

Collaborative Safety Strategies ***New Employee Training Program***

PARTICIPANT ***HANDBOOK***

Developed by



Office of the Commissioner
Division of Safety Services
Safety Education and Training Unit
July 2013

in collaboration with the
New England Healthcare District Bargaining Unit 1199

Collaborative Safety Strategies
New Employee Training Program

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This Collaborative Safety Strategies (CSS) Participant Handbook is for educational purposes and is designed for use in conjunction with the CSS training program conducted by a certified DMHAS, Division of Safety Services, Safety Education and Training Unit CSS Instructor. The content reflects best safety practices for the prevention and management of dangerous behavior however, they should not be considered inclusive or exclusive of all the methods of service provision reasonably directed to obtaining the same results. New knowledge, procedures, technologies, clinical or research data, and clinical service experiences may provide sound reasons for alternative approaches even though they are not described here. The ultimate judgment regarding the use of any specific actions or procedures taken to prevent or manage dangerous behavior must be made considering the specific individual circumstances presented at the time.

State of Connecticut, Department of Mental Health and Addiction Services
Division of Safety Services, Safety Education and Training Unit
July 2013

INTRODUCTION

COLLABORATIVE SAFETY STRATEGIES TRAINING PROGRAM For NEW EMPLOYEES (CSS-N)

The goal of this training program is to **reduce the rate and severity** of patient and staff injuries related to violent behavior. **Research** shows that a critical factor in reducing the rate and severity of injuries related to dangerous behavior is training.

Upon completion, you will learn be able to:

1. Create safe recovery oriented treatment relationships and cultural environments that are grounded in a) understanding the underlying causes of threatening behaviors during any phase of the Crisis Continuum, b) the effects of trauma, c) DMHAS Policies and philosophy related to the prevention and management of dangerous behavior, d) and the principles of recovery oriented systems of care.
2. Use clinical risk management strategies to prevent dangerous behavior from escalating to violence in DMHAS facilities that provide on-site programming or 24⁰ care and in the outpatient setting, how to respond in these situations.
3. Use verbal and non verbal communication with co-workers and patients in non-emergency and emergency situations to reduce the risks to staff, patients and others that are associated with dangerous and violent behavior:
4. Use a variety of safety strategies in escalating and crisis situations to reduce adverse and potentially emotionally traumatizing effects and physical injuries resulting from dangerous and violent behavior and the use of R/S and Safety Interventions.
5. Correctly use all of the CSS physical techniques in emergency situations and should they fail to be executed correctly, take immediate corrective action to reduce the rate and severity of injuries to staff, patients and others.
6. Identify essential facts that must be documented in the person's medical record should a behavioral emergency occur and require restrictive interventions.

Those who work in settings where mechanical restraints and seclusion are used will learn how to:

7. Demonstrate the safe application, use of and discontinued use of mechanical restraints or seclusion according to DMHAS Policy and manufacturer's instructions to prevent use related physical injury or death.

Those of you who work in the community settings where mechanical restraints and seclusion are not used will learn how to:

7. Avoid and/or escape dangerous situations and using a variety of prevention strategies and self protective physical skills should criminal assault occur.

Successful full completion is demonstrated by achieving:

- A score of at least 80% on the **written Post-Tests that you will take on Day 3** and by,
- 100% active class participation in discussions, group exercises and practice sessions,
- Accurately demonstrating all of the CSS **physical skills**.
- Complete the Participant Evaluation

CONTEXTUAL FRAMEWORK

Contextual Framework

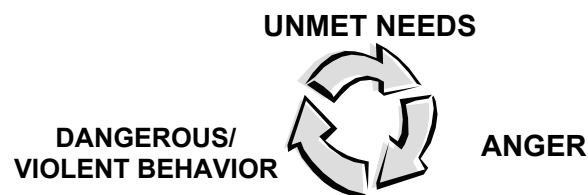
The DMHAS mission is to “improve the quality of life of the people of CT by providing an integrated network of comprehensive, effective and efficient mental health and addition services that foster self-sufficiency, dignity and respect.”

The major symptoms of mental illness are behavioral and the majority of people on our inpatient treatment units have symptoms that are so pervasive, that they can't live safely in the community. As a result, those of you who are working on inpatient units are working with some of our most symptomatic patients. The majority of people treated in our outpatient community settings generally are not acutely dangerous, but some pose a chronic risk for dangerous and violent behavior.

The vast majority of the people we treat are not a danger to others; however some pose a serious threat of harm. However, the risk of violence increases during periods of relapse and stress.

Cycle of DB

There are many reasons that dangerous and violent behavior occurs. To help you understand the cyclic nature of angry behavior, we've developed the Cycle of Dangerous Behavior model. The working assumption is that unmet needs start with a triggering event. Unmet needs may lead to anger which may lead to dangerous behaviors.



Crisis Continuum

The escalation of anger to violence typically occurs in 4 phases and along a continuum called the Crisis Continuum. This continuum includes the Trigger, Escalation, Crisis and Post Crisis Phases.

- The trigger phase A trigger is something that sets off emotions e.g., anger, fear, panic, that can lead to an action or series of events. The first step to interrupting the cycle of Dangerous Behavior is identifying the triggers- we'll be focusing a lot on triggers throughout the training.
- The escalation phase is when these behaviors are increasing in intensity.
- The crisis phase is when the behavior presents an immediate risk of physical harm.
- The post crisis phase occurs immediately following the crisis – which is when the person is calming down.

Restraints, Safety Intervention and Seclusion Defined

Restraints: as any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Safety Intervention: any physical (manual) holding or redirecting of the client's body that limits, even if only briefly, the freedom of movement and access to his/her body needed to prevent injury to self/others(6).

Seclusion is defined as: The involuntary confinement of a patient alone in a room or an area from which he/she is physically prevented from leaving.

There is an assumption that restraints and seclusion keep the people we serve safe. While they *do* keep people safe, their use comes with risks of injury and even death – to both clients and staff. Reality: The Hartford Courant reported 142 deaths during or shortly after restraint or seclusion use in various healthcare setting within a 10 year time period (1988-1998) In addition, the Harvard Center for Risk Analysis estimated 50-150 deaths occur nationally each year due to R/S.

History of R/S Use

The use of restraints dates back hundreds of years. During the colonial era in America they were used for safety and also to “chastise” people for their behavior. During the mid-to late 1800’s in Connecticut and into the mid-1900’s, this philosophy changed and restraint use markedly reduced. As medications were developed and began to treat many of the symptoms of mental illness, this contributed to reduced use.

In the late 1960’s, American society began to address the human/civil rights of people with mental illness. Patient advocates and civil rights groups continued to challenge the use of R/S over the 1970’s-80’s ultimately, resulting in state and federal court decisions that upheld patients’ right to treatment under least restrictive conditions.

In 1992, the Food and Drug Administration (FDA) issued a warning about restraint use and estimated that at least 100 restraint related deaths or injuries occurred each year.

In 1999 and 2002 the Center for Medicare/Medicaid Services (CMS) Conditions of Participation, Patients’ Rights: published an Interim Final and in 2007 made it a Final Rule: Part 482.13 – Conditions of Participation for Hospitals: (e) Standard: Restraint or Seclusion which regulated the use of R/S.

Importantly, this rule is now tied to Medicare/Medicaid funding – so if facilities are not in compliance, they can lose funding.

Patient Rights

DMHAS believes that patients have the right to be free from seclusion and restraints and cannot be imposed as a means of coercion, discipline, convenience or retaliation by staff. Restraints and seclusion may only be used when there is immediate risk and non restrictive measures have been determined to be ineffective in protecting the patient, staff members, or others from harm. Therapeutic and non restrictive interventions are preferred as the first intervention, unless they have been determined to be ineffective or when safety issues require a restrictive response. Likewise, in our outpatient settings, all patients have the right to be free from the use of Safety Interventions, which are restrictive.

DMHAS Philosophy

The concepts of Trauma Informed Services and Recovery underpin the services that we provide. Trauma informed services recognize that many of the people that we treat in our service system have experienced some type of trauma in their lives.

Some suffer from post-traumatic symptoms which exacerbate their other behavioral health problems, impair their psychosocial functioning, and interfere with the quality of their and their loved ones’ lives. When coupled with mental illness and or substance abuse, hope can diminish.

Still, we believe that people can and do recover. Recovery is the “process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and then rebuilding one’s life despite, or within the limitations imposed by that condition.” Recovery requires that people change behaviors, learn new skills and engage in treatment. Change is difficult even in the best of circumstances.

Unfortunately, the process of recovery can include periods of relapse when people struggle with change. Thus, the DMHAS service system addresses the needs of people over time and across different levels of disability. For some, during times of relapse, the risk of dangerous and violent behavior increases. While we know that some of our clients may become dangerous or violent, DMHAS believes that staff have the right to work in a safe environment. Commiss. Policy 2.23

Workplace Violence

STATEMENT OR PURPOSE: The State of Connecticut has adopted through Executive Order No. 16, a statewide zero tolerance policy for workplace violence. The Department of Mental Health and Addiction Services (DMHAS) fully supports this policy and recognizes the right of its employees to work in a safe and secure environment that is characterized by respect and professionalism.

Workplace violence is defined by the state of CT as any physical assault, threatening behavior, or verbal abuse occurring in the work setting.

A **workplace** may be any location either permanent or temporary where an employee performs any work-related duty. This includes, but is not limited to, the buildings and the surrounding perimeters, including the parking lots, field locations, clients' homes and traveling to and from work assignments.

Healthcare Injury Statistics

It is well documented, that nursing staff in in-patient settings, particularly public sector psychiatry, are the most likely to be attacked and face a greater risk of occupational injury from violence alone than workers in other high risk occupations.

The US Dept. of Labor, reported in its News Release Nov. 9, 2011 a high incidence rate for nonfatal occupational injuries involving days away from work for all health care and social assistance workers as a result of assaults and violent acts. Note that the data does not indicate if the statistics are patient related, nor is it separated by setting type, i.e. psychiatry. Still, other literature supports findings that injury rates from patient assaults are high, especially in the public sector mental health inpatient settings.

A survey conducted by the Bureau of Labor Statistics reported in 2006 that the rate of nonfatal assaults on home healthcare workers was 5.5 per 10,000 full time workers. This is more than twice the rate for all US workers.

In the 1990's, OSHA developed *Universal Precautions for Violence*. This Precaution was part of the first official OSHA document related to Health Care worker safety:

**Violence should be expected but
can be avoided or mitigated through preparation.**



COLLABORATIVE RISK PREVENTION STRATEGIES

**Strategy 1:
Creating Safe and Therapeutic
Relationships and
Environments of Care**

Strategy 1: Creating Safe and Therapeutic Relationships and Environments of Care

Collaborative risk prevention strategies are the things that you do to minimize or eliminate the risks and prevent a behavioral crisis from occurring, or interrupt it before someone is harmed. DMHAS believes that EVERYONE shares in the responsibility for safety and that dangerous behavior in any form hurts the community and adds to life crisis.

Safety

We're going to start by talking about the word, safety – because it's a word that gets used a lot and typically, people are referring to physical safety. But safety has other aspects. Safe environments and relationships are essential to providing care.

Physical safety is the easiest to describe – it includes all aspects of the environment that keep you physically safe – such as equipment as well as policies e.g., workplace violence, R/S. Physical safety is a critical aspect of safety and without it, other forms of safety are hard to achieve.

Psychological safety refers to the ability to be safe with oneself, specifically, the ability to self-protect against destructive impulses from within, or from others threat to self (keeping out of harms way). Examples of threats to psychological safety include being talked to sarcastically, lectured at, put down, humiliated, and talked to in a negative tone, infantilized, blamed or shamed. Most of us think about this as emotional abuse.

