15 ■ Staff Safety and Workplace Violence Education (SAVE) Training

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Background

Mental health professionals working in community settings routinely encounter challenges to their personal safety. Unfortunately, few staff have received training to effectively minimize this workplace violence (WPV) risk or to prevent violent situations within community clinic settings. Over the past few decades, trends in community mental health services have encouraged engagement and treatment outside of traditional clinic settings. Examples of such treatment approaches include case management, assertive community treatment, mobile crisis teams, and police-based crisis intervention teams. Clients who require these services are typically those who are unable or unwilling to engage in traditional office-based care. As such, a new and growing workplace actually exists in the streets. This workplace includes clients' homes, temporary shelters, public parks, bus stations, parking garages, and various correctional settings. As a result, staff providing mental health services and outreach in these settings may be at especially high risk for violent encounters. This type of WPV may emerge from various sources including enrolled clients, relatives and friends of patients, and from other individuals or situations existing in the community. Although serious incidents of WPV against mental health workers remain relatively low, fallout from their occurrence tends to inspire staff and agency reactivity, and further stigmatizes mentally disordered individuals.[1] Furthermore, WPV may impact staff morale, recruitment and retention, and ultimately the quality and delivery of patient care.

Historically, individuals with serious and persistent mental disorders are more likely than those not disordered to experience violent victimization,[2] yet there is a small subgroup of individuals with mental illness that are at increased risk for violence. In particular, those with known violent and criminal histories, with active symptoms of their illness, and those with medication non-adherence and coexisting substance use disorders, may be at greatest risk for violent activity.[3] Such high-risk individuals tend to be referred to community outreach services due to their histories of poor treatment compliance, active substance use, and use of intimidation and other disruptive behaviors that impede access to community mental health centers. In one study by Erickson and colleagues, several risk factors for criminal behavior were identified among individuals served by a FACT (Forensic Assertive Community Treatment) outreach team. In particular, factors impacting client arrests included histories of violent arrests before treatment, eviction for residential placement during treatment, and presence of antisocial traits.[4] In these cases, like many others, the danger of injury to staff may arise from symptom escalation, anger, fear, and unmet personal needs outside the traditional clinic setting.

Unsafe workplace conditions and violent acts inflicted on mental healthcare workers can have significant consequences. According to various reviews, clinicians who have experienced

violence report subsequent stress, role conflict, and demoralization.[5] Others report effects that included constricted thinking, restricted coping, and states of fear, anxiety, and depression.[6] Such concerns can impede the daily routine of afflicted staff and contribute to performance impairment and further personal risk, especially for those without proper training. As a result, staff involved in outreach treatment may become less effective if afraid, or faced with dangerous situations with little or no knowledge of what to do next.[7] Witnessing episodes of violence, and the stress of observing such events directed toward colleagues can contribute further to feelings of helplessness and loss of control and predictability in the workplace.[8]

Community mental health staff members usually receive some degree of violence prevention training early in their careers and training for staff working with violent patients is frequently recommended.[9] Typically, this training includes a brief overview of risk factors for violence, and more focused interventions relative to inpatient or emergency psychiatric services like protocols for restraint and seclusion. However, this training usually offers little in the way of proper combinations of environmental preparation, situational awareness, and verbal and non-verbal management techniques to stave off WPV in street settings. Excellent programs are available to deliver audience training and instructor development courses on general crisis intervention management, but may be limited in their scope and specificity for violence prevention for caregivers primarily operating "in the streets."[10] In light of increasing patient acuity and the demand for mental health outreach services in the community, proper staff preparation for this high-risk work is crucial. The SAVE training curriculum was developed in large part due to the necessity of promoting safe practice in a team of new case workers responsible for the management of high-risk individuals in a University-based Forensic Assertive Community Treatment (FACT) team in Rochester, New York.[11,12] This chapter will focus on the development of this unique educational training curriculum for outreach providers, discuss program content and training methods, and consider future utility for this WPV prevention curriculum.

