DISTRIBUTED SIMULATION PROJECT

Managing Challenging Behaviours

Facilitators

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Teaching and learning methods

This presentation:

1. was developed by an interprofessional team including nurses, psychologists and a pharmacist.
2. is designed to be given face to face in small groups. This workshop involves a presentation and scenario-based simulated learning activities.
3. preferably this would be a half day workshop facilitated by a health professional with experience in this field.
4. is targeted to all healthcare professionals and support staff.
5. includes a reflective debrief that will reinforce learning outcomes.
6. includes an evaluation that should be conducted at the end to inform quality improvement.
7. requires; a computer with internet connection and projector, and butchers’ paper and pens.
## Suggested program schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Duration</th>
<th>Topic</th>
<th>Method of Delivery</th>
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<tbody>
<tr>
<td>0900 or 1300 hrs</td>
<td>15 minutes</td>
<td>Introduction</td>
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<tr>
<td>0915 or 1315 hrs</td>
<td>45 minutes</td>
<td>Part 1a – Understanding challenging behaviours</td>
<td>Powerpoint, Case Studies, Video, Group Activities</td>
</tr>
<tr>
<td>1000 or 1400 hrs</td>
<td>15 minutes</td>
<td>Break</td>
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<tr>
<td>1015 or 1415 hrs</td>
<td>30 minutes</td>
<td>Part 1b – Physiological and Pharmacological reasons for challenging behaviour</td>
<td>Powerpoint, Clinical Learning</td>
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<tr>
<td></td>
<td>30 minutes</td>
<td>Part 1c – Monitoring and managing behaviour</td>
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<tr>
<td>1115 or 1515 hrs</td>
<td>60 minutes</td>
<td>Part 2 – Managing conflict</td>
<td>Powerpoint, Scenarios</td>
</tr>
<tr>
<td>1215 or 1600 hrs</td>
<td>45 minutes</td>
<td>Debrief and Conclusion</td>
<td></td>
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</tbody>
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Workshop outline

Part 1a
Understanding challenging behaviour

Part 1b
Physiological and Pharmacological reasons for challenging behaviour

Part 1c
Assessing, monitoring and managing challenging behaviour

Part 2
Managing conflict - Communication and negotiation strategies
Objectives

On completion of this activity you should have:

• Increased confidence in managing challenging behaviours.
• An understanding of how one’s own behaviour can affect others.
• Gained skills to defuse challenging situations with the aim of negating the need for physical interventions.
• Gained an understanding of the causes of challenging behaviour.
• Developed an awareness of the importance to work within the law and to follow organisational policies and procedures.
• An understanding of the importance of debriefing and self-care following incidents involving challenging behaviour.
Understanding challenging Behaviour
What is challenging behaviour?

Definition:

- “Behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities”

Activity 1

• What are some of the issues/ challenging behaviours that people present to your facility with?
• What challenging behaviours have you or your co-workers had to deal with in the past 12 months?

Group brain storm
Activity 1

Have you considered?

- Substance abuse
- Aggressive behaviour
  - Phone
  - Threatening and intimidating behaviour
  - Bullying
  - Mental health presentations
- Anti-social behaviour
  - Verbal abuse
  - Swearing
  - Yelling
Challenging behaviour

- Aggression/violence
- Passive aggression
- Forceful refusal to co-operate
- Harassment (bullying, racism, stalking)
- Mental health – irrational behaviour, confusion, disorientation, delusions
- Alcohol and drug abuse

Other challenging behaviours include:
- Anything that causes offence or distress
- Is life threatening
- Threatens the emotional well-being of others
- Does not comply with organisational policy or procedure
Activity 2

What factors contribute to aggression?
In groups, discuss what these factors could be.

Consider:
- Physical
- Social
- Illness
Activity 2

Have you considered?

Physical
- Frustration
- Sleep deprivation
- Hypoxia
- Dehydration
- Disability
- Trauma e.g. head injury, concussion, amnesia,
- Cerebral irritation
- Self harm

Social
- Isolation
- Financial pressures
- Grief
- Language
- Culture
- Self-esteem
- Peer pressure
- Perceptions

Illness
- Infections including
- Urinary tract infections
- Pain
- Anxiety
- Stroke
- Central Nervous system disorders
- Mental illnesses
- Cancer
- Diabetes
Activity 3

• Describe a challenging situation involving a mental health presentation.

Group activity
Activity 3

Have you considered?

