HEALING HANDS

Workplace Violence: What You Need to Know

As this issue of Healing Hands *was going to press, we learned of the murder of Rita Ciofani, director of the Veterans' Resource Center of the Volunteers of America in Cleveland, and the death of her apparent killer, Raymond Ice, as the police responded. We were reminded of the murders of Kevin Collins in Phoenix, recounted below, and of Buddy Gray at the Drop-Inn Center in Cincinnati years ago, and of scores of homeless people every year. We offer this issue to the cause of overcoming all violence, with deep gratitude for those who face danger every day, yet bravely and lovingly choose to continue to help their neighbors heal.*

Workplace violence is defined as any act of physical assault or threatening or violent behavior, including harassment, intimidation, threats, or disruptive acts occurring at the work site whether its location is temporary or permanent.[1] This is not a new phenomenon, and in the 1960s, psychologists and physiologists developed programs for crisis management. A number of organizations emerged with structured approaches designed to help workers, two of which are widely regarded training and certification programs:[2]

■ Professional Assault Crisis Training—Pro-ACT—evolved from psychologist Paul Smith's Professional Assault Response Training (PART) program. The training provides risk management and safety enhancement practice-based tools emphasizing critical thinking and behavioral supports[2,3]

■ Crisis Prevention Institute, Inc., (CPI) offers crisis prevention and intervention training and behavior management strategies including its foundation program, Nonviolent Crisis Intervention[2,4]

Both programs promote situation analysis and communication practices based on interpersonal respect, and prevent violent behavior by deescalating situations exacerbated by anxiety or hostility.

Training to increase awareness and understanding of dynamic interactions is a benefit to workers on the job and in the larger community. Response to unsafe workplaces must also include long-term planning for quality improvement designed to reduce violence.[1,2,5,6]

SCOPE OF THE PROBLEM A recent National Occupational Research Agenda report on health care and social assistance workers documents the sector at 17.4 million (11 percent of the U.S. workforce in 2006). Citing two national surveys, the report affirms that 17 percent of nurses were physically assaulted and more than half were threatened or experienced verbal abuse within the previous year. Similarly, 44 percent of licensed social workers faced personal safety issues in their practices.[7] A 2006 Bureau of Labor Statistics report confirms this trend, showing the health sector leading all industries with 45 percent of all non-fatal assaults, and specifically, a rate of 31.3 assaults per 10,000 in nursing and personal care facilities versus 2.8 per 10,000 in the private sector.[8]

While these are significant figures, the number of actual non-fatal violent incidents may be much higher because of underreporting. Failure to document may be due to institutional reporting procedures, employee beliefs that reporting will not be beneficial or could jeopardize employment, or because such incidents are believed to be part and parcel of health care and social service employment.[6,8]

> " For many years, health care and social service workers have faced a significant risk of job-related violence. Assaults represent a serious safety and health hazard within these industries . . . . OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults. Although not every incident can be prevented, many can, and the severity of injuries sustained by employees can be reduced. "
>
> —*OSHA Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers*[6]

Workplace violence has many sources. In order to discuss causes and solutions based on common understandings, Injury Prevention Research Center (IPRC) researchers developed four categories that include most incidents:[9]

■ *Criminal Intent (Type I)*: A crime is committed in conjunction with the violence (i.e., robbery, shoplifting, trespassing)

■ *Customer/Client (Type II)*: The perpetrator has a legitimate relationship with the business and becomes violent while being served (i.e., customers, clients, patients, students, inmates)

■ *Worker-on-Worker (Type III)*: An employee or past employee of the business attacks or threatens another employee(s) in the workplace

■ *Personal Relationship (Type IV)*: The perpetrator usually does not have a relationship with the business but has a personal relationship with the intended victim (i.e., domestic violence)

RELEVANCE TO HCH SETTINGS While any of the IPRC categories might prove tragic, Type II—client violence against caregivers—is of concern here. In homeless shelters and clinics, everyone's safety must be a top priority. While stress and trauma can have a deleterious affect on some clients' ability to relate appropriately, providers must be able to respond effectively to individuals who are struggling to cope and may be acting out.

