Crisis De-Escalation in Jails, Corrections, & Treatment Settings

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LEARNING OBJECTIVES

At the conclusion of this presentation you will be able to:

• Know the statistics on why crisis-de-escalation training is essential
• Know the triggers (initiating factors) for events and how to monitor and address prior to escalation
• Demonstrate the effective use of positive verbals and non-verbals
• Know the essential strategies for effective interactions during particularly difficult situations
• Differentiate between therapeutic and non-therapeutic care
• Know strategies for suicide crisis management
Who we are...

Office of Forensic Mental Health Services (OFMHS)

• We are part of the Behavioral Health Administration of the Department of Social and Health Services.

• Established in 2015, we are responsible for the leadership and management of Washington’s adult forensic mental health care system (RCW 10.77.280)

• Services include:
  – Competency evaluations
  – Competency Restoration Treatment (we operate three facilities)
  – Not Guilty by Reason of Insanity (NGRI) Assessment/Treatment
  – Diversion programs
  – Workforce development and training
Trueblood Settlement Agreement

*Trueblood v DSHS* (Trueblood) (2015) challenges unconstitutional delays in competency evaluation and restoration services. The State has been ordered to provide court-ordered competency evaluations within fourteen days and competency restoration services within seven days.

The settlement agreement (2018) aims to resolve the Trueblood lawsuit (contempt) by creating a plan for an array of services for class members and potential class members. The agreement includes:

- Expanding residential mental health with crisis services
- Additional training for jail staff and law enforcement
- Hiring forensic navigators and more mental health professionals
- Expanding diversion programs
- A phased implementation approach

https://www.dshs.wa.gov/bha/trueblood-et-al-v-washington-state-dshs
Jail Technical Assistance Program

The OFMHS Jail Technical Assistance Program provides informational support to Washington jails in the following areas:

- Pre and post-booking options
- Identification of need and access to treatment
- Guidelines for administration of involuntary medication
- Continuity of care
- Use of segregation
- Release planning
- Crisis de-escalation

Our team of expert consultants and trainers may be contacted through the following email: jailassistance@dshs.wa.gov

www.dshs.wa.gov/bha/jail-technical-assistance-program
The Importance of Crisis De-escalation Training and Skills
Staff exposure to violence is high

- Health care workers are 4 times more likely to be victims of workplace violence than those in non-healthcare fields.
- Violence rates for psychiatric aides are 69 times higher than the national rate of violence in the workplace.
- Violence rates for psychiatric technicians are 38 times higher than the national rate of violence in the workplace.
- Police officers and sheriff’s patrol officers experience an incidence rate of 151.3 per 10,000 full-time, equivalent workers, with Corrections Officers presented with an even larger rate.

Trauma exposure is higher

- Direct Experience of violence and witnessing violence
- Injuries and witnessing injuries
- Vicarious trauma
- PTSD and depression for police (and firefighters) is approximately five times higher than the civilian population.

(NASMHPD, 2004)
Suicide Risk

• Suicide – particularly high among correctional officers and law enforcement (detectives/criminal investigators/police)
  – More police die by suicide than in the line of duty. In 2017, there were an estimated 140 law enforcement deaths by suicide.
  – 1 in 4 police officers has thoughts of suicide at some point in their life
  – Higher in working police officers vs. separated/retired officers (110.5 vs. 13.1 per 100,000 person-years respectively)

System Responses

• Federal Agencies (OSHA, NIOSH) prioritizing Workplace Violence Prevention Plan Development and Implementation
• Growing trend in “De-escalation” trainings and expectations in nearly all human services organizations
• Media coverage uptrend in “Use-Of-Force” vs. De-Escalation events driving agency initiatives
Definitions & Essential Concepts
What is a Psychiatric Crisis?