Barriers to Staff Safety Training

In order to provide comprehensive and timely staff safety training, many barriers must be addressed:

- Gathering together large groups of very busy and widely dispersed staff for training purposes can be a monumental task. This challenge may be compounded by limited financial resources and increasing agency demands for staff productivity.
- Few professional training programs offer specific safety training as part of their curricula, and staff and their agency leaders may feel unprepared to conduct such training by themselves.[11]
- Administrative leadership may believe that such training will incite unnecessary fear in staff and hamper recruitment and retention of new and existing employees.
- Behavioral health norms, including client-centered perspectives, may contribute to workers' beliefs that patient service supersedes worker safety.[13]

Counterarguments

- The presence of these barriers may contribute to supervisors and program leadership overlooking the potential risk and safety issues faced daily by their outreach staff.
- The fiscal impact on agencies from direct and witnessed traumatic events may be considerable. Within agencies doing mental health outreach, a higher incidence of staff burnout, sick leave, turnover, and medical and legal expenses have been noted.[6]
- Ultimately, agencies may find themselves liable for injuries and loss of life suffered by victims of WPV.[14]

Training on violence prevention and workplace safety is a critical area of staff skill development, and it is recommended that agency supervisors and administrators ensure that all outreach staff receive safety training.[15] If safety training is offered, efforts to train staff should occur early on with provision for refresher courses similar to Basic Life Support programming.[11]

Admittedly, staff training is only one of many facets in the prevention and management of violence in the mental health workplace. Other important factors include, but are not limited to, staff confidence and abilities, the quality and caliber of agency leadership and teamwork, and the mix of clients and staff.[16]

Overcoming barriers to workplace safety training programs requires coalition building leveraged by providing evidence-based information to all relevant staff supervisors and agency leadership. Details not only related to the training benefits, but also the risks, pitfalls, and unintended costs and consequences of WPV require disclosure.

Safety and Workplace Violence Education (SAVE) Training

One strategy to reduce the risks associated with community outreach mental health services is to improve the awareness, and thus prevention of violence through safety training.[11] The Safety and Violence Education (SAVE) training is a modular program developed and delivered by the author, and since its inception has been provided to several hundred mental health agencies from across the United States and Canada. Onsite SAVE programs for community mental health centers, case management, Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) teams, mental health security, home-health aides, law enforcement, and legal professionals, have been provided, since 1998. Program development, content, and related outcomes have also been presented at national conferences.[17–20] The SAVE program was provided as mandatory training for 74 New York State ACT teams during their rollout in 2004, and was sponsored by the New York State Office of Mental Health.

Program Methods and Feedback

- The majority of safety trainings are delivered via onsite didactic seminars, and typically audiences have consisted of multidisciplinary groups of clinical providers, administrative staff, and agency leadership. The SAVE training curriculum is delivered in half-day seminars in consideration of staff time and agency budgets. This design allows for coverage of all SAVE

topics and interactive role-play exercises, rest breaks, and ample time for questions and answers.

- The SAVE training program can be delivered to audiences via video teleconferencing and webinar technology. One program director from a large community mental health center from Long Island, New York, stated, "This webinar was right on the money as far as identifying safety needs and proactive methods to impact on this very recidivist, high-risk population."[21]
- For greater training flexibility, an interactive SAVE CD-ROM was created with support from the Local Initiative Funding Partners of The Robert Wood Johnson Foundation.[20] This one and one-half hour user-friendly training option has been created for staff to learn violence prevention on a personal computer at their own pace. This training option allows those unable to attend onsite trainings to gain safety and violence prevention skills, and as a standalone as a refresher SAVE course for previously trained individuals. Feedback from this training modality has been overwhelmingly supportive. A training coordinator for a multidisciplinary mental health agency in Massachusetts commented, "I have been fortunate enough to view one of your SAVE videos and would like to obtain 15 copies for our agency that consist of outpatient clinics, home-based programs, and residential services."[22]

Multidisciplinary audience members attending SAVE programs reported a high level of satisfaction with this type of WPV prevention training. Published results suggest that the SAVE curriculum was well received and relevant to their day-to-day work.[11] Additionally, feedback continues to be encouraging for onsite delivery of the SAVE training to a variety of mental health outreach and criminal justice programs; "The comments on the safety training were overwhelmingly positive, (staff member) has already started to work on a new safety plan with our team,"[23] and from court personnel, "Great training today-overall our Court staff really appreciated the heads-up training."[24]

Training Program Preparation

The SAVE curriculum consists of a thorough review of risk factors for violence, awareness and preparation training that promotes safe staff interactions with clients, as follows. The SAVE training process begins with a pre-training assessment in order to tailor to the curriculum according the needs of a particular audience.

Procedures used to tailor safety trainings:

1. Safety and risk information is gathered in advance of each visit through teleconferences and email correspondence with program representatives and leadership. Information requests typically include details about staff and programmatic concerns, their physical plant, recurring risk factors and violent incidents, and comments regarding the success or failures of attempts to remedy current challenges to staff safety.
2. Plans for the training setting to include necessary audiovisual equipment, appropriateness of theater for role-play, and a recommended class size of 50 or less for improved interaction.

