SAFETY FIRST:

Personal Safety and Risk Management for Assertive Community Treatment Teams

Contributing Authors:

Sharon Pratt
Deborah Allness
Laurie C. Curtis
Jessica A. Jonikas
Terri Horton-O'Connell
Ed Stellon
Catherine Bennett
Judith A. Cook

Edited by:

Laurie C. Curtis
Jessica A. Jonikas

Illinois Assertive Community Treatment Training Institute
Mental Health Services Research Program
University of Illinois at Chicago, Department of Psychiatry

Safety First

Personal Safety and Risk Management for Assertive Community Treatment Teams

Contributing Authors
Sharon Pratt
Deborah Allness
Laurie C. Curtis
Jessica A. Jonikas
Terri Horton-O'Connell
Ed Stellon
Catherine Bennet
Judith A. Cook

Edited By:
Laurie C. Curtis
Jessica A. Jonikas

Illinois Assertive Community Treatment Training Institute
Mental Health Services Research Program
University of Illinois at Chicago, Department of Psychiatry

SAFETY FIRST

Personal Safety and Risk Management for Assertive Community Treatment Teams

Contributing Authors;
Sharon Pratt
Deborah Allness
Laurie C. Curtis
Jessica A. Jonikas
Terri Horton-O'Connell
Ed Stellon
Catherine Bennet
Judith A. Cook

Edited By
Laurie C. Curtis
Jessica A. Jonikas

Acknowledgments

This manual was developed as a project of the University of Illinois at Chicago, Illinois Assertive Community Treatment Training Institute, directed by Judith A. Cook, Ph.D., coordinated by Terri Horton-O'Connell, MSW and Stella D. Nelms, MA. The contents of this publication were developed under a contract from the Illinois Department of Health and Human Services, Office of Mental Health. The content of this publication does not necessarily reflect the views of the state agency and does not imply endorsement.

The editor would like to acknowledge the expertise of each of the contributing authors, and to personally thank Staci Anne Visco, who provided a wide range of personal support, technical assistance, and contributed her personal knowledge of martial arts to the contents of this monograph.

The UIC ACT Training Institute project personnel also would like to gratefully acknowledge the assistance of several individuals in finalizing this manual. Special thanks to Melissa Williams for conducting extensive literature reviews to inform much of the manual content and to Alexandra Laris and Terri Horton-O'Connell for making final corrections and directing the production of the manual.

Produced and distributed by:

UIC Center on Mental Health Services Research and Policy
Department of Psychiatry
1601 West Taylor Street, MC912
Chicago, IL 60612
312-355-1696
http://www.center4healthandsdc.org/

SAFETY FIRST

Personal Safety and Risk Management for Assertive Community Treatment Teams

TABLE OF CONTENTS PAGE

Notice:

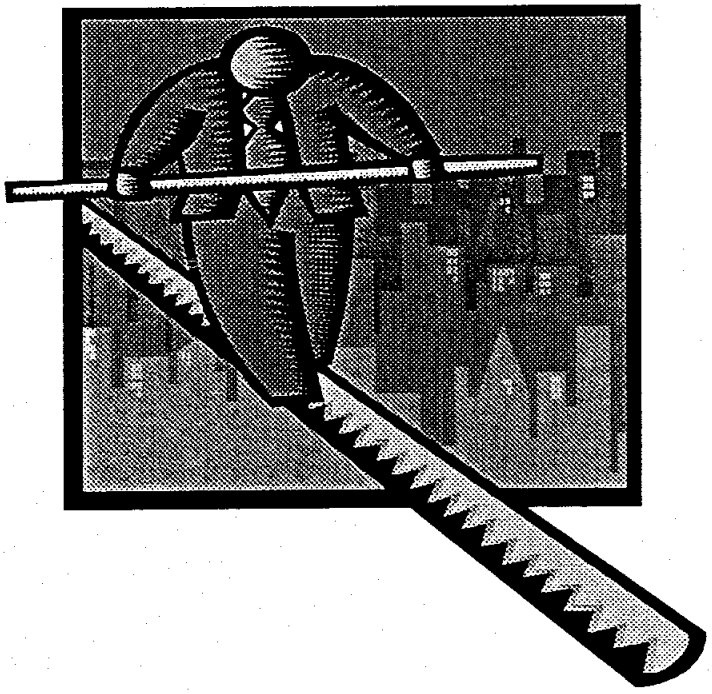
It is not the intent of the University of Illinois at Chicago, nor any of its affiliate organizations, staff, or contractors to provide legal advice. The information and recommendations in this manual are derived from government, industry, researchers, and other sources that are considered experts in the fields of workplace safety, risk management, and ACT.

The intent of this manual is to provide the reader with general information and areas for consideration. While every effort has been made to ensure the accuracy of these materials, the University of Illinois at Chicago, the editor and authors of this manual are not responsible and assume no liability for any damages caused or alleged to be caused directly or indirectly, incidentally, or consequently to any individual or organization using the information contained in this manual. Any person or agency using this material does so at their own risk.

LIST OF TABLES

Section 1

Introduction to Workplace Safety and Risk Management



Chapter

1

Introduction

Overview: *This chapter introduces this manual, explains why and how it was developed, and provides a brief overview of key elements of Assertive Community Treatment (ACT).*

Bad Things Happen

Bad things happen. Sometimes they involve a person with a serious psychiatric disorder as a victim or as a perpetrator. Nobody wants these things to happen, but they do. They do not happen often, but when they do, they are devastating. They affect not only the people directly involved in the situation, but many other people -- friends, family members, agency staff, and administrators. Community members, legislators, and other agencies also are touched in many ways.

Russell Weston Jr. shot and killed two police officers at the U.S. Capital in July 1998. He had received treatment for mental illness. The incident made national headlines. You may remember some of them: The New York Times *Treatment Can Be Illusion for Violent Mentally Ill;* The Wall Street Journal *Why Deinstitutionalization Turned Deadly.*

The ensuing media and public discussion about Russell Weston Jr., however, was different this time. Rather than sensationalizing potential risks posed to the public by persons with psychiatric disorders, the dialogue focused public attention on the role and importance of treatment for people with serious mental illness as a means to prevent violence. Advocacy

groups and mental health professional organizations spoke out about the failure of the mental health system to help Russell Weston.

On July 28, 1999, shortly after the incident, the *Washington Post* published the following report.

> ***Weston Case "Fell Through the Cracks"***
> ***Violence by Mental Patients Hard to Predict, Experts Say.***
>
> *Russell Eugene Weston Jr.'s sudden descent into violence probably could not have been predicted, but it might have been prevented by a mental health system better equipped to monitor patients before they become obvious threats. "Obviously the system is not perfect," said Jerry Weiner, chairman emeritus of the psychiatry department of George Washington University Medical Center. "But it's impossible to predict dangerousness with complete accuracy, and this man didn't seem to represent a threat. The tragedy is that he didn't get the treatment he needed and he became a threat." Weston's relatives in Illinois said they hoped his experience would call attention to the treatment of the mentally ill. "We don't want this to happen to any other families ever again," said Weston's sister.*

The next day, on July 29, 1999, The New York Times published ***This Way Lies Madness***, which included the following statement.

> *It is the gaping cracks in the American mental health care system, not Capital Security or gun-control laws, that most clearly delivered Russell Weston Jr. to his rendezvous with history. Mr. Weston's paranoid schizophrenia surfaced long ago. Yet, this now 41-year-old man "received no regular psychiatric medication over the last two decades and his family seemed to understand little about how to seek help for him. They obviously love their child; they knew he was sick; they wanted to get him help." However, as Russell Weston Sr. said, "He was a grown man. We couldn't hold him down and force pills into him." A comprehensive system of mental health services, including support for parents with sick adult children who refuse treatment doesn't exist.*

A statement followed from Laurie Flynn, Executive Director of the Alliance for the Mentally Ill: "Russell Weston's story is really the tragic story of schizophrenia in this country. For Russell Weston and thousands like him, recovery is never fully within their grasp because the care they need is simply not available. In fact, a national study documented that fewer than 50 percent of individuals with schizophrenia are receiving the care science has proven to work. Studies have shown that individuals receiving appropriate treatment for schizophrenia are no more prone to violence than the general population. However, the inability to provide immediate, flexible, and humane treatment to those who are suffering increases the potential for violent acts" (Flynn, 1998 a). Flynn was quoted by *Psychiatric News*, "We believe that had Russell Weston had an Assertive Community Treatment (ACT) program when he was discharged from the hospital, this tragedy might not have happened. Like many with severe mental illness, when he failed to keep two or three appointments, he was dropped from the rolls" (Flynn, 1998b).

Assertive Community Treatment is recognized as an effective approach to providing mental health treatment and support for persons with complex and disabling mental illness. Part of the strength of this approach is focusing on those individuals who do not seem to "make it" in other kinds of mental health services or programs -- and on doing whatever it takes to help these individuals lead safe and productive lives in the community. It is designed to be a treatment system specifically for people with high-risk profiles.

This manual is about risk and personal safety for Assertive Community Treatment team members, consumers, and administrators. It is for everyone who has ever had to deal with a difficult situation, walk into areas that did not feel safe, intervene with someone who was losing control, or worried about what would happen if... It is not intended to provoke alarm or fear, but to provide ACT workers with information about how to maintain personal safety by learning to recognize and manage risky situations and to assist ACT workers in helping others to develop personal safety skills.

There is growing public awareness and concern about violence in the streets, in the schools, and in the workplace. The papers are full of gruesome incidents. The term "going postal" has become common slang to refer to those individuals who become violent, seek vengeance, and/or lose control. Use of metal detectors is increasing in public settings such as libraries, government buildings, and even the schools. Individuals who live on the streets or in impoverished neighborhoods are at high risk of becoming victims of violence. Employees who work in service-related industries such as mental health and other health care services, retail trade, and public transportation are at increased risk of assault and other forms of work-related violence (NIOSH, 1999). Sadly, some of us have personally seen evidence of this.

The personal safety of mental health workers and consumers -- or anyone -- can never be 100 percent guaranteed. However, it is possible to understand and be alert to risk factors, take reasonable precautions, and know what to do if a situation becomes difficult or hazardous. This manual is about personal safety for ACT staff and consumers. It addresses risk, both physical and emotional, and discusses ways to take reasonable precautions that manage risk and minimize potential danger and harm. And, because bad things do happen sometimes, it provides information about basic personal defense and coping when tragedy strikes.

Safety is Worth Your Attention

Mental health agencies cannot afford to ignore violence in the workplace. Aside from physical injuries, violent, abusive, or threatening incidents in the workplace often result in serious and sometimes debilitating psychological damage to both providers and consumers. Unaddressed workplace violence can result in increased rates of absenteeism, low staff morale, high turnover rates, staff who are fearful and/or unwilling to continue delivering services in areas in which they feel unsafe and so forth. Consequently, the quality of services offered to consumers may be jeopardized.

Staff and consumers who are the targets of violence may experience symptoms associated with post traumatic stress disorder, such as heightened fear and anxiety and exacerbated physical and/or psychiatric symptoms. If the violence took the form of sexual assault, the person has an increased exposure to sexually transmitted diseases and unwanted pregnancy.

It is incumbent upon organizations to begin viewing personal safety and risk management as essential ingredients in quality assurance planning. This manual presents "promising practices" that have been useful in reducing workplace violence in mental health agencies. However, successful implementation of many of these practices requires that personal safety and risk management be viewed as an organizational priority. The extent to which organizations address safety issues is determined in large part by the importance that individual agency administrators place on safety.

How This Manual Was Developed

This manual is the result of a collaborative effort between the University of Illinois at Chicago, Assertive Community Treatment (ACT) Training Institute, and the Illinois Department of Human Services/Office of Mental Health (DHS/OMH).

The ACT Training Institute was established in 1997 through a grant from the Illinois DHS/OMH, and it is located at the Department of Psychiatry at the University of Illinois at Chicago. Its mission is to improve the provision of ACT services in Illinois through three distinct training programs that include didactic classroom training, mentorship training, and practicum training.

In December of 1997, DHS/OMH staff requested that the ACT Training Institute develop training that focused specifically on personal safety and the management of aggressive, potentially threatening behavior. The DHS/OMH and the ACT Training Institute convened two focus forums in different parts of the state to understand the safety issues which most concern ACT staff. Approximately 75 providers attended the first focus forum held in Chicago in January of 1998. The second focus forum took place in early February of 1998 in Springfield, Illinois and 42 providers attended. Representatives from DHS/OMH and the UIC ACT Training Institute reviewed written transcripts from both focus forums. Key themes and risk factors identified included the following:

- Functioning as a financial advisor/money manager for clients. For example, serving as representative payee;
- Working with consumers who committed violent crimes *in* the past;
- Providing services to consumers with severe personality disorders such as anti-social personality disorder and borderline personality disorder;
- Working in unsafe and/or remote locations – especially without back-up support staff and adequate access to communication devices. This issue was mentioned more frequently during the Chicago-area safety forum;
- Working with newly enrolled ACT clients, with insufficient background information and diagnostic records available;
- Providing services to consumers who have severe drug and alcohol addictions;

- Working in residential facilities without adequate staffing to ensure safety – especially during the midnight to 8:00 a.m. shift;
- Inadequate training in personal safety and risk management;
- Inability to set clear parameters around admission criteria due to administrative pressures.

These themes served as a guide for designing a training curriculum on personal safety and risk management for ACT providers. Experts in the field of risk management and safety delivered the two-day training on two separate occasions in June of 1998. Eighty-eight ACT providers attended the training – 45 in Oakbrook, Illinois, and 43 in Springfield, Illinois.

After completing the safety training, representatives from DHS/OMH requested that the UIC ACT Training Institute create a manual on personal safety and risk management based on the training. By November 1998, a team of qualified authors was assembled to develop the manual content. These authors included staff from the UIC ACT Training Institute and four additional contributors. An editor was engaged to help organize and finalize the manual. An initial draft was sent to field review and the document was revised to incorporate input from the reviewers.

Overview of the Manual

This manual offers readers realistic suggestions, ideas, and tools for addressing the complex issue of workplace safety. It addresses issues of concern to individual workers, to ACT teams, to the organization as a whole, and to the consumers who receive ACT services. It is divided into the following sections.

Section I:Introduction

Section II:Organizational Responsibilities

Section III:Team and Individual Responsibilities

Section IV:Managing Critical Incidents

Section V:Helping Consumers Develop Personal Safety Skills

Each section presents information in a practical, reader-friendly format. References for all chapters are located at the end of the manual along with biographical sketches of contributing authors and additional resource materials.

About Language

This manual makes every effort to use inclusive, gender-neutral, and respectful language in reference to mental health workers, the people they serve, family members, and community members. Because there is not one fully accepted term to denote people with psychiatric issues, this manual uses a variety of terms, including "client," "consumer," "survivor/ex-

patient," and "persons with personal experience with psychiatric issues." Person-first language is used consistently, and the term "patient" is avoided. Similarly, ACT team members are referred to as mental health workers, service providers, team members, and employees. We also were confronted with the best way to use inclusive gender pronouns as we wrote each of the manual chapters. Thus, throughout this document, we use the pronouns "she" and "he," as well as "his" and "her," alternately to reduce awkward phrasing and to minimize sexist biases in our language.

General Use of This Manual

This manual is designed specifically for the workers, consumers, and administrators of ACT teams. However, many programs provide active outreach, in-vivo treatment or support, and services to individuals with complex and challenging psychiatric disorders. It is our hope that other community psychiatric service providers will find this material informative and applicable to their programs. After all, safety is important for everyone.

Brief Overview of Assertive Community Treatment (ACT)

ACT is defined as a specialized service model in which a staff *team* assumes ultimate accountability for a small, defined caseload and becomes the single point of responsibility for that case load. Developed in Madison, Wisconsin in the 1970s, ACT has been replicated across the country. It uses a prescribed method for providing treatment. Each team is accountable for implementing the program according to a set of guidelines, which, if applied correctly, have been shown to increase the efficacy of treatment and reduce the threat of violence to providers and consumers.

Team members share responsibility for the entire ACT caseload, which has an average ratio of one staff for every 10-15 clients. The team is multi-disciplinary and draws upon the expertise of a psychiatrist, a registered or licensed practical nurse, a substance abuse specialist, a vocational specialist, and other mental health professionals. ACT streamlines the manner in which services are delivered, as most treatment is coordinated and provided by the ACT team itself, rather than by multiple programs or services.

ACT targets those individuals who have cycled in and out of in-patient settings and who have had limited community tenure. Services are comprehensive and specific to the individual needs of each consumer. Examples of services might include medication management and monitoring, assistance with activities of daily living, money management and budgeting, skills training, vocational assistance, etc. The majority of services are delivered in the clients' homes or community environments; thus the responsibility and burden of making scheduled clinic visits by consumers is removed as a treatment obstacle.

Services are available 24 hours a day, 7 days a week. Therefore, services are continuous and individualized to the specific needs of each client. ACT offers services as long as they are deemed necessary and without arbitrary limitation or restrictions.

Chapter Summary

Safety in the work place is important for everyone – staff, clients, managers, and the community. This manual was written to help ACT teams increase their awareness of personal safety and risk management in their worksites and to address specific situations confronted by staff. Illinois ACT providers helped to identify core issues to be included in the manual through discussion forums about workplace safety. This chapter provided specific information about the process for developing the manual and its structure. Finally, the chapter provided a brief overview of essential components of the ACT service model.

Chapter

2

Risk, Safety, and Workplace Violence:

Introduction to Safety Issues Confronting ACT Administrators, Providers, and Consumers

Overview: *This chapter provides a brief synopsis of emerging issues and risk factors in workplace safety. It discusses risk factors associated with community outreach service delivery and ACT, overviews current literature on violence and people with psychiatric disorders, and considers factors which affect the personal safety of consumers.*

Consumer and staff safety is a growing concern among health care providers. There has been a rapid expansion of community based psychiatric treatment, support, and outreach services during the past decade, with increased expectations that these services will reach individuals who have very challenging and often multiple disorders. With greater frequency, front line workers are questioning their own safety and that of the people they serve. The mobile, community-based, 24-hour design of ACT services, as well as its mission to serve very challenging individuals in a wide variety of community situations, provide some unique safety concerns for ACT staff, consumers, and administrators.

About Workplace Violence

Definition of Workplace Violence

Workplace violence is any verbal, written, or physical action that is intended to cause harm to oneself or others, or damage to property. It includes harassment, threats or threatening behavior, intimidation, robbery, rape, and assault. Workplace violence may result in bodily or emotional injury, pain, distress, and loss of property. It can affect employees, consumers, visitors, other service providers, and community members such as family, friends, and neighbors (HHS, 1996).

Types of Workplace Violence

There are four primary forms of workplace violence: violence by strangers, violence by customers or clients, violence by co-workers, and violence by personal relations (WDLI, 1998).

- Violence by Strangers: When the assailant has no direct business relationship with the victim and/or is unknown to the victim. This may include community members with whom a worker comes into contact in the course of work such as landlords, gang members, abusive neighbors of clients, and so forth.
- Violence by Customers or Clients: When the assailant has a direct business or clinical relationship with the victim or is under custodial care by the victim. In behavioral healthcare, this type of violence represents the majority of non-fatal injuries related to workplace violence.
- Violence by Co-Workers: When the assailant is a current or former employee of the organization. Sexual harassment, intimidation and interpersonal disputes that ignite into verbal arguments are included in this category and are much more common than the rare homicides perpetrated by "disgruntled employees." High stress work, organizational change, and demographic/cultural changes within the workforce can contribute to work environments that breed workplace violence among co-workers.
- Violence by Personal Relations: When the assailant is a family member, current or former friend, or intimate of the worker. Women are more frequently targets of this kind of over-spill domestic violence than are men. The United States Department of Labor, Bureau of Labor Statistics, found that three-quarters of employed women who report being abused at home, are also harassed by their abusive partners at work. Further of these women, over half miss at least three full days of work a month and twenty percent lose their jobs. Very few organizations have protective policies for these situations (BLS, 1995).

Prevalence of Workplace Violence

Workplace violence appears to be increasing (or perhaps is now more accurately reported) in the United States. A study published by Northwestern National Life Insurance in October, 1993, indicates that in the preceding year, one out of every four workers (of any occupation) was harassed, threatened or attacked on the job (cited in HHS, 1996). While there are significant sampling and statistical questions about this study, it does suggest that workplace violence is uncomfortably common. It been found in banks, post offices, libraries, schools,

insurance companies, law offices, shopping malls, hospitals, convenience stores, and virtually every place people work.

In 1996, the National Institute on Occupational Safety and Health (NIOSH) released a report on fatal and non-fatal workplace violence, based on data from the federal Bureau for Labor and Statistics (BLS). The 1996 NIOSH report indicates that workplace violence may not be equally distributed across all occupations. Respondents working in retail and service fields were victims of a higher percentage of both fatal and non-fatal assaults than those in any other industry. Respondents working in nursing home, social service, and hospital settings lost the highest number of work days as a result of non-fatal workplace violence -- the highest of any industry reported. Further, female staff were most likely to report being assaulted by someone they knew — an intimate (husband, ex-husband, boyfriend, etc). The remainder was acquaintances or well-known persons, often customers, clients, or a person with whom the woman had an ongoing professional relationship. For women, workplace fatalities appear to be closely linked to domestic problems. The Bureau of Labor Statistics reports that over 20 percent of the women *killed* in the workplace were murdered by a male intimate (BLS, 1995).

Risk Factors Associated with Workplace Violence

The following figure, "Risk Factors Associated with Workplace Violence," identifies a number of factors that increase a worker's risk of being involved in any workplace violence (NIOSH, 1996).

Risk Factors Associated with Workplace Violence

- Contact with the public;
- Exchange of money;
- Delivery of passengers, goods, or services;
- Having a mobile workplace (such as a car or taxi);
- Working with unstable or volatile persons in healthcare, social service, or criminal justice settings;
- Working alone or in small numbers;
- Working late at night or during early morning hours;
- Working in high-crime areas;
- Guarding valuable property or possessions;
- Working in community-based settings.

Because of the nature of behavioral healthcare, there are additional safety considerations. The U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) has identified factors which increase the risk of workplace violence in healthcare settings (see *Guidelines for Preventing Workplace Violence for Health Care and Social Services Workers;* OSHA 3148, 1996). These risk factors include:

- The prevalence of handguns and other weapons among clients, their families, friends, and communities;
- The increasing number of people with acute and/or persistent mental illness released from hospitals without adequate follow-up care;
- The availability of drugs or money at clinics, making staff prime targets for robbery by clients, family members, and/or acquaintances of the client;
- Situational and circumstantial factors such as the increasing presence of gang members, drug or alcohol abusers, or distraught family members, as well as long waits in clinic areas or emergency rooms, leading to heightened frustration by clients prevented from receiving treatment promptly;
- Low staffing levels during specific times of increased activity such as during meal times, visiting times, and transporting clients (of particular concern within residential facilities);
- Isolated work with clients during examination or treatment;
- Independent work, often in remote locations, without back-up staff or means of communicating through the use of technical devices;
- Lack of staff training in assessing and managing violent and/or aggressive behavior;
- Poorly lighted parking areas.

To what degree does this list describe the kind of work you or your staff members perform on a daily basis? Mental health service is considered one of the high-risk industries for non-fatal workplace violence.

Workplace Violence and ACT

These risk factors are quite familiar to most community mental health service providers. Many of these factors are present when delivering in-vivo services, such as ACT. It is notable that the risk factors identified by experts in the field of risk management closely parallel the concerns outlined by participants in the ACT provider forums discussed in Chapter 1. Mobile outreach services designed specifically for individuals with intensive psychiatric problems living in a wide range of community settings may be a successful approach to treatment, but it has inherent risk for mental health workers. ACT organizations have a primary obligation to address the safety concerns of their staff members, to recognize and

manage risk factors, and to ensure that staff members know how to take reasonable precautions and how to respond to high-risk situations in a safe manner.

The following discussion presents some of the specific risk factors associated with ACT service delivery.

Working Alone or Without Adequate Back-Up

In Illinois it is estimated that individual ACT team members deliver services alone in 80-90 percent of all outreach contacts. In rural areas, working alone may require staff to travel to remote locations 50-75 miles away from their home agencies. If confronted with a difficult situation, access to immediate assistance or back-up is not often available.

Tough Neighborhoods or Communities

ACT team members provide services wherever the consumer is. Limited economic resources require many ACT clients to live in areas with lower rents; higher neighborhood violence; gang, crime, and drug activity; in homeless shelters; and other high-risk settings. This is difficult for the workers as well as the consumers who may be victims of neighborhood violence.

Limited Access to Cellular Phones and Other Communication Devices

While a good investment in safety for staff in both urban and rural ACT teams, not every staff person on every team has a cellular phone or other communication devices for personal work use.

Consumer Demographics

ACT intentionally serves individuals with very intense or high needs for treatment and support. ACT clients often have histories of frequent psychiatric hospitalizations, legal involvement, significant medical concerns, and substance use. Many consumers have symptomatology that is difficult to control or have poor compliance in taking prescribed medications. Consequently dealing with acute psychotic episodes and crises are part of the day-to-day work of ACT team members.

Co-occurring Mental Illness and Substance Abuse

It is estimated that approximately 50-70 percent of all consumers receiving ACT services have co-occurring mental illness and substance abuse. Research demonstrates a significant link between violence and substance use in people with and without psychiatric disorders (Krakowski, & Czobor, 1994).

Power and Coercion

ACT workers have a considerable amount of power and influence in the lives of consumers. Workers are morally, ethically, clinically, and legally accountable for using this power in productive and appropriate ways. However, there is great potential for abuse of power and authority in the lives of consumers. For example, workers have misused/abused the role of representative payee, good relationship boundaries, and neglected their "duty to protect" by allowing for inappropriate "natural consequences."

Violence and Mental Illness: What Do We Know?

Are People With Mental Illness More Prone to Violence Than the General Population?

This question has lingered for many years. Is there a definitive answer? Yes. No. Well, maybe. We know that the vast majority of people with who are violent do not suffer from mental illnesses ("Violence and Mental Illness," 1997). Not every perpetrator of child abuse, spouse battery, harassment, rape, or assault has a mental illness. While these acts may seem "crazy," they are not necessarily indicators of a clinical diagnosis of mental illness. Monahan (1999) reports, "Three percent of the variance in violent behavior in the United States is attributable to mental disorder." In real numbers, three percent translates into thousands of real people. Nevertheless, in the larger scope of things, it is actually quite small.

We know that persons who *are* clinically diagnosed with major mental illness are no more likely to commit violent crimes than is the general population (Steadman et al., 1998). Other studies have found that people with mental illness are more likely to be victims than perpetrators of violence (Monahan, 1999). However, a small portion of people with major psychiatric disorders does act violently. Why? Who? When? Can we figure this out and then use this knowledge to predict more accurately who will and will not become violent?

Factors That Increase the Likelihood of Violence

How do we account for patterns of violence in our communities? What kinds of people are more likely to commit acts of violence? From a public health perspective, certain variables appear to increase the risk of violence in persons with and without serious mental illness. The MacArthur Foundation Research Network on Mental Health and the Law Risk Assessment Study (See Monahan, 1999) suggests that risk factors for violence fall into four distinct categories:

- **Personal and dispositional factors** such as age, gender, ethnicity, impulsiveness and so forth;
- **Developmental/historical factors** such as history of child abuse, history of violence, work history, history of hospitalization and so forth;
- **Contextual factors** such as environmental stress, lack of social supports, weapons accessibility, inability to access treatment, etc.;
- **Clinical factors** such as substance abuse, delusions, hallucinations and so forth.

The degree to which any one specific factor or combination of factors predicts violent behavior continues to be an active area of study.

Substance and Drug Abuse

It does appear that substance use and abuse increases the likelihood of violence among all people: males, females, youth, employed/unemployed, and those with a diagnosis of mental illness. One epidemiological analysis of violence found that people with major mental

illnesses such as schizophrenia had higher rates of violence than those who did not (11-13 percent compared to 2 percent). However, persons with substance abuse problems had rates of violence twice that of those with psychiatric disorders (25 percent), and people with drug abuse habits were higher still (35 percent) (Swanson, 1996).

Violent Backgrounds

People who come from violent backgrounds are often violent themselves – whether or not they have a mental illness (Gelles, 1993). One study held that "chaotic, violent family environments in which alcohol or substance use is common, ongoing conflict among family members, and a controlling atmosphere [are] associated with violence by persons with mental illness" (Estroff, Zimmer, Lachiocotte, & Benoit, 1994).

Neurological Impairments

People with certain types of neurological impairments are at greater risk of becoming violent (Krakowski and Czobor, 1994). Neurological impairments can stem from diseases such as Huntington's Chorea or Alzheimer's Disease, or from head injuries which damage the brain. These impairments can have psychological effects, interfering with the person's ability to interpret what is real, and to act and relate to others appropriately (APA, 1996). Remember though, not every person with a neurological disorder or brain damage will exhibit violent behavior.

Not Everyone With a Psychiatric Disorder is Violent. Can We Predict?

Can we distinguish those people with a psychiatric disorder who are at high risk for becoming violent from those who are not? Torrey (1998) suggests that the rate of violence among people with psychiatric disabilities is increased when the following variables are present:

- A past history of violence (violent background, violent behavior);
- Co-occurring mental illness and substance abuse disorders;
- Non-compliance with prescribed psychotropic medications.

Psychosis

Under certain conditions, evidence of psychosis does appear to increase risk. Psychosis is defined as a "severe mental disorder characterized by gross impairment in reality testing, typically shown by delusions, hallucinations, disorganized speech, and disorganized or catatonic behavior" (American Psychiatric Glossary, 1994). Psychosis can be present in a number of psychiatric disorders (such as schizophrenia) and mood disorders (such as some forms of bipolar disorder). It can be symptomatic of some abnormalities in the brain structure, as well as arise from extreme physical or psychological distress (such a sleep deprivation, war, and so forth). Remember though, not all mental illness involves psychosis.

While evidence of psychosis itself is mildly associated with violence, Link and Stueve (1995) found the risk of violent behavior increases considerably when a person's psychosis includes any or all of the following beliefs:

- That others wish them harm;

- That their minds are dominated by forces beyond their control;
- That others are inserting thoughts into their heads.

One study found that elevated levels of suspiciousness, hostility, agitation, excitement, and thinking disturbances were actually less predictive of assaultive behavior among persons diagnosed with schizophrenia than among people in other diagnostic groups (McNiel & Binder, 1994). It appears that it is the psychosis – not the diagnosis – that is the risk factor here.

For many people – even those with high-risk profiles – *levels* of risk fluctuate. Psychosis is not unremitting. For example, a person diagnosed with schizophrenia is not typically psychotic all the time. Further, not all people with psychosis have beliefs that others wish to hurt or control them. The degree to which the individual, by using medications or other means, is able to manage or question these beliefs may be a mitigating factor.

Community and Family Support

Living in stressful environments can aggravate the symptoms of mental illness. Consider how having limited or no income, living in substandard housing, in shelters or on the streets, eating irregularly and poorly, coping with the disdaining looks of others, and living with fear of being "locked up" in jail or hospitals would affect your stress level! This stress is magnified when an individual has little family or community support.

Swanson and colleagues (1996) suggest that in addition to substance abuse and psychotic symptoms, the lack of mental health services in the community is associated with greater risk of violence. Services also play a helpful role: when people do engage in regular treatment and support services from a mental health professional, they tend to be less likely to act in a violent manner (Torrey, 1998).

A study by Estroff et al. (1994) found that people who became violent felt threatened or attacked by another person. The source of the perceived threat tended to be the target of the violent behavior. Family members, especially mothers, are much more frequently targets of threatening, intimidating, and violent behaviors by persons with psychiatric disorders than are any other group (such as mental health workers, strangers, employers). The rate is higher when an individual lives at home with family members and when the family's coping resources are overly taxed (Hyde, 1997).

Medications

A report by the American Psychiatric Association (1996) suggests that when people with high risk factors chose to not take prescribed medications, their ability to manage frightening thoughts and impulses decreased. Further, some people will begin using alcohol and/or street drugs in an effort to feel better. The consequence of these choices, however, is often an increase in symptoms or symptom intensity, as well as a reduced ability to accurately perceive situations and to self-manage feelings and impulses.

Predicting Violence

Risk factors are not predictors. Just because a risk factor is present does not mean that violent behavior is imminent or even probable. The American Psychiatric Association *Statement on Prediction of Dangerousness* says, "psychiatrists have no special knowledge or ability with which to predict dangerous behavior. Studies have shown that even with patients in which there is a history of violent acts, predictions of future violent acts will be wrong in two out of every three patients" (APA, 1983).

It is assumed that men are more violent than women and many statistics bear this out – the gender mix in our jails, spouse abuse data, and so forth. However, there have been some recent questions about the accuracy of these assumptions. Lidz, Mulvey, and Gardner (1993) studied how accurately clinicians predicted violence in people discharged from an acute psychiatric hospitalization. They found that clinicians were moderately accurate in predicting violence among males, but significantly underestimated the violence among the women. The reason, they suggest, that violence by women often is overlooked is because it is of a different character than violence by men. For example, women are less frequently arrested for violent acts. Women are not usually violent in public places. Women are less likely than men to seriously injure their victims.

Clearly, violence perpetrated by consumers is complex and not easy to predict. At the same time, it would appear that one of the best ways to prevent it is through coordinated services and treatment.

Factors Affecting Personal Safety of Consumers

While workers need to be concerned about their personal safety when they provide services to mental health clients, it is important to remember that consumers lives are full of environmental and medical risks. In fact, many consumers engage or re-engage in mental health services because case managers and outreach workers agree to help them address ongoing medical and/or environmental problems. You will not always be able to eliminate the risks confronted by clients. But, understanding these risks and talking about them directly with clients (and families, when appropriate) can go a long way towards helping them to develop awareness and skills to ensure their personal safety. Furthermore, it may help you to protect *yourself* from exposure to the various risks that your clients face.

Environmental Risks

As an ACT provider, you are aware of the poor physical conditions in which many of your clients have lived, and in which they may continue to live. Many ACT clients live on the streets (sometimes episodically), in overcrowded shelters and residential programs, or in structurally unsafe housing. Many eat food that has been taken out of garbage cans, panhandled, or is otherwise lacking in nutrients, while others are financially unable to eat more than once or twice per day (Bassuk et al., 1996). Risky environmental conditions, especially for those who live in urban or suburban areas, also can involve interaction with gang members or criminals, the dealing of drugs and alcohol, and prostitution.

It is not surprising, given these risky environmental conditions, that rates of injuries and criminal victimization are elevated among mental health consumers. One study reports the rate of *violent* (fatal and nonfatal) criminal victimization of consumers at 8.2 percent, which is more than 2.5 times greater than that of the general population at 3.1 percent (Hiday et al., 1999). In this same study, rates of nonviolent criminal victimization of consumers did not significantly differ from that of the general population (22 percent vs. 21 percent).

Medical and Health Risks

Even when in the care of the mental health system, people with psychiatric disabilities are developing serious physical illnesses and dying at rates greater than those of the general population (Hutchinson, 1996). They also tend to develop physical illnesses which significantly shorten their lives, dying 10 to 15 years earlier than the general population from such ailments as cardiovascular disease, hypertension, respiratory illnesses, and diabetes (Koran et al., 1989; Leff, 1996). These health problems are complicated by the low levels of physical activity, poor fitness and nutrition, and cigarette smoking often found among consumers (Hutchinson, 1996).

Homelessness

Not surprisingly, given their living conditions, research also has shown that most current or formerly homeless persons, particularly those who have mental illness, tend to have serious physical health problems which are often unique to their situation (Tessler & Dennis, 1989). These include, for example, sleeping in an upright position (resulting in venous stasis and its consequences); extensive walking in poorly fitting shoes; inadequate nutrition; and the excessive use of alcohol, illegal drugs, and tobacco (Gelberg, 1997). Furthermore, people who are homeless are at increased medical risk due to exposure to inclement weather and harsh environments (Gelberg, 1993). They often lack opportunities for good hygiene and personal care that can compound many other factors. The rate of mortality is three to four times higher among the homeless than among the general population (CDC, 1992; Hibbs et al., 1994; Hwang et al., 1997). Recent research of over 17,000 homeless adults found that homicide is the leading cause of death among homeless men aged 18 to 24 years and women aged 25 to 44 years (Hwang et al., 1997).

Tuberculosis and HIV/AIDS

Recently, much attention has been given to the growing rates of tuberculosis among persons who are homeless. Studies show that TB is more common in those who are homeless than in the general population (Zolopa et al., 1994; McAdam et al., 1990). Homeless persons with TB also tended to be more infectious than other people with TB. The authors speculate that this is likely due to diminished immunity from malnutrition, delayed access to care, substance abuse, or co-infection with HIV that is typically experienced by the homeless.

Rates of HIV infection among mental health consumers have received increasing attention in recent years (Razzano & Cook, 1998). The rate of HIV infection has been estimated at between 5.5 percent and 8 percent among inpatient consumers (Cournos & Bakalar, 1996); 3 percent among psychiatric rehabilitation clientele (Cook et al., 1994); and an alarming 19 percent among one sample of homeless consumers (Susser et al., 1993). Given that the rate of

HIV infection in the general population is about .9 percent, these findings are cause for serious concern among mental health providers, especially those serving the homeless.

Violence and Abuse History

The prevalence of childhood and ongoing violence against persons with psychiatric disabilities is only just receiving attention in service systems in this country (Carmen, Rieker, & Mills, 1984; Muenzenmaier, et al., 1993). There is a growing awareness of the ways in which histories of abuse and violence impede community integration for survivors who also have psychiatric disorders. This phenomenon is just emerging as a critical issue. These issues are addressed in more detail in Chapter 12.

It is important to educate yourself about the types of vulnerabilities commonly experienced by ACT clients. You can be more effective in helping the people you serve, as well as protect yourself from potential harm, by knowing the risks people face, their individual and system-related struggles in addressing their environmental and health problems, and how these health concerns may interact with or influence their psychiatric status.

Chapter Summary

This chapter has discussed workplace violence, the risk factors associated with violence among the general population, what we know about violence and mental illness, and risk factors affecting the personal safety of mental health consumers.

It is easy to come away from discussions about violence with the perception that all people with mental illness are violent, unpredictable, carriers of disease, and prone to harming others. We know this is not true. Yes, there are some difficult situations and community service work has inherent risks. Yes, you need to take reasonable precautions to assure your personal safety, the safety of your co-workers and the people you serve, and your community. Your motto might be "Don't be stupid." Nevertheless, do not let stigma and stereotyping blind you. All people -- staff, consumers, and other community citizens -- are at risk when our streets are not safe, when people do not care or respect one another, and when good resources are not available or accessible in a timely manner.

Section II

Organizational Responsibilities

Chapter

3

Staff Safety

Basic Polices and Procedures

Overview: *This chapter provides a brief overview of organizational risk management and the elements of a basic safety program. Further, it presents examples of practices, policies, and procedures that have been found to help reduce the threat of workplace violence. It includes discussions about management and employee responsibilities, developing a safety program, and basic safety policies.*

Prioritizing Safety

Organizations have a duty to ensure that their employees are not unduly placed at risk and that risk factors inherent in the work are minimized. Because workplace violence occurs in the field of human services, an agency must prioritize worker safety and risk management in its organizational plan – for its own sake as well as that of its staff members, clients, and

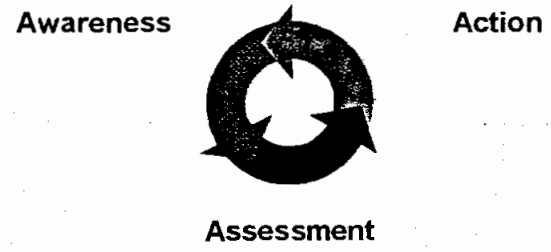
community. Many agencies view staff safety and risk management as yet one more thing on that long list of things to do. This "it's just another thing to do" approach may work – until something happens. Remember, workplace violence can, and does, kill people. And those who survive serious assault experience trauma, which can have profound impact on their work and personal lives.

Workplace violence is expensive. The greatest cost is that rare situation in which a worker or client is seriously injured or killed (There also are workers' compensation costs and sometimes litigation costs. Courts are increasingly finding agencies "guilty of negligence" in cases involving work-related injury or death of a worker or client (HHS, 1999).) Thus, while it can be time-consuming, prioritizing safety is clearly "smart business."
Workplace violence also has a direct impact on the organization. For example, workplace violence often results in loss of productivity and low morale among both staff members and clients, and higher staff turnover. When a serious incident occurs, the agency must then spend time doing "damage control" by talking with the media, and by reassuring staff, consumers, their families, and the public.

Organizational Risk Management

Awareness, Assessment & Action

All organizations are obliged to provide a safe work environment for their employees and to take appropriate steps to minimize workplace risk. Organizational risk management is a formal and ongoing process that an agency undertakes to proactively and continually address issues of worker safety. It is related to, but distinct from, clinical risk management, which is discussed in Chapter 8. When evaluating organizational risk management activities, remember AAA – no, not the travel club. AAA represents the cycle of activities used in developing an effective risk management program in an organization (Nelson, 1996). This model is applicable to both developing organizational policy and to providing clinical services safely.



Awareness refers to knowing that safety is important and requires being alert to the situational, interpersonal, clinical, and organizational factors that contribute to workplace violence. It also means educating staff, consumers, and others about risk factors, teaching people how to be alert to risk factors, and knowing ways to handle a risk situation when confronted by one.

Assessment means the ongoing identifying and monitoring of risk factors in interactions, in policies and practices, and in physical environments. When developing organizational risk management policies and practices, staff input about their concerns and recommendations is

fundamental. One mechanism for ongoing assessment is the Safety Committee. Practical procedures for forming a Safety Committee are presented in Chapter 4. Assessing environmental risk also includes an analysis of hazards in the worksite, a neighborhood or other community setting, or clients' homes or work places. Chapter 5 discusses in detail methods for formal environmental assessments or Safety Audits.

Action is doing something. Doing something about conditions that may make a worksite unsafe. Doing something about the concerns staff members raise about personal safety for themselves or the people they serve. Doing something to increase staff and consumer knowledge about personal safety and their ability to handle risky situations.

Organizational Factors which Contribute to Workplace Violence

An organization that provides consultation and training about preventing workplace violence to a wide variety of businesses and organizations compiled the following list of factors that may contribute to workplace violence (Chavez, 1999). How many of these are present in your organization?

- Weak or non-existent policy against all forms of workplace violence.
- No clearly defined rules of conduct.
- Lack of training in preventing and handling workplace violence.
- Negligent human resource practices (such as lack of pre-employment screening, inadequate supervision and training of employees, poor employee disciplinary system, failure to take immediate disciplinary action at first indication of violence).
- Ineffective or non-existent reporting procedures for workplace threats or violence.
- No in-house employee counseling or support systems.
- No working relationship with local law enforcement for contingency planning.
- Poor or non-existent media relations.
- Failure to seek legal consultation or initiate legal interventions as needed.
- Inadequate physical security.
- An atmosphere of indignity which tolerates bigotry, sexual harassment, disrespect, and intolerance.
- Poorly handled downsizing/layoffs and increased workloads for remaining employees.
- Labor-management antagonism.

Decision-Making and Organizational Risk

There are many tools to help organizations identify risk factors. A number of them are presented in other sections of this manual. Administrators have to make thoughtful decisions about risk not only from a clinical or personnel standpoint, but also from a legal and economic basis. Statistics tend to show that it is uncommon for a psychiatric outpatient to commit an act of serious violence against a staff member. However, it is one of the greatest fears of many mental health workers. Just one incident may cause great trauma and result in high personal costs to the individual as well as to the agency. Administrators must weigh potential risks thoughtfully and make reasoned decisions about priorities for action. See the figure, "Key Questions for Organizational Risk Assessment," for a decision-making framework to help administrators evaluate risk and make thoughtful decisions about priorities and actions (Grose, 1994).

Key Questions for Organizational Risk Assessment

- What ARE the potential risks?
- What is the SIGNIFICANCE of the risk to organizational goals, mission, and objectives?
- What is the SEVERITY of the risk? How much does this risk factor affect the safety and security of employees, persons served by the agency, and others?
- What is the PROBABILITY that the risk factor will develop into something serious?
- What are the COSTS associated with the risk factor? What is the cost of preventing or removing the risk factor? What is the cost of inaction – if nothing is done? What is the cost of a negative outcome and backlash?
- What is the PERCEPTION of key stakeholders? How important is this specific issue to others?
- What is the full range of options that might address this issue?
- Does the risk factor need to be eliminated, reduced, or can it be put on "watch?"
- Is immediate action required or can the situation be addressed at a later time?

