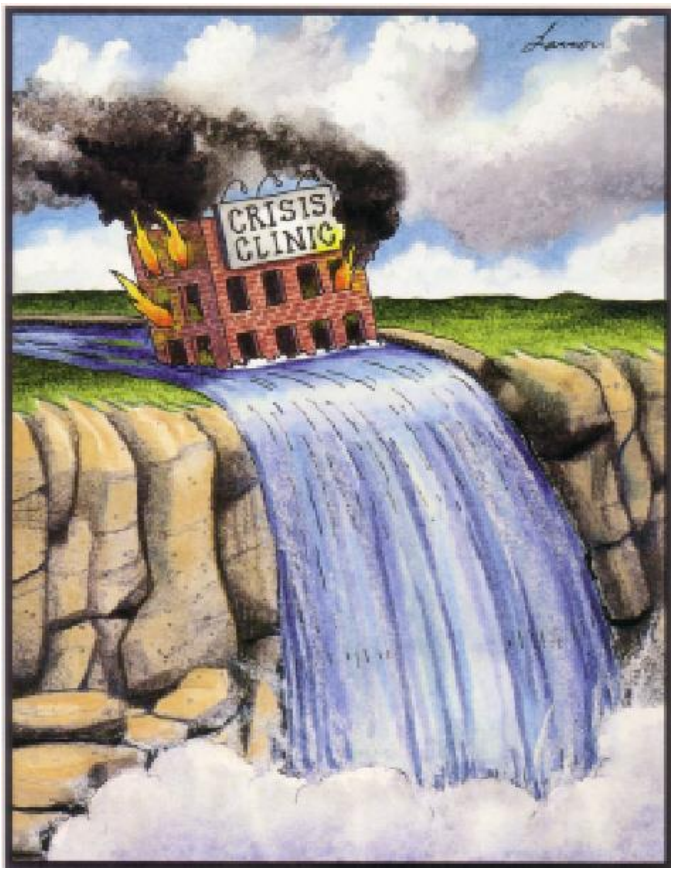
MAINTAINING PHYSICAL AND EMOTIONAL SAFETY:

A Primer for Social Workers

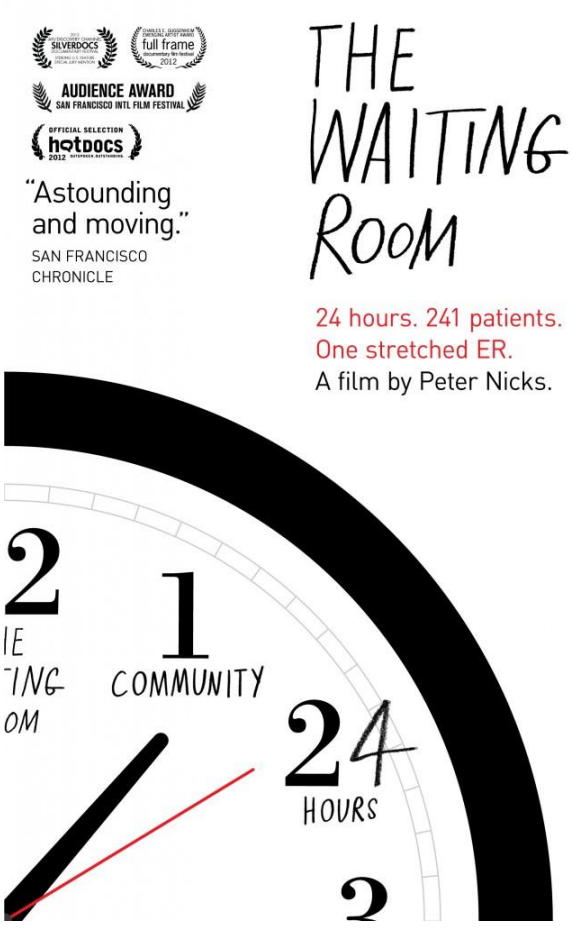


Greg Merrill, LCSW

Berkeley Social Welfare

Goals for Today

- Increase awareness of physical and emotional occupational risks that social workers face
- Understand steps you can take to prevent and/or reduce risks
- Develop a thoughtful learning approach to navigating your personal and professional risks and developing related protections



Discussion Questions

1. Who were some of the most memorable persons and/or what were some of the most memorable scenes?

2. When you think about the kind of work you see yourself doing, what are some of the challenges, fears, and concerns that come up?

