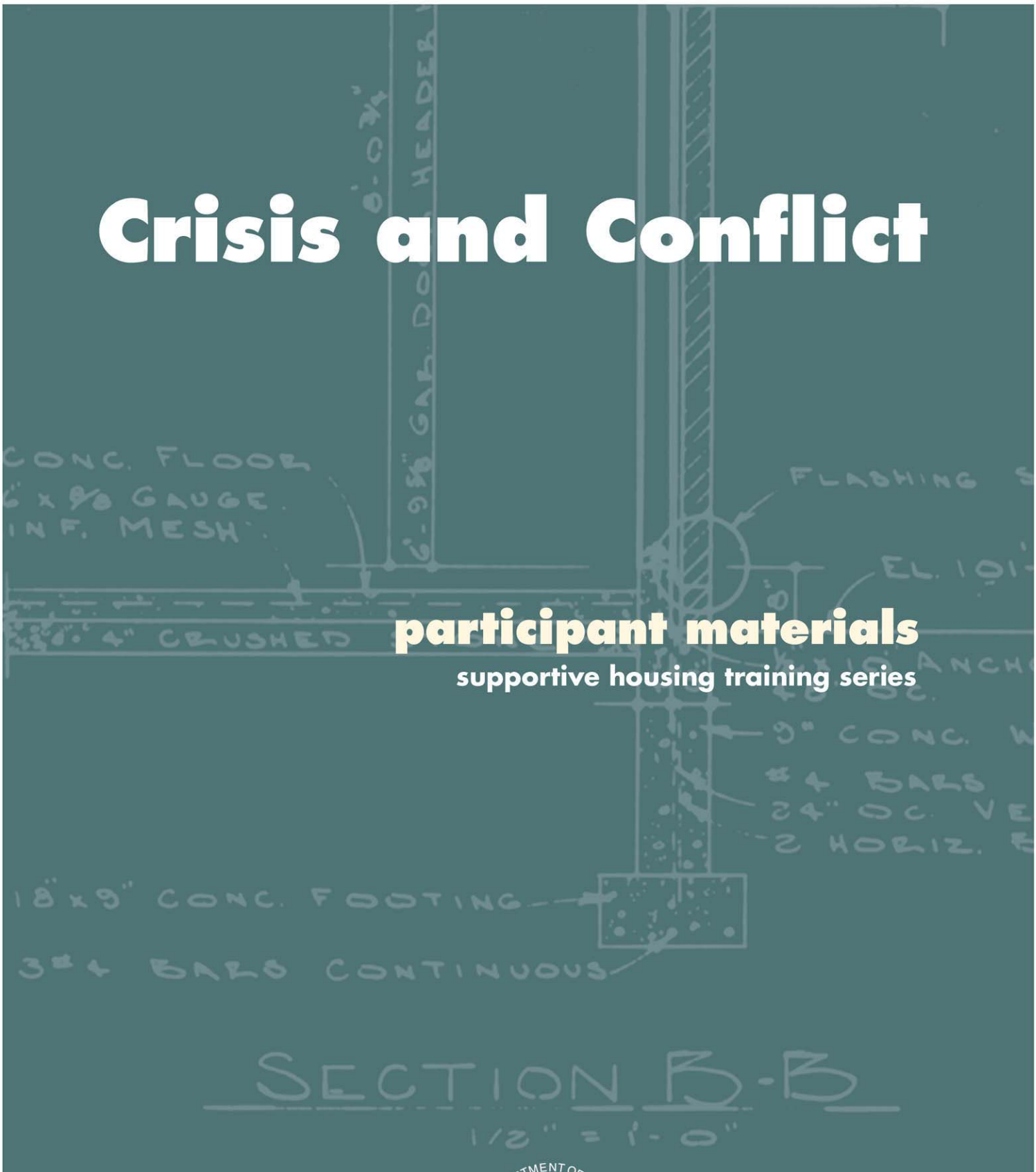
Crisis and Conflict

participant materials

supportive housing training series



CSh
CORPORATION *for* SUPPORTIVE HOUSING

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

CUCS
Center for Urban Community Services, Inc.