Essential Elements of Workplace Safety

The United States Department of Labor, Occupational Safety and Health Administration (OSHA, 1996) gives special attention to "Community workers, such as visiting nurses, home health aides, social service workers... (who) are at risk for workplace violence because they work alone or in small groups, may have to work late night or early morning hours, often work in high-crime areas or in community settings and homes which by definition involve extensive contact with the public" *(See Fact Sheet No. OSHA 96-53 Protecting Community Workers Against Violence)*. It goes on to say that, "Employee safety and health should receive the same priority as client or patient safety. Essential elements in developing a safety and health program include: management commitment, employee involvement, (worksite) analysis, risk prevention and control, and training and education." Further, these components should be formalized into a written program or incorporated into the overall agency policy.

ACT agenices have special workplace safety concerns that are different from many other worksites. For example, the ACT team worksite is the community. ACT staff provide the majority of treatment and rehabilitation interventions in the clients' own residence and neighborhood, at their employment sites, and generally in the everyday places where people spend time such as restaurants, grocery stores, and laundromats. ACT staff work rotating shifts and provide on-call availability overnight. Services are available 24 hours a day, 365 days a year, including weekends and holidays.

When developing safety policies or a workplace violence prevention program, it is very wise to get expert consultation. Many policies deal with issues that have legal or liability implications. *Use your agency lawyer* to review your polices. Further, solicit comment from your state or local Protection and Advocacy Office, consumer and family organizations, and other interested stakeholders (for example, your local police department).

Management Commitment

Prioritizing safety means that management and employees are involved in creating an effective personal safety and risk management program. This includes active endorsement and visible participation by top management. In its "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers," (1996) OSHA suggests that management commitment should include the following elements:

- Demonstrated organizational concern for employee emotional and physical safety and heath;
- Equal commitment to worker safety and client safety;
- Mechanism for regular employee and consumer input;
- Initiatives to get a variety of people involved (managers, supervisors, and employees);
- Allocation of necessary resources and authority;
- Oversight to ensure accountability;

- Commitments to support and to implement appropriate recommendations from safety committees.

Management is responsible for creating and disseminating a clear policy for zero-tolerance of workplace violence. This includes verbal and non-verbal threats or intimidation, harassment, as well as assault or other forms of physical violence. Management is responsible to make sure that *all* staff members (clinical and non-clinical, management and workers, full time and part time), clients, and visitors are aware of the policy and how to report violations of the policy. (See the example policy statement, "Preventing Workplace Violence," on the following page.) Further, management must make sure that there are no reprisals against individuals reporting violations or who experience work place violence. Policies specifically prohibiting weapons also may be a wise legal precaution. (See example policy statement, "Workplace Weapons Policy," on page 36.)

Employee Involvement

Employees are partners in ensuring their own safety, and that of their co-workers and clients. Their involvement and feedback is essential in developing workplace safety programs that are relevant to the issues and concerns specific to your agency or program, the clients you serve, and the kinds of work performed by your staff. Workers are also responsible for securing the safety of their own workplace by following basic safety precautions such as locking doors behind them when appropriate, letting people know where they are, not displaying large amounts of cash, medications, or expensive jewelry, and so forth.

The OSHA Guidelines further recommend that employees should minimally:

- Understand and comply with workplace safety and security measures, including workplace violence prevention policies;
- Provide input and express concerns in appropriate forums;
- Report promptly and accurately potentially hazardous situations or violent incidents;
- Participate in staff training activities for managing violent, intimidating, or threatening behavior.

Worksite Assessment

The worksite assessment or Safety Audit is a common sense evaluation of various work settings to identify existing or potential safety hazards. It may be either formal or informal. In addition to eliciting for staff input, a worksite assessment may include reviewing specific policies and procedures, examining physical settings such as offices, reception rooms, and common areas, and assessing records for patterns of workplace violence. Chapter 5 provides practical "how to" information on assessing environmental risks and conducting a Safety Audit.

Sample Policy Statement On Preventing Workplace Violence

This agency is concerned and committed to our employees' safety and health.

We refuse to tolerate violence of any form in the workplace. This includes, but is not limited to, verbal and non-verbal behavior that is threatening, harassing, aggressive, or violent; physical assault on oneself or another person; actions which damage or destroy property; profane, vulgar, or offensive language.

We will make every effort to prevent violent incidents from occurring by implementing a Workplace Violence Prevention Program. We will provide adequate authority and budgetary resources to responsible parties so that our goals and responsibilities can be met.

All managers, supervisors, and employees are responsible for implementing and maintaining our Workplace Violence Prevention Program. We encourage employee participation in designing and implementing our program.

We require prompt and accurate reporting of all violent incidents whether or not physical injury has occurred. We will not discriminate against victims of workplace violence.

All employees, including supervisors and managers, shall adhere to work practices that are designed to make the workplace more secure, and will not engage in verbal threats or physical actions which create a security hazard for others in the workplace.

All employees, including managers and supervisors, will actively assist in maintaining a safe and secure work environment and, to that end, will follow all policies and practices.

The management of this agency is responsible for ensuring that all safety and health policies and procedures involving workplace security are clearly communicated and understood by all employees.

Managers and supervisors shall enforce the rules fairly and uniformly.

It is the responsibly of management of this organization to:

- Inform employees, supervisors and managers about workplace violence;
- Evaluate the performance of employees in complying with safety policies and practices; Provide training and/or counseling to employees who work in high-risk settings and/or need to improve personal safety and risk management skills;
- Discipline employees who fail to comply with workplace security practices;
- Protect employees who reports threats or violence from retaliation;
- Conduct regularly scheduled meetings to discuss staff concerns about workplace safety.

Adapted from the Washington State Department of Labor and Industries (WDLI, 1998)

Sample Workplace Weapons Policy

In order to ensure a safe environment for employees and customers, this agency prohibits the wearing, transporting, storage, or presence of firearms or other dangerous weapons in our facilities, on our property, or in any setting where agency services are provided.

Any employee in possession of a firearm or other weapon within our facilities/property or while otherwise fulfilling job responsibilities may face disciplinary action including termination. Possession of a valid concealed weapons permit is not an exemption under this policy. To the extent allowed by law, our company prohibits clients or visitors from carrying weapons in our facilities, on our property, or in any setting where services are provided.

Definition
"Firearms or other dangerous weapons" means:

- Any device from which a projectile may be fired by an explosive;
- Any simulated firearm operated by gas or compressed air;
- Sling shot;
- Sand club;
- Metal knuckles;
- Any spring blade knife;
- Any knife which opens by an outward, downward thrust or movement;
- Any instrument that can be used as a club and poses a reasonable risk of injury.

Exemptions
This policy does not apply to:

- Any law enforcement personnel engaged in official duties;
- Any security personnel engaged in official duties;
- Any person engaged in military activities sponsored by the federal or state government, while engaged in official duties.

Notification
"No Firearms or other Dangerous Weapons" signs shall be conspicuously posted within all facilities and in parking areas and grounds surrounding our facilities. These signs will clearly indicate that firearms and other weapons are not to be carried onto our property or into our facilities. All staff and clients will be made aware of the policy.

Management or security personnel should be notified immediately if any staff member, client, or visitor is found with a firearm or other dangerous weapon in violation of this policy. Local law enforcement will be called promptly, if necessary, to help handle a situation.

Special Instructions for Employees
Any employee concerned about personal safety may request an escort (e.g., to a parking lot off premises; a buddy for site visit). Educational materials will be made available on request regarding the magnitude of the workplace violence problem in the United States and the role of firearms and other dangerous weapons in this violence. Training will be provided to employees on this and other workplace violence prevention measures that this agency has implemented.

Adapted from the Washington State Department of Labor and Industries (WDLI, 1998)

Risk Prevention and Control

After workplace risks are identified the next step is to develop mechanisms for removing, managing, or minimizing these risks. Some risks can be addressed fairly easily. For example,

- Provide mobile staff with cellular phones or other communication devices;
- Maintain agency vehicles in good repair to avoid break-downs;
- Make sure there is bright lighting in offices, on building grounds, and in parking lots.

Because ACT is specifically designed to provide services to individuals with high-risk profiles in community settings, not all potential risks can be removed. However, organizations can and must develop policies and practices that minimize risk to staff members and consumers. For example,

- Instruct staff members not to enter a location in which they feel unsafe;
- Ensure that back-up is available when employees are confronted with an unsafe situation; team members work in pairs in high-risk neighborhoods or during evening hours;
- Require staff to collect detailed information about risk factors in a client's home or worksite, such as parking facilities, neighborhood characteristics, emergency exits, and so forth.
- Use staff meetings to discuss clients with high-risk profiles and specific ways to provide effective treatment and support in a safe manner;
- Discourage staff members from carrying purses or wearing jewelry (especially flashy or expensive jewelry);
- Have a clear process for knowing where team members are at all times. For example, use the ACT daily assignment schedule to know where each staff member is expected to be throughout the day and require staff members to keep the team leader or shift manager informed of their location throughout the day.

The figure, "Street Smart: Personal Safety Precautions for ACT Staff," is an example policy document based on OSHA recommendations (1996) and tailored to ACT teams. You also may want to refer to, "Tips for Safe Community Outreach" in Chapter 6.

Whenever possible, safety policies should be developed with the team and responsive to team members' specific concerns. The figure, "Thinking Proactively: Policy Checklist for Mobile Staff Safety," may help to stimulate thinking about other kinds of basic information that ACT teams and other service workers need in order to make good judgments and to take appropriate action when facing a difficult situation.

Street Smart:
Personal Safety Precautions for ACT Staff

In order to maximize the safety of ACT team members and to minimize the risk of threat, intimidation, or violence, staff will comply with the following personal safety policies and precautions.

Each ACT staff member shall:

- Be knowledgeable about the organization's policies regarding workplace safety.
- Be responsible for identifying risk factors and potentially dangerous situations, and reporting these to team leader.
- Be aware of any threats, physical or verbal, and/or disruptive behavior in male and female clients; report such to team leader.
- Be familiar with emergency resources (such as police, ambulance, back-up personnel, and so forth) and how to access them when needed.
- Never enter any situation or location where you feel unsafe without calling for back-up.
- Work in pairs or request police assistance when confronted with a potentially dangerous situation or at night.
- Avoid carrying purses, wearing expensive jewelry, and displaying cash or medications.
- Make sure someone always knows your whereabouts. Use the ACT daily staff assignment schedule to indicate anticipated itinerary and notify team leader or shift manager about any changes throughout the day.
- Participate in training to increase competence in recognizing, avoiding, and diffusing potentially high-risk situations.
- Continually collect and assess risk factors associated with client's home, workplace, or behavior, including parking facilities, emergency exits, neighborhood characteristics, situational factors such as client's loss of job or important relationship, sudden changes in client mood or temperament, and so forth.
- Take all threats seriously.
- Comply with policies for reporting and documenting critical incidents such as threats, injury, and violence.
- Discuss circumstances of incidents with team and continually develop better ways to handle high-risk situations in the future.

Adapted from: OSHA. (1996).Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers

Thinking Proactively: Policy Checklist for Mobile Staff Team

- ❑ How do we define a risky situation?
- ❑ Do we have the knowledge, skill, and guidance to make good decisions?
- ❑ Under what conditions should we leave an active situation?
- ❑ Under what conditions should we not enter a consumer's apartment?
- ❑ What is the process for getting staff back-up support?
- ❑ Under what conditions should we request back-up? Do we know who to call? What is the specific "telephone tree" for getting help as needed? How high do we go?
- ❑ What is the process for getting guidance when we are uncertain how to proceed in a situation?
- ❑ What is the process for when we believe a situation is too risky for one person?
- ❑ What is the procedure when we are confronted with a critically ill person — medically or psychiatrically?
- ❑ When a critical incident has occurred, who is in charge?
- ❑ Who talks to the media, other consumers, and other staff? Who cannot talk to the media, other consumers, and other staff?
- ❑ Who makes formal notifications to the family?
- ❑ When do we seek legal consultation from the agency attorney? Who has authority to talk with the attorney? What is the procedure for accessing the attorney? Who needs to be notified? Give approval? How is information gathered from the attorney disseminated?
- ❑ What should be documented in high-risk or "on alert" situations? How should critical incidents be documented? How should "close calls" be documented or flagged?

Adapted from Curtis, (1990) "When Bad Things Happen."

Documentation and Record Keeping

Establishing a uniform reporting system and keeping accurate documentation is necessary from a prevention and control standpoint as well as from a liability perspective. Good records help employers gain information about the specific kinds and patterns of workplace violence within their organizations. For example, in the past three years how many staff were physically assaulted? Were these incidents in people's homes, on the streets, or in an agency facility? Did they happen during the day, at night, when the worker was alone or working with a partner? Was the situation identified as potentially risky or was it sudden and unprovoked? Does there seem to be a trend in the kinds of people (staff or clients) who become involved as a victim or perpetrator of workplace violence? This information helps the organization tailor its policies and practices to address the kinds of workplace violence most commonly experienced by staff and consumers of that agency.

Good data help to build an accurate picture about the nature, intensity, and frequency of workplace violence experienced within an agency. Solid data help to dispel some of the myths and fears that can sprout about workplace violence and to identify training needs. For example, in response to staff complaints about feeling "unsafe" at work, one agency conducted an assessment of workplace conflict and found that the rate of staff-to-staff violence was actually much greater than the incidence of consumer-to-staff violence. This information prompted the agency to initiate a series of training and consultation activities focused on helping staff members to improve their ability to resolve interpersonal workplace disputes and cultural differences.

Further, good records are critical should an incident trigger a review of agency policies and practices. Should a staff member, a consumer, or a consumer's family member sue the agency for workplace violence, documentation is critical in refuting claims of negligence or dereliction of duty.

Staff Education and Training

Staff education and training are fundamental in any workplace safety program. Training helps to ensure that all staff and clients are aware of risk factors; understand organizational policies and procedures for preventing, managing, and reporting critical incidents; and know how to protect themselves and others in difficult situations. Training should never be considered the sole prevention or control strategy, but should be viewed as an essential component of a comprehensive personal safety and risk management program.

Practical and Tailored

To be effective, training needs to be ongoing and emphasize the importance of **Awareness, Assessment, and Action** *in response* to workplace violence (See Chapter 2). In addition to presenting basic safety precautions, training should focus on specific concerns of staff members and safety issues unique to various agency services. The training must provide information and skills that are directly relevant, useful, and help staff members to do their jobs better. For example, training for ACT teams and other direct service workers needs to identify common risks in community outreach treatment and support, while offering practical skills for decreasing their vulnerability. Training for management must heighten awareness of

the inherent risk attendant to ACT services and should include ways that managers, supervisors, and team leaders can reduce worker vulnerability. Management staff is advised to participate in the training offered for direct service staff so that management gains a clearer understanding of the risks employees face daily and what they need to minimize these risks.

Mandatory for All Staff

Participating in safety training needs to be required of all staff. Non-clinical staff such as those working in business and records, the executive office, administrative support, transportation, maintenance, and food service are not exempt from the risk of workplace violence. They each have contact with co-workers, clients, and strangers, and sometimes have problematic domestic situations that follow them to work. By making safety training mandatory, an agency underscores the importance of worker safety for *all* its employees. Requiring participation in safety training in the annual performance review of employees, including management, can help the agency make an additional statement about its concern for employees and commitment to employee workplace safety.

Uses an Effective Training Design

Training needs to be offered regularly throughout the year. Depending on the size of the agency and the staff turnover rate, core safety training should be available at least quarterly. Monthly reviews can be useful, particularly when done in team meetings and when applying information to a specific person or situation. Asking strategic questions can keep safety lessons practical and fresh. For example, "What is the best way to manage those gang members hanging out on the steps of Robert's building? What is the best way to handle the situation if one of the gang "gets in your face" or tries to challenge you? How should we safely transport and deliver Robert's medication and money? What would you do if something bad happened? What precautions are necessary to ensure team safety and Robert's safety?"

One way to minimize the cost of safety training while maximizing its benefits, is to train staff collaboratively with other agencies. One agency may open up its training to other organizations' employees for a small fee or in exchange for some other service or assistance. Since worker risk is part of the human service field, finding ways to cooperatively address this issue is to everyone's advantage.

Key Content Areas

The following topics should be included in a safety and risk management training for staff (USDA, 1998). Some topics should be included in all safety training programs while other topics may be more directly relevant to clinical staff. This is not an exhaustive list, but a good place to start!

- Agency workplace violence policies, security procedures, and critical incident reporting;
- Street smart: Personal safety in the community;
- Recognizing and assessing risk factors;
- Recognizing and managing warning signs and escalating threat;

- Preventing and defusing volatile situations;
- Dealing with hostile or angry persons;
- Resolving conflicts and disputes in the workplace;
- Discouraging sexual harassment or assault;
- Basic personal defense strategies;
- Preventing and resolving crisis;
- When a weapon is present;
- Physical restraint;
- Considering cultural differences in conflict management;
- Resources for help: how to access police and emergency personnel;
- Obtaining personal medical care and counseling, workers' compensation, or legal assistance after experiencing workplace violence;
- Skills for managers: Critical incident debriefing and trauma support.

Supervisors and team leaders benefit from special supervisory training. The same supervisory approaches that produce healthy, productive workplaces can also help prevent potentially violent situations (USDA, 1998). Supervisors and team leaders are the front-line support and back-up for staff members working in the community. Further, they play a pivotal role in helping staff members to be aware of risk factors and to take reasonable precautions. They are models for effective conflict resolution and often have a direct role in helping to manage crisis situations in the field. They influence staff participation in personal safety training and how seriously staff views the training. When a critical incident does happen, it is the supervisor or team leader who often calls in emergency personnel (such as the police or ambulance) and notifies appropriate people (such as executive director, other team members, clients, and so forth). They are usually involved in follow-up counseling, debriefing, and other aspects of critical incident management.

Conflict Management and Grievance Procedures

Conflict Management

Most social service and mental health agencies are invested in providing a productive and comfortable workplace for their employees. Inevitably, however, conflicts and grievances will arise at work, just as they do in all life situations (Shore & Curtis, 1998).

Such conflicts may be different between employees, between programs or teams, between workers and clients, or even between advocates and agencies. Sometimes, these conflicts and grievances will be relatively minor and will be resolved relatively quickly and painlessly.

Other conflicts are harder to resolve. Some of the most difficult disputes to resolve involve differences in values, interpersonal issues, or when the parties are not willing to compromise or to work out a negotiated solution. Unresolved disputes, particularly if they become a pattern, can create an unsafe or unproductive work environment for the individuals involved in the dispute as well as others in the workplace.

Safety training should involve helping workers to develop better skills in negotiating solutions for interpersonal disputes that are affecting employees' productivity or ability to fulfill their work functions, or that are creating a stressful workplace environment (Shore & Curtis, 1998) (See figure, "Resolving Workplace Conflict"). While they are very important in organizations, relying on formal grievance procedures may inhibit early recognition of (and timely response to) problems, and diminish employees' abilities to effectively resolve disputes (Denenburg, Denenburg, Braverman and Braverman, 1997).

Mediation skills should be included in all conflict management training programs. Knowing when and how to act as a mediator can help ACT team members know how to help others to resolve their disputes – without getting involved in them or becoming a judge or decision-maker. For example mediation skills are helpful when assisting housemates to resolve a problem about sharing cleaning chores before it erupts into an ugly situation, or when facilitating productive discussions between a client and her neighbor about appropriate times to play loud music.

When individual parties cannot resolve a dispute independently to everyone's satisfaction, they may need to get help from a third party such as a supervisor or a human resource worker, the employee assistance program or the worker's union. And, there are times when an individual should file a formal grievance.

Personnel Disciplinary Action

Threatening, intimidating, harassing, or violent behavior in the workplace can be viewed as a work performance issue. The organization's "Code of Conduct" or "Statement of Ethics" should include clear statements about respectful interactions and resolving differences between employees, and between employees and clients, family members, other agencies, and so forth. Ensuring appropriate personal conduct of staff on the job is within the disciplinary authority of most supervisors and team leaders. Supervisors and team leaders need the authority to impose appropriate sanctions on workers who violate these guidelines, including termination for serious or repeated problems.

With the increasing employment of people with disabilities in the mental health workplace it should be noted that the Equal Employment Opportunity Commission (EEOC) has issued guidelines that address violent misconduct by employees with psychiatric and other disabilities (Cited in USDA, 1998, p.14).

> *Agencies may discipline an employee with a disability who has violated a written or non-written rule that is job related and consistent with business necessity, as long as the agency would impose the same discipline on an employee without a disability.*

> *An agency is never required to excuse past misconduct as a reasonable accommodation. A reasonable accommodation is a change to the workplace that helps an employee perform his or her job and may be required, along with discipline, when the discipline is less than removal.* (USDA, 1998).

Grievance Procedures

Every organization should have written procedures for handling work-related conflicts and for submitting grievances for formal review. All staff members should be made aware of these policies and procedures.

Each workplace dispute is different and needs to be handled on a case-by-case basis. However, there are some general procedures which when used consistently can help staff to resolve conflicts, especially the more difficult ones. The figure, "Checklist for Grievance Procedures," is adapted from the University of Illinois at Chicago National Research and Training Center's policy handbook (UIC NRTC, 1997) and provided as an example.

Grievance procedures should be integrated into the agency's policy handbook and should be reviewed with all new and existing staff on at least an annual basis. A procedure also should be established for allowing *clients* to activate grievance procedures when they feel they are being treated in an unfair or unsafe manner.

Resolving Workplace Conflict

Initiate and Listen

- If you are aware something is wrong, be the first to bring it up.
- Set the tone for the discussion by your calm attitude and willingness to discuss and resolve situation.
- Initiate discussion at place and time that is safe and good for all.
- Listen, Listen, Listen, and listen some more.
- Find out what is really being said -- listen behind the words.
- You don't have to agree with everything that is said, but hear it out.
- Clarify what you are hearing – restate what you hear, ask questions.
- Respect differences in communication styles and cultural differences in approaching conflict.

Don't be a Trigger

- Avoid using language that triggers – reframe to neutral language.
- Use "I" rather than "You."
- Don't over react – your attitude and actions will increase or decrease the conflict.
- Don't get sucked into side issues – ignore challenges. Focus on the issues.
- Be careful of your non-verbal communication. What is your body saying?
- Respect person's need for personal space and for "face."
- Avoid standing or sitting directly in front of another. Instead be a bit off to the side.

Set Respectful Limits

- Be clear about limits and consequences.
- Don't threaten. State facts, don't make person feel threatened.
- If the discussion gets out of control, take a break, make an exit, and/or get help. Resume when things have cooled off.
- Never use violence or physical means to set a limit.

Find Win-Win Solutions

- Generate solutions that meet the needs of each person.
- Know that the real needs might not be what is initially stated.
- Make sure everyone walks away with something.
- Use a fair process for deciding – even when you need to exert authority.
- Check in later – is solution working, did process of resolving situation work?

Adapted from Shore & Curtis (1998). Managing Workplace Conflict A skills training workbook for mental health consumers and supervisors.; Curtis (1999). Managing Workplace Conflict in the Inpatient Setting; Workplace Violence Research Institute (1996). Resolve Conflict in the Workplace.

Checklist for Handling Grievances

- ☐ Document the circumstances surrounding the conflict(s). This should help you and others sort out the best methods for resolving the conflicts. Try to decide which circumstances are actually interfering with your work, or how you feel about your work, since these are the only ones that can be truly addressed by your employer.

- ☐ Try first to discuss the situation directly with the person who is involved in the conflict. This may be very awkward, so you may wish to try practicing what you might say with a trusted colleague, your supervisor, or a friend outside of work.

- ☐ If discussion does not resolve the conflict, bring the situation (including your written documentation) to your supervisor. If your supervisor is the person with whom you are having conflict, then arrange a meeting with the program director or another member of upper-management. During this meeting, you should expect to be asked to document your desired solution to the problem, as well as steps that you might take to implement your solution.

- ☐ After discussing the conflict, decide upon the following two courses of action:

  - A meeting between your supervisor and the other person(s) involved in the conflict to try to resolve the situation; or

  - A meeting between you, the other person(s) involved in the conflict, your supervisor, an internal or external advocate, and the program director (or other upper manager) to try to resolve the situation.

  The other person(s) involved in the situation will be asked to document their desired solutions to the problem, as well as strategies to resolve it, so that the two plans can be compared. Negotiation and problem solving (rather than blaming) will be encouraged, so that the situation can be comfortably resolved for all parties.

  If this meeting does not resolve the situation, then it may be time to explore further mediation, arbitration, and/or litigation services provided by the agency and other relevant entities.

Adapted from the University of Illinois at Chicago, National Research and Training Center Policy Handbook (1997)

Chapter Summary

This chapter presented information relevant to organizations. It provided a general overview of risk management and offered specific suggestions for developing basic policies and practices that would reduce the threat of workplace violence. It provided examples of policy statements for prevention of workplace violence and for general precautions relevant to ACT teams. Specific content for safety training programs was offered. A brief introduction to conflict management and grievance procedures was provided.

Chapter

4

Sexual Harassment & Workplace Safety

Making safe work environments for everyone

Overview: *This chapter discusses sexual harassment as a workplace safety concern for agency staff and clients. It presents a definition of sexual harassment and provides examples of situations and policy statements. Further, it discusses how to address sexual harassment from an organizational level and how to respond to it.*

Policies Regarding Sexual Harassment

Part of creating a safe workplace environment includes establishing and enforcing a policy prohibiting sexual harassment of clients and staff. By law, most agencies already will have developed such policies. However, in many programs, *actively promoting* them among the staff, and especially among the clientele, is often less common or sporadic.

Make sure that your agency has an up-to-date sexual harassment policy, guidelines for how to file complaints, and clear procedures for continually educating all staff and clients about their

rights in this area. Such policies and procedures should also include the agency's position on minor and aggravated sexual or physical assault.

What is Sexual Harassment?

Sexual harassment takes many different forms. It ranges from repeated offensive jokes to actual sexual assault. When sexual advances, harassment, or assault negatively affects hiring or promotion, it constitutes a violation of Title VII of the Civil Rights Act of 1964.

Harassment of or by Staff

The first step in developing a policy regarding sexual harassment is to put a clear definition in writing. The following is one such definition, adapted from the UIC NRTC's policy handbook (UIC NRTC, 1997).

What is Sexual Harassment?

Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, sending/downloading/viewing sexually-related materials electronically, and other verbal or physical conduct of a sexual or gender-related nature that creates a hostile, humiliating, or offensive environment. This includes written, verbal, non-verbal, and electronic communications.

Unwelcome sexual advances become *actual harassment* when they interfere with required tasks or career/educational opportunities, or are used as the basis for decisions affecting an individual's employment, academic standing, or ability to receive social/mental health services. In general, unless the harassment affects decisions about workplace status (such as hiring, firing or promotion, conferring or removing privilege or authority), then the unwelcome behaviors must establish a *repeated pattern* that creates a hostile or offensive environment. For example, it is harassment if a manager stonewalls a raise because you did not "go along." One off-color joke by a colleague is not harassment unless that colleague continues to share such jokes after you've informed her that they make you feel uncomfortable or seems to actually take delight in making you feel uncomfortable.

However, in the case of physical contact or intimate touch, *one occurrence* can be sufficient to constitute actual harassment and/or assault. The following are examples of sexual harassment in the context of someone's employment status as well as the creation of a hostile environment due to repeated verbal offenses.

Example 1: *A supervisor asks one of her team to meet with her over dinner to discuss the annual performance review. Because the team often plans social outings as part of morale-building, the team member does not view this as inappropriate and accepts. After dinner, however, the supervisor invites the team member back to her apartment, "to unwind over*

a drink, and discuss a future as a Team Leader." When the team member refuses, the supervisor states that she will let the Program Director know that team member isn't mature enough to handle the promotion.

Example 2: *During their staff meetings, one of the team members persists in telling offensive jokes about how absent-minded and nagging women are "by nature." When several of the staff members ask him to stop, he refuses and tells them they are too uptight to appreciate good humor.*

To avoid creating an environment which tolerates sexual harassment or favoritism, agencies should strongly discourage staff and clients from entering into romantic relationships with anyone whom they have any professional or clinical responsibility over, even if by mutual consent. If a relationship exists *prior* to an individual assuming professional or clinical responsibility over a romantic partner, plans should be made to switch that partner to another supervisor, case manager, or program. Bottom line: people in authority positions should not have intimate relationships with people directly subordinate to them.

Harassment of or by Clients

The definitions and considerations discussed above apply directly to sexual harassment of individuals served by the agency. However, special circumstances may arise where clients are harassing other clients or staff, or a staff member is harassing a client. Although it may not be openly discussed, some front-line providers experience sexual harassment by their clients, particularly when they go into their residences alone to deliver services.

Similarly, there is sad evidence that mental health professionals of all disciplines and positions, including psychiatrists, psychologists, social workers, hospital ward technicians, "buddies" or volunteers, and so forth, have harassed and/or assaulted the people they serve. Further, consumers may experience sexual harassment from other consumers as well as from individuals in their neighborhoods and workplaces. Because of the high rates of trauma among mental health clients, harassment or perceived harassment may be a very serious emotional and psychiatric trigger for many people.

Agencies need to develop policies and training for *both* staff and clients about sexual harassment and assault, and what individuals can do to prevent it, and manage and report it when it occurs. The following are examples of sexual harassment perpetrated by staff members and by clients.

Example 1: *A client tells her case manager that one of the team members makes consumers feel uncomfortable because she talks frequently and openly about her sex life and troubles with her boyfriends. Even when clients tell her it makes them uncomfortable, she continues, stating that it's just "small talk" and that she is teaching her clients what a jungle the world of dating really is.*

Example 2: *A provider tells her supervisor that when she visits their apartments, several of the male clients make sexual remarks about her appearance and that they would like to "get together with her one night." She tells her supervisor that she ignores these sorts of*

comments or makes jokes back, because she doesn't know any other way to deal with it, even though it makes her feel uneasy or unsafe.

Example 3: *A client tells her case manager that one of the male consumers is actively propositioning women clients, even upon their intense discouragement. He seems to think that their saying "no" is a coy way of saying "yes," and will not stop bothering them for dates.*

Kettl, et al (1993) developed a particularly educational program developed to help staff deal effectively with sexual harassment from a client. As part of this training, staff learn not only how to identify and respond to harassment, but to better understand the sexual behaviors and feelings of clients, especially those who are lonely and largely isolated from society. The program also teaches staff how to predict when harassment might occur, so that they can take steps in advance to avoid it. The best way to avoid sexual harassment is to educate all staff and clients about what it is, why it is unacceptable, and what to do when it occurs.

Key Points to Remember

- Gender is irrelevant. The victim as well as the harasser may be a woman or a man. The victim does not have to be of the opposite sex.
- The victim does not have to be the person harassed but could be anyone affected by the offensive conduct.
- The harasser's conduct must be unwelcome (EEOC, 1997).

Who Can Be Harassed?

Anyone can be sexually harassed, from program directors, to administrators, to direct service workers, to consumers. Although the majority of reported cases involve women being harassed by men, certainly women have been known to harass men, and a person may harass another of the same gender. Sexual harassment does not have to be aimed at just one person, but might affect an entire group of staff and/or clients, particularly when sexual offenses or sexually-related favoritism create a hostile or discriminatory work environment.

How is Harassment Recognized?

Harassment occurs when someone is not in a position to refuse *unwelcome* sexual advances or to object to a hostile environment without fear of reprisal. While it can be easiest to recognize in situations where the offender is in a position of power or authority, harassment also can occur between two employees at the same staff level or between clients. In some cases, even

if direct or overt threats are not made, if the instigator holds a position of power it can constitute harassment. For example, a supervising co-worker invites a student intern to her apartment to discuss his career plans. he declines, and she goes on to suggest that they should attend an art exhibit together to "broaden his horizons and improve his skills." This is a form of sexual harassment because the co-worker has work-related power over the intern and he does not welcome the attention.

It is another form of harassment when someone in authority does not address harassing or assaultive behaviors of which he has knowledge, in a setting within his control. In situations where a consensual relationship results in a work atmosphere laden with favoritism or preferential treatment, other people can experience and report harassment as a form of discrimination.

Policies Regarding Sexual Harassment

All agencies should make it explicit that they will not tolerate sexual harassment or assault in the workplace and they are committed to providing an environment sensitive to all people. This policy should be distributed to all staff members and discussed in staff/team meetings at least annually, as well as in group or individual meetings with consumers. For those new to the agency, the policies and procedures for filing complaints also should be discussed during staff and consumer orientations. Some agencies also post their policies and procedures regarding sexual harassment and assault in public areas (e.g., break rooms, lunchrooms, or bathrooms) to reinforce their commitment to creating a safe environment for all workers and consumers.

Addressing Sexual Harassment at the Staff-Level

Sexual harassment is against the law. Your agency consistently should deliver the message that it will not be tolerated in any form. Specifically, it should be made clear that sexually harassing other staff and/or clients will result, minimally, in written warnings, probation, and/or termination of employment or from the program. At the same time, accusing someone of sexual harassment is a very serious charge, not to be taken lightly (Jonikas & Cook, 1994). If you or someone you know believes he or she is being sexually harassed, it is best to first discuss the situation with family, friends, co-workers, therapists, or case managers, in order to double-check your perceptions and options.

What to Do if Harassment Occurs

The figure, "Checklist for Responding to Sexual Harassment," gives example guidelines for dealing with sexual harassment. This checklist is based on procedures from the UIC NRTC's policy handbook (UIC NRTC, 1997). Of course, this is not meant to be a complete list of actions to be taken, nor is it legal policy. Rather, it is a set of guidelines a person may follow or that you may use to help your agency develop more comprehensive procedures for responding to sexual harassment.

Expectations of Directors, Supervisors, and Managers

It is useful to establish in writing the responsibilities of directors, administrators, supervisors, and managers for preventing and addressing harassment in the workplace. All staff, but particularly those in authority, are responsible for maintaining an environment free of sexual harassment. They are obligated to take every complaint seriously. If they cannot resolve the situation directly, they are to consult with the agency's personnel, human resources, or affirmative action office. They must model strict compliance to the agency's policy and procedures regarding sexual harassment, and remember that they are also for their *own* protection. Agencies, as well as individual administrators, supervisors and team leaders may be liable for neglecting to address sexual harassment and could be held legally accountable for creating or tolerating a hostile work environment.

Staff Training

Some organizations find it useful to sponsor special staff and consumer in-service training regarding sexual harassment. This training addresses how to identify sexual harassment, how to respond to it, and ways to cope with the associated emotions or feelings that arise when harassment occurs.

Sexual or Physical Assault

What is Sexual or Physical Assault?

When sexual offenses by a staff or a client move beyond verbal, nonverbal, written, or electronic harassment to actual physical touch, the agency might be at great risk for a lawsuit. Assault can range from someone pushing or aggressively touching another staff member or client to someone actually raping or beating up another person. At the organizational level, a policy document about what constitutes assault, what to do when it occurs, and how to prevent it should be distributed annually as part of the agency's overall policy on sexual harassment.

Addressing Sexual or Physical Assault

As is true of sexual harassment, all individuals (staff and clients) in the agency should be informed about the organization's policy and procedures regarding violence and assault. Just acknowledging your sensitivity to this issue can go a long way towards making staff and consumers feel safer, and will help them be clear that violent behaviors will not be tolerated. Also, all people in positions of power must be made aware of their responsibilities to directly respond to any complaint of sexual or physical assault. Staff and consumer in-service training on recognizing, preventing, and responding to assault should be provided.

Understanding and responding to the physical, mental, and emotional needs of individuals who have been assaulted is discussed in greater detail in Chapter 11.

Checklist for Responding to Sexual Harassment

- Read your agency's policies and procedures on the prohibition of sexual harassment to ensure that you understand your rights and are proceeding correctly.

- Carefully document in writing what has happened, including dates, times, places, what was said or done, and how you responded. This log should be stored in a safe place, preferably at home.

- Directly tell the harassing individual or group of individuals what behaviors are unacceptable and unwelcome, if you feel safe doing so. You should provide concrete explanations of the unacceptable behavior, speaking firmly, without smiling, laughing, or apologizing. If possible, you should provide actual dates, locations, and details. Threats and name-calling should be avoided.

- If you do not feel safe speaking to someone directly, you can express your objections to the offender in a factual letter or an email message. This has the benefits of avoiding any tendency you might have to become apologetic or overly upset, and providing documentation that you did indeed request that the harassing behaviors be put to an end. Again, actual dates, locations, and details should be provided, with name-calling or threats to be avoided. Keep a copy of the letter or the email message for your records.

- Ask others if they witnessed what happened or if they have had similar experiences with the offender(s). Ask them to document in writing what they have seen or experienced, and to sign and date it. This documentation can be very important should you wish to lodge an official or legal complaint against a person or a group of individuals.

- Inform your supervisor or the upper-level management about what is happening. Provide them with copies of your written documentation. In your own records, write out the details of your meetings/correspondence with persons in authority (including dates, times, locations), as well as the results of the meetings. This information can be very important, especially in cases where individuals in positions of authority do not act directly and swiftly to end the harassing behavior.

- Contact the agency's personnel, human resources, or affirmative action offices to confirm your rights, get advice, and obtain support or advocacy services. These offices can advise you on how to proceed with an official or legal complaint, should you wish to take that route. Most agencies mandate some type of response to all sexual harassment complaints, so you should track whether or not this occurs as well.

Check out the Equal Employment Opportunity website, located at http://www.eeoc.gov, which provides useful information on sexual harassment and your rights. It also provides information on how to receive technical assistance and other services/information from the EEOC.

Chapter Summary

This chapter provided a brief overview of the legal and policy issues attendant to sexual harassment. It included discussions of sexual harassment from both staff and client perspectives and a brief discussion about sexual assault. Sexual harassment in the workplace is not only a legal and liability concern, but also a staff safety issue. Sexual harassment can affect anyone. It can be a component of staff -- staff relationships, supervisor -- staff relationships, staff -- client relationships, and client -- client relationships. Managers must take sexual harassment seriously and ensure that staff and clients receive the needed information and training in order to promote a safe environment for staff and consumers.

Chapter

5

Assessing Organizational and Environmental Risk

Overview: *This chapter shows ways for organizations to assess the risk factors presented by workplace violence in services, policies, and facilities. It discusses how and why to form a safety committee, approaches for gathering information directly from staff members, and mechanisms for informal and formal safety audits. A Tool Kit of example forms, assessments, and surveys is provided.*

How do you actually know the specific safety concerns of your staff? The degree to which your facilities are safe for employees and others? The level of risk present in a client's apartment or neighborhood? Which safety concerns are immediate and require priority attention and which require more long-term solutions?

The answers to these questions lie in a worksite risk assessment, or a practical evaluation of various work settings to identify existing or potential risks for violence. An assessment may be formal or informal and include discussions with staff, policy review, examination of physical settings, and analysis of data and records for patterns of workplace violence. The worksite risk assessment is a core component of a comprehensive violence prevention program as discussed in Chapter 3.

OSHA (1996) recommends that good worksite security evaluations should include the following:

- Analysis of incidents, including characteristics of the assailants and victims, an account of what happened before, during, and after the incident, as well as relevant details and outcome of the situation.
- Identification of jobs or locations with the highest risk of violence as well as the processes and procedures that put employees at risk of assault or other forms of workplace violence.
- Listing of specific high risk factors such as the types of clients served, physical risk factors of the buildings or environments, isolated locations and job activities, lighting problems, lack of phones or other communication devices, areas of easy or unsecured access, and areas with previous security problems.
- Evaluation of the effectiveness of existing security measures and policies and of previous efforts to reduce risk.

Creating a Safety Committee

Who should conduct the assessment? It is important to have a centralized point of authority to coordinate all the organization's activities to enhance workplace safety and risk management. Many agencies have found that forming a safety committee serves this function better than assigning the duties to one individual or department. This committee's purpose is to guide and oversee the risk management process of the organization. Because of the ongoing need to monitor patterns in workplace violence and to develop policies and mechanisms that respond to evolving issues, it should be a standing committee. It is essential that the Board of Directors endorse this committee. Further, it should be an integrated part of the agency structure and report to the Executive Director.

The formation of a Safety Committee is an explicit statement that the organization is committed to decreasing the vulnerability of its workers. When an agency has a standing safety committee that is assigned the tasks of addressing safety issues for employees, workers are assured that concern for safety is integrated into the structure of the organization.

Membership

Membership on the committee must be representative of all types and levels of positions within the organization. A safety committee could include, for example: ACT team members, other direct service staff, clients, managers, representatives from non-clinical services (such as business, clerical, records, maintenance) human resource representatives, union representatives, security staff, and possibly legal or media relations staff. Optimally, participation on the safety committee should be voluntary. Voluntary interest demonstrates greater commitment to increasing workplace safety for staff. It can be useful to request members to commit to two-year terms. This enhances effectiveness, consistency, and continuity.

Scope of Responsibility and Authority

The first task of the Safety Committee is to define the scope of its responsibility and authority. Establishing these parameters provides clarity, focus, and direction for the work of the committee. The tasks of a workplace Safety Committee could encompass many things from conducting discussion forums, collecting and analyzing incident data, developing training, consulting with other staff about potentially critical situations, developing plans and policies, organizing fire drills, and initiating structural changes. Not every agency will expect its Safety Committee to be responsible for all of these activities. Therefore it is critical for your committee to carefully define its specific scope of work.

The effectiveness of a Safety Committee may be diluted if its scope of work is so broad as to include all components of workplace health and safety. It is preferable, at least initially, for the Committee's focus to be limited to the prevention of workplace violence, an area of safety that is broad and complicated in its own right. The Executive Director and Board of Directors should approve the Safety Committee's scope of responsibilities and authorities and they should be written into a document for ongoing reference.

Developing an Assessment Process

A preliminary task of the Safety Committee is to develop an assessment plan for gathering staff concerns and identifying risk factors in the workplace. The Safety Committee or a sub-committee also may want to research various assessment and data collection tools and forms. Examples of some of these tools are provided later in this chapter, but should be tailored for the specific needs and context of each organization. It is the Committee's responsibility to make sure that staff and team leaders know how to complete these forms and do so in a timely, accurate manner. The Committee must develop a mechanism for regularly reviewing and analyzing the data in order to maintain accurate and timely information about risks and incidents that compromise staff safety. This knowledge assists the Committee to refine policies, procedures, and practices that have an impact upon worker safety.

Report, Recommendations and Oversight

The results of the worksite assessment should be compiled and translated into a report, with recommendations for specific changes in policies, procedures, and practices. The report and recommendations should be reviewed and approved by the Executive Director and Board of Directors, as well as disseminated among staff for comment. The Safety Committee should be the point of oversight for the implementation of the recommendations and for monitoring the effectiveness of the changes through continual evaluation. The Agency Safety Report is discussed in greater detail later in this chapter.

Hands-on Assistance

The Safety Committee also may function as an ongoing resource for the total agency. Members of the Committee may serve as consultants to other staff in situations where there is a serious safety concern for staff or clients. The Committee may design, develop, and even deliver a regular training series on safety and workplace violence prevention. They may develop a component on policies and practices for personal safety and risk management as part of new staff orientation. They may be partners with others in forming and implementing a trauma response plan in the event of an emergency situation or critical incident.

Gathering Information from Staff about Safety Concerns

Employees are one of the best sources of information about risk and workplace safety issues in any organization. Their knowledge is based on actual experiences and situations which arise daily when providing services. A comprehensive workplace risk assessment should begin with gathering accurate and complete information from staff about their safety concerns. Management must convey to staff that it values and takes seriously this information.

Before You Begin

Before initiating the review process, address and clarify several key questions.

- **Why Are We Seeking This Information?**
  It is essential that the primary reason for gathering the information is sincere concern about the potential dangers involved in the work. Genuine concern for employees' well-being and acceptance of the inherent risk in providing ACT services should precede any other factor which may stimulate a workplace safety assessment, such as responding to a specific incident, concerns about agency liability, or requirements to comply with an outside governing or regulating body. These factors are very important, but are secondary to the well-being of employees and clients.

- **What Do We Want To Learn?**
  The collective motivation needs to be to gain a clear, complete picture of work in the field, including inherent risks. Management must be open to learning whatever lessons the information carries.

- **What Will We Do With the Information?**
  The organization must be committed to listen to staff concerns and be willing to find practical solutions. Staff must be assured that the information they share is confidential and that their identity remains anonymous. They must feel free to be honest without fear of retribution or retaliation.

Methods for Gathering Information

There are several effective methods to gather information from staff. These include focus groups, staff surveys, individual staff interviews, and/or a combination of any of the three. Each are discussed below and samples are provided in the Tool Kit at the end of this chapter.

STEPS FOR FORMING A SAFETY COMMITTEE

1. Board of Directors approves the formation of an employee Safety Committee that reports to the Executive Director.
2. Executive Director solicits volunteers who are representative of services and positions within the organization.
3. The Safety Committee meets and defines the parameters of its work. It seeks clarification as needed and develops a formal, written scope of work which is approved by the Board of Directors and the Executive Director.
4. The Committee meets weekly as it begins its work.
5. The Committee develops an assessment plan to identify the primary areas of concern and magnitude of worker risk.
6. The Committee gathers information about safety concerns from staff, conducts safety audits, work environment inspections, and reviews current policies and practices.
7. The Committee analyzes information and makes recommendations to the Executive Director and the Board of Directors to maximize worker safety.
8. The Committee develops and implements a training plan pertinent to the issues of workplace safety.
9. The Committee continually reviews and assesses policies, procedures, and practices as they relate to worker safety.

