIOLENCE

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.)
- 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 turnover)
- 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)

THE ASSAULT CYCLE

- **TRIGGERING PHASE:**
The tenant exhibits changes in their baseline behavior or mood. S/he may appear upset, angry, withdrawn or demanding.
- **ESCALATION PHASE:**
The tenant progresses to the point where s/he becomes clearly agitated, provocative and verbally abusive. Adrenaline is building up in the body, which interferes with the ability to think rationally and react rationally.
- **CRISIS PHASE:**
The tenant is now definitely out of control, assaultive or physically threatening. At this point, the safety of others is jeopardized.
- **RECOVERY PHASE:**
The tenant begins to return to their baseline behavior and mood. Heightened adrenaline remains in the body for at least ninety minutes, causing the tenant to react more forcefully if provoked.
- **POST-CRISIS DEPRESSION PHASE:**
The tenant may feel remorseful, ashamed, humiliated about the incident/outburst.

SKILLS AND STRATEGIES FOR INTERVENING IN VIOLENT OR POTENTIALLY VIOLENT SITUATIONS

BEFORE ENTERING ROOM, NOTIFY OTHER STAFF, IF POSSIBLE, IN CASE YOU NEED BACK-UP: Always communicate with your co-workers so you can get back-up if you need it. If you are aware that a crisis may be brewing, do not keep it to yourself. If there is staff available, establish who will intervene with the tenant or tenants, who will call 911 and who will perform crowd control with the rest of the community *before* entering the conflict situation.

BE AWARE OF YOUR STATE OF MIND: Although it is difficult to remain self-aware during a crisis, it is important to try to stay as calm as possible and not show fear or agitation. One way to do this is to *take a deep breath* before entering the conflict and not to forget to keep breathing throughout. Also important, avoid conveying impatience or annoyance with the tenant, even if s/he is pushing all of your buttons. Try to remain neutral and talk in a calm, even voice.

WATCH YOUR BODY LANGUAGE:

- Remain a leg's distance away so the person cannot strike or kick you.
- Do not hide your hands (this may indicate that you are carrying a weapon or have clenched fists).
- Respect tenant's physical space, do not get "in their face." Studies have shown that the *intimate zone*, the amount of physical space between close family and friends, is within 18 inches. The average amount of space between *social acquaintances* is 18 to 36 inches. For the rest of us, we should be at least 3 feet away when dealing with someone who is agitated or psychotic.
- Do not position yourself between the person and the door or behind a static object like a desk. Try to be conscious of this and always position yourself near an exit, if possible.

CLEAR THE AREA OF POTENTIAL WEAPONS: It should become second nature to quickly scan the scene of any potentially explosive situation for sharp instruments or household/office items that could be used as weapons and remove them from reach. Three-hole punches, scissors, even staplers and lamps could be extremely dangerous if forcefully hurled during a violent conflict.

DO NOT INTERVENE WITH A TENANT WHO IS CLEARLY DRUNK OR HIGH EXCEPT TO CURTAIL DISRUPTIVE BEHAVIOR: As we said before, drugs and alcohol disinhibit a person's impulses and exacerbate the potential for violence. If a person is not posing an immediate threat by engaging in disruptive behavior, then you should allow them to sleep off the effects of the drugs/alcohol (given that they are not indicating danger of overdose or

withdrawal). Wait to address the behavior when the person is sober. If they are disruptive, then 911 should be called.

AVOID USING HUMOR OR SARCASM, WHICH COULD BE MISUNDERSTOOD: In times of stress, some of us may react by trying to sound casual or using humor. While this may work with some tenants, it can often backfire and lead the tenant to believe we are not taking them seriously. It is generally better to remain calm and communicate that we are hearing the person's issues and are taking them seriously.

DO NOT ENGAGE IN POWER STRUGGLES; INSTEAD REFLECT BACK THE TENANT'S CONCERNS: Trying to convince someone or becoming involved in a power struggle is almost always counterproductive. This is not the time to argue with a psychotic person's perceptions or to try to convince someone to see the other side of the story. The best response is to reflect back the person's concerns as we understand them, for example: "I see you are really upset about this, let's talk more about how we can help you to feel safe."