- Walk-in clients, their friends or family members
  - Eg Schizophrenia, intoxicated clients
  - Lack of access to medical history
  - Feelings of fear, apprehension or anxiety
- Confused, disoriented and dementia patients/ family members
  - Difficult to manage
- Follow up care, ‘revolving door,’ ‘frequent flyers’
Schizophrenia

- Schizophrenia is a chronic, debilitating disorder, characterized by an inability to distinguish between what is real and what isn’t.
- A person with schizophrenia experiences hallucinations and delusional thoughts and is unable to think rationally, communicate properly, make decisions or remember information.
- Schizophrenia is a complex interplay of genetics, biology (brain chemistry and structure) and environment.
Schizophrenia

- **Characteristic symptoms:** Two or more of the following, each present for much of the time during a one-month period (or less, if symptoms are remitted with treatment).
  - Delusions
  - Hallucinations
  - Disorganised speech pattern
  - Grossly disorganised behaviour (e.g. dressing inappropriately, crying frequently) or catatonic behaviour
  - Negative symptoms: Blunted affect (lack or decline in emotional expression/response), alogia (lack or decline in speech), or avolition (lack or decline in motivation)
Schizophrenia and substances

• Significant Comorbidity
• ‘self-medication’ common with nicotine, alcohol, cocaine and marijuana
• Due to impairments in insight and judgment, people with schizophrenia may be less able to judge and control the temptations and resulting difficulties associated with drug or alcohol abuse.
Schizoaffective disorder

A diagnosis that includes symptoms resembling a mood disorder together with symptoms of schizophrenia, particularly psychosis and social withdrawal.

The main types of associated mood disorder include:

• bipolar (characterised by manic episodes or an alternation of manic and depressive episodes) and
• unipolar (characterised by depressive episodes).
Schizoaffective disorder

- **Psychotic symptoms** - losing touch with reality, hallucinations, delusions, disorganised thoughts, chaotic speech and behaviour, anxiety, apathy, blank facial expression, inability to move.

- **Manic symptoms** - increased social, sexual and work activity, rapid thoughts and speech, exaggerated self-esteem, reduced need for sleep, risky behaviours, impulsive behaviours such as spending sprees, quick changes between mood states such as happiness to anger.

- **Depressive symptoms** - loss of motivation and interest, fatigue, concentration difficulties, physical complaints such as headache or stomach ache, low self-esteem, suicidal thoughts, loss of appetite, insomnia.
Psychosis

• Psychosis – a state of being in which a person loses touch with reality and experiences hallucinations, delusions or thought disorder.

• Psychotic episode – a temporary event in which a person experiences symptoms of psychosis:
  – Delusions
  – Hallucinations
  – Disorganized speech
  – Grossly disorganized or catatonic behaviour
Bipolar disorder

• Characterized by constantly changing moods.
• A person with bipolar disorder experiences alternating “highs” (mania) and “lows” (depressed mood).
• The periods of mania and depression vary from person to person – many people may only experience very brief periods of these intense moods (and may not even be aware that they have bipolar disorder).
Bipolar disorder

- **Bipolar I** – ‘classic’ type of bipolar disorder. Individuals experience both manic and depressive episodes of varying lengths.

- **Bipolar II** – less severe manic episodes than bipolar I; however, their depressive episodes are the same.

- **Cyclothymia** – is a chronic but milder form of bipolar disorder characterized by episodes of hypomania and depression that last for at least two years.

- **Mixed episodes** – mania and depression occur simultaneously. Individuals might feel hopeless and depressed yet energetic and motivated to engage in risky behaviors.

- **Rapid-cycling** – bipolar individuals experience four or more episodes of mania, depression or both within one year.
Personality disorders

- Characterized by long-lasting rigid patterns of thought and behaviour.
- The inflexibility and pervasiveness of these patterns can cause serious problems and impairment of those afflicted.
- An enduring pattern of inner experience and behaviour that deviates markedly from the cultural norm.
- Onset of the pattern can be traced back to – at least – the beginning of adulthood.
- To be diagnosed as a personality disorder, a behavioural pattern must cause significant distress or impairment in personal, social, and/or occupational situations.
Borderline personality disorder

A pervasive pattern of instability in interpersonal relationships, self-image and emotions

Symptoms
- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships
- Identity disturbance
- Impulsivity in at least two areas
- Recurrent suicidal behaviour
- Emotional instability
- Chronic feelings of emptiness
- Inappropriate, intense anger
- Transient, stress-related paranoid thoughts
Major depressive disorder

- A person who suffers from MDD must have either a depressed mood or a loss of interest or pleasure in daily activities consistently for a period of at least 2 weeks
- This mood must represent a change from the person’s normal mood
- Social, occupational, educational or other important functioning must also be negatively impaired by the change
- A major depressive episode is also characterized by the presence of 5 or more of the following symptoms:
Characteristics of a major depressive disorder