Crisis and Conflict

Participant Materials

Developed by Center for Urban Community Services

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

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

For more information:
U.S. Department of Housing and Urban Development: www.hud.gov
Center for Urban Community Services: www.cucs.org
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AGENDA

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II. STRATEGIES FOR CRISIS PREVENTION

A. Identifying intrapersonal factors: knowing our own response
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IV. SPECIFIC CONFLICT/CRISIS CASE SITUATIONS AND STRATEGIES FOR DEALING WITH EACH

A. Acute vs. non-acute situations
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WARNING SIGNS OF IMPENDING ESCALATION/VIOLENCE

TENANT FACTORS

- Changes in Baseline Behavior (increase or decrease in ADL skills)
- Past History of Violence (#1 Predictor)
- Low Frustration Tolerance (knowing a person's triggers is useful)
- Change in Psychiatric Symptoms (increased paranoia, shift in baseline)
- Anniversary Reactions (e.g., anniversary of the death of someone special or a date that has particular significance, either positive or negative)
- Aggressive Body Language (pacing, hand wringing, agitation)
- Aggressive Verbal Content (provocative, inflammatory or paranoid statements)
- Change in Medications (noncompliance, lower dosage, new trial, new side effects, including insomnia, restlessness, agitation, sedation)
- Substance Abuse (Most drugs and alcohol increase the potential for violence by disinhibiting one's emotions such as anger, and making it easier for people to act out aggressive impulses.)
- Unresolved Conflict
- HALT (AA motto — Hungry, Angry, Lonely, Tired)

ENVIRONMENTAL FACTORS

- Tension Centers (every supportive housing building has tension centers, areas where it is known that arguments arise because of conflicts or obstacles in getting needs met: TV room, public phone, food lines)
- Climate (bad weather, snow or rain can increase tension if persons feels "cooped up;" hot weather can cause agitation)
- Changes in Normal Routine (therapist on vacation, change in schedule, visit from family, staff turnover)
- Special Times of the Month ("Check day," visit with the psychiatrist or Medical Clinic day)
- Social/Political/Racial Tensions (persons may feel discriminated against, delusional material may get stirred up by current events)
- Unresolved Conflicts
- Unmet Needs (managed care denying access to services resulting in shorter hospitalizations, bad romance, recent disappointments)

THE ASSAULT CYCLE

- **TRIGGERING PHASE**:
  The tenant exhibits changes in their baseline behavior or mood. S/he may appear upset, angry, withdrawn or demanding.

- **ESCALATION PHASE**:
  The tenant progresses to the point where s/he becomes clearly agitated, provocative and verbally abusive. Adrenaline is building up in the body, which interferes with the ability to think rationally and react rationally.

- **CRISIS PHASE**:
  The tenant is now definitely out of control, assaultive or physically threatening. At this point, the safety of others is jeopardized.

- **RECOVERY PHASE**:
  The tenant begins to return to their baseline behavior and mood. Heightened adrenaline remains in the body for at least ninety minutes, causing the tenant to react more forcefully if provoked.

- **POST-CRISIS DEPRESSION PHASE**:
  The tenant may feel remorseful, ashamed, humiliated about the incident/outburst.

SKILLS AND STRATEGIES FOR INTERVENING IN VIOLENT OR POTENTIALLY VIOLENT SITUATIONS

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

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

WATCH YOUR BODY LANGUAGE:

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

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

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

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

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

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

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

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

ANGER-MANAGEMENT TECHNIQUES

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

SOME POSSIBLE ANGER-MANAGEMENT STRATEGIES MIGHT INCLUDE:

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

SEVEN STEPS TO RESOLVING A CONFLICT

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

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

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

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

Facilitator's role:

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

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

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

Facilitator's role:

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

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

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

Facilitator's role:

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

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

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

Facilitator's role:

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

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

STEP 5 – BRAINSTORM SOLUTIONS.

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

Facilitator's role:

- List all options on paper for review by participants.

STEP 6 — EVALUATE OPTIONS.

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

Facilitator's role:

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

STEP 7 — CREATE AGREEMENT.

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

Facilitator's role:

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

ASSISTING PERSONS EXPERIENCING SUICIDAL IDEATION

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

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

8.