3. What messages did you take away from the movie about how providers respond to the challenges they face?

Health Precautions

- Wash hands frequently, after *every* client visit
- Obtain annual PPD test
- Vaccinate: Measles, mumps, rubella, varicella; Hepatitis A and B; influenza
- Remain home if you have a fever, muscle aches, or other acute flu symptoms
- Cough or sneeze into your inner elbow
- Avoid contact with potentially infectious body fluids: blood, pus, feces, non-intact skin, and all body fluids except sweat
- Be alert to sharps or used needles in medical settings or on home/community visits
- Immediately report any potential infectious exposure

Incidence of Injury from Clients

General Findings

- Bureau of Labor Statistics (2001) places injury incidence for social services at 15/10,000 workers (vs. 2/10,000 for private sector)
- About 20% of social workers report feeling "sometimes unsafe" with clients
- Less experienced workers may be at higher risk for assault and/or injury

Canadian Social Work Workplace Study (2005) (n=179)

Type of Violence	Last 2 years	Entire Career
Verbal Harassment	56%	88%
Verbal Threats	20%	64%
Stalking	5%	16%
Physical Assaults (no injury)	6%	29%
Physical Assaults (Injury)	<1%	8%

Social Work Risk Factors

- We often work alone, in isolation
- We often conduct our work in community or home settings
- Deinstitutionalization may have resulted in more dangerous clients in the community
- The communities we respond to are often socially deprived, oppressed, and stressed
- As helpers, we may have a professional culture of avoiding discussing risk to ourselves

Highest Clinical Risks of Assault

- Clients with a history of:
  - Prior aggressive or impulsive behavior
  - Drug and alcohol use
  - Mental disorders that include command hallucinations, irritability, perceptions of persecution, and emotional reactivity
  - Being mandated to attend services
- Clients currently facing situations that lead to feeling high levels of fear, frustration, loss of control

Prohibited Student Activities

Activities

- Physical restraint of clients
- Transportation of a client in the student's private car
- Transportation of a client with a recent history of violent behavior
- Work in the agency at times when and/or in areas where other staff, are not present;

Clinical Assignments

- Treatment of a client with a history of violence toward staff
- Clinical responsibility for a client at high risk for suicide or homicide or other serious risks without reviewing if the student possesses the requisite time, skills, knowledge, and supports

Protective Factors

- Empathic engagement with client, emphasis on strengths, AND thorough assessment of safety and risk factors
- Friendly, Frank, and Firm discussion with client about expectations related to safety -- theirs and yours
- Advance agreements, when possible, that create respectful, exit plans for all
- Trusting and refining intuition
- Thoughtful agency protocols and supports

A Lesson from Antoinette Tuffs: A School bookkeeper who talked a gunman into surrendering

- http://youtu.be/Nh77mD_O6Tw

From the 911 Transcript

It's going to be all right, sweetie. I just want you to know I love you, though, OK? And I'm proud of you. That's a good thing that you're just giving up and don't worry about it. We all go through something in life. . .

Don't feel bad, baby. My husband just left me after 33 years. ... I've got a son that's multiple disabled. It's all going to be well . . . I thought the same thing, you know, I tried to commit suicide last year after my husband left me. But look at me now. I'm still working and everything is OK.

You didn't harm anyone, you didn't harm me, and you can still surrender peacefully.

We're not gonna hate you, baby. It's a good thing that you're giving up. I love you and I will pray for you.

Office De-Escalation Tips

- Use observational data
- Call for back-up and choose space to talk with client strategically
- Use own physiology to project calmness, empathy, confidence
- Offer empathy and options, when possible
- Ask directly and simply for most concerning behaviors to change
- Debrief

TIPSHEET: De-Escalating Agitated Clients in the Office

1. Use observational data to recognize the signs of escalation including the client's posture, eye contact, facial expressions, physical gestures, muscle tone, voice and speech patterns etc.

2. Call for back-up assistance when possible which can include either a supervisor or another clinician to directly assist you or to simply stand back and observe discretely.

3. If client is overtly threatening, carrying a weapon of any kind, is assaulting property, or appears to be in acute medical distress, alert 911 immediately.

4. Choose the safest possible location to talk to the client. This may mean moving other clients out of the waiting room so you can talk with the client here; or it may mean stepping just outside the front door with assistance; or there may be a special room available in your clinic for circumstances such as these. You do not want you or your client to be or to feel trapped so easy access to exits, open doors, and windows are recommended.