TRY TO DELINEATE OPTIONS: People respond negatively when they experience someone else attempting to limit their personal freedoms and dictate or demand certain behavior. Most of us will respond less defensively when provided with options rather than being told what to do. On the other hand, too many choices, particularly when a person is disorganized or agitated, can be further confusing. Instead, use simple statements, such as, "You have one of two choices here. You can either put down the remote control and speak with me privately, or you can continue to hold onto it and no one's needs will get met." This points out the natural consequences of the situation and gives the tenant a choice.

ABOVE ALL, ADOPT A SUPPORTIVE YET FIRM STANCE: Remember that an alliance is crucial when working with an agitated person. Try to approach the situation as a problem that can be solved together. You are both invested in working out a solution and minimizing the adverse consequences. However, protecting the health and safety of the tenant and the community is never negotiable.

ANGER-MANAGEMENT TECHNIQUES

THE FOLLOWING ANGER-MANAGEMENT STRATEGIES CAN BE INTEGRATED INTO THE INDIVIDUAL'S SERVICE PLAN.

SOME POSSIBLE ANGER-MANAGEMENT STRATEGIES MIGHT INCLUDE:

- ✦ Journaling mood swings: what was the situation, the triggers, how did you respond, etc.
- ✦ Learning deep breathing
- ✦ Identifying triggers to aggression and making a plan to avoid them
- ✦ Relaxation techniques: progressive relaxation, guided visualization (tapes), meditation, yoga
- ✦ Weekly exercise: develop a realistic plan
- ✦ Martial arts participation
- ✦ Affirmations and positive self-talk

SEVEN STEPS TO RESOLVING A CONFLICT

The goal of a conflict resolution meeting is to facilitate the understanding of the reasons for a conflict and to arrive at a mutually acceptable solution to the conflict, with a plan for implementation and review of the solution.

Before a conflict resolution meeting begins, the facilitator will need to review the roles of those present, and the rules and goals of the meeting.

STEP 1 — SET THE TONE AND RULES FOR THE RESOLUTION PROCESS

Feelings of anger are probably the first emotions that the participants will have to contend with, their own, and the other person's. Knowledge and reminders of the rules are particularly important at this time. Give tips to participants on *anger management*. Participants should use "cool" thoughts and time-outs to collect thoughts and prevent escalation.

Facilitator's role:

- Review rules of meetings and the resolution process.
- Stress the importance of maintaining calm and trying to hear all sides.
- Encourage participants to ask for time-outs if they're feeling angry.
- State that the tone/words/body language being used indicate that the person is angry, and that although it is OK to feel anger, the way that it is expressed is crucial.
- Help participants to reframe statements, for example, instead of "She's wrong, she's lying!" the new statement might be "We're disagreeing".

STEP 2 — ASK CLARIFYING QUESTIONS, GET INFORMATION, LISTEN.

This is the time to focus on communication skills and to begin to help participants get past the initial reason for the conflict.

Facilitator's role:

- Help the participants ask each other the clarifying questions, or ask the participants questions themselves.
- Help the participants to listen to one another.

STEP 3 — FOCUS ON THE INTERESTS, THE “WHYS” OF THE CONFLICT.

If we understand the “whys” of a conflict, we will be better able to identify ways to resolve it.

Facilitator's role:

- Allow each participant to explain their “why” while remaining within the rules.
- Help the participants to look beyond the initial incident to the reasons for the conflict, “dig” for the feelings and reasons that underlie the conflict.

STEP 4 — ARRIVE AT MUTUALLY AGREED DEFINITION OF THE PROBLEM.

Defining the problem in a way that all participants agree on is the first step to solving the problem.

Facilitator's role:

- “Sum up” each definition of the problem.
- “Check in” with each participant to see if they agree with the summation of the problem.
- Help participants to reach agreement on one version of the problem.

If there is no agreement at this time, the facilitator may need to go back to Step 3 to help the participants look more deeply at the “whys” of the problem, or it may be that the participants are unable to reach a mutual definition. If the participants cannot agree, the facilitator may have to state a definition of the problem which grew from the evidence and the meeting, and which will stand as the statement of the problem. Either way, it may still be possible to go on to Brainstorming Solutions. If not, the facilitator may make the decision to stop the meeting, or to determine a solution by which the participants will be asked to abide.