Social safety is the trust that exists in the environment between everyone that is in it. In a safe social setting, people feel cared for, trusted, free to express feelings, unafraid of being abandoned or misjudged. And, they feel connected to each other and not isolated. Rules exist for safety and structure – they make clear what is socially acceptable and what is not. Rules should be clear and firm, but flexible when safety is not compromised. In a socially safe setting, there is a high level of awareness about group and individual dynamics. Staff recognizes that behavioral change is hard and works collaboratively with patients to help change behavioral patterns that are destructive. There is a shared willingness and commitment to learning how to get out of tough interactional situations without emotional or physical harm.

Moral Safety encompasses honesty, integrity and doing the right thing. It refers to clear social norms that are not hypocritical. It answers the questions:

- What do we believe in, what are we trying to achieve, will the means get us to the ends and are they justified?
- Do the therapeutic activities we use lead to autonomy, connectedness, empowerment, or dependence, alienation and helplessness?

The Golden Rule is an ethical principle that best describes moral safety as it pertains to caring for and treating people with behavioral disorders: **Treat others as you would like to be treated.**

Know Yourself

In order to develop therapeutic relationships, you need to know yourself. Know that you and the patient bring dimensions of yourself to the relationship: biophysical, intellectual, psychological, socio-cultural and spiritual. In order to be the most effective in using yourself as a tool, you must possess self awareness, self-understanding, and a philosophical belief about life, death and the overall

human condition because these beliefs and attributes affect the way you each perceive, interpret, and ultimately respond in every interaction that you have. So, think about who YOU ARE in relationship to the person you are interacting with:

- Values, attitudes and beliefs
- Culture or religion, which may provide the basis for ways of thinking
- Social status: Social status can influence communication. High status persons often convey their high power position with gestures of hands on hip, power dressing, greater height and more distance when communicating with individuals considered being of lower social status.
- Gender e.g., masculine and feminine gestures influence messages conveyed.
- Age or developmental level
- The environment: territoriality, density (# of people within a given environmental space) and distance communicate messages.

Building Therapeutic Relationships

Requirements for a therapeutic relationship include: rapport, trust, respect, genuineness and empathy. To build a relationship that is grounded in trust, respect where you are genuine and empathetic:

1. **Treat everyone as an individual.** It is important to see patients as individual people beyond their mental illness. Values, attitudes and beliefs-Attitudes of prejudice are often expressed through negative stereotyping. This is harmful to building and maintaining relationships.
2. **Make yourself accessible and available.** The presence of staff, even without speaking has been shown to help therapeutic relationships develop. Being genuine or authentic is essential.

Treat people with Respect and dignity. You need to make patients feel respected and important. Always think about what your intention is when interacting with patients. **Intention** is a specific purpose in performing an action or series of actions toward an end or goal that is aimed for. Outcomes that are unanticipated or unforeseen are known as unintended consequences – they are not deliberate or intentional. Your intention should always to *Treat others as you would like to be treated*, with dignity and respect.

Dignity: Human dignity refers to a state of [integrity](#), or [virtue](#) in [human beings](#). The term dignity is defined as "the state of being worthy of honor or respect. It is directly linked to respect:

Respect: means to hold someone in esteem – high regard.

Therapeutic Attributes

Empathy: Is when you understand the person's perceptions without losing objectivity. Empathy allows you to feel **with** the person rather than **about** them. This frees the person to explore their perceptions without worrying what you think about them. It also helps you to identify the feelings and potential problems and focus the person on problem solving

Compassion: on the other hand, is a profound emotion that is prompted by the pain of others. More intense than [empathy](#), compassion leads to the desire to alleviate another's suffering.

Compassion is best captured in the [Golden Rule](#): **Treat others as you would like to be treated.**

3. **Provide support** – this helps patients feel safe and comfortable.

Methods would include active responses, such as giving suggestions and feedback, conveying hope, reflecting concern in one's voice and providing reassurance. Doing things for and with the patient; e.g. getting a blanket or taking a patient shopping.

4. **Maintain your boundaries.**

Boundaries are essential to protect both patient and staff and to maintain a functional therapeutic relationship. For the purpose of this course, boundaries include use of space and use of touch. The use of touch should be based on a thorough understanding of each person and what it means to them. For example, someone who's experience with being touched was abusive may not want to be touched. On the other hand, touch can be supportive and healing e.g., a hand on a shoulder.

Always respect the person's wishes.

Barriers to Therapeutic Relationships

Transference is when the person's unconscious feelings, that originate from past or other relationships that were significant in the person's life are transferred onto you, the staff. This can be due to specific superficial similarities, e.g. facial features, or can be generalized; e.g. "older women remind me of my mother – I hate my mother." Generally, transference is a good thing because it provides you with the opportunity to help people resolve problems they've had in past relationships. It is a complex process that can create difficulties in your relationship with the person. You should actively discuss transference with your supervisor, so that you can learn how to use it to help people learn how to change their behavior.

Counter-transference is the same as transference; however it occurs when you, the staff reflect your unconscious feelings onto the patient. It can have positive and negative effects on your relationship. Clearly, healthy adaptive past relational experiences that are transferred have a positive

Change Model

We know that there are times when people aren't ready to change or may not want to change specific behaviors, yet, because the behaviors are maladaptive or perhaps dangerous, they need to change. When the person disagrees with what behaviors they need to change and how, they often won't listen. So it's important to figure out where they are in their readiness to change. The Stages of Change Model developed by James Prochaska, PhD and colleagues in 1983 describes several stages:

Pre-contemplation: not thinking about change, feeling of lack of control, denial of need to change, belief that consequences are not serious (Costs great, no benefit to change)

Contemplation: thinking about the idea of change, but is ambivalent – is weighing benefits and cost. There's a risk of getting stuck at this phase, all talk – no action. At this stage, staff need to provide a roadmap for change and help motivate the person.

Preparation: Experimenting with small changes, trial and error phase (Benefits of change begin to outweigh costs in this stage). At this point, it's really important to praise the small changes that are occurring and reinforce them.

Action: Takes definitive action to change behavior. New behaviors and coping skills develop, but there may be unexpected grief/loss as old behaviors become obsolete. Staff should continue reinforcement and offer correction as needed.

Maintenance: Maintaining behavior change for 6 months or more, achieves definitive improvements in life related to behavior change. Constant reinforcement is essential.

Relapse: A normal part of any process of change, it's important not to over react, and help people recognize that it's normal – then help them return to newer learned behaviors.

Overcoming the Barriers

Anger and fear are normal human emotions and there may be times you experience these toward the people that you work with. Because your relationship is focused on helping people learn healthier adaptive coping skills, your anger and fear must be managed in a way that is helpful, not hurtful, to this learning process and your relationship.

Examples of hurtful behavior (words and actions) include:

- Using disrespectful language -“get away from me”, authoritarian directives “go do this now”, using foul language, or arguing.
- Using coercion- both your voice tone and the words that you use including, for example being sarcastic, arguing, threatening or critical. You'll **know that your words or voice tone were coercive** if the person:
 - *Responds as though it was coercive (avoid, “get even”, escape) or*
 - *You did it to try to stop a person from doing something that is not necessarily unsafe i.e., not allowing them to go for a walk right now – even though it's safe and they have the privilege to do so.*
 - *You were angry and trying to “get back” or “get even”.*

Fearful responses that are not helpful are similar to angry responses. Instead of an angry tone, you project a fearful tone. Either response can escalate the anger or fear that the person is experiencing. In extreme situations, the fight/flight/freeze response can further contribute to escalating situations. Key to managing your emotions is knowing what your personal triggers are and what the warning signs are.

Personal Triggers

My personal triggers are:

If I am triggered I recognize it because I feel:

Strategies/soothing techniques I use to control my responses are:

Work Place Stress

Job stress is defined as the “harmful physical and emotional responses that can occur when the responsibilities of the job does not match the capabilities, resources or needs of the worker.

*The National Institute for Occupational Safety and Health (NIOSH)]

The work that you do requires a high level of emotional labor. An environment of recurrent or constant crisis can make it challenging for you to manage your own emotions and provide a healing environment for your patients. Workplace stress is created by uncertainty, particularly when there is a mismatch between work (which is often difficult and uncertain) and the individual resources.

Some signs and symptoms of excessive job/workplace stress include:

- Feeling anxious, irritable, or depressed
- Apathy, loss of interest in work
- Problems sleeping
- Fatigue
- Trouble concentrating
- Muscle tension or headaches
- Social withdrawal
- Loss of sex drive

Vicarious Trauma

If you ignore these warning signs of work stress, you can develop more serious signs and symptoms. EAP is available and can help you. If you ignore the s/s, or experience chronic or intense stress related to a greater exposure to witnessing and having to respond to aggressive behavior, you are at risk for vicarious trauma. This can lead to physical and emotional health problems. Being involved, either directly or by witnessing restraint/Safety Intervention or seclusion related emergencies may be traumatizing.

Signs and symptoms include:

- Difficulty managing your emotions; e.g.: depressive symptoms, pessimism, cynicism, fatigue, specific somatic problems, Irritability, anxiety, guilt,
- Difficulty accepting or feeling okay about yourself;
- Difficulty making good decisions;
- Problems managing the boundaries between yourself and others (e.g., taking on too much responsibility, having difficulty leaving work at the end of the day, trying to step in and control other’s lives);
- Problems in relationships;
- Physical problems such as aches & pains, illnesses, accidents;
- Difficulty feeling connected to what’s going on around and within you; and
- Loss of meaning and hope.
- Poor performance at work, absenteeism, avoiding restrictive interventions. It’s important to take care of yourself and each other when these crises occur.

Unhealthy ways to cope with stress

- Drinking too much
- Overeating/under eating
- Zoning out in front of TV
- Withdrawing from friends, family & activity
- Using pills/drugs
- Sleeping too much
- Procrastinating
- Filling up your days to avoid facing problems
- Taking stress out on others

Dealing with Stressful situations

Avoid unnecessary stress:

- Learn how to say “no”
- Avoid people that stress you out
- Take control of your environment
- Avoid hot button topics
- Pare down your to do list

Alter the situation:

- Express your feelings instead of bottling them up
- Be willing to compromise
- Be more assertive
- Manage your time better

Adapt to the stressor:

- Reframe problems (try to take more positive perspective)
- Look at the big picture (will it matter in a month? Year?)
- Adjust your standards
- Focus on the positive

Accept thing you can't change:

- Don't try to control the uncontrollable
- Look for the upside. As the saying goes “what doesn't kill you makes you stronger.” Try to look at them as opportunities for personal growth.
- Share your feelings
- Learn to forgive

Make time for fun and relaxation:

- Set aside relaxation time. Take a break from responsibilities.
- Connect with others
- Do something you enjoy everyday
- Keep your sense of humor

Adopt a healthy lifestyle:

- Exercise regularly
- Eat a healthy diet
- Reduce caffeine and sugar
- Avoid alcohol, cigarettes, and drugs
- Get enough sleep

It is important to remember that your ability to manage stress has an impact on the quality of your interactions with your patients and co-workers. The better you are managing your own stress, the more positively you affect those around you and the less other peoples stress will negatively affect you.

**“People will forget what you said, and people will forget what you did,
but people will never forget how you made them feel.”**

Maya Angelou

COLLABORATIVE RISK PREVENTION STRATEGIES

Strategy 2: Risk Management

Risk Management (RM)

The steps of RM process include:

Assess: identifying the problem and its severity. Risk assessment (RA) is the first step in the RM process. It begins at admission and includes a comprehensive assessment of numerous risk factors including neurological functioning, psychiatric, substance abuse, and medical disorders, developmental, physical and sexual abuse or a witness to violence, trauma, and environmental factors. Every time you come into contact with pts who present a risk of violence, you'll be assessing their risk.

Analyze: draw conclusions, based on your assessment and consider the possible interventions to address the problem in the context of the person(s) involved, the situation that you are in, and who is available to help.

Select: select the intervention/s, using the person's treatment plan, or if there isn't a plan for the specific problem, develop one that will best eliminate or minimize the impact of the problem. Your decision should ensure that **the benefits of your selected intervention outweighs the risks**, since there will always be risks.

