
Sample Safety Guidelines In Homeless Health Services Programs

Compiled by the
Health Care for the Homeless Clinicians' Network

with support from the

U. S. Department of Health & Human Services
Substance Abuse & Mental Health Services Administration
Center for Mental Health Services, Homeless Programs Branch

and the

U. S. Department of Health & Human Services
Health Resources & Services Administration
Bureau of Primary Health Care
Division of Programs for Special Populations

March 1996

Big City Mental Health Center Violence Policy & Procedures

INTRODUCTION

These policy and procedures were written for a medium-sized mental health agency in a downtown urban area. The agency consists of an outpatient clinic and several types of client residences. The guidelines give specific responses for the different agency settings, and were developed for use by both clinical and support staff.

The guidelines are valuable because they clearly state in writing the agency response to escalating and violent incidents. This increases the confidence and security of staff and clients, thereby decreasing the number of potentially dangerous incidents.

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Big City Mental Health Center Violence Policy & Procedures

- I. **Definition.** Violence is defined as any act or attempted act of physical aggression intended to hurt or harm oneself, another person or property. Physical aggression includes assaultive physical contact such as slaps, kicks, punches, tripping, pushing, and shoving as well as throwing objects or destroying property. The Big City Mental Health Center does not tolerate violence in the office, in homes, or in apartments operated by the agency.

- II. **Assessment.** Assessment of violent incidents must include the following considerations:
 - A. Assessment of the type, intent and result of an act of violence.
 1. The **type** of violence includes the actual act or threat.
 2. The **intent** of the violence includes the amount of control the person had over his/her behavior. For example, was the client influenced by drugs or alcohol? Is the individual psychotic? Was the aggression intentional or premeditated?
 3. The **results** of the violence include the consequences of the threat or action.

 - B. Assessment of the milieu of the act or threat of violence.
 1. Assess the involvement of other clients and/or staff. Was there provocation?
 2. Assess the perceptions of clients and/or staff who were present. What did the clients and/or staff see and hear?

 - C. Using information gained from the assessment, staff then uses his or her clinical judgment to address the situation.

III. Policies for facilities and programs. Each program, because of its circumstances and parameters, responds differently to perceived threats or incidences of violence.

A. Main offices. A Crisis Resolution Team consisting of four clinicians is assigned to each week day. Each Team is responsible for covering client crisis situations at the agency during its assigned day. All members of the Crisis Resolution Team are volunteers so that only staff members who feel that they can handle crisis situations are called on to do so. Each team member is aware of his or her assignment and who is to be Team Leader for that day. In the event that more than four clinicians are needed to handle a crisis, the Team Leader can call for more staff support. An act or attempted act of overt physical aggression initiates the following staff response:

1. The identifying staff person calls the Crisis Resolution Team into action by making a system-wide telephone page stating, "*We have a code strong,*" and giving the location. The Team Leader directs the intervention. The identifying staff person should not intervene alone.
2. The Crisis Resolution Team directs other clients to clear the area. The Team then attempts to contain or remove persons from the room through verbal interventions. Physical contact should not be attempted unless it is necessary to protect self, other clients or the violent client.
3. If verbal interventions are ineffective or if a physical intervention is necessary, the Team Leader will instruct a staff person to call for police assistance by dialing 911. The Team Leader may also ask that a second Code Strong be called to alert general staff that assistance is needed.
4. Staff should always obtain appropriate back-up support. It is important to know who is available to help and what the group's limitations are regarding controlling an individual.
5. Once the violent client is contained, the Crisis Resolution

Team and other staff on the scene need to process the incident. The client's case manager is informed so that appropriate follow-up interventions may be planned.

6. After the violent episode is resolved, the building coverage clinician or the Crisis Resolution Team Leader should take charge in the absence of the case manager or the case manager's supervisor. The clinician in charge should:
 - a. Provide follow-up attention to other clients and staff after resolution of the incident.
 - b. Notify absent case managers and supervisors whose clients were affected by the incident.
 - c. Obtain and/or provide supervision and support by appropriate personnel—supervisors, senior staff—for all staff immediately affected.
 - d. If both the clinician and building coverage person are available, they should work together to attend to both the individual and the milieu.

- B. **Supervised group residences.** A violent act results in an immediate call to the police. House staff should notify the clinical coordinator and the client's case manager or on-call clinician. If before 5 P.M., a threat of violence will be evaluated by the clinical coordinator and case manager and a course of action will be determined.
- C. **Crisis Residences.** The Crisis Team initially screens incoming residents for potentially violent behavior. Any client who acts out violently is removed immediately.
- D. **Apartment Program.** The Apartment Program has a policy of no violence. Each incident is separately evaluated and a plan of action is determined by the clinical case manager in consultation with the residential team.
- E. **Case Management.** If a person becomes violent or appears to be at risk for violence, the case manager and supervisor develop a plan of action including options such as hospitalization, counseling, time out, or contracts. This plan should be clearly communicated to appropriate agency staff. Unless the violent act is imminent,

individualized treatment plans prevail.

Wasatch Homeless Health Care Program Safety Protocol

INTRODUCTION

These safety and violence guidelines were developed for use by staff and volunteers within a clinical setting. They emerged after episodes of violence had occurred in waiting rooms as well as after patients had left the clinic or dental office. The guidelines are intended for use by all persons on staff with no differentiation due to profession or job duties.

These guidelines have been in place at our facility for two years, giving staff and volunteers guidance and explanations focusing on violence reduction and prevention. In addition, they provide a clear means to evaluate our response to violent episodes. We have found them easy to read and to put into action, and they seem to impact positively our patient interactions.

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Wasatch Homeless Health Care Program Safety Protocol

Goals & Priorities

The primary goal of the Wasatch Homeless Health Care Program is to interact with patients in such a manner that prevents the escalation of negative actions and potentially violent situations. The secondary goal is to persuade patients who act out to leave the premises willingly and quietly.