5. Use your own physiology, whenever possible, to cue the client's physiology to calm and self-control. Examples include staying relaxed and empathic, keeping a reasonable distance, keeping yourself a bit lower than client, hands down and palm out, a

sideward stance, relaxed breathing, meeting gaze but not staring down, lowered voice and slow speech and friendly, confident tone.

6. Identify what the client's immediate goal is by asking: *"I can tell you are really upset today. Thank you for coming in to see me. What can I do for you right now to help you feel safer?*" Or "*I'm worried about you, and I want to make sure that you and everyone else is safe right now. Can you tell me what's going on please?"* Try to uncover what the real, underlying issue may be for this client today that has led them to be so activated.

7. Express a desire to help without making promises you can't keep. *"I appreciate you coming in today. I'd like to help you if I can."*

8. Avoid questions, statements, or information that may imply the client is to blame for his/her circumstance. While this conversation will need to happen, today is probably not the right time. The client needs to "save face" and feel in control right now.

9. Set firm limits in a compassionate, respectful manner. Use specific behavioral language. "*In order for me to be more able to help you today, I'm going to ask you to please lower your voice, stand back a bit from me, and let's take a few deep breaths together*."

10. If verbal redirections do not succeed, then move to limit-setting in a firm but flexible manner, offering choices when possible. *"I still want to help you and I also need to keep everyone here feeling safe. I need you to either take a cool-down break right now or for you to*

leave and come back at another time. Which option do you prefer?" "I'm going to step out of the room for a moment and get some water. May I bring you some?" "We are unable to give you or any client cash. Is there some other way I can help you today?"

11. Following resolution of the crisis, a debriefing with all involved clinical staff and supervisor is recommended. Clinical follow-up with client that is sensitive not to induce shame but does help them to analyze what happened, reassess their coping, and revisit safety-related agreements can advance the therapeutic alliance, can help the client learn to self-regulate better, and can prevent or reduce future incidents.

Safer Home and Community Visits

The Home Advantage

- Consistent with social work values and the history of our profession
- Engages clients who may not be active help-seekers but may be treatment-acceptors
- Allows for a fuller, more complete, person-in-environment, ecological assessment
- Creates access for homebound clients
- Involves day-to-day social supports

SAFETY WHEN CONDUCTING A HOME OR COMMUNITY VISIT

Greg Merrill, LCSW (developed at UCSF Trauma Recovery Center)

THE PRE-VISIT ASSESSMENT

Of the Client:

- Does the client have a history of assaultive, reckless, impulsive, and/or other dangerous behavior? How do use of substances affect this? How likely is it that the client will be actively using?
- How well do you know the client? How honest do you think they have been with you? (And remember: most clients are, understandably, not forthcoming about potentially dangerous behaviors). What do available records reveal?
- Is the client an ongoing target for violence from others?
- Does the client own or keep guns or knives on his/her person or in his/her home?
- When you call the client to set or confirm a home visit, introduce the idea of your safety to them. "*I would appreciate your help finding where you live, parking, and entering your building safely. What should I be aware of?*" How does the client respond when you are upfront about needing to ensure the site is safe for you? Do they understand and respect your limits?

Of the Home or Community Site:

- How likely is the assailant to know or discover where the client is staying or meeting you?
- How familiar are you with the neighborhood and location in which you plan to meet the client? Are there people you trust who may be more familiar with whom you can consult?
- Who else will be in the residence or at the site? Do these people have a history of assaultive, reckless, impulsive, and/or other dangerous behavior? Are there animals, particularly dogs?
- What is the safest way to travel to the site (MUNI, BART, county car, your own car etc.)? Time of day? Day of week or month?
- Are there other safer sites where you could meet the client? Be creative!

Of Yourself:

- How comfortable/uncomfortable are you about seeing this client outside of our office? If you are uncomfortable, are you talking about this with your supervisor? If not, do so before scheduling.
- Are you frequently overly anxious or cautious? Or, do you frequently minimize or deny risky situations?
- Are there categories of people who tend to make you more concerned about safety? Are your stereotypes creating a false sense of danger or security? Are you ignoring your gut because you are afraid others will think you are stereotyping or prejudiced?
- What does your gut honestly tell you?