PROTOCOL FOR IMPLEMENTING AN INVOLUNTARY HOSPITALIZATION

The issue of hospitalization should be raised with the tenant, if possible. For hospitalizations done on a voluntary basis, admissions can be arranged beforehand with the hospital or the managed care/insurance plan.

If you suspect that such a discussion could result in violence, then the tenant should not be informed of the hospitalization until after the police or EMS have arrived.

1. Notify all staff and security of impending action, assign roles and coordinate plans.

2. Move tenant to private space, or, if necessary, ask other tenants to clear the area. All potential weapons and sharps should be removed beforehand. A staff member should be with the tenant at all times.

3. Designate a signal for staff communications around calling emergency services. For example, if two staff are with the tenant, one may say, "I'm thirsty, and want some water. Do either of you want some?" This would alert staff that the designated person will call emergency services. When staff has worked together for some time, a certain "look" from one person to the other will indicate calling emergency services.

4. Call emergency services requesting a transport for someone who is dangerous to self or others. Be prepared to give tenant information: name, age, address, type of residence, Medicaid #, medications.

5. Gather documentation. This can be a form letter which is kept for psychiatric hospitalizations. It should include:

   -name
   -date of birth
   -dx (psychiatric and medical)
   -meds
   -hx of psychiatric illness (last hospitalization, doctor's name, etc.)
   -reason for current need for inpatient stay detailing homicidal or suicidal ideation/behavior.

   Make three copies, one for the EMS team, one for the ER and one to accompany the tenant to the unit.

6. When emergency services arrive, speak to the person in charge. Be specific when emphasizing behaviors or statements indicating need for psychiatric evaluation.

7. Attend to the fears/concerns of tenants who may be witnessing the events.

8. Accompany tenant to hospital in the ambulance, if possible.

9. Present ER staff with documentation, and request to speak to the attending doctor and the social worker.

10. Remain at the ER until the tenant is admitted.

11. Exchange names and numbers with the ER staff or the floor staff, if tenant has been moved already.

12. Reassure tenant that you will be in close contact, and make sure s/he knows how to reach you. Offer quarters for the phone and food or cigarettes, if allowed.

13. Call tenant's outpatient psychiatrist and inform them of the hospitalization.

SUICIDE PREVENTION AND ASSESSMENT

Following are some suggested tools and strategies, but they do not represent a comprehensive approach to suicide assessment or prevention.
"What Do I Need to Ask? What Do I Need to Do?"

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

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

BE AWARE OF WHO MAY BE AT RISK

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

BE AWARE OF WARNING SIGNS

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

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

Talking about death and/or threatening suicide

KNOW THE QUESTIONS TO ASK IN ORDER TO ASSESS "SUICIDALITY"

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

To assess this, ask the person:

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

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

2. DOES THE PERSON HAVE SUICIDAL IDEATION?

To assess this, ask the person:

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

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

To assess this, ask the person:

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

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

To assess this, ask the person:

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

Comparison of Signs and Symptoms Across Categories of Substances

	WITHDRAWAL				INTOXICATION						OVERDOSE					
SIGNS & SYMPTOMS	ALCOHOL	STIMULANTS	DEPRESSANTS	OPIATES	ALCOHOL	STIMULANTS	DEPRESSANTS	OPIATES	HALLUCINOGENS	PHENCYCLIDINE	ALCOHOL	STIMULANTS	DEPRESSANTS	OPIATES	HALLUCINOGENS	PHENCYCLIDINE
Abdominal Cramps			X	X											X	
Aches, Muscle	X			X			X									
Affect, labile (fluctuating, unstable					X	X			X	X						
Analgesia (pinprick)										X	X	X	X	X		X
Angina (chest pain)												X				
Anxiety	X		X	X	X	X	X	X	X	X		X			X	X
Arrhythmia (abnormal heartbeat)						X						X				
Ataxia (unsteady gait)					X		X			X			X	X		X
Chest Pain												X				
Chills				X												
Circulatory collapse			X											X	X	
Coma											X		X	X		X
Comprehension, slow	X	X			X		X	X		X	X		X	X		X
Convulsions	X	X					X					X				
Delirium	X		X		X	X	X			X	X	X	X	X	X	
Depressed mood	X	X			X		X			X						
Diarrhea				X	X							X				
Diplopia (double vision)					X		X									
Dizziness					X	X	X		X	X					X	
Dysmetria (muscular disturbance)					X		X			X						
Euphoria					X	X	X	X	X	X						
Facial grimacing										X		X				
Fatigue	X	X					X									
Floating feeling					X		X	X	X	X						
Flushing	X		X		X			X	X			X			X	
Hallucinations	X		X			X			X	X		X			X	X
Headaches			X									X				
Hypertension (high blood press.)				X		X			X	X		X			X	X
Hyperthermia						X			X			X			X	
Irritability	X		X	X	X	X	X			X		X	X		X	