In order to achieve these goals, we must establish behavior guidelines that enable us to identify problem behaviors and deal with them effectively and appropriately before they escalate into a crisis situation. In order of priority, these are the personnel who will be involved with problem clients:

1. Front desk personnel and dental personnel who receive patients and make appointments are usually first to encounter possible difficulties.
2. Medical assistants and dental assistants are second in this role.
3. Medical and dental providers, other staff and volunteers are usually last in this interaction process.

Regardless of our role, however, when serving patients we are equally responsible for our own behavior and for protecting the security of coworkers.

Guidelines

Here are guidelines to follow in our everyday interactions with patients. In order to promote workable relationships, we must address our patients with respect and kindness. It is imperative that we do not react to verbal abuse with anger or disrespect. Instead, we should remain calm and in control.

Occasionally patients use aggressive and intimidating tactics to get what they want. It is important that we be aware of this type of behavior and learn to respond without being manipulated.

- Answer patients' questions assertively and assure them that they will be seen as soon as possible or according to their respective appointments.
- Do not offer lengthy explanations or excuses. Responding in this manner may increase the patient's frustration level.

- Simply state the facts and repeat them if necessary. If appropriate, refer the patient to other possible resources.

If a patient becomes verbally abusive or physically threatening, appropriate staff—the medical receptionist and the care coordinator [males]—should be alerted to assist in a supportive capacity. Staff members should be present on a standby basis and be prepared to intervene if required. For example, if the designated staff person becomes ineffective with the patient, another staff person should take over giving the same message.

People whose behavior escalates beyond communications will be asked to leave and be informed that it is not our policy to serve belligerent people. If they can remain calm and discuss the problem, however, we will attempt to serve them and work out a solution. If necessary, the medical receptionist and the care coordinator will escort them off the premises.

In extreme situations, the police will be called to intervene and staff will stop further involvement unless it becomes necessary to restrain a patient for his or her own safety or for the safety of the staff. In this situation, only designated, trained staff will perform the task of restraint. It is our goal to prevent escalation of a possible confrontation and to serve our patients.

In the event of a traumatic encounter, all staff members involved will meet to support each other through the debriefing process. They will document the encounter, file notations in the patient's chart, and determine if our services will be offered to the patient in the future. If the patient is denied further services, a letter stating this will be handed to him or her at the final encounter.

Wasatch Homeless Health Care Program Safety Manual

Purpose

The purpose of this manual is to outline proper procedures for handling situations with aggressive patients which have the potential to further escalate into violence. Staff safety is our top priority at all times. It is also important to respond to aggressive or violent situations in a professional and sensitive manner. Our patients are individuals who deal with grave physical and emotional difficulties daily, and they should not be subjected to unnecessary suffering from interacting with clinic staff or volunteers.

Patient Stress and Special Extenuating Circumstances

When serving our patients, it is important to keep in mind the extremely adverse living conditions and backgrounds patients come from. Stressful living situations break down morale and social behaviors such as courtesy and patience. Under these circumstances, it can be challenging to deal with such a person. If the patient is involved with drugs or alcohol, suffers from a mental illness, or has a serious antisocial background such as a history of criminal activity or prison, they can be especially difficult.

Another factor exacerbating a patient's frustration is the fact that many of them frequently interact with a multitude of private and public agencies to get basic needs met. Consequently, during the process of waiting, answering personal questions and applying for various types of assistance, their frustration level often becomes elevated. By the time that they visit our clinic, they may be—understandably—in the mood to react negatively towards our requests or instructions.

Although a patient's negative behavior may appear unwarranted, this behavior may be a learned survival technique. Through hard living, some patients have found that an aggressive, demanding behavior will get their needs met no matter how inappropriate.

In addition, there are individuals who blame the system for everything that has happened to them. These patients give up very easily using passive-aggressive behaviors—such as walking out—to express frustration. It is important to

remember not to take a patient's negative or aggressive behavior personally. There are reasons for this behavior, and most likely you are not the reason.

Regardless of the patient's actions, it is imperative that staff reactions not encourage further negative behaviors or responses. Instead, we can employ simple intervention strategies when a patient begins to act inappropriately within the clinic environment.

Guidelines for Addressing Aggressive Patients

Strategies for dealing with aggressive individuals are best formulated around the principle of least restrictive measure. This means starting with the least invasive tactic for subduing the aggressor and not advancing to the next level of restriction unless absolutely necessary. The three levels of intervention are:

- Level 1: Prevention;
- Level 2: De-escalation of tension; and
- Level 3: Action aimed toward safety for all individuals involved.

Our goal of preventing violent behavior can be achieved by effectively employing these four basic steps:

- Observing,
- Skilled Listening,
- Talking, and
- Actions.

LEVEL 1: PREVENTION

The first and best method for managing physically or emotionally assaultive behavior is to anticipate and prevent. Management can be achieved by early assessment of the patient. For example, what are his or her needs? Can we meet these needs? If not, what options can we offer the patient, e.g., *"Would you like to speak to a supervisor?"* Consider whether there is another facility that can assist the patient and ask, *"Can we make a referral for you?"* or *"Would another time be more appropriate?"*

Observation. As you work, pay attention to the following warning signals that may hint of escalating tensions:

- Defiant attitude
- Excessive swearing
- Aggressive motions

- Unusual demands
- Increase or decrease in voice volume
- Challenging demeanor
- Tightening of jaws
- Deep sighs
- Fidgety movements
- Rapid pacing
- Clenched fists
- Advance or retreat actions

LEVEL 2: DE-ESCALATION OF TENSION

Listening. The listening and attending skills of therapeutic communication are the most effective tools of averting violent behavior. Even though you may be having a busy, stressful day, remember to clear your mind and pay attention to what the other person is trying to tell you. Don't rehearse your response. Don't defend yourself verbally.