Other Preparatory Steps You Can Take:

- Discuss your concerns and fears about the visit honestly with your field instructor until mutual agreement can be reached about reasonable precautions;
- Arrange to complete the home or community visit before 1 p.m., preferably early in the a.m.; consider the day of the week or month as well;
- Arrange for someone to accompany you (research assistant, fellow intern, co-worker, field instructor);
- Together with field instructor decide that the client can only be safely seen in the agency or a community office space;
- Sign out a cell phone from the front desk and the visit log indicating where you are going, who you intend to see, what time you are departing and what time you intend to return;

AT THE TIME OF THE VISIT

- Wear clothes that match professional roles but are comfortable and allow for easy movement;
- Upon arrival, park in an area where you can safely exit quickly, if needed; lock valuables in trunk before parking in that area;
- Observationally scan the environment for potential threats and resources;
- Walk with confidence and purpose, display friendliness and assertion, ask community members for help, and/or cross street discretely to avoid potential threats. "Put your 'game face' on."
- After client answers door, ask for permission to enter, exchange polite greetings (*"Thanks for inviting me into your home. I appreciate being your guest very much.")*, and eyeball the surroundings carefully. It is Ok to ask animals to be placed in another room, if available. "*Would it be all right if you either leashed your dog or placed him or her in the other room while we talk?*"

If Danger Seems Present:

- At the first sign of danger from the client or other household or community members, exit immediately. Common red flags include intoxication, verbal insults or escalations, intrusions upon your personal space or body, sexually suggestive remarks, unresponsiveness to limits, pleasure-taking in your anxiety, presence of any weapons, impulsivity or recklessness, etc.
- You do not have to explain why you are exiting. In fact, it may be helpful to lie (i.e. "I just received a text and need to return to my office immediately");
- After exiting, get to a reasonably safe location and call 911 if appropriate or call Supervisor for consultation about how to proceed.
- Debrief with your supervisor as soon as possible.

If it Seems Safe to Proceed:

- When sitting down, look carefully for signs of drug paraphernalia or sharps that could inadvertently cause injury;
- Call the office in front of the client as soon as you arrive and state your location, his/her name, and your estimated time back in the office

- Early on you can start with friendly but assertive gestures (e.g., asking the client if they could please turn the TV or radio down or off; asking the client if he minds putting a shirt on etc.) and set limits as needed, being careful not to be overly passive or overly aggressive;
- At completion of visit, ask the client how the meeting went for them and what, if anything, was helpful. Also provide them with reinforcement of any of their behaviors that you think made the visit effective and also ask for future cooperation as needed ("*I really appreciate that you were waiting for me and looking out for me when I arrived. Thank you. The only thing I'd recommend for next visit is that the television be off since I couldn't always listen to you the way I usually like to. How do you feel about that?*")
- Set next visit time and revisit the best and safest day and time; ask about alternate locations, if feasible or indicated, including office visits.
- Upon departure, call the office again in front of client to state you are departing and again give your estimated time of arrival.
- *"Thank you so much. I really enjoyed seeing you today and want to thank you again for having me as your guest."*

AFTER THE VISIT

- Pay attention to any discomfort you feel as you think back on your visit and try to discern if it was based on your lack of familiarity with the client, client's family, or the client's social environment or based on objective risk factors;
- Particularly consider whether there were any boundary violations that may lead to a future unsafe situation;
- Debrief the visit fully with your field instructor to determine if home visits are appropriate and to develop additional precautions, if needed.

PLEASE REMEMBER:

YOUR SAFETY ALWAYS COMES FIRST. PERIOD. NO EXCEPTIONS. REPEAT: YOUR SAFETY ALWAYS COMES FIRST. YOU CAN'T BE EFFECTIVE IF YOU DON'T FEEL SAFE.

YOU WILL NOT DISAPPOINT US BY EXITING A SITUATION. YOUR COMMITMENT TO THIS PROFESSION, WORK, AND YOUR CLIENTS WILL NOT BE QUESTIONED. WE APPRECIATE YOUR HONESTY.

YOU ARE HELPING YOUR CLIENT BY MODELING SAFETY CONSCIOUSNESS. CLIENTS MAY EVENTUALLY BE ABLE TO INTERNALIZE YOUR MODELED BEHAVIOR OF RESPECTING YOURSELF AND OTHERS EVEN IF IN THE MOMENT THEY THINK YOU ARE OVERREACTING.

OVERREACTING IS USUALLY SAFER THAN UNDERREACTING.

Eddie from *The Empress*

Discussion Questions About Eddie

1. What are Eddie's strengths?

2. What factors seem to lead Eddie to aggressive behaviors?

3. If your field placement assigned you to work with Eddie, what would your honest thoughts, feelings, and reactions be given who you are?