Act: put the plan into action

Evaluate: the person's response to the intervention/s. It's important that you **perform each** step of the process to manage the risks.

Risk and Protective Factors

There are many factors that increase or decrease the potential for dangerous or violent behavior. Risk factors increase the chance that something else will occur. Factors that decrease the risk are Protective Factors . Protective factors work to protect the person against the risk factors by either reducing the risk itself or by providing an alternative.

Typical **protective factors** include:

- Religiosity – faith and a belief in a higher power provides comfort to many
- Life Satisfaction
- Reality testing ability
- Engagement in treatment: compliant; responding to and perceives treatment as effective
- Demonstrated internal ability to cope with feelings e.g., hobbies, interests; problem solving skills
- Positive social support (family and friends)
- **Positive relationships:**
 - Treater's e.g., primary clinician, case manager, etc.
 - Other supports e.g., family, friends, etc.

A trusting relationships is one of THE most important protective factors.

The clients at risk typically have more risk factors than protective factors and vice versa. The goal of inpatient treatment is to tip the scale so that the protective factors outweigh the risk factors. And the goal of outpatient treatment is to keep the scale tipped on protective factors.

Risk Assessment (RA)

On admission, an extensive assessment is conducted by a clinically licensed professional and the person specific risk factors should be identified at that time. An extensive review of past situations when the person was violent should be conducted and should provide information about:

- What type of violence the person is capable of?
- When: How frequently the violence is likely to occur?
- Where: What conditions make the subject more likely to be violent?
- Who the likely targets is likely to be?
- How severe the damage is likely to be?

The information from the admission RA should be included in the treatment plan including what interventions are likely to reduce the risks. **The greatest predictor of future violence is knowing the specific situations when the person was violent in the past.**

B=P X S

We've adopted this equation: B (behavior) = P (person) X S (situation), to help you quickly and systematically **assess** the risk factors present in a specific situation. This equation was developed by Dr. Joel Dvoskin, a leading authority in risk assessment of violent behavior.

The 3 major categories that you will assess include the:

1. Behavior of the people involved
2. Persons involved in the situation
3. Situational factors that are present at the time.

	Patient/Client	Staff	Others
BEHAVIOR	Irritability: easily annoyed or angered, unable to tolerate others presence.	Words or actions provoke/trigger intentionally or unintentionally. Poorly managed anger or fear. Fatigue and letting your guard down (situational awareness).	Depends on relationship: can be similar to patient/client or staff.
	Impulsivity: behavioral and affective instability, inability to remain composed and directed.		
	Unwillingness to follow directions and becomes angry and/or aggressive when asked to adhere to rules, treatment, etc.		
	Sensitivity to Perceived Provocation: sees others actions as deliberate and harmful, may misinterpret others behavior or respond with anger disproportionate to provocation.		
	Negative attitudes; antisocial and negative attitude/beliefs which may related to violence and aggression		
	Verbal Threats that is threatening, loud or profane and may include ideation or plan. Intent is to intimidate or threaten.		
PERSON	Increased muscle tension and/or agitation. Displaying physical aggression against objects or people.	Youth and inexperience related to lack of knowledge and skills	Identified target: role of significant other and/or caretaker (either provocative or not protective) Wrong place, wrong time
	Increased diagnostic symptoms		
	May be unseen and related to thoughts		
	Untreated active psychosis especially paranoia, command hallucinations, belief that thoughts controlled externally.		
	History of Violence		
	Substance use/intoxication		
SITUATION		Is similar to situations when past violence occurred. Risks outweigh the protective factors. IDEATION plus Plan and available MEANS to carry out the plan.	

Cultural Considerations

Sometimes, you might trigger a person by not respecting cultural norms. There are many cultural norms for human behavior and we will address eye contact, speaking volume and touch. Most information on cultural differences is generalized, it's dangerous to generalize because so much of how we behave is influenced by more than just our culture. So, these are just general tips – as always, learn what triggers your individual patients.

Eye Contact

The duration and frequency of eye contact communicates a great deal—honesty, respect, shame, interest—but the norms can differ widely among cultures.

- African-Americans use more eye contact when talking and less when listening with reverse true for Anglo Americans.
- Among Latinos, it is respectful to avoid direct eye contact with authority figures.
- Among Asians, direct eye contact is very brief, with the gaze then sliding away to the side, especially with superiors or members of the opposite sex.

Speaking Volume

White Americans typically interpret raised voices as a sign of anger or hostility. Among non-white Americans and other ethnic groups such as Latin Americans or Africans, raised voices may simply signify an exciting conversation.

Touch

Compared to other cultures, Americans rarely touch each other, limiting ourselves to handshakes and occasional pats on the shoulder or arm in business relationships, or hugs in closer friendships.

- Latin Americans and Middle Easterners touch with much greater frequency. In these cultures, it is not uncommon for two men to hold hands, signifying nothing more than friendship.
- Japanese, touch less than Americans and may be uncomfortable being touched in a casual relationship. Touching someone on the head is offensive to most Asians.
- People from cultures with conservative customs regulating inter-gender relationships may be extremely uncomfortable being touched by someone of the opposite sex.

Triggers and Responses

There are many other factors that can affect how people respond when triggered:

- Poor impulse control
- Poor coping skills or ability to self manage angry behavior
- Don't care and/or anger is used as part of intimidation.
- Fatigue
- Being overstimulated/overactivity
- Being medically sick/ill
- Adverse medication reaction

Risk Analysis: B= P X S

Risk analysis is when you have identified all the risk and protective factors in the context of the situation that is occurring to determine **IF** violence will occur, **WHEN** and **how serious** it might be.

To best determine **IF** violence will occur, you have to pay close attention to the situational context . This is called situational awareness. It's the ability to understand what is occurring in the immediate environment and give meaning to what is happening to form a clinical picture, and importantly – to determine what will likely happen in the immediate or near future. It is the assessment /analysis (**B=P X S**) process in action. A way to determine IF violence will occur are to consider the protective factors. Remember, the protective factors we discussed earlier. Here's what happens when you break it down:

First, you may hear or see **behavior** that catches your attention and raises the question *what is s/he he doing?* Then, you attach meaning to it based on the **person** risk factors that answer the questions: *what do we know about this person and their capacity to harm others?* Then you put the information (what you heard, saw, who's involved, etc) together in the context of the **situation** which answers the questions, *who else is there..where is s/he located, who is watching?* Based on the answers to these you determine what you think may or may not happen in the immediate or near future – that's your analysis.

What's critical about this thought process is that it happens very quickly. If you miss any of the important pieces of information, your decisions and actions will be made based on missed information and will have a direct impact on what actually happens. Being situationally aware is especially important in the community setting because they are not controlled settings. For your personal safety, there are assessments that should occur before and during every home or community based visit.

To determine **WHEN** you think the person might become violent, use these timelines:

- Immediate – is about to happen or is happening right now.
- Short Term – high likelihood within 24 hours (24⁰ care settings only)
- Chronic Long-Term risk means that it can happen in the future. People who are a chronic risk may become aggressive in a specific situation –. e.g., an anniversary date...or a court hearing. And this is especially true if they are relapsing or under significant stress e.g., stopped taking their medications, abusing substances, lost a job or living situation.

Thinking about *when* dangerous or violent behavior might occur is important because it helps you think and plan ahead. Think not only about specific clients, but consider all the at risk people in context.

To determine **HOW SERIOUS** you think the risk of violence is, you must consider all the risk factors you learned in the context of the situation that is occurring. Remember to always consider the 3 highest risk factors: history of violence, active psychosis and active substance abuse.

When performing a **risk assessment**, keep in mind all the staff and client risk factors present at the time of the incident. Focus on assessing the CLIENTS current behavior in the context of all of the risk factors that might be present.

COLLABORATIVE RISK PREVENTION STRATEGIES

Strategy 3: Workplace Practices

Workplace Practices: Communication and Planning

Information sharing plays a significant role in reducing risks – the more you know, the more opportunities you have to safely intervene or respond.

Constant Communication: All staff should know – at all times - who is at risk for dangerous behavior, what the immediate plan is to prevent a behavioral crisis and what the emergency contingency plan is.

This starts immediately upon arrival at work and includes a thorough shift report or Team Meeting where you are briefed about what has happened on the previous shift. You should minimally:

- **Identify** who the at risk clients are and what the potential triggers are – consider flagging charts, notifying the TX team. **Assess** all the B = P X S factors, the potential triggers & warning signs
- Determine the acuity (immediate, short or chronic risk).
- Have a **Plan** for reducing the risk AND an emergency contingency plan

The non-emergency plan should include the interventions that will minimize triggers and support the client's ability to self control unsafe or dangerous behavior while ensuring the highest level of safety. The **non-emergency plan is the immediate action plan that provides more intensive care**. The intensity of care will depend on all the factors we just discussed.

Here's the analogy – medically hospitalized patients whose vital signs are dropping dangerously are monitored more closely and medical interventions are immediately implemented to stop the decline. Medical staff don't wait until they are near death and then initiate life saving measures, they work rapidly and aggressively to stabilize the patient at the first signs of danger.

In behavioral healthcare, the signs that people are decompensating are primarily behavioral – we see their behavior change. Typically, when triggered, we see a response that indicates whether or not they are able to self interrupt the cycle of dangerous behavior – or self control their behavior. Waiting until the person's behavior has escalated to dangerous levels is too late. You must immediately intervene to provide more intensive care and the assessment will tell you how intensive the care should be.

If you work in the outpatient setting, you might recommend that the person go to Respite, an acute unit or even be hospitalized.

On the inpatient setting, you might recommend closer monitoring – 15 minute checks or even constant observation. Regardless, make sure that your plan takes into consideration:

- Interactions: Staff, other clients, and *in 24⁰ care settings*-visitors
- Activity: Less or more stimulation (group participation, activities, jobs, etc)
- Less or more structure
- Medications: Reassessed and modified as needed
- Other?

The emergency plan for 24⁰ care settings includes:

- Identifying the primary person who will work most closely with the client to prevent an emergency and should an emergency occur,
- Identifying the team leader and members and pre-assigning tasks/responsibilities.
- Notifying the supervisor or clinician or others per facility policy, of the potential for an emergency and the plan.

The emergency plan for Outpatient settings vary according to the location. Know the plan for your location e.g., if you work in the courts, be clear about how an emergency would be responded to and what your responsibilities are. If you are providing services in the home, typically you would contact the municipal or state police in an emergency. You may be required to contact your MCT also – make sure you are clear about your facility procedure. Typically, you're be considering hospitalization in emergency situations and in chronic long-term risk situations, you will consider increased monitoring, structure, support and a variety of other options.

Planning ahead reduces the risks that you or others will get hurt because everyone knows the plan and has a role and responsibility in making sure it's acted on. Teamwork at every phase of treatment is what helps keep you and everyone involved safer.

Communication Threats and Limitations

Interruptions and distractions - which can happen frequently especially in 24⁰ care or outpatient clinic settings.

Attentional Narrowing – which is when you focus too much on one piece of information and miss peripheral factors that are equally important. This happens especially under great stress, or when you are deeply involved in managing an emergency situation.

Memory overload – working memory is keeping information in your thoughts so that if you need it, you can use it. Again, there are limits to what you can remember and overload is not uncommon, especially when you consider all the detailed information that you are paying attention to.

Add to these, other things like time pressures, fatigue, poor teamwork, poor communication and it's understandable, that paying attention to everything and constantly being aware of each situation can be difficult. One of the best ways to overcome these limitations is to communicate frequently with those that you are working with about what you are seeing and hearing. This helps keep information flowing and allows everyone to help in putting the pieces of information together.

The 3 W's. Using the 3 W's keeps communication simple, direct and focused.