- Thoughts/actions of self-directed violence (suicide) or physical harm to others,
- Acute psychotic symptoms, and/or
- Deterioration in mental status
- ...resulting in the person’s behaviors putting them at risk of harming themselves or others

(National Alliance on Mental Illness of Virginia, 2013 www.namivirginia.org)
What is De-escalation

• *dēˌeskəˈlāSH(ə)n*

Reduction of the intensity of a conflict or potentially violent situation.
What is Crisis Intervention

• krīsis in(t)ər'vən(t)SH(ə)n

An immediate and short-term psychological care aimed at assisting individuals in a crisis situation in order to restore equilibrium to their biopsychosocial functioning and to minimize the potential of long-term psychological trauma.
Understanding Crisis
Application

The research, skills, and techniques outlined in the verbal procedures of this workshop are best applied during stand-alone, day-to-day interactions (for prevention) and early-stage escalation. During psychiatric emergencies and behavioral crisis episodes, they remain equally valuable but are delivered within the crisis intervention algorithm, known as INSERT, from the Advanced Crisis Intervention Team (ACIT) program of the Department of Social and Health Services, Behavioral Health Administration.

- Identify Escalating Behavior
- Needs Assessment
- Safely Approach
- Engage the patient
- Reinforce patient self-management and self-control
- Teaching moment for patient, staff, and team
Aggression

Aggressive behavior may occur when a person lacks the chance or the ability to express feelings and meet needs.

In other words...

When you are looking at a person who is upset, you are looking at a person with an unmet need, expressed through an aggression type
Aggression Types

Reactive or Impulsive – anchored in abrupt emotional deviation...generally most common encountered by staff and easiest to de-escalate.

Instrumental/Intentional – pre-planned, learned over-time...less frequent overall, but more common in Criminal Justice System...harder to de-escalate.

Psychotic – biologically rooted...generally requires chemical intervention as part of the intervention modality.
Interactions and Consumer Outcomes

• Decades of research shows that increased interactions with staff is associated with better patient outcome regardless of type of milieu
  – Faster discharge
  – Longer community tenure
• Staff interactions are crucial to patient outcomes
• Increasing the frequency of therapeutic interactions and decreasing the frequency of non-therapeutic interactions leads to improved clinical outcomes.
• Positive interactions lead to positive outcomes.

* References for peer-reviewed scientific publications are provided at the end of the slideshow
Types of Interpersonal Interactions

- Overall interactions predict consumer outcomes but particular interactions can be therapeutic and non-therapeutic
- Therapeutic:
  - Positive verbals and non-verbals in response to appropriate behavior; giving positive items after appropriate behavior; prompting to failure behavior; ignore/no response to bizarre behavior or repeated requests that cannot be met; setting boundaries, deflecting, and maintaining boundaries
- Non-Therapeutic:
  - Negative verbals; should statements; taking something away; reinforcing undesirable or dangerous behaviors
  - Discussion: what are some positive non-verbals and verbals, what are some negative non-verbals and verbals.
Interactions and Aggression

• **Cause of Aggression**
  – Feeling at the mercy of an uncaring system or staff member
    • Aversive staff interaction
      – “Directed”
      – “Denied”
      – Taking appropriate items away
      – Non-therapeutic interactions
    • A system with no hope for discharge

• **Preventing Aggression**
  – Increasing therapeutic interactions
  – Decreasing non-therapeutic interactions
Trauma Informed Care
What is Trauma?

• Definition (NASMHPD, 2004):
  – The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism and disasters.
Prevalence of Trauma within Mental Health Population

- 90% of public mental health clients have been exposed
- Most have multiple experiences of trauma
- 34-53% report childhood sexual or physical abuse
- 43-81% report some type of victimization

A majority of adult and children in inpatient psychiatric treatment settings have trauma histories
Recognizing Trauma

- Trauma is under-reported and under-diagnosed

- Trauma symptoms can include inattention, disorganization, depression, problem eating behaviors and impulsivity
Definition of Trauma Informed Care

Mental Health Treatment that is directed by:

- A thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and

- An appreciation for the high prevalence of traumatic experiences in persons who receive mental health services.

“Many providers may assume that abuse experiences are additional problems for the person, rather than the central problem…”
Least Restrictive Means

- Collaborative Relationship
- “watchful waiting”
- Verbal De-Escalation

- Physical Restraints
- Seclusion
- Chemical Intervention
Initiating Factors
(Possible Triggers)
Your Behavior Matters!

Remember, how YOU act/react can make all the difference in a crisis de-escalation scenario. You have the power to escalate or de-escalate a situation.

