

Crisis Management

5

CHAPTER

CRISIS MANAGEMENT

BY JAIMIE PAGE

Crisis will occur in Safe Havens. Crises may occur inside the Safe Haven facility, in its immediate neighborhood, or in the community-at-large. Types of potential crises include:

- threatening behavior,
- dangerousness to self or others,
- medical emergencies,
- missing persons,
- outsiders attempting to victimize a Safe Haven resident, and
- fires and natural disasters.

Effective Safe Havens anticipate and prepare for crises. These programs develop crisis management procedures and train staff to respond efficiently and calmly. Effective crisis management reduces potential harm to residents, staff, community members, and property. It also minimizes the potentially traumatic effects of crises on Safe Haven residents.

This chapter suggests five tenets of crisis management to guide a program's response to emergency situations. It then describes several potential crises and effective responses. The chapter also contains a scenario of a crisis common to Safe Havens and outlines immediate, secondary, and follow-up responses.



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FIVE TENETS OF EFFECTIVE CRISIS MANAGEMENT

- Prevention is key.
- Interventions are always client-centered.
- Interventions balance consistency with flexibility.
- Safe Havens are committed to residents for “the long haul.”
- Staff need to know when and how to get help.

1. Prevention is key. Many crises that could potentially develop in Safe Havens can be prevented or minimized. Not only can Safe Havens and staff anticipate and take action to prevent general crises, but they can also identify and address potential crises that could occur with individual residents.

Staff, for example, will observe that one resident who has organic deficits as well as chronic mental illness is prone to smoking in his room and sometimes drops his cigarette without knowing it. The resident may not be able to follow the standard “rule” of no smoking in rooms, and staff will need to take a more proactive approach. The response could include more vigilant monitoring of the resident’s room, having him check his cigarettes at the front desk, or having him smoke with staff accompaniment.

Another resident may have a behavioral “red flag” of further escalation once he/she begins to think that others are “part of a plot” to control his/her mind and body. Effective responses include assigning staff to more intensive one-on-one interaction, considering additional medications as needed in addition to any regular medications he/she may be taking, keeping other residents at a distance, and preparing to intervene quickly should an incident arise.

2. Interventions are always client-centered. The resident’s individual care plan identifies potential problems and lists appropriate interventions that will be effective and caring. Safe Havens support the dignity, respect, self-esteem, and greatest possible self-determination of any resident affected by an intervention.

As program staff and the individual resident collaborate to develop the resident’s care plan, a case manager may ask the resident, “If you should start to get angry when you think people are plotting against you, what can we do together to keep you and everyone else safe?” While full participation on the part of the

resident will not always be possible, many residents can suggest and ordinarily should know of specific interventions identified in the plan. The plan will also assist residents to develop their capacity to manage crises to the greatest extent possible. Prior identification and discussion is usually less surprising and traumatic for residents. In time, through use of this approach, many residents will begin to expect certain responses to specific behaviors. These expectations will function as safety mechanisms for all involved parties.

Although physical restraint of residents by staff is almost never appropriate, involuntary transport to emergency rooms for involuntary psychiatric evaluations is an intervention that many Safe Havens will probably use in a few instances. Prior to initiating this response, staff must determine that such an intervention is in the best interest of the resident and that the resident will benefit from it. This type of intervention is often traumatic for the resident, as well as for other residents who witness it. Questions about the trustworthiness of the Safe Haven and its staff can frequently arise among residents. An effective intervention will address these concerns and usually include debriefings after public incidents. A major goal of the residents’ debriefing is to increase feelings of safety and security.

3. Interventions balance consistency with flexibility. Staff should be consistent with each resident. For example, staff working with the resident who has difficulty managing his smoking should carry out the intervention of keeping his cigarettes at the front desk and accompanying him while smoking. Otherwise, the variation of interventions may confuse or frustrate the resident, and the risk of fire will increase.

The appropriateness of a particular type of intervention, however, varies depending on the specific situation of an individual resident. For example, a woman who was frequently victimized on the street has recently moved into the Safe Haven after a particularly long

period of outreach to her. Upon moving in, this new resident is gently informed of the need to keep the Safe Haven safe by smoking only in a designated area. If she doesn't remember this "rule" initially, staff will be more lenient and flexible because they want to continue to engage her with less intrusion and structure so as to avoid her return to the streets.

What is appropriate for one resident may be counterproductive or damaging for another. Fairness does not become an issue because the Safe Haven neither makes nor advertises generic interventions to specific behaviors. If one resident would question why he has to turn in his cigarettes while another resident does not, staff can respond in a manner appropriate to the resident by saying that each resident's care plan is different and that confidentiality and privacy requirements prohibit staff from discussing another resident's care plan.