- Depressed mood most of the day
- Markedly diminished interest or pleasure in all, or almost all, activities Significant weight loss when not dieting or weight gain
- Insomnia (inability to sleep) or hypersomnia (sleeping too much)
- Psychomotor agitation or retardation most days
- Fatigue or loss of energy most days
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day
- Diminished ability to think or concentrate, or indecisiveness, nearly every day
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
Anxiety disorders

- Anxiety, worry, and stress are a part of life.
- Anxiety is a necessary warning signal of a dangerous or difficult situation. Without anxiety, we would have no way of anticipating difficulties ahead or preparing for them.
- Anxiety becomes a disorder when the symptoms become chronic and interfere with our daily lives and our ability to function.
Anxiety disorders

- Generalized Anxiety Disorder (GAD)
- Panic Disorder (including panic attacks)
- Social phobia (also known as social anxiety disorder)
- Specific phobias (also known as simple phobias)
- Obsessive-compulsive disorder (OCD)
- Posttraumatic stress disorder (PTSD)
Autism Spectrum Disorders

Criterion based on the DSM-5 (2013)

A. Social Communication
(need to meet all 3 for diagnosis)

Deficits in social-emotional reciprocity
• E.g. showing, sharing enjoyment, returning a social smile, difficulty responding to and initiating social interactions

Deficits in non-verbal communicative behaviours
• E.g. poor eye contact, difficulty recognizing and interpreting other’s facial expressions

Deficits in developing, maintaining and understanding relationships
• E.g. difficulties establishing and maintaining relationships, difficulty adjusting behaviour to changing social situations
Autism Spectrum Disorders

Criterion based on the DSM-5 (2013)

B. Restricted, Repetitive patterns of behaviour, interests or activities (need at least 2/4 for a diagnosis)

Stereotyped or repetitive motor movements, use of objects, or speech
- E.g. Echolalia (“parroting”), repetitive hand movements, lining up objects, pedantic speech, whole of body movements

Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behaviours
- E.g. insistence on rigidly following specific routines, repetitive questioning about a topic, compulsions and difficulty with transitions

Highly restricted, fixated interests that are abnormal in intensity or focus
- E.g. preoccupations, obsessions, attachment to unusual objects and a narrow range of interests

Hyper- or hypo reactivity to sensory input or unusual interest in sensory aspects of the environment
- E.g. aversion to tactile inputs, odd responses or atypical focus on sensory input, high pain tolerance
Autism Spectrum Disorders DSM5

C. Symptoms must be present in the early developmental period (but may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life)

D. Symptoms together limit and impair everyday functioning

E. Not better explained by intellectual disability or global developmental delay.
Dementia

Dementia is not one specific disease. It is a collection of symptoms caused by disorders affecting the brain.

- Brain function is affected enough to interfere with the person’s normal activities of daily life.

**Dementia affects**
- thinking
- memory
- mood
- behaviour and the ability to perform everyday tasks.
Dementia

Alzheimer's disease, one form of dementia, is characterized by the development of multiple cognitive deficits manifested by:

Memory impairment

One (or more) of the following cognitive disturbances:

- Deterioration of language may be manifested by difficulty producing the names of individuals and objects (aphasia)
- An impaired ability to carry out motor activities (such as combing their hair) despite intact motor abilities, sensory function and comprehension of the required task (apraxia)
- A failure to recognize or identify objects despite intact sensory function (agnosia)
- A disturbance in executive functioning (e.g., planning, organizing, sequencing, abstracting)
Assessing behaviour

It is important to recognise risk factors:

• Physical Conditions
• A history of aggression/violence/acting out
• Hallucinations
• Drug and alcohol abuse
• Incorrect use of medication
• Feelings of paranoia
• Feelings of entrapment and powerlessness
• High levels of frustration
• Lack of impulse control
• Anxiety arising from conscious/subconscious conflicts
• Delusions of persecution
• Use of inappropriate defence mechanisms (e.g. lying, projected hatred)
Physiological and Pharmacological reasons for challenging behaviour
Physiological reasons

• Some physiological reasons for challenging behaviour can be mistaken for mental illness eg:
  • Diabetes
  • Hypoglycaemia
  • Hypoxia
  • Na depletion
  • Metabolic alkalosis leads to Na excretion
  • Hormones
  • Hypothermia
  • Sleep deprivation/Insomnia
  • Sepsis
  • Toxaemia
Physiological reasons
Depleted Na+/over hydration