Focus Groups

A focus group is a structured, small discussion forum used to solicit information about a specific issue – in our case, workplace safety. Typically, facilitating at least two or three groups is necessary to gather sufficient information about a given issue. A predetermined format and set of questions are used universally with all groups to ensure consistency and to help organize the information for interpretation.

The first step in conducting focus groups to generate four or five questions that specifically address the issues of workplace safety. The questions should be focused on the topic, but broad enough to allow for dialogue and a range of responses. Examples of effective questions include:

- What worries you about the personal safety of ACT workers?
- What about ACT work feels dangerous to you? Makes you feel uneasy?
- When have you felt your safety or the safety of others was at risk?
- What strategies have been used by you, your team mates, or the organization that have been effective to ensure your personal safety or that of others?
- What changes in practices/procedures would be helpful in minimizing the risk of providing ACT services?

The moderator or facilitator of a focus group can be an outside consultant or an agency representative. When using an agency representative, the moderator needs to voluntarily take on the job – rather than be assigned the task. If more than one agency member facilitates the focus groups, they should represent various programs or perspectives.

The size of a focus group may vary from five to fifteen people, but ten is typically the most effective. The group may be comprised of persons with similar positions (for example, all case managers or all ACT team members) or mixed to gather different perspectives from one group (for example an ACT team member, a residential staff, a medical records clerk, a vocational program employee, and so forth). The advantages of having persons with like positions in one group are that they have a shared understanding of the work and often have had similar experiences. However, this can work two ways. The natural camaraderie that exists among persons doing the same kind of work can create an atmosphere that is supportive for workers – but at the same time might be competitive. A group of mixed members can provide a setting that feels safer because workers may feel less exposed or vulnerable – but it may lack the elements of shared perspective. The Committee will need to decide what makes the most sense for their work setting. Input from many persons working with the same consumer population also can be valuable. The committee might consider sponsoring focus groups that include consumers, family members, representatives from other agencies, probation officers, and so forth, as well.

In order to maximize staff participation, focus groups should be offered at varied days and times to accommodate different schedules. The location needs to be comfortable and convenient. There may be some benefit to conducting focus groups off-site rather than in the work place.

Staff Surveys

Staff surveys are a simple way to gather information about safety concerns of employees. They are time efficient and can allow for complete anonymity of respondents. To be useful, surveys need to ask targeted questions that will elicit information about specific risks and concerns of staff. Surveys also can be used to gather information about the range and effectiveness of current approaches to personal safety and risk management approaches, and to solicit recommendations for change. An example of a staff survey can be found in the Tool Kit section of this chapter.

Individual Staff Interviews

Individual staff interviews offer employees the opportunity to discuss their concerns in private. They create an atmosphere that encourages open, frank, and full discussion of the worker's concerns. As with focus groups, the basic questions for individual interviews need to be predetermined and used consistently for each interview. The questions may be similar to those suggested for focus groups or tailored to a specific program situation.

The interviews can be conducted by outside consultants or agency personnel. It is best if the interviewer is not the employee's immediate supervisor or an administrator. When interviewing ACT team members, it is good to have an interviewer who understands the special style and challenge of ACT work. If the interviewer is not seen as trustworthy or genuinely interested in the information the participant has to share, the interviewer will not be effective.

Not every staff person needs to be interviewed. Interviews are time consuming for both the interviewer and the participant. Go for representativeness. Make sure that enough interviews are conducted to have information representative of various positions and perspectives of staff. The pool should be large enough so that an individual employee is not identifiable by his or her responses. For example, if you interview only one man and he talks about his fears of being wrongfully accused of sexual assault when alone with a female client, he may identifiable simply because he was the only participant with that particular perspective.

Interviews should be held in a private, comfortable setting, either on-site or off-site. It is advisable that all interviews be conducted and completed within a set time frame so that the assessment process moves along smoothly. Taking weeks or months to complete a series of interviews can result in losing focus and reducing the significance of the interviews from the employee's perspective.

Informal Safety Audit

An informal safety audit is a structured and comprehensive worksite assessment completed by a designated individual or the Safety Committee. When done correctly and thoroughly, it can involve a good deal of staff time and commitment. However, it is the best way to get a solid picture of the risk factors and patterns within the agency and its service teams, to identify potential areas of liability, and generate a thoughtful set of specific recommendations for promoting staff safety and risk management. The basic components of an audit are a document review, a policy and procedure review, and employee interviews.

Document Review

The cornerstone of a safety audit is a careful review of recent workplace violence, critical incidents and other documentation to gather data about the type, frequency, magnitude, and resolution of workplace violence. Because of the nature of the audit, the reviewers must have access and authorization to examine these records. Clearly, confidentiality is absolutely critical and must be inviolate in this process.

The review begins with immediately available documents related to incidents of staff-to-client, client-to-staff, staff-to-staff and client-to-client violence. For the recommendations of a safety audit to be practical and proactive, rather than reactive, it is essential that the review consider not just incidents of direct violence, but threatening, intimidating, and harassing incidents as well. Much of the learning comes from the "close calls" that never matriculated into full-blown incidents.

The auditors look for common issues, trends, themes, and obvious problems within the documents. The lack of critical documentation or spotty, incomplete records may surface as an issue itself. Further, the reviewers may need to make a recommendation for changes in the process or format of critical incident reporting. The review includes documents such as:

- Critical incident reports;
- Threat and assault logs;
- Records of clients involved in any reported critical incident;
- Personnel records of staff involved in any reported critical incident;
- Worker compensation claims;
- Accident investigations;
- Police reports;
- Grievances;
- Insurance records.

Remember, the purpose of reviewing documents is to *extract* key information in order to better identify trends. Reviewers should avoid making judgements about the case or getting caught up in extraneous details. It is helpful to use a Key Information Form to make sure the important information is captured. An example is provided in the Tool Kit.

Policy and Procedure Review

For a policy and procedure review, the auditors first locate copies of all relevant documents that provide guidance, standards, or directions to staff regarding how to do their work in a safe, effective, and respectful manner. The auditors would note what documents exist and which do not, how accessible the information is physically as well as in written language, and the process for ensuring that staff know and understand the important information. Examples of the kinds of documents to be reviewed include:

- Policy statements on workplace violence;
- New employee orientation materials;
- Employee handbook;
- Training schedule and curricula on safety related topics;
- Workplace security policies;
- Emergency action and notification procedures;
- Sexual harassment policy statements;
- Grievance procedures for staff as well as for consumers;
- Codes of Conduct and Ethics Statements;
- Best practice documents and standards for practice;
- Compliance reports for regulatory bodies (CARF, for example).

Employee Interviews

Employee interviews also are an important part of safety audits. The auditors may select any or all of the methods identified above and may want to include questions about staff knowledge of current policy, how they access information, what they do when they are unsure of what to do, and so forth. It is useful to probe for areas of incongruence between stated policy and actual practice; for example, when someone says, "Sure, I know I'm supposed to log it every time a client yells at me, but I hardly have time to keep up with all the other documentation. I only do it if something turns physical." During employee interviews, auditors may want to note the attitudes of staff about personal safety and risk management, including cavalier, indifferent, anxious, practical, reasoned, and so forth.

Formal Safety Audits

A formal safety audit is much like a case record or financial audit. They are uniform reviews conducted primarily by independent consultants or professionals external to the agency. For a formal safety audit to have credibility and to be of assistance to an organization, the reviewer must be a qualified expert who is knowledgeable in the field of workplace violence prevention, personal safety, and/or security. Because of the credentials of the reviewer, formal safety audits can be more expensive than internally managed and informal audits. However, they are much less taxing on agency staff time and energy.

The value of a formal safety audit lies in its thoroughness and the feasibility of the ensuing recommendations. Like the informal safety audit, it is based on the comprehensive review of cases involving critical incident reports and/or threatening situations. Formal safety audits are by nature thorough and in-depth. They have credibility and demonstrate a commitment by management to address safety.

However, a formal audit, because of its structure and detail orientation, may run the risk of being removed from and less relevant to the day-to-day work of the team. For example, an uninformed auditor may look at ACT services and suggest that staff remain in locked offices for their safety, receiving clients who have been security cleared at the front door. Whoops! That won't work for ACT!

Assessing the Physical Environment

The physical environment can contribute either to the sense of safety and well-being or the vulnerability and fears of staff. Environmental assessments may be called Safety Inspections, Safety Assessments, Security Inspections, Workplace Hazard Inspections, and so forth. They all focus on identifying and evaluating physical factors that contribute to the safety and/or vulnerability of staff. Assessments of the environment consider both the buildings and facilities operated by an organization and any out-of-office settings where most ACT work occurs.

Internal Safety Inspections

Internal safety inspections are conducted regularly at office and facility settings. The site is carefully appraised from the perspective of intrusion, safety, and escape routes. If an organization operates in more than one location, each site needs to be reviewed. Internal inspections look at the kinds of questions presented in the figure, "Key Questions for Internal Safety Inspections." Because the checklist is adapted from those typically used in a variety of business and industrial settings (for example, WDBI, 1999), not all the components may be appropriate for your mental health setting or to ACT philosophies and values. The State of Washington Department of Labor and Industries (1999) recommends reviewers assess for each of kind of workplace violence discussed in Chapter 2: risk of violence by strangers; risk of violence from customers or clients; risk of violence by co-workers; and risk of violence from personal relations.

External Safety Inspections

External safety inspections are conducted at out-of-office settings where services are provided. These settings may include individual consumer homes, neighborhoods, restaurants, laundromats, parks, and so forth.

Because ACT services are offered in a wide variety of unsecured settings, answering questions on the safety inspection checklist may be difficult. For the findings of an external safety inspection to be useful, the results should focus on commonalties and differences of the various service settings. When coupled with a review of available supports to workers in the field, the assessment can give direction for possible changes in procedures and practices that may help reduce or minimize risk factors for staff and consumers in these settings.

ACT staff should be trained and then prompted as necessary to do a quick safety assessment any time they approach a new or potentially risky setting. See figure, " Key Questions for External Environment Assessment."

Safe and Secure or Open and Welcoming?

In mental health services there is a tension between providing office and treatment environments that are welcoming and help individuals to feel included and respected, and environments that establish high degrees of safety through a variety of barriers, security

screening devises, and other distancing mechanisms. One outcome of a safety assessment should be to help organizations establish and maintain a psychologically friendly atmosphere for clients and employees, and, at the same time, minimize risk to employees or to clients.

Agency Safety Report

The end result of the safety assessment process is an agency safety report, which summarizes the findings and makes recommendations. It is also a useful tool for educating staff and others. Before broader distribution, the Executive Director and the Board of Directors should review the report for comment and endorsement.

The report should increase the readers' general awareness about workplace risk and then explain the results of the safety assessments conducted at the organization. To help to raise awareness, the report may contain factual information about the prevalence and nature of workplace violence in mental health care services and other settings. The 1996 NIOSH report, Violence in the Workplace, is an excellent source of statistics and data relating to workplace violence (see the references for how to access this and other useful documents). Including such information in the report puts the results of the safety assessment in context and helps readers to understand the seriousness of the issues and the reality of the risks.

The main body of the report is a presentation of the findings from the safety audit, the work environment inspection, and the information gathered from staff. It is important to remember that the purpose of the report is to inform readers about the key findings, not to overwhelm them with statistics. It is generally useful to place raw data in an appendix. The report needs to be concise and to the point. The conclusion of the report includes recommended next steps for the agency to reduce and manage workplace risks. It begins to answer the question, "Given this, where do we go from here?"

The report should be circulated the report to all employees as well as to agency consumers. Distribution is most effective if the report findings and recommendations are presented in person and are accompanied by discussion. Board meetings, staff and/or team meetings, and consumer meetings are ideal settings to present and discuss the report. Ultimately, the value of the safety report is that it provides a starting point for action to improve personal safety and risk management within the organization.

Key Questions for Internal Safety Inspections

Building design
Does it have one or more stories? Are offices and meeting rooms close to one another or remote? What is the traffic flow of people? Are stairways open or closed? Are there places that are difficult to see because of turns in the hallways? Are there separate restrooms for staff?

System to control access into the building
Is it the same or different during working hours and after hours? Is it keys, electronic card, etc.? Do clients and visitors enter and exit through the main entrance? Does the main entrance lead into the waiting area and reception? Is there a separate entrance/exit for staff?

Layout of the waiting area and reception
Is there a physical barrier between the receptionist and the waiting area such as a counter and glass window? Are there weapons of opportunity in the waiting area? Is access from the waiting area into the rest of the building physically controlled by a locking system? Is the receptionist isolated from other staff or are others working close by? Do all clients and visitors check in with reception?

Control of access to and layout of offices and meeting rooms
Does staff from and to the waiting area escort all clients and visitors? Are there any rooms that have two exits? Are offices arranged so that both staff and clients have easy access to the office door? Is the furniture arrangement such that staff do not have their backs to a door? Are there weapons of opportunity? How close by is available support?

Security system
Is there a security guard? Is there an alarm system? Are there panic buttons for staff? Is there a stationary weapon screening station or a hand held metal detector? Is there an immediate way to summon police?

Interior and exterior lighting
Are entries, halls, stairways, and other building areas well lighted? Is the parking area also well lit?

Parking
Is it near the building or off site? Is there a restricted area for employee parking? Is it close to an entrance?

Grounds
Is it an open area or congested? Is there perimeter fencing?

Key Questions for an External Safety Assessment

Physical conditions of the neighborhood or community
Is it well maintained or run down? Are there empty buildings in the area? Is there good lighting in the area? Is there safe parking nearby?

Location of the client's residence or other service setting
Is it in a populated area? Is it isolated? Is it urban, suburban or rural? Is it a high crime area? Are there other buildings around?

Type of residence or service setting
Is it a single-family dwelling? Is it a group home? Is it in an apartment building? Is it part of a housing project? How public is the space? If it is a park, how many other people are present? Are their clear avenues for exit?

Kinds of activity in the area
Is there drug dealing? Are there gangs? Is there prostitution? Are there vagrants?

Presence of weapons
Are there known weapons in the individual's residence or nearby? Are guns secured in a locked cabinet with trigger locks? What kinds of "instant weapons" are readily available (for example, kitchen knives, scissors, bottles)

Access to assistance
Is there a phone in the home? Where is the nearest phone? Are police nearby? Do staff have cellular phones? Who is available for immediate assistance if needed?

Chapter Summary

This chapter presented a variety of tools to help organizations identify risk factors through structured internal safety reviews. These tools include forming a safety committee, methods for gathering information from workers about their perspectives on safety at work, and various approaches to evaluating the magnitude and patterns of workplace risk through document reviews, policy analysis and safety inspections. It provided a schema for creating the final report and provided a Toolkit of assessments.

For those in the human service field it is sometimes difficult to recognize workplace violence as something that can be managed, rather than a condition of work. The reality is that each of us are always potentially at risk of personal harm – at home, on the streets, and at work. As human service organizations recognize and understand workplace risk factors they are in a better position to implement policies, procedures, training, and structural changes that will help reduce and manage workplace risk. Worker safety is related as much to management attention and commitment to keeping staff safe, as it is to the actual degree of risk present. Addressing employee safety is an evolving process. It takes time, thought, recognition, and commitment by individuals and organizations.

Toolkit for Safety Assessments

This collection of tools is derived from multiple sources and is provided for example only. Materials in the Toolkit include the following:

- Assault Incident Report Form
- Threat and Assault Log
- Memorandum to Staff Requesting Assistance
- Employee Survey on Workplace Hazards
- Staff Experience and Opinion Survey
- Focus Group Moderator's Guide
- Key Incident Information
- Organizational Safety Review
- Internal Safety Inspection Checklist
- External Safety Inspection Checklist

ASSAULT INCIDENT REPORT FORM

From http:/wa.gov.lni/pa/workvil.htm

Complete one form for each person involved in the incident.

Date of Incident: Month Day Year Time	
Location of Incident:	
Name of Victim:	Gender: Male Female
Victim Description: ❑ Client ❑ Visitor ❑ Employee (Job title)_____ Assigned work location_____ Supervisor_____ Has the supervisor been notified? Yes No	
Describe the assault incident.	
List any witnesses to the incident (Include name and phone number).	
Did the assault involve a firearm? *If so, describe.*	Did the assault involve another weapon. *If yes, please describe.*
Was the victim injured? If yes, please describe.	
What was the gender of the person(s) who committed the assault?	
Who committed the assault (name, if known)?	

What is his/her relationship to the victim?

❑ Stranger	❑ Co-worker	If other, describe:
❑ Personal relation	❑ Supervisor	
❑ Client/ Patient/ Customer	❑ Other	

Please check any risk factors applicable to this incident

❑ Working with money	❑ Working in a high crime area	❑ Poor lighting
❑ Working with drugs	❑ Working late at night	❑ Other risk factor?

What steps could be taken to avoid a similar incident in the future?

Other comments:

Send completed form to:

THREAT AND ASSAULT LOG

From: http:/wa.gov.lni/pa/workvil.htm

Threat and Assault Information	January-June		July-December	
Number of Threats and Assaults				
Type of Threat or Assault				
Threat or assault by stranger				
Threat or assault by customer / clients				
Threat or assault by co-workers				
Threat or assault by personal relations				
Gender of Perpetrators and Victims				
Number of female victims				
Number of male victims				
Number of female perpetrators				
Number of male perpetrators				
Time of Threats and Assaults				
Day shift				
Evening shift				
Night shift				
On weekend				
Location of Threats and Assaults				
On work premises				
Parking lot				
Other duty station				
Other considerations				
Threats and assaults involving firearms				
Threats and assaults involving other weapons				
Cases where the victim was working in isolation				
Result of Threat and Assaults				
Death				
Physical Injury				
Stress / psychological impairment				
No injury				

EMPLOYEE SURVEY ON WORKPLACE VIOLENCE AND HAZARDS

From http:/wa.gov.lni/pa/workvil.htm

Please assess your department/unit over the last year. Thank you for your honest assessment.

Management Commitment and Employee Involvement			
	True	False	I Don't Know
Violence and threats are not accepted as "part of the job" by managers, supervisors and/or employees.			
Employees communicate information about potentially assaultive/threatening clients or visitors to appropriate staff.			
Management communicates information to employees about incidents of workplace violence.			
Employees feel other employees and management treat them with dignity and respect.			
Employees are basically satisfied with their jobs.			
Employees are basically satisfied with management.			
Employees are basically satisfied with the organization (i.e., mission, vision, goals).			
Employees generally feel "safe" when they are at work.			
Employees are familiar with the department or unit violence prevention policies.			
Potential Risk Factors			
Employees do not work in high-crime areas.			
Employees do not work with drugs.			
Employees do not work with cash.			
Employees do not work with patients or clients who have a history of violent behaviors or behavior disorders.			
Employees do not work in isolated areas.			
Hazard Prevention and Control			
The department/unit has adequate lighting to, from and with the worksite.			

There is safe employee parking.			

Access and freedom of movement within the workplace are restricted to those persons who have a legitimate reason for being there.			
Alarm systems such as panic button alarms, silent alarms, or personal electronic alarm systems are being used for prompt security assistance.			
Employees know to use security escort service after hours.			
After hours, the building is locked down with only one access point.			
Visitors are signed in and out.			
Exits are accessible and clearly marked.			
Employees are able to locate emergency equipment such as fire alarm boxes and emergency generator outlets.			
Emergency equipment is accessible and free from obstruction.			
Employees are able to locate cellular phones, power-failure phones and/or radios for emergency communications.			
Employees know proper procedures if a bomb threat is announced.			
Employee emergency call-back list is up-to-date and available.			
Employees provide privacy to reflect sensitivity and respect for clients and visitors.			
Employees use the "buddy system" to work together if problems arise.			
Employees working in the field have cellular phones or other communication devices to enable them to request aid.			
Staffing levels are appropriate for department/unit functions.			
Reference materials are up-to-date and available for employees.			

There is a grievance policy available to employees.			

Training	True	False	Don't Know
Employees have received training on the company's workplace violence prevention program.			
Employees know how to ask for assistance by phone or by alerting other staff.			
Employees have been trained to recognize and handle threatening, aggressive or violent behavior.			
Employees have been trained in verbal de-escalation techniques.			
Employees have been trained in self-defense / restraint procedures.			
Incidents and Reporting	Yes	No	Don't Know
This work unit/department has not experienced violent behavior and assaults or threats from strangers.			
This work unit/department has not experienced violent behavior and assaults or threats from clients or customers.			
The work unit/ department has not experienced domestic violence issues.			
Employees are required to report incidents or threats of violence, regardless of injury or severity; the reporting system is clear.			
Assistance is available to employees who have been assaulted or threatened.			

Staff Experience and Opinion Survey

We are in the process of gathering information about the potential risks that you may face as you do your work. We are interested in your experiences and your ideas about risk in your job. Please take a few moments and fill out this survey. Please return to _____. Thank you for your help.

Do you sometimes worry about your safety as you do your job?	Yes ❑ No ❑
If yes, what causes the worry? ❑ The area where I work ❑ Working alone ❑ Some of my clients ❑ Transporting clients ❑ No way to call for help ❑ Being responsible for and carrying clients' money / medication ❑ Other	
While doing your work have you ever had a person become aggressive towards you? ❑ Be verbally aggressive ❑ Physically threaten you ❑ Threaten using a weapon ❑ Assault you ❑ Harass you ❑ Stalk you ❑ Other	
Have you raised your safety concerns to management? With your team leader? With your colleagues?	Yes ❑ No ❑ Yes ❑ No ❑ Yes ❑ No ❑
Did you feel that your concerns were heard?	Yes ❑ No ❑
What ideas do you have about ways to reduce risk to your safety?	
How do you presently handle these kinds of situations?	
How do you presently help consumers with their personal safety?	

Title: Example Focus Group Invitation

Memorandum

To:All Staff

From:Vera Concerned, Executive Director

Date: June 30, 1999

Re:Focus Groups/Interviews

As you may know, we are in the process of looking at safety issues as they pertain to your work. A key part of learning about the risks you face and your concerns is hearing from each of you. Thus, I want to invite you to participate in a focus group/interview to talk about your concerns. The time of your focus group/interview is 3:00 PM. It will be held at the Conference Room. Refreshments will be served.

I want to personally assure you that any of your comments or information will be kept confidential. I tell you this so that you will feel free to discuss your concerns. For us to address safety issues effectively, it is essential that we truly know and understand what they are.

Thank you for your contribution to this important process.

Focus Group Moderator's Guide

1. Welcome and introductions
2. Housekeeping
3. Brief overview of organization's commitment to addressing worker safety issues
4. Concise outline of known risks in field
5. Explanation of focus group format and rules, including confidentiality of responses
6. Questions asked and answers recorded
7. Categorization by group of similar responses
8. Rank ordering of concerns
9. Wrap up

CRITICAL INCIDENT INFORMATION

For Critical Incidents / Threatening Situations Between Staff and Clients

Client Profile

Age:	**Gender:**	**Diagnosis:**
History of Hospitalizations? Yes ❑ No ❑ If yes, date of most recent hospitalization:		**Medication Compliance** Yes ❑ No ❑ Mixed ❑
History of Victimization/Abuse: Yes ❑ No ❑ Type:		**History of Violence?** Yes ❑ No ❑ Type:
Substance Abuse? Yes ❑ No ❑ Describe:		

Staff Profile

Age:	**Gender:**	**Position:**
Years of Experience:		

Others Involved:
Yes ❑ No ❑ Specify:

Location: In Office ❑ Out of Office ❑ **Specify:**	**Time:**

Type of Service:

Purpose of Contact:

Special Circumstances:

Description of Incident:

Outcome/Resolution of Incident:

ORGANIZATIONAL SAFETY REVIEW

I. Staff/ Job Responsibilities

List types of positions, where work is done and hours of operation

Position	Place of Work	Hours
Example: ACT case manager	*In shared office at ACT, Wright building and community settings Includes: Central Shelter, client homes, street work.*	*Days & evenings. Emergency on-call at night*
Example: Business Manager	*In Elm Street office complex. Private office*	*Monday-Friday, 8:30 – 4:30*

II. Staff Profile

Give the numbers of staff

GENDER:	Male:	Female:		
AGE:	20-30	30-40	over 40	
EXPERIENCE:	0-3 years	3-5 years	5-10 years	Over 10 years

III. Training

Please mark training staff have received this past year

Crisis Management ❑	Conflict Resolution ❑	Dealing with Difficult People ❑
Restraint Training ❑	Non Violent Crisis Intervention ❑	De-escalation Training ❑
Defense Against Armed Attackers ❑	Sexual Assault Prevention ❑	Weapons Training ❑

Others:

IV. Critical Incidents /Situations Endangering Staff

Mark any that have occurred in your agency in the past five years and estimate the number of times.

Type of Incident	# of times
❑ Verbal threat against staff	
❑ Physical assault against staff by a client	
❑ Physical assault against staff by non-client while performing work	
❑ Victim of robbery or theft	
❑ Harassing / obscene phone calls to staff	
❑ Stalking / harassment of staff	
❑ Hostage situation	
❑ Other	

V. Safety Planning / Practices

Standing Safety Committee ❑	Critical / Threatening Incident Report Form & Procedures ❑	Client Crisis Plans & Procedures ❑
Trauma Plan ❑	Written Emergency Procedures for Assault ❑	Evacuation Procedures ❑
Risk Assessment Form & Procedures ❑	In-Office Safety Procedures ❑	Out-of-Office Safety Procedures ❑

Describe the most serious incident of workplace violence during the past five years:

INTERNAL SAFETY INSPECTION CHECKLIST

I. Building Design

Number of Floors:	Proximity of rooms to each other: Close Remote	Stairways Opened Closed
Mirrors at turns in hallways? Yes ❑ No ❑	Separate staff restrooms? Yes ❑ No ❑	

II. Building Access

Keys Yes ❑ No ❑	Electronic Card Yes ❑ No ❑	Hours Building is Locked:
Users of Main Entrance: Staff_____ Clients_____ Visitors_____	Users of Alternate Entrance: Staff_____ Clients_____ Visitors_____	Main Entrance Leads to Waiting Area? Yes ❑ No ❑
Separate entrance/ exit for staff? Yes ❑ No ❑		

III. Waiting Area and Reception

Physical Barrier Between Receptionist and Waiting Area?	Yes❑ No❑
Weapons of Opportunity in Waiting Area?	Yes❑ No❑
Access to Rest of Building Physically Controlled?	Yes❑ No❑
Receptionist isolated?	Yes❑ No❑
Clients and Visitors Check in With Receptionist?	Yes❑ No❑

IV. Office and Meeting Rooms

Access is Controlled	Yes❑ No❑
Some Rooms Have two Exits	Yes❑ No❑
Staff and Clients have Easy Access to Doors of Offices?	Yes❑ No❑
Staff Sit at Desk with back to Door?	Yes❑ No❑
Weapons of opportunity?	Yes❑ No❑
Help is close by?	Yes❑ No❑

V. Security System

Security guard	Yes❑ No❑
Alarm system	Yes❑ No❑
Panic buttons	Yes❑ No❑
Stationary weapons screening station	Yes❑ No❑
Hand held metal detector	Yes❑ No❑
Immediate way to summon police	Yes❑ No❑

VI. Interior and Exterior Lighting *Check all that are well lighted.*

Entries ❑	Halls ❑	Stairways ❑
Offices ❑	Storage areas ❑	Parking lot ❑

VII. Parking

Near building	Yes❑ No❑
Off-site?	Yes❑ No❑
Restricted parking for employees	Yes❑ No❑
Close to entrance	Yes❑ No❑

VIII. Grounds

Open area	Yes❑ No❑
Perimeter fencing	Yes❑ No❑

EXTERNAL SAFETY INSPECTION CHECKLIST

Please check all that apply.

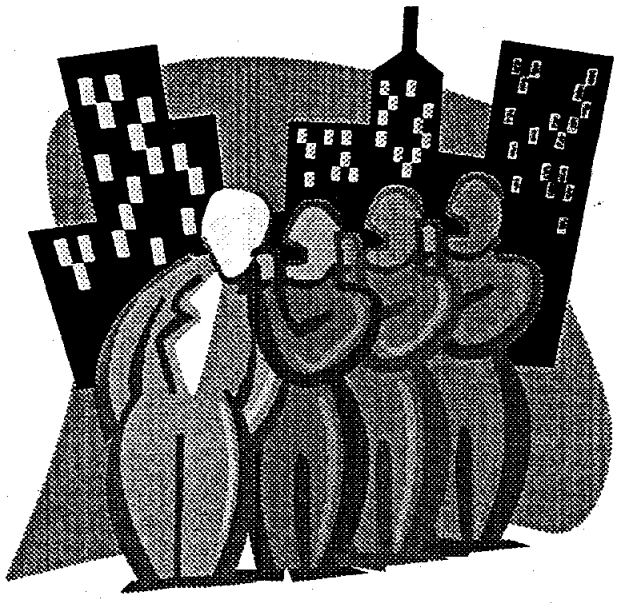
I. Physical Condition of Neighborhood		
Run down ❑	Well-maintained ❑	Empty buildings in area ❑
Good lighting ❑	Safe parking ❑	
II. Location of Client's Residence		
Populated area ❑	Isolated ❑	Urban ❑
Suburban ❑	Rural ❑	High crime area ❑
III. Type of Residence		
Single family home ❑	Group home ❑	Apartment ❑
Condominium ❑	Housing project ❑	
IV. Visible or Known Crime Activity in Area		
Drug dealing ❑	Gangs ❑	Prostitution ❑
Vagrancy ❑		
V. Staff Access to Residence or Contact Site		
Public Transportation ❑	Access within one block ❑	Access more than one block ❑
Personal or Agency Vehicle ❑	Parking within one block ❑	Parking more than one block ❑
Walk or Bicycle ❑	One block or less ❑	More than one block ❑
V. Access to Assistance		
Phone in home or at site ❑	Police nearby ❑	Cellular phone for staff ❑

VI. Prevalence and Types of Crime in the Area (use police reports and other data sources).

VII. Has client(s) in residence or at site been victim of crime in the area. Describe kind(s), frequency, and intensity.

Section III

Team and Individual Responsibilities



Chapter

6

Good Practice is the Best Protection

Overview: *This chapter discusses the responsibilities of ACT team members and leaders. It emphasizes the importance of good and competent clinical practice and provides information about clients and legal obligations of staff. It discusses common sense precautions for day-to-day activities that inherently are risky such as representative payeeships, community outreach, and transport.*

Begin with Good Practice

As an Assertive Community Treatment service provider, you are part of a treatment model that has demonstrated some success in providing effective community-based care for individuals with the most severe and persistent mental illnesses. Research suggests that ACT is one of the most effective service approaches for reducing and managing the risk of violent behavior by people with psychiatric disorders who live in the community (Dvoskin & Steadman, 1994).

Because ACT is designed to provide tailored services for clients with high-risk profiles, it is especially important for you, your team, and your organization to pay careful attention to issues of safety and identified best practices. When people receive the kinds of treatment and support that both increase their level of functioning and help them to develop a good quality of life, working conditions for you are better and your personal safety risk is reduced. Why? Because violence often is based on a person's need to fulfill some critical emotional or psychological need. When the needs are great, the risk of violence in some people is increased.

It is beyond the scope of this manual to provide an in-depth discussion of all recommended ACT best practices. However, you will find discussions of many of these practices as they relate to personal safety and risk management in the published literature (Allness & Knoedler, 1998) and throughout this manual. These include:

- Prompt and ongoing delivery of appropriate treatment and supports (this chapter);
- Upholding client rights and ethical practice (this chapter);
- Attending to fiduciary and legal responsibilities of staff (this chapter);
- Assisting with money and medication management, and transport (this chapter);
- Building rapport and trust (See Chapter 9);
- Continuous assessment and treatment planning (See Chapter 9);
- Recognizing warning signs and crisis planning (See Chapter 7);
- Ongoing risk assessment (See Chapters 8 and 9);
- Holding people responsible (See Chapter 9)
- Maintaining employee safety (See Chapter 3).

Practice Standards and Policies

Good and safe practice takes work. ACT program administrators and team leaders should ensure staff and client safety, develop and implement good clinical practice standards and safety policies, and develop and provide training on the ACT model and safety policies. They need to be held accountable for these activities, but also acknowledged and rewarded when their efforts result in positive outcomes for clients and well-managed safety risks for staff (Allness & Knoedler, 1998).

ACT practice standards define acceptable clinical practices and staff competency requirements. One of the purposes of these practice standards is to effectively meet the needs of clients by providing positive treatment and rehabilitation by competent, knowledgeable, and skilled staff. This minimizes risk to both staff members and clients. To be effective, ACT teams must consistently demonstrate at least the minimal level of competency required by ACT practice standards. Self-ordained competency is unacceptable. There must be professional documentation, such as staff members' educational preparation and degrees for their respective fields of practice; licenses to practice; staff training, experience, and supervision; and program accreditation or certification.

Program policies are general guides to action, established rules, standard operating procedures, or written instructions describing what should be done in a specific situation. They include elements that focus not just on achieving clinical outcomes, but on how to achieve those outcomes and, at the same time, assure the personal safety of staff and clients.

If the quality of your service falls short of a reasonable standard of care – and there are harmful consequences as a result – you and/or your agency could be found negligent in court. To minimize this liability as a team or agency, you should clearly specify in writing what you

can and what you *cannot* provide. It is useful to have a brochure that expresses these parameters of practice and the agency policy on the standard of care. Any informational brochure should be geared to the reading ability and comprehension of the layperson.

Prompt Delivery of Appropriate Treatment and Supports

As a member of an ACT team, you and your co-workers are responsible to make sure that the kind, intensity, and responsiveness of the treatment and support provided by your team is adequate to minimize risk. Responsiveness is a critical factor in ACT services. One of the common triggers for crisis and violence is frustration. If a person in crisis needs to wait for hours and hours to make contact with an ACT team member, the risk factors may increase dramatically. Similarly, when a worker delays or misses a scheduled meeting -- especially without informing the person -- the worker has just cranked up the risk quotient. Certainly some individuals are more triggered by these situations than others (see Chapter 10 for a discussion about the role of triggers in the escalation of incidents). The team structure of ACT and its mechanisms for rapid communication are some of its assets for quick and responsive service delivery.

If a person requires more than your team is able to provide, it is your responsibility to arrange for more intensive, restrictive, or involuntary services. This helps protect you, the client, and the community from potential harm.

Client Rights and Ethical Practice

All citizens in this country are meant to enjoy universal, basic civil rights – freedom of speech, civil liberty, rights to vote, to be mobile, and so forth. People with psychiatric disorders have the same rights as any other citizen, though sadly, these rights frequently are not respected by the professional or exercised by the client. In addition to civil rights, people with mental illness also have a set of statutory and "consumer" rights that are given by law (Curtis, 1995). You *must* respect these rights, and ACT policies should clearly operationalize them. These rights include the rights to:

- Least restrictive treatment;
- Prompt and adequate treatment;
- Refusal of treatment;
- Informed consent;
- Private communication;
- Filing of grievances.

Written policies should ensure that the staff of the program understand and consistently uphold the rights of the people they serve.

Integrity must be a core value of ACT teams. How you perform your work communicates a great deal to your clients and your co-workers about your trustworthiness, honesty, reliability, and positive intent. Part of integrity is to respect informed consent. You need to provide consumers with continual information about intervention options and the efficacy, benefits, and risks (such as side effects) of each possible intervention, as well as alternatives. Further, from the onset of treatment you must make sure that the people you serve are not only informed about their rights, but that they understand them and know how to exercise them.

An important part of integrity is not making promises you cannot keep. You need to keep people informed about the limits of confidentiality and privileged communication. For

example, you need to disclose to clients that you may not be able to "keep a secret," that information is shared freely among team members to ensure coordinated services for the client, and that you are obligated to report illegal activities, and any action or threat of action that may pose harm to the individual or to others.

ACT Staff Duties and Liabilities for Risk Management

Fiduciary responsibilities are those you have because, as an ACT team member, you are in a position of power to influence the life of a consumer. For example, you handle medications; you often control an individual's finances; you make decisions about what service is provided, how much, when, and for how long; you make decisions about hospitalizations and often play a role in community treatment orders or probation. You must not abuse this power or bend it for your own gain in any way. Further, you must make sure that any vulnerabilities of the consumer are protected from exploitation or abuse when that person is unable to protect himself or herself adequately (Curtis & Diamond, 1997). This is commonly known as the "Duty to Protect."

Balancing Rights and Risk

One of the most difficult decisions in mental health services is when to make assertive or even coercive interventions for the protection of the person, his or her family, and the larger community. The struggle comes from trying to balance the individual's right and need for autonomy and self-determination (important in successful recovery) with the rights and needs of others to be free from harm or risk. You must weigh the immediate and long-term costs of taking no action with the costs of action, and then, make the best choice you can.

This dilemma is common when the consumer is demonstrating high risk of harm to herself, violent behavior, illegal or law-breaking behavior, destruction of property, or when the person is at risk for being a victim of violence. Other situations may be less obvious, but no less important, such as when deciding to support self-medication regimens or return management of an individual's financial benefits to her control.

All of these situations carry risk. That is, they each have the potential for causing harm, although the kind, imminence, or severity of the potential harm may vary in each situation. How you choose to respond in any of these situations is risk management. What you are doing to protect the individual and others from potential harm is risk management. How you tailor your response to specific considerations unique to the situation is risk management. How you make decisions about the "right" amount of intervention at the "right" time is risk management. Risk management is an integral part of service provision and planning, and it is a core component of your fiduciary responsibilities and duties.

Chapter 8 will consider risk assessment from the perspective of clinical service planning and provision. Here, we will outline some of the ways fiduciary responsibility has been defined and established by the courts, in particular the Duty to Warn and Duty to Commit. Because these duties are founded on state and federal law, there may be some variations in how they are applied from state to state.

Duty to Warn

You are probably aware of *Tarasoff v. Board of Regents of the University of California* (1976). This a famous court case which established the responsibility of mental health professionals to break confidentiality, even against a client's wishes, and to protect third

parties from threatened harm by a client. Reamer (1995, p 85) summarizes the court record as follows:

> *Prosenjit Poddar, who was receiving mental health counseling as an outpatient at Cowell Memorial Hospital at the University of California at Berkeley, informed his psychologist, Dr. Lawrence Moore, that he was planning to kill an unnamed young woman (easily identified as Tatiana Tarasoff) upon her return from her summer vacation. After the counseling session during which Poddar announced his plan, the psychologist telephoned the university police and requested that they observe Poddar because he might need hospitalization and he might be "dangerous to himself or others." The psychologist followed up the call with a letter to the chief of the university police.*
>
> *The campus police took Poddar into temporary custody but released him based on evidence that he was rational; the police also warned Poddar to stay away from Tarasoff. At that point Poddar moved into an apartment with Tarasoff's brother near where Tarasoff lived with her parents. Shortly after that the psychologist's supervisor asked the university police to give back the letter, ordered that the letter be destroyed, and directed that no further action be taken to hospitalize Poddar. No one warned Tarasoff or her family of Poddar's threat. Poddar never returned to treatment. Two months later he killed Tarasoff.*
>
> *Tarasoff's parents sued the Board of Regents of the University, several employees of the student health service, and the chief of police, along with four of his officers, because their daughter was never notified of his threat. A lower court in California dismissed the case on the need for the psychologist's need to preserve confidentiality. The parents appealed, and the California Supreme Court upheld the appeal and affirmed that failure to protect the victim was irresponsible. The California Supreme Court ultimately held that a mental health professional who knows that a client plans to harm another individual has a duty to protect the intended victim.*

The California Supreme Court wrote,

> *We recognize the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication. Against this interest, however, we must weigh the public interest in safety from violent assault... We conclude that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins (551 P.2d 334 at 336-37).*

The original ruling was based on a "duty to warn" principle that was later expanded by the California Supreme Court to a "duty to protect." This means that if a client tells you that he or she intends to harm another person, you must not only break confidentiality and inform the intended victim, but you must also make sure the individual has the resources to secure necessary protection.

Does this mean that *every* reference to harm, however mild or off-hand, must be reported? How do you predict which threats will be acted on and which will not? The courts and lawyers have been busy with this question for over 20 years. While there are still considerable gray areas, there is increasing clarity about the circumstances under which mental health professionals are obligated to disclose confidential information against client wishes. Reamer (1994) provides four conditions that clearly justify disclosure.

Conditions for Executing Duty To Warn Obligations

- The mental health professional should have evidence that the client poses a threat of violence to an identified party;
- The evidence should present good reason that the client is likely to carry out the violent act;
- There should be evidence that the violent act is imminent;
- The mental health professional is able to identify the victim.

Example 1:

A client tells you that he is so mad at his girlfriend for dumping him that he is going to "make her pay with her life" because "no woman does that to me and gets away with it." You must disclose when there are specific threats and foreseeable harm against identified victims, as is seen in this example. You have an absolute duty to warn that takes precedence over confidentiality. You must make sure the girlfriend not only knows about the threat, but also knows how to get to a safe place to protect herself.

Example 2:

....Well, maybe. A male client talks to you about being so angry with women he'd "like to shoot every last one of them." Is this an expression of feeling, a fantasy, or an implicit threat? Do you have a duty in this situation? There continue to be questions if the threat is vague or the victim(s) unidentified. You are obligated to follow "reasonable standards" and use ordinary skill in predicting violence in gray area. It would be reasonable in this situation where there is no identified victim minimally to assess intensity and tone of the statement, history of violence, availability of means, whether there is a particular woman or "foreseeable victim" at risk (such as a girlfriend or mother), any specific plans, and so forth.

The introduction of HIV/AIDS has raised new questions in the "duty to protect" dialogue. For example, do you have a responsibility to inform a woman's partner that she is HIV positive? While there remain many opinions about this, the general guideline for ACT workers is to do absolutely everything you can to encourage the client to disclose the information to an intimate other. You also have a responsibility to make sure all the people you serve are aware of the risks attendant to unprotected sex and make sure people have the

knowledge, resources, and ability to protect themselves (Reamer, 1990; Razzano & Cook, 1998).

Precise guidelines do not exist in "duty to warn" or "duty to protect," situations and it is likely that continuing litigation and dialogue will gradually provide clearer parameters. Your clinical judgment is required to balance clients' rights and expectations of confidentiality with the protection of potential victims. These can be tough calls because you may find yourself in a "damned if you do; damned if you do not" position. You can minimize your personal liability and the team's liability in "duty to warn" situations with the following recommendations (Austin, Moline, & Williams, 1990; Reamer, 1994).

- Consult an attorney who is knowledgeable about state law regarding duty to warn and/or duty to protect.
- Seek the client's consent for the mental health professional to warn the victim.
- Disclose only the minimum of information to protect the potential victim or the public.
- Encourage the client to surrender any weapons he or she might have to family or the police.
- Increase the frequency of client contacts with ACT staff and other forms of monitoring.
- Establish availability to the client, at least by telephone.
- Have the ACT psychiatrist evaluate and determine need and usefulness of medication.
- Consider hospitalization, voluntary or involuntary.

Duty to Commit

Is there a "duty to commit?" This can be sticky and highly divisive among mental health professionals, family members, advocates, and consumers — particularly in reference to involuntary commitments. State laws provide some specific guidance and administrative rules in this arena, and you should be familiar with the law in your state. The role of psychiatric hospitals in commitments and treatment has been challenged and questioned during the past decade or so. Are they facilities for treatment? Containment and safety? Punishment? All of the above?

Courts are increasingly recognizing "duty to commit" as a professional responsibility in situations where individuals present a serious danger to themselves or others. In some states the involuntary treatment criteria include "gravely impaired" which focuses more on capacity to care for oneself than on dangerousness per se. Failure to provide reasonable care, to commit to hospitalization, or to protect an individual from harm (whether the client or a victim) all have been elements in professional malpractice or negligence litigation. Yet the courts also have established the legal doctrine of "least restrictive alternative" which requires that all treatment settings be no more harsh, coercive, or intrusive than necessary to achieve specific therapeutic objectives and to protect the individual and others from harm (Corey, Corey, & Callanan, 1993).

At least one case (*Currie v. United States, 1986*) states that therapists have a duty to commit to hospitalization potentially dangerous clients in an effort to protect potential victims. The case can be summarized as follows.