OFFICE VIGNETTE: EDDIE FROM THE EMPRESS

You are a social work intern for a support housing program whose mission it is to provide psychosocial assessment and intervention to residents of SRO (single room occupancy) hotel rooms to prevent, when possible, their eviction or being homeless again. Your office is not located in the hotel but is in the same neighborhood.

You have successfully engaged Eddie into a case management relationship, and specifically, you and he have agreed to work on his goals of reducing his use of alcohol and drugs and increasing his ability to get along with others (reducing conflicts and fighting). He has signed a release for you to speak to his building's management and they have recently called you to report that he is drinking heavily and has been very aggressive in the lobby with other residents and front desk staff.

Today, he drops into see you at your office. He appears as though he has an altered mental status. Specifically, he is pacing in an agitated manner, his body posture and facial gestures appear tense and intimidating, his eye contact is characterized by focused staring/glaring, he appears to be breathing in a shallow rapid fashion, and he is using a very loud voice in the reception area. As soon as you greet him in the waiting area, he approaches you at a close distance and loudly demands $15 as a loan because he states he was "robbed" and "has not eaten."

Key Question:

1. How would you respond to this scenario in a manner that balances your clinical duties and goals with your attention to his, your, and other members of the clinic's safety?

HOME VISIT VIGNETTE: EDDIE FROM THE EMPRESS

You are a social work intern for a support housing program whose mission it is to provide psychosocial assessment and intervention to residents of SRO (single room occupancy) hotel rooms to prevent, when possible, their eviction or being homeless again. Because your office is in a different location, you usually meet your clients at their hotel rooms.

You have successfully engaged Eddie into a case management relationship, and specifically, you and he have agreed to work on his goals of reducing his use of alcohol and drugs and increasing his ability to get along with others (reducing conflicts and fighting). You have had several productive visits and feel you have good rapport with Eddie.

When you arrive at his room, you notice that he appears to have an altered mental status. He looks and behaves differently, seems agitated and "amped up," and you suspect drug-related intoxication. He has a guest in his room, George, who he says he met in prison. George has tattoos all over his face, is not wearing a shirt, glares at you, seems similarly intoxicated, and says "You don't look like you belong here," laughing in a manner you consider menacing.

Key Question:

1. Given this scenario, what steps would you take to respond to this situation?

Vicarious Trauma (VT)

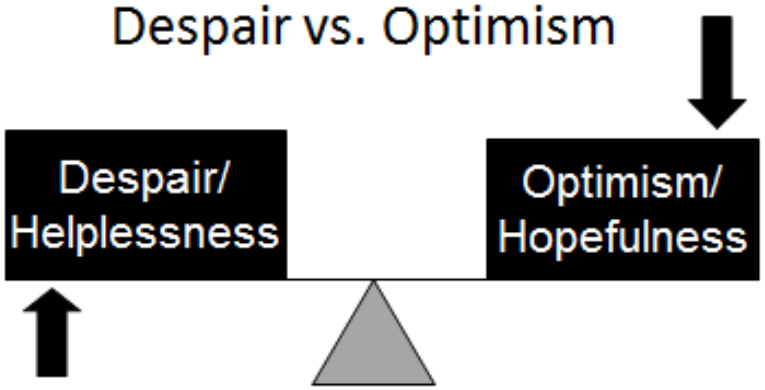
- *Vicarious Trauma is the process of change that happens because you care about people who have been subject to trauma and injustice. Over time, this can lead to changes in your psychological, physical, and spiritual life that also affect your family, your organization, and your patients/clients.*

Pearlman, L.A. & McKay, L. (2008). Understanding and addressing vicarious trauma. www.heading-institute.org

Vicarious Risk Factors

- Early career and later career risks may vary
- Greater similarity to patients served and/or personal trauma history
- Volume and severity of client presentations
- Personal temperament
- Higher levels of life stress
- Not yet fully developed personal coping repertoire, support systems, and spiritual beliefs
- Organizational context unsupportive

The Struggle for Meaning: Despair vs. Optimism



I don't matter.
I don't make a difference.
I am alone/the only one.
I give up.

I *am* important.
I *make* a difference.
I *have* support.
I *can* do this.

Vicarious Resilience Happens, too

- Absorbing Client Strengths
- Feeling more grateful about your own life
- Learning to be more comfortable suffering and bearing witness, seeing this as an important part of life
- Strengthening your ability to balance remaining empathic and detaching

The Best Coping Plans . . .