3. At the beginning of each onsite SAVE training visit, audience members are asked to list their perceived safety challenges and to rate them on a scale from 1 to 4, with 4 representing the areas of greatest concern.
4. Feedback is gathered at the conclusion of each training session for relevance, effectiveness, and audience satisfaction to assist in tailoring future trainings.
5. Contact information for the principle trainer including website, email address, and additional technical assistance is provided for all trained staff and their respective agencies.

SAVE Training Module Content

The following key topics are reviewed in detail at each onsite SAVE training program utilizing a team-based approach to prevention[12]:

1. Understanding risk factors for violence
2. Using clinical skills to prevent and deescalate crises
3. Safety precautions for transporting individuals
4. Home visit and safety: Situational Awareness
5. Staff well-being
6. Developing an agency safety plan

Understanding Risk Factors for Violence

Following introductions and questions eliciting audience member's description of local challenges to personal safety, a thorough review of individual risk factors for violence is discussed. This part of the training includes an overview of risk factors affecting the general population, those with particular mental disorders, and/or substance related dual-diagnoses.[25] Additionally, factors contributing to violence in the community (streets), their environment, and specifics regarding violence toward self versus others are explored. Following this general overview, techniques and sources to assess risk are shared with the audience. These sources include, but are not limited to, review of medical, school, and criminal records; communication with current and prior clinical providers; family members and caretakers; and, finally, direct observation and evaluation of the client. Risk factors frequently contributing to clients requiring mental health outreach such as medication non-adherence and variable compliance, homelessness, coping skills, and intelligence, along with antisocial attitudes are also presented. The importance of uncovering past histories and recent violence and aggression histories is emphasized, and considerable attention is given to determining where possible, the frequency and possible precipitants to an individual's violent behavior. Finally, a brief overview of Tips on Evaluating Dangerousness, static versus dynamic risk factors, and commonly used violence risk assessment tools is shared.[20]

Using Clinical Skills to Prevent and Deescalate Crises

This portion of the SAVE training is directed at how best to use learned clinical care skills and employ them into violence prevention or mitigation techniques. Audiences are instructed to

identify key individual and situational stressors for their clients, while evaluating these challenges within a crisis continuum. After developing a more holistic view of a client, a review of practical support techniques is discussed. Such techniques taught can vary from simple empathic listening to assisting individuals to obtain basic necessities, and how to best support their client's identified existing coping mechanisms. In addition, this training emphasizes the power of offering choices to escalating or hostile clients. A large component of this section is dedicated to providers developing both verbal and non-verbal techniques to aid in preventing behavioral escalation and to safely deescalate high-risk individuals (see Figure 15-1). The staff SAVE training program is primarily directed at community-based staff who typically do not have immediate backup or security presence, and thus stresses absolutely no physical interventions such as restraint or hands-on redirection at anytime. Escape techniques and "in the moment" physical management strategies will be addressed elsewhere in this text (see Chapter 16). Furthermore, case-based examples in the SAVE training help demonstrate how to offer timely, unbiased, and clinically sound responses to family members, other providers, and phone calls. During training of outreach and community mental providers in particular, the program focuses on how best to manage the when, where, why, and how of emergent hospitalization of individuals in the streets, and how to avoid common pitfalls during these high-risk interactions. Finally, and frequently the most well-received portion of the SAVE program, the audience is encouraged to participate in situational role play scenarios. The instructor tailors each scenario and the volunteers based on information previously gathered and reported by audience members and their agencies.

Examples of common role play scenarios include:

- Approaching an unknown residence
- Transporting a client who becomes upset in a vehicle
- Managing a restless client demanding money
- The need to escape a threatening family member or friend
- Presentation of bad news (e.g., loss of enriched housing) to a client

Safety Precautions for Transporting Individuals

Transporting clients poses one of the most high-risk workplace situations for outreach mental health workers. Many staff assist their clients with transportation to necessary medical, legal, and other social services appointments. The mantra shared for driving any client is "Safety First." Each SAVE program reviews ground rules and the "Do's and Don'ts" of proper client transportation that include:

a. Maintaining daily logs of transportation activity
   i. Who, what, where, when
   ii. Vehicle sign out