Both the Occupational Safety & Health Act of 1970 and its voluntary guidelines published in 2004 aim to ensure employees a "workplace free from recognized hazards likely to cause death or serious physical harm."[6] Although few state laws protecting workers exist, Casteel and colleagues' (2009) comprehensive study of violent event rates to hospital employees before and after the enactment of California's Hospital Safety & Security Act provides an encouraging picture that policy may effectively affect improvement in health care worker safety.[10]

Research has not been published about the risk of violence to staff working in community- and shelter-based clinics that treat individuals with physical and mental illness and addiction disorders. "On one hand, well-known client risk factors—such as a prior history of violence, diagnosis of comorbid substance use and mental health disorders, non-compliance with medications, long waits for service in crowded waiting areas, and being under the influence of intoxicants—are highly prevalent in this clinic population," according to **Kathleen M. McPhaul, PhD, MPH, RN**, of the University of Maryland School of Nursing. "On the other hand, the [HCH] care model espouses a compassionate humanistic approach and colocation of medical, psychiatric, substance use, and social work services that potentially offset the provocative effect of client risk factors."

Participatory-based research is emerging that illustrates the benefit of involvement and feedback from managers, consumers, and staff as well as the impact of legislation on designing comprehensive approaches using Occupational Safety & Health Administration (OSHA) guidelines to prevent violence.[8,9,11–15] ■

Strategies for Promoting a Safer Workplace

In the mid-1990s, an HCH Clinicians' Network task force compiled policies, procedures and protocols for HCH projects and other health centers. Published in 1996 and still relevant, *Sample Safety Guidelines in Homeless Health Services Programs*[16] includes four modules: administrative issues for a mental health agency; comprehensive safety and violence guidelines for staff and volunteers; the Mandt system (a systematic deescalation training program) as practiced in a hospital mental health department; and a resource for outreach workers.

The document touches on three keys to effective preventive policies recommended by OSHA and the IPRC:[8,9,13]
- *Environmental*: Awareness of physical surroundings that discourages possible assailants: entrances and exits, overcrowded waiting areas, lighting, security hardware; caution when working in high crime areas or mobile settings, transporting clients, or working in isolation from coworkers
- *Organizational and Administrative*: Development of programs, policies, and work practices aimed at maintaining a safe working environment
- *Behavioral and Interpersonal*: Implementation of training so entire staff anticipates, recognizes, and effectively responds to conflict and potential violence

The desired outcome is a zero-tolerance policy for workplace violence structured to meet the organization's needs. The policy must be prominently noted in handbooks and training materials. Expectations of good conduct and consequences for physical or psychological threats or violent acts must be clearly stated and consistently enforced. These guidelines encourage staff members to remember the adverse living conditions that their homeless clients experience and to respond with empathy and respect, treating each individual with dignity.[16]

CRISIS PREVENTION TRAINING
HCH Improvement Advisor **Karen Rotondo, BSN, RN**, does not get questions about workplace violence from the new HCH grantees that she mentors, but is not surprised. "Providers in homeless shelters and clinics incorporate safety and compassion into their daily practice; these skills are basic to their work. The Network's *Sample Safety Guidelines*[16] show a concern for patients and staff that may be ahead of what companies are doing in the private workforce."

"When I managed the Mercy Health Care for the Homeless Program in Springfield, Massachusetts," Rotondo continues, "I made sure our staff received crisis prevention training. In 1996, the Network collaborated with CPI trainers to present intensive workshops in Portland, Oregon, and Philadelphia. This training incorporated a train-the-trainer approach, which encouraged workshop participants to teach these nonviolent intervention techniques to others on staff." **Linda Barnet, BSN, RN**, adds, "The knowledge was invaluable and we continue to rely on many CPI principles of intervention." (*See* Skills to Promote a Safer Work Site).