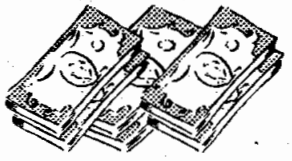
> *In this case, a patient at a North Carolina veteran's outpatient clinic who was in treatment to address a post-traumatic stress syndrome, threatened to blow up a building owned by IBM, his former employer. The therapist involved in the case believed that the patient posed a threat and contacted IBM officials, the FBI, local police officials, and the U.S. attorney's office. The therapist did not, however, believe that the patient met the commitment criteria under North Carolina law. Some time later the patient took homemade explosives and a gun to an IBM office and killed an employee.*
>
> *The victim's estate sued the Veteran's Administration, claiming that it had not warned all the victims and was allegedly negligent in not seeking the man's commitment. The defense argued that the duty to protect did not pertain because the victim was one of many IBM employees and hence could not have been identified. The defense also argued that there was no duty to commit because the patient did not meet the involuntary commitment criteria. In an important ruling the U.S. District Court held that patients who act out a random or in only broadly predictable ways do create a duty for therapists. The court also warned that the therapist wrongly interpreted the state's commitment law and that the patient was indeed commitable* (Meyer, Landis, & Hayes, 1988, pp.45-46).

Again, you may be between a rock and a hard place. There is a critical balance between protecting the individual from *undue* incarceration and protecting the safety of the individual and the community. There are some practical ways you can affirm your professional judgement in a situation and minimize liability in difficult situations.

- Be familiar with your state laws and regulations;
- If you notice a client's condition is deteriorating, consult with colleagues;
- Assess the degree to which the client is a danger to self or others;
- Determine specifically how a hospitalization will benefit the client;
- Consider all the options, including alternatives to hospitalization;
- Know the precise steps that must be followed by law to involuntarily commit a person in your state;
- Document your actions and reasoning (Bennet, 1990, cited in Corey, Corey, Callanan, 1993, p. 101).

Considerations and Guidelines for Becoming a Representative Payee

ACT workers often advocate for their agency to be selected as the Representative Payee for ACT consumers. Representative Payees receive and oversee the appropriate use of Social Security benefits checks.



The Social Security Administration requires Representative Payeeship when there is clear evidence that the recipient is unable to manage her funds to sufficiently meet basic subsistence living requirements (food. shelter, clothing). Generally, those with co-occurring substance use disorders and those who have poor money management skills due to mental health or cognitive problems are required to have a Representative Payee in order to receive their benefits. It is assumed that the Representative Payee will act in the best interest of the consumer, ensuring that the funds available to the consumer are spent on such things as rent, utilities, food, and clothing. The Representative Payee may be a family member, a friend, or a social service provider. Commonly, the agency that provides ACT services is selected to serve as the Representative Payee for ACT clients.

Often, an ACT client is satisfied with the way in which the Representative Payee manages his funds, which grows out of the trust the individual has developed in the members of the team. Trust is earned and usually develops over time when a client consistently experiences an *effective, respectful, flexible,* and *collaborative* working alliance with the members of the ACT team.

Then there are those times when a Representative Payee and a consumer disagree about the use of her funds. These disagreements arise over many issues. However, one significant source of tension is when the consumer wants to use these funds to purchase drugs or alcohol rather than securing basic needs. Disagreements over money and substance use are identified as high risk factors for violence. Functioning as a Representative Payee or any kind of a money manager for clients brings with it some important safety considerations. Every ACT team should have standard procedures that promote safety for both the provider and the client.

Organizational Issues

You, as an ACT worker, should *never* personally apply to be a client's Representative Payee. This always should be done through the auspices of the agency, which has financial oversight and accountability systems to ensure that funds are handled in an ethical and legal manner. This protects you, the agency, and the client.

A Centralized Approach

Representative Payeeship programs tend to be set up by organizations in two ways: centralized or decentralized. Centralized programs have one administrative component, such as an accounting department or an internal "consumer bank" to handle all client funds. In such systems, as the ACT workers assist consumers with day-to-day money management tasks such as developing a budget, paying bills, and making purchases. But the provider does

**Note: Broad portions of this section are derived from a report presented to the Money Management Task Force in Milwaukee, WI, entitled Money Management: A Continuum of Services (Hitz Graf,1990).*

not actually handle the consumers' funds. Rather, staff request withdrawals from the centrally managed account. Accounting or the bank are responsible for account balances and general oversight.

A Decentralized Approach

In a decentralized system, the ACT workers actually do the banking with, or on behalf of, consumers. The agency remains official Representative Payee, but service providers do the hands-on work of managing funds, writing checks, balancing accounts, and assuring accountability. In this approach, the ACT team is directly responsible for oversight of each account.

Which Is Better?

Both the centralized and decentralized approach have strengths and weaknesses. From a personal safety and risk perspective, the centralized system ensures that administrative personnel provide regular and professional oversight of accounts on a daily basis. There is less chance of mistakes or "lost" funds. Because ACT team members do not personally have direct access to the consumers' funds, they are somewhat removed from accusations of mismanagement by consumers. Further they are less likely to be the target of intimidation or threat by a consumer in order to get extra cash.

The decentralized system can be significantly more flexible and responsive to changing consumer needs than the centralized system with its layers of authority and discrete job descriptions. In addition, the decentralized system is more likely to assist consumers with developing banking skills as the ACT workers themselves perform banking functions, often side-by-side with the person.

Cash or Checks?

In either system funds can be distributed to consumers in the form of cash or checks. Neither is risk-free. Checks tend to provide a clear "paper trail" for both auditors and consumers to know that funds are being used appropriately. Lost cash is irreplaceable, whereas lost checks can be canceled and re-issued. If workers are not carrying cash, they are less likely to be "marked" or be a target of theft. On the other hand, to cash checks, consumers often need to use currency exchanges. These enterprises charge fees for each check cashed which can be a hardship for those on fixed incomes. Further, consumers may easily become a target for a mugger who knows that people exiting the currency exchange are likely to have cash.

Policy Guidelines

Whether the agency chooses a centralized or decentralized model, its system for Representative Payeeship should include basic accountability standards. See the figure "Guidelines for Representative Payees."

Consumers have the right to expect consistency and predictability in the management and distribution of their income. When consistency and sound management are an intrinsic part of a Representative Payeeship program, most conflicts can be avoided before they start.

Provider Issues

Acting as a Rep Payee directly affects your relationships with the people you serve. In both centralized and decentralized systems, the ACT team itself is the gatekeeper for consumers' funds. Extra effort must be taken to ensure that money management is a collaborative process to the greatest degree possible. A written budget, developed in partnership with the

consumer, and signed by the consumer, is a necessity. Each consumer must have a copy of his or her budget. In developing the budget with clients, ACT workers should clearly address the following questions:

- **Why budget?** Remind the person that this process is to make sure basic needs for food, shelter, and clothing are met. It is done in compliance with Social Security Administration requirements.

- **How and when will the funds be distributed?** People need to know when they will have access to their funds. This is vital for both predictability and creating confidence that basic needs will be met.

- **What is the process for complaining about or redressing problems with Rep Payeeship practices?** Every consumer should be made aware of the agency's grievance procedures. Knowledge that problems can be redressed on a higher level will help most consumers feel more confident in the program.

- **What is the process for changing the budget?** Is this a monthly, quarterly, or annual budget? When will it be reviewed? What is the process for initiating change? What are the definition and procedures for "emergencies" or special events such as holidays or vacations?

- **What are the objective criteria for satisfying the Social Security Administration so that the person can regain personal control of her benefits?** In what ways is the Rep Payee program helping the person meet these criteria and regain her financial independence?

Having polices and reasonable procedures in place can make a big difference for both consumers and staff. Proactive mechanisms for decision-making, assuring predictability in when and how funds are distributed, and knowing appropriate avenues for making changes in budgets and money management programs can reduce the feelings of frustration, anger, and indignity often associated with having a Representative Payee.

Guidelines for Representative Payees

- Treat each consumer with dignity and respect. All participants in the Representative Payee program should be accorded equal procedural protections and safeguards.
- Ensure that funds are spent on basic necessities such as food, shelter, clothing, and personal comfort items.
- Comply with all administrative requests from the Social Security Administration in order to avoid any disruption in benefit status.
- Maintain accurate records of payments, receipts, and financial transactions undertaken on behalf of consumers.
- Not co-mingle program funds and those of consumers.
- Not borrow from or lend funds to consumers for any reason.
- Have in place and explain to consumers the process to redress any real or perceived problems with the system.

Streetsmart and Savvy: Safe Community Outreach and Transport Tips

ACT practice guidelines require that 70-75 percent of all services be delivered "in-vivo." This means you're out there — wherever the people you serve live, work, or recreate. As noted many times in this manual, this crucial aspect of ACT services is also inherently high-risk. Simply by being on the streets you are exposed to a multitude of dangers. Does this mean the service should stop outreach? No way! It is one of the core ingredients that makes ACT effective. Does it mean you should be smart about how you do it? You betcha!

Working in the community and on the streets has different hazards and risk factors than working in an office setting. Many of the precautionary measures available for people working within mental health office buildings are not realistic or applicable when providing treatment in a street environment. The following figures, "Tips for Safe Community Outreach," "Tips for Safe Car Transport," and "Attitudes that Increase Your Safety," are derived from practical street experience of workers like you. They are provided in handout form for quick reference and discussion with your team members. If you are not already using these practices regularly, consider integrating them into how you handle yourself in day-to-day situations. You may have some tips of your own to share as well. Add them to the list for your team. We'd love to hear about them, too!

Chapter Summary

The foundation of safety in ACT services is the provision of good clinical practice. By complying with recognized guidelines, understanding your fiduciary obligations for consumer as well as community safety, and by applying practical approaches to everyday activities, the risk factors inherent in community service delivery are reduced. This chapter has provided an overview of some core ACT practice guidelines and reviewed worker responsibilities regarding duty-to-warn and duty-to-protect from the context of risk management. Policies for representative payeeships, community outreach, and car transport were presented in practical, hands-on ways.

Tips for Safe Community Outreach

- Thoroughly prepare before visiting the client, especially when meeting with a new person. For example, review clinical chart, meet as a team, determine if there is a history of documented violence, and so forth.
- Determine where to conduct the outreach, such as person's home, worksite, your office, or a neutral location like a restaurant.
- Determine whether visits should be conducted with another staff person.
- Determine the best time of day to visit the client.
- Make sure to provide your supervisor and other team members with a detailed itinerary of your daily responsibilities.
- Make sure to dress appropriately. No flashy clothes, expensive jewelry, or cumbersome articles that may make exiting difficult or draw undue attention to yourself. Avoid carrying a purse or large amounts of cash.
- Assess the situation as you drive up to the location of the visit. Notice individuals in the general vicinity, the types of activities they are engaged in, etc. If you sense danger, trust your instincts and leave...you can always call to reschedule a visit.
- Park for an easy exit if needed.
- When approaching the door, stand to the side, knock loudly, and identify yourself
- When the door is answered, quickly survey the scene. Make note of noise level, amount of people in the residence, signs of drugs and/or alcohol.
- Determine whether meeting should occur in the residence or outside on the porch.
- If meeting occurs inside the residence, stay alert and aware. Seat yourself close to the door and present a calm, confident demeanor that does not project aggressive authority.

Tips for Safe Car Transport

- Be thoroughly prepared before transporting any client in your and/or your agency's vehicle.
- Review diagnostic/clinical information, conduct assessment with client, meet with team members, and so forth.
- Decide if there needs to be another staff person present when transporting the client.
- It is preferred to have a cellular phone easily accessible during all client transports.
- If the client has a past history of becoming assaultive during transports, establish a policy indicating under which circumstances the client may be transported; for example, only in a secured vehicle, with two or more staff present, with police escort, and so forth.
- It is preferable to have the client seated in the back behind the passenger seat rather than next to you. It would be easier for the client to grab the steering wheel sitting directly beside you than in the back.
- Make sure the client does not have any concealed weapons or objects that could be used to harm you during transport.
- Assess the situation. Look for any visible signs of distress the client may be exhibiting. Check for restlessness, stiff posture, voice tone becoming louder, eyes dilated, and so forth.
- If the client seems agitated and/or becomes verbally abusive or threatening, pull over the vehicle to the nearest public place and attempt to de-escalate the situation. If the client continues, set a limit and indicate that you will not be able to transport under these circumstances. You can also call for assistance..
- If during transport, a client attempts to grab the wheel or you, do your best to remain calm and focus on controlling the car. Attempt to stop if possible and escape.

Attitudes which Increase Your Safety

- Recognize the person's right to be treated with dignity.
- Recognize your right to be treated with dignity.
- Know yourself, your triggers, and how you respond to conflict.
- Keep calm; keep calm, keep calm.
- Listen and keep on listening.
- Allow room for people to vent and express feelings.
- Make sure you HEAR people's concerns.
- Remember the need for "face" – never render a person powerless.
- Expect that even when upset, the individual can and will remain in control of himself or herself.
- Distinguish between the person and the behavior. It is the behavior that is unacceptable, not the individual.
- Focus on what you can do – and not on what you cannot.

Adapted from Curtis (1990). *When Bad Things Happen*

Chapter

7

Crisis Prevention

Proactively Minimizing Risk for Everyone's Sake

Overview: *This chapter describes the warning signs that often precede violent behavior, along with techniques for assessing how crises develop. Crisis planning is discussed as a risk management tool, and concrete suggestions for becoming more proficient in learning how to recognize when a crisis may be imminent are offered.*

Why is This Important to Know?

Most crises can be prevented. In the period that precedes a crisis or violent act, there are usually identifiable changes in a person's demeanor and/or behavior. There are many names for these changes – some formal and some colloquial: prodromal symptoms, red flags, warning signs, "the aura," getting sick, sliding, escalating, spinning up, and so forth.

These changes, however slight, are often the first signals alerting you that a different course of action and/or intervention may be required. It is important to establish a framework for understanding and assessing warning signs because early recognition and intervention can prevent a situation from escalating into violence.

Violence is always unacceptable, but do not confuse violence with crisis. Violence is better conceived of as the final expression of a building situation. From a recovery standpoint, while violence should be avoided or contained, crisis situations provide both you and clients with an opportunity to learn warning signs and to try out alternate approaches to prevention and management. It is a period of disorganization, which can be an instrumental point in helping a person make important changes.

Think about when *you* last made major changes in your life. More often than not, these changes stemmed from a period of difficulty or crisis in your own life, and making the change was one way you got things back together. It is the same with people you serve -- although many people's lives are so disordered that they may have even lost the sense that things could be different. That's where you and your team come in.

Preventing and managing crisis should be a collaborative effort between you and the client. When the situation becomes high risk – evolving to a point of serious danger or when there are imminent serious consequences – you must become highly directive (Curtis, 1993).

Warning Signs

Warning signs are those behaviors, personality traits, signs, and symptoms that are distinctive to the individual and signal that a crisis may be developing. Every person has a set of warning signs, although they may not be recognized as such. Warning signs vary widely from person to person.

Idiosyncratic Warning Signs

Each person you serve has a unique set of warning signs. Some examples of idiosyncratic warning signs are given below. You will have to work with each consumer you serve to learn his/her unique signals for oncoming crises or violence.

- Missing appointments;
- Getting headaches;
- Actively vocalizing worrying about the "baby" when there is no baby;
- Increased pacing to relieve the "itch;"
- Growing a beard;
- Worrying that coworkers or housemates "are out to get you;"
- Constantly listening to music that "jazzes" or "psychs" one up;
- Buying *Guns and Ammo* magazine while grocery shopping.

The extent to which you are able to detect warning signs and address them with the person is dependent on your relationship. The better you know the person, the more likely you are to recognize specific triggers and warning signs. The more you know these signs, the better you will be in helping clients to recognize and learn to effectively self-mange them.

General Warning Signs

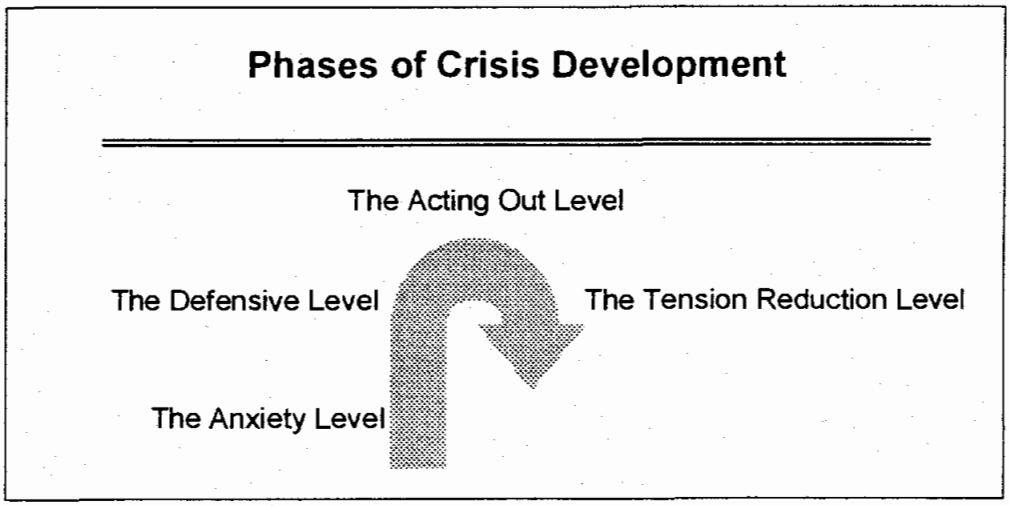
It takes time to learn idiosyncratic warning signs. Sometimes you have to go through a crisis to figure out in retrospect what the signs actually were. So naturally you will have greater difficulty recognizing the unique warning signs of new clients. However, there are some general signs to be alert for. The material in the figure, "Be Alert! Warning Signs of Violence," was developed by the Illinois State Police (1999) as a guide for employers concerned about employee violence, but is relevant to people with psychiatric disorders as well.

These factors are relevant when assessing risk anywhere with anyone, including your co-workers, family members (yours and clients'), partners, and spouses. No one is immune from losing control under extreme duress. Of course, such a perspective does not mean that you should over-analyze or over-interpret others' behaviors, but you should be alert to danger signs.

Remember, not everyone who displays these characteristics will become violent. You know many clients served by your ACT team who struggle daily with auditory hallucinations and never have had an episode of violence. You have colleagues who have won skeet-shooting competitions, but do not pose a risk to co-workers. You have known people who get depressed on a regular basis. However, identifying more than one of these traits in your clients should stimulate you to follow-up with additional risk assessment measures (See Chapter 8).

Levels of Crisis Development

The National Crisis Prevention Institute's (1987b) research on crisis suggests that crises develop in four very distinct phases. These phases are the anxiety level, the defensive level, the acting out level, and the tension reduction level.



Be Alert! Warning Signs of Imminent Violence

History of Violence

- Criminal Acts
- Domestic Violence
- Verbally Abusive
- Anti-Social Behavior

Elevated Frustration with Environment

- Family, Peers, Co-workers, etc.

Interest or Obsession with Weapons

- Frequently talks about fascination with weapons
- Has easy access to weapons

Chemical Dependence (alcohol and drug abuse)

- Alters judgement
- Impairs thinking

Romantic Obsession

- The object of fixation may not know the degree of the attraction
- The object of the attraction often holds higher position of authority or status

Habitual Blamer

- Unable to accept responsibility for any behavior and/or actions

Active Psychosis

- Schizophrenia (acute psychosis, hallucinations, bizarre behavior, extreme paranoia)
- Major Affective Disorder (often present with delusions and hallucinations, and often mood congruent)
- Paranoid states (characterized by delusions of grandeur and persecution, suspiciousness, jealously, and resentment)

Depression

- One in seven depressed people will commit an act of violence against themselves or others

Severe Personality Disorders

- Antisocial Personality Disorder
- Borderline Personality Disorder with extremely poor impulse control

Adapted from Illinois State Police (1999)

The Anxiety Level

Indicators

A standard definition of anxiety is: "***A state or cause of uneasiness and apprehension; worry; intense fear resulting from anticipation of a threatening event***" (The American Heritage Dictionary, Third Edition, 1994). In this phase of crisis escalation you will often notice the individual displaying signs of anxiety. Some of the common behaviors you may observe in a person experiencing anxiety include the following. Remember, each person also may have his own idiosyncratic ways of communicating these feelings.

- Pacing;
- Restlessness;
- Increased voice tone;
- Psychomotor agitation;
- Nervousness;
- Hypervigilence.

Intervention

Your intervention during the Anxiety Level should focus on responding in a supportive, empathic, and non-confrontational manner to the individual in distress. You should demonstrate active listening and try to better understand the situational factors that are upsetting the person. When done correctly, most potentially explosive situations can be defused at this point. (CPI, 1987b).

Example:

You're meeting with a client at his residence to review his monthly budget. Your agency acts as his Representative. Both you and the client begin reviewing expenditures for rent, utilities, groceries, personal needs, and so forth. The client becomes visibly distressed and demands to have more money allocated for his personal needs. His voice becomes louder and he continues stating that he doesn't have enough money for his personal needs.

You respond by acknowledging his frustration, validating his feelings about his financial situation. You attempt to encourage him to talk more about why he needs more money this month. You ask him if everything is okay or if there has been some change in his life that he'd like to talk about. If the client does have something going on in his life that has resulted in the need for more money, you respond by actively listening to his story. If the situation seems justified and if it's financially feasible, you may approve additional personal needs money for the month. If you and the client are working on a fixed income and have no room to increase the budget, discuss it openly and honestly.

The intervention techniques in this example illustrate the importance of acknowledging and validating a person's experience without being judgmental. Active listening and encouragement also are evident. Encouraging communication from the client reinforces that you are interested in better understanding his situation. It is hard for individuals to continue responding defensively when they feel supported and accepted. Most ACT providers know it is not easy to be a Representative Payee. However, always consider how a client feels when he is required to relinquish his financial independence to others. Being genuinely empathic and sensitive to this experience can go a long way in minimizing the likelihood of conflicts about money issues.

The Defensive Level

Indicators

An individual enters the defensive level when she begins to lose rationality and self-control. There typically will be visible signs of this shift either verbally, non-verbally, or both. These can include:

- Verbal belligerence and hostility;
- Challenging authority;
- Testing limits;
- Strong accusations;
- Heightened voice tone and/or abusive language.

Intervention

Intervention during the defensive level should include firm limit-setting by you. In this stage, many individuals actually are seeking some form of structure and control over their environment and may be looking to you (consciously or unconsciously) to provide that structure. "Help me get myself back in control," is the implicit message.

At this level, you need to provide clear, simple, and enforceable behavioral limits (CPI, 1992). Avoid being threatening and/or unreasonable in the limits that you're trying to implement. Explain why the behavior that is being displayed is not acceptable or appropriate. Let the agitated individual know that the consequences of the behavior are up to her. Proceed as though you assume that the person can manage her behavior, perhaps with some guidance, structure, or support from you. See Chapter 10 for more ways to deal with these kinds of situations.

Example:

A person in an agitated state is disturbing the overall milieu of a residential setting by yelling and swearing at people. Folks are just finishing dinner and want to settle in front of the television. You should try to talk to the person alone, tell her why the behavior needs to stop, and offer options on how to the person on how to address it. For example:

"It's obvious that something has upset you. However, the program rules that we all agreed upon require that you not verbally abuse staff or members. Your option is to refrain from the verbal abuse, or to find a quiet place -- maybe your bedroom -- where you can calm yourself down. Which would you like to do?"

"I'm unable to talk to you when you're in such an agitated and angry state. When you've calmed yourself down and can talk without being verbally abusive and threatening, I'd be happy to hear what has gotten you so upset. Until then, I need to ask that you leave the room."

The Acting Out Level

This level signifies a total loss of control on the part of the agitated individual. Verbal escalation will heighten to the point of physical aggression directed towards you, another person, or something in the environment (windows, chairs, televisions, and so forth). Your attempts to defuse the situation will not work or you simply will have arrived on the scene too late.

Intervention

In this phase, you will need to use non-violent crisis intervention techniques and/or self-protection skills, while at the same time striving to protect the safety and well-being of the agitated individual, and anyone else at risk. See Chapter 10 for more detailed information and strategies.

NOTE: *Caution! Physical, non-violent crisis interventions only should be used as a last resort, and only after you have received training from a professional.*

If the incident occurs in the community while visiting a client at his residence, your emphasis should be on "safety and escape." If the person becomes combative, aggressive, and/or physically assaultive, leave at your earliest opportunity. Leave and call for help!

Tension Reduction Level

The fourth and final stage of crisis escalation is one of the most neglected areas. A great deal of energy will have been used during the crisis, and then, will dissipate. The person(s) involved will begin to regain control and rationality.

Tension reduction is both physical and emotional. Physically, individuals will become more relaxed, muscles which were taut and rigid will loosen. The person will feel drained and tired from the amount of energy that was just expended. Emotionally, the person may feel remorseful, apologetic, and/or embarrassed by the incident. Sometimes, individuals in extreme distress who are experiencing severe psychotic symptoms may not remember the incident – or not remember it until symptoms have been treated and some balance regained.

Follow-up

From a clinical standpoint, remember that this "coming down" phase and follow-up period are very important. Violence in and of itself is not a criterion for expelling an individual from ACT services. While an individual may require a period of hospitalization to regain equilibrium before returning to her life in the community, the ACT team has a responsibility to maintain contact and provide services upon discharge.

The Chinese character for crisis is comprised of two symbols: danger and opportunity. Once an individual has regained self-control and some rationality, a member of the team (usually not the victim if a physical assault was involved) should initiate discussion and reflection *with the client* about the incident. Now that the immediate danger has passed, there is an opportunity to learn something. What can be learned or understood about the person's triggers and escalation patterns? What else might have helped in the situation? Could anything have been done differently? What kinds of things will help the individual avoid being in such a situation in the future? It is precisely this information that helps individuals develop knowledge about themselves, their feelings, their reactions, and things they can do to better manage their problems and prevent a reoccurrence. This learning is core in the recovery process and must develop within the person, not just within the team. However, this process is not a substitute for other team debriefing activities (Curtis, 1993).

Any person who has been the victim of physical attacks or abuse has very personal and often strong reactions to the experience. These emotions need to be addressed. See Chapter 11 for more detailed information about how to cope and recover from assaults.

Proactive Crisis Prevention Strategies

Early intervention is the key to both preventing crises and to managing critical incidents as they develop. The earlier the better. Well-developed crisis prevention strategies can be very empowering to consumers, their families, their friends, and their care providers. They are a core part of good practice in any service approach for helping people with psychiatric disorders. Of course this is not a quick and easy process. It may take a considerable amount of time, even years. But it is at the heart of recovery from psychiatric disability and of your goal as an ACT provider to help consumers live quality, safe lives with as little intervention from professionals as possible.

Some of the most useful and proactive crisis prevention strategies are identifying patterns, monitoring changes on a continual basis, developing coping skills, and conducting crisis planning (Curtis, 1993). Each of these will be described briefly below.

Identifying Patterns

Crisis patterns can be episodic, periodic, or coping. Episodic patterns are the sequences of events that commonly occur during or just before an incident and include an individual's early warning signs and specific triggers. When you look at a set of incidents that occurred over time, it is likely that you and/or the person can identify some common elements or themes across the incidents.

Periodic patterns take a longer-term view. Timeline assessments can help you and the person to spot periodic patterns. Examples of periodic patterns may include figuring out that the person becomes very symptomatic every three years; that the person has major difficulties every time he is assigned to a group living situation; that every time the individual goes into crisis she goes off medication, and so forth. These kinds of patterns are obscured when you focus only on single episodes and incidents.

Coping patterns are the ways that individuals respond to stressors and triggers. They can be either helpful or hurtful over the long-run. For example, certain types of behaviors, while soothing in the moment, are not particularly adaptive, can be viewed as symptoms themselves, and may make things worse. For example, "I'm feeling very anxious, so I'll take my allowance and get as blasted as I can." These types of coping patterns often have short term gain, but long-term loss.

Alternatively, in every situation that *does not* develop into a full-blown crisis, the individual is demonstrating extraordinary internal coping skills. For example, "I'm feeling anxious and worried, so I'll go to a friend's house and drink a soda instead of going to the party store for a six-pack." These are precisely the kinds of coping skills you want to help the individual learn and use regularly. Like all habits, identifying and trying to alter more negative coping strategies can take time and a lot of work on the part of consumers. Yet, this is the level at which many crises can be averted over the long-run.

Monitoring Changes

On-going assessment and monitoring are important capacities of ACT teams when working with people who have the potential to commit violence. Part of monitoring is to be very alert to early warning signs and take them seriously. However, it is not just the team who should do the monitoring. Part of your responsibility as an ACT provider is to help each individual increase her own awareness about how her feelings and symptomatology change in various situations. This knowledge is the first step toward self-regulation and finding alternatives for destructive patterns.

Developing Coping Skills

Stress and unfulfilled emotional or physical needs are at the core of most incidents of violence. The efforts the individual has made to try to meet his needs have been unsuccessful. His frustration compounds and escalates the situation. ACT workers help people to identify the coping strategies that do not work and to find other ones that might work better. Often people are not satisfied with the outcomes themselves. These sentiments are not uncommon: "I ended up in the hospital;" "I'm embarrassed because I lost it;" "I didn't get the respect I deserved;" "I lost a friend;" "I end up feeling awful because of hangovers." Such statements can serve as springboards for exploring alternative ways to manage difficult situations.

Crisis Planning

A crisis response plan is a collaboratively developed set of responses to a potentially high-risk situation. Most crisis response plans focus on what the team needs to do when a crisis is anticipated: the coordination, the intervention, the notifications, the back-up plans, and so forth. This is usually different from treatment planning. You hope you'll never have to use this kind of crisis plan! The crisis response plan is further discussed in Chapter 9.

Another kind of crisis planning involves de-escalation and management strategies. This type of personal crisis plan is developed collaboratively between a client and her support system. In this kind of crisis planning the consumer plays an active role in identifying triggers, personal preferences for treatment or intervention, and what she wants from her professional and natural supporters (Copeland, 1997). This type of crisis de-escalation plan often is integrated into the treatment plan, and outlines skills and strategies the consumer will work on over time. The crisis management plan should be developed when a person is feeling relatively well and minimally include the following components. It is always written from the perspective of the consumer.

- Early warning signs and triggers, and the ways I will manage them. When I will call for help and from whom.
- Any symptoms or indicators that tell me or others that I cannot make good decisions for myself.
- Family members, supporters, and health care professionals who I rely on for assistance.
- My preferences about medications, treatments, and facilities. My back-up preferences.
- Information about care of children and pets, bill paying, housekeeping, and how to notify family members, employers, and others.

The handout, "Developing a Crisis Plan," provides examples of questions that help you initiate conversation and gather information for proactive crisis planning. For consumers who are survivors of trauma or abuse in particular, these plans can help minimize the potential for re-traumatization through mental health treatment and service delivery.

Chapter Summary

This chapter reviewed idiosyncratic and general warning signs that often precede incidents of aggression and violence. Stages of crisis escalation were presented along with examples of appropriate intervention strategies in each stage. The importance of proactive and early intervention was stressed at all levels and some strategies for proactive crisis prevention were outlined. Emphasis was placed on the importance of consumers knowledge about their personal patterns and warning signs, and developing more effective alternatives for handling them. Crisis planning was introduced as an important way to involve consumers in proactive discussions as well as meet team needs for coordination and information.

Developing a Personal Crisis Plan

1. What does a really great day look like for you?
2. What does a crisis look like for you?
3. What are the good and bad parts of a crisis for you?
4. What helps you move through a crisis and not get "stuck?"
5. What does support look like for you?
6. What do you keep hidden from people when you are in a crisis?
7. How do other people experience your crisis?
8. Are you a person whose crisis becomes more intense in a safe environment or does it subside in this kind of atmosphere?
9. What makes things worse for you? Why?
10. Are there people, places, or things that have been helpful in the past? Why?
11. What things have you tried that are not particularly helpful?
12. When you are in crisis do you prefer to be with people or alone?
13. What happens when you are alone? With people?
14. Who else is affected when you are in crisis? Family? Children? Pets? Employer?
15. Does connecting with these people help or hinder when you are in crisis?
16. What obligations do you still have to take care of when you are in crisis? (Such as work, bills, household, plants, pets, kids?)
17. Do other people recognize that you're having a hard time before you realize it?
18. What do you want your life to look like after crisis?
19. Who else should be involved in developing and/or agreeing to your crisis plan?

Adapted from Crisis Respite Interview, Stepping Stone, Claremont, NH

Chapter

8

Clinical Risk Assessment

Overview: *This chapter provides a brief synopsis of emerging issues and risk factors in workplace safety; discusses risk factors associated with community outreach service delivery and ACT; overviews current literature on violence and people with psychiatric disorders; and considers factors which affect the personal safety of consumers.*

NOTE: Considerable portions of this chapter are drawn from a report by the New Zealand Ministry of Health and Health Funding Authority. (1998). Guidelines for clinical risk assessment and management in mental health services.

Understanding Risk

Research and experience show that mental health workers are not particularly good at predicting precisely which people, in what circumstances, will become violent. To be fair, the more imminent the violence, the more likely we are to be accurate. Will Joe hurt someone three months from now? Can't say exactly. Will Joe hurt someone when he is drunk, agitated, throwing magazines across the room, carrying a stick in his hand and yelling threats at another person? The chances are much greater. It is rather like weather forecasting. If it looks like rain, it is more likely to rain.

Yet, when something goes wrong, one of the first questions asked will be, "Why didn't you predict this?" Despite the lack of refined technology to make accurate identifications and predictions about who will become violent, there are approaches and tools that can help you to make determinations about the potential or the likelihood that a person will become violent.

Definitions of Risk

Risk is the likelihood of an adverse event. Risk assessment is estimating the likelihood of certain adverse events occurring under particular circumstances within a specified period of time. Risk management is the process of minimizing the likelihood that the anticipated or potential harm will occur.

Defining Risk

Risk: The likelihood that something adverse will happen.

Risk Assessment: Making estimates about the likelihood of a defined harm under particular circumstances within a specified time period.

Risk Management: Minimizing the likelihood of the occurrence of the potential harm.

Risk assessment is not only relevant for determining potential for dangerousness, though this is frequently the vocal concern of the public or media.. It also is useful for determining the likelihood of harm that may result from any decision or action. For example, you may do a risk assessment as part of your determination about recommending to the Social Security Administration that an individual resume personal control of her funds. What is the worst thing that could happen because of this action? What is the best thing that could happen? What are the consequences of doing nothing or maintaining the status quo? The answers to these questions, and the degree of risk you or your agency can tolerate, help to guide your treatment decisions.

You also use risk assessment when you help an individual to make decisions about how to solve a problem or which opportunity to take. Every problem-solving paradigm includes some way of asking about potential positive and negative consequences of each option.

When you teach people how to scan their environment for potential hazards and problems, or how to maintain personal safety in their apartments and neighborhoods, you are teaching them how to assess risk.

Insurance companies turn risk assessment into an actuarial exercise of formulas, probabilities, and statistics. From an actuarial point-of-view, when the risk factors increase, your insurance rates do, too. Crack two windshields on your car in a year and see what your insurance company does. These actuarial procedures identify high-risk groups based on profiles of factors -- they may not be accurate for any specific individual. You probably know the frustration of being clumped with a group that does not feel right. "Hey, just because I got nailed with stones and cracked two windshields does not make me a high-risk driver!" As an ACT worker, you also must carefully balance the presence of high-risk factors with the tendency to over-generalize.

From a clinical standpoint, risk assessment is only useful if it leads to better management of the risk and therefore better outcomes for everyone -- the client, his or her family, the community, the workers, and the agency. Therefore, clinical risk assessment should be an integral part of treatment planning, intervention, and risk minimization activities.

Kinds of Risk

There are four broad categories of risk. The risk of:

- Exacerbation of illness and increased health problems for the individual;
- Deliberately induced harm to oneself, including suicide;
- Unintentional harm to oneself, including exploitation;
- Intentional or unintentional violence; aggressive or intimidating behavior toward others.

Examples of risks within these categories may include the following.

Risks to Self	Risks to Others
Safety – including suicidal acts and self-abuse **Health** – including drug and alcohol abuse, physical harm, psychological harm **Quality of life** – including dignity, social and financial status **Vulnerability**—including exploitation, re-traumatization, sexual abuse/violence from others **Self neglect**	**Violence** – including emotional, sexual, and physical violence **Intimidation and threats** **Neglect and abuse of dependants** **Stalking and harassment** **Property damage,** including arson **Reckless or endangering behaviors,** including careless driving

Consumers also experience risk because of the nature of mental illness and current treatment technologies. Examples include side effects of medications, negligent medical care, ineffective psychiatric care, social stigma, internalized disability, learned helplessness, and so forth. Often these risks are neglected when developing treatment plans. See Chapter 12 for more detail about this.

Risk is not a static thing. It fluctuates over time and is affected by environmental and psychological factors, resources, and support. Therefore, there is a need for ongoing assessment. The degree of risk does not necessarily parallel legal status. There may be people you know who have involuntary community commitment orders who have few apparent risk factors. Yet there are others who go freely about their lives like a loaded cannon, just waiting for the right trigger.

Assessing Risk

When to Assess Risk

Risk assessments are ongoing and may be an informal screening or a more formal, detailed formulation. You are performing an informal risk assessment every time you visit a client or make a service decision, though you may not recognize that this is what you are doing. There are times when a more formal risk assessment is necessary. These include:

- First contact with the ACT team;
- Change in legal status;

- Change in life situations (eviction, loss of job, broken relationship);
- Significant change in psychiatric stability or substance use;
- Discharge from hospital or jail.

Elements of Risk Assessment

The following chart, "Elements of a Risk Assessment," summarizes many of the factors that influence risk probabilities and are typically found in formal risk assessment tools. In an urgent situation, focus on the first two columns. A full, formal risk assessment would include all of the factors.

Conducting a clinical assessment may require that you seek information from a variety of sources, including the person, records, police reports, family members, and others who know the person well. (Remember your confidentiality policies when you seek external information.) Make sure that you get *accurate* information and beware of the phenomenon of "Severe Reputation Disorders," where myth, fear, and reputation may color the validity of the information you are gathering.

Elements of a Risk Assessment

Adapted from Guidelines for clinical risk assessment and management in mental health services, New Zealand Ministry of Health & Health Funding Authority, 1998

Mental State	Environment/Current Situation Factors	Historical Information
Behavior ◆ Dangerous or threatening actions ◆ Verbal/nonverbal risks ◆ Deliberate self harm ◆ Aggression **Affect** ◆ Arousal, anger, hostility, fear, irritability, suspiciousness ◆ Low mood or elevated mood **Cognition** ◆ Thoughts or fantasies of deliberate self harm or harm to others ◆ Persecutory thoughts and delusions ◆ External control ◆ Confusion ◆ Preoccupation, obsession, jealousy ◆ Cultural/spiritual beliefs **Perceptions** ◆ Command hallucinations, especially linked with delusional beliefs ◆ Misidentification **Medications** ◆ Current non-compliance ◆ Recent changes	**Demographics and Culture** **Immediate Stresses** ◆ Substance use, intoxication or withdrawal ◆ Relationships ◆ Presence/absence of support ◆ Presence/absence of treatment ◆ Compliance with treatment and medications ◆ Persecution or threats from others ◆ Arrest or criminal charges ◆ Loss, including loss of a peer, a pet, a job ◆ Financial stress **Community Factors** ◆ Incidents of violence that spark copy-cat actions **Access** ◆ To weapons, pills, victims **Situation** ◆ Home, jail, hospital, streets, so forth ◆ Legal standing, including probation, restraint orders **Individual's Attitude** ◆ Cooperation ◆ Refusal to cooperate, including fear of compulsory treatment process	**Illness and Incidents** ◆ Patterns of illness ◆ Psychiatric history ◆ History of incidents, including context ◆ Treatment and outcomes ◆ Features of past crises ◆ Personal history **Trauma** ◆ Sexual ◆ Emotional ◆ Physical ◆ Experience of re-traumatization **Incarceration** ◆ Periods of incarceration ◆ Conditions of release or parole ◆ Restraint orders **Personality** ◆ Usual coping style **Protective Factors** ◆ Natural support networks ◆ Supporters who do not experience same problems as person ◆ Use of services ◆ Evidence of impulse control ◆ Effectiveness of medications **Family Background** ◆ Demographics, age, gender, culture ◆ Configuration ◆ Dynamics

The most important source of information is the client. The process of developing a viable risk assessment is part of other ongoing assessments performed by ACT case mangers. Like any other ongoing assessment it begins with developing rapport and trust between you and each person you serve. Even though some of the information asked during the assessment might be sensitive and/or confidential, it is still important to begin exploring the areas identified in the list above. If clients are unable and/or unwilling to share specific information, you need to respect their right to privacy. However, if there is reasonable cause to believe that a threat of danger and/or violence does exist, make a concerted effort to obtain the necessary information so that the team can design an appropriate treatment approach, including a plan for safety and protection.

There are a variety of formal scales and risk assessment tools available, many of which are proprietary -- you have to pay to get and use them. These are typically used primarily for violence and aggression research, but may have some utility in day-to-day practice. For examples, see Maiuro, 1987; Mehrabian, 1998; Plutchik & van Praag, 1990; Monahan & Steadman, 1994.

The MacArthur Foundation developed a Community Violence Instrument to measure violence in the community as part of its Risk Assessment Study. The instrument measures self-report of violence to or by other persons only. See the figure, "Community Violence Instrument," which shows the first part of the Instrument. Other parts ask for specific details about where and what kind of violence occurred, victims, and so forth. It divides violence into two levels of seriousness: 1) violence which includes weapon use or threat, or sexual assaults; and 2) all other violence which results in injury to a victim. This instrument is not designed specifically for persons with mental illness, but is intended to see how often people have problems that involve violence. This instrument is not proprietary and may be useful in determining some of the specific ways and the frequency with which your clients use violent approaches in problem solving. It also may be useful in assessing some elements of risk of victimization as well. It is available via the worldwide web, with more information, at http://ness.sys.virginia.edu/macarthur/macciv.html.

Limits of Risk Assessment

Risk cannot – and probably should not – be entirely eliminated. Without risk-taking there is no growth, no creativity, little development. However, as an ACT provider, your objective is to identify and minimize the likelihood of serious negative outcomes for the people you serve, their families, your co-workers, and others.

Cultural Considerations

Crisis, crisis prevention, aggression, trauma, and violence must be viewed from a cultural as well as personal context. Culture includes not only a person's ethnic background, but also geographic, economic, religious, sexual preference, age/generation, gender, and community considerations. Concepts about mental illness, tolerance for deviant behavior, the role of family and extended family, the importance of spiritual perspectives and healers all vary from culture to culture.

For example, mental health workers are increasingly serving refugees from war-torn countries around the world. These people often bring debilitating trauma issues as well as psychiatric disorders. It is difficult for an ACT worker to fully appreciate the experience of these individuals as they try to adjust to a vastly different culture or the events that precipitated their emigration.

Assessment of Community Violence

MacArthur Foundation http://ness.sys.virginia.edu/macarthur/violence.html

	YES	NO	Number of TIMES
Since (Date).... 1a. Has anyone thrown something at you? 1b. Have you thrown something at anyone?			
2a. Has anyone pushed, grabbed, or shoved you? 2b. Have you pushed, grabbed, or shoved anyone?			
3a. Has anyone slapped you? 3b. Have you slapped anyone?			
4a. Has anyone kicked, bitten, or choked you? 4b. Have you kicked, bitten, or choked anyone?			
5a. Has anyone hit you with a fist or object or beaten you up? 5b. Have you hit anyone with a fist or object or beaten anyone up?			
6a. Has anyone tried to physically force you to have sex against your will? 6b. Have you tried to physically force anyone to have sex against her or his will?			
7a. Has anyone threatened you with a knife or gun or other lethal weapon? 7b. Have you threatened anyone with a knife or gun or other lethal weapon?			
8a. Has anyone used a knife or fired a gun at you? 8b. Have you used a knife or fired a gun at anyone?			
9a. Has anyone done anything else that you consider violent? What? 9b. Have you done anything else that might be considered violent? What? TOTALS:			

Further, you may have little knowledge about how mental illness is perceived within the culture, who are considered healers, the expectations of women, and social norms in general. It is important, whenever possible, to have someone who is of the individual's culture carry out or assist with a risk assessment or service plan. This may not be practical in all situations; if so, the best alternative is to involve a team member who demonstrates high levels of competency in cultural issues.

When doing a risk assessment with a person from a different culture, the following factors should be considered.

- Accurate communication;
- Different concepts about mental illness and wellness;
- Social norms (including gender and class expectations);
- Language;
- Reluctance to disclose or shame of disclosure;
- Tolerance and management of risk;
- Protective factors inherent to the culture;
- Involvement of family, extended family, and ancestors;
- Involvement of cultural or spiritual healers;
- Unique trauma issues such as war, torture, and loss of relatives.

The Risk Profile

The Risk Profile is the summary of findings from the Risk Assessment. It sets the stage for service planning or a specific risk management plan.