Comparison of Signs and Symptoms Across Categories of Substances

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

11.

CASE STUDIES

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

1. One of the tenants tearfully tells you that another tenant is dealing illicit drugs and having loud visitors throughout the night. The tenant says that she cannot disclose this person's identity to you because he threatened to harm her if she said anything to anyone.

2. In the middle of the night, a tenant tells security that "I can't take it anymore," and slams the door to his room. When another tenant knocks on the door, he does not answer. Security is the only staff present on site.

3. A tenant stumbles into the front door bleeding profusely. He passes out in a pool of blood as other tenants gather around.

4. You are running a weekly current events group. A new tenant who has never attended enters late and staggers into the area. He smells of liquor, is slurring his words and begins to talk loudly in a provocative manner.

5. A female tenant has a male guest who is yelling and acting threatening to her in the lobby. The security asks her visitor to leave. He leaves. The female tenant follows him out into the street.

6. A frail, well-liked mentally ill man had a fight with young, much-disliked tenant. You observed the fight and called 911. The well-liked man is arrested for possession of a weapon. A group of tenants, who did not observe the situation, gather as police escort the elderly man out the building and accuse you and other staff of taking sides with the other tenant.

7. You hear through the grapevine that a tenant beat up a prostitute last night and she left the building bleeding. You look in the report log to find nothing

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

8. A tenant tells staff that her neighbor showed her a gun stating that he wasn't going to take abuse from anyone anymore.

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

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

PROGRAMMATIC INTERVENTIONS FOR CRISIS PREVENTION

OFFER CLASSES/WORKSHOPS IN ANGER MANAGEMENT

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

CONSIDER ESTABLISHING A DISPUTE-RESOLUTION SERVICE

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

ENCOURAGE OPEN COMMUNICATION BETWEEN ALL LEVELS OF STAFF

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

LOOK AT TENSION CENTERS

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

MAINTAIN CLEAR NORMS AND RULES OF CONDUCT

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

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

CONSISTENTLY ENFORCE CONSEQUENCES FOR VIOLATIONS OF RULES AND NORMS

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

WRITE DOWN PROCEDURES FOR INTERVENING IN CRISES

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

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

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

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

FACILITATE COMMUNITY BUILDING

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

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

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

PROVIDE TRAINING

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

13.

GUIDELINES FOR DEVELOPING EMERGENCY POLICIES AND PROCEDURES

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

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

INFORMATION TO INCLUDE IN EMERGENCY POLICIES AND PROCEDURES

1. ASSESSMENT STEPS:

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

If there is an immediate danger to any staff or tenant, the first line of action should be to get people to a safe place and call 9ll. Be prepared to describe the location and type of residence, the nature of the emergency (include menacing behavior or verbal threats), if any person with special needs is involved (police may respond more quickly in cases involving an Emotionally Disturbed Person/EDP) and any past episodes of violence with the involved party(s).

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

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

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

2. PROTOCOL FOR DEALING WITH EMERGENCY SERVICES

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

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

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

3. FOLLOW-UP PROCEDURES

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

The staff involved should know the procedures for:

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

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

14.

CRISIS & CONFLICT BIBLIOGRAPHY

Callahan, J.: "A Specific Therapeutic Approach to Suicide Risk in Borderline Clients," *Clinical Social Work Journal*, (24): 443–459, 1996
This article reviews the various types of suicidal behavior exhibited by people with borderline personality diagnoses, including self-destructive behavior and overt suicide attempts. Frameworks are offered for understanding and managing both kinds of behavior.