ASSERTIVE COMMUNICATION
Mike Arrajj, RN, who works with the San Francisco Department of Public Health in psychiatric health care, provides services to residents living in subsidized hotels. He appreciates the OSHA statistics naming health care workers as the number one risk group for non-lethal assault. In 1992, Arrajj attended Smith's PART program about management of aggressive behaviors using verbal and physical skills. He was so impressed, that with Smith's approval, he condensed the two-day workshop into a four-hour session on assaultive behavior that he has since presented to over 400 groups. "These principles speak to everyone," Arrajj says, "and are as applicable to San Francisco police officers and school district employees as they are to health care workers. The initial premises are
- Being emotionally prepared for work
- Understanding what causes violence
- Becoming fluent in verbal deescalation skills
- Learning to use evasive self-defense"

Without such preparation, workers will often succumb to frustration and a sense of powerlessness, which can exacerbate confrontation into personal power struggles. "I encourage people to assess each client for

violence because everyone is capable of aggressive actions and we don't want to miss signs of escalation," Arrajj adds. "In the outpatient world, the only tools we have are our minds and words. Words rapidly lose effectiveness if we overlook early warning signals and respond late to a dangerous episode.

"Virtually all interpersonal violence is either reactive or predatory," Arrajj notes. "In a health care setting, the majority of these cases are reactive with the client responding to strong emotion—fear, frustration, or a combination—and exhibiting loss of impulse control. In addition, we need to watch for altered mental states: psychosis, substance-related, metabolic imbalance, and dementia [Alzheimer's, traumatic brain injury]. While these conditions do not cause violence, they can trigger impulsive action.

"The way you talk to someone who is agitated becomes extremely important," Arrajj continues. "Assertive communication that is supportive and respectful recognizes that each of us has control over only one person. Everything is negotiable, so successful deescalation approaches give the individual two choices with two clear consequences. Our frequent error is either to tell someone what to do or be unclear about what choices are available. Everyday there is someone yelling about something in a clinic, but if we help a person who is agitated regain control without becoming physically violent, that is success."

SET A STANDARD In Savannah, the Union Mission, Inc., operates the J. C. Lewis Health Center serving indigent, uninsured, and homeless people who need primary and medical respite care. **Aretha Jones, MPH, MA**, vice-president of primary health services, describes their commitment to structure, process, and training as a route to better service. "All staff receives deescalation training," Jones points out. "In outpatient clinics, when patients refuse to calm down, they are asked to leave and not allowed to walk back in. They must call to make a new appointment and visit with a case manager before seeing the health care provider. If they refuse to leave, we call the police. The word on the street is that we are strict; you go to J. C. Lewis if you are serious about your health."

Jones continues: "Our homeless clients are so grateful for care that unless they are using mood

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SKILLS TO PROMOTE A SAFER WORK SITE

1. **Understand** that many of our clients are at an increased risk for violent behavior because of head trauma, mental illness (mania, psychosis, paranoia), substance abuse, or a history of violence—we must expect the unexpected

2. **Never work alone**: Always make sure at least one other staff person is in close proximity to provide aid if needed; have a panic button, alarm, cell phone, or intercom to communicate with other clinic or shelter staff

3. **Be aware**: Know signs of increasing agitation (i.e., loud voice, verbal anger, increased energy level, body language, distrust) but don't over react

4. **Avoid**: Arguing or defending a point, threatening postures such as arms folded across the chest, fixed eye contact

5. **Utilize tension diffusing tools**: Maintain a calm demeanor; speak slowly yet firmly; be caring and acknowledge client feelings; state expectations simply with clear choices that have related consequences

6. **Decrease risk of being choked**: Don't wear things around your neck (i.e., stethoscope, necklace, scarf, or name tag,

unless it's designed to breakaway)

7. **Keep desks and counters clear**: Make sure items that could be used as weapons are not within easy access (i.e., scissors, syringes, loose heavy objects)

8. **Be aware of surroundings**: Don't have your back against a wall or door; although being between the client and door is often suggested, clinicians often find that clients generally leave if their path is unblocked

9. **Get help early**: Contact a coworker, supervisor, or security worker if an encounter escalates

10. **Deescalation**: If agitation increases (i.e., louder voices, menacing gestures, posturing), help client reestablish self-control by moving him or her to a quieter, less stimulating environment (the more agitated someone becomes, the less they hear); provide plenty of personal space; engage a neutral party or mental health worker to intervene with a different approach

11. **Out of control encounters**: Protect yourself, other staff and patients, and, if possible, the violent client (i.e., physically

Sources: Linda Barnet, BSN, RN, Mercy Medical Center, Springfield, Massachusetts, and the American Association of Occupational Health Nurses[17]

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altering substances, they generally aren't disruptive." In the 32-bed respite facility, Union Mission follows a point policy: three points and the consumer must leave. "People ask why just three points," Jones says. "Disruption by a few rapidly interferes with care for all. We spend about a quarter of our intake process reinforcing behavior rules so consumers know upfront what is expected. Our staff includes a psychiatrist and mental health and substance abuse practitioners who identify clients with potential for violence within the first 24 hours. We reserve private rooms to stabilize these patients."