Risk Determination: The Judgement Call

We all know people - clients and non-clients - who have a significant number of risk factors in their lives, but seem to manage just fine. When determining actual risk, everything you know about risk factors and protective factors must be weighed. You and your team need to avoid dismissing risk factors that may turn critical or becoming overly focused on things that are not particularly important from a risk and safety perspective. Sundram (1994) offers a framework for analyzing risk using four key elements: 1) the probability of harm, 2) severity of the harm, 3) duration of the harm, and 4) imminence of the potential harm. By including these elements in your assessment, you are more likely to make a realistic determination of risk. These factors also are a useful way to consider the level of action you or your team needs to take in response to a situation.

Determining Risk Probability			
Probability of Harm	**Severity of Harm**	**Duration Of Harm**	**Imminence of Harm**
None Low Moderate HIGH Unknown	None Minor Moderate SERIOUS Unknown	None Brief Temporary PERMANENT Unknown	None Distant Short term IMMEDIATE Unknown

Obviously this approach requires you to make judgements and "best guesses" about probability based on everything you know. It can help you be as realistic as you can be. Clearly, those situations which have a high probability of harm that is serious, permanent, and immediate deserve swift attention. You should pay careful attention to how you plan and develop intervention and support approaches for individuals with elevated risk profiles. For example, just because an individual set fire to his apartment seven years ago does not mean there is a high probability that it will happen again since many of the risk factors, situational stresses, and protective factors have changed. However, should those factors re-emerge, you should be alert and ready to proactively talk with the individual about how to prevent things getting that far out of control again. Risk determination should help you to develop and implement more effective approaches to managing clinical risk.

Victimization Risk

A similar process can be used when assessing an individual's risk of victimization. This receives considerably less attention than risk of violence, yet we know that people with mental illness are very frequently the targets, rather than the perpetrators, of violence. In conducting a victimization assessment, you would use many of the same factors presented above, paying careful attention to environmental, situational, and relationship factors. Trauma history can be an important consideration in victimization risk. Chapter 12 addresses this topic further.

A number of psychological factors have an impact on risk of victimization, such as lack of awareness of the risk factors, the belief that the potential victim can do nothing to change the situation, or that they deserve the abuse. Protective factors would include not only awareness and support systems, but also access to safe places and self-protection skills. Sundram's framework is useful in making determinations of probability when necessary. While you may not be able to protect people you serve from victimization, you can help them be aware of and minimize their own risk factors. Approaches to education are further discussed in Chapter 13.

Mental health workers often overlook the victimization risk of family members of a person with psychiatric disorders. Studies suggest that when a person with mental illness is prone toward aggressive, intimidating, or violent behaviors, it is family members, frequently mothers, who are the most common targets (Hyde, 1997). Chapter 13 provides some additional information on this topic. The National Alliance for the Mentally Ill is an excellent resource for materials addressing family victimization and ways family members can minimize their risk.

Elements of a Risk Profile

An individual risk assessment profile is a summary report that focuses only on those issues of direct relevance to the particular individual. Typically, a risk profile will include the points found in the figure, "Individual Risk Profile," as well as those outlined in the previous section. The risk profile is used to help guide service planning and other risk management activities.

Some agencies place the people they serve into general categories of risk or levels of concern such as low-risk, moderate-risk, and high-risk (though beware of over-generalizing here). Intervention approaches are geared to the assessed level of risk as well as the specific needs of the individual. For example, you may have different communication, documentation, and intervention approaches or safety policies for working with people with high-risk profiles. One way to avoid over-generalizing in this area is to regularly assess whether clients categorized as high-risk can move into a lesser risk status over time. That way, depending on

personal, situational, and other factors, certain people could be "put on alert," but taken off this status when crisis management strategies work or the crisis passes.

People with High Risk Profiles

When we identify a person with a high-risk profile, we are typically recognizing that the individual demonstrates one or more of the following risk factors and insufficient protective factors to minimize risk:

- Active or recent substance abuse;
- Involvement with legal system (jail, prison, probation);
- Current non-compliance with medication or treatment orders;
- Histories of violence and aggressive behavior toward self or others;
- High frequency of psychiatric hospitalization or emergency service utilization.

One of the most important functions of ACT services is to provide an appropriate system of care for individuals with these types of high-risk profiles. Service planning for these individuals is discussed more fully in the next chapter.

Management of Risk

Risk assessment and management should be integrated into your service planning with each individual you serve. Where risk is present, your management decisions start with the degree of imminence of the risk.

Imminent Risk

If the risk is immediate and *now*, you need to take steps to protect yourself, others, and the individual. In emergency situations, you have the greatest legal and ethical latitude to use involuntary interventions such as restraint, hospitalization, and so forth. Some of the intervention options you and the team may utilize include the following, as suggested by Sundram (1994).

- Immediate action!
- Increase in supervision;
- Protective orders;
- Involuntary interventions;
- Restraint;
- Surrogate decision-making -- having someone else legally make decisions on behalf of the person, such as guardian or person with assigned Durable Power of Attorney.

Non-Imminent Risks

If the risk of harm is not imminent, you have time to consider other options. These can include education approaches, collaboratively exploring ways to increase protective factors, adding safeguards, discussions of risks and consequences, discussions of less risky ways to meet personal needs, and so forth. Sundram provides the following list.

- Discussion of risks and potential consequences;
- Explore other choices and alternatives;
- Encourage discussion with friends and family;

- Provide or help individual find related experiences with lower risks;
- Provide education and training;
- Add safeguards;
- Strengthen or develop protective factors;
- Determine ways that risk can be minimized, rather than eliminated.

Individual Risk Profile

Background

- Relevant demographic characteristics
- Culture
- History of violence, deliberate self harm, other aggressive behavior

Current Situation

- Legal status and existence of probation, restraint orders
- Current sources of stress
- Precipitating events and circumstances
- Comparison of current context, stresses, and circumstances to previous contexts, stresses, and circumstances

Risk Factors

- Identification of relevant risk factors for this person
- Prioritization of risk factors for this person

Determination of Probability

- Nature of potential risk or adverse event
- Probability of adverse event
- Identification of likely circumstances and precipitants
- Imminence of risk
- Seriousness of consequences
- Means or access

For how long is the assessment valid?

When is the next assessment due and by whom?

Harm Reduction Strategies

Harm reduction strategies are used when a risk cannot, for any reason, be fully controlled or eliminated. The question then becomes, "What are the ways that the harm can be reduced?" For example, providing illegal drug users with clean needles is a way to minimize needle sharing and reduce their likelihood of contracting HIV/AIDS or other needle-spread diseases. Providing sexually active minors with condoms is a way to reduce occurrences of sexually transmitted diseases and unwanted pregnancies. Handing out sleeping bags to people sleeping on the streets when the temperature goes below freezing is a way to minimize death from exposure.

Harm reduction approaches can be legally, ethically, and clinically challenging because they seem to support undesirable behaviors, such as drug abuse, sexual activity, and so forth. They feel compromising, and like either the totally wrong approach or not enough. Yet, the decision must be made to determine whether doing nothing will result in even greater harm than doing something that may challenge our values or beliefs.

Harm also can be reduced by building or strengthening protective factors. Can supports be increased? Can awareness be developed? Can skills be built and more constructive attitudes established? For example, women attending street-smart and rape prevention training are reducing the likelihood of harm because of the knowledge and skills they gain. These approaches do not eliminate or prevent risk, but they can reduce the likelihood that an individual would be seriously harmed should a dangerous situation occur.

Risk Tolerance

Risk tolerance is the level of risk you, your agency, or your clients are willing to accept. Zero-tolerance is difficult to live with over the long-haul, but necessary in some situations. Airport metal detectors are an example of zero-tolerance for weapons in those areas. You may have zero-tolerance for weapons in your facilities and grounds. This would mean that anyone with a weapon, even legally registered, would not be allowed on the property. If you are willing to allow a client, family member, or worker to park in your lot with a shotgun on a rack in the back window of the truck of pheasant season, you are accepting some risk and no longer operate with zero-tolerance.

Sometimes the level of acceptable risk is dictated by law or liability concerns. Other times, it is an organizational policy issue. Different organizations, and even different ACT teams, may have varying risk tolerances. This can have an impact on the degree of creativity and amount of individualization in service planning. If, as a team, you are willing to accept no or very low amounts of risk, you also may minimize clinical gain because you are less likely to encourage or support people to take on personal responsibility for money, medications, or lifestyle decisions.

Risk tolerances may fluctuate over time, from situation to situation, from person to person. Individuals who have had a traumatic experience are likely to have a lowered tolerance for risk, at least for a while. Their focus is on building up their protective forces including emotional, social, and physical defense mechanisms. This dynamic is as true for organizations and ACT teams as it is for individuals. If you or your agency is required to undergo a full audit or are sued for malpractice, it is likely that the organizational tolerance for risk will subsequently go down.

Chapter Summary

The devil you know is easier to deal with than the devil you don't know. The more you are aware of risk factors and ways to make reasoned determinations about the probability and potential severity of risk, the better you are able to manage specific risk concerns and people with high-risk profiles. The purpose of clinical risk assessment is not the full elimination or absolute containment of any and all risk. Though containment through incarceration, hospitalization, and other mechanisms is certainly necessary in some situations, our greater challenge is to manage risk through education, strengthening protective factors, reducing the probability of high-risk events occurring, and minimizing the severity of any potential harm should the event occur.

This chapter has addressed issues pertaining to assessing and managing clinical risk. It provided frameworks for defining and understanding the characteristics of risk, approaches to assessing and making reasoned determinations about the probability of high-risk events, and strategies for developing an individual risk profile summarizing key information. Further, it has discussed risk management and the role of risk tolerance in management decisions.

Individual Risk Profile

Date Completed:

Client Name:

I. Past History of Violence (For example, type; contributing factors; against whom; mental status during; when; where; and so forth)

II. Incarceration Record (for example, number of arrests; type of charges; misdemeanor/felony; jail time served; forensic commitments; and so forth)

III. Medication Issues (for example, history, types, consistent or sporadic use, side effects, reaction when not taking medications, and so forth)

IV. Drug & Alcohol Use (e.g., history, frequency, quantity, consequences, age of onset, etc.)

Chapter

9

Dealing with Known Risk

Overview: *This chapter provides a broad overview of special treatment components that are needed when serving clients who have histories of violence or high-risk profiles. Because this is a complex treatment issue that cannot be fully addressed in this manual, resources for further reading and skills development for ACT teams also are provided. Also addressed is how to deal with perpetrators in the lives of clients, including batterers in domestic violence situations*

Clients with Histories of Violence

As an ACT provider, you regularly deal with individuals who have high-risk profiles. And if current trends in arrest patterns of individuals with mental illness are any indication, your team will find itself working with increasing numbers of consumers who have had criminal justice involvement. One recent review of studies involving consumers in the Philadelphia area, for example, found that 42-52% of them had been arrested at least once (Solomon & Draine, 1995). Of course, not all the crimes that consumers are arrested and/or convicted for are violent. Many times, these violations consist of destruction of property, stealing rides on public transportation, and theft of food. However, some of your clients will indeed have high-risk profiles for violence and, once clients have experienced criminal detention, for whatever the reason, your assessments and service plans will need to reflect this history and any special needs related to it.

Consumers with arrest histories for serious crimes tend to have small social networks and are likely to have no positive familial relationships (Draine & Solomon, 1993). They typically have less stable living arrangements, along with a higher likelihood of exhibiting antisocial personality traits which have hindered their acceptance into traditional community programs. Many individuals with high-risk profiles also have trouble establishing and maintaining stable relationships, and have had very difficult lives fraught with abuse, abandonment, and inappropriate treatment. Many of them have had highy mobile lives as well, moving from program to program, city to city, and hospital/jails to the streets. Sound familiar? It should, since many ACT clients without high-risk profiles for violence share these same characteristics. In a very practical sense, this means that many of the services you already are set up to provide are just what consumers with criminal justice involvement need: resources for slowly building relationships with others; providers who will meet concrete or immediate needs before addressing clinical issues; flexible programming without cumbersome rules; and the ability to meet clients in their own environments rather than forcing them to come into programs where they might feel threatened or frightened. You and your team should view these aspects of your service approach as assets upon which to draw when serving clients with forensic involvement. In many ways – even if it doesn't always feel like it – you do have the set-up most conducive to helping clients with high-risk profiles to recover and to manage their criminal or violent tendencies.

Of course, having said that, there also are some special considerations and alterations that should be made to service plans for clients with violent histories. These adjustments to services are done to ensure the safety of your team and the consumer himself. Care must be taken, however, not to come off as punitive or as though this client is somehow very different from others you serve. This only will increase the person's alienation and possibly his levels of aggression or agitation. Try your best to proceed with special treatment planning in a matter of fact fashion, which does not imply that their services are completely different from those that any other client would be offered. Your sensitivity to this issue may help to build the levels of trust and rapport that are very important when serving clients with forensic involvement.

Service and Treatment Planning

Comprehensive and Continuous Assessment

As discussed throughout this manual, the first step in serving individuals with high-risk profiles is to conduct thorough risk assessments (see Chapter 8 in particular). Conducting these assessments regularly with forensic clients as you get to know them better will help you to learn what their lives have been like, their propensity towards repeated violence, and their coping mechanisms. In other words, these assessments should be conducted on a continual basis, to note changes or other special needs over time. Again, rather than using these assessments in a punitive way – to identify "troublemakers" – these continuous assessments should be used therapeutically to assist such clients in recognizing and responding to areas for growth and development. The tools, "Assessment for Community Violence" and "Individual Risk Profile," will be particularly important for these clients (see Chapter 8).

When you already know that a client has committed a violent act, there are some special areas for assessment that must be clearly and forthrightly addressed. To develop appropriate, safe services, your team has the right to know what the consumer was accused of; what, if anything, she was convicted for; who or what was involved in the violent act; the circumstances and behaviors surrounding the act; and how it was resolved. Try to get as much detail as possible about these aspects of the criminal history, as they can help you and the client better recognize warning signs for the future, as well as special treatment considerations. Keep in mind that you may have to develop a certain level of trust before the

client feels comfortable sharing these personal details. Thus, you may need to get some of this information from the person's parole or probation officer, family members, or others involved in her life, respecting confidentiality of course. However, it is your right to know the aspects of a person's history that may put you or her at serious risk. In this case, ignorance is *not* bliss!

Of course, you also must develop early on with clients who have violent histories crisis de-escalation plans, as well as clear crisis response plans (see Chapter 5 for examples), to be immediately integrated into their treatment plans. Pay special attention to personal violence triggers, as well as levels of tolerance for stress/distress. Helping these clients develop better ways to manage rage and frustration can go a long way towards reducing violence. Try to find out what sorts of things enrage these clients, how they dealt with rage or stressful situations in the past (trying to "normalize" by letting them know that many of us don't handle frustration all that well), how their responses worked, how their responses made them feel after the situations passed, and how they may wish to have handled these situations differently.

If they do not have a lot of insights to share, remember that this may be because they have not often been asked to review their tendencies towards rage and violence in this way. Thus, part of your therapeutic work over time will be to help these clients to identify their personal triggers and how they would like to manage them in the future. In the meantime, if you reach a roadblock in these discussions, try giving the client an example of a frustrating situation, asking him how he would respond and why. "Pretend a stranger bumps into you on the street, doesn't say 'excuse me,' and keeps right on walking. How would that make you feel? What would you do?" Or, "Let's say one of our team members asks you to do something you really don't want to and it pisses you off. What would you say to handle it?" Or, "Pretend somebody you know yells at you and threatens to hit you. How would that make you feel? What would you do in response?" Asking clients questions like these may help them to tell you about their personal rage tolerance in a more hypothetical, and thus, less threatening manner. At this point, try to avoid either reacting negatively to what you are told or addressing what should be done in a given situation. You will have time for this as your relationship builds, and if you act too quickly here, the client may not feel it is safe to share these details about himself with you.

You may need to draw on others in the client's life to develop crisis plans, especially if he is not ready to share these details with you. Although it should be used only as a last resort, if you cannot help the client to share details about his past triggers and crises, and he has nobody else in his social network, you may need to develop crisis plans based on what has worked with similar clients in the past. This should be the last course of action you take because each person is different and because this may encourage over-generalization or avoidance of difficult conversations on the team's part. However, it is better to have some plan in place than none.

Once developed, the risk assessments and both of the crisis plans should be thoroughly presented in team meetings, so that all staff who have contact with these clients will know how to best deal with potential risks and crises in order to avoid violence. Don't wait until something bad happens to develop a response! Also, the team should continually update these assessments and plans as it gets to know high-risk clients better.

Individualized Service Planning

Service plans for ACT clients with criminal or violent histories should contain many of the same elements as service plans for all of your clients. These folks, too, will need concrete assistance in finding housing, establishing a stable income and leaning to manage money,

adhering to medication protocols, dealing with physical health problems, building relationships with others, and avoiding unnecessary hospitalization. Clearly, however, service plans for clients with histories of violence also will need to outline special treatment considerations.

First, specific plans should be outlined for skills in the area of anger and crisis management, which will grow out of your comprehensive assessments. Assisting these clients to develop ***specific strategies*** to cope effectively with rage without resorting to violence towards self or others is a key part of this service plan. In this area, you may need to draw on or link the client to providers with special expertise, such as forensic psychiatrists, social workers specially trained to work with violent individuals, and trainers in nonviolent crisis intervention (see the Resources listed at the end of this manual). Because in this case you're developing plans for clients who already have committed violent acts, draw on this history, reminding clients that you want to help them avoid this type of behavior in the future. Be careful not to sound threatening, though, when using this engagement strategy. Just remain matter of fact and demonstrate an honest desire to help the person better manage his complex emotions.

Second, you should detail in the service plan whether certain providers may be at-risk when visiting the client. In particular, when working with clients who have been convicted of raping women, particularly repeatedly, you may find it best for everyone to have male staff be the primary caregivers. If this is not possible, then you should ensure that a woman is paired with another staff person – preferably male – during all visits. It may be therapeutic for the client to have normative interactions with women on the team, but special attention to her comfort and safety is paramount. If you decide that women are to be involved in visiting clients with such histories, then you also should make sure that each of them has had self-defense training just to be safe.

Third, you'll need to outline in the service plan any conditions of the person's parole or probation, if relevant. This would include conditions of release, the expectations of the client during parole, and how often the client is to meet with her parole or probation officer. You should make a plan to meet with the parole officer both to introduce yourself and to explain your role in the client's life, if he doesn't know this already. You also should be prepared to give a brief overview of ACT services, philosophies, and values. Out of respect to the officer, you should inquire for specifics about how he views his role in the client's life, what he already knows about her, and what he might need from you. You also may wish to meet with the lawyer involved in the client's case, providing and obtaining the same information from him/her. You will need to work especially closely with consumers who have disorganized or confused thinking to ensure that they meet all of the conditions of their parole or probation, to avoid future incarcerations or legal problems. To accomplish this, it will be useful to review in the team meeting each morning exactly what conditions these clients are expected to meet that day and who will see to it.

For clients who are on "home confinement," you will need to outline the specific terms of the confinement and how these may interfere with such things as his being able to meet with providers, go to public aid appointments, attend treatment groups, or get a job. For example, you wouldn't work on getting somebody a job on a night-shift at a factory if he is required to be at home from 5pm to 9am every night (unless, of course, you can get agreement from the court to alter confinement to day hours, which is possible depending upon the crime, the person's history, and legal personnel involved). The conditions of home confinement are strict, with parole officers personally coming to and/or calling the individual's home each day/night to ensure compliance. Depending on the crime and the legal personnel, even one violation could result in incarceration or extension of confinement terms. Here, too, you will need to work especially closely with consumers who have disorganized or confused thinking

to ensure that they are where they need to be at all times to meet conditions of confinement. Again, reviewing this each morning with the team will ensure that "no balls get dropped" in this important area.

Whether the client is on parole or confinement, your team may find it useful to involve the parole or probation officer(s) in actual team meetings or staffings, as you may do with collaterals in clients' lives such as landlords or employers. Of course, including officers in these meetings can only be done with the client's consent. Over time, and depending upon the individual circumstances of each client's criminal history and parole, you may find that you don't need to involve the officer in *each* staffing regarding the client, but rather, can accomplish collaborative planning in less regular staffings such as monthly or bi-monthly. When first meeting with the officer to introduce yourself and the ACT model, you should discuss these staffings and how you envision him being involved in them, addressing any questions or concerns about the process.

Any court-mandated treatment also must be outlined in the service plan. Many times, part of the person's parole or release terms may require that she attend certain types of counseling appointments or support groups. There will be little room to alter these conditions, even if the client responds better to flexible treatment options. Therefore, you will need to work with the client to ensure that she attends all mandated treatment appointments. If it makes sense and doesn't violate confidentiality, you may arrange to meet with the therapists or counselors involved with the client in this way, explaining your role in the person's life, as well as the values and philosophies of ACT.

Of course, if your ACT team ***is*** the treatment to which a client is mandated, you also should make note of this in the treatment plan. Working with mandated clients can be especially tricky since, by definition, they are not willingly taking part in the treatment. It can be hard to develop partnerships and alliances with clients who are forced to spend time with you. However, it can be done. You will need to acknowledge upfront that you understand that the client probably doesn't want to meet with you, but given that it's a requirement, you might as well make the most of your time together and try to meet his concrete and immediate needs. Helping him to see that he personally can get something positive from the mandated treatment – other than just meeting conditions of parole or confinement – can help you work more effectively together. It may take time to show the client that you can be helpful, even if he is being forced to see you, so remember to be patient, just as you are with all reticent or hesitant clients.

Activating Safety Plans

If ongoing assessment reveals that a client with a history of violence is becoming a potential safety risk, immediate plans should be made among the team to step up visits, activate the crisis de-escalation plan, and review how staff members will maintain personal safety (including visiting the client only in pairs, with back-up communication devices). Perhaps developing some ways that the client can safely vent or "let off steam" with the team (or several members of it) may be in order, to help prevent explosive or dangerous behaviors. An immediate medication or psychiatric evaluation may be helpful as well. If appropriate, and without violating confidentiality, the escalation may be discussed with the parole officer and mandated therapist, who also are likely to have recognized a change in the client during their regular visits. If the client lives at home, you also should review safety and crisis management plans with family members (see Chapter 12 for more information about this). If there is reason to believe that the client is beginning to pose a risk for violence, don't try to wait it out. Respond immediately. This often will help the client, even if he seems angry at the time, to know on some level that others are there to help him manage his life and his behaviors, ultimately increasing his trust in the team.

Holding Clients Responsible

Holding people responsible for their behaviors means exposing them to the same natural consequences that are faced by all citizens of a community. When an individual demonstrates behavior that is non-lawbreaking, but inappropriate (such as idiosyncratic behavior or actions that infringe on the rights of others), you can encourage community members to give direct feedback to the person about this behavior. For example, you may encourage a shopkeeper to talk directly to the client who is sitting on the step and being a general nuisance to people coming and going from the store. As the worker, you can serve as a sounding board to help clients understand and incorporate this type of feedback.

Direct feedback is not untherapeutic and it will not cause the client to "fall apart." It may be stressful, but receiving feedback is one of the ways each of us learns how to act in different social situations. At the same time, you should be cognizant of when this type of feedback may cause agitation or violence, so that you don't put community members in risky situations. However, part of working with adults – even those with a propensity to crisis – is conveying that you believe they have the maturity and inner resources to be treated just like any other adult and to learn to manage the responsibilities that this entails.

In order to hold people responsible for their behavior you also must know about the norms and expectations of the community. What are the prevalent standards of conduct? Are there cultural norms that should be respected? What does a particular landlord expect of his tenants? You need to know the answers to these questions for each of the various communities where consumers live. Do not make assumptions based on the norms or rules of your own home or neighborhood. To do this well, you have to work closely with members of the community such as landlords, employers, law enforcement, family members, clergy, and so forth.

Develop Team Specialists

Depending upon how many clients with violent histories your team serves, you may find it expedient to designate one or two individuals to become team specialists. These staff can take the lead on learning more about violence among consumers, working effectively with known perpetrators, uncovering resources in the community, liaisoning with criminal justice and legal personnel, and the like. Of course, in line with the ACT approach, all team members still would be expected to work with clients who have criminal histories, but responsibility for educating the team may be better accomplished by one or two individuals. These key staff also may serve as liaisons to the Safety Committee, discussing special needs and considerations the team faces in serving clients with forensic involvement.

Additional Supervision and Support

Working with clients who have a known history of violence can create some understandable anxiety among team members, particularly those who don't have experience in this area. Often times, staff may be reluctant to bring these concerns to the team leader for fear of appearing unable to do their jobs, weak, or somehow prejudicial. Thus, the best way for team leaders to address these concerns is to proceed as though everyone has them, especially because, at some point down the line, most everyone is likely to experience some hesitation or worries about clients who have perpetrated violence. Furthermore, if these fears are not openly addressed on an ongoing basis, they are sure to interfere with the effectiveness of the team in the client's life.

As service planning proceeds, the team leader should openly state that many people have at least some level of anxiety about working with clients who have violent histories, that this is

natural, and that it should be shared as a team issue. Time should be given both during team meetings and individual supervision for staff to *safely* explore these concerns without fear of reprisal or humiliation. Clinical supervision in these instances should focus on "normalizing" the fears and on how to specifically cope with them. Team discussions may focus on how to interact normally and effectively with clients, in spite of any inner anxieties. Additionally, the team leader may find it helpful to shadow staff members during their visits to these clients to offer advice and guidance, as well as to role model the safety procedures outlined throughout this manual. Emphasis also should be placed on appropriate service planning to ensure safety, with specific provisions that no staff person would be expected to meet with these clients alone – especially at first – and that back-up communication devices would be mandatory. While team leaders may worry that these precautions would heighten anxiety – making it seem as though there is something to be afraid of – these measures actually can serve to reassure staff that their personal safety is being addressed. Over time, the team may find that some of these precautions are not always necessary (e.g., visiting in pairs), but it's better to be safe than sorry when first starting out. Of course, these conversations on the part of the team leader should be balanced with reminders that not all clients are violent and that past violence is not a guarantee or solid predictor of future violence.

Resources for Helping High-Risk Clients

When providing services to clients with histories of violence, you will likely find it necessary to access additional assistance and/or resources from organizations with expertise in this area. These resources can prove very helpful in serving to educate and/or assist the ACT team in developing comprehensive, coordinated service plans for individuals determined to be high-risk. Below is a list of agencies and/or organizations you can contact when providing treatment to clients who pose safety concerns.

National GAINS Center
Henry J. Steadman, Ph.D.
Center Manager
262 Delaware Ave.
Delmar, NY 12054
1-800-311-4246

Behavioral Health Advantages, Inc.
410 Fayette Street
Peoria, IL 61603
1-800-837-3041

Isaac Ray Center
1725 West Harrison Street
Suite 110
Chicago, IL 60612
1-312-829-8021

National Crisis Prevention Institute, Inc.
3315-K North 124th Street
Brookfield, WI 53005
1-800-558-8976

Michael Howie, Director
Forensic Mental Health Services
Department of Human Services
400 William G. Stratton Building
Springfield, IL 62765
1-217-782-6480

Dealing with Violent People in Clients' Lives

Many ACT providers have faced situations in which people who are known perpetrators of abuse, threatening gang members, or otherwise violent individuals visit the agency or the residences where they are visiting a client. Many staff, especially in urban areas, also have confronted threatening individuals hanging around *outside* of the agency or residences – although still quite visible – waiting for certain clients or staff to emerge. Often, these people are looking for their partners (and perhaps, their children) whom they have abused, vulnerable clients who owe them money or other favors, fellow gang members served by the program, or other agency staff or clients with whom they have gotten into some kind of troublesome situation.

Providers are not always comfortable discussing their apprehensions about these situations because they fear appearing unable to perform their jobs, overly sensitive, or prejudiced in some manner. The repeated need to confront known perpetrators or violent visitors can be very stressful for staff, and it may compromise not only staff and client safety, but also morale, energy levels, and job stability within an agency. It is good practice for organizations or programs to develop a set of procedures for staff and clients to follow when dealing with known perpetrators who are not clients or potentially violent visitors.

In general, it is not necessary to be *overly* fearful – although you certainly must be cautious -- of known perpetrators who visit your agency or the residence where you are providing services. You will rarely be the target of this person's anger or interest. However, if you get into an altercation with the person, you are likely to stimulate anger or interest. Do be careful to remain "on your toes." Should you be verbally assaulted by anyone, stay calm and do what you can to calm the person. If necessary, get help. Should you be physically assaulted, leave the situation immediately and call for help. See Chapter 10 for more information.

It is useful to be able to recognize when a visitor might be planning to verbally or physically assault you or one of your clients. Arnett (cited in Murphy, 1993) notes that overly solicitous attention to the client on the part of a perpetrator should arouse some suspicion in you about his or her motives. Someone with information to hide may become aggressive, demanding to stay with the victim during an outreach visit to prevent her/him from making accusations or seeking help. Batterers have been known to bully their way into service or health care delivery sites, often intimidating the staff. At other times, however, perpetrators may take a very compliant, remorseful attitude, hoping to engender the sympathy of the staff. Others have been known to impersonate family members or authorities on the telephone to obtain information about their victims. Of course, any one of these behaviors in isolation, or without specific knowledge of a violent history, should not be enough to arouse your suspicions. However, if you know the person has perpetrated violence or that your client is afraid of someone, then you should be cautious in dealing with the alleged batterer and in sharing any information about your client or her/his children.

Domestic Violence

Domestic violence is abusive behavior that is physical, sexual and/or psychological, intended to establish and maintain control over a partner (WDLI, 1998). It affects people of both genders, all cultures, and every socio-economic status. It may be present in the lives of the people you serve, their partners and family members, your co-workers, even your own life. It seriously affects the lives of anyone it touches, whether as victim, perpetrator, or witness. Every organization should have domestic violence hotline information prevalently posted. One effective place to post the information, in addition to public areas, are in the bathrooms where people can discreetly write down the information should they so choose.

Be responsive when you become aware that a colleague or a client is dealing with domestic violence. If the person asks for help, provide what you safely can. Make sure people know the local hotline number for domestic violence and how to find a shelter or safe house.

If you are a victim of domestic violence, please tell a trusted co-worker or supervisor and ask for help. Remember, a significant portion of workplace violence occurs when your abuser follows you to work. If you need to be absent from work, comply with agency policy, but be as open as you can with your supervisor and maintain communication. If there is a restraining order on your abuser, make sure to let others know. You may want to give a picture of the individual and a copy of the order to your supervisor. This assists others in identifying the abuser if he or she appears at your workplace. Further, you should consider other steps that may protect your safety, and that of your colleagues and clients in your workplace. This may include having your telephone calls screened, making sure your supervisor has an emergency contact number for you, and so forth.

If you are a perpetrator of domestic violence yourself (or wonder if you might be), tell a trusted co-worker and get help – for your sake and everyone else. Please do it *now*.

In the event that you must confront batterers or perpetrators in your clients' lives, it is helpful to have some general guidelines for protecting yourself and your clients. Arnett (as cited in Murphy, 1993) suggests the protocol found in the handout, "Domestic Violence and Batterers." It bears repeating that you should never deal with a threatening individual on your own, even if you are physically strong. It is always better to call the police in these situations. Your security is more important than your pride.

Chapter Summary

This chapter presented a broad overview of considerations for ACT teams in serving clients with known histories of violence. Highlighted was the tenet that the safest practice is best practice. The ACT model may be among the most effective service models available to help consumers with forensic involvement, and the team can view this as a position of strength on their part. Special service plans to help these clients manage violence triggers and meet conditions of parole were emphasized, along with attention to the overall safety of the team. Also discussed were basic guidelines for dealing with known perpetrators in the lives of clients, including situations in which one of your clients or team members (or yourself) is experiencing domestic violence.

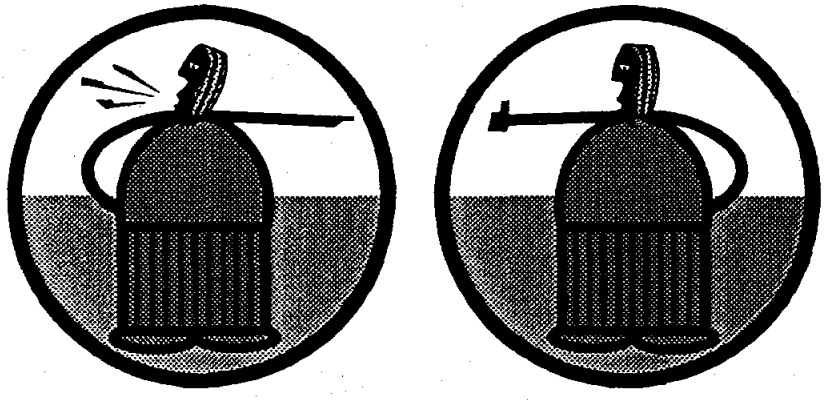
Domestic Violence and Batterers

- Maintain confidentiality of your clients who are confronting domestic violence. NO information of any kind is to be given to unauthorized persons for any reason. Beware of solicitations for information on clients over the telephone from people you do not know and trust. NEVER reveal the location of a shelter, safe house, or residence to people you do not know well. Let your client know that you are maintaining her/his confidentiality.
- Call the police or security IMMEDIATELY to have perpetrators removed from the agency or residences if they are threatening and are refusing to leave the premises. This action is especially important if the victim has an official order of protection against the perpetrator. Never assume that you can handle the situation or person on your own.
- Report any threats to children to the proper authorities as soon as possible.
- Arrange for a private and quiet space to meet with victims who are your clients. Victims of abuse are unlikely to be frank about their needs and the situation if children, the perpetrator, or others are present.
- Work on developing trust and rapport with the victim. Do not pressure the person to file a complaint, or demand that he or she leave the abusive relationship or terminate gang-related activities and so forth. Victims need to leave abusive situations in their own way and on their own timeline. You can, however, provide factual information about abuse, power dynamics, services for victims (including hotlines), and other issues of interest. If your agency has policies regarding gang related or criminal activities among clientele, these certainly should be shared.
- Assist the victim in arranging to escape, if needed and requested. Help her or him to develop a private plan of action for how to escape, outlining community resources, safe houses, support systems, and so forth.

From, Arnett in Murphy, P. (1993). Making the connections: Women, work, disability, and abuse. Orlando, FL: Paul M. Deutsch Press, Inc.

Section IV

Managing Dangerous Situations Safely



Chapter

10

When Confronted with a Dangerous Situation

Violence Prevention & Self Protection

Overview: *This chapter explores ways in which our responses to high-risk or deteriorating situations affect what happens. It provides information about how to act to defuse dangerous situations and to ensure personal safety through effective communication skills. It provides a basic overview of some common sense actions individuals can take to preserve personal safety when confronted with a direct assault. These actions are emphasized as a last resort and staff is encouraged to get formal training in non-violent crisis intervention.*

Assessing Degree of Immediate Danger

Aggression typically is defined as consisting of four categories: 1) verbal aggression, 2) physical aggression against objects, 3) physical aggression against self, and 4) physical aggression against other people (Yudofsky, 1992). Any of these categories can include relatively mild examples of aggressive behavior as well as extremely dangerous or life-threatening behaviors. The degree of danger in a given situation can be assessed by the intentionality of the action (is it meant to hurt?), the amount of force used, and the seriousness of the potential outcome.

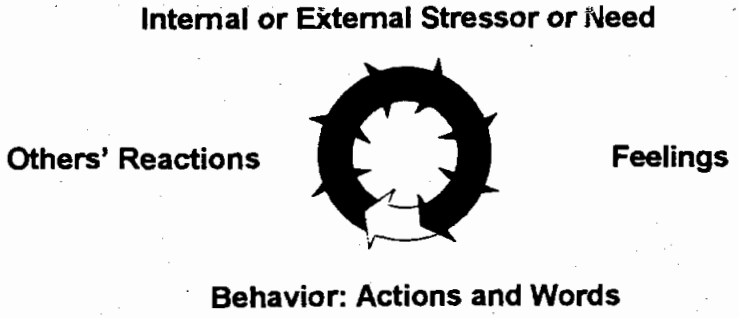
Throwing a magazine across the room is an aggressive act. Throwing it toward someone makes it aggression toward a person. A gentle toss makes it mild. Coming at you with it rolled up and held like a weapon makes it an assault and immediately dangerous. If a harder object is used such as a pipe, bat, stick or even fist, it can be life threatening.

If a person calls you nasty names in a loud tone of voice it is verbal aggression. Shouting one epitaph makes it mild. Shouting multiple and continuous profanities increases the degree of aggression. Making threats against your self, your home, your family, or your job further increases the risk and danger.

When confronted with any aggressive behavior or high-risk situation, you must gauge your response to the degree and imminence of the danger. Your objective is to make sure that the situation does *not* become worse and that the degree of dangerousness declines as a result of your action.

You Are a Player

The best way to deal with dangerous situations is to take the precautions and use the practices described earlier in this monograph to prevent and minimize them. However, sometimes things just happen, no matter how well crisis prevention strategies are planned or orchestrated. When confronted with a dangerous or potentially explosive situation, your actions and reactions can make the difference between whether things calm down or whether they explode into something worse.



The figure above shows the trigger and response cycle. The trigger is the stimulus or stressor that causes someone to respond in some way. Internal triggers can be needs, beliefs, psychosis, emotional states, failure, and so forth. External triggers can be almost anything:

loss, change, interpersonal problems, financial struggles, and so forth. These stressors or events raise feelings in a person: anger, fear, frustration, self-loathing, and so on. Actions come from the feelings and may be a desire to fill the need, express the feeling, seek balance through revenge, and the like. Actions may be physical behavior or words. People in distress tend to act more from their feelings than from their rational thinking. The greater the distress, often the less the person's capability to think clearly.

You respond to the distressed person's actions and words. How you respond may serve as yet another trigger and the cycle can spiral into increasing agitation and danger. Or your response can move the situation toward greater calm and control. It is not uncommon for people to mimic or mirror the actions or feelings of the distressed person, for example to yell back, challenge or threaten, react emotionally rather than rationally, and so forth. These responses typically make matters worse. However, you can chose to react in ways that will keep things from getting worse. This chapter discusses some of the ways you can respond to these situations in helpful, calming ways.

ACT Worker Responsibilities in Dangerous Situations

Understand Your Primary Responsibilities to Yourself and Others

When confronted with a dangerous situation an ACT worker has several primary responsibilities.

Personal Safety

The first is your personal safety. Don't be a hero! In a life-threatening situation you must protect yourself. For example, always know where the exit is, have a plan for reaching it, and use it if necessary. Protecting yourself allows you to be more effective in managing the overall situation and to help others involved to get or to stay safe. Later in this chapter you will find a more detailed discussion of ways to protect yourself.

Safety of Others

Your second responsibility is to make sure that any other people on the scene are protected or removed from the situation. This may include asking people to leave or telling them to find a secure place or safer position. Do what you can to keep the person or situation in a reasonably contained place, such as one room. Property damage or destruction is less important than personal injury.

Avoid Making it Worse

Your third responsibility is to avoid doing anything that might make the situation worse. This is not the time to argue with a person or threaten him with consequences. Use every communication skill you have! Communication strategies that are effective in dangerous situations are outlined in this chapter. Some of them come from martial arts, some from approaches used in hostage negotiation, but most come from common sense and the experience of those who have "been there."

Helpful Interventions

Finally, and only after you have attended to the responsibilities addressed above, you may attempt to directly intervene in the situation. This may mean engaging in negotiations with the person, using non-violent physical restraint, or calling in experts in violence control such as the police or security officers. If the individual is a client, as an ACT provider, you have special responsibilities to make sure that the person is helped and not unduly harmed by your actions. Physical involvement is *always* the last resort.

Know What You Bring to the Situation

Any person who is intensely distressed and/or angry can be extremely intimidating. It is reasonable for any ACT worker, whether male or female, alone or with another staff member, to feel threatened or scared when dealing with a person who is yelling, stomping around, waving their hands, or demonstrating other forms of physical threat.

Some ACT workers have experienced or witnessed serious violence in the past. People who have experienced this kind of trauma may find themselves emotionally triggered by a person who is displaying even relatively mild forms of threat, intimidation, or violence. Such painful memories can affect how the worker responds to the person and to the situation -- they may over-react or under-react. If you or one of your co-workers have personal histories with trauma that might affect how you respond to a situation, let your supervisor and team members know. If you find your past experiences are significantly affecting your ability to do your job, you may want to seek personal counseling and/or talk with your supervisor about on-the-job support.

Use Your Team

ACT workers have a special capacity to work as a team. This is a wonderful resource! Use it! Your team should discuss together what members might need from each other to manage threatening or dangerous situations in the best possible way. The more proactive and up front these discussions are, the better.

Ideally, teams should practice handling several different threatening scenarios to identify effective ways of working together to manage the situation. This would be similar to the kinds of Emergency Response Preparedness exercises many communities engage in annually. Issues about authority, communication, coordination, logistics, as well intervention skills are surfaced and addressed during these drills. Hopefully such practiced responses will not be needed, but should there be a crisis, the advance preparation can be life saving.

Of course, no amount of practice can precisely re-create real life-threatening situations. Your emotional response is different. You know it is a simulation. Therefore, after any encounter that is perceived by a worker to have been a hostile or uncomfortable one, the team and the team leader should debrief the situation. Debriefing can help you to avoid that, "I'm sick to my stomach and I don't want to go to work," feeling that commonly follows even mild traumatic incidents. The purpose and process of debriefing after serious incidents is discussed in more detail in Chapter 11.

The Relationship Between Communication and De-escalation

People communicate in lots of ways: with words, with music, with their bodies, with actions, with their eyes. When a person is being disruptive or threatening, he or she is trying to make a point in the only way the person knows *at that moment.* Often the communication is that the person feels his or her needs are being over-looked or misunderstood. Active psychosis, acute intoxication, and environmental or situational stressors exacerbate such feelings. Defusing of a disruptive encounter with a person relies primarily on *communication.*

Triggers

All of us have been in arguments: at home, at work, with our kids, our relatives, our partners. What kinds of things make the argument worse? Ignoring your last statement? Raised voice? Biting voice tone? Physical contact? Reminding you about something you did a long time ago? Not answering the question you asked, but answering a different one? Strategies to "win" by diminishing you? These are examples of "triggers" and we all have them. What triggers me may be different from what triggers you. But if either of us gets triggered we are more likely to respond to the situation from an emotional rather than a practical place. You may unintentionally trigger another person – simply by something you said, how you said it, the way you held your body, even by wearing purple that day.

When dealing with a dangerous or potentially dangerous situation, it becomes critical that you are sensitive to the ways you may intentionally or unintentionally trigger the other person and hence make the situation worse. You must be acutely aware of what you are saying, how you are saying it, what your body is saying, and how the other person is responding to these messages.

Talking Without Words

We all communicate non-verbally. In dangerous situations the non-verbal messages you send are just as important as understanding the non-verbal messages communicated by the other person. You should be very alert to non-verbal cues – yours and others! Messages are imbedded in the way one looks at another person, or how touch is used, or how one person physically positions in relation to another. Consider the kinds of messages people communicate non-verbally. For example: How do people communicate a need for safety? For respect? To establish or maintain boundaries? To express fear or anxiety?

There are three primary kinds of non-verbal communication: para-verbal communication, kinesics, and proxemics.

- Para-verbal communication is *how* you say what you say. It is your tone of voice, the volume, how fast or slow you speak, and so on. Consider all the ways you can impart meaning through the simple word, "oh." Surprise, question, disappointment, innuendo, delight, insight, and challenge are just a few messages you can send depending on the para-verbal communication attached to the word.

- Kinesics is a "system of postures, facial expressions, and body motions that convey messages" (Haviland, 1990, p. 99). It is essentially the way people communicate through motion or body language such as eye contact, hand gestures, and touch. Is your body turned toward, away, or at an angle from the other person? Is your eye contact brief,

sustained, or a challenging stare? The supportive stance described below is an example of how you can use kinesics to both increase your safety and promote calm.

- Proxemics is how we define and use the space around us. For example, many people prefer to have others stay "at arms length" from them unless in an intimate situation. Any closer, and we feel uncomfortable. People are uncomfortable in crowded elevators because others have to invade their personal proxemic comfort zones. It is helpful for you to be very aware about your personal comfort zones and ask that others respect them. Because we are all so different in culture, age, gender, and experiences, it is natural and appropriate that different team members will have different comfort zones. The same goes for our clients.

Non-verbal communication is a major source of triggers for people. When managing a difficult situation, you must be fully alert to the messages you are communicating non-verbally. Also remember that the other person is trying to communicate something very, very important. He or she will use verbal as well as non-verbal means to try to get the message across. You must "hear" and do your best to accurately interpret the verbal as well as the non-verbal messages.

Cultural Differences

Like verbal communication, non-verbal communication follows certain culturally specific rules. In delicate or dangerous situations, the nuances of cultural communication can take on exceedingly important dimensions.

For example, there are clear cultural and gender differences in body language. In the United States, for example, frequent eye contact is usually perceived as friendly and appropriate whereas in other cultures it may be perceived as rude or even threatening. Touch during conversation may, in some cultures, convey connection and intimacy between the speakers. In other areas, including many cultures in the United States, touch during polite conversation is perceived as inappropriate, overly intimate, and threatening unless specifically approved by both speakers.

