2012 Negley Awards Application

Keeping People Safe – "It's What We Do"

INTRODUCTION -

LifeStream is a comprehensive behavioral health organization with a wide ranging array of service components. Keeping people safe is the very core of what we do. From the most obvious example of inpatient care for persons that are "dangerous to self or others" to those making poor decisions relating to drug, alcohol, unprotected sex, and other life and death decisions, staff in the behavioral health arena are cognizant of the safety needs of those served. Most people going into the behavioral health field do so with the goal of helping others, and believe that the therapeutic bond that they strive to achieve is a protective factor against violence towards them.

School violence emerged as a national concern in the second half of the 1990s. Incidents at Moses Lake, WA, West Paducah, KY, and Jonesboro, AR, brought the problem of school violence to the attention of the American public. On April 20, 1999, the horrible shootings at Columbine High School in Littleton, Colorado, that left 15 dead and many wounded, indicated the need for the development and implementation of effective school violence prevention programs, and research to help understand why tragedies like Columbine occur. Halfway through the first decade of the 21st century, it is clear that workplace and school violence incidents and prevention efforts have changed since the early 1990s. [1]

Unfortunately this realization has not greatly impacted the behavioral health community and its understanding or attention to workplace violence. National statistics show that individuals within the psychiatric healthcare industry are among the most common recipients of assault and violence in the

[1] Workplace Violence in the 21st Century: Emerging Trends, James N. Madero, Ph.D.; Violence Prevention International, July 2005

workplace[2]. We believe that safety for everyone involved breaks down to three major areas: training, facility controls, and monitoring.

TRAINING –

Each component has its own set of risk factors associated with the target population and for staff serving these individuals in care. The dangers facing a member of the inpatient treatment team are much different that those of a single case manager traveling in the field to conduct home visits. Staff are made aware of the potentially dangerous nature of psychiatric healthcare from the time of general orientation provided by the organization. The OHSA study cited above detailing the level of violent assaults and injuries that occur within the psychiatric healthcare field are shared with all new employees, and the statistics associated with LifeStream's occurrences are cited as evidence that we are not immune from such events. This leads nicely to a discussion of the importance of training offered to employees working in direct care roles. Job Descriptions guide the level of training provided to employees. Those employees working within inpatient and residential programs receive the highest level of aggression control training which incorporates physical controls of individuals who demonstrate aggressive behavior and/or a lack of self control. However, the organization strongly endorses de-escalation of any such events through the use of nationally endorsed NAPPI[3] trained verbal skills. We monitor the use of seclusion, chemical and mechanical restraint on a monthly basis and actively review each usage. Although fifteen years ago staff would have flatly stated that that operating a psychiatric inpatient facility without utilizing seclusion or restraints on a daily basis was impossible, a focus on eliminating these practices has virtually erased this questionable component of care from our organization. Primarily through the introduction of relationship building, establishing trust, verbal de-escalation staff have gained a new set of skills to prevent violence from occurring. Training also is important for individuals in care and each person that receives care from our organization obtains orientation to services which contains 'Rights and Responsibilities' including understanding "being held responsible for any physical or verbal abuse of staff".

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[2] Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers;
U.S. Department of Labor Occupational Safety and Health Administration, OSHA 3148-01R

[3] Non Abusive Psychological & Physical Intervention; NAPPI *International*

Within the inpatient setting every admission is asked to read and sign an advisory addressing their and other recipients' of care civil rights, the protections offered and the consequences of violations. At assessment every individual is processed through the FBI database which can identify if the person has previous charges related to violence or sexual crimes. This information is a part of a larger assessment where the person is identified as needing specific monitoring for 1) Suicide; 2) Violence or 3) Sexual Precautions – the three are not mutually exclusive and an individual may be simultaneously on all three. Upon assessing an individual with presenting behaviors or crime history, the Supervisor of the clinical unit onto which the individual is being admitted is verbally notified, and the individual is placed on the appropriate monitoring schedule which begins upon arrival to the clinical unit. Minimally the individual on "precautions" gets monitoring recorded in 15 minute intervals. Individuals that demonstrate verbal or behavioral cues suggesting these behaviors may be demonstrated on the unit may be placed on 'constant visual observation' or the most restrictive level of monitoring 'one to one' where a staff member is always within arms reach of the person.

Our ranks of staff providing home, school or field based services continue to grow. While we find that we have a better clinical return on investment by seeing children in the school setting, or case managing severely mentally ill in their homes, the advent of independent single practitioners traveling alone is an emerging concern being addressed. Earlier this year we established a multi-disciplinary team to wrangle with these apprehensions. Although we have not directly experienced any critical events of robbery, rape, hostage taking or murder of a staff member, these are all potential experiences which could befall providers engaged in such services. Through consensus the team has determined that three areas are concerns of priority: Timely assessment of state (versus trait) characteristics, training of staff and establishing a seamless Staff Check Out / Check In process. The team reviewed the HCR-20 and determined that the scale was too focused on trait aspects of the individual which staff have previously assessed. Our concern is the manifestation of the illness for individuals with severe mental illness and potential for violent or inappropriate behaviors related to his/her immediate mental condition. The other component needing ongoing assessment is the environment in which the consumer will be seen. Unfortunately mental illness is a disease that impacts all domains of an individual's life including social economic status. Many of our consumers do not live in the best parts of town and thus the "environment of care" must be evaluated repeatedly to determine if it presents as safe for our