- Your behavior may trigger a patient’s pre-existing traumas
  - For example, command statements, postures that imply dominance or physicality, touch
- Consumers who are already agitated may mirror your agitation, frustration, etc., causing them to react.
  - For example, you visibly in fear or dyscontrol will signal that their aggressive behavior is working for them
Your Behavior Examples

• Standing too close
• Blocking “exits”
• Acting rude, un-empathetic
• Ignoring the person
• Agitating behavior, loud voice, “should”-use
• Your interactions with other staff
Environmental Factors

The environment in which the person is in can contribute to agitation and crisis...

• The overall milieu, or entry of new person(s) may agitate
• Lack of, or encroachment of personal space
• A new patient (or staff member) that reminds person of traumatic experience
• Noise (such as a loud TV set)
Consumer Factors

- Anxiety
- History of trauma, abuse
- Psychotic Symptoms
- Organic brain disorders, dementia
- Medications
- Lack of self-regulation/coping skills
Therapeutic Interactions
Validation

- I see you
- I hear you
- I want to understand you
Levels of Validation

**Level One Validation – Listening & Observing**
This level of validation allows the staff to understand where the patient is in the moment through listening to and observing the patient’s words, feelings, and actions. The staff is interested in the patient and actively attending to the patient’s verbal and non-verbal output.
Examples: “Can you explain that?” “Tell me more.” “What were you thinking just then?”

**Level Two Validation – Accurate Reflection of What is Stated**
This level of validation is accurate reflection using a nonjudgmental stance. This allows the patient to know that he or she has been understood in a deep and meaningful way.
Examples: “So you were saying that....” “In other words....”

**Level Three Validation – Articulating the Unverbalized**
At this level of validation, the staff “reads” the patient’s behavior and articulates emotions and meanings that the patient has not expressed. This does not mean that the staff uses consequences of behavior as proof of intent. This allows the patient to know that his or her responses to events are justifiable and for the patient to know him- or herself better than before.
Examples: “It sounds like you were very upset/angry/hurt.” “This must be really difficult for you.”
Levels of Validation Continued...

**Level Four Validation – Validating in Terms of Sufficient (but Not Necessarily Valid) Causes**
This level of validation is viewing the patient’s feelings, thoughts, and actions as justified and understandable in light of the following: 1) historical antecedents, 2) invalid current antecedents, and 3) disordered antecedents due to biological factors. Validating means highlighting and reinforcing the adaptive aspects of the patient’s behavior, without emphasizing the inherent dysfunction of the behavior. This allows the patient to make sense of his or her behavior.
Examples: “So when she turned you down, you were angry and embarrassed. You were thinking of every other woman who had ever rejected you.”

**Level Five Validation – Validating as Reasonable in the Moment**
At this level of validation, the staff communicates that behavior is justifiable, reasonable, well-grounded, meaningful, or efficacious in terms of current events, normative biological functioning, and the patient’s ultimate life goals.
Examples: “You were really confused by that. I think most of us probably would have felt confused at that moment.”

**Level Six Validation – Radical Genuineness**
At this level of validation, the patient is responded to as a person of equal status, due equal respect. This requires the staff to be genuine, and to respond spontaneously and completely in the moment. At this level, the staff communicates that the person is valid.
Examples: “Being here is really difficult. I don’t think I’d like to live here either.” “What you did really scared people. I would have been scared too if I had been there.”
Positive Verbals and Non-Verbals to Appropriate Behavior

• Positive appraisal of an appropriate behavior
  – Verbal
  – Non-verbal

• Examples:
  – A consumer says that his goal is to live in the community and never assault anybody and then staff says, “That’s a great goal!”
  – Consumer demonstrates an appropriate hand shake during social skills group and then staff says, “Nice handshake! Thank you.”
  – Consumer comes to Community Meeting for the first time and then staff pats him on the shoulder a few times and says, “Great to see you in Community Meeting today.”
Giving Positive Items After Appropriate Behavior

• Identify rewarding items
  – Having specific target behaviors and associated items listed on the treatment plan will help with consistency

• Most effective when paired with a positive verbal and non-verbal

• Examples:
  – Consumer goes to groups and then staff hand him his reward and say, “Nice job getting to group today.”
  – Consumer hands staff a point sheet to buy an item from the incentive store and then staff hand him the item and say, “Nice job earning points to buy [specify item].”
Prompting to Failure Behavior

- Explaining the consequences of behaviors
  - Negative Prompt describes undesired consequence(s)
  - Positive Prompt describes desired consequence(s)
  - Always follow negative prompt with positive prompt

- Example:
  - Consumer has his eyes closed during group and then staff says, “[Name] if you keep your eyes closed during the group, you will not be able to earn your participation point. However, if you open them now, you will have a chance to earn the participation point.”
  - Identify the specific behavior during the prompting, note “eyes closed”. Avoid inferences as a function of specific behavior such as “falling asleep”.