Goleman, D.: Emotional Intelligence: *Why it Can Matter More than IQ*. Bantam Books, 1995
Drawing on groundbreaking brain and behavioral research, Goleman discusses the bio-psycho-social roots of emotions. Findings on trauma, temperament and social adaptiveness can be used to help clients learn how to identify and work with emotions.

Kaplan, S.; Wheeler, E.: "Survival Skills for Working with Potentially Violent Clients." *Social Casework*, (64): 339–346, 1983
This article discusses the roots of violence, predictors of violence, the concept of the assault cycle, violence prevention and intervention. Modalities such as assertiveness training, transactional analysis and anxiety management training are briefly reviewed.

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

McKay, M.; Rogers, P.R.; and McKay, J.: *When Anger Hurts*. New Harbinger Publications, Inc., 1989
This book discusses theories about anger and anger management and provides specific exercises and interventions for use with individuals and groups.

Monahan, J.: "Mental Health Violence Study." National Mental Health Association, *The Bell*, September 1989
This article discusses the impact of alcohol and drug abuse in the increase of statistics regarding mental health and assault. The study indicates that persons discharged from psychiatric facilities who did not abuse alcohol or illegal drugs had a rate of violence no different than their neighbors in the community.

Murdach, A.: "Working with Potentially Assaultive Clients." *Health and Social Work*, (18/4): 307–312, 1993
This article discusses a variety of reasons why violence occurs, how clinicians and other social service professionals can recognize clues to impending danger and various clinical approaches for intervening.

Rooney, R.: *Strategies for Work with Involuntary Clients*. Columbia University Press, 1992
This book discusses techniques to engage difficult clients and work effectively with treatment resistance.

Yeates, C.; Cholette, J.; Duberstein, P.: "Suicide and Schizophrenia: Identifying Risk Factors and Preventative Strategies." *Medscape Mental Health*, 3(3), Medscape, Inc., 1998
This article discusses the prevalence of suicide and suicide attempts among different groups of people diagnosed with schizophrenia and outlines risk factors and implications for preventive strategies

Internet Sites:

Center for Urban Community Services
http://www.cucs.org
Center for Urban Community Services (CUCS) provides a continuum of supportive services for homeless and formerly homeless people, including street outreach, a drop-in center, transitional and permanent housing programs, and vocational and educational programs. Particular emphasis is placed on specialized services for people with mental illness, HIV/AIDS and chemical dependency. This website provides information and links to a variety of resources regarding transitional and permanent housing.

Corporation for Supportive Housing
http://www.csh.org
CSH's mission is to help communities create permanent housing with services to prevent and end homelessness. CSH works through collaborations with private, nonprofit and government partners, and strives to address the needs of tenants of supportive housing. CSH's website includes a Resource Library with downloadable reports, studies, guides and manuals aimed at developing new and better supportive housing; policy and advocacy updates; and a calendar of events.

Guidelines for Workplace Violence Prevention Programs
nsi.org/library/work/violence1.html
This website offers visitors both an outline and text on recommended guidelines for workplace violence prevention.

National Alliance to End Homelessness (NAEH)
http://www.naeh.org
The National Alliance to End Homelessness (NAEH), a nationwide federation of public, private and nonprofit organizations, demonstrates that homelessness can be ended. NAEH offers key facts on homelessness, affordable housing, roots of homelessness, best practice and profiles, publications and resources, fact sheets and comprehensive links to national organizations and government agencies that address homelessness.

National Resource Center on Homelessness and Mental Illness
http://www.prainc.com/nrc/
The National Resource Center on Homelessness and Mental Illness provides technical assistance, identifies and synthesizes knowledge, and disseminates information. Users can be linked to findings from Federal demonstration and Knowledge Development and Application (KDA) projects, research on homelessness and mental illness, and information on federal projects.

Training Institute for Suicide and Clinical Interviewing
www.suicideassessment.com
This website is designed specifically for mental health professionals, substance abuse counselors, school counselors, primary care physicians, and psychiatric nurses who are looking for information on the development of suicide-prevention skills, crisis-intervention skills and advanced clincial interviewing skills.