- Respect your temperament, preferences, reactions, and lifestyle, all of which change over time.
- Involve active strategies that require investment of your time and energy even when you feel you have neither.
- Balance:
  - ***Escape***: Simply getting away physically, mentally
  - ***Rest:*** Activities with no goal or timeline
  - ***Play:*** Fun, creative, positive energy.

Best Organizational Practices

- Culture of talking about emotional impact of the work on personnel
- Debriefing Incidents fully while respecting staff who prefer privacy
- Staff and management partnership, inclusion of emotional impact on supervision agenda
- Culture of gratitude, appreciation, creativity, celebration, strengths, successes, and learning
- Respect for different coping and working styles
- Thoughtful meetings and retreats
- Hard work *and* vacations/time-off encouraged ☺

Transforming Vicarious Trauma: Tips for Social Workers

Developed by Greg Merrill, LCSW

1. ***Be Mindful***. Because you are empathically connected to traumatized patients, you may be "infected" by their traumatic stress symptoms. As a result, you are likely to experience disruptions in memory, feeling, your body, behaviors, and relationships that are both acute and cumulative.

2. ***Invest in a Regular Coping Routine.*** Engage yourself with a regular, active, and intentional routine of self-care activities. Include a range of activities that replenish or restore your body, your mind, your heart, your spirit, and your social connections. Think *escape*, *rest*, *play*.

3. ***Avoid Excessive Inactivity.*** Although it may seem desirable to spend the evening silently watching television, chronic inactivity is not restorative. That being said, activities that explicitly have no goal orientation may be an important part of your overall coping plan.

4. ***Know and Respect Your Style.*** Learn, respect, and nurture your own style. When overwhelmed, you may want to go deep into your emotions and talk in depth; you might instead prefer a healthy distraction such as a period of intense exercise; or you might prefer other strategies altogether. Try a variety of activities over time to discover what combination is most potent for you.

5. ***Conduct Daily Rituals.*** Short rituals at the beginning and end of your workday can signal your body, mind, and heart about the transition between your professional and personal life. For example, consider starting or ending your workday with a cup of tea, a moment of silence, or a brief visualization; when arriving home, consider changing your clothes and showering to signal a new beginning.

6. ***Plan Ahead for Occasional Acute Episodes of Overwhelm.*** Certain stories or patients can overwhelm even the most resilient caregiver. These more acute episodes can last hours to days. Recognizing these symptoms and enacting a more intensive self-care plan will help restore your sense of control. To combat physiological arousal, intensive aerobic activity is usually recommended.

7. ***Increase Your Emotional Management.*** When emotionally overwhelmed, simply accepting your overwhelm, tolerating the unwanted feelings, and knowing that they will naturally reduce over time can be helpful. These are called "tolerance" or "acceptance" strategies, and they prevent your self-judgments from adding to your distress. Balance these strategies with more active "change" strategies in which you engage in activities (such as exercise, mediation, prayer, and/or seeking social support) to reduce your negative feelings and increase positive feelings.

8. ***Discover The Positive Meaning.*** To counterbalance feelings of despair and hopelessness, intentionally cultivate an appreciation of strengths and resilience, look for small signs that you've made a difference, and praise yourself and others for the amazing daily efforts you make. *You are an everyday hero*.

9. ***Cultivate Creativity.*** The opposite of destruction is creation. When you engage yourself in creative activities (such as art, music, dance, writing, cooking, gardening, and even spontaneous acts of humor or improvisation), you actively restore balance to your world

10. ***Know When to Ask For Help.*** Although many people prefer privacy, when your reactions begin to negatively affect your personal and professional life, it is time to accept that you may need outside help. As a caregiver, you have a right to receive care, too. Accepting help doesn't mean you aren't strong or professional. Rather, it means you are strong and ethical enough to care for yourself so you can continue to provide care to others.

School and Campus Resources for Social Work Students

Courses:

SW 400, Field Seminars
SW 210A, Stress and Coping
SW 250X, Domestic Violence

Faculty:

Your Field Consultants

Student-Led Support Groups:

Rachel Hahn, rachelhahn@berkeley.edu
Laura Burns, laurajeanburns@berkeley.edu

University Health Services, Counseling and Psychological Services:

510-642-9494

Books:

Van Dernoot Lipsky, L. & Burk, C. (2009). Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others. Berret-Koehler Publishers: San Francisco, CA.

Kabat-Zinn, John (2011). Mindfulness for Beginners: Reclaiming the Present Moment – And Your Life. Sounds True: Boulder, CO.

Website:

Free online module for understanding and addressing vicarious trauma

http://headington-institute.org/Default.aspx?tabid=2646