Therapeutic
No Response to Bizarre Behavior or Repeated Requests that Cannot be Met

- Consumer walks up to staff and says, “I have a microchip in my tooth” and then staff does not make eye contact and safely walks away.
- Staff informed the consumer that he does not have enough points to purchase a candy bar but then the consumer repeatedly demands a candy bar. In response, staff break eye contact with the consumer and serves another consumer. Once the patient behaves appropriately, staff resumes eye contact and responds.
- When breaking eye contact, do not turn away or lose sight of the consumer peripherally, for safety.
Setting Boundaries, Deflecting, and Maintaining Boundaries

• Consumer walks up to the hall monitor and requests a facilitated phone call and then staff says, “I am the hall monitor right now and need to stay here to watch the halls. If you ask that staff over there, (s)he may be able to help you.” The consumer continues to ask and then the hall monitor does not respond to the request.
Non-Therapeutic Actions
Expressed Emotion (EE)

- Higher EE associated with poorer patient social functioning
- 3 Major Forms of EE:
  - Hostility
    - Blaming patient
  - Emotional Over-Involvement
    - Pitying patient; Staff taking blame/responsibility, taking blame approach
  - Criticism
    - Point out “bad” things
- Re-phrase negative comments towards patient behavior to combat high EE:
  - Example: You observe a Patient pulling a half eaten apple out of a garbage can and he immediately starts to take a bite out of it.
    - Perception: That is disgusting, he needs to stop.
    - Reality: The Patient has been homeless for most of his life and has gotten food this way in the past as a method of survival. He is hungry.
    - Change the negative perception of the situation. Instead, approach the Patient with support and validation.
- Avoid shaming and/or criticizing the Patient.

“I saw you get that apple from the garbage, this is a Hospital and we have resources here to provide you with an apple if you need one. Let me show you.”
Negative Verbals

• Negative verbal to appropriate behavior
  – A consumer is appropriately using utensils to eat and then staff says, “I don’t like how you did that.”

• Negative verbal to a failure
  – A consumer is struggling with writing a letter to his mother and then staff say, “You really suck at writing.”

• Negative verbal to request
  – A consumer hands staff a point sheet and asks to buy a coffee and then staff says, “I don’t want your frickin’ points sheet and you’re not going to get any coffee.”

*Non-Therapeutic*
Dealing with Bizarre Behavior

- Arguing with patients
- Challenging their delusions (unless done with an established therapy protocol)
- Reinforcing delusions
- Reinforcing bizarre behavior

Non-Therapeutic
Should Statements

• “Shoulding” on a patient
  – “You should go to group.”
  – Variations include “you need to” or “I need you to”
  – A consumer is presenting agitation and then staff say, “You need to calm down.”
  – A patient has his eyes closed during group and then staff say, “Hey! You should wake up.”

Non-Therapeutic
Taking Something Away

• Taking something appropriate away while consumer is behaving appropriately or failing to perform a task
  – A consumer traded points for a cup of coffee and then staff grab the coffee from the consumer before she finishes the cup.
  – A consumer is not using his utensils correctly during a meal and then staff take the meal away from the consumer and say, “You don’t get a meal if you can’t use the utensils correctly.”

• Bottom line – never take something away from a patient unless it is a __serious__ security concern

Non-Therapeutic
Reinforcing Undesirable Behavior

• Consumer says, “F*&# you!” and then staff hand him a coffee.
• Consumer is in restraints and then staff says, “I’m so sorry you were placed in restraints. Let me add some points to your points sheet so that you will be able to get that candy bar you like.”
• Consumer fails to perform a target behavior on her treatment plan but staff give her the reward that she did not earn.
• Consumer is talking to unseen others and then a staff member says, “I like how you do that crazy stuff.”

Non-Therapeutic
Strategies for Effective Interactions During Particularly Difficult Situations
V.D.S.P.