Causes
• Sports people
• Elderly
• Diuretics
• Burns
• CF
• Cirrhosis
• Diabetes
• Glucocorticoid deficiency
• Liver failure
• Pneumonia
• Hypothyroidism

Symptoms
• Nausea/vomiting
• Headache
• Confusion
• Lethargy
• Fatigue
• Restlessness
• Irritability
Physiological reasons
Hypoxia

Causes

- CO poisoning
- COPD
- Sleep apnoea
- Post surgical
- Reduced O$_2$ intake
- Narcotics/reduced respiration
- Cardiac failure
- Pulmonary embolism

Symptoms

Onset Rapid/severe
- Ataxia
- Confusion
- Disorientation
- Hallucinations
- Behaviour changes

Onset Gradual/chronic
- Light headedness
- Fatigue, Anorexia
- Numbness/paraesthesia
Physiological reasons
Diabetes

Causes
• Hypoglycaemia
• Ketonuria
  – Leads to Na loss
• Ketoacidosis
  – Leads to Na loss
  – Hyperventilation

Symptoms
• Adrenergic
  – Dysphoria
  – Sweating
  – Anxiety
  – Pallor
  – Dilated pupils
• Neuro-glycopenic
  – Personality changes
  – Ataxia
  – Automatic behaviour
Physiological reasons

Hormones

Causes

- Menopause
- Addison's disease
- Testosterone (natural or abuse)
- Hyperthyroidism

Symptoms

- Menopause
  - Depression
  - Irritability
  - Memory loss ‘senior moment’
  - Mood disturbance
  - Insomnia

- Testosterone
  - High levels leads to aggression

- Hyperthyroidism
  - Anxiety
  - Hyperactivity
  - Irritability
  - Psychosis/paranoia (T3 storm)
Physiological reasons

Insomnia

Causes

• Drugs
  – Stimulants
  – Withdrawal from sedatives
• Pain
• Fear, stress, anxiety
• Disturbed circadian rhythm
• ABI (Acquired Brain Injury)

Symptoms

• Irritability
• Fatigue
• Behavioural problems
• Long term negative health outcomes
Pharmacological reasons

- Pharmacology is merely an artificial method of altering normal physiology or pathophysiology
- Drugs that alter behaviour do so via normal and explainable pathways
- Many drugs, both legal and illegal can cause challenging behaviour
Pharmacological reasons

Steroids

Prednisolone. From the 1950’s reports of

- Hypomania, depression, irritability, anxiety, insomnia, overt psychosis
- Relates to Cushing's syndrome (increased cortisol)

Androgenic steroids eg Testosterone

- Clear link between testosterone (above physiological levels) and aggression
Pharmacological reasons

Hormones

Clomid

- Patient often already facing emotional distress
- Improves ovulation by altering normal hormonal responses.
  - Can cause: Anxiety, sleep disturbance, mood swings and irritability
  - Other related drugs cause depression, mania, irritability and thinking problems
Pharmacological reasons

Aciclovir (high dose)

- Hallucinations, depersonalisation, confusion, insomnia, hyperaesthesia

Atenolol

- Nightmares, confusion, violent behaviour

Baclofen (used for chronic back pain)

- Hallucinations, paranoia, mania, anxiety, confusion, depression
Pharmacological reasons

Ketamine
- Hallucinations, delirium, nightmares, crying, change in body image

Levodopa
- Symptoms are most frequent in the elderly and with prolonged use
  - Hallucinations, paranoia, delirium, agitation, nightmares, night terrors, hypomania, depression

Methylphenidate
- Hallucinations, paranoia
Pharmacological reasons

Drug problems on withdrawal
  • Benzodiazepines
  • Opioids
  • Alcohol
  • Tobacco

Consider:
  • the additive effects of poly-pharmacy
  • the expanded excretion time related to ageing/ renal or liver function impairment
Pharmacological reasons

Amphetamines

• Amphetamine induced psychosis
• Very similar to acute phase of schizophrenia
• 15% may never completely recover
• Easy to make analogues
Part 1c

Assessing, monitoring and managing challenging behaviour
Assessing and monitoring behaviour

- Observing, assessing and monitoring behaviour can be required of health professionals and community workers in a range of situations and for a number of purposes.
- Behaviour can provide useful information about clients for the purpose of:
  - Identifying and recognising triggers and patterns of behaviour
  - Identifying escalating behaviour
  - Monitoring a client’s changing coping skills
  - Tracking behaviour modification
  - Referring and/or reporting/documenting behaviour to a Psychologist, GP, other staff; and
  - Communicating with a clients’ family and/or friends.
Monitoring behaviours

Formal

- Use of Behavioural observation charts to observe and monitor the client’s behaviour for a period of time
- Checklists and inventories
- Case notes

Informal

Observe for:
- Pacing
- Agitation or fidgeting
- Raised voices
- Certain tone of voice
- Sighing or rolling of the eyes
- Defensive posture – arms crossed
- Clenched fists
- Withdrawn or unusually quiet
- Staring in a confronting manner
Unacceptable behaviour

It is likely that rural health workers will, at times, be confronted with people who exhibit unacceptable behaviour.