Practice reflective listening. This involves finding out information about what a person is thinking and feeling, and what may be done about a problem. Don't assume that you know. Ask open-ended questions to elicit more informative responses than a simple yes or no answer. Listen carefully to what is said. Spending two or three minutes interacting with the patient may prevent an altercation. The more information you have, the better you will be able to work out a solution.

Steps for Effective Listening

- Tune in to your personal anxiety level. Assess your feelings and ask yourself if your feelings are interfering with your communication skills.
- Acknowledge the other person's feelings. Identify the anxiety or anger and acknowledge the potential for violence. You might say *"You seem very upset," "I know how you must feel,"* or *"I'm concerned that you might hurt yourself or others here."*
- Try to elicit the real issue and determine what is behind the anger.
- Demonstrate appropriate affect. Be sincere and assertive.
- Convey calmness, control and a willingness to help.

Talking. Being able to talk down an angry, agitated patient is a valuable skill for anyone providing patient care services. It is a skill dependent upon having and demonstrating a positive regard and respect for others. While talking, be aware

of your voice. The tone of your voice will have an immediate affect upon the patient. It is imperative that your voice remain calm and soft yet firm. If you become angry or aggressive like the patient, you will be giving away your control of the situation. Simply state the facts and if necessary, repeat them. Avoid using your title or authority. Do not offer lengthy explanations or excuses.

The Don'ts and Do's of Therapeutic, Effective Talking

The Don'ts — Verbal

- Don't threaten the patient or demand obedience.
- Don't argue with the patient about the facts of the situation. Both of you may be right, but this does not help ease the situation.
- Don't tell the patient that she or he has no reason to be angry.
- Don't become defensive and insist that you are right.
- Don't offer placating responses such as *"Everything will be OK"* or *"You're not the only one."*
- Don't make promises you can't keep.
- Never challenge the patient or call his or her bluff.
- Never criticize the patient.
- Never laugh at the patient.

The Do's — Verbal

- Do ask, *"What can I do to help?"*
- Do use simple, direct statements.
- Do ask opinions: *"In what way do you feel we may be of service to you?"* or *"How would you like to see the situation resolved?"*
- Do offer choices and alternatives: *"If our services are not appropriate, may we assist in referring you to another facility?"* or *"May we make another appointment for you at a more convenient time?"* Try to leave the patient with options.
- Do encourage verbalization of anger rather than acting out. Express your limitation with this verbalization, however, such as expressions or language that is too offensive and not necessary.
- Do provide reassurance while setting limits and identifying behavioral expectations in a kind manner.
- Do assume that the patient has a real concern and that she or he is understandably upset.
- Do recognize and acknowledge the patient's right to her or his feelings.

LEVEL 3: ACTION

Taking Action. Everything that we have learned so far about interacting with difficult patients becomes part of the process and culminates when we take action. A key concept in violence prevention is to try to decrease the person's sense of powerlessness or helplessness in order to minimize his or her

frustrations. Communicate verbally and behaviorally that the person is responsible for his or her own actions. The following steps promote successful interactions:

The Don'ts and Do's of Successful Interactions

The Don'ts — Actions

- Don't ignore the patient.
- Don't come too close to the patient or hover over him or her. Keep a comfortable, nonthreatening distance between you and the patient that still allows you to hear and be heard.
- Don't make threatening physical gestures.
- Don't analyze or interpret the patient's motivation.
- Don't personalize the patient's anger.

The Do's — Actions

- Follow instinct and intuition. Use common sense.
- Detect danger signals.
- Keep everyone feeling safe:
 - Open the door to the room;
 - Identify an escape route convenient to you and the patient;
 - Position yourself closest to the room exit;
 - Keep furniture positioned with safety in mind; and
 - Assess the environment for potential weapons.
- Identify a code word that will alert the need for additional help. For example, clinic staff and volunteers are to say *Code Red* through the telephone intercom and identify the area where they are. At that point, designated staff are to respond.
- Protect others in nearby surroundings.
- Ask the patient to sit down.
- Establish and maintain eye contact.
- Observe social distance. Don't touch the patient.
- Decrease environmental stimuli by:
 - Minimizing the presence of staff and other patients,
 - Turning down any loud music, and
 - Minimizing distractions.
- Promote privacy.
- Attempt to meet as many of the patient's reasonable requests or demands

as possible.

- Follow through with promises. Do not make promises that you can't keep.
- Remember who you are and practice professional behavior.

Summary

These principles, guidelines and procedures are basic suggestions to assist in averting abusive and violent behavior. They are for the express purpose of effectively serving our patients as well as protecting staff from dangerous and abusive behavior. When put into practice, these steps of observing, listening, talking and action can help achieve our goal of preventing violent behavior. Using common sense while practicing courtesy, concern and compassion will greatly enhance everyone's experience at our clinic.

Always keep in mind the adverse living conditions that our homeless patients deal with day and night. If we can be empathetic, and treat them as we would like to be treated, then we have not only provided good health care, but perhaps we have empowered them in their attempt to take control of their lives.

Good Health Medical Center Crisis Prevention & Intervention

INTRODUCTION

These guidelines were developed by a small hospital for use in its mental health department. In addition to the regular training and review of these written policies, staff are encouraged to attend a workshop on managing people, Crisis Prevention & Intervention, The Mandt System. While these policies are very specific in nature, the concepts described can be translated into a more general approach for use in an ambulatory setting.

The guidelines are clear and brief, and we have found that they work because staff take them seriously. Our facility is in the process of updating these guidelines. Their weakness is that they need to be expanded to help staff recognize when violence might be directed towards others including violence towards children, the elderly, spouses, etc. In addition, the revised guidelines will be modified to include Critical Occurrence Follow-up so that the debriefing following a violent incident is required, not optional.

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Good Health Medical Center Crisis Prevention & Intervention

The Mandt System: A workshop on managing people

This workshop is available to all hospital personnel to provide them with options that will help them manage an individual's behavior, the individual's family and visitors' behavior, as well as that of his or her coworkers. The workshop is offered to all Good Health Medical Center employees including but not limited to: RNs, psych techs, social workers, security guards, CNAs, residential staff workers, emergency department techs, therapists, psychologists, psychiatrists, MDs, DOs, and administrators.

