Objectives

- Define what is meant by workplace violence
- List at least three reasons why workplace violence appears to be increasing
- Explain how workplace violence can impact a helper’s emotional and physical well-being
- List at least three areas of knowledge that an agency’s skill training program should include
- List at least 4 suggestions for making agency facilities safer
- List at least 2 things a helper should know about their clients prior to going into field
- List 4 signs of increasing agitation
- List at least three de-escalation techniques
“The Best way to manage violent behavior is to prevent it”

Susan Weinger, author of *Security Risk: Preventing Client Violence Against Social Workers*
Personal Safety

- Work-related violence
- History of Violence against helpers
- Causes of increasing helper assaults
- Implications of violence on the helper
- Predicting participant violence
Just because a person doesn't put hands on you, that doesn't mean they aren't abusive. Abuse is control, blatant disrespect, and also hurtful words. Don't settle for emotional abuse thinking it's ok because it's not physical. @TonyGaskins
Personal (ancient) History

- Methadone program
- Street Outreach
- PsychoSocial Rehab
- Home Visits
- Jail
- Hospital
- Self-defense training/Crisis Prevention Institute (CPI)
- Crisis Intervention Team Conference (CIT)
Agitation

- Defined
- Signs
- Causes
Risk factors for sudden related violence:

- Younger age
- Male gender
- Lower income
- History of violence
- Past juvenile detention
- History of physical abuse by parent or guardian
- Substance dependence only
- Comorbid mental health and substance disorder
- Victimization in past year
- Unemployed and looking for work in the past
Paranoia

- Fear something bad will happen
- Thoughts that other people or externals are trying to harm
- Belief exaggerated or unfounded
- Signs
PSYCHIATRY

IT'S NOT MY GRIP ON REALITY
THAT I'M WORRIED ABOUT --- IT'S REALITY'S GRIP ON ME!
A woman who appears about 40 approaches you on the street and complains that her husband installed an electronic tracking device in her arm. She shows you where it is, but there is nothing noticeable there. She has also recently begin to notice others following her and she suspects her husband has hired them.

WHAT DO YOU SAY?
Empathy

- Accurate statement of another person’s experience: don’t need to have the experience; don’t judge or evaluate
- Conveys understanding
- Others feel understood and supported
- Encourages others to share more
- Creates a connection
- Establishes rapport

CONNECT-THEN DIRECT
ABC of assessing the potentially violent patient:

- **A= Assessment:**
  - Primary Survey
  - Appearance
  - Current medical status
  - Psychiatric History (history of violence)
  - Current medication
  - Oriented (time, place, person)

- **Physiological indications for impending aggression**
  - Flushing of skin
  - Dilated pupils
  - Shallow rapid respirations
  - Excessive perspiration
ABC of assessing the potentially violent patient

- **B= Behavioral indications:**
  - Observation of behavior
  - General behavior (intoxicated, anxious, hyperactive)
  - Irritability
  - Hostility, anger
  - Impulsivity
  - Restlessness, pacing
  - Agitation
  - Suspiciousness
  - Property damage
  - Rage (especially children)
  - Intimidating physical behavior (clenched fist, shaping up)
ABC of assessing the potentially violent patient

- **C= Conversation**
  - Patient self-report
  - Admits to weapon
  - Admits to history of violence
  - Thoughts about harm to others
  - Threats to harm
  - Admits to substance use/abuse
  - Command hallucinations to harm other
  - Admits extreme anger
you’re making me nervous
STOP ROCKING!