STEP 5 – BRAINSTORM SOLUTIONS.

If there is agreement on the problem, or if the facilitator has made a problem statement, we can begin to explore ways to solve it. Some solutions are easy, and all participants can readily agree. Others solutions are less obvious. Enlist the participants’ problem-solving skills. Have they ever encountered anything like this before? What worked?

Facilitator's role:

- List all options on paper for review by participants.

STEP 6 — EVALUATE OPTIONS.

Participants may come up with a list of solutions that range from “never speak to her again” to “agree to check in with each other before a phone call” to “agree to pause in the call long enough to listen to the other person’s reason for needing to use the phone.” Some of the solutions arrived at may seem better than others to us.

Facilitator’s role:

- Help participants to discuss the pros and cons of each solution, for themselves individually, and for each other, if possible. The larger community can also be factored into the evaluation of options.
- Help participants identify options that “work” for both of them.
- If the solution is that the participants don’t want to talk to each other, this may or may not work. They may need to come up with another solution, both for their own personal growth and for the good of others around them. This may be a time when the facilitator will have to intervene with another solution.

STEP 7 — CREATE AGREEMENT.

From the discussion of the pros and cons of the list of solutions, participants will agree on one of the solutions. By agreeing, they are not committing themselves to this solution for the rest of their lives, but there needs to be agreement to make the solution work for a long enough period of time to see if it can be effective.

Facilitator’s role:

- Summarize and state the agreed-upon solution.
- Set a time period during which the solution will be implemented.
- Set up a future meeting to see how the plan is working at this time.

ASSISTING PERSONS EXPERIENCING SUICIDAL IDEATION

When responding to a person with suicidal ideation or warning signs, the staff person should assess where the person is at on the continuum of suicide and the responsiveness to support being offered. The following are some useful tools.

- Intervene as early as possible.
- Solicit assistance from supervisor or seasoned clinical staff.
- Notify other staff and supervisors for assistance.
- Help the person partialize what may seem to be insurmountable.
- When asking, "What would help you want to live?" work with what the person identifies.
- Provide adequate support (i.e., medication, therapy, no isolation).
- Help person to imagine the real consequence of suicide on others.
- If appropriate, remind the person they felt this way before and it changed.
- Avoid superficial "cheering up."
- If enraged, allow the person to express.
- Express genuine concern and positive feelings for the person.
- Obtain a psychiatric consultation, if possible.
- Remove potential hazards (i.e., medication, sharps, etc.)
- Do not leave the person alone while evaluating.
- Follow your agency protocol for responding to this type of incident.
- Document all relevant information.

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.

SUICIDE PREVENTION AND ASSESSMENT

Following are some suggested tools and strategies, but they do not represent a comprehensive approach to suicide assessment or prevention.

“What Do I Need to Ask? What Do I Need to Do?”

BE AWARE OF OUR OWN ATTITUDES & FEELINGS ABOUT SUICIDE, DEATH AND WORKING WITH THESE ISSUES

Do you have any attitudes or feelings that may get in the way of approaching a person about the issue of suicidal thoughts?

BE AWARE OF WHO MAY BE AT RISK

- Due to Diagnosis (depression, schizophrenia, borderline personality disorder)
- Due to Current Stressors (recent loss, change of life circumstances)
- Due to History of Past Attempts
- Due to Family History
- Due to Chronic Pain/Illness

BE AWARE OF WARNING SIGNS

Depression: (the #1 cause of suicide), hopelessness, isolation, sleeping/eating changes, feeling overwhelmed, tearfulness, recent loss, irritability, command hallucinations

Tying up loose ends: giving away possessions, sudden improvement in mood (signaling resolution)

Talking about death and/or threatening suicide

KNOW THE QUESTIONS TO ASK IN ORDER TO ASSESS “SUICIDALITY”

1. **ARE WARNING SIGNS PRESENT? IF THERE ARE, HOW IS THE PERSON FEELING AND COPING?**

To assess this, ask the person:

- “You seem sad/upset. Are you going through a tough time, how are you managing?”