Other provisions for worker safety include having two nurses on the night shift who stay in constant contact via walkie-talkies; using color codes, blue for medical emergencies and green for potential violence; and having a security officer on-site during after-hours clinics and on weekends, not because of behavior problems but for staff safety when fewer team members are present.

BE PREPARED "I've worked in our homeless health care project for over 16 years and I'm amazed that no one has been hurt and no one has used a gun," says **Monte J. Hanks**, client services director, Wasatch Homeless Health Care, Inc., in Salt Lake City. "You need to be prepared: train everyone, ban

weapons, post signs, create response teams, layout the clinic carefully using physical barriers where needed, and make sure patients and staff are as safe as possible. Don't think it won't happen at your site because it can.

"Our mission is to serve without judgment and help our clients access the care they need. We start from the premise that we are equally responsible for our own behavior and for protecting the security of coworkers," Hanks continues. "It is imperative that we not react to verbal abuse with anger or disrespect but instead, remain calm and in control, and never take the interactions personally."

Clients sometimes use aggressive, intimidating tactics in an attempt to get what they want, so it is important to learn clear responses that prevent manipulation. Answer clients' questions assertively; assure them that they will be seen as soon as possible. Do not make excuses or offer lengthy explanations that may increase frustration. Differentiate the disruptive from the dangerous:

- *Disruptive* behaviors: verbal abuse, pestering, demanding, loud, moving into places that are off limits
- *Dangerous* behaviors: verbal threats, posturing, weapons, property damage, violence against people

"Experience is helpful, but being comfortable in your own skin and framing the conversation so that a client has clear choices with enforceable consequences can lead to successful communication with someone who is belligerent," Hanks advises. "Even with completely uncooperative patients, keeping a level voice with a neutral tone and sticking to the facts helps diffuse a difficult encounter.

"In truth, we don't know how our clients feel," Hanks continues. "If a person can vent without an audience and without disturbing others, he or she may be able to get it out and move forward, but that doesn't always work. One of our patients was behaving in obnoxious, aggressive, and belligerent ways; no one would work with her anymore. As I spoke with her about how we might help, she said 'Well, in my anger management program they had me sign a contract' and I asked 'Was that helpful?' She answered yes, so I composed a document on agency letterhead that addressed our concerns and together we read it. She made several changes, signed it, and there's never been another problem." Hanks adds, "Sometimes a client will wad up the contract and stomp out, but contracts can be a versatile tool and structured to meet various needs."

When an encounter escalates or turns violent, staff members must reassess and consider what happened, what went well and what would be more helpful next time. This process—referred to as *debriefing*—evolved from successful stress management frameworks with emergency services teams.[18] "Debriefing is an integral part of our plan and designed to support the team as well as reinforce training," Hanks says. "I'm a CPI certified instructor, but we are always open to new training approaches. A recent *Workplace Violence in Health Centers* webinar presented by Firestorm for the National Association of Community Health Centers pointed out that 'in many ways the end of an event is just the beginning:[19]
- A catastrophic event is often the first of many crises that will be faced
- Recovery is a non-linear process in which individuals reconcile to a new world view that accepts vulnerability
- Connection, communication, and perceived intentions of others become acutely significant'"

Resources that support patient-centered, collaborative approaches to violence prevention are available on the National Health Care for the Homeless Council's website, including PowerPoint slides, sample policies, and behavior contracts from the 2008 workshop *Preventing and Responding to Violence in Clinics* and *A Curriculum for Training Health Care for the Homeless Outreach Workers.*[20,21]