What I see – Share clinical information that you see e.g., *I just visited Bill and think that he has been drinking again – there is a liquor bottle on the counter. And he said he stopped his medications 2 days ago. He is talking more to himself and looks angry and preoccupied.*

What I am concerned about – *I'm concerned that this can escalate quickly because he has not been taking his meds and has a history of violence, especially when he is drinking.*

What I Want/Need – (To supervisor or clinician) *I believe he needs to be evaluated and he's refusing to come in to be seen. I don't think he should be alone, I can stay with him until you come.*

Workplace Practices

Dress for Safety:

- Wear clothing that you can move freely in
- Wear closed toed, flat and rubberized soled shoes
- Avoid dangling jewelry on wrists, neck and ear
- Keep hair pulled back and not hanging to reduce targets for hair pulls.
- Keep fingernails short less than one quarter inch long (past finger)
- Never flash cash: bring only the cash you must have, leave extra cash/credit cards home
- Follow your facility's dress code policy

Transporting clients:

- One staff/one patient = patient in front seat next to you
- Two staff/one patient = patient in back seat opposite side of driver and a staff in back with client
- Always wear seat belts
- Assess the level of risk before the person gets in the car. If person appears to be under the influence of alcohol or drugs or severely angry; seriously consider not transporting; if person becomes unsafe - pull over and stop the vehicle: exit the vehicle and /or use horn to attract help if needed.

When walking with clients, walk beside them. If you come to a place where someone has to go in front...it should be the client.

When meeting/sitting with clients: Best if both staff and individual have an equal access to the door. If that is not possible, staff should always sit closest to the door for rapid exit. Make sure the pathway is clear. Leave the door open and make sure that other staff members know that you will be meeting alone with the individual.

When assisting with Activities of Daily Living skills: remember to always use the ready stance. Stay to the side of the person and slightly behind them, not directly in front, ask before you touch. Provide privacy, be aware of possible barriers to use in an emergency—whatever is available.

Workplace Practices: Environment

The environmental practices include two major areas for staff to develop an on-going awareness of. One is the physical environment. Is there anything in the environment that can pose a risk?

- Don't become complacent: always monitor the environment
- Make sure that the areas of limited access are secured / locked
- If your office has a panic button, make sure it is working.
- Always, conduct periodic safety rounds to ensure that unsafe items are not around.
- Make sure that areas are well lit/bright.
- If you carry a cell phone, always make sure that it is working and charged.

In settings where R/S are used, always make sure that the mechanical restraints are located where they are supposed to be and working and that the seclusion room is maintained and easily accessed.

Workplace Practices: Acuity

In treatment settings where patients come for care, or reside there, you will always have a sense of the emotional tone. Remember all the aspects of safety – if the Unit or outpt group you are with feels tense, there is agitation, someone is in distress – it will impact others.

Is it calm? If not, take action to restore calm. This might include calling a community meeting to discuss the sense of unrest and engage people in returning a sense of calm. Or it might mean getting people involved in more diversionary activities, or separating some people from each other.

All of what you've learned to this point contributes to a safe and recovery oriented environment. These positive attributes can only occur when you:

- Use yourself as the tool to recovery and establish Therapeutic Relationships built on trust, dignity, respect, empathy and compassion.
- Work together to communicate these messages. That means providing support and feedback to each other – including constructive criticism. We are all human – sometimes, you might act in ways that you don't mean too – having someone point that out, or step in to take over in a supportive way can help. Working together enhances everyone's safety. When you work together to communicate the message of hope, the *potential for change* and have a sincere expectation of safety, non-violence and respect, the result will be positive – people will heal.

Every interaction you have each day is a learning opportunity if you put all of this knowledge into action. Strive to create an environment that will include many opportunities to provide positive comments and praise. Every small step toward behavior change must be reinforced.

COLLABORATIVE RISK PREVENTION STRATEGIES

Strategy 4: Therapeutic Interventions

Therapeutic Interventions

Effective Communication Skills

The vast majority of work that you do to help people recover from MI and SA is talking to them. There are the everyday conversations that you have related to activities of daily living...to more in depth conversations about their lives, the impact of their illness and the work they are doing to recover.

The current philosophy makes a clear distinction between **therapeutic** and **restrictive** interventions. While the use of restrictive interventions continues to be necessary to assure immediate physical safety (when other interventions have failed or are determined to be ineffective), R/S are **not therapeutic**. In fact, “they traumatize both those who experience them and those who administer them”.

Therapeutic Interventions

Consistent with the recovery model and the DMHAS philosophy, we want you to focus on using the **most therapeutic – person centered** interventions. With this perspective, your focus will be on preventing behavior from escalating using the most therapeutic interventions.

Most Therapeutic Interventions include but are not limited to:

- Interaction and therapeutic activities
- Redirection , Distraction
- Conflict Resolution
- Limit Setting
- Voluntary or prescribed use of Time Out to decrease stimuli
- Verbal De-Escalation

Two points to consider:

1. If you **Always** match your interventions to the individual and base them on their personal preferences, the treatment/recovery plan and consistent with best practices for the care and treatment of the specific individual, they will have the most therapeutic value.
2. Interventions are considered therapeutic when the **benefits to recovery** outweigh the risks **because** they create an opportunity to build on the person’s strengths and abilities.

In order to be the most effective in helping people self regulate their behavior, you’ve learned that your attitude and approach are really important. If your relationship isn’t based on trust and mutual respect, or you select interventions randomly, rather than specifically for the individual, or you use an intervention for coercion, discipline, convenience or retaliation, you are not using therapeutic interventions, thus there is no therapeutic value. In fact, coercion, discipline, convenience or retaliation **are prohibited** by federal regulations and our Policies.

Basic Guidelines: Setting the Stage for Verbal Interventions/Responses

Remember, you are creating a situation when you are verbally intervening, so situational awareness is important during verbal interventions. Whatever verbal technique you decide to use, you should always :

1. Respect personal space – personal space will be greater with people who are escalating.
2. Actively listen: we'll be talking in more detail about this in a minute
3. Do not be provocative: Always talk to people in a calm, respectful, compassionate and caring tone of voice. Remember, treat people the way you want to be treated.
4. Establish verbal contact if the pt/client hasn't already. Consider using the 3 W's Approach
 - What I see
 - What I am concerned about
 - What Can I/we do to Help?

The 3 W's that you learned about earlier are also a great way to communicate with the clients that you are concerned about. What you change is the last W and the client is asked: What can we do to HELP? This model structures the discussion for you and the patient and is a great way to discuss non-emergency planning with the clients who are a short term risk for dangerous behavior.

5. **Identify wants and feelings:**
6. **Be concise** - don't use long winded questions, or responses.
7. **Avoid power struggles.** Always consider how you request or respond to a patient – remember that it is not about power and control, rather every interaction you have has therapeutic value.
8. Consider **focusing on the positive versus the negative.** For example if you want someone to stop doing something, consider phrasing it with what you *want them to do* rather than what you don't want them to do.

Communication is the process of sending a message, whether it is verbal or nonverbal. This process requires a variety of skills including processing, listening, observing, speaking, questioning, analyzing, and evaluating. It is through communication that collaboration and cooperation occur.

Effective Communication Skills

The communication process includes the three components: sender-message-receiver. Messages are communicated in these three ways:

HOW YOU ACT: Body Language: gestures, body movement, facial expression, use of physical space

WHAT YOU SAY: Words

HOW YOU SAY IT: Voice, Tone and Volume

Listening is one of the most important communication skills you'll use. Equally important is that you convey through conversation and body language that you are paying attention. Active listening (define – essentially is listening with both eyes and ears...watching non-verbal and verbal information to get the "total message" that someone is sending) is one that takes practice and focus.

Active Listening

Signs that you are actively listening:

- Remaining silent, but asking questions or commenting as needed e.g., If you are confused by what is meant/said, you can repeat back and clarify as needed..."Tell me if I have this right"...
- Maintaining eye contact
- Giving them your undivided attention

Signs that you are most likely not actively listening:

- Talking to another person or doing something else at same time (phone, text, etc) the person is talking to you
- Cutting the person off, interrupting them while they are talking
- Starting to talk over them
- Assuming you know what they mean or are about to say, so you tune out

Common Mistakes

Communicating and using the various verbal intervention techniques requires that you will learn take practice and skill. It's the day to day interactions that occur where you can gain the most experience. Give each other feedback to master these. Despite your best efforts, common mistakes that occur that end up escalation situations typically involve the staff being:

- Being disrespectful
- Arguing
- Losing own composure (not managing own emotional response especially if transference/ counter transference issues): We are all human and mistakes happen. Don't be afraid to apologize – it could be the most valuable thing you role model. And if you find yourself struggling during an intervention, get help from a co-worker.
- Using Power and Coercion for it's sake vs. being therapeutic
- Not using the staff who are most connected to the client
- Not matching the verbal intervention to the specific person
- In your attempts to use these therapeutic interventions, you may be tempted to use **bargaining, deal-making or saying/promising anything** to gain compliance. These responses are typically caused by your anxiety or unmanaged fear. They are not recommended as they **ultimately violate trust**.

As you develop a trusting relationship, some of your work will include helping clients to develop better skills for getting their needs met and expressing anger in an appropriate way. Your goal in using these therapeutic interventions is to ...**help the individual “talk it out, rather than act it out”**.

Conflict Resolution: NEAR Model

The conflict resolution model you are going to learn is called **NEAR**. This approach is designed to interrupt the cycle of dangerous behavior. The steps in **NEAR** are:

N = Neutralize... Be Neutral...It is a method to intervene without escalating the situation by your approach

Be prepared – know what your triggers are and make a plan how to respond

Ready Stance...at least 4 to 6 ft of personal space

Manage your anger or fear:

- Don't take the hook or bait (Avoid responding, “What are you stupid?”)
- Know Yourself (Tired, Personality Conflict)
- Be aware of your “Hot Buttons” (Being called stupid, liar)

E = Empathize...Try to see the Person's Perspective

Validate person's feelings

Acknowledgement i.e., “Its OK to be upset about not getting your level increased ... I'm aware that you were looking forward to being able to go outside alone.” Or “I can see you are angry about not getting your level increased.”

Choose words that take the heat out of the situation – always think about what you know about the person - what works for one person, may not work for another. Try to avoid “I know, need you to or understand” type statements; unless you have a strong therapeutic relationship with the person.

A = Actively Listen

Identify the Issue

Ask Open-Ended Questions i.e., Can you tell me what is upsetting you right now? Is there one thing that would be good to have changed (different)?