- “How is your sleep, energy level, appetite?”
- “Are you feeling hopeless, helpless, like you cannot imagine a positive future in sight?”

2. DOES THE PERSON HAVE SUICIDAL IDEATION?

To assess this, ask the person:

- “When people are depressed, very angry, feeling overwhelmed, they sometimes think about dying. Have you had thoughts like that?”
- “Are there times you wished you wouldn’t wake up?”
- “Have you ever felt life isn’t worth living? Have you felt that way recently/now?”

3. DOES THE PERSON HAVE A PLAN FOR HOW TO HURT/KILL HIM/HERSELF?

To assess this, ask the person:

- “Have you recently made any plans to hurt/kill yourself?”
- “Have you thought about how/where/when you might kill yourself?”
- “Have you thought about how easy or difficult it would be to kill yourself?”

4. DOES THE PERSON HAVE THE MEANS TO ACHIEVE THE PLAN?

To assess this, ask the person:

- “How would you do it/kill yourself?”
- “You said you feel like shooting yourself. Do you have access to a gun?”
- “You said you feel like taking an overdose. How many pills do you have? Have you been saving your pills? Can you get enough pills to do that?”

Comparison of Signs and Symptoms Across Categories of Substances

SIGN & SYMPTOM	WITHDRAWAL				INTOXICATION						OVERDOSE					
	A L C O H O L	S T I M U L A N T S	D E P R E S S A N T S	O P I A T E S	A L C O H O L	S T I M U L A N T S	D E P R E S S A N T S	O P I A T E S	H A L L U C I N O G E N S	P H E N C Y C L I D I N E	A L C O H O L	S T I M U L A N T S	D E P R E S S A N T S	O P I A T E S	H A L L U C I N O G E N S	P H E N C Y C L I D I N E
Abdominal Cramps			X	X											X	
Aches, Muscle	X			X			X									
Affect, labile (fluctuating, unstable)					X	X			X	X						
Analgesia (pinprick)									X	X				X	X	X
Angina (chest pain)											X					
Anxiety	X		X	X	X	X	X	X	X	X	X			X	X	
Arrhythmia (abnormal heartbeat)						X							X			
Ataxia (unsteady gait)					X		X			X				X	X	X
Chest Pain											X					
Chills				X												
Circulatory collapse			X											X	X	
Coma											X		X	X		X
Comprehension, slow	X	X			X		X	X		X				X	X	X
Convulsions	X	X					X				X					
Delirium	X		X		X	X	X			X				X	X	X
Depressed mood	X	X			X		X			X						
Diarrhea				X	X						X					
Diplopia (double vision)					X		X									
Dizziness					X	X	X		X	X					X	
Dysmetria (muscular disturbance)					X		X			X						
Euphoria					X	X	X	X	X	X	X					
Facial grimacing											X					
Fatigue	X	X					X									
Floating feeling					X		X	X	X	X						
Flushing	X		X		X		X	X	X				X		X	
Hallucinations	X		X			X			X	X				X	X	
Headaches			X								X					
Hypertension (high blood press.)				X		X			X	X				X	X	
Hyperthermia						X			X					X	X	
Irritability	X		X	X	X	X	X		X		X	X		X		

Comparison of Signs and Symptoms Across Categories of Substances

SIGNS & SYMPTOMS

WITHDRAWAL			
A L C O H O L	S T I M U L A N T S	D E P R E S S A N T S	O P I A T E S

INTOXICATION					
A L C O H O L	S T I M U L A N T S	D E P R E S S A N T S	O P I A T E S	H A L L U C I N O G E N S	P H E N C Y C L I D I N E

OVERDOSE					
A L C O H O L	S T I M U L A N T S	D E P R E S S A N T S	O P I A T E S	H A L L U C I N O G E N S	P H E N C Y C L I D I N E