Effective responses not only defuse the particular situation, but also contribute to a safer environment for residents and staff.

4. Safe Havens are committed to residents for "the long haul." Once a person is identified as a potential Safe Haven resident, the program is committed to the person during all phases of treatment: engagement, treatment, crisis intervention, transition, and follow-up. For a resident who has experienced a crisis, **the time period after the crisis is critical.** Residents can often feel embarrassed, remorseful, in need of support, and ambivalent about returning to the Safe Haven. They may wonder how they will be received. Outreach may need to take place following a crisis. These intensive engagement efforts may occur in hospitals, jails, the streets, a crisis shelter, or other locations appropriate to the resident's situation. Even in cases in which the resident is transferred to another facility or to a state hospital, the Safe Haven staff can contribute to a smooth transition.

5. Staff need to know when and how to get help. A comprehensive manual containing up-to-date policies, procedures, and referral information, as well as on-going staff training in de-escalation, medical triage, and crisis management is essential. Program operators must ensure that staff are sufficiently trained and that the necessary supports are in place. Crises are easier to manage when staff feel competent and supported.

POTENTIAL CRISES AND RESPONSES

When dealing with crises, there is a need for immediate, secondary, and follow-up responses. Effective responses not only defuse the particular situation, but also contribute to a safer environment for residents and staff. In a crisis, the first staff member to respond usually becomes the crisis manager and directs other staff and residents. Staff should observe and "size up" the situation before taking action. While there is often more than one correct way to respond, drills can help staff develop and practice appropriate responses.

Threatening/escalated behavior is the most common crisis that a Safe Haven will face. This type of behavior includes: raising of one's voice, yelling or screaming, subtle or veiled threats, cursing, increased psychomotor activity, irritability, accusations, intrusions, and gestures or positioning with or without objects that suggest throwing or hitting. It has several possible causes: a mental illness; response to being close to others after having been isolated; interaction between two or more people with untreated mental illness; substance abuse, adjustment to new structures and routines; and perceptions of intrusion by staff and other residents. Threatening behavior may pose a danger to other residents or staff.

In cases of threatening behavior, staff need to attempt to calm the resident through body language, a soft, low voice, and comforting, empathic language. De-escalation may also include attempts to distract the resident; persuade the resident to leave the area or ask the persons causing the behavior to leave; request the person who is "bothering" the resident to leave the immediate vicinity for a time; or address the escalated resident's perceived needs.

If de-escalation does not work, staff need to get help. Safe Havens should have a code system that alerts staff to a crisis. With a code system, a staff member would announce via intercom or in another way, "Code One in the dining room." Staff would know that there is a crisis in the dining room.

If a particular staff person is the target of the escalation, he or she should ordinarily leave the immediate vicinity once another staff member arrives. Only one staff member should ordinarily talk to the escalated resident. With sufficient staff, a "show of support" is often useful. It may allow the resident to submit without losing face.

Staff, however, should look for signs that the resident is escalating even more due to the increased number of staff. In that case, the extra staff should remove themselves from the resident's view, but be close enough to respond if needed. The crisis manager will direct staff according to the resident's response. In cases where danger is clear and imminent, the crisis manager should ensure that 911 is telephoned immediately.

A secondary response would be gently guiding other residents who witnessed the crisis to a different area and assuring them of their safety. One follow-up response would be debriefing sessions, one with the residents and another with the staff. A few staff members may want to avoid the debriefing because it may be misperceived as a process of criticizing each other's interventions. When debriefing is done collegially, however, it builds the Safe Haven team and assists staff to develop insight and skills. Other follow-up responses include communicating the incident via progress notes, shift reports, or other means, and reviewing the escalated resident's care plan. A report on a crisis incident should include: 1) nature of the event and persons involved; 2) precipitating factors; 3) the chosen intervention; 4) information/alternatives/choices given the resident; 5) staff response; and 6) suggestions for responses to any future situation.

Dangerousness to self is another common crisis. A number of Safe Havens have experienced that, as residents begin to take medications regularly or as they continue to live in Safe Havens, their symptoms may begin to dissipate. During this time, residents may begin to realize where they are, what they've been doing, and what or whom they have lost. By not

allowing weapons in the facility and by having staff monitor usage of medications and other potentially harmful substances or instruments, a Safe Haven can reduce opportunities for this crisis.

Staff generally should accompany the resident back to the Safe Haven upon discharge and ensure a smooth transition and welcome home.