Proxemics also varies across individuals and cultures. For example, in a number of cultures the standard distance between people in a conversation is much smaller than most people in the United States may find comfortable. The physical distance that you find comfortable and "normal" in a conversation may be seen by a person of another culture as aloof, distant, or even reflective of ill feelings held toward them. Alternatively, you might find yourself very uncomfortable and feel threatened by the close conversational proximity preferred by some cultures.

Silence is used differently and means different things in different cultures. Non-responsiveness is not necessarily pathological or an indicator of disrespect or lack of interest. In some cultures silence needs to be understood as a way of maintaining face or of carefully formulating a response. The shame of disclosure or use of "unnecessary words" is prevalent in a number of cultures.

Considering the Other's Perspective and Needs

Despite the fact that a hostile situation is intimidating, remember that the other person is very distressed, experiencing extremely intense emotions and feeling immediate needs.

As an ACT worker, you know that some people with mental illness may have difficulty communicating their thoughts or feelings in a manner that others can easily understand. Therefore, it is up to you and your co-workers to calmly help clients find other ways to sooth their distress or to resolve their immediate problems. People who are enraged are extremely afraid that their immediate needs are unrecognized or misunderstood, and therefore, will go unmet. What are those immediate needs? What can be done *right now* to help reduce the pain? It is up to you to remain objective and thoughtful as the consumer may not be able to do so at the moment. The client may be looking for some degree of direction and help from you to understand and meet his or her immediate needs.

Basic, but Ever So Important Communication Skills

Restating

When you restate a consumer's message you are simply telling the person what you heard her say. For example, you might say, "What I hear you saying is that...." You should ask the person whether what you heard is what she meant. In other words, ask her to clarify or even elaborate on her point. Asking for clarification makes sure that you really *do* understand what the person is trying to say, and demonstrates your good faith desire to really listen to what the person is communicating. Be careful! Relying solely on re-stating without helping the client to resolve the issue in some way can begin to feel condescending over time.

Reframing

Reframing allows you to use different words to offer another perspective on the person's issue. You are, in essence, holding up a different lens through which to look at the situation. For example, a consumer confronts you about visiting too often and complains that you are always "in their face." You could reframe the comment by saying, "These regular visits help me to make sure you're still doing OK. It seems to me that they give you some time you can rely on to take care of your business."

Validating

As much as possible, validate what the consumer is stating verbally and non-verbally. For example, "I understand that this money management process can get confusing. But you know, we've been working on this together for a while and you've really gotten good at knowing when your bills come in and what to do with them. You can really stick with things."

Deflecting Challenges

All ACT workers should be prepared for challenges to their authority, skills, training, and the like. Recall the stimulus and response cycle discussed at the beginning of this chapter. How you respond *will* make a difference. You should avoid directly responding to such challenges even when your inclination is to defend yourself. Generally, these challenges are intended to shift the focus onto you and to put you on the defensive.

A better approach is for you to redirect the person's attention to the main issue at hand. This is often difficult because many of us naturally feel triggered and angry when we are personally attacked. Our instinct is to immediately defend ourselves and to counter the

challenges in an effort to defeat the other. You should remember that these challenges are not really about you but an intentional or unintentional desire on the part of the other person to change the subject. When you are triggered and let your emotions drive your response, you are likely to escalate the situation.

Managing Difficult Situations

Start with Common Sense

When you are confronted with a person who is enraged, disruptive, losing personal control, or potentially dangerous – start with common sense! Avoid anything that you instinctively know will make the situation worse. Be aware of your attitude, your body, the messages you are sending, what the other person is saying, and any changes in the level of tension or dangerousness. Get others out of harm's way. Make the setting as safe as you reasonably can, such as removing the scissors or other sharp objects from the table. Check for the exit – and how to reach it quickly.

Start with Common Sense

Pay attention to:

- Your attitude
- Your personal comfort zone
- What the other person is saying – verbally and non-verbally
- Your non-verbal messages
- Allowing enough space and distance
- "Face" – never strip a person of dignity
- Increases in tension or agitation
- Where the nearest escape exit is and how you would reach it
- Providing simple, clear direction when needed

Create Calm through Communication

The list of techniques outlined in, "Creating Calm through Communication," have been found to be useful by professionals who deal with crisis management and de-escalation on a regular basis and in a variety of settings. They are compiled from a number of sources (CPI,

1987; HHS, 1998; USDA, 1998; Skidmore, 1990; Begley, 1994; Kaplan & Wheeler, 1983; Curtis, 1990; Workplace Violence Research Institute, 1996).

Demonstrate Desire to Understand

Since the primary objective of the person is to convey something important, your primary communication goal is to understand the message. Let the person know that you are taking him seriously. You can see that he is upset. Listen carefully and demonstrate that you understand, or are trying to understand, the person's requests, feelings, and immediate needs. Use communication skills such as re-stating, re-framing, and validating. You cannot rush this.

Allow for Venting

Venting is a way of releasing pent up emotional energy. While it might seem frightening to listen to a tirade of anger, frustration, sadness, or other intense emotions, venting can provide you with information about what is bothering the person and it lets the person drain off some of the emotional charge. As the emotional intensity is released, both you and the individual may be better able to name the core issue. Of course, continual venting without a shift to calmness or resolution can be very draining for you, so while it's helpful to let clients vent, it's also okay to set some limits on it.

Creating Calm through Communication

- Appear centered and calm. Breathe! Control your own emotional response. Be relaxed, but attentive.
- Allow time. Listen and acknowledge the anger. Let the person know you see that something is wrong. Don't judge or belittle.
- Lower your voice, tone, pitch, and tempo.
- Ask the person to sit down.
- Allow extra physical space. Do not touch.
- Allow full expression of needs and grievances. Verbal venting can release energy and promote calming.
- Do not be defensive. Don't argue with the person. Don't take sides or agree with distortions.
- Help the person find words to describe what he or she is feeling or experiencing.
- Do not talk over the consumer when someone is yelling. Wait until a breath is taken and speak in the quiet seconds.
- Clear up misunderstandings and respond to valid complaints.

- Respond selectively; only answer informational questions, not abusive ones. Ignore challenging questions.
- Ask what would be helpful to regain control. For example, "What can you do to try to regain control of yourself?" "What can I do to help you regain control of yourself?"
- Don't offer solutions. Point out choices. Don't attempt to bargain.
- Build a momentum of agreement. What can be genuinely agreed upon? For example, "We both want you to feel better." "Yes, that seems very unfair."
- Set limits respectfully, but firmly, and explain the consequences.
- Use delay to give person time to calm down. For example, "Would you like a glass of water?" (Remember to deliver in a disposable cup!)
- Know when to stop trying. Exit the meeting, if possible, and call back-up or security, if necessary.
- Never turn your back.

Talk

Try to get the person to talk with you. Speak softly, slowly, and clearly. Ask questions. Give reassurance. Examples of questions and comments you may find helpful are the following:

- Tell me what happened. (Solicit the person's perspective about who, what, when, where, why).
- I can see you're really upset.
- I want to help.
- I'm really concerned about you right now.
- Is there anything that I can do to help?

You may find it helpful to talk softly enough that the person has to naturally quiet in order to hear you. If that doesn't work, you could try matching the loudness of the person's voice and gradually bringing your voice down to a calm level (HHS, 1996).

Preserve Face and Dignity

Sadly, at the center of many difficult situations is the fact that the individual does not experience respect -- either from others or from himself or herself. By recognizing and validating this primary need in the other person, you can help to contain or defuse the situation without sacrificing your own authority and responsibilities. Never do anything that strips the person of dignity.

Build Alliances through a Momentum of Agreement

Try to find things you and the other person can agree upon – no matter how basic. Don't agree with distortions, but do find elements that you can agree with such as, "You're right, that doesn't seem fair." " We would both feel better if that phone would stop ringing!" "We both want you to feel better." These kinds of agreements help build trust and alliances without diminishing your objectivity.

If you can get the individual to agree with you on any level or even say "yes" to something, it can help to shift a person from an intense adversarial position. For example, "Would you be more comfortable if you sat down?" "Is it easier to think when the telephone is not ringing?" "Would you like to feel better?" You are working to create a momentum of agreement so that the person might say to himself or herself, " If I already agreed to that, well, it's not such a big step to agree to this other thing."

Offer Direction

The greater the immediate danger, the greater the need for direction. Situations escalate when people become increasingly emotional and less capable of rational thinking. Alcohol and drug use also diminishe rational thinking and the person's ability to talk through the situation. The less rational the thinking, the more dangerous the situation. The more dangerous, the greater the need for clear, simple directives, such as, "John, I want you to put the chair down." "John, we can talk about that after you put the chair down."

Using Non-Verbal Communication to Create Calm

The more the person loses self-control, the less likely she is to listen to your actual words. At these times, you must pay more attention to the non-verbal cues she might be sending (CPI, 1987a.). The consequences of misunderstandings and confusions regarding non-verbal messages can be very grave. You must be *very* conscious of the messages you are sending non-verbally and do your best to keep these messages both non-threatening and consistent with what you want to communicate.

The Supportive Stance

In situations in which the person is disruptive, angry, or hostile, a physical position called "*the Supportive Stance*" can be very useful (CPI, 1987). The Supportive Stance helps you position your body so that you are not sending a message which can be perceived as threatening or challenging. It also provides you with balance in case you need to move quickly to the right or left to avoid a sudden physical attack or flying object. When you are in the Supportive Stance, you are automatically positioned so you can move quickly if escape becomes necessary.

You might find it easiest to understand the Supportive Stance if you try it yourself now. Stand up and relax. Place your feet comfortably apart, but no wider than your shoulders. Now turn one foot out ninety degrees and place it a bit behind the other. This will naturally turn your body slightly away from the person and, at the same time, give you a solid footing. Slowly shift your weight from foot to foot and your trunk from right to left. Feel the amount of control and balance you have while, at the same time, avoiding a confrontational position directly in front of the person. Does it make a difference which direction the foot faces? Not really. OK, now you can sit down.

Non Verbal Communication and Psychiatric Disorders

Often, people who experience disturbances in mood or thinking have difficulty expressing themselves through verbal communication. Like people from other cultures, individuals with mental illnesses may sometimes feel "out of sync" with the majority of those around them.

Some may be less responsive or extremely responsive to non-verbal messages from others, for example, not sensing that you are uncomfortable because they are standing too close to you, or not reading social cues about talking too much. Conversely, some may worry exceedingly because you glanced out the window during a conversation.

Some people may have idiosyncratic internal rules about non-verbal communications that may or may not make sense to you. You should try to identify and respect them, however. For example, one person may tell you, "Don't talk to me about my parents when I'm wearing blue," while another may use obscene gestures to express his sentiments toward voices he is hearing – not toward you. Mood and thought disorders can affect how people express themselves and how they perceive their interactions with other people. For example, individuals with mood disorders may be much more expressive about feelings of elation or sadness than other people.

It is always wise and respectful to ask a person what he thinks is appropriate regarding touch and conversation. Making poor assumptions regarding touch or space considerations during conversation can leave people feeling disrespected or threatened. Avoid touching an angry person – too often the person sees this as threatening or disrespectful and it may trigger an escalation of the situation. Always ask before you touch a person in distress – even to provide comfort. For example, "Would it help if I held your hand?"

You may find that people who are experiencing mania or hypo-mania often stand too close or touch too often. Some may lunge toward you in an effort to intimidate. In such situations you must clearly, calmly, concisely establish and enforce reasonable limits.

Consumers with fears and suspicions may be more aloof and require more personal space. You might want to clarify with the person exactly how far away she would prefer you to stand. Act accordingly. Subsequently, you should convey this information to other team members. *Always respect personal space.* This is critical in situations in which the consumer is disruptive, angry or hostile. You should stand at least an arm's length away from a person who is disruptive or enraged. Your arm is about three feet long which is a typical proxemic comfort zone for many – and it keeps you out of striking distance. Encroaching on the person's comfort zone may cause the individual to feel attacked and may provoke a violent, self-protective reaction (CPI, 1987).

Getting Help

It is not your job to remain in a dangerous situation and try to manage it alone. Leaving is OK – especially if you are alone. In fact, it is better to leave than to be attacked. When a person continues to be agitated or aggressive, get yourself to a safe place and remain calm. This is an excellent time to have a cellular telephone or another two-way communication device.

Leaving the immediate situation is to ensure your safety, but you do have responsibilities as an ACT worker to make appropriate notifications and/or get help. You will need to decide who to call first, depending on the kind and intensity of the situation and on available resources. If you can, try to make sure any others involved in the situation (children, neighbors, and so forth) are safely out of the situation. In situations that are serious, but not

out of control, contact your team for immediate back-up. If your area has mobile crisis intervention teams, use them according to whatever protocol or agreements exist between your team and this service. You may need to take steps to initiate an emergency hospitalization.

If the situation is very dangerous or life-threatening to anyone involved, immediately call 911 or other emergency numbers for the police, security officers, or paramedics. If you or any other person has sustained an injury, call an ambulance immediately. Remember if, in the course of your work, you are injured, even slightly, you *must* have the injury evaluated by medical personnel as soon as possible after the injury occurs (no longer than 24 hours). Not doing so could jeopardize any workers's compensation benefits for which you may be eligible.

When emergency personnel arrive, cooperate with them fully. Once they are on the scene, they will assume control of the situation. Be prepared to provide them with an accurate and succinct description of the individual, the details of what happened to reach this point, your observations and actions, and so on.

Dealing with Direct Assault

> ***Notice:***
> *The intent of this manual is to provide general information and areas for consideration by the user. Self-defense skills cannot and should not be taught through a manual. Active training by qualified professionals is critical.*

There may be situations where you cannot get out of the way quickly enough. Or when your attempts at de-escalation do not defuse the situation, and you suddenly are faced with imminent physical assault. In such situations, you need to know how to protect yourself from serious harm. Your first instinct is to protect yourself by getting out of the situation as fast as you can. Good plan! If you are faced with a direct assault, you need to protect yourself. But REMEMBER, physical action is always and only used as an absolute last resort.

Responsibility to Protect Yourself – and Others

As an ACT team member you have responsibilities to protect and to minimize harm not only to yourself, but also to the people you serve. If your assailant is a client, you must protect yourself, but at the same time, you should not use any force that may unduly injure or harm the individual. Of course your safety is paramount, but in the process of securing your safety you must do as little harm to the consumer as possible. There are federal and state laws that specify the responsibilities of mental health workers to protect clients from harm, even if he or she is the perpetrator in explosive and dangerous situations.

Get Formal, Hands-on Training

Do not rely on this chapter to provide you with expertise on self-protection. This chapter provides some very basic common sense information about how to protect yourself in a direct

assault – it is not about restraint, therapeutic intervention, or martial arts. Its purpose is to encourage you to get the skills you need from professional trainers.

It is *very strongly* recommended that every ACT team member attend a formal and professionally offered training in non-violent crisis prevention, and practice these skills on a regular basis. These interactive, hands-on programs are structured to ensure that staff members learn how to use appropriate preventative measures, but also approaches to restraint and self-protection that are safe, effective, and legal in human services. There are a number of excellent programs offered in non-violent crisis intervention. See the Resources section for a listing and description of a number of these training programs. Many of these services offer training-of-trainers programs. Training some ACT team members to be trainers increases the agency capacity to regularly offer self-defense training and provide in-house "refresher" programs at least annually.

There are other sources of personal safety training in most communities. For example, check with your local rape crisis center, YMCA/YWCA, community college, and/or law enforcement agencies. Some martial arts schools provide seminars and workshops as well. Be careful, however. These courses are usually focused on self-defense tactics for attacks by people other than consumers and may promote approaches that would be inappropriate for a staff person to apply to an agency client.

A basic course will offer fundamental concepts and skills in self-protection. Individuals can build on these and become more proficient over time with additional training and practice. Self-defense does not require years of study to perfect; however refresher courses are recommended. In an emergency situation, your reaction should be swift and natural, almost without thought. Shop around, ask questions, and observe classes in order to make a well-informed decision in a course selection that meets your needs.

Common Assaults

Most assaults are unplanned and impulsive – and intimidating. They may be a form of self-protection for the assailant (such as shoving you out of the way, flailing at you to make you move back), a way to get something you have (such as your purse or wallet), or to intentionally cause you harm (as in hitting, biting). Ennis (1993) identifies the most common kinds of "street" assaults as:

- Shoving;
- Striking -- including a slap or a punch with an open or closed fist; tripping; use of a weapon;
- Grabbing -- the assailant takes hold of some part of you: your wrist, clothes, hair;
- Spitting -- especially common in children;
- Biting.

Most rare, but also most serious, is when the assailant tries to grab you by the neck. Any chokehold is life-threatening. Also be aware that sexual assault usually begins with grabbing or striking. If the assault can be deflected at this stage, an even more serious trauma may be avoided.

Common Sense Self-Protection

There are no guarantees here. In any dangerous situation you are at risk for harm. Using these strategies will not assure your safety. However, they may give you enough time to get out of immediate danger. As presented here, these tactics are escape, get help, shout, and block.

Research on the efficacy of self-defense training has found that the vast majority of persons who are attacked are able to escape when they yelled to attract attention and resisted the attack. When victims did only one or the other, they escaped over half the time. People who did neither, rarely escaped (Javorek, 1983).

Escape

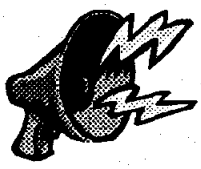
Your first objective must be to get yourself physically out of the situation. If you can avoid an imminent assault by getting out of the situation, it is better than being attacked. Any other strategy used is only to give you an opportunity to run. And when you have that window of opportunity, run like your life depended on it. It just might. If you are followed get into a public place such as a restaurant or shop. Avoid dark places such as parks and alleys.

Get Help

After you have escaped, get help. This may mean shouting "HELP" as loudly and as often as you can or screaming. These shouts not only draw attention to you, but they also can startle or scare the assailant. Get to a telephone and call 911 for emergency assistance.

Shout

Shouting is an effective tool for more than calling for help. It may distract the assailant just long enough so that you can move and get out of the way. It can serve as a "wake-up" call to all of your own nerves and muscles. This is a reason why martial arts experts use shouts as part of their strategy. When you shout, don't be shy or dignified. Be as loud and blood curdling as you can.



Block

If someone tries to strike you, your natural instinct is to raise your arm across your face or chest to push the blow off to your side. This is a block. You are trying to deflect an oncoming object and prevent it from hitting you. Blocking can help you avoid a blow to your most vulnerable places: your internal organs, your face, your throat and chest. Once you have blocked an assault, don't wait around and give the person another chance at you. MOVE! SHOUT FOR HELP!

A simple way to ingrain in your brain the basic steps of self-protection in a direct assault is to remember this mantra:

Block, Move, Call for Help!

Block, Move, Call for Help!

Block, Move, Call for Help!

Block, Move, Call for Help!

Block, Move, Call for Help!

Releases

When an assailant grabs you or something on you, such as your hair or clothing, you need to get yourself out of the grab before you can escape. You can and should still shout and call for help, even while an assailant has hold of you. The basic principles for getting free of a grab are:

- If it is your purse or some other object that has been grabbed, drop it, and RUN! SHOUT! CALL FOR HELP!
- If the grab is on some part of your person, look for a weak spot in the grab and attack it. This is often a finger or thumb. Bending back the assailant's finger or thumb may make him loosen his grip enough for you to escape!
- Use all your strength to break loose. Use both hands to bend back his appendages if you can.
- Once you're free, RUN! and SHOUT FOR HELP!

Wrist Release

The assailant has grabbed hold of your wrist. Steps that can help you get your wrist free again are:

- SHOUT!
- Make a fist of your trapped hand.
- Take your free hand and cover your own trapped hand.
- Pull your hand back sharply and forcefully. This may break the hold through the weakest point – the thumb and forefinger.
- RUN!
- CALL FOR HELP!

Bites

Bites are serious injuries, especially if the skin is broken. There are significant health risks when a bite breaks the skin because body fluids (saliva and blood) are exchanged. You are at risk for infection, but also HIV and Hepatitis C. Never hit the biter's face or any other part of his or her body. This may make the person clamp down harder and risk greater damage to you (Pence, 1999). One of the safest and most effective ways to make a biter release his or her grip is to:

- SHOUT!

- Grab a handful of hair and pull backwards from the mouth. This will force the mouth open.
- RUN!
- GET HELP!

Following Up

Depending on the situation, you or your team members may need to contact other agency staff (such as the Medical Director or Executive Director). If the incident involved an assault you need to make immediate notification. If the situation was relatively mild and you were able to defuse it quickly, follow your team policies and protocol for notifications and documentation.

If children are involved, their immediate welfare must be addressed. The individual's emergency contact persons and family members should be notified, especially if the situation resulted in personal injury to the client or an emergency hospitalization.

After the situation is under control and everyone is safe you must make sure it is appropriately documented and the required incident reports and logs are completed. The agency Safety Committee may ask you to provide further information in order to assess it in the context of the larger agency safety plan.

Always debrief with your team. See the section above on informal debriefing. If the incident was serious, the agency should assist with a more formal debriefing and counseling process, which is discussed in Chapter 11.

Chapter Summary

What you do, and how you do it, have a significant impact on the development and outcome of high-risk situations. Your actions can trigger the situation into greater disruption and violence. Or, they can help to de-escalate the situation and regain some degree of calm.

This chapter has presented some of the specific ways that you can use verbal and non-verbal communication to keep a bad situation from getting worse, and provided some specific guidelines for dealing with difficult situations. It also discussed the importance of hearing and trying to accurately understand what a distressed person is trying to communicate through verbal and non-verbal messages. Some of the ways that culture and psychiatric disorders affect non-verbal communication also were presented.

When confronted with a direct attack or assault, your primary responsibility is to protect yourself by getting out of the situation. You may need to protect yourself from a strike or get released from a grab before you can make the dash and get help. This chapter presented some basic, common sense approaches to self-protection in assaults. It emphasized that ACT workers need to have hands-on interactive training in non-violent response to crisis situations, and opportunities to regularly refresh their knowledge. ACT workers must protect themselves in an assault, and if the assailant is a client, they also must avoid causing undue harm to that person.

Chapter

11

After the Fact

Dealing with Victimization, Trauma, and Tragedy

Overview: *This chapter discusses the emotional aftermath of a tragedy. It overviews common reactions to a violent incident and its impact on the workers and consumers of an organization, organizational responses for managing the consequences of a tragedy, and approaches for handling specific situations.*

It's your worst nightmare and it is real. The ACT Team nurse was sexually assaulted by a stranger when making a home visit tonight; she is now in the emergency room. A client was killed in an accident when an ACT team member was driving; the staff is shaken, but unhurt. One of the business office employees was killed by her ex-husband in the photocopy room. A client who was very high and very psychotic stabbed a staff member. An ACT team member found a client hanging in the shower, dead. The worst has happened and you have to help your colleagues, the consumers you serve, and your community to deal with it. And, of course, the media are calling for the story.

One of the most challenging aspects of delivering ACT services is dealing with the emotional aftermath of traumatic events such as serious verbal threats, suicide, homicide, or physical or sexual assault. Many organizations are uncertain about how to respond appropriately when either staff or consumers are involved in violent incidents. Shulman (1993) argues that

human service agencies are some of the least effective in dealing with traumatic incidents in a manner that protects staff and clients from negative impact. Shulman further worries that agency response often is focused primarily on investigations to minimize liability and assign blame – all approaches which actually can make the problem worse for staff members. Typically, the best organizational response involves consideration of the emotional and concrete needs of the person who was victimized or threatened, the entire staff, the consumers served, and relevant family members, as well as the possible legal and media consequences that may arise due to the traumatic event.

How People Are Affected by Traumatic Events

Workplace violence puts many people into emotional distress. We are out of our comfort zones. We feel vulnerable and in a state of emotional disequilibrium. To be most helpful to each other, staff and clients need to have a good understanding of what people typically experience and need when they have experienced trauma. Wolf and colleagues (cited in HHS, 1996) report that following a violent or traumatic incident, employees will commonly experience three stages of reaction and recovery.

Stage 1: The individual has immediate reactions of shock, disbelief, denial, and numbness. The person may experience physiological changes associated with shock and fight/flight reactions such as increased heart rate, heightened or distorted perceptions, and high levels of adrenaline.

Stage 2: After the immediate physiological reaction, a psychological or emotional reaction emerges. This is a highly emotional period where the individual often feels anger, rage, terror, grief, helplessness, depression, withdrawal, and other strong emotions. This stage may last for a few days or weeks, or for a very long time.

Stage 3: The person tries to make sense of what happened, integrate it into his or her life experience, and understand how he or she was affected by the event. Moving through this stage brings closure to the event so that it does not continue to interfere with the individual's work, life, and emotional health.

Stages of Reaction to Traumatic Events

Stage 1: Reactive: Shock, disbelief, denial, and numbness, physiological changes

Stage 2: Emotional: Psychological reaction emerges: anger, rage, terror, grief, helplessness, confusion, insomnia, depression, withdrawal, and other strong emotions.

Stage 3: Integration: Trying to make sense of what happened and understand how one was affected by the event.

Despite these commonalties experienced by many people, each survivor will have different strategies to cope with trauma. The intensity of the trauma is affected by the duration of the event, the amount of terror or horror the survivor endured, how much personal control the person felt she or he had in the situation, and the amount of loss the survivor experienced (such as property, self-esteem, physical well-being, and so forth). Also the person's previous experience with victimization and loss affects the reactions (HHS,1996). Van Fleet (1992, p. 32) identifies some of the specific ways in which a traumatic event affects individuals.

- Incident specific anxiety: uneasiness, panic attacks. This may combine with other stresses that individuals already are experiencing and may be a "last straw" for some folks.
- Snowball events: critical incidents may result in other life changes which may not be directly associated with the initial event, either in time or content.
- Depression, irritability, and withdrawal immediately following the event is common. These should be handled as event-related, not as an exacerbation of any pre-existing symptomatology.
- Intrusion: any public scrutiny, media attention, investigations, and so on may add to stress, anxiety, fear, and frustration.
- Flashbacks: some individuals may experience flashbacks to the traumatizing event. These may be vivid and in slow-motion. Over time, flashbacks tend to become less intrusive, although the individual may be retraumatized by similar circumstances, anniversaries, or "triggering" stimuli.
- Demand for explanations and closure: when things don't seem to make sense, the human mind often looks for explanations. Rumors and inaccuracies can abound. People want closure and sometimes retribution.

- Survivor guilt: people may worry about what things could have been done differently, "If only...x...then things would have been different." This is useful when reviewing organizational policies and practices which, in fact, may need to be changed. However, when it is personal and preseverative, it becomes one aspect of a phenomenon known as guilt. Another component of survivor guilt typically occurs when serious personal injury or death occurs. This is the feeling of the survivor that he or she should not have been spared the trauma that affected another (i.e., when only one person in a car accident dies).

Organizational Responses to a Serious Incident

Organizational response to violent incidents in the workplace begins with ensuring that the safety, medical, and emotional needs of those involved are sufficiently addressed; debriefing the entire staff and clientele about the event; documenting what occurred; and managing the media and potential legal issues.

Organizations can use a three-step model to structure their responses to a serious incident. In reality, there is considerable overlap in these steps.

Steps of Organizational Response to Critical Incidents

Step 1: Assuring immediate safety, necessary notifications, and personal follow-up with survivor(s);

Step 2: Debriefing staff and clients; documentation; legal considerations; managing the media;

Step 3: Attention to the *ongoing* emotional needs of survivors.

Response Teams

Because all of these concerns are equally important, depending on the magnitude of the incident, it may be useful to have a team of individuals to address them simultaneously. Some organizations have established emergency response teams who are responsible for assuming these responsibilities. These are often the same teams that are representing the agency in community disaster preparedness planning and may be comprised of representatives from emergency services, employee assistance programs, media relations, medical services, and the executive committee. Some organizations may request that their internal Safety

Committee function as the coordinating point for traumatic incidents. Other agencies will try to organize a team ad hoc after the fact. Ideally, the teams will have a contingency plan or at least a basic framework that outlines what needs to be done and a coordinated process for doing it.

Even with a team in place, managers, team leaders, and staff will all play a role in helping colleagues, consumers, and sometimes the public to process what happened and their emotional and physical reactions to it.

First Things First: Immediate Safety and Notifications

There are immediate procedures that a manager or team leader needs to perform following a violent or traumatic incident. All organizations should already have these procedures developed and all staff informed of them. The following list is adapted from, "Guidelines for Understanding and Responding to Violence in the Workplace" (HHS, 1996). Your organizational Safety Committee may wish to add other points or tailor the list to the specific policies guiding the ACT teams at your agency. These points are summarized in the figure, "Checklist for Organizational Response to Critical Incidents."

- Make sure the immediate area and people are safe. Is the perpetrator contained? Any weapons confiscated? Is everyone accounted for? Is anyone trapped or at risk for further assault? Is the physical area secured for investigation, if necessary?

- Make sure any person harmed or injured in the incident receives immediate medical attention. Even if the person does not have obvious physical injuries, medical evaluation can help diagnose and treat individuals for shock and internal injury.

- Gather as much accurate information as you can about what happened. This includes who was involved, where and when the incident occurred, and the current status of the situation and individuals involved. Later you can get more information about what led up to the incident, and the details about what happened, when, and who did what.

- Notify the agency chain of command, including the emergency response team. If your emergency response team does not include people responsible for employee assistance, personnel, or media relations, then make sure these people are informed. Depending on the situation, the agency lawyer should be notified to ensure that any legal considerations are addressed up front. Agency policies should specify who can make this contact and when.

- Notify people outside the agency who immediately need to know what happened, such as family members or identified emergency contacts.

- Notify staff and other consumers. Inform staff and clients as soon as possible about what has happened (without violating confidentiality of those involved) and what is being done in response. To hold such events in secret, while understandable, often leads to the creation of rumors, increased anxiety, and inappropriate feelings/actions on the part of personnel and consumers. Generally, it is advisable to at least let everyone know that staff and/or consumers have been involved in a critical incident and that swift actions are

being taken to help those people to cope and to ensure the continued safety of everyone else.

Attend to Survivors

Attending to the *ongoing* emotional and psychological needs of survivors is addressed in more detail later in this chapter. Immediately following an incident the team leader and/or others should take the following actions. If team members are involved, the role of the team leader becomes especially important, as he or she is the initial support person and the primary link to the larger organization and its policies. When clients and consumers are involved, the ACT team members may be the ones providing immediate follow-up.

- Provide support, comfort, and reassurance. People will be in emotional distress, if not also physical pain. Express your personal concern for the person. Individuals may need assurance that they did not cause the event and that the choices they made resulted in their being alive, which is good. If the individual is in the hospital, visit there, at least briefly, at the earliest medically appropriate time.

- Make sure the person has other support people to call on (family, friends, colleagues). Don't let the person feel abandoned. If necessary, help these supporters to understand what happened and what the individual needs at this time. These supporters will need to help make sure that the person's immediate practical needs are covered. For example, be sure any children are cared for, pets are attended to, and so forth.

- Allow for some personal leave from work. An employee may need some time off. However, unless there are ongoing medical issues, the individual should not take too much time away. There is some truth about the importance of "getting back on the horse that threw you" as a way to diminish the long-term trauma of the incident on the person.

Debriefing

After a critical incident, emotions run high. Deal with them now or deal with them later. After the immediate emergency actions have been completed, the organization *must* provide debriefing and/or counseling services (HHS, 1996). These debriefings provide an opportunity for expression of emotional responses to the incident such as anger, grief, pain, and the like. They can offer support as well as provide a channel for communication, disseminating information, and educating participants. They also offer the organization an opportunity to assess the traumatic impact of the incident on employees, clients, and others (Van Fleet, 1992; HHS, 1996).

There are many forms and styles of debriefing: formal organizational debriefing meetings, informal debriefing and discussion within the ACT team, and individual debriefing meetings, sometimes with ongoing counseling. Not every incident requires all three approaches. In any approach don't joke about or trivialize the event. "It could have been worse" does not feel good to hear, even when true. It's bad enough and the people involved are affected in real ways. Take it seriously. Demonstrate your concern.

Formal Debriefing

Use formal debriefing when the impact of the incident has significant traumatic impact on the team, other agency personnel, consumers, and others. If the event is simply stressful or sad, but not traumatic, other forms of debriefing may be more appropriate. Van Fleet, (1992, p. 29) provides the following guidelines for deciding when to formally debrief.

- When the event is unique or outside the limits of normal expectations. (A formal debriefing is not required every time a staff member is yelled at or a magazine is thrown.)
- When the event caused fatalities or serious injuries.
- When the event posed serious danger to the workplace or the community.
- When there were a number of people affected such as victims, participants, observers, colleagues, friends, family members, rescuers, etc.
- When the event stimulated or resulted in strong emotional impact.
- When the workplace activity or culture may have difficulty returning to "normal."

A formal debriefing should occur shortly, but not necessarily immediately, after the event. HHS (1996) suggests that 24 to 72 hours after the incident is best. Gathering accurate and adequate information about the event may take a little time. After a day or two, sometimes the shock wears off and people are better able to absorb the information. The debriefing should be held away from the place where the event occurred, if possible, and be facilitated by an individual viewed by the participants as caring.

The facilitator does not need to be an administrator, though administration should be represented and play an active role in providing information and assurance. The facilitator may be a person from employee assistance, from emergency services, from outpatient counseling, or someone skilled in trauma debriefing. One large or several smaller program-focused debriefing meetings may be held. Different debriefings may be held for different groups such as ACT team members, other agency workers, consumers, management, community members, and so forth. Regardless of the structure, the meeting should be open to anyone who was involved in the event, who felt traumatized or victimized by the event, or who was personally affected by the event, including family members. Attending group debriefings should be voluntary. Persons who prefer an individual consultation should be provided that opportunity, if possible.

The number of formal debriefing sessions held should be based on need and may be variable. The tone of the meeting needs to be supportive and non-judgmental. Each person should have the opportunity to participate and share his or her feelings about what happened. Formal debriefings should always provide participants with information about other support resources available to them through the agency or elsewhere – including where to find personal counseling and peer support groups.

Informal Debriefing

Informal debriefing is typically more program- or team-specific. Coming to terms with traumatic events may be very difficult for an ACT team. It is not uncommon for individual workers to feel guilty or for the team to wonder whether they could have done something more to prevent tragedy. The team also might experience intense anger at one another or the

client(s) involved, feeling that they have been let down or treated unjustly. Of course, the team also is likely to feel grief and loss during times of tragedy.

It is essential to arrange for the team to process all of these feelings as a unit. At such times, special sessions should be arranged in order to help all workers come to terms with the particular issues surrounding the tragedy. If the client had been involved with family or friends recently, then these individuals also might be invited to these sessions so that they too will have a place to process the tragic event. Team members also may need time to openly mourn, so that their negative and painful feelings do not interfere with delivering quality care to other clients. Again, if some team members are having a particularly hard time dealing with the tragedy, it may be necessary to suggest individual counseling or support groups to help them work through their pain and reactions.

After the intensity of the initial emotional impact has dissipated a bit, informal debriefing can be used to help the ACT team objectively review its policies and procedures to determine whether changes are necessary for increasing personal safety and effective risk management. Further, the team should review intervention approaches and service plans for specific individuals for necessary changes. Three basic questions help guide this discussion.

Informal Team Debriefing

What happened?

Allow the staff involved in the incident to vent and gain support from team members. Allow consumers involved (if not the perpetrators) to do the same.

What changes need to be made?

Allow the team to modify the consumer's current service plan in light of the incident, whether this person was the perpetrator or one of the victims.

What can we learn from this?

Allow the team to learn from the incident and develop procedures that might help to avoid similar incidents from happening in the future.

Documentation

As discussed in Chapter 5, most agencies already have established methods for documenting "critical incidents." If your agency does not have a way to do this, then one of the first tasks of your Safety Committee will be to design such a reporting system. Chapter 5 has example forms in the Toolkit. Documentation is important not only to determine how to address the needs of those involved in a situation, and to alter service plans if need be, but also to demonstrate that everything was handled properly, for possible legal purposes. When preparing documentation, it is important to address the following types of questions at the organizational level.

- Where did the incident take place? Who was involved in the incident?
- What event prompted the violence?
- What strategies did the staff person or consumer use to prevent the violence?
- Was anyone injured? What were the specific injuries?
- What are the emotional needs of those involved?
- Was hospitalization needed, either of the injured person(s) or the perpetrator?
- Was a police report filed?
- What steps can be taken to prevent this type of incident in the future?

Legal Considerations

Although agency directors and administrators do not want to appear callous, consideration also must be given to the possible legal consequences of critical incidents. As soon as possible after an incident occurs, the agency's lawyers should be contacted to discuss appropriate procedures. Liability is a consideration. The agency will need to demonstrate that:

- It has considered potential risk *proactively* and has appropriate policies and procedures in place to minimize and manage potential risk;
- Staff and clients are not wittingly placed into service delivery situations where there is a high probability of danger, especially without back-up and resources;
- Appropriate steps have been taken to provide staff with knowledge, skills, and resources (such as cellular phones) to minimize risk factors.

Of course, incident documentation will be a large part of this process, as well as demonstrating that the victimized individual was not inappropriately put into a risky situation without back-up and support. If the violence was staff to staff, then documentation and procedures for formal reprimand of the perpetrator (and possible dismissal, depending upon the seriousness of the incident) must be put into place.

As discussed throughout this manual, careful consideration must be given in advance -- and on a continual basis -- to events likely to trigger violence, as well as how to manage the risk inherent in ACT service delivery. The best legal protection is prevention. Of course, even with the best procedures and supports in place, tragedies still may occur, and thus, legal advice regarding documentation and response is very important.

Revisiting Policies and Procedures

After the dust settles, and the agency has arranged to meet the needs of those involved and their own legal obligations, it is time to revisit the policies and procedures for dealing with critical incidents and for serving those with histories of violence. Part of consultation with the agency lawyer may be decisions about whether the current policies and procedures are legally adequate. Further, review of whether staff is adequately supported when working in the community, particularly in risky situations or neighborhoods is important. Policies and procedures should be revised if necessary, and released to all personnel and consumers. Follow-up discussions may be held in staff and team meetings, as well as during visits with clients, about the kinds of support and information the people involved may need in such situations and what should be done differently should something terrible happen in the future.

Responding to the Media and the Public

After a violent incident, organizations also must be prepared to deal with the media and the community at large in a formalized manner. Most violent crimes get reported in the mainstream media in some way. Incidents occurring in the mental health field in particular often become the target of media sensationalism, which has served to reinforce the negative stereotypes often associated with mental health consumers by uneducated members of the public.

Organizations need written procedures for addressing such incidents with the media and the public in a professional, educated, and careful way. If the organization does not have a media relations department, it should consider designating an articulate individual from within the agency to serve as a *public relations specialist.* Many agencies have standing policies that prohibit employees from talking to the media directly, requiring that the designated person be the liaison and agency spokesperson. This helps ensure that consistent information is provided in a way that maintains the confidentiality of those involved and considers any potential legal issues. It also protects staff members from being harassed by members of the media for the "inside scoop."

Checklist for Organizational Response to Critical Incidents

Immediate Safety and Notification

- ☐ Make sure the immediate area and people are safe.
- ☐ Obtain medical attention for any person harmed or injured in the incident.
- ☐ Gather as much accurate information as you can – who, what, when, where, current status.
- ☐ Ensure internal notification of agency chain of command, including the Emergency Response Team.
- ☐ Notify staff and consumers that an incident has occurred.
- ☐ Arrange external notification of family members or identified emergency contacts.
- ☐ Minimize rumor.

Attend to Survivors

- ☐ Provide support, comfort and reassurance.
- ☐ Make sure person has other support people present (family, friends, and colleagues).
- ☐ Allow for some personal leave from work.

Debrief

- ☐ Assess need and process for formal debriefing.
- ☐ Begin formal and informal debriefing 24 – 72 hours after the incident.
- ☐ Assist individual teams with informal debriefing.

Documentation

- ☐ Do it!
- ☐ Carefully follow all guidelines and procedures.
- ☐ Check for completeness and accuracy.
- ☐ Determine whether personnel disciplinary action is necessary

Legal Considerations

- ☐ Review situation with legal counsel.
- ☐ Consider agency liability factors.

Revisit Policies and Procedures

- ☐ Determine what needs to be done differently to prevent or manage critical situations

Respond to the Media

- ☐ Use the existing policy about who talks to media.
- ☐ Verify who is the official spokesperson.
- ☐ Remind employees to avoid discussing incident with the media and refer inquiries to the official spokesperson.
- ☐ Emphasize that these events are not common and that the agency is taking appropriate steps to ensure the safety of everyone.

If there is no standing policy, some agencies release correspondence immediately following the incident asking staff and consumers to avoid discussing the incident in any way with the media or community members, instead directing curious individuals to the agency's director, lawyer, and/or public relations specialist. Efforts should be made by those discussing such incidents with the media and public to reinforce that this type of violence is *not* commonplace among those with mental illness (or their providers, as the case may be) and that steps are being taken to respond to the critical event and ensure everyone's safety.

Addressing *Ongoing* Needs of Traumatized Individuals

Although the immediacy and intensity of a critical incident has lifted and the workplace begins to return to normal, the individuals involved may continue to struggle with significant emotions, worries, physical problems, and so forth. The effects of serious trauma can linger for a very long time – and how people cope with the trauma is unique and personal.

Certain individuals may need talk about the incident and to express their emotions to coworkers, supervisors, and/or peers. Others, however, may cope with trauma by getting back into a regular routine, deciding not to openly address the incident with co-workers, supervisors, and/or peers. Some workers even experience a surge of energy after a traumatic incident. No one coping strategy is right or most appropriate, and individuals heal in different ways and in varying lengths of time. Whatever the needs of those involved, it is important to remember that administrators can have an instrumental role in assisting staff and consumers to deal with the emotions resulting from a traumatic event.

The event will seriously affect the relationship between the worker and the client. If the perpetrator is remorseful after an incident, these strong feelings may prevent a worker from responding to the person in an empathetic or therapeutic way. His or her own emotions may prevent response to the consumer's needs. If this is the case, the worker should not attempt to process the incident with the consumer. Another team member and/or supervisor should do the follow-up work with the client. Moreover, some case managers may not want to work with the individual that committed the attack. In these situations, it's important for case managers to process their feelings associated with the incident in a safe environment. Talking through a frightening experience is often the first step towards healing and recovery.

There is a rapidly expanding knowledge base about how trauma affects individuals. It is beyond the scope of this manual to provide a detailed presentation of this knowledge. In what follows, we highlight some recommendations that supervisors and/or team members find most useful when dealing with the ongoing emotional needs of those who have been victimized (HHS, 1996; USDA, 1996; Kaufer & Mattman, 1997).

Helping a Staff Member or Consumer Recover from an Assault

Show Support

Encourage supervisors, coworkers, and case managers to show support. It is likely that at some point the survivor of a traumatic event will need to tell his/her story about the experience. Others can help by simply listening and empathizing with the individual. It is important to remember, however, that this initial phase is not the time to offer advice or to recommend a different manner in which the incident could have been handled. This type of response is to be held for later, once the person has come to terms with the emotional aftermath of the victimization.

Encourage Discussion

Supervisors, coworkers, and case managers also can aid those who were victimized in the recovery process by meeting with them individually to discuss the event. Keep in mind that the individual may be too traumatized to discuss the experience, but it can be very reassuring for her to know that others will be there when she is ready to talk about the incident. In the interim, supervisors or case managers should provide the survivor with information about support groups, individual counseling services, and hotlines. When appropriate, family members, spouses, and other supportive persons should be involved in these discussions and efforts.

Make Personal Follow-up Contact

If an employee or consumer is hospitalized as the result of an assault, it is a good idea to make an effort to demonstrate the agency's concern. Consider sending a card or visiting the individual while in the hospital. These actions will reflect genuine care about the person and his recovery. For most people, receiving no response or support from people in his daily life further increases the traumatization and sense that what has happened to him is larger than life, which only impedes recovery.

Make a Plan for Leave, Accommodations, and Return to Normal Schedule

Work collaboratively with the traumatized individual to plan for her return to work (for consumers, this may mean working with the person's employer, only with the consumer's permission). Time away for an individual who has been victimized may be of paramount importance in the healing process.

The supervisor and employee need to strike a balance about what represents a reasonable amount of time off, and supervisors should try to be open to flexible hours when the employee returns. Offering a modified schedule can help the employee feel supported, while providing the opportunity to get back into her routine. Some people prefer to resume regular work activities without interruption, and this needs to be respected by the supervisor. Remember, some people cope with trauma by immediately recommencing their normal schedule - having time away to heal from the event may actually make matters worse for these individuals.

Be sensitive to the needs of the survivor in terms of future work or contact with the perpetrator. Of course, a team may not have enough resources to enable the victim to avoid being directly involved with the attacker -- at least for a while. If this issue arises make what accommodations are possible to help the individual in trauma recovery. Depending on the seriousness of situation, the team leader may wish to facilitate a discussion with the client and the victim to debrief together, permit apologies and feelings to be expressed, and to set boundaries regarding their future relationship.