Lack of Appetite	X		X	X	X	X			X	X
Memory, poor	X				X				X	
Motor seizures (grand mal)	X		X						X	X
Mouth dry					X	X			X	
Muscle spasms (rigidity)										X
Nausea			X	X	X	X		X	X	X
Nystagmus (Involuntary eye move)	X					X				X
Orthostatic hypotension	X		X			X				
Piloerection (gooseflesh)										X
Psychosis	X		X		X	X			X	X
Pupils, dilated					X			X		
Pupils, pinpoint									X	
Reflexes, hyperactive	X		X			X		X	X	
Respiration, slow & shallow									X	X
Restlessness	X				X			X	X	
Rhinorrhea (nasal mucous +/-)		X								X
Skin picking					X		X			
Sleep disturbances	X	X	X	X	X	X		X		
Sleepiness		X			X	X				
Speech, slurred					X	X				X
Stare, blank										X
Suspiciousness					X	X		X	X	
Sweating	X								X	
Tachycardia (rapid heartbeat)	X		X			X		X	X	
Talkative					X	X				
Tremors	X		X			X				
Violence					X					X
Vomiting	X				X		X		X	
Yawning						X				

CASE STUDIES

DIRECTIONS: Read the following cases and discuss together how you would handle the situation, taking into account your various roles on the team. Also consider whether there are implications for developing policy and procedures and for staff training.

1. One of the tenants tearfully tells you that another tenant is dealing illicit drugs and having loud visitors throughout the night. The tenant says that she cannot disclose this person's identity to you because he threatened to harm her if she said anything to anyone.
2. In the middle of the night, a tenant tells security that "I can't take it anymore," and slams the door to his room. When another tenant knocks on the door, he does not answer. Security is the only staff present on site.
3. A tenant stumbles into the front door bleeding profusely. He passes out in a pool of blood as other tenants gather around.
4. You are running a weekly current events group. A new tenant who has never attended enters late and staggers into the area. He smells of liquor, is slurring his words and begins to talk loudly in a provocative manner.
5. A female tenant has a male guest who is yelling and acting threatening to her in the lobby. The security asks her visitor to leave. He leaves. The female tenant follows him out into the street.
6. A frail, well-liked mentally ill man had a fight with young, much-disliked tenant. You observed the fight and called 911. The well-liked man is arrested for possession of a weapon. A group of tenants, who did not observe the situation, gather as police escort the elderly man out the building and accuse you and other staff of taking sides with the other tenant.
7. You hear through the grapevine that a tenant beat up a prostitute last night and she left the building bleeding. You look in the report log to find nothing

was written about the incident. Upon questioning other tenants, you find out the sentiment was that she deserved it because she tried to steal his wallet.

8. A tenant tells staff that her neighbor showed her a gun stating that he wasn't going to take abuse from anyone anymore.
9. A tenant who is extremely functional at baseline has been decompensating steadily for weeks. She now appears paranoid, agitated and has threatened other tenants and staff. You call EMS but when they arrive she appears calm and they refuse to take her in the ambulance, saying she does not appear in danger.
10. A tenant lights up a cigarette in a no smoking public area. When you approach him, he states that he does not have to follow rules in his own home. This is not the first time that this tenant has disobeyed the house rules.

PROGRAMMATIC INTERVENTIONS FOR CRISIS PREVENTION

OFFER CLASSES/WORKSHOPS IN ANGER MANAGEMENT

Providers may want to consider offering classes on-site and/or referring out to classes in meditation, yoga, stress management, communication skills and martial arts as part of an overall strategy to prevent violence by developing and enhancing coping skills.

CONSIDER ESTABLISHING A DISPUTE-RESOLUTION SERVICE

Many conflict situations could have been prevented if there was an attempt to intervene before the situation reached a crisis point. Some supportive housing providers have adopted a dispute resolution/mediation service that is staffed by tenants who have been trained in formal mediation processes.

ENCOURAGE OPEN COMMUNICATION BETWEEN ALL LEVELS OF STAFF

In order for service staff to intervene early, it is essential that there be vehicles for relevant information to be shared among staff, either on the same shift or on different shifts, within confidentiality guidelines. Acknowledge and appreciate that different staff have different views. For example, sometimes security staff knows things that are happening before social service staff knows. Additionally, non-clinical staff will be more apt to share with you if they feel respected. Share the load and stress of conflict and crisis.