On-going suicide assessment and a plan for intervention will be critical elements in the care plans of more than a few residents. While "suicide rounds" are generally inappropriate for Safe Havens, the Safe Haven and its staff need to be sensitive to the condition of residents in this situation. If program staff observes symptoms indicating an increased risk of suicide, it may increase staff monitoring and support, relay information to the resident's psychiatrist for a medication adjustment, or refer the resident to a crisis shelter or program.

If the resident is at high risk for self-harm, staff may need to attempt to persuade the resident to enter a hospital for a psychiatric evaluation. Obviously, a voluntary admission is preferable to an involuntary one. If a voluntary admission does not take place, the Safe Haven may have to initiate an order for involuntary transport. Ordinarily, staff should wait to tell the resident about the order until the transporting authorities have arrived in order to reduce risk of the resident fleeing the facility. When the authorities arrive, staff should assure the resident that they care about the resident and that a staff member will visit them at the hospital. Safe Haven clinical staff or the resident's psychiatric care provider will communicate pertinent information to the hospital.

Prior to visiting a resident, Safe Haven staff will inquire of the resident if he or she needs any clothing or personal items, and then will bring the requested items. This kindness expresses to the resident the staff's commitment and esteem. Prior to discharge, the appropriate Safe Haven staff member will consult with the resident, hospital staff, and the care plan team to update the resident's care plan. Staff generally should accompany the resident back to Safe Haven upon discharge and ensure a smooth transition and welcome home.



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- suggestions for responses to any future situations.

Medical Emergencies are also likely to occur. A Code One and immediate call to 911 is warranted for any of the following:

- loss of consciousness;
- seizures lasting more than one minute or any seizure for a person without a history of seizures;
- choking;
- deep lacerations;
- significant bleeding;
- appearance of confusion or significant personality change;
- severe numbness or tingling in or inability to move extremities;
- difficult breathing; or
- fainting.

If a Safe Haven has 24-hour on-call medical consultation, staff should call and receive direction for the following: inability to urinate or incontinence in a resident who usually does not have this problem, vomiting blood (looks like black coffee grounds), blood in their stool (looks like black tar), burns, severe abdominal pain, copious diarrhea and vomiting, allergic reactions to food/medication, sudden appearance of rash, or resident eats or drinks something not meant for consumption. If medical consultation is not available, staff should help the resident seek emergency treatment. The general rule is to err on the side of safety.

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During a medical crisis, staff should attempt to distract other residents away from the immediate area of the crisis and advise them that an ambulance is on the way. If residents witness an incident, a debriefing meeting should take place. Communication is critical in emergency situations: communication between Safe Haven staff, administration, and collateral staff; communication of medical history and information to emergency and hospital staff; and receiving information from hospital staff on the course of treatment and discharge. After the emergency, the resident's care plan may need to be adjusted.

Safe Havens may also experience a **missing person** crisis. Occasionally, a Safe Haven resident may "disappear" for one or several days. This situation becomes a crisis when any of the following occur:

- The resident does not usually leave unannounced and is missing for an unusually long period of time;
- The resident does not return to pick up checks, food stamps, other entitlements, or allowances;
- Collateral contacts, including family, have not seen the resident;
- The resident has left important belongings behind;
- The resident needs to take medication for pressing health reasons.

In this type of situation, staff usually will contact hospitals, jails, police, diversion teams, crisis shelters, emergency shelters, and the coroner's office. Staff may also increase outreach efforts and collaborate with other outreach and social service providers in attempting to locate the resident. The Safe Haven may also "get the word out" on the street that it is looking for the resident, if this approach would be in the resident's best interest. The Safe Haven could also contact an agency that specializes in locating missing persons.

An outsider attempting to **victimize a resident** is another type of crisis. This problem will vary depending on the location of a Safe Haven. Many Safe Havens are located in urban neighborhoods, which persons who are homeless frequent. Many, if not most, Safe Haven residents have been victimized on the streets or in shelters. Predatory behavior and abuses of persons who are homeless and who have serious mental illnesses can include threat of or actual physical or sexual assault; financial abuse; persuasion of residents to use illegal substances to provide more income to dealers; and "setting up" residents to handle illegal drugs or drug-related money. Predators may be subtle about these activities and lead residents to believe that they are not in any danger by associating with them.

One prevention is to only allow approved visitors into Safe Haven facilities. Another is to have a single, monitored, and secure point of entry. A Safe Haven that has a drop-in center or in which screening or intake for services take place in the hours of operation should be sure to limit entrance to the residential areas of the facility.

A CRISIS AND A RESPONSE

The Scenario:

A resident, John, hears voices that command him to hit another resident, Sarah, because she has planted a microchip in his brain so that the enemy can track him. Sarah gets a black eye.