It is important to keep your own behaviour in check by remaining calm and objective so that you can assess the situation clearly and respond appropriately.
When confronted with conflict, ask yourself some important key ‘P’ questions

- Proof?
- Possibilities?
- Positive aspects?
- Perspective?
- Personalising the situation?
- Panic paralysis?
- Problem solving?
- Persistence?
- Put it aside for a while?
Ask yourself some key ‘P’ questions

• **Proof** Is your perception of the situation the same as others around you?
• **Possibilities** Is it possible that you are misinterpreting the situation?
• **Positive aspects** Is there any positive aspect of this situation that can provide some comfort?
• **Perspective** Do I have this in perspective? Is anyone in danger of being hurt?
• **Personalising** the situation Am I taking this too personally?
• **Panic paralysis** Am I panicking? Or Over-reacting?
• **Problem solving** What options do I have to control and defuse this situation?
• **Persistence** Have I given up too soon on a strategy I was using to change or manage the situation?
• **Put it aside for a while** Can I take some time out so that when I return later I will be calmer and more able to deal with it more effectively?
Policies and procedures

• Every organisation will have policies and procedures in place that describe techniques to ensure personal safety and the safety of any clients or colleagues caught up in the situation

• You need to follow these as much as possible in the moment

• All workers need to be clear about what techniques they can use to ensure their own personal safety and the safety of clients/colleagues in the event of aggression or violence
Risk process

Step 1: Identify hazards

Step 2: Assess risks

Step 3: Decide control measures

Step 4: Is there a Regulation, Ministerial Notice or code of practice about the hazard?

Step 5: Monitor and review

- NO: You must choose an appropriate way to manage the risk.
- YES: Follow the information in the Regulation, standard, code or guide.

UTAS
Preventing an aggressive incident

Before an incident employers and employees need to implement preventative measures

Question
What preventative measures does your facility employ?
Conflict escalation curve

1. Calm
2. Trigger
3. Agitation
4. Acceleration
5. Peak
6. De-escalation
7. Recovery

TIME
INTENSITY
Agression scenario
Early warning signs

- Rapid breathing
- Clenched fists and teeth
- Flared nostrils
- Flushed expression
- Pacing
- Repetitive movements,
- Loud talking or chanting, swearing excessively,
- Aggressive gestures, veiled threats, verbal abuse, unprovoked outbursts of anger or emotion or
- Panic, restlessness and clinging to staff
Signs of escalation

- Argues frequently and intensely
- Blatantly disregards ‘normal’ behaviour
- Obsessional thinking and behaviour
- Throw/sabotages/steals equipment or property
- Makes overt verbal threats to hurt others
- Rage reactions to frustration
- Violent or sexual comments sent via email, voicemail, SMS or letter and
- Blaming others for any difficulties
Urgent signs

• Severe distress
• History of substance abuse/ violence
• Marked changes in psychological functioning:
  – exotic claims (losing touch with reality),
  – social isolation or poor peer relationships,
  – poor personal hygiene and
  – drastic changes in personality
• Fascination with weapons
Preventing escalation

To prevent escalation of unacceptable behaviour consider:

- Keep calm
- Use active listening to find out what the problem is
- Acknowledge the concerns/emotions of the client whether you agree with them or not (validation)
- Use positive language and avoid negative language
- Let them know you want to help them
- Let them know the consequences of their behaviour if it continues or escalates
- Seek help from co-workers or the client’s family/ friends
Manifestations of violence

- Involvement in physical confrontations or assault (including self-harm)
- Damage/Destruction of property
- Display of /or use of weapons
- Evidence of sexual assault
- Arson
- Suicide risk
Managing aggressive behaviour

If a client becomes violent, aggressive or threatening:

• Follow your organisation’s procedures
• Clear the space as much as possible (make it as safe as possible)
• Remove others from the scene (danger)
• Speak to the client in a clear, non-provocative manner
• Give the person enough personal space/ maintain a safe distance
• Use voice and eye contact to attempt to maintain the balance
• Use diversion if possible – a change of focus, distraction, or interrupt train of thought
• Contact/Inform other staff as soon as possible (duress alarm)
• Call emergency response teams if needed (e.g. police, ambulance, mental health response teams)
## Danger and safety zones

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<tr>
<th>Zone</th>
<th>Description</th>
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<tbody>
<tr>
<td>Zone 1</td>
<td>The distant safety zone, where you cannot be reached by a punch or kick.</td>
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<tr>
<td>Zone 2</td>
<td>The close safety zone, where the aggressor cannot effectively deliver a major blow to you with their knees, elbows or head.</td>
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<tr>
<td>Zone 3</td>
<td>The danger zone, where an employee can be struck forcibly.</td>
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Helpful tips

• The following may help you to deal with aggressive clients:
• An individual who is violent is more likely to move straight ahead, less easily sideways and with difficulty backwards
• Avoid standing directly in front of the aggressor and stay away from the danger zone
• Keep your posture relaxed and stand slightly off centre to the aggressor’s weaker (non-dominant side). Though this can be hard to determine it is usually opposite to the hand they write with.
Helpful tips

• Adopt a safe, defensive stance: Stand with feet slightly apart to maintain balance. If an attack seems likely, ensure the dominant leg is slightly to the rear, knee bent and other leg slightly forward of the body and bent slightly. This will minimise the likelihood of being knocked to the ground.

• Maintain visual contact. Never turn your back on a person behaving aggressively.

• Use eye contact carefully, as too much direct eye contact can be interpreted as challenging.

• Walk away. If the situation seems totally uncontrollable, leave as quickly as possible and go to a safe place.
Managing an aggressive incident

- Agencies usually have specific procedures in place to deal with crisis situations including acts of verbal abuse, intimidation, bullying, violence and aggression.

- Regardless of the procedures in place to support workers in a crisis situation, it is also important that aggressive incidents are managed at an agency level.
Managing an aggressive incident

• During an incident, staff involved must use strategies that will assist the client to regain control, and prevent injury
  • to worker(s)
  • to the client
  • to others and
  • to property

• Question
  What strategies can you use?
Following an aggressive incident

**After** an incident, a debriefing needs to be conducted with all of those involved.

Debriefing can be provided on a group or an individual basis.

**Question**
What supports are in place at your facility following an incident?
Part 2

Managing conflict
Interacting with clients

• Know in advance what you want to communicate before you say it (mental rehearsal)
• Consider the words you will use, the tone of voice and non-verbal issues such as body language
• Do not assume your client understands your meaning – seek clarification and look for feedback
• Keep your message simple
• Speak clearly

• Make eye contact
• Monitor the client’s response
• Use appropriate language to suit the client
• Be specific, clear and precise
• Summarise your message periodically, checking that the client has understood.
Listening skills

- We tend to confuse listening with hearing
- Hearing is a natural process but effective listening is a skill that requires energy and effort.
Listening for meaning

• Listen with the intention of understanding what the client is really saying and feeling.

• Tune into the other person’s internal viewpoint and don’t assume you know how they feel or what they mean.

• Messages can contain an underlying meaning.

Example – when a client asks “Do you like my painting?” on one level the meaning is clear and you could answer ‘yes’ or ‘no’; but on another level the person may want support and positive feedback.
Respect others’ viewpoints

- Respect clients as individuals with rights to their own thoughts and feelings
- This does not mean we have to agree with everything they say – just that we respect what they say as their version of reality
- Accepting others also means allowing them to grow and develop on their own terms
- Cultural differences can be challenging
Effective listening

• Concentrate fully
• People generally speak at 150-160 words a minute
• But we are capable of listening at up to 600 words a minute
• To receive a message effectively we need to focus the extra brainpower available and concentrate hard
• Clear away any baggage (deal only with the now)
• Use active listening (clarify, paraphrase, summarise)
• Check that you are picking up the message correctly
• Give feedback at the end of the message
Scenario

• ‘John’ presents to your facility. He appears agitated and unkempt. You notice the smell of alcohol. He leans over the reception desk and speaks to you in a loud, aggressive tone demanding to see the doctor immediately about his mother.

• What are you thinking?

• How could you respond?
Reducing conflict

Workers can use positive communication strategies for problem solving, including:

✓ Advising and evaluating
✓ Reassuring and supporting
✓ Questioning and probing
✓ Paraphrasing and understanding
Advising and evaluating

• Advice should be given tentatively, when it is timely and relevant

• People are essentially the experts on their own lives and with appropriate encouragement can take the tentative advice and come up with solutions that fit their own situation

• This strategy also encourages ownership rather than having advice imposed
Reassuring and supporting

• When you rush in with support and reassurance, this often denies the other person’s feelings.