LOOK AT TENSION CENTERS

Each site has certain tension centers where tension easily builds. More often than not, they include community areas, lunchrooms, smoking areas, shared facilities and other spaces where tenants are forced to closely interact with one another. Agencies can look at these centers and re-evaluate or re-design these areas to be more accommodating and less stressful.

MAINTAIN CLEAR NORMS AND RULES OF CONDUCT

Clear rules, procedures and expectations for behavior within the residence should be in place, known by all service recipients and staff, and uniformly asserted and enforced by staff. This includes rules of conduct describing both desired behavior and behavior which will not be accepted. Tenants should know the rules from the time of admission, and they can be repeated when tension might be growing in the building. Keep rules few and enforceable.

Regular tenant meetings can help reinforce community norms in addition to orienting new tenants to the program and providing a vehicle for tenants to express their concerns. Beware of venting sessions that never address problem solving as a community. These can serve to increase agitation and frustration.

CONSISTENTLY ENFORCE CONSEQUENCES FOR VIOLATIONS OF RULES AND NORMS

Staff and tenants should be clear about the consequences for violations of rules/norms. Consequences may include: being barred from program space, denied access to program resources or activities, a warning letter from building management notifying the tenant of the rule violation, or dialing 911 and involving the police. Ways to environmentalize norms include posting rules and policies on the community bulletin board, discussing problems in community meetings, and providing new tenants with written rules as part of orientation.

WRITE DOWN PROCEDURES FOR INTERVENING IN CRISES

Being unprepared can escalate conflicts and crises. Not knowing whom to call, what to do or how to handle a situation can increase staff anxiety and result in less effective interventions and potential violence.

At a minimum, WRITTEN procedures should be in place for:

- dealing with physical violence or threats of violence
- dealing with people who are intoxicated

These procedures should be posted where all staff has easy access and a place that ensures knowledge of them.

FACILITATE COMMUNITY BUILDING

The community within a building can be very helpful in maintaining a safe environment. Regular tenant meetings, tenant patrols, floor captains and other protocols can be implemented. Peer pressure is often heard when staff is not around and can act as a foundation for setting boundaries of behavior within a building. All efforts should also be made to develop outside relationships with external sources, such as hospitals and local police precincts.

"PROCESS" ALL CRISIS AND VIOLENT INCIDENTS AS SOON AS POSSIBLE AFTER THEY OCCUR

An assessment of why the incident occurred; a review of what worked and what didn't in responding to the incident; consequences for the individual(s) involved; and necessary follow-up with the individual(s) involved and the community should be discussed. A plan should be developed that delineates who will do what and includes time frames. Incident review should also discuss changes needed in program policies and procedures to avoid similar incidents in the future.

PROVIDE TRAINING

Staff Training is an important component to programming for any agency. All levels of staff should receive training. Training can include a variety of topics including but not limited to Crisis & Violence, Stress Reduction, Cultural Sensitivity, Borderline Personality Disorders and others. The more information and resources available, the better programs can plan to curb violence and assaultive behavior.

GUIDELINES FOR DEVELOPING EMERGENCY POLICIES AND PROCEDURES

All staff should receive **crisis management** and **emergency protocol** training and know:

- When to ask for help
- Acceptable & non-acceptable interventions (e.g., physical restraint, self-protection)
- Roles & responsibilities of staff in emergency or conflict situations
- Program policies & procedures — include when to call emergency services and policies for dealing with outside agencies such as police or EMS

INFORMATION TO INCLUDE IN EMERGENCY POLICIES AND PROCEDURES

1. ASSESSMENT STEPS:

➤ **IMMEDIATE DANGERS** are acute situations. These dangers may involve a person with a weapon, physical confrontations, suicide/homicide threats with a clear plan and/or past attempts and medical crises.

If there is an immediate danger to any staff or tenant, the first line of action should be to get people to a safe place and call 911. Be prepared to describe the location and type of residence, the nature of the emergency (include menacing behavior or verbal threats), if any person with special needs is involved (police may respond more quickly in cases involving an Emotionally Disturbed Person/EDP) and any past episodes of violence with the involved party(s).

➤ **NON-IMMINENT DANGERS** include verbal arguments or threats, psychotic episodes, intoxication and individuals displaying behaviors indicative of agitated states or emotional turmoil. Situations of this type should be closely monitored and may become immediate dangers at any time. Interventions should be aimed at de-escalating the conflict or crisis.