R = Resolve

Look for Alternatives WITH the person

Try to have several choices or options

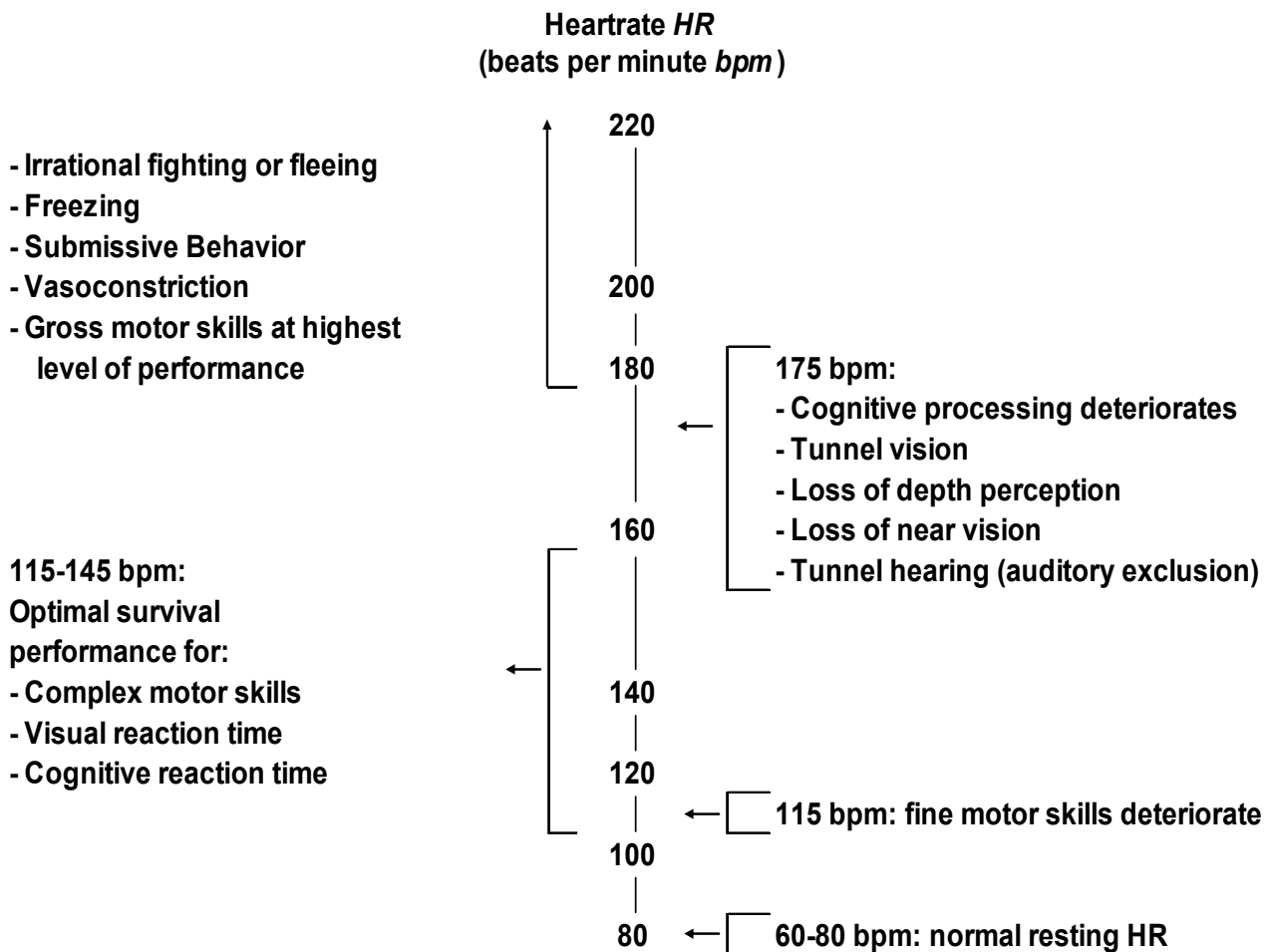
Empower the individual to choose i.e., “Do you have any ideas that would help you”? We've discussed many options – what would you like to do to increase the likelihood that your level will be increased next week? This builds collaboration.

Anger and Fear

Anger is a normal human emotion that occurs when someone feels offended, wronged or denied. Anger becomes a risk factor when the person is unable or unwilling to control how they express it.

Fear is a normal and common response to a threatening situation. In many cases a little fear helps to keep us safe. Fear becomes a risk factor when the person responds to this emotion with violence. Angry and fearful behavior can cause similar responses based on how a person responds to a threat.

For some, anger or fear at it's extreme can cause the **"Flight or Fight or Freeze" survival mechanism** to kick in. The physical and psychological changes that occur are related to the sudden flood of **adrenaline** that causes blood to divert to your vital organs (for energy) and away from your brain. This bodily response is designed to give people more physical power to fight or flee a threatening situation. But it also causes a number of other symptoms including, dilated pupils, difficulty thinking clearly, tunnel vision and hearing and loss of perception which can make it difficult to contain violence during the adrenaline rush because the brain is depleted of blood and oxygen. While the fight flight response occurs rarely and in extreme situations for most people, for some (people) anger and fear triggers it more easily.



Effects of hormonal induced HR increase

Triggers

A trigger is something that sets off emotions e.g., anger, fear, panic, that can lead to an action or series of events. Violence never occurs in a vacuum – it always occurs in the context of the situation.

Situational Triggers

Typical situations that trigger anger with your for example, include:

- Hearing bad news (laid off, divorce, loss of Level) including being told no, or wait
- Lack of Privacy
- Being stared at, touched, isolated, teased, shamed, humiliated
- Particular time of day, night or year
- Contact with people e.g., family, friend...staff with whom they have issues.
- Access to his/her money
- Access to own bedroom
- Smoking ban
- Patient contraband and bartering
- Required attendance at programs/activities
- Medication administration time
- Access to telephones

Emotional Triggers

It's not just situations that trigger anger, feelings can too e.g., feeling:

- Betrayed
- Treated unfairly (he got to do it, why can't I)
- Threatened (can include being forced to talk about feelings that you don't want to talk about)
- Disrespected (rumors about you, ignored, long waits)
- Wrongly Accused

...can be triggers. Remember, how you talk to your co-workers and patients sets the stage for a safe environment. Your behavior, words and actions can trigger a patient or escalate a situation.

And, sometimes the thought of an unresolved situation can trigger anger or just being in a situation that triggered anger in the past can trigger anger in the present. Importantly, if you have unresolved conflicts with your patients - that may be a result of transference or counter transference, you need to address it to avoid inadvertently triggering them.

Triggers & Misperceptions

Remember, things that trigger anger can be real or perceived. It's not uncommon for people with chronic and persistent symptoms of mental illness, neurological deficits; or people who experienced trauma, or who are abusing substances, or are extremely medically ill to misperceive situations or what is said.

- Are experiencing voices or delusions misperceive reality because of these disconnects with reality.
- Have brain injuries, mental retardation or other cognitive deficits can misperceive/ misunderstand as a result of these deficits.
- Have been physically or emotionally abused (trauma) typically have difficulty with anger – both expressing it and responding to it. While the majority of our patients have experienced trauma, our young adults with personality, behavioral and developmental disorders are at greatest risk for being easily triggered as are those with PTSD. People with PTSD can be triggered by flashbacks.
- Are intoxicated; in withdrawal or have long abused substances.
- Are extremely medically ill or are having an adverse medication reaction are also more vulnerable to being easily triggered.

Limit setting

Limit setting is used to maintain agency or social rules/norms, for safety, or to set parameters for socially acceptable behavior when the person still has some ability to self-regulate their behavior. It's typically used for people who are:

- **Uncooperative** with tasks that they are expected to complete i.e., Maintaining personal space, meeting with the doctor, going to scheduled groups
- **Displaying inappropriate social behavior** i.e., yelling, swearing, baiting-provocative statements like... "I'll hurt myself if I can't talk to you now".
- **Violating program/social rules** those rules that serve to maintain and/or create security for the patient, the staff and others in the environment.
- **Displaying disruptive behavior**-in the therapeutic environment

There are 2 ways you can set limits: behaviorally or verbally. The behavioral limit is set by your behavior e.g., the individual says something sexually inappropriate; *staff responds with a disapproving look and walks away.*

Verbal limit setting can be either directive or you can use wondering reflective interventions.

Directive limit setting uses these three steps – in this order:

- Point out the maladaptive BEHAVIOR
- Explain the limit
- Explain the consequences (without being threatening): Sometimes, explaining the consequences will be perceived as a threat or challenge, despite a helpful tone of voice. You should only do so when you've assessed that there is therapeutic value in stating the consequence. The more an individual is able to self regulate their behavior, the less explicit you need be with stating the consequences. Your ability to state a consequence without sounding threatening is one of the most challenging skills to learn.

A wondering reflective limit setting statement is typically used to gain cooperation through acknowledging the behavior and are effectively used with people who are more able to self regulate their behavior.

Importantly, you can use **both approaches** at the same time for example you can say: *You are refusing to go to group because you want a snack. You know that you are expected to go to group and must go now since the group is about to start and I am wondering what will happen if you miss this group since you feel better when you attend. And, I know that you have some things that you'd like to discuss.*

When patients are testing limits always consider the meaning or purpose of the behavior e.g., psychotic, testing, reenacting transference? And the context e.g., specific time, place and situation and what is the consequence of setting or not setting the limit? In this context, your on-going therapeutic conversations will focus on exploring the issues raised by rule violations in relationship to transference and interpersonal relationship issues.

This is critically important when setting limits as the long-term goal of limit setting is that the individual will be able to **self regulate their own behavior**. And remember to consider your intention and manage your behavior when limit setting. An angry approach will only escalate the situation. Be mindful of your own behavior as it relates to counter-transference issues with particular individuals or types of individuals.

Limit setting, often times isn't in response to typical limit testing, but can be in response to a request. One of the things we want to talk about briefly is saying No or "wait" (can't do it now) and sharing bad news (loss of status/level, family emergency, etc) because they are often triggering events. And, they happen pretty routinely with your patients. They may be asking to go out for a walk and you can't take them right now...or you might be the person telling them that they are not getting a level/status change.

No, Wait and bad News

Limit setting, often times isn't in response to typical limit testing, but can be in response to a request. One of the things we want to talk about briefly is saying No or "wait" (can't do it now) and sharing bad news (loss of status/level, family emergency, etc) because they are often triggering events. And, they happen pretty routinely with your patients. They may be asking to go out for a walk and you can't take them right now...or you might be the person telling them that they are not getting a level/status change. ALWAYS consider ahead of time what the response/impact will be and if it will be a triggering event:

1. How likely is it that No, Wait or sharing Bad News will be a trigger?
 - How important is it to the person?
 - Have they asked repeatedly?
 - Are they expecting a Yes?
 - Are they expecting Bad News?
2. How soon after hearing your response are they likely to get angry/upset (immediate or short term risk)?
3. How severe will the outcome be if it does occur?
4. What do we need to do to reduce the risks starting NOW? Just because it's a minor request doesn't mean that it's not a big deal to the person.

Plan Ahead to interrupt the Cycle

To interrupt the cycle when you think the person might be triggered by your verbal response of no, wait or giving bad news, plan ahead and consider these things:

WHO: The greater the response or impact to your verbal intervention, the more familiar and trusting the person should be that's verbally intervening - BUT, sometimes – it's better for a neutral person to give the news.

WHAT: you will say and how much detail in light of the specific situation e.g., someone asks for an item that they can't have. A simple no – might be fine, or you might need to give more details.

WHEN: Timing can be everything – consider time of day, weekday vs. weekend or Holiday and your availability e.g., don't give bad news "drop the bomb" at end of shift or prior to your being unavailable to talk further.

WHERE: Always where e.g., Public vs. private space and chose depending on anticipated reaction. Always make sure co-workers know where you are.

WHY: Sometimes your interventions might be related to staff convenience rather than how they should have therapeutic value (not necessarily mutually exclusive) – in short, think about WHY you are limit setting or saying no..wait or giving bad news and if it could be a yes -

HOW: Choose your words carefully – to lessen the potential impact and remember that your actions communicate the message also.

Verbal De-Escalation

The goal of Verbal D is to decrease agitation and reduce the potential for violence by interrupting the cycle. Earlier, you learned basic guidelines to set the stage for verbal interventions. We'll revisit some of them now and tell you how they apply in an escalating situations.

Basic Guidelines for Verbal De-Escalation

1. Respect Personal Space and Ensure that the physical space is safe and calm:

- Maintain 2 arms length,
- Maintain equal egress/exits for staff and patients - both should be able to exit (or enter) the area without being blocked (unless the patient is being blocked in for safety)
- Remove other clients from the area or move the client to a quieter, but public location
- Remove any object that could be a weapon should you need to physically intervene - remember personal belongings in the personal space – client may be overly protective.
- Reduce stimulation e.g., turn down noise TV, music and arousal – encourage deep breaths; don't require that the person sit or walk to a specific location to be able to engage in conversation.
- **Make sure there are adequate staff available and they are the best for the situation** and that they are aware of what is happening

2. Use Active listening - convey through conversation and body language that you are paying attention. Repeat back and clarify as needed..."Tell me if I have this right"...