• While there are times when people need to be reassured as to their value and worth, often reassurance and support just serve to inform the client that they shouldn’t be feeling as they do (e.g. ‘don’t feel so bad’, ‘cheer up’, ‘in time you’ll forget about it’).
Questioning and probing

• Questioning is an important skill for resolving conflict and tension and finding solutions
• To use questions skilfully, it is important to understand the difference between open and closed questions
• Open questions encourage people to answer in greater length and in more detail
• Closed questions require only a simple yes or no answer
• Probe beyond a brief response
• Use silence to get expanded responses
Paraphrasing and understanding

• The benefits of paraphrasing and understanding indicate that this is the optimum way of supporting a client to clarify their thoughts.

• It is important to reflect back to the client what they have said, and identify whether what they are saying has been interpreted accurately by you and others.
Scenario

• ‘John’ is 49 and has just discovered that his mother is terminally ill. He has had schizophrenia since age 22 and has lived with his mother since then. She has been his main carer.

• What are you thinking?

• How would you respond?
Assertiveness

Each human being has rights:

• You have the right to be human and take full responsibility for your decisions and actions
• You have the right to be wrong
• You have the right to tell others what you are thinking and feeling
• You have the right to change your mind
• You have the right to stand in judgement of your thoughts and actions
• You have the right to express yourself without intimidation or guilt
• You have the right to not accept responsibility for others
Characteristics of assertiveness

- The assertive person states clearly what they are thinking and feeling
- There is no apology for expressing emotions and thoughts
- The assertive person refuses to be manipulated by false guilt
- The assertive person respects the rights of others
Confronting conflict assertively

Keep it short
• ‘I hear you’, ‘I understand’…

Slow down
• your words will be more powerful and effective

Deepen your voice
• slow your speech and make an effort to relax and you will hear your voice deepening

Use a firm tone
• remain firm and assertive (practice)

Paraphrase
• Summarise what the other person has said.
Confronting conflict assertively

Use descriptions
• Describe the facts /omit opinions

Confirm the facts
• If not entirely sure paraphrase and ask for confirmation
• Check what they are saying... ‘Are you saying... ? If I heard you correctly, you are.... ? Am I right in thinking...? So, you are telling me/ feeling...? Is this what you mean...?’

Keep in check –
• Never interrupt someone’s conversation
• Never answer for another person
• Don’t lose eye contact - unless to maintain it would be rude or culturally insensitive
• Don’t label or judge people or ideas
• Don’t play psychologist /attempt to work out others’ problems.
Examples of invalidation

- Avoid invalidation: patronising/belittling/dismissing someone’s feelings/behaviour
- ‘Don’t worry’
- ‘Calm down’
- ‘Turn that frown upside down’
- ‘You shouldn’t feel that way’
- ‘Nobody else feels like that’
- ‘It’ll be okay’
Negotiation

• Negotiation is a process of arriving at a mutually satisfying outcome through discussion, bargaining and compromise
• However, negotiation can be very difficult if you are dealing with someone who is angry and aggressive
• The most effective way to deal with anger is to respond thoughtfully, while remaining focused on your goals
• Negotiation is not about winning; it is about solving the problem in a way that protects the relationship between you, the organisation and other.
Negotiation

• When responding to an angry client you should **focus on any areas of agreement**, then state where you stand on the issue while empathising with the client

• **Focus on the issue** / don’t try to defend yourself or the organisation

• **You will not change a client’s mind by arguing or debating**

• Try to negotiate solutions/ negotiate a satisfactory compromise

• Obviously a win-win situation would be ideal but if this is not possible then seek a solution that is reasonable
Negotiation techniques

• Keep calm when speaking, take a deep breath and use self-soothing thoughts to keep your own anger and anxiety under control
• When you relax your tone of voice, the client’s anger may start to subside as well
• Calmly assert yourself and listen to the needs of the client
• If you don’t listen, you are less likely to be able to assist them
• Don’t become side-tracked into defending yourself and don’t take the anger personally even if it seems personal.
Negotiate for resolution

1. Identify the apparent conflict or problem
2. Understand and explore the conflict/problem
3. Identify the actual conflict
4. Identify alternatives
5. Explore alternatives
6. Choose course of action
7. Implement course of action
8. Evaluate
Identify the issues