If there is the possibility of danger or a crisis situation:

- Inform a co-worker and a supervisor
- Ask for assistance/back up (if possible)
- Attempt to de-escalate conflicts/confrontations by separating parties
- Avoid hostile verbal exchanges or threats
- Present options in a calm and non-threatening manner
- Attempt to minimize stresses (loud noises, crowd of onlookers, etc.)

2. PROTOCOL FOR DEALING WITH EMERGENCY SERVICES

Whenever possible, have needed documents available prior to the arrival of EMS. This means preparing documents in instances when an emergency hospitalization or police intervention is suspected. Information given to outside emergency staff depends on the type of emergency but may include the person's name, DOB, medical and/or psychiatric history, list of medications, recent hospitalization history of violence, recent behaviors or symptoms leading up to the emergency. Psychiatric information should only be given in cases of a psychiatric emergency. Information related to HIV status should not be given unless the person has signed consent to release the information or the situation is life threatening.

A staff person should escort tenants to the hospital whenever possible. This allows staff to advocate for proper treatment. If this is not possible, staff should be available by phone and ask to be informed of all decisions. The tenant's medical doctor or psychiatrist often has more influence with outside agencies than the social service staff. The tenant's doctors should be contacted whenever hospitalization is being considered.

Staff should have emergency contact names and phone numbers readily available. All charts should include a face sheet with up-to-date emergency contacts, child-care arrangements, allergies, medical & psychiatric clinics. A plan for crisis prepared with the tenant prior to an emergency situation is often the most helpful tool.

3. FOLLOW-UP PROCEDURES

Write an incident report and give copies to the appropriate staff persons.

The staff involved should know the procedures for:

- Keeping supervisory or clinical staff
- Informing caseworkers or other staff of an emergency
- Following-up with the police or hospital
- Evacuation procedures
- Smoke alarm & fire procedures
- Policies for follow-up communication with staff and tenants (what will be said when tenants ask questions about what happened?)

Security and front desk staff should have a policies and procedures manual detailing protocol for enforcing house rules and emergency procedures.

CRISIS & CONFLICT BIBLIOGRAPHY

Callahan, J.: "A Specific Therapeutic Approach to Suicide Risk in Borderline Clients," *Clinical Social Work Journal*, (24): 443–459, 1996

This article reviews the various types of suicidal behavior exhibited by people with borderline personality diagnoses, including self-destructive behavior and overt suicide attempts. Frameworks are offered for understanding and managing both kinds of behavior.

Goleman, D.: *Emotional Intelligence: Why it Can Matter More than IQ*. Bantam Books, 1995

Drawing on groundbreaking brain and behavioral research, Goleman discusses the bio-psycho-social roots of emotions. Findings on trauma, temperament and social adaptiveness can be used to help clients learn how to identify and work with emotions.

Kaplan, S.; Wheeler, E.: "Survival Skills for Working with Potentially Violent Clients." *Social Casework*, (64): 339–346, 1983

This article discusses the roots of violence, predictors of violence, the concept of the assault cycle, violence prevention and intervention. Modalities such as assertiveness training, transactional analysis and anxiety management training are briefly reviewed.

Mathews, L.: "Effects of Staff debriefing on post-traumatic stress symptoms after assaults by community housing residents." *Psychiatric Services*, (49/2): 207–212, 1998

This study examines the efficacy of critical-incident stress debriefing in ameliorating the impact of post-traumatic stress on direct-care psychiatric workers after a traumatic event at work.

McKay, M.; Rogers, P.R.; and McKay, J.: *When Anger Hurts*. New Harbinger Publications, Inc., 1989

This book discusses theories about anger and anger management and provides specific exercises and interventions for use with individuals and groups.

Monahan, J.: "Mental Health Violence Study." National Mental Health Association, *The Bell*, September 1989

This article discusses the impact of alcohol and drug abuse in the increase of statistics regarding mental health and assault. The study indicates that persons discharged from psychiatric facilities who did not abuse alcohol or illegal drugs had a rate of violence no different than their neighbors in the community.

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://www.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

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.