Be Alert to Serious Problems

The course and pace of emotional and psychological recovery from trauma is different for each individual. However, if the individual is showing no signs of improvement over the course of weeks or months, or is displaying signs of decompensation, it is important to advise a more progressive course of action. Warning signs might include an unkempt appearance, lack of motivation or interest in work activities, increased anger directed at staff or consumers, inability to sleep, depressive symptoms, and so forth. The individual may be experiencing symptoms of post traumatic stress disorder which you alone cannot treat. Let the survivor know you are concerned about her well-being, and refer her again to personal counseling services and support groups. Try to help her overcome barriers or fears about accessing treatment.

The following are examples of when survivors of trauma may require more intensive intervention than you are able to provide as a supervisor and/or case manager.

Example 1:

Two weeks ago, a member of an ACT team was battered by a consumer while visiting him at his home. The injuries were not severe enough to require hospitalization, but there was evidence of bruising and abrasions on the team member's face and arms. Immediately following the incident, the team member was visibly upset and shaken. Although she refused offers for support groups or individual counseling, she indicated that she no longer wanted to visit <u>any</u> consumers by herself. She also has made statements to her team members that she has been experiencing paralyzing fear ever since, and is now worried that all consumers are dangerous. When accompanying this team member on outreach about one month later, coworkers observed a dramatic change in her demeanor when interacting with clients which included refusing to go into their apartments, spending as little time as possible on their treatment objectives, and being short and abrupt in communications.

In this example, the team member has generalized her fear to all consumers, which has negatively affected her ability to provide effective treatment. If left unaddressed, this staff person could potentially go on to develop strongly negative stereotypes about individuals with mental illness that would prove detrimental in carrying out her responsibilities.

Intervention Plan

In this example, team members who have ***witnessed*** her change in demeanor and interaction style with clients, as well as her statements regarding paralyzing fear and worries that all clients are dangerous, should discuss these issues with the team supervisor. The team

supervisor should meet privately with the individual to express concern and offer options for additional intervention. The supervisor also might require the individual to take some time off from the position for a designated period. Upon return to work, the supervisor should consider shadowing the individual in the field to assess the manner in which services are being delivered to consumers.

Example2 :

One of the longer-standing clients of an ACT team has recently displayed some severe behavior changes about which the staff is very concerned. Over the past several years, this individual has maintained part-time employment, frequently interacted with other consumers, and participated in various agency-sponsored social events. The team has just been informed that this individual has missed the last five days of work. Upon visiting the client, her case manager notices that she has a knife under her bed, the shades are drawn, and she appears to have neglected showering or changing clothes in many days. When talking to her, the staff member sees that her mood is very somber and depressed, which is not typical for her. Upon further exploration, she reports that she was sexually assaulted by one of her coworkers who, up to that point, had seemed to be her friend. She says that she's been thinking a lot about death and that "she'd rather be dead than face this person again."

In this example, the consumer is suffering from the depression, fear, anxiety, and suicidal thoughts that typically result from sexual assault. Her functioning seems to be greatly impaired and the knife under her bed indicates extreme fear that the attacker may repeat the alleged crime. The five consecutive days of missed work also may be indicative of her heightened fear of facing the perpetrator again, as well as her depression and inability to function due to intrusive memories of the traumatic event.

Intervention Plan

In this example, there are many pressing issues that need to be addressed, with the protection and well-being of the consumer being paramount. The team needs to display a great deal of empathy and compassion towards the consumer, as she may be harboring feelings of shame, guilt, fear, and embarrassment. She needs to be calmly reassured that she was brave for disclosing such a painful event. Immediate action should be taken to make sure that she feels safe and supported. This could mean asking one of her relatives or friends to stay over for moral support, housing her in a crisis respite program, and/or linking her to an agency specializing in sexual assault in which counseling, support groups, and advocacy would be provided.

This also would be a good time to call for assistance from the team supervisor. Since a crime allegedly has been committed, the police may need to be involved in taking a report, filing charges, or gathering any potential evidence, ***only with the expressed verbal consent of the consumer.*** Many victims of sexual assault do not want to report the crime to the police for a variety of complex reasons. What's most important is providing the consumer with what she needs to feel safe.

NOTE: ***As with any assault, agency procedure should be followed in reporting the types of incidents described in these two examples to the appropriate authorities,***

completing critical incident reports, participating in debriefing sessions, and so on. Legal responsibilities and obligations respective to such incidents also must be addressed promptly.

Review Written Procedures for Ongoing Trauma Support

In dealing with the emotional aftermath of a traumatic event, it is important for the agency to establish procedures for meeting the coping needs of staff, consumers, and/or family members who have been affected by trauma. Since coping needs vary from individual to individual, flexibility on the part of the organization is paramount. Areas for agencies to consider when developing such policies include the following:

- Establish minimum/maximum time off allowances for dealing with the aftermath of trauma;
- Set up modified or flexible work schedules, as well as employment support plans with the survivors, outlining what they need and what to do should they go into crisis while on the job;
- Formulate written procedures on how to access an Employee Assistance Program, counseling services, support groups, victims' assistance programs, etc.;
- Provide instructions for debriefing meetings that include the victimized individual, team supervisor, team members, peers, family members, etc.;
- Disseminate guidelines for holding special team meetings for the staff to mourn and move on from traumatic events;
- Develop procedures to follow when certain staff or clients are unable to cope effectively over time with traumatic events;
- Establish a training curriculum to teach staff how to respond when someone has been victimized.

Chapter Summary

This chapter discussed the aftermath of a critical incident and how these events affect individuals involved. Appropriate organizational responses for managing critical incidents were described, including attending to the ongoing recovery needs of people traumatized by an incident. Emphasis was given to developing a set of written guidelines for responding to the needs of traumatized staff and consumers, with the belief that staff and consumers are much more likely to feel safe and secure in an environment in which the physical and emotional well-being of all individuals are valued and prioritized by the organization. Discussion of legal liability and dealing with the media regarding violent incidents also was provided.

Checklist for Helping a Person Recover from an Assault

Show Support

- ☐ Encourage supervisors, coworkers, and case managers to show support.
- ☐ Do not offer advice or recommend a different manner in which the incident should have been handled at this time.

Encourage Discussion

- ☐ Meet with people individually.
- ☐ Be sensitive to needs to withdraw or not discuss the incident.
- ☐ Let person know you are willing to talk whenever he or she is.
- ☐ Provide information about support groups, individual counseling services, and hotlines.
- ☐ Involve family members, spouses, and other supportive persons when appropriate.

Make Personal Follow-up Contact

- ☐ Demonstrate the agency's concern for people.
- ☐ Make personal follow-up contacts.
- ☐ Consider sending a card, flowers, or make a visit, especially if the person is in the hospital.
- ☐ Don't let people feel abandoned.

Make a Plan for Leave, Accommodations, and Return to Normal Schedule

- ☐ Allow for personal leave – a few hours, days, or even weeks.
- ☐ Work collaboratively with the individual to plan for his/her return to work.
- ☐ Consider a modified schedule or other accommodations.
- ☐ Help person figure out what is best for him or her – some people cope with trauma by immediately recommencing their normal schedule, so having time away may actually make matters worse for these individuals.

Be Alert to Serious Problems

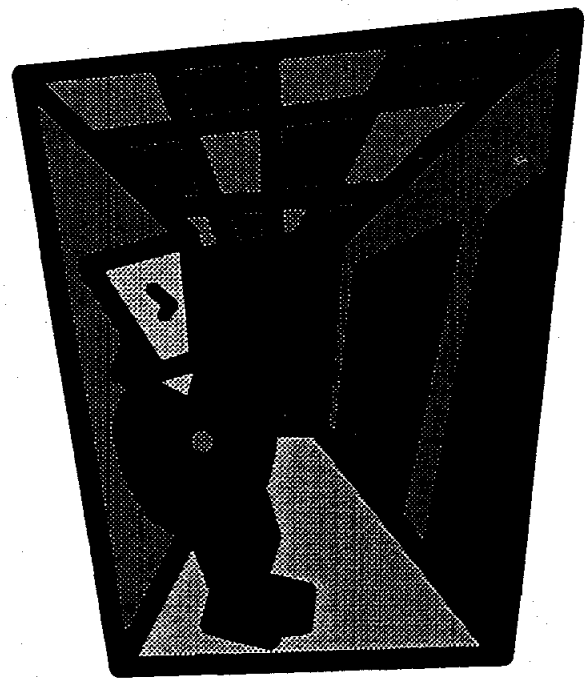
- ☐ Recognize individual nature of the course and rate of recovery.
- ☐ If no signs of improvement after weeks or months, again refer person to personal trauma support counseling.
- ☐ Recognize warning signs of possible post-traumatic stress: unkempt appearance, lack of motivation or interest in work activities, increased anger directed at staff or consumers, inability to sleep, depressive symptoms, and so forth.

Review Written Procedures for Ongoing Trauma Support

- ☐ Establish or review procedures for meeting the coping needs of staff, consumers, and/or family members who have been affected by trauma.

Section V

Helping Consumers Develop Personal Safety Skills



Chapter

12

Living with Risk & Creating Safety

Addressing Self-Perceived Safety Needs

Overview: *This chapter provides a brief overview of the prevalence of violence and abuse histories among people with psychiatric disorders and its relationship to consumer perceptions of safety. Guidelines for intervention and approaches for working with individuals to assess self-perceived safety needs are presented.*

Dare to See

In this manual we have focused primarily on the responsibilities of ACT workers to identify and assess risk factors for violence among consumers, as well as to develop ways to eliminate or minimize the likelihood of violence against themselves, their coworkers, clients, family

members, or others. The risks you face in providing day-to-day community treatment and support services are real. The need to manage these risks and maintain your personal safety is also very real. But, we tend to look at these issues through our own eyes – the eyes of workers, managers, and administrators. The world looks different through our eyes than through the eyes of the people we serve.

There are extraordinary rates of victimization and high-risk living situations among people with serious psychiatric disorders. In addition, individuals often experience the sad effects of poor medical attention, poverty, and significant environmental risks (see Chapter 2). As an ACT provider, you may find that you prioritize psychiatric problems for your clients over those related to their physical or environmental health. You may overlook their very practical need to protect their personal safety in the communities in which they live, work, and generally "hang-out." You may worry about the folks hanging out on the corner or the crack house across the street when you make a home visit, but the person you are visiting needs to deal with them day-in and day-out.

It is important to consider personal safety and risk management through the eyes of the consumers you serve. You need to understand the risks they face, not just the risks they present to our safety and that of others. You need to learn about what worries them the most and what they do to keep themselves safe. When necessary, you need to help people find more or better ways to manage risk in their own lives.

As an ACT provider, you are likely aware of many of the medical and environmental risks that people face. You know that many of the people you serve engage with you precisely because you can help them with some of these problems in their lives. Equally important, although sometimes less visible, are the needs related to individuals' past or current experience with being the victim of violence or abuse.

The conference proceedings from Dare to Vision (1994) bring together very powerful voices about the experience of individuals with psychiatric disorders and personal abuse and trauma histories. Beyond the sometimes excruciatingly painful stories, the conference proceedings explore how policies and practices of mental health treatment services help or hinder people with trauma or abuse histories. It makes clear, from a first person perspective, the degree to which mental health services fail to see, assess, record, accept, and appropriately treat the lingering impact of trauma on people with psychiatric disorders. The consequences are often devastating.

Violence and Abuse Histories Among Consumers

> *One woman became mentally ill at age 17 following the death of her mother and concurrent incestuous relationship with her father. Treatment personnel greeted the incest with disbelief, until the father himself reported calmly that it was true.*
>
> *A chart review at an outpatient psychiatric clinic showed that forty percent of the women had reported significant histories of trauma and abuse, but that only ten percent were given adequate assessment for treatment for trauma.*

One woman began psychiatric treatment at age 21 following a rape attack and the death of her 3-month old daughter. She later discovered that this information had never been recorded in her chart.

A study of female psychiatric inpatients to document the prevalence of within-family abuse and partner violence revealed that over seventy percent had been assaulted during the past year, but that fewer than twenty-five percent had this documented in the charts.

When an adult incest survivor reported to caregivers the damage caused by the response in the system, she was told that this alleged damage was an example of her delusional thinking.

The prevalence of childhood and ongoing violence against persons with psychiatric disabilities is only just receiving attention in service systems in this country (Carmen, Rieker, & Mills, 1984; Muenzenmaier, et al., 1993). The rates appear to be very high. Recent studies show forty-one percent of female and nine percent of male intensive case management clients (Rose et al., 1991) and ninety-seven percent of episodically homeless females (Goodman et al., 1995) self-report histories of abuse. There is also a growing awareness of the ways in which histories of abuse and violence impede community integration for disabled abuse survivors.

Childhood Abuse Histories

Most literature in the field today indicates that one-quarter to one-third of all female children in our culture are sexually abused before their eighteenth birthday (Rosenberg et al., 1996). A growing body of research also indicates that many adults with psychiatric disabilities have histories of childhood abuse (Jennings, 1994; Muenzenmaier et al., 1993). The rates are striking in women who are homeless and have co-occurring substance abuse disorders (Goodman et al., 1997). Recent studies estimate that approximately fifty to sixty-five percent of women who use public mental health services are survivors of childhood abuse (Carmen et al., 1984; Craine, et al., 1988; Muenzenmaier, et al., 1993; Rose, 1991). In one study of adult psychiatric inpatients, one in six men and one in five women reported histories of sexual abuse that often was recurrent (Jacobson & Herald, 1990). The majority of these individuals stated that past and ongoing abuse continued to affect their ability to function effectively in the community. This is not surprising since the effects of abuse may persist long after it has occurred, seriously disrupting functioning throughout life (Carmen et al., 1984; Den Herder & Redner, 1991).

Adult Domestic/Partner Violence

Although an issue of increasing concern during the past two decades, few reliable statistics exist regarding the incidence and prevalence of domestic violence in the U.S., especially against adults with serious psychiatric disorders (Walker, 1999). Rates of domestic violence have been difficult to determine due to the differing definitions (often focusing on only one type of violence in the home) used in many of the studies and by different disciplines (McKenzie et al., 1998; Walker, 1999). A comprehensive definition of domestic violence developed by the American Psychological Association (1996) describes a "pattern of abusive behaviors (physical, sexual, and psychological) used by one person in an intimate relationship against another to gain power unfairly or maintain that person's misuse of power, control, and

authority."

In one study of female psychiatric inpatients, twenty-six percent reported being abused by a husband or partner at some time, with nineteen percent reporting that it had occurred within the previous year (McKenzie et al., 1998). The few studies that have been done regarding domestic violence against homeless adults indicate that women are more likely to be victims of domestic violence than are men (Post et al., 1980). Further, domestic violence often contributes to a woman's homelessness due to her need to terminate the abusive relationship (Robrecht & Anderson, 1998). Studies of homeless or lower-income housed mothers found that nearly two-thirds of the overall sample had been severely physically assaulted by an intimate partner as adults (Bassuk et al., 1996). As with most forms of violence, these rates are likely to under-represent the levels of abuse in the home. Both women and health care providers tend to under-report actual violent experiences (Walker, 1999).

Sexual Harassment

Similarly, there is little documentation of the rates of sexual harassment against individuals with psychiatric disability, including those who receive ACT services. In qualitative interviews with women consumers from several urban mental health agencies, women reported being sexually harassed by coworkers while on job placements, by other clients (typically male) served within the agencies, and less often, by some male staff in their residences (Cook & Jonikas, 1992; Jonikas, et al., 1998). Refer to Chapter 4 for a more in-depth discussion on sexual harassment of clients by staff, providers, or other consumers.

Abuse through Exploitation

Individuals with mental illness can be particularly vulnerable to a variety of risks and dangers. The risk of exploitation can be greater during periods of an individual's illness when his or her judgment or perception is impaired. The exploitation can be sexual, financial, occupational, social, and even clinical. It can be perpetrated by family, friends, coworkers, or others. O'Brien, O'Brien & Schwartz (1990) discuss an extensive list of factors that dispose individuals with disabilities to be vulnerable to exploitation. These include lack of power, isolation, limited recourse, poverty, social alienation, avoidance of problems, symptomatology, and the like.

Consequences of Violence and Abuse

Symptoms that survivors of violence and abuse often experience include chronic depression, anxiety, dissociative states, recurring nightmares or intrusive daytime imagery, perceptual disturbances, psychosis, insomnia, and symptoms of post-traumatic stress disorder (Craine, et al., 1988; Den Herder & Redner, 1991). Many survivors also suffer from persistent physical illnesses such as migraines, chronic back and neck problems, asthma, arthritis, gynecological disorders (for women), and visual or hearing impairments (Bass & Davis, 1992). Victims of sexual assault also are likely to attempt or commit suicide (Briere & Zaidi, 1991), as well as to engage in self-injurious behaviors (Connors, 1996).

Clinical and anecdotal information demonstrates that many disabled survivors of abuse have extreme difficulty in securing and maintaining employment. This often goes unrecognized in community-based programs including those offering ACT and psychosocial rehabilitation services (Den Herder & Redner, 1991; Murphy, 1993; Raudenbush & Wilson, 1994). Clinical and personal accounts also have revealed that disabled survivors of abuse often have an extremely difficult time living independently in the community. They show higher rates of multiple hospitalizations and placement in restrictive settings (Harris, 1994; Jennings, 1994). Moreover, many childhood abuse survivors, whether or not they also have been diagnosed

with mental illness, often report later problems relating to both men and women, estrangement from parents or other family members, and difficulty in creating new support networks (Browne, 1993; D'Ercole & Struening, 1990; Gilbert, 1994). Still others struggle with intensive and disruptive anger towards self and others throughout life, damaging many relationships or compromising the ability to form them (North et al., 1996). Further, they often become abusers themselves, tending to repeat traumas through self-abuse and abuse of others (Van der Kolk, 1999).

Not every person with a history of abuse or trauma experiences – even those who also have a serious mental illness – will have all of these problems. However most people who have experienced abuse or trauma will recognize at least some aspects of them.

The wide range of ways that trauma and abuse histories can affect victims can be categorized roughly into three categories (Van der Kolk, 1999).

- ***Arousal*** *– impulsivity, aggression toward self and others, substance abuse;*
- ***Attention*** *– difficulties focusing, learning and occupational problems;*
- ***Attachment*** *– tendency to both cling and be detached, problems recognizing social cues.*

As an ACT provider, you may find that these issues make it difficult for you to engage people with abuse histories into treatment alliances or ongoing therapeutic relationships. However, by recognizing that trauma history may be the underlying cause for many behavioral or relational difficulties that ACT clients are exhibiting, you and your team may be able to alter treatment plans to deal more directly with helping consumers to get needed trauma services and support. Also as a provider, it is crucial for you to recognize that recovery from abuse histories, particularly for those who struggle with the additional vulnerabilities presented by psychiatric disability and/or homelessness, can be a long process that requires a good deal of support, understanding, and encouragement.

Assessing Consumers' Self-Perceived Safety Needs

One of the best things you can do when questioned about something you don't know is to ask each person her or his opinions about questions you cannot answer (Prothrow-Stith, 1987). Open discussions with consumers about personal safety issues can be informative and empowering to them, if handled carefully.

Educating Yourself About the Issues

When assessing consumers' self-perceived safety needs you must consider medical issues, environmental risks, and impact of trauma experiences. The first step is to educate yourself about these issues, as well as the relevant resources available to consumers in your community. In short, you do not want to uncover medical problems, environmental risks, and past or current abuse among clients without knowing about the resources and supports available in your community to help them.

To educate yourself about **medical issues** consumers face, use your agency's nurses or doctors as resources. There are a host of support groups to help people deal with illnesses such as cancer, diabetes, HIV/AIDS, heart disease, and substance use disorders that can be found via the Internet, the local telephone book, public clinics, and community newspapers. The best way to learn about the environmental risks that consumers face is to speak with them

about this directly, and to spend time in their residences and neighborhoods to see for yourself what they live with daily.

There are many organizations and groups to help you understand more about trauma, domestic violence, child abuse, rape, and so forth. Contact rape awareness training programs and crisis hotlines, self-defense training courses, women's health care programs, local hospital emergency rooms (medical and counseling services), local police departments, victims' assistance programs, protection and advocacy programs, and incest or survivors' groups. Additionally, organizations such as the local United Way Community Referral Information Service, Offices of Mental Health, Protection & Advocacy, and affiliates of the National Alliance for the Mentally Ill often maintain lists of community-based programs or agencies that they would be willing to share. Because of the significance of this issue in the lives of consumers and the rapidly expanding knowledge base, it may be useful to designate one or two members of the team to become "experts" in this area and to serve as resources to the team.

Finding or Creating Resources

There are some basic ways of finding resources in your community, state, or even nationally. These include the following.

- ***Go through the telephone book;***
- ***Surf the web;***
- ***Review materials at your local library;***
- ***Go to seminars and workshops on related topics as often as possible;***
- ***Speak with people you know inside and outside of your own program to gather relevant referrals or resources.***

Unfortunately, some community organizations or groups will not welcome people with mental illness, especially those who are or have been homeless. Often this is because they have not had experience working with people with psychiatric disorders and feel reluctant to help individuals with issues unfamiliar to the organization. Realistically, sometimes this position is better than a program or group accepting a person, and then, that individual feeling isolated or misunderstood rather than supported and helped.

When you contact a program or group, you should tactfully inquire whether they would be willing to work with people from your program. Before calling, prepare a list of questions regarding their services and philosophies. For example, you might ask whether they are familiar with your program or if they have ever taken referrals from similar agencies. You may ask if they have ever worked on issues of abuse, medical needs, or environmental risks with persons who have mental illness or people who have been homeless. Acknowledge any expressed or implied discomfort or reluctance by noting that your main concern is to make an appropriate referral.

In reality, you may want to consider developing support or educational groups within your own program to address the various safety risks that consumers face, especially if there are other staff available to help you with this important endeavor. One approach for designing such a group is presented in Chapter 13.

Ask and Discuss Issues with Consumer

Individual Approaches

After you have educated yourself about available community resources, your next step is to gain the perspectives of the consumers themselves. You might ask each person to describe his or her worries about staying safe and recent situations that felt unsafe. Further discussion about how the person typically handles unsafe or high-risk situations also is useful. Risk assessment tools such as "Risk Assessment Survey for ACT Clients," found at the end of this chapter and "Assessment of Community Violence," found in Chapter 8, can be useful to stimulate discussion as well as to catalog responses.

The purpose of these discussions is to help you and a consumer to identify specific areas of concern from that individual's perspective. With that information, you and the consumer can begin service and support planning. Expect that some of these concerns, as well as how the person weighs the importance of various concerns, will be different from yours. A well-designed service plan will attend to risk and safety issues from the consumer perspective as well as from any necessary legal, fiduciary, or clinical perspectives. You may want to discuss in team meetings how to help consumers formulate answers or solutions to complex, seemingly unanswerable problems.

Group Approaches

Sometimes you want information about the kinds of issues or concerns that a group of clients share. This is critical when your team or agency wants to evaluate or improve its effectiveness in helping consumers to feel safe and lead safe lives. There are a number of ways you can collect this information. For example, you could interview individual consumers and then collate, analyze, and summarize the information.

You also could arrange focus groups for consumers to discuss their risks in a group setting. Be aware, of course, that most people will not wish to discuss actual violent experiences in a one-time focus group setting, unless they know and truly trust everyone. When using a group approach, you may need to keep the focus on **current** risks or fears, rather than on actual violent experiences they have had in the recent or distant past. You'll need to use your judgment about how much the group is ready, willing, and able to discuss in that type of setting.

With either approach, and with their permission, take notes about what the consumers say to help you understand the things that they need from you and your program. For many people it is easier and more comfortable to talk about things rather than fill out a survey or form. However, some people may not want you to record anything he or she says. In such a situation, respect the individual's wishes by not writing anything down. It is more important to help him discover ways to feel safer than worrying about certain procedures.

Surveys

Another approach to gathering aggregate information is to use a survey. You and other interested staff members could design a survey to target whether or not consumers struggle with certain issues that are known to contribute to their lack of safety. The survey asks people to respond to a series of questions about their situations to help them get started in thinking about medical, environmental, physical, and sexual safety risks in their lives. A "Risk Assessment Survey for ACT Clients" is included at the end of this chapter as an example. Tailor this survey to address the specific needs and life situations of the people you serve.

Generally, it is best to allow approximately one to two weeks for people to complete the survey. For the survey to be of use in program planning activities, you will probably need to be very persistent and make sure that all of the participants fully complete the surveys and return them to you in time to be of use in program planning.

Obviously, this approach would be less desirable for individuals with consistently unstable housing arrangements or low levels of writing and reading abilities. You will have to use your judgment about whether written or verbal assessments would be the best approach. You also may decide that it is better to conduct the assessment in phases, addressing only 3-4 items at a time, in order to avoid overwhelming your clients with questions and/or painful memories.

Respect Confidentiality

No matter what approach you decide to use, confidentiality is always crucial. Part of the assessment may include descriptions of times that they felt unsafe in your program or of their otherwise undisclosed abuse histories. If people think that those who made them feel uncomfortable, frightened, or abused will see the surveys, they may not answer completely or truthfully.

Triggering

Whenever you raise safety concerns, trauma issues can surface. Some of the questions may remind consumers of painful experiences or thoughts and trigger an emotional or psychiatric reaction. You should be aware of the possibility that any or all of the participants may need to talk about what he or she felt when filling out the risk assessment. Possible emotional reactions may result from remembering abusive or otherwise painful experiences. You may decide that it is better to sit with people as they complete the risk assessment, so that you are readily available for debriefing and/or possible crisis intervention. You should have a list of crisis hotlines available to give to each consumer, so that he or she has someone to call when you or other team members are not available.

Dealing with Your Anxiety

As a case manager, you may feel uncomfortable or unwilling to ask clients questions about their histories of abuse, current medical risks (especially those related to HIV, which requires discussion of sexual practices), and environmental threats (particularly those related to the their possible gang- or crime-related activities). This is understandable, but the only way to overcome awkward or embarrassed feelings in talking about these issues is through practice.

Even though it may seem corny or silly, it is useful to practice these assessments and discussions first with your colleagues. Role-plays can be very useful. They help you learn how to frame the questions sensitively and articulately -- and how to get your nervous laughter and discomfort out of the way. If you truly find yourself unable to assess or discuss certain of these issues with clients, due to personal beliefs or your own history of abuse or trauma, immediately defer to a colleague who is able to conduct a thorough risk assessment.

You may wonder what will happen if consumers ask you questions about safety and medical risks that you cannot answer due to a personal lack of knowledge or experience. The best way to prepare for this is to acknowledge that it is likely to happen. This is another reason to educate yourself as much as possible about these risks, and to be sure that you have your facts straight, especially about controversial or often misunderstood issues such as TB or HIV/AIDS.

Silence and Discomfort

You may be concerned that people will be reluctant to talk about these issues, especially if it stirs up anxiety or painful memories. You are asking people to expose and discuss powerful vulnerabilities, and silence is a way of protecting oneself from the threat of exposure. You may find that consumers are:

- Scared to talk in front of others;
- Conditioned not to "break the silence" about their experiences;
- Uncomfortable or angry with your questions or exercises;
- Uncertain due to not having thought about these issues until now;
- Frustrated as though the topic is irrelevant to their lives; and in need of more time to consider what you have suggested or done.

If you are faced with a long silence try the following approaches.

- Ask the question a second time;
- Ask a different question;
- State your own opinion with which they can agree or disagree;
- Make the point you were trying to get them to make and move on to the next issue (Prothrow-Stith, 1987).

Depending upon the person, you might consider directly discussing her discomfort with the topic to see if that helps to ease the anxiety or tension. Never force anyone to discuss a sensitive topic that she is not ready to address. Many survivors of abuse cope by psychologically "blocking out" painful past events or thoughts, and you may do more harm than good by forcing them to deal with their past before they are truly ready. Certainly, if you feel that someone is putting herself at risk for certain medical illnesses, especially those that are life-threatening, you may judge it more important to discuss prevention now, and to deal with any upset feelings it may cause later. When in doubt about whether or not to address medical or safety risks with your clients, discuss it first with your supervisor or other trusted colleagues and peers.

Chapter Summary

This chapter has provided guidelines for assessing the self-perceived safety needs of consumers. It addressed in particular the often overlooked safety needs associated with trauma or abuse history. A brief overview of the prevalence and consequences of trauma and abuse was presented. Those with mental illnesses served in the public system are likely to have been physically or sexually abused at some point in their lifetimes. Recognizing and doing your best to directly address the many risks that consumers face every day are two of the best ways you will be able to help them to eventually lead more stable and productive lives in the community. Helping consumers to deal with these risks will go a long way towards improving their physical, psychiatric, and emotional well-being.

Risk Assessment Survey for ACT Clients

To begin the interview, the interviewer reads the following statement to the client:

"The following questions will help your ACT Team get a better idea of your needs and thoughts about safety in your neighborhood, the hospital, and our program. Feel free to ask us to explain any of the questions that you do not understand. Some of the questions may be hard to answer or may make you feel upset or uncertain. If this is the case, do not hesitate to talk about your feelings with your therapist, your counselor, your peers, or us at any time. It is okay if you decide that you cannot answer some of the questions, although we would like you to try your best to complete as many as possible. We will use this information to help us improve services at our program.

Everything you write on this form will be kept strictly confidential. Only the ACT team will read them, and the forms will be kept in a locked drawer at all times. If you feel more comfortable, you do not have to use names when describing your experiences in our program or elsewhere."

1. How do you define safety?
2. How do you feel when you are safe?
3. How do you define lack of safety?
4. How do you feel when you are not safe?

5. What do you usually do to feel safer when in dangerous or scary situations? Do these things help you feel better or more in control?	
6. Have you ever been the victim of a crime? *If yes, what happened?*	Yes❑ No❑
7. Do you feel safe where you are living right now? *Why or why not?*	Yes❑ No❑
8. Do you have any physical health problem or illness? *If yes, does it interfere with your daily life?*	Yes❑ No❑ Yes❑ No❑
9. Have you ever been tested for TB? *If so, do you know what the results were?* *Would you like more information on TB and the risks involved?*	Yes❑ No❑ Yes❑ No❑ Yes❑ No❑
10. Have you ever been tested for HIV? *If so, do you know what the results were?* *Would you like more information on HIV and the risks involved?*	Yes❑ No❑ Yes❑ No❑ Yes❑ No❑
11. Has anyone from our staff ever talked to you about medical and safety issues or how to protect yourself?	Yes❑ No❑
12. Have any of the other clients of this program ever talked to you about medical and safety issues or how to protect yourself?	Yes❑ No❑
13. Do you feel safe in our program? *Why or why not?*	Yes❑ No❑
14. Do any of the other clients of this program act in a way that makes you feel threatened? *How?*	Yes❑ No❑

15. Are you aware of sexual and physical abuse in psychiatric hospitals (e.g., patients being harmed by other patients or staff there)?	Yes❑ No❑
16. Has this ever happened to you? *If so, were you able to do anything?* *Would you like assistance in finding someone to help you deal with this experience?*	Yes❑ No❑ Yes❑ No❑ Yes❑ No❑
17. Have you ever participated in rape awareness training (this is for women and men)?	Yes❑ No❑
18. Have you ever been forced to have sex against your will (this happens to women and men)? Has anyone you know ever been raped? *If so, have you received counseling or support in dealing with it?*	Yes❑ No❑ Yes❑ No❑ Yes❑ No❑
19. Have you ever had assertiveness training or conflict resolution training? *If so, when?* _____ *Did it help you to feel more confident and more in control of your environment?*	Yes❑ No❑ Yes❑ No❑
20. What is the major thing you think can be done to help clients feel safer in our program?	

Chapter

13

Getting Safe, Secure, and Street Smart

Helping Others Develop and Use Personal Safety Skills

Overview: *This chapter provides a brief overview of a curriculum developed by the National Research and Training Center at the University of Illinois at Chicago to teach personal safety awareness and self-management skills to people with serious psychiatric disorders. Further, it discusses some of the ways that family care-givers can cope with threatening or dangerous behavior by a family member with mental illness.*

Studies continually indicate that individuals with mental illness are more frequently the victims, rather than the perpetrators of violence (Bell, 1994). As discussed in other parts of this manual, consumers' risk of victimization is magnified when they experience low socio-economic status, limited availability of affordable housing in "safe" neighborhoods, stigmatization, and personal vulnerability due to debilitating aspects of the illness and/or the lack of personal safety skills and awareness. As an ACT service provider, you help people

manage their personal safety concerns in a variety of ways, including service planning, direct skill teaching, modeling and coaching, and formal training. The first part of this chapter provides tools and curriculum resources to help you do this work.

When a person with mental illness does become violent, research has found that it is most frequently the individual's family members who are the direct target, as opposed to strangers, neighbors, mental health workers, and so forth (Estroff et al, 1994). While this statistic may be somewhat reassuring to some mental health workers concerned about violence directed toward them, it is *not* reassuring to family members. ACT providers should be sensitive to the needs of family members of a client with a high-risk profile and be able and willing to provide the family with information about dealing with potential dangerous situations. This becomes extremely important if the consumer is living at home with family members and when the person is financially or emotionally dependent on the family. The second part of this chapter overviews some of the ways that you can help family members to prevent and manage violence at home.

Safe, Secure and Street-Smart

With the increasing numbers of people with serious mental illness living and working in the community, and the growing recognition of the rates of trauma history and violence *against* people with psychiatric disorders, comes the awareness of how these factors affect successful community living for many people.

In 1993, the NRTC at UIC developed a fourteen-session training curriculum geared specifically for women with mental illness living in the community (Jonikas & Cook, 1993). While designed to address issues of key concern to women, such as sexual harassment and rape prevention, it provides material that is appropriate for men as well as women and for people with and without disabilities. It is intended for use in rehabilitation programs, residential programs, hospitals, clubhouses, self-help centers, and other mental health service settings. It is available for a moderate fee from the UIC NRTC by calling (312) 422-8180, ext. 10.

Although many communities have personal safety and trauma-survivor programs offered through recreation centers, YWCAs, and other agencies, many of these organizations are not prepared or willing to welcome people with serious mental illness into their groups. When these groups *are* inclusive of people with mental illness, every effort should be made to use these services before establishing or offering a program exclusively for people with mental illness.

Overview of Safe, Secure and Street-Smart Curriculum

The UIC NRTC *Safe, Secure and Street-Smart Curriculum* is comprised of fourteen, 90-minute meetings, each of which focuses on a specific issue. Presentation, discussion, role-plays, case studies, and problem-solving exercises are included in each session. The sessions include the following topics.

- Defining safety, danger, violence and their effects;
- Recognizing the effects of the media on one's understanding of safety and violence;
- The goal of independent living: personal and neighborhood safety techniques;
- Safety in mental health programs;
- Recognizing sexual harassment;
- Discouraging unwanted sexual advances or harassment;

- Rape awareness and prevention;
- Understanding and dealing with anger;
- Assertiveness.

There are benefits to addressing these issues in a group format which allows participants to share information, compare experiences, practice new skills in role plays, learn from each other, and so forth. However, the material presented in the curriculum is equally viable when discussing these issues with individual consumers and may allow you to tailor the content, pace, or specifics of the material to the exact concerns of the individuals you serve.

Assessment

Before beginning the training, it is recommended that you, as the facilitator, help participants to complete a personal and perceived needs assessment such as "Risk Assessment Survey for ACT Clients" presented in Chapter 12. Further, you may find it useful to conduct an environmental safety audit with individuals to identify specific hazards or signs of danger in their own neighborhoods. Use the following questions to get started:

- Are there parks, alleys, store fronts, deserted lots, or gang corners that are commonly known to be unsafe, especially to women?
- Where is the best lighting? Where are the dark places?
- How safe do you feel walking around this area?
- Where is the nearest "safe place" that you can go if you sense danger? Nearest telephone? Police station?
- How secure are the windows and locks in your apartment? Who else has access?
- Do you know of dangerous situations that have occurred in the surrounding area? What happened?
- How would you advise others to avoid such a situation?

Avoid answering these questions *for* people. Instead encourage individuals to notice things for themselves. Later discuss what they noticed and did not notice. Did significant risks go unnoticed?

Personal and Neighborhood Safety -- Tips and Hints

On the next few pages, some of the tips and hints discussed in the *Street-Smart* manual are provided in a handout format. If you are helping individuals on a person-by-person basis, rather than using a group training approach, you may find these especially helpful to initiate discussion. These are not exclusive lists and it is always useful to ask people to make changes or add to the list items that are relevant to them. See the curriculum for more information.

Personal Safety Tips on the Street

- Stay alert! Be aware of your surroundings at all times.
- Act like you know where you are going and what you are doing. Look confident and purposeful. Keep moving toward your destination.
- Walk in lighted and public areas. Do not take short cuts through parks or alleys.
- Carry a whistle.
- Avoid conversations with strangers. Respond to people politely, briefly and firmly.
- Don't be led into alleyways, doorways, or cars.
- If you sense someone is following you or taking "too much interest" in you, take action. Change directions, cross the street, go toward a place of greater safety such as other people, stores, traffic, and lighted areas.
- If the person continues to follow you, make eye contact and say loudly and firmly, "Leave me alone" or "Go away."
- Try to notice two or three things about the person so that if you need to tell the police or someone else what happened, you can help others identify the person. For example, physical features such as hair/beard, scars, tattoos, and so forth.
- Don't be afraid to go to the police if you continue to be frightened or are attacked. Always let the police know if you are attacked and provide them with as much information as you can about the person, where the attack happened, and so forth.
- Consider getting involved in a "neighborhood watch" where neighbors look out for each other and try to keep street crime under control.

Avoiding Purse Snatching and Pick-Pocketing

- Avoid carrying a purse, backpack, wallet, and so forth. Can you get away with putting your key, identification, and money in a front pocket or some other place on your body?
- If you must carry a bag, make sure it is kept securely closed. Put the clasp toward your body rather than away from it.
- Consider carrying your bag underneath your coat or sweater.
- Never carry more than you can afford to lose. Do not have large amounts of cash or credit cards with you, if possible.
- Avoid taking your wallet or purse out in public. For example, have the bus fare already in your pocket before you leave home or work. Don't flash what you have!
- Try not to carry lots of grocery or shopping bags. If your hands are full, you may not be able to protect yourself if necessary.

Personal Safety Tips for Public Transportation

- Stay alert! Be aware of your surroundings at all times.
- Avoid falling asleep because it makes it easier for people to steal from you.
- If you use a personal stereo, keep the volume low so you can hear what is going on around you.
- Sit close to the driver on a bus and avoid empty cars on trains.
- Know your routes ahead of time. Avoid looking confused.
- Try not to travel late at night or after dark.
- Have your fare in your pocket, not your purse or wallet.
- Keep parcels or personal items on your lap or, if necessary, on the floor between your feet.

Personal Safety Tips for at Home

- Make sure your windows and doors are locked. Some people feel safer if they are locked even when they are in the apartment.
- Lock your door when you go get the mail, do your laundry, or visit a neighbor.
- Ask your landlord for a deadbolt door lock or put one on yourself. Ask your landlord for window locks that allow you to have the windows partially raised, but will not allow an intruder to enter.
- Have your key out for your door before you get to the door. Don't stand in front of your door and fumble to find a key.
- If you have been given a ride home, ask the driver to wait until you are safely inside before leaving.
- Consider purchasing an automatic light timer to turn lights or the TV on and off, even if you are not home.
- Your landlord is legally responsible to provide adequate lighting in hallways and common areas. Tell the landlord if any lights are out.
- Never open your door to strangers. Ask for identification. If a person begins to yell or gain entry without your permission, call the police immediately.
- Have a telephone extension in your bedroom so you can call police at night if necessary. Keep emergency telephone numbers posted on or by the phone (including police, fire, doctor, ACT worker, crisis line, and so forth).
- Try to let someone know where you are at all times – a friend, a family member, a neighbor, the ACT team.

Sexual Harassment is *NEVER* OK

- Sexual harassment occurs whenever another person (male or female) makes any unwanted and purposeful or sexual touches to your body, especially to breasts, genitals, hips, buttocks.
- *This does include* any unwanted sexual touch by client or staff person. There is no reason any mental health worker should touch you in these places in the name of "treatment."
- *This does not include* being touched by a physician or nurse during a standard medical exam or for administration of medication, unless the exam becomes sexually or physically threatening.
- Sexual harassment occurs whenever another person (male or female) makes unwanted sexual advances, jokes, and references after you have asked the person to stop.
- *This includes* statements about liking or admiring your body, especially your breasts, buttocks, hips, or genitals.
- *This includes* requests to engage in sexual acts.
- *This includes* any unwanted conversations in front of you by clients, mental health workers, and others about sex with other people or sex seen in movies, books, magazines, and so forth.

If you feel you are being sexually harassed, talk to a safe person about what is going on.

Be aware that in order to file formal charges of sexual harassment, you will most likely need to demonstrate repeated instances of mistreatment. Further, you will probably need detailed documentation about every instance of harassment against you. If you have been sexually assaulted, you will likely need a medical exam, which may include both physical and gynecological examinations.

Filing formal complaints of sexual harassment is very serious for everyone involved.

Living at Home: Helping Care-Givers Cope with Violence

Many people with serious mental illness live at home with family members including parents, siblings, and/or their own children. As presented elsewhere in this manual, the incidence and severity of violent behavior among people with mental illness often is affected by factors in the physical environment and by interpersonal interactions.

Estroff and colleagues (1994) studied the influence of social networks on violence among people with psychiatric disorders and found that violence in family settings is connected to how consumers perceived their environment and other contextual factors. For example, when consumers sense hostility or feel threatened by people around them, they are more likely to both threaten violence and to act violently. Further, when consumers are financially and emotionally dependent on family networks, the risk of violence toward family members is increased. In general, mothers of adult children with schizophrenia are more frequently targets of violence than are other family members. Estroff cautions that domestic violence, substance abuse, and child sexual abuse are sadly common in many families, and that the incidence of violence within families of people with mental illness should be viewed in this broader social context.

Effects of Violence on the Family

Often families are taxed by their own problems as well as the stress of providing care and support for a family member with serious mental illness. When the family is trying to cope with financial concerns, substance use, social isolation, divorce, and other "everyday" family problems, their ability to provide the predictable and supportive environment which may be helpful to their relative with mental illness is diminished (Hyde, 1997). The greater the drain on the overall family emotional resources, the greater the vulnerability of the family to in-family violence of any kind.

In a review of the literature on how families cope with threatening, intimidating, and violent behavior by family members, Hyde (1997) found that families are better able to tolerate some behaviors than others. For example, many families seem better able to accept symptoms of psychosis (hallucinations, for example) than behavioral problems such as refusal to take baths, tantrums, deliberate destruction of property, incessant arguments, and so on. Further, while actual incidents of violence are difficult, the more subtle, implied, and repetitive threats do the greatest harm in a home environment and often lead to chronic or even catastrophic tension.

Hatfield and Lefley (1993) state that families responded to threatening, intimidating, or violent behavior by a family member with mental illness primarily through avoidance. "Parents avoiding confrontation or criticism and "walking on eggshells" was their primary response to assaultive behavior. The main coping response by families was to calm and sooth the patients, rather than to distance themselves or call the police (p. 82)." They further claim that this response is often counterproductive from a family safety perspective as it permits individuals to avoid taking responsibility for their actions.

How You Can Help Families

As an ACT worker, there are a number of things you can do to help consumers and their family members prevent and manage violence at home.

- **Provide Good Services**
  As an ACT provider, you help relieve family burden and stress by providing good and effective services for their family member. You or your team members are available and accessible 24 hours a day, 7 days a week. You are available to assist with medications, monitor changes and symptoms, respond to crisis, and help the family and the consumer resolve problems. For some families, your ability and willingness to take on financial management as a Representative Payee is a great help. (Remember, though, some families will desire to hold on to this responsibility themselves.)

- **Provide Information and Resources**
  If family members are not familiar with NAMI and other family support organizations in your area, help them to make those connections. Refer family members to the many excellent resource materials available to family members about mental illness and about caring for a person with serious psychiatric problems. Many of these materials are found in the Resources and References sections of this manual.

- **Educate Yourself and Others**
  Through this manual and other sources, become familiar with the issues surrounding mental illness and violence as well as personal safety and risk management. Be able to provide accurate information and dispel myths.

- **Take Family Violence Concerns Seriously**
  Listen to the concerns and needs of family members about violence within their homes or by their family members with serious mental illness. Recognize their concerns and/or fears for their family members. Help families distinguish between situations that are imminently dangerous and require immediate action and those that are less imminent and require ongoing management. See figures, "Managing Acute Threatening, Intimidating, or Violent (TIV) Behavior" and "Managing On-going TIV Behaviors," which provide basic principles that families may find useful.