Program Purpose

To present a person-centered, value-based process developed to encourage positive interaction with others. Concepts presented promote respect and dignity for all persons. The Mandt System is a systematic training program designed to help you de-escalate yourself and other people when you or they have lost control. To accommodate different training needs, we are offering the option of either the Basic or the Intermediate Workshop:

- The Basic Workshop is designed for staff who work on a daily basis with people who are for the most part cooperative.
- The Intermediate Workshop is designed for staff who work on a daily basis with people who are uncooperative and who may become aggressive.
The Basic Workshop is a prerequisite to the Intermediate Workshop.

Basic Workshop Objectives

1. List a graded system of alternatives in managing people and the advantages using a team approach.
2. Identify and match the stages and responses in the crisis cycle.
3. Identify how physical presence and body stance can de-escalate or escalate a situation.
4. Recognize the importance of nonverbal communication.
5. Complete the final exams at the end of each module with a score of 100 percent. Must attend 100 percent of workshop.
6. Demonstrate the proper body stances with no errors.

Intermediate Workshop Objectives

1. Explain the difference between support and restraint, including why pain compliance and hyperextension of joints is abuse.
2. Identify when you may need to restrain a person.
3. Explain how supporting and restraining are similar and how they are different.
4. Complete the final exams at the end of each module with a score of 100 percent. Must attend 100 percent of workshop.
5. Demonstrate the proper physical techniques with no errors.

**Mental Health Departmental Protocol
Violence Towards Others**

INITIATED

Date _____
Time _____
RN _____

DISCONTINUED

Date _____
Time _____
RN _____

- Title:** Potential for Violence Toward Others
- Purpose:** To outline the management of patients exhibiting potential for violence toward others.
- Level:** Independent
- Indications:** Implement protocol for patients who are violent or are assessed as a high risk to be potentially violent toward others.
- Patient Outcomes:**
- 1) The patient will be able to verbalize that violent behavior is impending and ask for help.
 - 2) The patient is able to identify alternatives for expression of anger, rather than striking out.
 - 3) The patient will be able to accept the limits of his or her environment.
 - 4) Prior to discharge, patient is able to demonstrate use of alternatives to striking out.

KEY WORDS

NURSING MANAGEMENT CONTENT

Assessment:

- 1) Complete admission assessment to determine past history of violent behavior or assault.
- 2) Assess past history of assault in a treatment setting.
- 3) Assess past history of disorders that may indicate that the patient has a predisposition to violence such as:
 - oppositional disorder
 - conduct disorder
 - delusional (paranoid) disorder
 - organic personality disorder
 - borderline personality
 - antisocial personality
 - history of substance abuse
 - psychotic conditions
 - post-traumatic stress disorder
- 4) Assess precipitating events to prior violent episodes.
- 5) Observe continuously for behavioral cues predicting violence such as:
 - anxiety
 - breathlessness
 - rigid posture
 - pacing
 - verbal outbursts or profanity
 - increase in voice volume
 - threatening stances

KEY WORDS

NURSING MANAGEMENT CONTENT, *continued*

**Psychosocial
Support:**

- 6) If patient is assessed as being on the verge of losing control, attempt to isolate the patient from the rest of the patient group or the stimulating situation. Recognize that the patient on the verge of violent behavior is usually experiencing a panic level of anxiety.
- 7) Speak to the patient softly, slowly and with assurance. Do not use a confrontational approach. Give concise, clear directions.
- 8) Assist the patient to verbalize feelings. This may require the staff member to point out to the patient body language and other behaviors that indicate that the patient is angry.
- 9) If patient refuses to talk about feelings, ask patient what may be helpful to assist the patient in staying in control such as physical activity, being alone, listening to music, etc. Provide these activities if possible. Be aware that although some patients respond well to physical activity, this needs to be used with care, since it may also precipitate loss of control.
- 10) Inform patient of acceptable limits for behavior and clarify the patient's responsibility for own behavior. Define consequences for acting out.
- 11) Be supportive of the patient and if he or she acts out, protect patient's self-esteem by keeping other patients out of area.
- 12) If patient does become violent, obtain order and institute seclusion or restraint and follow protocol for care of the patient in seclusion or restraint.

KEY WORDS

NURSING MANAGEMENT CONTENT, *continued*

**Educational
Needs:**

- 13) Explore with patient reasons for acting out and help identify alternative behaviors.
- 14) Assist the patient to recognize and label anger.
- 15) Communicate that angry feelings are normal. Anger is not inherently good or bad and expression of anger is not always positive or negative.
- 16) Teach patient that effectively dealing with anger implies that the person can accept his right to be angry and the reciprocal right of others to be angry.
- 17) When the patient has an experience of expressing anger, assist the patient in analyzing the event. The following questions can be used as a guideline:
 - What precipitated the anger?
 - What did you attempt to do to control your anger?
 - How did the other person behave in response to your anger?
 - What would you change in the future?
 - How would you do this?
- 18) Medication teaching on any medication ordered.

Medication:

- 19) Administer medication(s) ordered. These may be anti-anxiety or anti-psychotic medication.
- 20) Document effectiveness of medication. Observe for side effects, especially with anti-psychotic medication. Syntonic reaction and/or acathisia will increase the level of anxiety.

KEY WORDS

NURSING MANAGEMENT CONTENT, *continued*

Discharge

Planning:

- 21) Review education teaching with patient and significant other.
- 22) If referral is made, encourage patient to use outpatient services. Provide patient with appointment card.
- 23) Provide written instructions on any prescribed medication.

Documentation:

- 24) Complete flow sheet every shift per guidelines.
- 25) When indicated, complete seclusion or restraint flow sheets per guidelines.
- 26) Document teaching on teaching record or focus notes.