Immediate Responses:

1. The staff member who witnesses the incident or who arrives at the scene first calls a Code One. Other staff respond.
2. The first staff member:
 - a. in view of other staff, asks John to come with her to a different location, to “cool off;”
 - b. assigns a second staff member to accompany Sarah to another area to calm her and assess her injury; and
 - c. assigns a third staff member to assist and debrief other residents.
3. Based on John’s care plan and staff assessment of the situation, staff request John to seek a voluntary psychiatric evaluation. John agrees and a staff member accompanies him to the hospital.
4. Staff administer appropriate first aid to Sarah and offer her the option of additional medical attention.

Secondary Responses:

1. Staff communicate relevant information on John to the appropriate hospital personnel.
2. Staff continue to comfort Sarah and assist her to process the incident.
3. Staff debrief the other residents who witnessed the issue.
4. Staff record and communicate information on this incident to other staff as appropriate.
5. Staff debrief the incident in a staff meeting.

Follow-up Responses:

1. Staff visit John in the hospital and work with him, hospital personnel, and care plan team to revise his care plan. Staff accompany John back to the Safe Haven upon discharge.
2. Staff prepare Sarah for John’s return by listening to her concerns and assuring her that staff believes that John is safe. (It is my experience that residents are very forgiving of each other’s “incidents.”)
3. Staff and residents warmly greet John upon his return and reassure him that he is welcome.
4. Staff monitor John and Sarah, their interactions, and other residents’ response to John.
5. Staff praise positive behavior. If new medication seems to be a key factor in improved behavior, staff point out this benefit to John.

– Jaimie Page

As a Safe Haven limits visitors and educates residents about issues of safety, predators may view staff as a threat, and staff may be at risk. If a non-resident enters the Safe Haven and escalates for whatever reason, staff should attempt to de-escalate the individual with the goal of having the individual leave. If this does not work, a Code One should be called and 911 contacted.

All staff should be aware of any particular outside person who may pose a threat to residents or staff. The Safe Haven should have a set plan for responding to predictable incidents. For example, a resident has been harassed by a man about her entitlement checks. He comes to the Safe Haven on the day she receives her check and asks for her. If she is not there, or if staff are unwilling or unable to locate her for him, he escalates.

An immediate response may be for the person at the front desk to call for assistance as soon as the individual approaches and to have all staff present collectively inform him that they will not get the resident for him at that time or in the future. Secondary responses include informing the resident that the man is not an approved visitor. Staff may also accompany the resident on errands around the neighborhood to send a message that the staff are watching out for the resident. (While this approach may seem intrusive, residents are usually thankful for intervention because they often may have difficulties in setting boundaries themselves.) Follow-up responses may include seeking a court injunction against the outsider and addressing safety issues in house meetings or in the resident's care plan.

A fire or natural disaster, while unusual, is another type of crisis. The Safe Haven should make sure that there are complete and accurate safety policies and procedures, posted routes of exit, visible and accessible fire extinguishers, first-aid kits, and other necessary supplies.

The risk of fire is greater in Safe Havens for several reasons. Many residents smoke and may not be familiar with the risk of fire indoors. A few may smoke and have residual substances related to inhalant use on or near them. Others may have difficulty remembering to put their cigarettes out and inadvertently drop them. Still others may not be able to remember the "rule" of only smoking in designated areas and smoke in their rooms, where it is not easy for staff to monitor their smoking.

Preventative measures include education, reminders, and staff monitoring of the Safe Haven building. Some Safe Havens have designated smoking areas in or outside the facility. Staff can discuss fire safety in house meetings and conduct monthly or quarterly fire drills with residents. Notice of the drill will reduce any anxiety around it. One-on-one education can take place with those who refuse to participate as well as those who are frightened by the drill process. Staff should verbally announce a fire drill rather than pulling the fire alarm.

Safe Havens should expect that crises will occur, prevent them whenever possible, and intervene in an effective and client-centered manner.

Sometimes a resident will pull a fire alarm. At these times, staff need to conduct a fire evacuation for all persons in the building, rule out a fire, and then immediately deactivate the alarm. Staff will also need to calm the residents, notify the fire department (if there is no automatic notification system), and address the behavior of the resident who pulled the alarm.

Certain areas of the country are more prone to natural disasters than others. These disasters may include hurricanes, tornadoes, and earthquakes. Depending on the area and the prevalence of such disasters, staff may conduct drills or resident education sessions. If there are community drills where the Safe Haven is located, staff should prepare residents.

In conclusion, Safe Havens should expect that crises will occur, prevent them whenever possible, and intervene in an effective and client-centered manner. Programs should provide staff with the training, structure, and support to handle crises. Effective crisis management can enable Safe Havens programs to serve residents even more compassionately and successfully.