**Validate:**
I see you, I hear you, I want to understand you

**Defer:**
Defer to a procedure, policy or expectation. “Shared value system.”

**Suggest Alternative:**
Provide an alternate way and/or setting to go address the issue

**Positive Prompt:**
Describe a desirable outcome
Frequent Programmatic Situations

• Limit-Setting
  – Getting someone to stop doing something they want to keep doing

• Activity Demand
  – Getting someone to do something they don’t want to do

• Denial of Request
  – Situations goods or privileges cannot or should not be approved
Effective Limit Setting

• Strategies:
  – Validate, Defer, Suggest Alternative, Positive Prompt

• Example: Consumer tugs on the unit door and says, “I want to get out of here.” Staff says, “(V) [Name] it looks like you would really like to leave and I think it can be tough living here. (D) The Court Order requires you to be here until you meet your goals (S) If we sit over here, (P) I can share with you how you can help yourself get out of here.
Effective Activity Demand

• Strategies
  – Validate, Defer, Suggest Alternative, Positive Prompt

• Example:

• Consumer is sitting in the dayroom a couple minutes before a group. “(V) It looks like you might be comfortable. (D) The Treatment Plan that you signed requires group attendance (S) If you go to group today, (P) it will be anchored in your record that you participated and you’ll be closer to discharge.
Effective Denial of Request

• Strategies
  – Validate, Defer, Suggest Alternative, Positive Prompt
• Example: Consumer requests a candy bar from the points store. “(V) It looks like you would like a candy bar. (D) According to the program’s procedures, you have to have 2 points to purchase a candy bar. (S) It would be great for you to earn 2 points so that you can use them to trade in for a candy bar. (P) There is a group scheduled to run in about 10 minutes and if you go to it you will have a chance to earn 2 points.”
Let’s practice

• Positive Verbal – a positive, verbal appraisal of an appropriate behavior
• Positive Non-Verbal – a positive, non-verbal appraisal of an appropriate behavior
• Positive Prompt – describes a desirable outcome or consequence
• Negative Prompt followed by Positive Prompt
• VDSP for a limit set, activity demand, and/or denial of request
Managing Suicidal Crisis
Assisting the Suicidal Patient

Warning signs

- Distress not always vocalized
- Tearful, anxious
- Overly tired
- Medications (desperate to get, hiding, or not taking)
- Disoriented
- Agitated
- Change from usual behavior
- Giving away possessions
Assisting the Suicidal Patient

LEARN

- Look
- Empathize & listen
- Ask & assess
- Remove danger & plan for safety
- Next steps to continuous care
## Assisting the Suicidal Patient

**LEARN**

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<td>Next steps to care</td>
<td>Provide crisis resources/ escort to care</td>
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Best-Practices

Ask questions...

- Interact in a manner that communicates concern and understanding (empathy)
- Encourage the person to talk – don’t pressure them!
- Manage your own personal discomfort (i.e., anxiety, fear, frustration, personal, cultural or religious values).
- The most difficult yet most important question of all -
- “Have you had thoughts of harming or taking your own life?”
Best-Practices

- **DO NOT** ask the question as though you are looking for a “no” answer. “You aren’t thinking of killing yourself are you?”

- Explain confidentially/duty to inform as applicable*.

- Ask if there is anyone they would like to call (for support)

- Take immediate action to refer the person to mental health resource

- Stay with the person if you can (escort, hand-off, etc.)

- Document*
Best-Practices

Things to consider when you talk with the person:

- Remain calm
- Lend your ears - Listen more than you speak!
- Maintain good eye contact
- Act with confidence (takes practice if you are new to this)
- Use open body language
- Do not argue in any way
- Limit questions to gathering information in casual manner
- Use supportive and encouraging comments
- Be as honest and up front as possible
Recommendations

- Develop agency policy for crisis response
  - Who is lead?
  - Who had authorities (e.g., seclusion and restraint, medication)?
- Hold trainings, drills
- Critical Incident documentation and review process (for training purposes)
Resources

- SAMHSA's article "Practice Guidelines: Core Elements In Responding To Mental Health Crises"

- Suicide Prevention Resource Center - Law Enforcement
  https://www.sprc.org/settings/law-enforcement
Thank you!

Questions? Feedback?

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References