Homeless Health Care Los Angeles Safety Guidelines for Outreach

INTRODUCTION

These guidelines were developed for use by outreach workers in the downtown skid row area of Los Angeles. They are designed solely to assist staff in avoiding trouble on the street, and they do not address how to handle difficulties once they arise. The strength of these guidelines is that they address the needs of the street outreach worker who has a very different work environment than staff who are agency-based. The guidelines are intended as only one piece of an agency's overall safety policies and procedures. Staff have found them useful for addressing this particular safety need.

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Homeless Health Care Los Angeles Safety Guidelines for Outreach

1. Your supervisor needs to know where you will be at all times.
2. Learn as much as possible about the situation before setting out to do outreach.
3. Do not plan outreach for areas in which you have good reason to believe are inherently dangerous.
4. Be aware of gang areas and their colors. To be safe, do not wear red, blue or purple while conducting outreach.
5. Always carry business cards and California identification with you.
6. Inform collaborating agencies of your presence.
7. Introduce yourself and inform people of what you are doing and why.
8. Do not stand and argue with someone who does not agree with what you are doing.
9. Preferably, outreach is conducted in two-person teams. No team member shall conduct outreach activities alone unless receiving prior approval from their supervisor.
10. Never approach those who are giving "signs" that they do not want to be bothered.
11. Do not be critical of your partner in public while conducting outreach. Always present yourselves as a team.
12. Wear comfortable clothes and shoes. Do not overdress.
13. Do not carry valuables or other personal possessions such as jewelry, large amounts of money, radios, etc. If carrying incentives, make arrangements

- to hold these in a secure place.
14. Do not remain in a spot where you are privy to a drug deal in process or being set up to "go down." Leave area immediately without drawing attention to yourself or others.
 15. Do not linger with a person who you know is holding illicit drugs.
 16. Do not interrupt the sale of sex or drugs for money. Leave area immediately without drawing attention to yourself or others.
 17. Do not counsel or play the role of a social worker on the streets.
 18. Maintain confidentiality of all clients you meet.
 19. Do not accept gifts, food or buy any merchandise from clients.
 20. Do not give or lend money to clients.
 21. Do not accept or hold any type of controlled substance.
 22. Never enter any clients' cars, homes or any enclosed area.
 23. Tell clients approximately when you will be back and where you can be reached. Provide clients with a business card.
 24. Develop a contingency plan for worst-case scenarios or dangerous situations with your partner and supervisor.
 25. Keep your supervisor informed of any unusual developments.
 26. In case of an emergency, call or have another person call 911. Do not separate from your partner unless you feel that staying would increase your danger.

Employee Statement:

I acknowledge that I have received a copy of the safety guidelines for performing outreach. I certify that I have read and understand these guidelines, and I agree to comply with agency guidelines related to this issue to the best of my ability.

Print Name: _____

Signed: _____ Date: _____

Supervisor Signature: _____ Date: _____

Street Outreach Safety Thoughts from Street Outreach Workers

INTRODUCTION

These are comments gathered from several outreach workers based on their own personal experiences in the field. Thanks to workers from the following Seattle programs: the Mental Health Chaplaincy, Health Care for the Homeless Network, ACCESS, and the Harborview Medical Center/Pioneer Square Clinic.

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Street Outreach Safety

Thoughts from Street Outreach Workers

- Explore the territory with folks who are knowledgeable about the area such as local residents, someone who is or has been homeless, agency staff, shopkeepers, clergy, etc.
- Develop a route or routes that regularly take you to shelters, drop-in sites, survival service, parks, etc. Have eventual destinations, be on the way, but always be available, ready to stop and reach out.
- Avoid being isolated; stay in public areas.
- Get to know the neighborhood. Be a neighbor, get to know the whole fabric of the community. Foster others' capacity to share in the outreach effort. Help the neighborhood—business people, street vendors, apartment managers, community service officers, church secretaries—to become skilled outreach partners with you. Help the community to be able to identify needs and concerns early on, rather than waiting for situations to become critical
- Always *observe* first. Consider how an individual is reacting and interacting with others and the environment. Tune your approach to what each person can tolerate. A glance, a smile, a hello? What is the response?
- Monitor how you affect the other person as you approach and begin to converse. Is the person able to handle someone coming closer? Is the exchange causing him or her to become agitated? Is she or he trying to create more space for themselves?
- Pay constant attention to your basic feelings and instincts. Ask yourself, *Am I feeling uncomfortable? Uneasy? Unsafe? Frightened?* Trust is a two-way street. Take time, don't push. Be prepared to back off and come back later. The issues and concerns will still be there.
- Pair up whenever going to more dangerous-feeling places and situations. Don't hesitate to ask for accompaniment. We are not looking for martyrs. Ask a colleague, apartment managers, security guards, police, agency staff, etc.
- Tell someone at your agency or clinic how long you expect to be gone and your planned route when doing outreach.

Street Outreach Safety Thoughts from Street Outreach Workers

- Carry a cellular phone. It's handy for many purposes including personal safety.
- Keep a whistle in your pocket.
- Use good judgment with personal safety being the foremost consideration. Follow your instincts and intuitions.
- Consider meeting certain individuals in public spots or sites where others are around for safety support. Confidentiality becomes a possible trade-off.
- Keep in mind that with individuals who are experiencing a thought disorder, the brain's alarm system is highly and continuously active. A person in the midst of a manic episode, for instance, may already be easily irritated. Go as a bearer of peace, calm, safety, non-aggression, respect, warmth, genuine regard, openness, and patience. Treat people with dignity. Ask permission, say thanks. Be prepared to dust off your sandals and move on.
- The bottom line is *leave* if you feel unsafe or if someone is acting inappropriately.
- Be prepared to do what you need to do to protect yourself. Learn nonviolent physical defense and escape techniques.
- Think in advance of potential dangers that may exist. Operate in a cautious, defensive mode and attempt to predict what could happen.
- Beware of being too comfortable and overly confident in any situation; for example, "*I've been doing this a long time,*" "*I can take care of myself on the streets,*" or "*I know what street life is about.*"
- When visiting someone in an apartment, always ask permission first; "*May I come in?*" In addition to being a polite gesture, this request can help avoid being accused of illegal entry should something occur requiring legal action.
- When visiting an apartment, position yourself closest to the door. Always have an escape route in mind.
- Outreach is not crisis intervention. If someone is hostile, belligerent, violent, abusive, out of control or dangerous, it is work for the appropriate crisis intervention teams, involuntary treatment or police. The community doesn't need a "hero." We need you to be there tomorrow and again the day thereafter.