- Understand and explore the conflict/problem
- who or what is causing the conflict/problem?
- when does it occur?
- how long has the problem/conflict been occurring?
- in what situation does this occur?
- what evidence will indicate it has been resolved?
- what feelings are involved?
- is there conflict in values or attitudes?
Explore the alternatives

• Who is involved?
• What is the ‘cost and effort’ of the solution?
• What are the advantages and disadvantages of the possible solution?
• What are the consequences of each alternative?
• How do the parties involved feel about each option?
• What are the feelings of the parties involved?
Choose a course of action

• List the alternatives that are probable and improbable
• List the alternatives that need more information before judgement is passed
• Choose one or two alternatives or strategies to trial
• Identify the steps involved for the group or individual to achieve the solution
• Identify what will constitute a level of success
• Assign responsibilities for implementing the decision
Evaluation

Evaluation is continual

– If the outcome does not lead to the desired goal, new goals may need to be identified/negotiated

– Ask questions of the party:
  • How well did they do?
  • What did I learn?
  • Am I satisfied?
  • What could I have done differently?
Negotiation techniques

If a client stays angry or becomes overly aggressive:

1. Make it clear that you are willing to discuss the problem, but do not become argumentative
2. Keep calm and repeat to the client that you are there to listen to them
3. Be mindful of nearest exits and access to help
4. Terminate the discussion if the other person remains angry (e.g. ‘We don’t seem to be getting anywhere at the moment, I’ll have to speak with my supervisor’)
5. Call security or the police if you feel threatened
6. Leave the situation immediately if you feel in imminent danger.
Example

• ‘I agree with you that it is unfair. You shouldn’t have to wait an hour when you made an appointment one month ago. I also understand that you are busy and it is difficult to sit and wait when you have other matters to attend to.
• Unfortunately staff numbers are low today so we cannot see you immediately. I apologise for the inconvenience.
• Would it be possible to come back later or make another appointment later in the week so you won’t have to wait as long?’
Remember

• Attend fully to the client
• Use empathy
• Listen carefully to what they are saying
• Stay with them until they are calmer
• Don’t interrupt
• Seek information
• Check your understanding by paraphrasing
Scenario

• It is 7pm. There is one RN on duty. John is still demanding to see the doctor about his mother.

• What are you thinking?

• How would you respond?
Reporting and recording incidents

• Any unacceptable behaviour must be recorded and kept on file.
• This includes any formal observation and monitoring records.
• Records can then be analysed and any specific patterns identified for future reference or action.
• An Incident Report needs to be filed following an incident of challenging behaviour.
• A copy of this Incident Report should be kept on the client’s file as well as being submitted to the appropriate manager for follow-up.
• **Question** – When/under what circumstances would you file an incident report?
Completing an incident report

An incident report needs to include:

• Time, date and location of the incident
• Type of incident – abuse, threat, assault
• Who was abused/threatened or assaulted, and their role
• Client/person who committed the act and relevant details
• How the incident arose and progressed
• Activity underway at the time, including detailed description of any high-risk activities
• Nature of injuries/damage sustained
• Contributing causes
• Potential or actual costs
• Corrective action taken
• Follow-up recommendations
• Name, designation, date and signature of reporter
Self care

- Employee Assistance Program (EAP)
- CRANA Confidential 24-hour Support Line 1800 805 391
- Debriefing
- Social support
- Relaxation
- Physical activity
Summary

• Be aware of potential triggers and early warning signs indicating the potential for challenging behaviours
• Be aware of your own reaction and behaviour and its effect on others
• Be aware of policies and procedures to minimise risk
• Use active listening skills, probing and paraphrasing to confirm your understanding of the situation
• Aim to negotiate assertively to defuse the situation
• Maintain safety of self and others
• Attend to formal reporting requirements
• Seek support and debriefing
Useful websites/books

www.cci.health.wa.gov.au
beyondblue.org/
www.psychologytools.org/
www.dhhs.tas.gov.au/mentalhealth/useful_links_and_contacts
www.mifellowship.org/


References

- www.communitydoor.org.au
References

• Merritt, L. 2003, *Talking the talk: communicate with persuasion, panache and passion*, Choice Books, NSW.

Web links and video clips

• www.dhhs.tas.gov.au/mentalhealth/about_mental_illness/fact_sheets_about_mental_illness
• Centre for Developmental Disability Health Victoria. www.cddh.monash.org/products-resources/advice.html
• Active listening video: http://www.youtube.com/watch?v=4VOubVB4CTU
• Aggressive scenario: http://www.youtube.com/watch?v=7cZDfWcltig
• Poor communication video: http://www.youtube.com/watch?v=W1RY_72O_LQ