1. Maintain Calm
   a. Approach client in a calm manner to engage
      i. Enlist active partnerships
      ii. Maintain respect at all times
2. Provide adequate personal space
3. Appear to be in control, but not *controlling*
4. Listen
   a. Avoid interruptions at first
   b. Avoid interpretations
5. Speak softly and avoid judgmental or provocative statements
   a. Brief is best: Speak less and avoid over analysis
   b. Utilize empathic statements
      i. Comment on neutral items and follow with empathy
6. Speak only to a sitting or prone client
   a. Communicate desire to help
      i. Pay attention
      ii. Relaxed and open postures and gestures
      iii. We, instead of I or you
      iv. Peace offerings: food or cold drink
7. Avoid personalizing client's negative behavior
   a. "It's not about you"
8. Never promise what you cannot deliver
   a. Failure to do so may haunt you later
9. Back off quickly and obtain assistance if necessary
   a. Don't be a hero
10. Limit Setting
    a. Prudent use in community settings without security backup!
    b. Utilize polite and respectful requests such as "Please" and "Thank you"
    c. Avoid authoritative stance or strict dominance
    d. Save face
       1. Allow client to do so if limits are being set
       2. Avoid angry or arrogant stances that raise the ante

■ **Figure 15-1 Verbal and non-verbal techniques to prevent and deescalate agitation**

b. Pre-Transport Assessment
   Determining who can and cannot ride:
   i. Agitated or threatening
   ii. Intoxicated

iii. Medically compromised
iv. Acute psychiatric or emotional crisis

c. Location within vehicle and vehicle preparation
   i. Driver with respect to client location
   ii. What to carry and what to avoid

d. Rules of the Road
   i. All occupants must be belted
   ii. Client must agree with informed consent of Do's and Don'ts
   iii. No transport of friends/relatives unless previously arranged
   iv. No or low entertainment (radio, CD, etc.)

e. Emergency Protocols
   i. Right-hand lane rule (for quick pull off or exit if needed)
   ii. Accessible cell phone (with GPS location where available)
   iii. GPS mapping device (where available)
   iv. Urgent exit strategy

Home Visit Safety: Situational Awareness

Particular emphasis is placed on the module of home visit and outreach safety for staff. Utilizing chain of events Air Force training principles, audience members review the importance of not just knowing where they are at all times, but the importance of awareness for what lies ahead. As pilots cannot rely on their eyesight to alert them to what may be miles ahead during high-speed flight, outreach providers cannot begin to understand what lies ahead of them each day entering into an unpredictable, and at times, fully unknown workplace. Arriving into complex urban settings or an unfamiliar residence of a newly enrolled client requires forethought, anticipation, and continuous reassessment of their surroundings. Training to remove ever-present distractions and focus on what is important to accomplish during each outreach is stressed. Related concepts using examples and visual aids are reviewed during this part of the program and include Interpretation of Incoming Data, Maintaining a Forward Posture, and Spatial Orientation to guide each staff member in determining "where am I in relation to what is important at this moment."

During this training module exit strategies and consideration of particular high-risk situations for violence and aggression are reviewed. Strategic planning and preemptive thinking is discussed in the "when to talk and when to walk" section. A related failsafe concept, "when in doubt, get out and shout," supports a safety-first approach, followed by an assertive attempt to obtain consultation, and/or emergency assistance.

Finally, during home visit safety training frequent high-risk activities that may result in agitation and potential violence are considered. These include, but are not limited to, visits that may lead to anxiety, fear, and anger. Initial outreach by staff to a new or non-adherent client and crisis evaluations at, or emergent hospitalization from, an individual's residence, can portend significant danger. Additionally, cases involving custody issues, loss or change in a residential status, and in particular, any financial matters, require proper preparation and contingency

planning to minimize workplace risk to staff safety. Specific unpredictable times for outreach visits such as those taking place during the early morning, evening, or during on-call status, necessitate heightened concerns for safety. Audience members are reminded during this section of training to develop special protocols for these special situations, maintain adequate levels of supervision, and create appropriate backup coverage or buddy systems.

Staff Well-being

Managing staff safety, burnout, and turnover Staff who perform outreach services face clients with considerable risk factors for arrest and incarceration including homelessness, substance use, antisocial attitudes, and treatment non-adherence. While most arrests are the result of minor crimes such as trespassing and panhandling, these risk factors can also result in agitation, threatening behaviors, and physical violence. The expectation that some outreach workers and teams manage high-risk clients during working hours while maintaining around-the-clock availability, presents special challenges in terms staff safety and expectations of care delivery. This may be particularly stressful for inexperienced staff members and understaffed teams. Both new and experienced staff describe being overwhelmed by their job responsibilities. This can promote feelings of demoralization, failure, and burnout. It is well known that apathy and lethargy can lead to impaired judgment, decline of individual awareness, and subsequent poor outcomes.