Joseph Farris
Coersive De-escalation

- When staff members physically intervene to subdue a patient, it tends to reinforce the patient's idea that violence is necessary to resolve conflict.
- Patients who are put in restraints are more likely to be admitted to a psychiatric hospital and have longer inpatient lengths of stay.
- The Joint Commission and the Centers for Medicare and Medicaid Services consider low restraint rates a key quality indicator,
- Staff and patients are less likely to get hurt when physical confrontation is averted.
Non-verbal De-escalation

1. Appear calm, centered, and self-assured even if you don’t feel it.
2. Maintain limited eye contact.
3. Maintain a neutral facial expression.
4. Keep a relaxed and alert posture.
5. Minimize body movements such as excessive gesturing, pacing, fidgeting, or weight shifting.
Non-verbal de-escalation

6. Position yourself for safety:
7. Always be at the same eye level.
8. Do not point or shake your finger.
9. Do not touch even if some touching is generally culturally appropriate and usual in your setting.
Verbal De-escalation

- 3 Step Approach
  1. Verbally engaged
  2. Collaborative Engagement
  3. Participant is verbally de-escalated out of the agitated state
Verbal De-escalation 4 main objectives

- (1) ensure the safety of the patient, staff, and others in the area;
- (2) help the patient manage his emotions and distress and maintain or regain control of his behavior;
- (3) avoid the use of restraint when at all possible; and
- (4) avoid coercive interventions that escalate agitation.
Empathic Stems

- Maybe you feel......
- Sounds like a ________________ day
- What a day you’ve had.
- That is a lot to deal with
- That is the last thing you wanted
- That’s confusing when that happens
- It’s hard for you to know what to do
- You wish things were different
Guidelines for Environment, People, and preparedness

- Physical Space Should Be Designed for Safety
- Staff Should Be Appropriate for the Job
- Staff Must Be Adequately Trained
- An Adequate Number of Trained Staff Must Be Available
- Use Objective Scales to Assess Agitation
Behavioral Activity Rating Scale

1 = difficult or unable to rouse
2 = Asleep but responds normally to verbal or physical contact
3 = Drowsy, appears sedated
4 = Quiet and awake (normal level of activity)
5 = Signs of over (physical or verbal) activity, calms down with instructions
6 = extremely or continuously active, not requiring restraint
7 = violent, requires restraint
General De-escalation Guidelines

- Clinicians Should Self-Monitor and Feel Safe When Approaching the Participant

- 10 Domains of De-Escalation Exist That Help Clinicians' Care of Agitated Patients
  1. Respect personal space
  2. Do not be provocative
  3. Establish verbal contact
  4. Be concise
  5. Identify wants and feelings
General De-escalation Guidelines

6. Listen carefully to what the participant is saying
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the participant and staff
Verbal de-escalation

- Communication is key factor in crises
  1. Undivided attention
  2. Non-judgmental
  3. Focus on feelings
  4. Silence
  5. Clarify messages
Verbal de-escalation

- Rational detachment
  1. Develop a plan
  2. Use a team approach
  3. Use positive self-talk
  4. Recognize personal limits
  5. Debrief
If Aggression Occurs

- Leave room
- Call for help
- Self-defense strategies
Home Visits

- **Do some preparation**
  - Determine where to meet and whether there is a need for accompaniment
  - Would it be therapeutically acceptable to meet somewhere other than the participant’s home? If safety is a concern, consider meeting in the office or other public place (library, restaurant, etc.).
  - Err on the side of safety
  - Be sure of location, carry map of area
  - Bring a cell phone
  - Notify the participant in advance if you will be accompanied by others

- **Know the participant**
  - Know as much as possible before making a home visit
  - Read the chart and consult with colleagues
  - Consider if there is something in the participant’s experience *that day* which might increase the need for safety

- **Know the environment**
  - Consult with a colleague who can be informative about the area, the building, and helpful precautions
  - Consider making an initial visit with a colleague who knows the neighborhood or the participant
  - Meet the participant in the neighborhood and accompany the participant to his or her home
  - Be aware of other individuals who may be present during a home visit

- **Communicate appearance wisely**
  - Wear simple, professional attire
  - Consider wearing shoes that enable you to move quickly
  - Avoid expensive clothing, jewelry, other accessories
  - Travel light

Plan for connection with colleagues

- Be sure your supervisor and other colleagues know your itinerary
- Leave a schedule and emergency contact information with colleagues
- Consider routine check-ins by phone after each home visit
- Debrief at the end of each day with colleagues