IN THE AFTERMATH During the 2008 National Health Care for the Homeless Conference, many attendees toured the new Human Services Campus for homeless individuals in Phoenix. The concept of offering centralized services at a downtown campus close to other providers was working well and greatly admired. Tragically, the Campus experienced the reality of workplace violence. On the morning of February 22, 2009, Kevin Collins, a well-liked and respected manager at the Central Arizona Shelter Services, walked out of the shelter to take some paperwork to the clinic. In front of the clinic, George Overturf, a full-time shelter resident, shot Collins a number of times. Before collapsing, Collins called the shelter on his radio to warn coworkers and have them call 911. A physician and a physician assistant ran from the clinic to administer care. Security guards who had seen the shooting stopped Overturf and held him until the sheriff's deputy arrived.

Campus organizations are still working through the trauma. "We all react differently depending on our own life story and emotional framework. It took the shelter easily a week before it was up and running regularly; the day shift would arrive and then leave because they were upset," remembers **Sister Adele O'Sullivan, CSJ, MD**, former medical director of Maricopa County Department of Public Health. "Kevin was an American Indian and his extended family from a northern Arizona reservation came to perform rituals at the Campus and console shelter staff, encouraging them to forgive. We were so proud of our clinic staff. In the days and weeks following the shooting, they had many difficult feelings but were able to discuss them and move on."

O'Sullivan continues: "In the community at large, people said, 'Well of course, it happened at the homeless shelter,' but our staff knew that violence is not a uniquely homeless phenomenon. Violence is a problem across society, so we spoke out whenever the subject arose. Fear is such a difficult emotion. It feeds the notion that what happened once can happen again. Although the shelter already had a metal detector, the impulse for some was to increase security and add more barriers. [This response] highlighted the philosophical differences among the various organizations on Campus. How do we maintain safe workplaces while meeting clients' needs in a manner that espouses charity and kindness? How do we balance maintaining our belief in openness and not impeding care?"

A NEW SAFETY PLAN In Baltimore, when Health Care for the Homeless, Inc., began planning for a new location in 2007, they collaborated with the Work & Health Research Center (WHRC) at the University of Maryland School of Nursing, on a pilot study to translate workplace violence research into practice. **Kathleen M. McPhaul, PhD, MPH, RN**, was the principal investigator for the project. "This was an unusual opportunity because while we specialize in research-based programs about how clinical settings can keep workers safe, there is nothing in the literature that touches on the complexities of homeless care clinics or shelters," McPhaul says, "and so we extrapolated studies with emergency departments, mental health clinics, and nursing homes.

"HCH Baltimore provides an efficient model with three distinct services—medical care, mental health care, and substance abuse services—at the same site and works with consumers through home visits and outreach. We conducted direct environmental observation, interviews with managers and supervisors, and focus group discussions with non-supervisory staff. [The study concluded with] identification of risk factors for violence and recommendations for action. The entire staff was helpful, sensitive to the process, and shared the results with the whole team—100 strong—reinforcing the culture of compassion for homeless consumers through a genuine concern for staff members as well.

"There were safety concerns with the old building although many would be ameliorated in the new facility. In addition, there were concerns on the part of administrative staff about the need for training because many felt their ability to deescalate angry consumers was insufficient and they did not want their limitations to cause clients harm. There were also concerns about encounters with clients

outside the facility and in the community, which were sometimes unpleasant. The risk factors for workplace violence in community-based settings such as HCH mirror the risk factors in other health and social service care settings. The lack of overt physical violence such as experienced in the inpatient mental health settings is notable.[8,11]

"We found safety protocols in place including compassionate and energetic security guards at the front door who knew the staff and clients well. Their commitment to safety probably deterred violence. The policy of escorting clients to visits and throughout the building is sound and limits unpredictable encounters. Clinical, psychiatric, and substance abuse providers appeared to be above average in their commitment, caring, and competence in deescalating agitated clients. Staff teamwork and concern for each other's safety was notable; staff routinely listened at doorways or checked on colleagues who had agitated patients in their offices. In all, the providers were highly experienced and adept at communication among themselves."