Consistent with such problems, many assertive outreach and case management programs report experiencing an initial period of rapid staff turnover that compound hiring challenges and effective service delivery to high-needs clients. These same groups described the perception of "always playing catch-up." Of note, some outreach mental health staff report that these common morale problems were lessened by the daily presence and support of available team leaders and supervisors. Leaders and supervisors are instructed to be vigilant for poor clinical decision making, boundary violations with clients, and other indications that further staff training and supervision are needed. Circumstances for incident reviews and debriefings are also examined. Additional recommended strategies in this module in order to minimize staff burnout and turnover include promotion of continuing education, flexible use of vacation days, and granting time off requests for special events. Staff retreats, team building exercises, and staff recognition awards can also go a long way toward enhancing staff morale and promoting staff retention despite the rigors of intensive outreach work.

The final module of the SAVE training invites all audience members, leadership, and administrators to develop their own unique and effective safety plan for their outreach services. Core elements of a typical plan contain:

- A clear and easily endorsed sign-out system
- Consideration of joint visits for initial and anticipated high-risk visits
- A staff backup system
- A review of recommended communication strategies. Available technologies such as GPS-enabled cellular phones for routine and urgent matters is presented during this module.

Using the acronym, OBSERVE, a summary discussion of seven keys to successful violence prevention programming for mental health professionals, is shared with audience members (see Figure 15-2). Finally, in order to develop a unique agency safety plan, attendees are asked to gather with their respective teams or agencies and provided with a workplace safety plan template. After identifying key challenges to staff workplace safety, teams are then requested to briefly draft action steps to address each of the identified concerns. Teams are then advised to formalize and implement their safety planning over the next month after receiving workplace safety training.

Discussion and Future Directions

With the increased role of community mental health outreach services, the frontiers of the workplace and the potential for workplace related violence have expanded. Staff safety and WPV education training requires time and effort on behalf of staff, their supervisors, and agency administrators. Yet providing appropriate preparation and the necessary tools with which to practice may minimize, or even prevent, the likelihood for WPV while offering assertive mental health care in the streets. Proper safety and awareness training can pay significant personal, financial, and patient care dividends. If such training is made available to staff it is logical, based on other work-related competency courses, that it take place at the beginning of one's outreach career and at regular intervals thereafter. Although this chapter is merely a brief overview of the SAVE curriculum, it is one method that has been employed successfully on a national scale by a variety of community mental health professionals. This program affords both initial and follow-up training opportunities for mental health and allied staff, using both tailored onsite presentations and transportable multimedia learning methods. Admittedly, WPV in mental health settings is multifactorial, thus, WPV prevention training is only one element necessary among many components to minimize that risk. Additional elements include, but are not limited to, staff ability, provider confidence, and competent leadership support along with regular supervision.

My own experience with forensic assertive outreach teams and related mental health services helped inspire the development of the SAVE program. With the continuing development of community-based services for high-risk populations, delivery of comprehensive, effective, and efficient violence prevention training mechanisms is needed in this evolving workplace. The SAVE training has been more frequently requested and delivered to law enforcement, divisions of parole, probation, and correctional officers. One veteran officer offered the following post-program feedback: "This training made me revisit and review situations that I normally take for granted. I have a fresh pair of eyes going into everyday situations in the field." Future directions for this WPV prevention program may include emergency medical technicians, crisis intervention personnel, and residential providers working with at-risk clients in unpredictable settings. Although effectiveness studies of violence prevention trainings exist in acute mental health settings,[16] further research remains to assess the impact of WPV prevention programming on incidents and the security of community and outreach service providers.

"OBSERVE"

1. **O**bservation & Assessment
   a. Maintaining an index of suspicion
2. **B**road Communication
   a. Development of skills
   b. Crisis management
3. **S**upervised Teamwork
   a. When in doubt, shout
   b. Routine high-risk case review
4. **E**ducation and Training
   a. Identified expertise
   b. Certification and educational credit
   c. Refresher courses
5. **R**espect
   a. Client
   b. Co-workers
6. **V**isible Administrative Support
   a. Empowered management
   b. Safety plans and protocols
7. **E**arly Debriefing
   a. Review of all incidents
   b. Acknowledge all staff input
   c. Record appropriate details
   d. Medical/mental health treatment following incidents
   e. Time-out for employee

■ **Figure 15-2 Seven keys to violence prevention for mental health professionals**

Resources

- http://www.urmc.rochester.edu/smd/psych/special_prg/SAVECD.cfm
- www.crisisprevention.com
- http://www.caresllc.com/educational.htm

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