Conducting the home visit

- Be alert to nonverbal cues
- Stay aware of people in the vicinity
- If the situation seems unsafe or threatening, pass by or leave and return another day
- If driving, be mindful of where you park
- When ringing the bell or knocking, stand to the side of the door
- Promptly identify yourself so as not to be mistaken for someone else
- Do a quick visual scan of the room
- Learn who else besides the participant is at home
- If there is any indication of threats to anyone’s safety, promptly and politely ask to postpone the visit
- Note exits and sit in a front room close to the door
- If necessary meet with the participant outside his or her home, in the hallway, foyer, or outside the building
**Arrival (Set the tone):**
- Be prompt
- Introduce self and other staff
- Establish social connection ("small talk")
- If appropriate, include significant others or family members in conversation
- Modify the environment to put focus on the visit (e.g., TV, radio, etc.)
- Settle at a work place (e.g., kitchen, living room, ask for suggestions)

**During the Visit (Share information, conduct skills training, lend support):**
- Review the purpose of the visit
- Establish goals for the visit
- Elicit feedback form participant about interests, concerns, progress
- Share information about resources
- Observe participant interaction
- Reinforce skills, conduct skills training as appropriate

**Concluding the Visit (Summary):**
- Summarize content of the visit
- Provide information about future contacts or activities
- Plan next visit
- Make yourself available for phone calls and questions
- Closure and good-bye
Post Visit:
- Document visit
- Evaluation: modify ITP as indicated
- Process visit accessing support from colleagues and supervisor

Points to Remember:
- Be yourself
- Home visits and traveling within communities require special safety precautions
- Not all home visits should be made or made alone – options need to be explored when safety is a consideration.
- Prepare for a home visit with safety in mind:
  - Read the chart to determine any risk factors
  - Talk with informed colleagues
  - Think about the area and setting of the home visit
  - Keep others informed about your whereabouts
- Be alert and mindful while conducting a home visit
- Help participants become more independent
- Be a good listener
- Have specific goals/objectives for each visit
- Realize the limitations of your role
- Remember that small improvements are the building blocks for big ones
- Respect cultural values
- Monitor your own behavior – the participant is observing you
Resources

- Overt Aggression Scale
- Scale for the Assessment of Aggressive and Agitated Behaviors
- Staff Observation Aggression Scale
- Websites:
  1. Everyday Self-Defense Tip Sheet
     www.everydayselfdefense.com
  2. Guidelines on Personal Safety
     http://chhs/qsu.edu/socialwork/FEsafety.asp
References


References


- Rossi J, Swan MC, Isaacs ED. The violent or agitated patient. Emerg Med Clin North Am

INTRODUCTORY SELF-DEFENSE WORKSHOP & DISCUSSION PANEL

The Chancellor’s Committee on the Status of Women, Staff Advocacy Subcommittee invites all UIC staff, faculty, and students to come together to gain physical skills and develop an empowering mindset

Program Agenda
Welcome / Introductions
Information about interpersonal violence / Campus resources
Self-defense / Safety training
Panel discussion / Q&A session

Program Panelists
Andie Celerio, M.Ed., Assistant Director, Campus Advocacy Network
John Martin, UIC Ju-Jitsu Club Member & Self-Defense Instruction Facilitator
Officer Cesar Canizales, C.O.P.S. Officer

Registration
We encourage advance registration:
RSVP HERE (http://goo.gl/forms/mRPkzZ7qVW)!

*We suggest that attendees wear comfortable attire*

Friday, May 20th, 2016
3:30-5:30 p.m.
Student Recreation Facility East, 737 S. Halsted
First Floor Multi-Purpose Room A/B (142B)

This event is made possible with the partnership of the CCSW, the Campus Advocacy Network/Women’s Leadership and Resource Center, and the UIC Police

Campus Advocacy Network  UIC  Chancellor’s Committee on the Status of Women  UIC  Women’s Leadership and Resource Center

Questions? Please contact Erin, ebrophy@uic.edu or Leslie, lcarna2@uic.edu

Parking information: Anyone with a current parking assignment can relocate to the Halsted Taylor Parking Structure. Please have your valid i-card, and hang tag displayed. If you decide to park by the meter section, the pay box must be paid, and the lot has a maximum of 2 hours.
Questions