3. Do not be Provocative

- Self monitor emotional and physical responses
- Display confidence, not fear
- Remain neutral, caring, compassionate – remember your intention words and actions "**How can I help?**" demeanor
- Keep hands visible and not clenched, arms unfolded, fingers not pointing
- Remember body language should be non-confrontational
- Avoid excessive direct eye contact, especially staring
- Do not challenge, humiliate, insult or do anything else that can be perceived as humiliating – save face.

4. Establish Verbal Contact

- The first person to make contact should be the person designated to de-escalate the client unless not the best person. When possible, use staff that have a trusting relationship with the person – avoid using staff where transference/counter-transference issues are present.
- ONLY that person should do the talking – others can confuse, escalate the situation
- Explain that you are there to help (regain control)

5. Identify Wants and Feelings

- Identify wants and feelings, if unable to meet say so, but "even though I can't let you out, let's talk about what you can do to get out"
- Use "free information" to ID wants and feelings...e.g., the person is depressed, sad, hopeless – this helps connect

6. Be Concise

- Agitated people may be impaired in their ability to process verbal information – keep it short and simple. More complex statements can increase confusion and escalate the situation.
- Allow time to process
- Repetition

7. Avoid Power Struggles: Agree or Agree to Disagree

When a person is highly agitated, you can use **verbal overdosing** - agreeing, "yes" responses until the intense emotional arousal passes. This can help "buy you time" to get past your Fight-Flight-Freeze response.

- 3 ways to agree with a client:
 - Agree with the truth *"Yes, I can see that you are angry"*;
 - Agree in principle – if feels disrespected by someone, *I believe everyone should be treated with respect.*
 - Agree with the odds e.g., if angry about waiting, *There are others who would be upset too.*

8. Set Clear Limits as discussed earlier

- Offer choices – personal preferences. If reasonable, offer food, something to drink – acts of kindness. Do not say, "calm down" – that more often provokes rather than helps.
- Offer medications as appropriate - timing is everything. *I can see that you're having a difficult time, medications may help.* If absolutely indicated, offer PO or IM if possible – even though not necessarily a choice, Makes client feel that they have some control.
- Appeal to the client's desire to stay in control and your responsibility to keep everyone else safe: *I can't let you hurt yourself...or anyone else, or I need to protect you from hurting someone's...so I would like you to take medication to help you stay in control. Would you like it by mouth or in by injection?*
- Be genuinely optimistic – give realistic time frames for solving a problem and agree to help the pt work on the problem.

9. Debrief the Patient and Staff

- Start by explaining why the intervention was necessary and let the pt explain events from his/her perspective. Explore alternatives for self managing aggression in the future – e.g., time out, talking, other personal preferences. What works best when you get upset like today?
- Focus on positive vs. negative. Point out what healthy behaviors, responses they DID e.g., *when I suggested time alone in your room, you agreed and felt much better after that.*

Distraction and other therapeutic interventions:

Distraction There are situations with patients for whom verbal interventions don't work and/or are contraindicated, thus they can't engage in verbally. Generally, people who are profoundly impaired by psychosis, delirium or cognitive deficits – may not respond or benefit from verbal interventions. In fact, **less interpersonal stimulation, not more**, may help.

At these times, distraction is a good technique. The type of activity you select to distract the person, that will work best is one that they prefer i.e., alone time with music, being left alone quietly, doing a physical activity or writing in a journal. There are times when the your best option may be stop trying to engage the person and see if after a few minutes you can re-approach them.

- Comfort Room
- Sensory Modulation devices e.g., Weighted Blanket
- PRN Medications: To treat the underlying symptoms of specific diagnoses
- Personal Preferences
- Other:

COLLABORATIVE CRISIS MANAGEMENT STRATEGIES

Strategy 5: Strategies in Escalating and Crisis Situations

Escalation Response

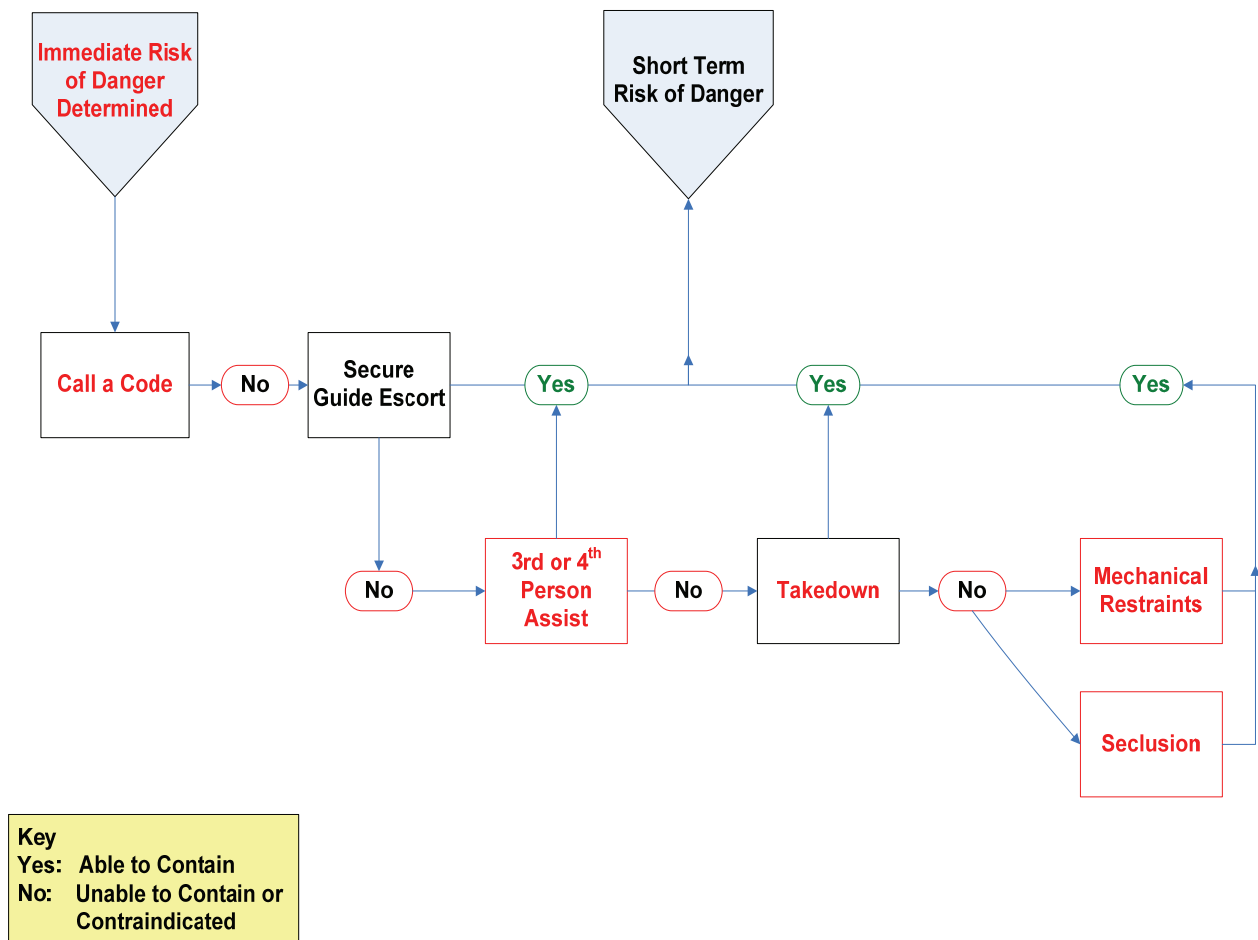
The single most important thing you will do in response to a rapidly escalating or crisis situation is to **manage your fear**. Use the skills you learned to manage your fears. Unmanaged fear can result in confused thinking and impulsive reactions (fight/flight) as you learned earlier in the program. The way you respond in a crisis can mean the difference between no or less severe injuries or injuries that are more serious.

During an escalating situation-based on your assessment if you've determined that it's safe to continue trying therapeutic interventions, focus on **changing the situation**. You can try to change the subject, use distraction, limit setting, verbal-d or whatever intervention you think will help de-escalate the person and help them regain behavioral control. If other staff are unaware that the situation is escalating, make sure you alert others and get help.

Crisis Response Inpatient or Outpatient setting with adequate resources:

If you work in an **inpatient treatment unit** or in an **outpatient setting where there are adequate resources to physically intervene**, your response will be to contain the behavior.

- Manage your fear
- Call a Code
- ID the team Leader
- Determine the intervention
- TL assigns roles and members intervene accordingly



Crisis Response Outpatient settings:

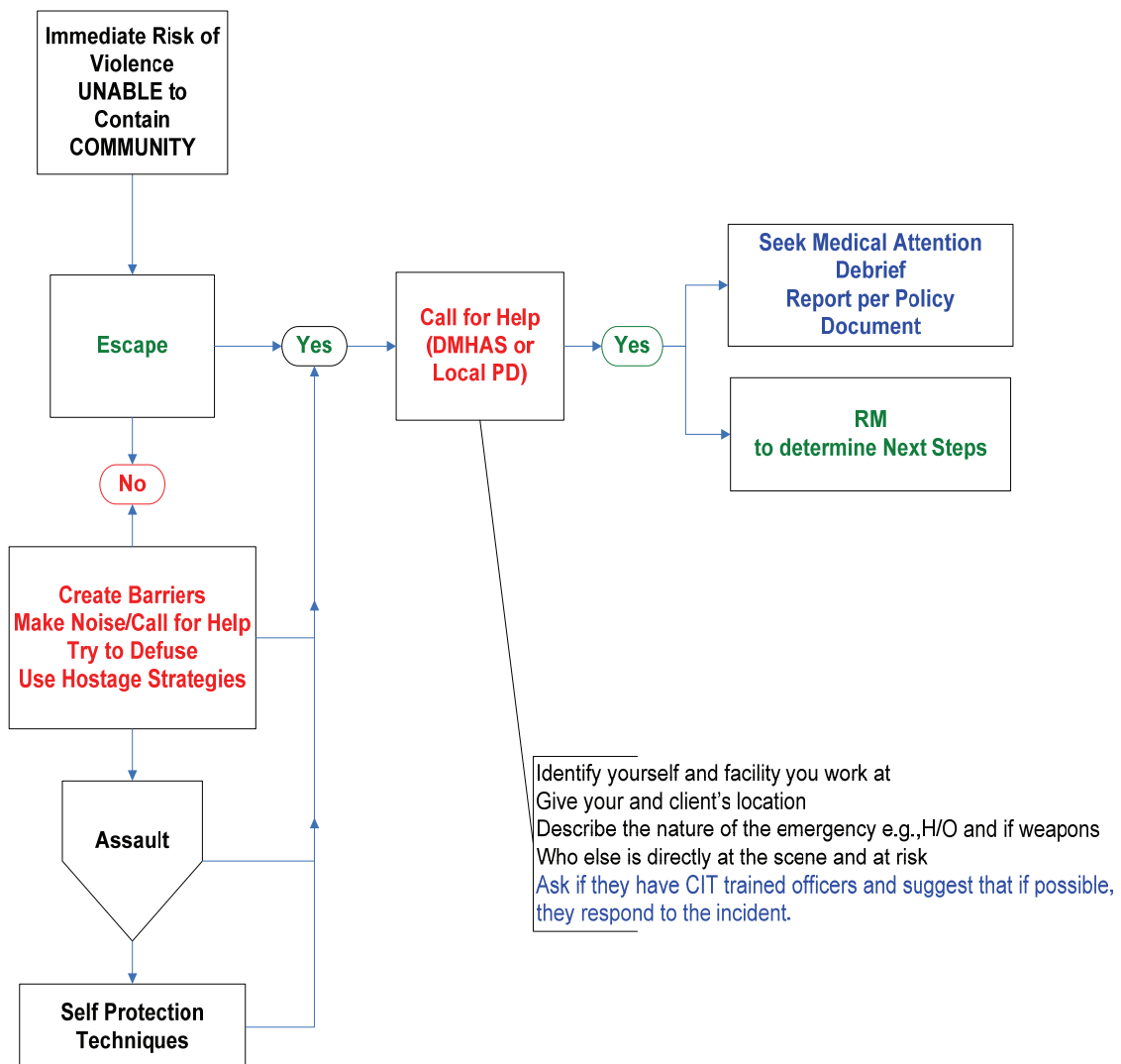
- Manage your fear
- Escape
- Call 911 or emergency number for specific location
- Contact supervisor
- Follow facility policy

Use of Municipal/State Police Outpatient Settings

In emergency situations in the community where municipal or state police officers are called to respond, always:

- Identify yourself and facility you work at
- Give your location and if different from where the client is, the client's location
- Describe the nature of the emergency e.g.,:
 - What the dangerous behavior is and if weapons are or maybe involved
 - History of violence
 - Who else is directly at the scene and at risk

If you are at another location/scene when 911 was notified, you must inform the Police Officer in charge of what has transpired and what assistance you want from them as well as follow your facility policy about who else to notify i.e., Mobile Crisis Team or supervisor.