- **Engage Families in Crisis Planning and Prevention**
  Common sense tells us that preventing violence and crisis is the best way to manage it. Earlier chapters in this manual discussed crisis planning and prevention. Whenever an individual with mental illness is actively connected with family members, encourage him or her to invite the family into discussions about crisis prevention and safety planning. Family involvement is especially critical when the consumer is living with family members. Mueser and Gingrich (1994) provide particularly useful and practical information for family care-givers about crisis management.

- **Make Sure Families Know Who to Contact in a Crisis**
  Encourage family members to get help when confronted with a threatening, intimidating, or violent situation. Sometimes fear or embarrassment will prevent family members from reaching out and getting the help they need.

  The ACT team access numbers should be readily available for family members. If you have family contact, this information should be shared directly with an invitation to the family member to contact you when necessary. If you do not have family contact, encourage the consumer to share this information directly with their family members and/or to take ACT team business cards with them whenever visiting family.

Managing Acute Threatening, Intimidating, or Violent (TIV) Behavior

These are some practical guidelines for family members when confronted with immediate danger by a family member with mental illness.

- Family members should not confront the person directly, but rather ensure their own safety by exiting the area. Property destruction is less important than personal injury.
- When possible, the family should wait until the rage dissipates.
- The family should not try to deal with the situation without first obtaining sufficient help from such sources as neighbors, relatives, crisis intervention teams, ACT team members, or the police.
- When possible, family members should remove guns, knives, and other dangerous objects from the area.

Adapted from Hyde, A, (1997). Coping with threatening, intimidating, violent behaviors of people with psychiatric disabilities living at home: Guidelines for family caregivers. Psychiatric Rehabilitation Journal, 21,2, 146-147.

Managing On-going Threatening, Intimidating or Violent (TIV) Behavior

The following are practical guidelines for family members when dealing with on-going or repetitive threats or danger by a family member with mental illness.

- Violent acts should not be ignored, denied, or excused simply because the person has mental illness.
- All forms of violence must be regarded as serious and prevented whenever possible.
- Family members, especially those present at the time of TIV behavior, must review together the sequence of events and symptoms that triggered the TIV behavior.
- Prevent relapse through quick response to early warning signs and expectations for medications.
- Use a problem solving approach to prevent little problems from triggering bigger ones.
- Don't let things "build up." Be alert to signs of stress and do what you can to minimize stress for yourself and your family members.
- Establish and maintain clear, realistic household rules.
- Limit the use of alcohol or street drugs by all family members.

Adapted from Hyde, A, (1997). Coping with threatening, intimidating, violent behaviors of people with psychiatric disabilities living at home: Guidelines for family caregivers. Psychiatric Rehabilitation Journal, 21,2, 146-147.

And

Mueser, K.T. & Gingerich, S. (1993). Coping with schizophrenia: A guide for families. *Oakland, CA: New Hargbinger Press.*

Chapter Summary

Violence is non-discriminate. Anyone can be at risk. This chapter has discussed ways that ACT providers can help others to learn about personal safety and risk management issues. ACT workers can be instrumental in teaching consumers to be more aware of the safety hazards in their environment and how to protect themselves from possible harm through common sense actions. The chapter provided an overview of a safety training curriculum developed by the UIC NRTC and designed specifically to address safety issues confronted by people with mental illness living in the community. The curriculum includes information of particular interest to women, but is relevant to all people. The information is relevant whether presented in a group or one-to-one context.

Family members, rather than strangers or mental health workers, are often the targets of violence committed by a person with mental illness. Yet families are very often alone with the fear, embarrassment, and frustration of their situation. Like mental health workers, families can increase their understanding about how their response to threatening, intimidating, and violent behavior affects the incidence and frequency of the behavior. This chapter provided some basic information that ACT providers can use to help families deal with these situations.

Chapter

14

Conclusion

This manual was written out of need. Lots of needs.

- The need of all employees to be free from workplace violence.
- The need for ACT staff to have specific tools and guidelines to ensure their personal safety when providing community outreach services.
- The need of people with mental illness to increase their capacity to self-manage situations and emotions that lead to violence, whether as a perpetrator or a victim.
- The need of managers and supervisors to have examples of proactive policy and practices to increase workplace safety and minimize risk factors.

We realize that some people who read this manual will not be satisfied. These are the people who believe that any risk is bad risk and that the only way to manage risk is to eliminate or

contain it. But the vast majority of readers will find these pages rich with ideas, guidelines, tools, and suggestions for safely managing the risk of violence in our workplaces, helping relationships, and communities.

The manual has emphasized the importance of awareness and proactive thinking. But being aware is not enough. Agencies and organizations are responsible to take reasonable steps to ensure the safety of their employees and clientele. Further, they have a civic responsibility to their communities to take reasonable precautions and actions to protect citizens from violence by clients (or employees). Appropriate policies need to be in place, staff training and resources available, and best practices identified to help guide workers in preventing and managing critical incidents. When bad things do happen, the agency must act responsibly and provide practical support to those involved.

ACT teams and team members have individual and collective responsibility to provide mental health treatment and supports that will help to protect community members from any risks to their safety that clients may pose. It also is their responsibility to try to help protect clients from any risks to their safety that the community may pose. Of course, the safety of the workers is paramount, and teams and individuals must use practices that reduce the likelihood that a worker will be exposed to or harmed by violence in their work sites. This manual has emphasized the importance of good clinical practices and crisis prevention. While ACT team members face inherent risks because of the nature and style of their service, they also have at their disposal a set of assets and resources that help to manage those risks.

Often as a result of the disorder itself, people with serious mental illness deal with a huge set of risks daily, such as lack of attention to basic needs encompassing good medical care, lifestyle issues, poverty, poor neighborhoods, stigma and alienation, and frequently, histories of trauma or abuse. Consumers as well as many family members are exposed to the violence, threats, and "walking on eggshells" tension as a result of living, working, or socializing with someone who is potentially violent. Helping individuals to recognize risk, learn personal safety skills, and increase their protective factors minimizes their risk of victimization.

No, risk cannot be eliminated from our lives. Nor should it be.

But, we can put safety first and make a commitment to ourselves, our coworkers, our organizations, our clients, and our communities to take reasonable steps to ensure that none of us are harmed physically, emotionally, or psychologically by violence in our lives.

Resources

The following is an edited list of resources on prevention and management of workplace violence. The US Department of Health and Human Services compiled many, but not all, of the resources listed here. They are contained in the HHS document, Understanding and Responding to Violence in the Workplace, (1998), which is available in booklet form from HHS in Washington, DC or online at http://www.hhs.gov.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HHS Workplace Violence Intervention and Prevention Group (Ad Hoc; Policy Oversight)

Contact: ASMB, Office of Human Resources
Telephone: (202) 690-8229

Centers For Disease Control and Prevention

National Institute for Occupational Safety & Health (NIOSH)
4676 Columbia Parkway
Cincinnati, OH 45226-1998
(800) 356-4674
NIOSH provides an array of training and training materials, including videos, and search services. The toll-free number is open from 9:00 a.m. - 4:00 p.m. EST. Upon request, information sheets can be faxed. A 3-packet guide, "Homicide in the Workplace," is also available.

National Institutes of Health

Center for Mental Health Services (CMHS)
5600 Fishers Lane, Room 7C02
Rockville, MD 20857
(301) 496-4513
In addition to other literature, CMHS publishes two free publications on depression (which has been found to be a factor in workplace violence), "What To Do If An Employee Is Depressed," and "Managing Depression in the Workplace."

National Domestic Violence Hotline

(800) 799-SAFE or (800) 787-3224 (TDD)

U.S. Public Health Service

Office on Women's Health
200 Independence Avenue, S.W. Room 730B
Washington, DC 20201
(202) 690-7650
Provides information, brochures, fact sheets, etc., on all matters related to women's health, including violence against women.

ADDITIONAL FEDERAL GOVERNMENT INFORMATION

Department of Justice

National Criminal Justice Reference Service
Bureau of Justice Assistance Clearinghouse (BJAC)
(800) 688-4252
BJAC has available to the public a catalog of National Institute of Justice documents. Many of the documents included in the catalog pertain to workplace violence.

Department of Labor (DOL)

Occupational, Safety and Health Administration
200 Constitution Avenue, N.W. Room N3107
Washington, DC 20210
Publications: (202) 219-4667
General information: (202) 219-8031
DOL publishes a free pamphlet, "Workplace Violence," available through the publications telephone number.

OTHER ORGANIZATIONS ASSISTING WITH WORKPLACE VIOLENCE

American Psychiatric Association (APA)

Division of Public Affairs
1400 K Street, N.W.
Washington, DC 20005
(202) 682-6000
The APA publishes a free pamphlet, "Violence and Mental Health."

American Psychological Association (APA)

1200 17th Street, N.W.
Washington, DC 20036
(202) 955-7600
For book/pamphlet orders: (800) 374-2721
An APA publication, "The Psychology of Violence," is available free through their toll-free number.

Crime Victims Research and Treatment Center

Medical University of South Carolina
Charleston, SC 29425
(803) 792-2945
The Center provides information about sexual harassment in the workplace.

Harvard University
School of Public Health
Violence Prevention Program
677 Huntington Avenue
Cambridge, MA 02115
(617) 432-0814
This program offers information about violence, including the prevention of violence, and program evaluation.

National Crime Prevention Council
1700 K Street, N.W., Suite 618
Washington, DC 20006
(202) 466-6272
NCPC publishes, "Taking a Stand," a kit on the prevention of crime and violence. There is a charge. Workplace, home, and community concerns are addressed.

University of Illinois at Chicago
National Research and Training Center on Psychiatric Disability
Department of Psychiatry
104 S. Michigan Ave
Chicago, IL 60603-5901
(312) 422-8180
The UIC NRTC publishes a variety of materials relevant to personal safety and conflict resolution for mental health workers and consumers, including: "Safe, Secure, and Street Smart: Empowering Women with Mental Illness to Achieve Greater Independence in the Community," and "Managing Workplace Conflict: A Skills Training Workbook for Mental Health Consumers and Supervisors."

Workplace Violence Research Institute
160 Newport Center Drive, Suite 210
Newport Beach, CA 92660-6910
(714) 720-0854
(800) 230-7302
WVPI publishes a good selection of materials on workplace violence, including training materials, posters, and so forth.

NON-VIOLENT CRISIS INTERVENTION TRAINING RESOURCES

This list does not represent an endorsement of any organization or curriculum, but is a limited sampling of available resources. Listed alphabetically:

CECP
http:/www.air-dc.org/cecp
Provides training on Life-Space Crisis Intervention designed specifically for classroom and educational settings.

Crisis Prevention Institute, Inc. (CPI)

3315-K North 124th Street
Brookfield, WI 53005
(800)558-8976
info@crisisprevention.com
http://www.crisisprevention.com
The Crisis Prevention Institute provides a range of training and resources on violence prevention and nonviolent crisis interventions. Books, videos, posters, and training resources available.

Edgework

http://www.enso-company.com/
Eamdur@halcyon.com
Offers advanced crisis negotiation training (including hostage negotiation) and training in communication with aggressive individuals with mental illness.

International Critical Incident Stress Foundation

5018 Dorsey Hall Drive, Suite 104
Ellicott City, MD 21042
(410) 730-4311
The Foundation provides training on stress reduction and literature on the prevention of workplace violence. They also certify practitioners of Critical Incident Stress Debriefing.

NAPPI

PO Box 473
Auburn, ME 04212
(800)358-6277
nappi@gwi.net
http://www.nappi-training.com
NAPPI offers hands-on skills training in crisis assessment, intervention, defusion, as well as restraint and physical intervention.

Response Training Programs

Shutesbury, MA 01072
(413)367-2485
info@ResponseTraining.com
http://www.responsetrainings.com
Offers training in crisis intervention for agencies working with children, adolescents, and adults. Website offers interactive forum for crisis interventions.

Therapeutic Crisis Intervention

Family Life Development Center
Cornell University
Ithaca, NY 14853
(607) 255-5440
http://child.cornell.edu/fldc.home.html
Offers training and training-of-trainers in Therapeutic Crisis Intervention, which they developed. Provides comprehensive training in crisis prevention including physical restraint.

COMPUTER SYSTEM

PAVNET

Accessible through the Internet, PAVNET is a clearing house with over 500 entries on violence. Information in PAVNET includes: funding grants, research projects, grass-roots efforts to address violence, and curriculum development. Government and non-government organizations addressing the subject of violence are listed.

LOCAL RESOURCES (COMPLETE THIS AT LOCAL LEVEL)

Local police:_____

(As a community service, many police precincts have police volunteers who will give talks on violence and crime to businesses and communities.)

Fire department:_____

Building security:_____

Chamber of commerce:_____

Others:_____

National Domestic Violence Hotline: 800-799-SAFE (7233) or 800-787-3224 (TDD)

Contributing Authors

Contact Information and Biographical Sketches

Deborah Allness, M.S.S.W.

7224 Elmwood (home address)
Middleton, WI 53562
Telephone: (608) 836-7774 home
(608) 263-4812 work

Deborah Allness, M.S.S.W., has been involved in the development, research, and dissemination of the Program of Assertive Community Treatment (PACT) model since 1973. She was a clinical social worker and associate director of PACT, Mendota Mental Health Institute, Madison, Wisconsin, from 1973-1986. As Director of the Wisconsin Office of Mental Health from 1986-1990, she was responsible for the promulgation of the Community Support Program (CSP) Standards and the reimbursement of these programs under Medicaid. She is Co-Principal Investigator of the second PACT study, Long Term Treatment of Young Adults with Schizophrenia Study, with William Knoedler, Co-Principal Investigator, and Mary Ann Test, Principal Investigator. Deborah Allness is currently lecturer in the area of severe mental illness at the University of Wisconsin-Madison School of Social Work and does consultation and training on the PACT model in a number of states and Canada.

Judith Cook, Ph.D.

Mental Health Services Research Program
Department of Psychiatry
104 S. Michigan Ave.
Chicago, IL 60603-5901
(312) 422-8180

Judith A. Cook is Professor of Sociology in Psychiatry at the University of Illinois at Chicago (UIC), Department of Psychiatry. Currently, she directs the Mental Health

Services Research Program (MHSRP) which houses three federally and state funded centers, and a number of research and evaluation studies: (1) The UIC National Research and Training Center on Psychiatric Disability; (2) The UIC Coordinating Center for the Employment Intervention Demonstration Program; (3) A SAMSHA Coordinating Center that directs a study of the effects of managed care on utilization, outcomes, and costs of children's mental health services; (4) The evaluation of the Illinois site of the national ACCESS program, studying outcomes of homeless mental health consumers; and (5)An Assertive Community Treatment (ACT) Training Institute that educates all Illinois providers of this community-based service delivery model.

Her published research includes studies of vocational rehabilitation, transition-aged youth with mental disorders, psychosocial rehabilitation outcomes, educational services for persons with mental illness, gender issues in psychiatric disability, and coping strategies of parents of adult offspring with severe mental illness.

Catherine Costello Bennett, M.A.

Prevention Unlimited
3232 Cobb Parkway, Suite 508
Atlanta, GA 30080
Telephone: (770) 435-8536
email: PreventOne@AOL.com

Catherine Bennett is an expert in Violence Prevention, and has been speaking on this topic since 1991. Catherine is a health educator and personal safety consultant. As a consultant in personal safety skills, Catherine has developed and presented Conflict Management, Violence Prevention, and Self-Defense training for a wide variety of public and private sector groups.

Catherine has over eleven years of experience in the self-defense field. Catherine's approach to personal safety is comprehensive, enthusiastic, practical, and ethical. Mrs. Bennett received her master's degree in Education from Lynchburg College in 1985. Her undergraduate degree is in Physical Education from Michigan State University, in 1983.

Jessica Jonikas, M.A.

Mental Health Services Research Program
Department of Psychiatry
104 S. Michigan Ave.
Chicago, IL 60603-5901
(312) 422-8180

Jessica A Jonikas, M.A. is the Managing Director of the UIC National Research and Training Center on Psychiatric Disability. She also serves as Principal Investigator on two federally-funded research projects; one a national needs assessment survey of women with mental illness, the other a crisis reduction project in a local psychiatric hospital.

For ten years she served as the Director of Dissemination and Training for the NRTC and oversaw the design, development, evaluation, and dissemination of all Center educational products. She also co-authored a number of nationally recognized educational manuals and curricula, and has provided national training and technical assistance on a wide variety of topics in community mental health services and support.

Terri Horton-O'Connell, M.S.W.

Mental Health Services Research Program
Statewide Assertive Community Treatment Training Institute
Department of Psychiatry
104 S. Michigan Ave.
Chicago, IL 60603-5901
(312) 422-8180

Terri Horton-O'Connell, M.S.W., L.S.W., is the program coordinator for the UIC Statewide Assertive Community Treatment (ACT) Training Institute. She is responsible for implementing and evaluating three distinct training components: 1) over forty hours of didactic classroom training; 2) one-on-one mentorship training; and 3) the provision of practica training for ACT providers throughout the State of Illinois. Ms. Horton-O'Connell also develops and organizes refresher as well as specialized trainings in relevant and emerging topical areas. Recently, she was involved in coordinating a safety training addressing risk factors associated with providing services within the ACT model.

Ms. Horton-O'Connell also has an extensive direct service background in the mental health field and was employed as a Community Services Manager at the Mental Health Association in Illinois, a statewide advocacy organization designed to improve treatment for persons with severe and persistent mental illnesses, before joining the Department of Psychiatry.

Sharon Pratt, M.A.

183 County Rd. 550
Marquette, MI 49855
Telephone: (906)

Sharon C. Pratt, MA, CSW, has worked at Family & Children Services, Inc. in Kalamazoo, Michigan for the past 24 years. For the past 15 years she has been the

Program Director of Home-Community Intervention Services (HCI). In that capacity, her main responsibilities have been to develop, oversee, and guide three intensive, in-home family treatment programs with a staff of approximately 32. HCI services are offered to multi-need, high-risk families with substantiated abuse/neglect or serious mental health issues and who are at risk of being separated. All HCI services are provided in the home or in the community and are available 24 hours a day, 7 days a week. Prior to becoming an administrator, Ms. Pratt was a clinician, both as an outpatient therapist and as an in-home treatment worker.

Since 1993, Sharon has been the chairperson of her agency's Safety Committee as well as the coordinator of Family & Children Services Work Place Violence Prevention Project. The work of the Committee has given Family & Children Services practical ways to address the issues surrounding worker risk and safety. Additionally, the Safety Committee has freely made available their work to other agencies and has provided training to a number of different organizations. In her role as chairperson of the Safety Committee, Sharon has struggled with and learned well the important elements of risk management both at the worker level and at an organizational level.

Ed Stellon, M.A.

Program Administrator
Chicago Health Outreach/ACCESS
4750 N. Sheridan, Suite 500
Chicago, IL 60640
Telephone: (773) 561-9566

Edward Stellon, M.A., C.A.D.C., is Clinical Administrator of the Chicago Health Outreach (CHO) ACCESS program. CHO ACCESS utilizes an ACT model of service delivery to provide outreach and comprehensive care management for individuals who are homeless and have a serious mental illness. Ed became the program's Clinical Administrator in 1995, and helped CHO ACCESS implement the ACT model of service delivery.

Prior to his position as Clinical Administrator, Ed served as Coordinator of Substance Abuse Services at CHO where he provided recovery support services to homeless adults in shelter sites throughout the city of Chicago. He has been working with homeless adults for eight years.

References

Allness, D.J., & Knoedler, W.H. (1998). The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up. Arlington, Virginia: Program of Assertive Community Treatment, Inc.

American Psychological Association (APA) (1996). APA Presidential Task Force on Violence and the Family Report. Washington, DC.

American Psychiatric Association (APA) (9 January 1996). Violence and Mental Illness. Washington, DC: American Psychiatric Association Online Public Information. Available: http://www.psych.org/public_info/violen~1.htm (25 June 1999).

American Psychiatric Association (APA), Statement on Prediction of Dangerousness, March 18, 1983, Washington, DC: Author.

American Psychiatric Press (1994). American Psychiatric Glossary. Washington, DC: Author.

Asch, S., Leake, B., Knowles, L., & Gelberg, L. (1998). Tuberculosis in homeless patients: Potential for case finding in public emergency departments. Annals of Emergency Medicine, 32(3), 144-147.

Austin, K.M., Molie, M.E., & Williams, G.T. (1990). Confronting Malpractice: Legal and Ethical Dilemmas in Psychotherapy. Newbury Park, CA: Sage Publications.

Bass, E. & Davis, L. (1992). The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse. New York, NY: Harper Perennial.

Bassuk, E.L., Weinreb, L.F., Buckner, J.C. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. Journal of the American Medical Association, 276(8), 640-646.

Begley, D. (1994) Managing problematic behaviors. In Surber, R.W., Clinical Case Management: A Guide to Comprehensive Treatment of Serious Mental Illness. Thousand Oaks, CA: Sage Publications.

Bell, C.C. (1994). Violent behavior and mental illness: Perspectives on papers in this issue. Hospital and Community Psychiatry, 45, 7, 711-713.

Berren, M., Hill, K., Merikle, E., Gonzalez, N., Santiago, J. (1994). Serious mental illness and mortality rates. Hospital and Community Psychiatry, 45(6), 604-605.

Bittenbinder, J.J. (1997). Tough Target: *The Street-Smart Guide to Staying Safe*. Philadelphia, PA: Running Press.

Breakey, W.R., Fischer, P.J., Kramer, M. (1989). Health and mental health problems of homeless men and women in Baltimore. Journal of the American Medical Association, 262(10), 1352-1357.

Briere, J & Zaidi, L.V. (1991). The long-term effects of sexual abuse: A review and synthesis. New Directions for Mental Health Services, 51, 3-13.

Browne, A. (1993). Family violence and homelessness: The relevance of trauma histories in the lives of homeless women. American Journal of Orthopsychiatry, 63(3), 370-384.

Bureau of Labor Statistics (BLS) (1995). National census of fatal occupational injuries, 1994. BLS News, USDL, 95, 288. Washington, DC: U.S. Department of Labor.

Carmen, E., Rieker, P.P., Mills, T. (1984). Victims of violence and psychiatric illness. American Journal of Psychiatry, 141(3), 378-383.

Centers for Disease Control (19xx). Deaths among homeless persons, San Francisco. Journal of the American Medical Association, 267, 484-485.

Chavez, L. (15 May 1999). Organizational Factors Contributing to Workplace Violence. Critical Incident Associates. Available: http://members.aol.com/endwpv/eworg.html. (3 July 1999).

Clarke, P.N., Williams, C.A., Percy, M.A., & Kim, Y.S. (1995). Health and life problems of homeless men and women in the southeast. Journal of Community Health Nursing, 12(2), 101-110.

Connors, R. (1996). Self-injury in trauma survivors: Functions and meanings. American Journal of Orthopsychiatry, 66(2), 197-206.

Cook, J.A. & Jonikas, J.A. (1992). "Focus group on the needs and views of women mental health consumers on Chicago's northside." Unpublished report. Chicago, IL: Thresholds National Research and Training Center on Rehabilitation and Mental Illness.

Cook, J.A., Razzano, L., Jayaraj, A. (1994). HIV-risk assessment for psychiatric rehabilitation clientele: Implications for community-based services. Psychosocial Rehabilitation Journal, 17(4), 105-115.

Copeland, M.E. (1997). Wellness Recovery Action Plan (WRAP). Brattleboro, VT: Peach Press.

Corey, G., Corey, M.S., Callanan, P. (1993). Issues and Ethics in the Helping Professions (4th edition.) Pacific Grove, CA: Brooks/Cole Publishing

Cournos, F., & Bakalar, N. (Eds.) (1996). AIDS and people with severe mental illness. New Haven, CT: Yale University Press.

Craine, L.S., Henson, C.E., Colliver, J.A., & MacLean, D.G. (1988). Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system. Hospital & Community Psychiatry, 39(3), 300-304.

Curtis, L.C. (1990). When Bad Things Happen. Training curriculum. Burlington, VT: Trinity College of Vermont, Center for Community Change through Housing and Support.

Curtis, L.C. (1993). Crisis prevention — the cornerstone of crisis response. Community, Innovations in Housing and Support for People with Psychiatric Disabilities. Burlington, VT: Trinity College of Vermont, Center for Community Change through Housing and Support .

Curtis, L.C. & Hodge, M. (1995). Ethics and boundaries in community support services: Raising a dialogue. In, Stein, L. and Hollingsworth, E.J. (Eds.) New Directions in Mental Health Series, No 66, 43-60. San Francisco: Jossey-Bass.

Curtis, L.C. (1996). Basic ethical guidelines for community support services. Burlington, VT: Trinity College of Vermont, Center for Community Change through Housing and Support. Available: http://www.ccc-international.org (30 June, 1999).

Curtis, L.C. & Diamond, R. (1997). Power & coercion in mental health services. In Blackwell, B. (Ed.) Treatment Compliance and the Therapeutic Alliance. Toronto, Canada: Harwood Academic Publishers. P. 97-122.

Curtis, L.C. (1999). Managing Workplace Conflict in Psychiatric Inpatient Settings. Training curriculum designed for the Connecticut Department of Mental Health and Substance Abuse Services, Education and Training Division. Burlington, VT: Trinity College of Vermont, Center for Community Change through Housing and Support.

Denenberg, T.S., Denenberg, R.V., Braverman, M., Braverman, S. (1996). Dispute resolution and workplace violence. Dispute Resolution Journal, January-March. Available online from Workplace Solutions Publications. http://www.wps.org/puts/dispute-resolution (30 March 1999).

Den Herder, D. & Redner, L. (1991). The treatment of childhood sexual trauma in chronically mentally ill adults. Social Work, 50-57.

D'Ercole, A. & Struening, E. (1990). Victimization among homeless women: Implications for service delivery. Journal of Consulting Psychology, 18, 141-152.

Dvoskin, J.A. & Steadman, H.J. (1994). Using intensive case management to reduce violence by mentally ill persons in the community. Hospital and Community Psychiatry, 45(7), 679-684.

Engstrom, K., Brooks, E., Jonikas, J., Cook, J., & Witheridge, T. (1991). Creating Community Linkages: A guide to Assertive Outreach for Homeless Persons with Severe Mental Illness. Chicago, Illinois: National Research and Training Center.

Estroff, S., Zimmer, C., Lachiocotte, W., Benoit, J. (1994). The influence of social networks and social support on violence by persons with serious mental illness. Hospital and Community Psychiatry, 45(7), 669-679.

Flynn, L.M. (1998a). The Russell Weston Tragedy is the Tragic Story of Schizophrenia in America . Arlington, Virginia: National Alliance for the Mentally Ill, NAMI Press Room, July 2, 1998.

Flynn, L.M. (1998b). Psychiatric News. Available: http://www.psych.org.

Gelberg, L. (1997). Homelessness and health. The Journal of the American Board of Family Practice, 10(1), 67-71.

Gelberg, L. (1993). Conducting research on the health of homeless persons. In M.J. Bass, E.V. Dunn, P.G. Norton, & S.M. Tudiver (eds.), Conducting research in the practice setting (pp.197-209). Newbury Park, CA: Sage.

Gelberg, L. & Linn, L. (1992). Demographic differences in health status of homeless adults. Journal of General Internal Medicine, 7, 601-608.

Gelberg, L. & Linn, L. (1989). Assessing the physical health of homeless adults. Journal of the American Medical Association, 262(14), 1973-1979.

Gelles, R.J. & Loseke, D.R. (Ed.) (1993). Current controversies on family violence. Newbury Park, CA: Sage Publications.

Gilbert, B.J. (1994). Treatment of adult victims of rape. Assessing and treating victims of violence, New Directions for Mental Health Services, 64, 67-77.

Goodman, L.A., Dutton, M.A. & Harris, M. (1997). The relationship between dimensions of violent victimization and symptom severity among episodically homeless, mentally ill women. Journal of Traumatic Stress, 10(1), 51-70.

Goodman, L.A., Dutton, M.A., & Harris, M. (1995). Physical and sexual assault prevalence among episodically homeless women with serious mental illness. American Journal of Orthopsychiatry, 65(4), 468-478.

Graf, M.H. (1990). Money management: A continuum of services. The Money Management Task Force. Milwaukee, WI.

Grose, V. (1994), Managing Risk: Systematic Loss Prevention for Executives, Arlington, VA: Omega Systems Group. Cited in Prior Report, 10 (5a)

Grunwalk, M., & Boodman, S.G. (1998, July 28). Weston case 'fell through the cracks'. The Washington Post.

Harris, M. (1994). Modifications in service delivery and clinical treatment for women diagnosed with severe mental illness who are also the survivors of sexual abuse trauma. The Journal of Mental Health Administration, 21(4), 397-406.

Hatfield, A.B. and Lefley, H.P. (1993). Surviving Mental Illness: Stress, Coping, and Adaptation. New York: The Guildford Press.

Haviland, W.A. (1990). Cultural Anthropology. Texas.

Human Resource Association of the Northeast (1995). Dare to Vision: Shaping the National Agenda for Women, Abuse and Mental Health Services. Holyoke, MA.

Hibbs, J.R., Benner, L., Klugman, L. (1994). Mortality in a cohort of homeless adults in Philadelphia. New England Journal of Medicine, 331, 304-309.

Hiday, V.A., Swartz, M.S., Swanson, J.W. (1999). Criminal victimization of persons with severe mental illness. Psychiatric Services, 50(1), 62-68.

Hutchinson, D.S. (1996). Promoting wellness in rehabilitation and recovery -- A call to action. Community Support Network News, 11(2), 1-3.

Hwang, S.W., Orav, J.E., O'Connell, J.J. (1997). Causes of death in homeless adults in Boston. Annals of Internal Medicine, 126(8), 625-628.

Hyde, A. (1997). Coping with the threatening, intimidating, violent behaviors of people with psychiatric disabilities living at home: guidelines for family caregivers. Psychiatric Rehabilitation Journal, 21 (2), 144-149.

Illinois State Police (1999). Available: httpl//www.state.ilus/ ISP/viowkplc/ vwpp4.htm

Jacobson, A. & Herald, C. (1990). The relevance of childhood sexual abuse to adult psychiatric inpatient care. Hospital & Community Psychiatry, 41, 154-158.

Javorek (1983). Unpublished materials from the Denver hospital crime prevention unit. Denver, CO.

Jennings, A. (1994). On being invisible in the mental health system. The Journal of Mental Health Administration, 21(4), 374-387.

Jonikas, J.A., Bamberger, E., & Laris, A. (1998). Having Our Say: Women Mental Health Consumers/Survivors Identify their Strengths and Needs. Chicago, IL: UIC National Research and Training Center.

Jonikas, J.A. & Cook, J.A. (1994). Safe, Secure, and Streetsmart: Empowering Women with Mental Illness to Achieve Greater Independence in the Community. Chicago, IL: University of Illinois at Chicago National Research and Training Center on Psychiatric Disability.

Kaplan, S.G. & Wheeler, E.G. (1983). Survival skills for working with potentially violent clients. Social Casework: The Journal of Contemporary Social Work, June, 339-346.

Kaufer, S. & Mattman, J.W. (1997). When Tragedy Strikes at Work: A Supervisor's Guide to Handling Traumatic Incidents. Laguna Beach, CA: Workplace Violence Research Institute.

Kelly, J.A., Murphy, D.A., Bahr, G.R. (1992). AIDS/HIV risk behavior among the chronic mentally ill. American Journal of Psychiatry, 149(7), 886-889.

Kettl, P., Siberski, J., Hischmann, C., & Wood, B. (1993). Sexual harassment of health care students by patients. Journal of Psychosocial Nursing, 31(7), 11-13.

Koran, L.M., Sox, H.C., Morton, K.I. (1989). Medical evaluation of psychiatric patients. Archives of General Psychiatry, 36, 114-117.

Krakowski, M., & Czobor P. (1994). Clinical symptoms, neurological impairment, and predication of violence in psychiatric patients. Hospital and Community Psychiatry, 45 (7).

Leff, H.S. (1996). Mortality rates for mental health clients drop in Massachusetts, but early deaths cause concern. Psychiatric Services, 47(3), 319.

Lehman, A.F. & Linn, L.S. (1984). Crimes against discharged mental patients in board-and-care homes. American Journal of Psychiatry, 141(2), 271-274.

Lidz, C., Mulvey, E., & Gardner, W. (1993). The accuracy of predictions of violence to others. Journal of the American Medical Association, 269, 1007-1010.

Link, B.G., and Stueve, A. (1995). Evidence bearing on mental illness as a possible cause of violent behaviour. Epidemiologic Reviews, 17(1), 172-181.

Maiuro, R.D., Vitalino, PP., Cahn, T.S. (1987). A brief measure for assessment of anger and aggression. Journal of Interpersonal Violence, 2, 166-178.

Mathias, R.L., & Jackson, J.H. (1985). Personnel Human Resources Management (4th ed.) (pp. 469-505). St. Paul, MN: West Publishing Company.

McAdam, J.M., Brickner, P.W., Scharer, L.L. (1990). Tuberculosis in the homeless: A national perspective. In Brickner, P.W., et al. (eds.), Under the Safety Net: The Health and Social Welfare of the Homeless in the United States (pp. 234-249). New York, NY: Norton & Co.

McKenzie, K.C., Burns, R.B., McCarthy, E.P., & Freund, K.M. (1998). Prevalence of domestic violence in an inpatient female population. Journal of General Internal Medicine, 13(4), 277-279.

McNiel, D.E. & Binder, R.L. (1994). The relationship between acute psychiatric symptoms, diagnosis and short-term risk of violence. Hospital and Community Psychiatry, 45 (2), 133-137.

Mead, S. (1998). Crisis Respite Interview. Stepping Stone Crisis Respite Training Manual. Claremont, NH: Stepping Stone.

Mehrabian, A. (1998). Pesonality Test: The Risk of Eruptive Violence Scale (REV). Availble: http://ablecom.net/users/kaaj/psych/scales/vio.html. (3 July, 1999).

Meyer, R.G., Landis, E.R., and Hays,J.R. (1998). Law for the Psychotherapist. New York: Norton.

Monahan, J. (1996, October). Mental Illness and Violent Crime: Summary of a presentation for University of Virginia Law School for US Department of Justice, Office of Justice Programs, National Institute of Justice. Available: http://www.ncjrs.org/txtfiles/mentilln.txt (21 May, 1999).

Monahan, J. & Steadman, H. (eds.) (1994). Violence and Mental Disorder: Developments in Risk Assessment. Chicago: University of Chicago Press.

Mowbray, C.T. & Chamberlin, P.C. (1986). Sex differences among the long-term mentally disabled. Psychology of Women Quarterly, 10(10), 383-391.

Muenzenmaier, K., Meyer, I., Struening, E. & Ferber, J. (1993). Childhood abuse and neglect among women outpatients with chronic mental illness. Hospital & Community Psychiatry, 44(7), 666-670.

Mueser, K.T. & Gingerich, S. (1994). Coping with Schizophrenia: A Guide for Families. Oakland, CA: New Harbinger Press.

Mulvey, E. (1994). Assessing the evidence of a link between mental illness and violence, Hospital and Community Psychiatry, 45 (2), 663-668.

Murphy, P. (1993). Making the Connections: Women, Work, Disability, and Abuse. Orlando, FL: Paul M. Deutsch Press, Inc.

National Crisis Prevention Institute (CPI) (1987a). 10 Tips for crisis prevention. Quick Reference Prevention Series #1. Brookfield, WI.

National Crisis Prevention Institute (CPI) (1987b). Nonviolent Crisis Intervention Participant Workbook. Brookfield, WI.

National Crisis Prevention Institute (CPI) (1992). The art of setting limits: A five-step approach to setting effective limits. Quick Reference Prevention Series #2. Brookfield, WI.

National Crisis Prevention Institute (CPI) (1994). Principles for effective verbal intervention. Quick reference prevention series #7. Brookfield, WI.

National Institute for Occupational Safety and Health (NIOSH) (16 July 1996). Violence in the Workplace. Morgantown, WV: US Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Institute for Occupational Safety and Health. Available: http://www.cdc.gov niosh/violabst.html (6 May 1999).

Nelson, J.M. (1996). Personal Safety Skills Training Program Instructors Manual , Safe Sense Inc., Lansing, MI.

Nelson, J.M. (1991). Self-Defense: Steps to Success. Champaign, IL: Human Kinetics.

New Zealand Ministry of Health and Health Funding Authority (1998). Guidelines for Clinical Risk Assessment and Management in Mental Health Services. Wellington, NZ.

North, C.S., Thompson, S.J., Smith, E.M., & Kyburz, L.M. (1996). Violence in the lives of homeless mothers in a substance abuse treatment program: A descriptive study. Journal of Interpersonal Violence, 11(2), 234-249.

O'Brien, J., O'Brien, C.L., & Schartz, D.B. (1990). What can we Count on to Make and Keep People Safe? Lithonia, GA: Responsive Systems Associates.

O'Rear, G., Bark, L., & Hutchinson, D.S. (1996). The promotion of wellness among people with psychiatric disabilities in community rehabilitation and treatment. Psychiatric Rehabilitation Journal, 20(2), 82-84.

Padgett, D.K., Struening, E.L., Andrews, H., & Pittman, J. (1995). Predictors of emergency room use by homeless adults in New York city: The influence of predisposing, enabling, and need factors. Social Science Medicine, 41(4), 547-556.

Pense, K. (1999). Personal communication. Metro Nashville Police Department. Nashville, TN.

Plutchik, R. & van Praag, H.M. (1990). A self-report measure of violence risk, II. Comprehensive Psychiatry, 31, 450-456.

Post, R.D., Willett, A.B., Franks, R.D. (1980). A preliminary report on the prevalence of domestic violence among psychiatric inpatients. American Journal of Psychiatry, 137(8), 974-975.

Prothrow-Smith, D. (1987). Violence Prevention: Curriculum for Adolescents, Teenage Health Teaching Modules. Newton, MA: Education Development Center (EDC), Inc.

Raudenbush, D.J. & Wilson, K. (1994). Adults with a Multiple Personality Disorder: Implications for Employment. Presentation at the Annual Conference of the International Association of Psychosocial Rehabilitation Services, Albuquerque, NM.

Razzano, L. & Cook, J.A. (1998). The changing face of HIV/AIDS: What consumers and providers ought to know. Community Support Network News, 12(3), 1-3.

Reamer, F. (1990). Ethical Dilemmas in Social Service: A Guide for Social Workers (2nd ed). New York: Columbia University Press University Press.

Reamer, F. (1994). Social Work Malpractice and Liability. New York: Columbia University Press, pp. 25-66.

Reamer, F. (1995). Ethical dilemmas in direct practice. In Social Work Values and Ethics. New York: Columbia University Press.

Robrecht, L.C. & Anderson, D.G. (1998). Interpersonal violence and the pregnant homeless woman. Journal of Obstetric, Gynecologic, & Neonatal Nursing, 27(6), 684-691.

Rose, S. (1991). Acknowledging abuse backgrounds of intensive case management clients. Community Mental Health Journal, 27(4), 255-263.

Rose S.M., Peabody, C.G., & Stratigeas, B. (1991). Undetected abuse among intensive case management clients. Hospital and Community Psychiatry, 42(5), 499-503.

Rosenberg, S.D., Drake, R.E. & Mueser, K. (1996). New directions for treatment research on sequelae of sexual abuse in persons with severe mental illness. Community Mental Health Journal, 32(4), 387-400.

St. Lawrence, J.S. & Brasfield, T.L. (1995). HIV risk behavior among homeless adults. AIDS Education & Prevention, 7(1), 22-31.

Shore, S.E. & Curtis, L.C. (1998). Managing Workplace Conflict: A Skills Training Workbook for Mental Health Consumers and Supervisors. Chicago, IL: UIC National Research & Training Center.

Shulman, L. (1993). Helping staff cope with trauma. In Interactional Supervison. Washington, DC: NASW Press.

Stein, J.A. & Gelberg, L. (1997). Comparability and representativeness of clinical homeless, community homeless, and domiciled clinic samples: Physical and mental health, substance use, and health services utilization. Health Psychology, 16(2), 155-162.

Steadman, H.J., Mulvey,E.P., Monahan, J., Robbins, P.C., Appelbaum, P.S., Grisso, T., Roth, L.H., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry, 55(5), 393-401.

Sundarm, C.J. (1994). Choice and Responsibility: Legal and Ethical Dilemmas in Services for Persons with Mental Disabilities. Albany, NY: New York State Commission on Quality Care for the Mentally Disabled.

Susser, R., Miller, M., Valencia, E. (1993). Injection drug use and risk of HIV transmission among homeless men with mental illness. American Journal of Psychiatry, 153(6), 794-798.

Swanson, J.W., Holzer, C.E., Ganju, V.K., and Jono, R.T. (1990). Violence and psychiatric disorder in the community: evidence from the epidemiological catchment area surveys. Hospital and Community Psychiatry , 41 (7), 761-770.

Swartz, M.S., Swanson, J.W., Hiday, V.A., Borum, R., Wagner, H.R., and Burns, B. (1998). Violence and severe mental illness: The effects of substance abuse and nonadherence to medication, American Journal of Psychiatry, 155(2), 226-231.

Tardiff, K. (1984). Characteristics of assaultive patients in private hospitals. American Journal of Psychiatry, 141, 1232-1235.

Tarasoff v. Board of Regents of the University of California, 551 P.2d 334 (1976).

Tessler, R.C. & Dennis, D.L. (1989). A Synthesis of NIMH Funded Research Concerning Persons who are Homeless and Mentally Ill. Amherst, MA: Social and Demographic Research Institute, University of Massachusetts; and Delmar, NY: Policy Research Associates.

Test, M.A., & Stein, L.I. (1976). Practical guidelines for the community treatment of markedly impaired patients. Community Mental Health Journal, 12(1), 72-82.

Torrey, E.F. (1994). Violent behavior by individuals with serious mental illness. Hospital and Community Psychiatry, 45 (7), 653-662.

Torrey, E.F. (1997). Out of the Shadows: Confronting America's Mental Illness Crisis. John Wiley & Sons, Inc., 43-60.

United States Department of Agriculture (USDA) (4 January 1998). The USDA Handbook on Workplace Violence Prevention and Response. Washington, DC. Available: http://www.usda.gov/news/pubs/violence/wpv.htm (3 July 1999).

United States Department of Agriculture, Safety and Health Management Division (December 1996). A Manager's Handbook Handling Traumatic Events. Washington, DC: United States Office of Personnel Management, Human Resources Systems Service. Available: http://www.usda.gov/da/shmd/wkviol.htm. (2 July 1999).

United States Department of Health and Human Services (HHS) (21 May 1999) Understanding and Responding to Workplace Violence: HHS Guidelines. Available: http://www.hhs.gov/progorg/ohr/eap/eap7vilg.htm (3 July 1999).

United States Department of Labor Occupational Safety and Health Administration (OSHA) (1996). Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers (OSHA 3148). Washington, DC: U.S. Government Printing Office.

United States Equal Employment Opportunity Commission (January 1997). Facts About Sexual Harassment. Available: http://www.eeoc.gov/ (3 July 1999).

University of Illinois at Chicago (1998). Sexual Harassment: Policy and Procedures. Chicago, IL: UIC Office for Access and Equity.

University of Illinois at Chicago, National Research and Training Center (1997). Employee Information & Policy Manual. Chicago, IL.

Van der Kolk, B. (1999). Abuse: A predictor for suicide, drugs, HIV. OMH Quarterly, 4, (4), 8-9.

Van Fleet, F.M. (1992). Debriefing and the critical incident. EAP Digest, March/April, 28-33.

Walker, L.E. (1999). Psychology and domestic violence around the world. American Psychologist, 54(1), 21-29.

State of Washington Department of Labor and Industry (WDLI) (August 1998). Workplace Violence: Awareness and Prevention for Employers and Employees. Olympia, WA: Washington State Department of Labor and Industries, WISHA Services Division. Available: http://www.wa.gov/Ini/pa/workvil.htm (15 May 1999).

Wolf, A. (1994). Helping the employee recovery from the trauma of workplace violence. EAP Digest. March/April. Cited in United States Department of Health and Human Services (HHS) (21 May 1999). Understanding and Responding to Workplace Violence: HHS Guidelines. Available: http://www.hhs.gov/progorg/ohr/eap/eap7vilg.htm (3 July 1999).

Workplace Violence Research Institute (1996). Resolving Workplace Conflict. Laguna Beach, CA: Workplace Violence Research Institute.

Wright, J.D. (1987). Homelessness and Health. Washington, DC: McGraw-Hill.

Yudofsky, S.C. (1992). Using a panel of experts to establish validity for patient assault vignettes. Journal of Applied Social Research, 16(1), 82-92.

Zolopa, A.R., Hahn, JA., Gorter, R. (1994). HIV and tuberculosis infection in San Francisco's homeless adults: Prevalence and risk factors in a representative sample. The Journal of the American Medical Association, 272(6), 455-461.