Street Outreach Project Safety Protocols & Guidelines

INTRODUCTION

These guidelines were developed for use by a mental health facility that specializes in providing outreach and housing placements to homeless individuals with psychiatric disabilities. They have been developed for use by clinicians, outreach teams and support staff.

These guidelines provide a foundation for understanding possible causes of violent and aggressive behavior, how to predict it, what signals or clues to look for when someone is about to act-out, as well as possible responses to de-escalate the behavior before clients or staff are injured. These guidelines have been especially useful in a classroom setting with discussion and role playing.

The chief weakness of the guidelines, however, is that they are incomplete. We need to add interventions and procedures for the specific situations where staff work with clients, such as in the clinic, in a client's residence, in shelters and on the streets. In addition, we need to develop skills and protocols that do not require physical restraints.

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Nonviolent Crisis Intervention Techniques for Clinicians
Planning Committee*

Street Outreach Project Safety Protocols & Guidelines

I. THE ENVIRONMENT

The environment you create around your client can greatly effect the safety for you, your client and others in the clinical setting. A client will feel less stressed, less nervous and less confused in a situation where care and concern are constant and well organized.

II. GUIDELINES FOR PROVIDING A SAFER ENVIRONMENT

- Make change very slowly. Prepare clients for any physical, emotional, personnel or geographic change.
- Maintain a routine. It is important to create a dependable world and a structured existence and environment for your clients.
- Maintain communication through every channel. Provide social stimulation without overload.
- Assist your clients in avoiding crowds or large spaces without boundaries. Be sure that the environment is designed to avoid sensory overload.
- Keep instructions short and concrete. Clients may not have tolerance for complex activities or conversations.
- Maintain positive input such as reinforcement for any worthy act. This helps maintain the client's self-esteem and encourages participation in healthy activities.

III. THE CRISIS CYCLE

- A. Crisis.** A crisis is a turning point; it is the decisive or crucial time, stage or event. It may be the actual event of aggression or assault. It is a situation that:
- causes a sudden alteration in the individual's expectations of himself and/or his environment;

- cannot be handled by the individual with the usual patterns of coping; and
- is an emergency or an "emerging situation."

- B. Catastrophic reaction.** This is an over reaction to minor stressors. Catastrophic reactions may occur out of distress when the person becomes overwhelmed by high expectations and demands. People with brain impairment often become excessively upset and may experience rapidly changing moods. It is precipitated by fear or misinterpretation of a person or a situation. The person may weep, blush, or become agitated, angry or stubborn, or may strike out at those trying to help them.
- C. Trigger.** When a person exceeds his tolerance for stress, he or she is said to have begun the crisis cycle. He/she has been triggered.
- D. Escalation.** Once a person has been triggered, he or she begins to escalate. Escalation is manifest by increasing levels of agitation and/or activity. This phase can take minutes to days to years and is generally longer than the crisis itself.
- E. Continued escalation.** When escalation continues as evidenced by exaggerated behaviors and louder, more specific verbal threats such as *"I can't take it any more, I'm going to hit someone,"* move to the following interventions:
- Bear in mind that attention is reinforcing. At whatever point you begin to attend to a client, you are giving reinforcement to that behavior.
 - Talking does little good at this point. Verbal interaction should be matter-of-fact and directed in short sentences.
 - Contract with the person—I'll do something for you, and you do something for me, *"I'll get you some coffee and you come outside and sit down."*
 - Keep the person talking—this will help distract them from assaultive thoughts; conversation is not usually compatible with assault.

- Set limits.
 - Use “*please.*” Please is a powerful word and gives the person control through providing an option.
 - Help the person save face. Make it look more attractive not to assault than to assault.
- F. De-escalation.** Characterized by decreasing levels of physical activity. Behaviors in this phase can look the same as those presented during escalation. Care must be taken to determine which phase it is.

IV. MANAGING THE DIFFICULT TO MANAGE CLIENT

- Be aware of the Karpman Triangle and counter transference which can be dysfunctional. Tips for recognizing and avoiding triangulation:
 - *Triangulation typically involves parties assuming the classical roles of victim, rescuer and persecutor.*
 - *When caught in triangulation, interactions tend to go round and round with no resolution and may lead to a power struggle.*
 - *Triangulation can also happen with only two parties.*
 - *Keep interactions simple and visual.*
 - *Be aware of staff being manipulated by the client.*
- To avoid triangulation, provide a lot of structure in order to maintain focus. Ways to provide structure to your interactions with clients:
 - *Contracting.*
 - *The treatment plan, which is a type of contract, provides structure and focus.*
 - *Contract for this session/encounter; make the contract clear and concrete; include time, goals and session content.*
 - *Anti-harm contract.*
- It is important to engage difficult clients in treatment—especially clients who are mandated and non-voluntary. Engagement can be accomplished by getting agreement, contracting in small increments, and reducing goals and expectations to the smallest, acceptable steps.
- Make use of very specific steps, especially when the task is difficult for the client.

- Do not accept passive agreements.
- Clearly identify your bottom line when negotiating agreements. Be up front and clear about what is nonnegotiable.

V. AGITATED AND AGGRESSIVE BEHAVIOR

A. Behaviors indicative of potential physical aggression:

- Loud or increased tone of voice; yelling
- Verbal threats
- Frowning
- Trembling
- Psychomotor restlessness (i.e., pacing, wringing hands, picking at skin, twisting hair, etc.)