Team Approach

Whenever you've determined that a physical intervention is needed, a key strategy is to manage the intervention as a team. The Team is made up of a Team Leader and Team Members- all of who must be certified in this course/CSS. The goal of the team approach in a crisis is to **physically interrupt dangerous behavior to reduce the rate and severity of injury's to everyone involved**. Anytime you physically intervene, regardless of the technique you use, you must use the team approach. DO NOT intervene until adequate human and material resources are available.

Human resources include the people needed to participate in the team intervention AND those needed to maintain safety of the treatment environment. In the community, material and human resources are also critical factors in making a plan. You may call upon community emergency personnel (e.g., police - EMT's - or mobile crisis personnel) to assist.

Material resources includes any items needed to respond safely. Inpatient or out-patient facility based material resources include mechanical restraints, beds/stretchers, cell phone, seclusion rooms, weighted blankets, etc.

Remember, don't intervene impulsively or without a plan – THINK SLOW then MOVE FAST but once you've intervened do SLOW DOWN to determine if the initial intervention is working...then proceed with additional interventions as indicated from your assessment.

Team Leader Role

The team leader is responsible for **directing all interventions** during the crisis. Once the Team Leader is designated, all others should defer to the TL for directions.

The team leader can be any member of the interdisciplinary team. At some facilities the team leader is determined by policy. S/he should possess leadership qualities, i.e., demonstrated leadership skills and self-confidence in crisis situations. The team leader can be the person:

- a. Most directly involved in the situation
- b. Most familiar to the individual
- c. Self-appointed: volunteers to lead
- d. Pre-determined e.g., at shift report

The leadership role can change during an emergency based on who is available at that moment. The change in leadership needs to be a formal and verbalized so everyone knows who is providing direction to the team.

Team Leader Responsibilities

This checklist will help you master being a Team Leader – work on memorizing it. It includes the tasks that must be done to enhance safety and reduce risks during a Crisis. Your responsibilities in the Crisis include:

1. **Identifying self** as the team leader and communicating it verbally. **Provide clear and specific directives** to the staff involved, throughout the intervention.
2. Assign someone to **call a code (or 911). SHOW OH DMHAS Police**
For those of you who work in settings with DMHAS police (CMHC, CRMHC, SW/GBCMHC and CVH) they respond to Codes. However, their role is only to **assist** you. These are clinical crisis situations, not law enforcement situations. So, they should only assist when you need more help than is already available. Do not automatically assign an officer a physical intervention role; use the clinical staff for the team. Should you exhaust your ability, to contain clinically dangerous behavior, then the team leader can turn over the leadership and management of the crisis event to the Police. The team leader should provide the basic information about what has happened and how you want them to help.
3. **Assign limbs** (arm-arm-ankle-leg-head, if needed extra arms-arms). Be prepared to provide to verbal directive (secured guide escort 1-2-Go).
4. **Assign someone to secure the scene** remove others from the immediate area to a safer location so the incident is out of view and remove items from the environment that present a risk.

5. **Assign someone to the door** to the unit to inform code responders of the situation and instruct them as needed
6. **Assign someone to get the MD.**
7. **Assign a nurse to get PRNs** medication if applicable
8. **Assign someone to get the restraints** and bed/stretchers or prepare the **seclusion room**
9. **Manage the emergency** through to the end, including:
 - Talking to the patient throughout the intervention...
Only you (or your designee) will talk with the individual during the behavioral emergency. Talk directly to the person and make eye contact as appropriate. Encourage the individual to take deep breaths and focus on you.
 - Provide reassurance and support e.g., if they take deep breathes, say – *great! That will help you begin to feel better.* Be specific and clear about what the expectations throughout the intervention. Continuously re-evaluate responses.
 - All directives during physical interventions include the technique that you want executed and on the count of 3. For example, you will say: On the count of 3, take the patient down 1-2-Go.
 - Continually monitor and assess the person's **physical condition**, watching for any signs or symptoms of distress.
 - Organizing the post-crisis staff debriefing/wrap-up.
 - CVH Staff ONLY** – *additional role of a monitor. The monitor's job is to observe the patient and immediately report any signs of distress to the team leader.*

Selecting Team Members

Consider these **staff related factors** to determine which staff will make the most effective team for the specific intervention:

Typically, there should be at least **five** members for a takedown. There are times when fewer staff are immediately available. The decision to physically intervene with less people is based on your risk assessment at the time considering the risk of intervening with less and should always consider that additional help will arrive almost immediately. Remember that the risk of injuries increases with less people, so this decision should be made very carefully.

The question you are attempting to answer in determining who will physically intervene is: "Of those available, who and in what mix are most appropriate to physically intervene with the safest possible outcome?" Select staff based on their strengths/abilities as related to the specific patient.

Consider these **patient related factors**:

Trauma issues. Consider the individual's response to gender of team members (especially in situations where there is a history of sexual assault).

The age and/or physical condition of the patient. Give special consideration to the elderly as well as those with medical complications. The elderly skin integrity and bones tend to be more fragile, thus more susceptible to injury. Evaluate the person's strength and physical abilities and when possible, match them to meet the staffs abilities.

Issues of **developmental or cognitive disabilities** should also be evaluated.

People with Traumatic Brain Injuries (TBI) or Acquired Brain Injuries (ABI) and individual's in the Young Adult Services (YAS) program should be evaluated for reactions to touch and the need for space. These individual's often feel threatened and have a need for greater personal space and are sensitive to being touched.

The **person's relationship with potential members.** Be sensitive to known transference or counter-transference issues when selecting team members, especially in roles where they would be in view of the patient.

Ethnicity: If a patient has identified a preference for speaking with someone in their native language all efforts should be made to accommodate that. If there is a known trigger related to an ethnic sensitivity staff should make every effort to reduce the presence of that trigger during the crisis intervention

Team Members Role and Responsibilities

Team members are those staff identified by the team leader to participate in the crisis intervention. The team members are responsible for following the directions of the leader. Team members:

- Follow the team leader's instructions without question during the emergency unless you observe something that jeopardizes the current safety during the intervention.
- Always monitor the individual's physical status and observe for any possible injury and tell the team leader of any physical concerns that you observe immediately.
- Continue doing what you've been instructed to do until instructed otherwise. If you are unable to complete the task assigned - tell the team leader. The team leader will direct the transfer of your responsibility to your replacement.
- Never physically intervene alone! Remember DO NOT intervene until the team is in place and everyone knows what their role is. The cue to implement a physical intervention will be provided by the team leader with the technique you are to use and on the count of 3: 1-2-go. If you respond to a Code and can not determine who the leader is – ask. Do not proceed to assist or intervene unless you are directed to do so by the Team Leader. The team approach is the safest and only DMHAS authorized method for intervening physically to contain violent behavior.

Assessing the Risk of Injury/Death

While restraints and safety interventions are used to ensure the immediate safety of the patient, staff or others, their use is not without risk.

WHEN to assess:

Step 1: Done on admission to identify risks and the treatment plan should indicate the plan for reducing risks or if R/S or safety interventions should not be used (are contraindicated).

Step 2: Done immediately prior to use on inpatient settings to determine whether seclusion is safer, or restraints – or neither in view of the risks present at the time.

Step 3: Done during application of whatever restrictive intervention you are using to determine whether to modify your intervention or whether in fact it's safe to proceed.

Step 4: Done during R/S use to determine whether it's safe to proceed as well as when it's safe to discontinue.

Step 5: Done immediately prior to release to ensure that it's in fact safe to do so and to determine if any specific monitoring should occur following discontinuation (in addition to the standard monitoring).

WHAT to assess:

The A-E model was developed by L. Hollins, the F was added by DSS/SETU. Think CPR and the ABC's and think of this as the Restraint/Safety Intervention ABC's. This assessment is a head to toe assessment. Starting at the head/neck, check the airway and proceed anatomically down the body.

Airway

Can they get air in?

Is there any pressure to their neck?

Is there or other item blocking their airway

Is their mouth or throat free from vomit?

Are there any signs of airway obstruction? e.g., gurgling/gasping sounds; verbal complaints or difficulty speaking?

Airway Obstruction secondary to anatomical abnormalities such as septal deviation, cancer of the nasopharynx can compromise breathing. Dentures or bridges can present a problem if they become loose during the struggle. If they remain intact – do not remove them.

Breathing

Are they able to breathe?

Is their chest free to move?

Is their abdomen free from pressure?

Are there signs they are having difficulty breathing? i.e., an increased effort to struggle or heightened distress/anxiety

Respiratory problems related to acute conditions such as seasonal allergies, upper respiratory infections or viruses, asthma and or chronic conditions like emphysema, heart disease or breathing problems related to chronic smoking can contribute to difficulty breathing. Other factors that can contribute to difficulty breathing include:

Obesity

Extreme physical exertion or struggling prior to restraint. An especially dangerous acute *physical* condition can occur as a result of excessive physical struggles: Excited Delirium.

In this state, the person is at risk of respiratory distress because of the high levels of adrenaline. Signs & Symptoms include: extreme physical agitation with unusual strength, increased confusion, paranoia; rapid speech and actions and an inability to respond appropriately to reason which can progress to extreme muscle tension (rigidity), dehydration, high body temperature, irregular heart beat. If left untreated, death can result. ED is a high risk especially if there is a pre-existing medical condition. ED can be missed as the early signs may be typical during the restraint process as the person fights the intervention – NEVER ignore any complaints or signs of ED and intervene immediately. Remember that people who are obese, are abusing substances or prescribed medications with cardiac risks are also at risk for breathing related problems. Physical Exertion can also be a risk factor.

Often times, excited delirium is misinterpreted as a “bigger fight” and staff ignore expressed complaints that the person can’t breathe, and other signs like muscle rigidity. You MUST constantly monitor breathing and evaluate complaints of pain during the use of any restrictive technique.

Patient positioning can contribute to a blocked airway or breathing:

- Supine (face up) predisposes to aspiration
- Prone (face down) restraint predisposes suffocation-positional asphyxia – prohibited in DMHAS

Regardless of the cause, when breathing is seriously compromised, the person can become hypoxic. Hypoxia is defined as a condition in which there is an inadequate amount of oxygen in the blood. Observable signs that a person is becoming hypoxic are a slight blue tint to the skin especially around the mouth and lips and confused speech.

Circulation

Can blood be circulated efficiently?

Are their limbs free from pressure

Are there any signs of tissue hypoxia? i.e., pale/grey/blue skin coloring to the lips, nail beds or earlobes

Are there reported symptoms of compartment syndrome? i.e., pain, pins and needles, pulselessness and/or paralysis

Deformity

Is there a risk of injury to any joints, limbs, or other skeletal/muscular structures?

Is the spine in correct alignment?

Are the joints of the upper and lower limbs free from end-of-range stress?

Is the patient complaining of discomfort or pain to any part of their body?