"Before partnering with WHRC, I had become complacent about the potential for violence," admits **Jan Caughlan, LCSW-C**, director of mental health and social work. "We had a nearly perfect track record and I was confident in our approach. During our pilot study with WHRC, however, I learned valuable lessons. One, complacence puts experienced workers at risk for violence; and two, that same complacence has an impact on how staff feels their concerns about workplace safety are being heard. I received feedback that staff felt discounted about their concerns, which is not a good situation for our clients or us.

"What changed for many of us through this process was the creation of an ongoing dialogue about safety." Caughlan adds. "In planning our new facility, we actively listened to staff concerns with new ears. I pay a lot more attention to safety issues now."

PRACTICE SAFETY SKILLS EVERY DAY
"I spend most of my time in a satellite clinic in downtown Seattle where many homeless shelters are located," says **Leslie Enzian, MD**, medical director of the Seattle-King County Medical Respite Program. "We have two security officers on-site and alarms

in all treatment rooms, but in 15 years I have never used an alarm. If I feel uncomfortable, I open the door—not to get out but to help relieve the tension and alert other providers. We have a general understanding among staff that if a situation starts, everyone comes to provide help. If a patient is agitated—abusive and disrespectful—I tell them 'If you yell at me, I cannot help you. If you will lower your voice, I will try to help you.'

"In addition, all staff is trained in deescalation," Enzian continues, "and practices physical role playing to learn evasive movements. I hope that an encounter can be resolved before it gets to that, nevertheless I find the training useful.

"It's good to check our own pulse and make sure our voices aren't rising along with our client's. Being aware of the space around us, staying calm and centered, and to the extent possible, reflecting our position as a patient advocate—how we are trying to serve the patient's best interests—helps avoid being pulled into an argument," Enzian adds. "This can be tricky when patients want narcotic meds that are inappropriate to their condition. On the other hand, being familiar with the challenges of homelessness and how pervasive severe abuse and neglect are in our clients' backgrounds can help clinicians empathize and understand that the behaviors clients need to survive on the street don't always translate well to a health center."

"Our multidisciplinary team serves seven shelters and for the most part things are safe," says **Helene Freint, MPH**, program director for West Side Community Health Services in Saint Paul, Minnesota. "Occasionally a client becomes frustrated and upset but everyone keeps a keen ear and is prepared to provide backup. Our goal is to have people seen by our providers, get the treatment they need, and feel good about the experience so they will come back when they need care again.

"In Saint Paul, the main drop-in center uses a restorative justice process, which creates a verbal contract with clients about behaviors and expectations. There is also a Police/Provider Forum that brings the shelter community and police precincts together to find the best ways to serve and protect everyone in the community. This forum led to having a homeless advocate

in the police department. It allows us to solve problems without them becoming enforcement issues. Recently a client repeatedly harassed a staff member and it became a safety issue. Within hours the community was able to help resolve the problem with a restraining order, and at the same time, it became a training opportunity for our team as we emphasized the importance of setting personal boundaries."

Karin Roach, LMHC, CASAC, program director at Bowery Residents Committee Chemical Dependency Crisis Center in New York City, says: "We begin by understanding that most violent acts involve family, people who are intoxicated, or people who have personality disorders. In our treatment facilities, we work with people who use substances and often have comorbid mental illness. Our philosophy is patient-centered; there is no uniformed security at any of BRC's 30 sites.

"We know going in that folks may act out violently, which allows us to be prepared and factor in the interpersonal resources needed," Roach adds. "Everyone on staff including our maintenance support has deescalation training but we don't do any restraining holds. We find that knowing our clients and working as a team leads to better care. In addition, these strategies are helpful:
- Watch for agitation
- Know if the patient is intoxicated
- Know if the patient has mental illness or traumatic brain injury
- Leave your ego at the door, there are no points to prove
- Don't touch clients you don't know, many have experienced trauma
- Don't step up close or stare the client in the eye—it may be considered a challenge
- Foster a strong relationship with your local police precinct so when you call, they know you need them"

Providers who display professional and sensitive attention even in the face of negative action, and use reflective listening skills that employ open-ended questions to elicit information about what a person is thinking and feeling may establish a productive starting point. Practice that is based on client-centered models in which caregivers incorporate common sense, courtesy, and concern enhances good health care while empowering clients in their attempt to control their lives. ∎

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