B. Overt physical aggression:

- Hitting
- Kicking
- Biting
- Pushing
- Throwing things
- Pinching
- Head banging
- Scratching

Verbal agitation and aggression can lead to violent and destructive physical behavior. Verbal aggression frequently occurs prior to or concomitant to physical violence.

C. Potential etiologies of agitated and aggressive behavior:

- Infection and fever
- Polymedicine, drug interaction, drug side effect, drug toxicity, or abrupt drug discontinuance
- Chronic psychosis
- Paranoid psychosis often presents as agitation
- Depression
- Bipolar disorder; manic phase
- Anxiety
- Chronic pain

- Acute discomfort or pain related to unmet physical needs
- Lack of sufficient coping skills needed to handle life and environmental changes
- Fear of misinterpretation
- Trauma, especially head injury
- Malnutrition
- Anemia
- Dehydration.
- Seizures—during or following a seizure
- Tumor—may present as confusion and/or agitation or aggression
- Cerebrovascular disease
- Hypothermia
- Hypothyroidism—known to be associated with psychological changes
- Hyperthyroidism—presenting as apathy, depression or a confused state
- Liver disease or failure
- Decreased cardiac output, secondary to congestive heart failure or pulmonary embolism
- Acute heart attack—may present mainly as confusion
- Respiratory disorders—pneumonias, hypoxia, chronic lung disease with hypoxemia and hypercapnia, pulmonary emboli
- Renal insufficiency (kidney)
- Azotemia (presence of excessive amounts of nitrogenous substances in the blood)—secondary to obstructive uropathy or over zealous diuresis
- Hypoglycemia (low blood sugar)—associated with hypoglycemic agents or over zealous attempts to control blood sugar with insulin
- Hyperglycemia (high blood sugar)—associated with ketoacidosis, lactic acidosis or hyperosmolar states
- Electrolyte imbalance
- Substance abuse or withdrawal

D. Behaviors indicating agitation or aggression:

- Tears
- Eyes may widen
- Increased volume to voice
- Rate of speech may quicken
- Increased psychomotor behavior (pacing, grabbing, picking).
- Frowning
- Shaking or trembling

- Catastrophic reaction; over reaction to a minor stress. May exhibit some escalating behaviors or lose control explosively.
- E. Environmental conditions contributing to agitation or aggression:
- Increased noise from the television, radio, or voices
 - Crowded room
 - Increased lighting
 - Increased heat

VI. ASSESSING DISRUPTIVE AND AGGRESSIVE PATIENTS

Any behavior that presents a danger to the patient or others or that delays or prevents appropriate care is disruptive and may lead to a crisis situation.

A. Assessing the situation

- Describe what information you have; what happened
- Assess the environment—emotional, social, and physical; does it seem dangerous to you or others?
- Does the patient seem agitated, elated, depressed, or restless?
- Has he/she already demonstrated violent or aggressive behavior?
- Does he/she talk loudly and in a sarcastic way?
- Is he/she easily provoked to anger?
- Does he/she have a limited attention span?
- Does the patient seem to be out of control or disoriented?
- Does he/she seem to be afraid or panicky?
- Does he/she have a weapon?
- Is there evidence of alcohol or drug use?
- Is a domestic disturbance involved?
- Has criminal activity occurred?

If you answer *yes* to three or more of the above questions, use extreme caution. If possible, try not to control or suppress the patient's behavior. Instead, allow him or her to express these feelings. The most effective way to deal with a patient who exhibits aggressive and/or violent behavior is to reduce the crisis and prevent further disruptive behavior. Probably the safest thing to do in these situations is to call the police.

B. Clinical assessment of agitation:

- Thorough assessment of behaviors and circumstances is needed before intervention

- Is the onset acute or chronic? Was there a precipitating event?
 - Define specific behaviors being assessed
 - Describe the physical changes being observed
 - Assess environmental or recent life changes
 - Complete a physical exam; include a mental stress exam
 - Complete lab tests and review results
 - Review medication
- C. Guidelines for clinicians
- After checking to be sure that the patient is not injured, helping the patient feel safe and secure should be the focus of the intervention, not the agitated behavior itself. You may say, *“This is a safe place. You are safe here. There is no need to act that way here. I won’t let anyone hurt you.”*
 - The goal is to help the patient regain control.
 - The clinician should not show fear or agitation.

VII. INTERVENTION STRATEGIES

- A. Behavioral strategies to reduce agitation:
- Speak in a soft, quiet voice
 - Use a calm, even tone of voice and calm manner
 - Repeatedly call the patient by name
 - Maintain appropriate eye contact
 - Do not point
 - Avoid folding arms or taking a “John Wayne” stance
 - Ask in a calm manner what he/she needs. Allow time and space for a response. The goal is to help the patient regain control of his/her situation.
 - Turn down the brightness of the lighting
 - Turn down the volume of the television or radio
 - Relocate to a less crowded or noisy area
 - Try playing soft music
 - Encourage the patient to sit down by sitting down yourself
- B. Safety strategies with assaultive or potentially assaultive persons:
- Look for a door or an escape route
 - Look for other people
 - Scan the room for potential weapons

- Scan the area for obstacles
 - Stand sideways
 - Maintain appropriate eye contact; call the person by name
 - Consider territory
 - Change place, position
 - Keep the person talking
 - Help the person save face. Make it look more attractive not to be assaultive than it is to assault.
 - Do not mistake anger for aggression
 - Use “*please*”
 - Know methods of talking “to and through” the individual to let other staff know your plan
 - Be aware of the usual progression of aggression:
 - Stance;
 - Looks at you;
 - Looks away; and
 - Hits you.
 - If the person grabs you:
 - Say “*Please let go*”
 - Make a fist; this will facilitate a release
 - Get out of their grip
 - If you can't get out of the grip, get in.
 - If you are hit at:
 - Don't let the blows land.
 - Dodge toward the side of the attack and turn your back to person.
 - If hit, use the momentum to push yourself off in a different direction.
- C. Medical management—start low, go slow
- Try to use only one drug at a time.
 - Target specific symptoms to treat.
 - Consider half doses for younger persons.
 - Use multiple doses instead of one big dose.
 - Change dose in small increments.
 - Make changes slowly:
 - Consider drug half-life;
 - Wait for a steady state; and
 - More aggressive dose changes may be indicated for violent or assaultive behavior.