In addition to the risk of respiratory and cardiac risk factors, remember, that the elderly pose risks associated with poor skin integrity and that their bones tend to be weaker / brittle, so there is a greater risk for injury.

Physical deformities on any part of the body are considered a risk factor when they interfere with proper and safe application of restraints.

Existing medical condition or injury?

Is there anything known about this patient medical history that influences risk?

Any known respiratory disease?

Any known cardiac or vascular disease?

Any other relevant pathology or injury?

All medications have side effects and some include cardiac or respiratory side effects that can increase the risk of death during restraint use. For those of you that are licensed healthcare providers, remember to factor in the risks of the medications that your patients are taking when assessing the patient.

Also, it's important to know that any substances that depresses or stimulates the Central Nervous System (CNS) has the potential for leading to death resulting from cardiac or respiratory failure because they increase or decrease the heart rate, blood pressure, and respiratory rate. If you are working with people who abuse substances, learn what they are.

Fear

Regardless of the type of restraint or seclusion you use, fear can be a major factor. It may be related to past trauma and even related to the current situation. Despite the fact that you've determined that the use of R/S or a safety intervention are justified, your assessment should include any signs of emotional distress. Specifically, listen and look for signs of fear, emotional detachment, tearfulness, or any other emotion related to your use of R/S. This is especially important in determining which intervention to use: restraints or seclusion.

Reduce the Risks of Injury/Death

To decrease the risks any time you physically intervene, you must:

1. Use restrictive interventions only when their use is determined to be safe and indicated (the only alternative left to ensure safety) based on the risk assessment.
2. Use ONLY the authorized CSS techniques.
 - Match the type of restraint with the specific person. Consider the individual's age, strength, and history of physical violence as it relates to the current situation.
 - The incorrect application or modification of any physical technique can result in pain to the person or can increase the risk of injury or death.
Pain compliance techniques are not authorized for use in DMHAS.
 - NEVER restrict breathing by placing pressure on the person's chest or abdomen, or by placing any material on their face.
3. ALWAYS monitor and immediately report signs of physical distress.

Post Crisis Management

Vicarious Trauma

Being involved, either directly or by witnessing restraint/Safety Intervention or seclusion related emergencies may be traumatizing. Staff that are directly involved can experience post traumatic symptoms as can staff who witnessed the event. Signs and symptoms include:

- Difficulty managing your emotions; e.g.: depressive symptoms, pessimism, cynicism, fatigue, specific somatic problems, Irritability, anxiety, guilt,
- Difficulty accepting or feeling okay about yourself;
- Difficulty making good decisions;
- Problems managing the boundaries between yourself and others (e.g., taking on too much responsibility, having difficulty leaving work at the end of the day, trying to step in and control other's lives);
- Problems in relationships;
- Physical problems such as aches & pains, illnesses, accidents;
- Difficulty feeling connected to what's going on around and within you; and
- Loss of meaning and hope.
- Poor performance at work, absenteeism, avoiding restrictive interventions. It's important to take care of yourself and each other when these crises occur.

Intensive Care for the Staff involved in R/S Situations

Always

- Debrief immediately after – the TL is responsible for making sure it happens and may lead the debriefing, or have another person who is aware of what happened conduct the staff debriefing.
- Immediately assess if there are any physical injuries
- Immediately assess the emotional status of all involved and
- Support each other and use additional supports to decrease the risk or signs of trauma: EAP, CISM, Staff meetings, Supervisory support, Others e.g. Chaplain

Then briefly discuss what worked - in terms of the roles, responsibilities and mechanics of techniques used - and what didn't work. Make sure the information is incorporated into the plan that's developed for the patient upon release from R/S.

Intensive Care for Others

Involved Patient Debriefing

A staff member should also immediately debrief the patient who is in crisis depending on their mental status and willingness to debrief. Similar to the staff debriefing, this debriefing should focus on immediate emotional/psychological needs, but should not be detailed. Supportive, reality based comments, such as "*we are here to keep you and everyone here safe*" are helpful. This conversation is typically held in the context of describing the criteria for discontinuing the use of R/S or other restrictive interventions.

Others

Always consider the impact of these emergencies on others who may have witnessed the violent behavior, or who know about it and may be impacted in some way. This is an excellent time to call an emergency Community Meeting to address the concerns of others and to reassure them that they are safe. Pay special attention to the persons roommate(s) and meet with the as needed to provide reassurance. The community meeting may also provide information about what was happening prior to the crisis that you didn't know about.

Finally, the Treatment Team must meet with the patient to review the incident in detail and consider changes to the Plan. Make sure that you communicate what happened, what worked or didn't and any new information about the patient that would help redevelop the plan. Again, the revised plan should address all the aspects of after care that we talked about earlier.

Documentation

Make sure that the following information is documented in the patient's medical record:

What happened Prior to the use of R/S or a Safety Intervention?

- The condition or symptoms) that warranted the use of R/S or a Safety Intervention;
- The response to all of the intervention(s) attempted, including the rationale for continued use of the intervention;
- The rationale for the type of restraint or seclusion or Safety Intervention used;

What happened during or immediately after R/S use or a Safety Intervention?

- The 1 hour and any other face to face medical and behavioral evaluation;
- Notification of the individual's family/conservator/legal advocate, when appropriate;
- Written orders and telephone orders for use;
- 15-minute assessments of the individual's status;
- Assistance provided to help patient meet the behavioral criteria that was identified for discontinuation of R/S;
- Continuous monitoring;
- Debriefing of the individual with staff;
- Death or injuries that are sustained and treatment received for these injuries

COLLABORATIVE SAFETY STRATEGIES

Physical Skills

Protective Physical Techniques

READY STANCE



- Turn to the side (45 degree angle)
- Feet shoulder width apart

PROTECTIVE POSTURE



- Assume Ready Stance position
- Forearms upright, in front of upper body

BLOCKS - Upper



- Extend your forearm above and out from the front of your head

BLOCKS - Inner



- Bring forearm across the front of your chest, slightly past your centerline

BLOCKS - Outer



- Extend your forearm away from your centerline

BLOCKS - Lower



- Bring your forearm down across your centerline

BLOCKS - Leg



- Lift the heel of your front foot
- Pivot and turn your body to the side
- Absorb impact on the back or outside part of the thigh

Two Handed FRONT CHOKE



- Tuck chin and raise both arms
- Place one foot back
- Pivot your body towards your back foot



Two Handed REAR CHOKE



- Tuck chin and raise both arms
- Place one foot forward
- Pivot your body towards your back foot



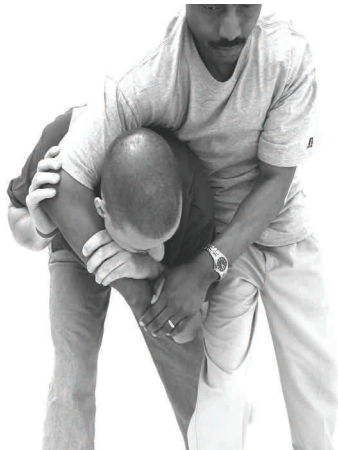
Rear Arm CHOKE



- Tuck your chin, pull down on arm & forearm,
- Widen your stance & lower your hips, turn your face away from the Pt's elbow



- Pivot your hips and turn your upper body towards the Patient, then place your foot behind the Pt's foot



- Release the grip on the wrist then,
- Place your inside hand on top of Pt's wrist



As you push forward on elbow—push down on the wrist; slide your head out



SECURE GUIDE ESCORT

- Your outside hand holds slightly above the patient's wrist
- Place your inside arm underneath patient's armpit and grab your other wrist
- Extend patient's arm across your body
- Palm facing you, trapped to your hip



Alternate Secure Guide

- From Secure Guide Escort, reposition inside hand to secure the upper arm
- Bend knees, widen/lengthen stance



Third Person Assist

- From the Secure Guide, third staff member approaches patient from behind
- Place one hand on patient's shoulder, other hand secures the waistband

Optional: Both hands secure waistband

- From the Third Person Assist
- Staff in the Secure Guide Escort place their inside leg across and in front of the patient's leg
- Staff in the Third Person shifts over, Fourth Person slides in
- Fourth Person and Third Person help secure the patient, they are in a side stance, back to back



OPEN APPROACH TAKEDOWN

- Two staff approach the patient from the front, at a 45 degree angle
- Outside Hand holds the patient's wrist
- Simultaneously step forward and place Inside Foot behind patient's heel, heel to heel
- Inside Arm hooks under patient's armpit
- Take two steps and kneel on inside knee
- Remain hip to hip, feet shoulder width apart





Head:

- Place knees on opposite sides of the head
- Overlap open hands and place on patient's forehead

**FLOOR CONTAINMENT POSITIONING
Following a Takedown**

- The patient is always **(Face Up) Supine**, the prone (Face Down) is prohibited
- All staff are positioned facing the patient
- Never apply pressure to the chest or joints, pain



Arms:

- Pt's arms at a 45% angle, palms down
- Hold the patient's upper arm and just above the wrist

Additional Support: Facing staff securing arms, two additional staff can kneel and hold arms above and below the elbow



Ankles & Legs:

- Cross closest leg over furthest leg
- Wrap your arm around & under patient's Ankles
- Place other hand on shins close to your chest and lean back
- Leg staff are on the opposite side, above or below the knees, hand positions same as Ankle staff



THIRD PERSON TRANSITION TAKEDOWN

- Staff in Secure Guide will step forward and away from the patient
- Pivot 180 degrees, facing patient
- Release your inside hand from holding your wrist and use this hand to secure patient's wrist
- Step forward, heel to heel, your heel behind patient's heel
- Place your inside arm, palm open, underneath patient's armpit
- Third person disengages as staff take two steps, kneeling on outside knee as the patient is lowered to the floor



FOURTH PERSON TRANSITION TAKEDOWN

- Two additional staff (5 & 6) approach patient from opposite sides, at 45 degree angle
- Staff 5 & 6 will grip patient's arm closest to them, above the wrist and above the elbow
- Upon verbal cue, staff in Secure Guide will move their Inside leg from in front of patient, pivot to the side while maintaining grip of patient's wrist
- Simultaneously, staff in 3rd and 4th positions will disengage and become Safety Spotters
- Staff 5 & 6 will step in, heel to heel, take two steps and kneel on outside knee

Collaborative Safety Strategy Physical Techniques Descriptions for Documentation

When documenting in the medical record, correct use of the technique name(s) used is critical to accurate documentation.

Technique Name	Describes methods for:
Personal Space:	Creating physical space around you that separates you from another person. When describing the space, describe how physically close the person was.
Ready Stance:	Standing in a position to prevent injury to major body organs/parts.
Step Slide:	Moving toward people in a manner that prevents falling.
Pivot and Parry:	Moving out of the way of a person approaching aggressively.
Blocks:	Using arms or leg, to protect against strikes.
Wrist Release:	Escaping from a single or double wrist grab.
Choke Escapes:	Escaping or surviving a front, back or side arm choke hold.
Bear Hug Escapes	Escaping bear hugs – arms trapped or arms free.
Hair Pulls:	Protecting scalp area and neck from a hair pull.
Bite Escapes:	Protecting against further injury from bites.
Guide Escort:	Escorting a person with 2 staff members.
Secure Guide Escort:	Escorting a person with 2 staff using a more secure holding technique.
Alternate Secure Guide Escort:	Escorting a person with 2 staff using a different hands/arms secure holding technique.
3rd or 4th Person Assist:	Immobilizing and stabilizing a person by adding a third or fourth staff member who holds the person from behind.
Take Down:	Taking a person to the floor in the supine position typically using 5 or more staff members.
Verbal Altercation Separation:	Separating people involved in a verbal altercation by using re-directionality.
Physical Altercation Separation:	Separating people involved in a physical altercation by using the alternate or secure guide escort to separate one person from another.
Ground Position:	Protecting self when on ground being assaulted.