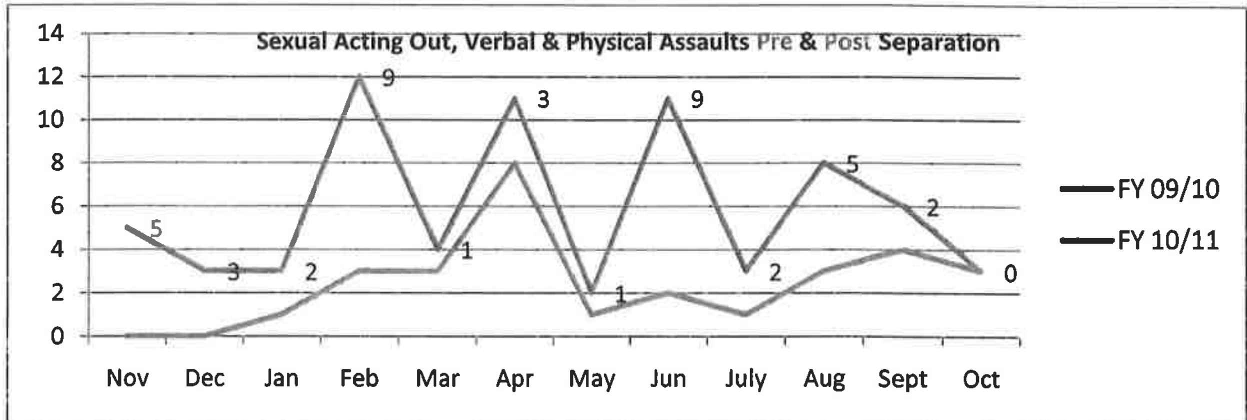
staff. In a similar manner, staff providing on-site services to children often have the need to visit the home for parent conferences. While they may know the consumer that they are seeing in the safe environment of the school setting, they do not always know the family members or neighborhoods that they may be visiting. Procedures have been written to direct staff in these functions. Training of staff has begun focusing on reading the environment, assessing the consumer and fostering personal ownership for safety. The Team continues to struggle with implementing a "staff locator" system that is practical, reliable and affordable and one that supervisors will endorse.

FACILITY CONTROLS -

Despite training staff and consumers about safety and responsibility, we know that events have the potential to occur sometimes unexpectedly and without warning. For these reasons the organization has multiple facility controls to enhance safety. These include the most common deterrents such as locks, sign-in logs, badging and escorts for visitors at each facility. More recently the organization has turned toward video surveillance as another source of facility control. Our inpatient facility built in 1989 was retrofitted with fifty cameras. Some cameras are monitored in real time and all are recorded digitally to a DVD for review as necessary. Our newest facility built in 2008 to house outpatient and residential services was designed with video monitoring as a part of the construction. While staff were initially resistant to the concept of video surveillance they have come to now request a review of the video. Our inpatient facility was built to have five distinct clinical units and the facility has been reconfigured in many variations over the years. With an eye towards safety, the largest clinical unit has been divided by sexual gender to allow separate men's and women's units. This greatly diminishes the potential for the somewhat common inappropriate verbal exchanges and the much less frequent but reported and observed sexual battery (unwanted touching). A concomitant benefit is the ability to conduct more gender specific clinical programming. Because we are a retirement community, a significant portion of admissions are geriatric individuals, some with dementia and other cognitive impairments that frustrate, anger and intrude on the personal space of younger individuals in care. We also have created a distinct clinical unit for older individuals which allows their slower pace and treatment needs to be better addressed. Feedback through satisfaction surveys from these groups supports their perceptions of this providing a more secure and comfortable clinical setting.

MONITORING

How do we know that these changes are making a difference? The chart below shows a marked decrease in the number of incidents being reported with the inpatient facility related to sexual acting out,, verbal assaults and inappropriate touching.



CONCLUSIONS

While horrific events such the school shootings at Columbine, and the still fresh Giffords shooting, as well a seemingly multitude of similar public violence headlines suggests that the potential for harm is always a potential for the general population, A study by the Department of Labor's Occupational Health and Safety Administration confirms that psychiatric and "social work" employees are five times as likely to be assaulted or violently injured in the work setting. So while the core nature of behavioral health services is to keep and improve the safety of those we serve, organizations cannot and must not ignore the serious potential for danger to their greatest asset: staff. Only through acknowledging the potential for violence, having informed and invested staff and making recipients of care partners in psychiatric workplace safety can an organization demonstrate a clear commitment to 'Keeping People Safe'. This year's Negley Award should begin a national agenda for MHCA and its sister organization – The National Council for Community Behavioral Health Centers, to take this issue to center stage. It is imperative that the dedicated and caring individuals that make up the staff of the member organizations receive the resources to bring this era of workplace violence to a close.