- Monitor risk for side effects, toxicities and interactions.
- It is sometimes helpful to increase the dose, and sometimes better to lower it.
- Sometimes the best thing to do is to discontinue all medications, i.e., a drug vacation.
- PRN medications should be given during the escalation phase and before the crisis when behavioral interventions are ineffective to help the person regain control.

VIII. DOCUMENTATION

The recording of incidents involving agitation and/or aggression must be specific and thorough. Essential elements include:

- **Biography:** Briefly describe who the person is, and his/her history with the agency. Add relevant details about why the patient is here today.
- **Behavior:** (Problem) State what the patient is doing that is a problem. Be specific with behavior descriptions. The note should include the first sign or signs of the trigger, escalation and a step-by-step progression of events. Descriptive, direct quotations from clients are helpful. Include the specific time the incident began or occurred as well as the incident's location. A description of the environment is also important. Note the problem on the Problem List.
- **Intervention:** (Method) Describe what you are doing to solve the problem and why you are doing it. The note should reflect step-by-step interventions in cases where the first intervention or interventions are ineffective. It should be noted as a "method" on the Treatment Plan.
- **Outcome:** (Response) Describe the patient's response to the intervention and what the patient does when you intervene (i.e., is the plan working?). The outcome should relate to the goal on the Treatment Plan. Outcome charting involves the patient's immediate response to an intervention as well as a longer-term response (e.g., follow-up notes indicating effectiveness or lack thereof from PRN medication, time-out, diversional activity, etc.). In addition, the note should contain recommendations regarding further treatment (i.e., are current interventions helpful or not; has a new method been discovered which should be added to the treatment plan; etc.).

IX. POST-CRISIS DEPRESSION

A. Behaviors

- May be sleepy.
- May attempt to harm self.
- May refuse to care for self—eat, groom, etc.

B. Intervention strategies

- One-to-one to provide support. Ask *“Can I do anything to help you feel better?”* or *“I’ll sit with you.”*
- Watch closely.
- Reassuring touch.
- Attempt to elicit information regarding the nature of the trigger. Generally patients have a lowered resistance and are receptive one-to-one.
- Allow the person to rest. Failure to allow the body time to rest may serve as another stressor.

X. OTHER PROBLEMATIC BEHAVIORS

A. Sun-downing: increased confusion and/or agitation in the evening or at night. Interventions include:

- Plan the day so that fewer things are expected in the evening.
- Reduce the number of things going on around the person.
- Plan a walk or a car ride in the late evening.
- See that he/she has gone to the bathroom before going to bed.
- A night light may help.
- Check room temperature for comfort.
- Is the bed comfortable?
- Sit with the person or allow them to sit with you; offer quiet reassurance.
- If they get up, allow them to stay up; provide a safe environment and a chair to nap in.
- Consider medications and be alert to side effects.

B. Paranoia

- Do not argue or confront.
- Give the person as much control as possible; for example, in decision making.
- Provide calm, consistent support.

GLOSSARY OF MENTAL HEALTH TERMS

Abusive language: Use of language that is not acceptable to you. In fact, it is not acceptable to most people.

Acting out behavior: Behavior that is not tolerated in your facility; for example, yelling, swearing, hitting or throwing things.

Affect: An immediate expressed emotion (i.e. euphoria, anger, sadness). Terms frequently used to describe affect include blunted, flat, inappropriate, and labile.

Anxiety: Nervous, may be shaky, may walk a lot, complains of being restless, seems to be anticipating danger.

Attention span: The length of time that a client has the ability to sustain focus on one task or activity.

Blocking: Interruption of a train of speech before a thought or idea has been presented.

Confabulation: Fabrication of facts or events in response to a question about situations or events that are not recalled due to memory impairment.

Confused: A client does not know the time, place, his or her own name, or location; may show all or part of these symptoms.

Delusion: May have one or more thoughts or fears with no external reality, but the person continues to have the thought, belief, or fear.

Depression: Not talking, looking sad, showing no interest in anything, not taking care of self (personal hygiene, grooming, etc.), eating and/or sleeping poorly.

Disorientation: Confusion about date, time of day, place, and person.

Empathy: A current understanding of an individual's feelings gained by "borrowing" that person's feelings in order to understand them, sensing their world as if it were your own, while never losing the "as if."

Feeling: Affect—the immediate expression of feeling inferred from appearance, behavior and comments; and mood—the predominant and pervasive general feeling such as anger, fear, elation, anxiety, depression, and apathy.

Hallucination: A client may hear something that others do not hear—auditory hallucinations—or may see something that others do not see—visual hallucinations.

Illusion: A misperception of a real external stimulus, i.e., seeing a tray cart in the room as a load of wood.

Labile: A rapid change of moods for no apparent reason, i.e., the client may cry and then start laughing when there has been no change in the conversation. A client may look very sad and then suddenly start laughing or be laughing and suddenly start crying.

Orientation: Awareness of where one is in relation to time, place and person.

Paranoia: A tendency on the part of an individual or group toward excessive or irrational suspiciousness or distrustfulness of others.

Psychosocial: Involving both psychological and social aspects—the non-medical aspects of the total patient.

Sympathy: Helper “takes on” the feelings of the patient as if he or she were in other’s place and stays there. The helper loses the “as if” aspect and shares the patient’s feelings.

Withdrawn: A patient may stay in his or her own room, may not talk to others, may not take part in usual activities, or may not want to leave their residence for outside activities.