MODULE TWELVE

Dealing with Abusive Behavior and Difficult Situations

Policy

Occasionally medical case managers will need to address abusive behaviors and difficult client situations. In each instance, safety must be balanced with serving clients, many of whom have histories of violence related to substance abuse, mental health, and other circumstances. What follows are definitions of abuse and difficult situations and methods of assessment and possible interventions. Case conferencing and team approaches work best in these situations.

Programs may suspend or terminate a client if the client has threatened violent behavior or bodily harm to the medical case manager or any member of the agency staff. Medical case managers must discuss this action with the supervisor and document it in the case notes. Clients with substance abuse problems must not be terminated from medical case management solely for active substance use. Programs must identify a back-up plan for client services when using a suspension plan, "cooling off period," which allows a client who acted in a violent or threatening manner the opportunity to continue services with improved behavior. Clients can be terminated from the programs if they have made fraudulent claims about their HIV status or have falsified documents.

Procedure

Abusive Situations

Abusive situations are defined as acts that involve physical, sexual, or verbal abuse, and/or other types of abuse. Examples include the following:

Physical Abuse: Hitting, punching, kicking, grabbing, spitting on or otherwise striking an individual.

Sexual Abuse: Sexual assault or sexual harassment of either a staff member or another client. Examples include rape, lewd conduct, creation of a hostile environment through sexual innuendos, advances, etc.

Verbal Abuse: Verbal assault including belittling, screaming, threatening, blaming, or using sarcasm in an abusive manner.

Other Abusive Situations: Includes acts of violence such as threatening someone with or without a weapon, displaying a weapon, and/or using a weapon on the premises or around clients/staff.

Medical case managers (MCMs) have a variety of behaviors to pay attention to in the course of delivering services. It is the MCM's responsibility to do their best to ensure their own safety and the safety of others through assessment and prevention of abusive situations or through knowing how to respond to abusive situations. Clients may engage in violent behavior in response to real or perceived rejection or confrontation by the MCM or as a result of their active drug use. When a MCM is in the position of setting a limit or denying access to a service because of non-compliance with the care plan or another protocol, the MCM may become the target of the client's entire frustration. Sometimes this limit setting will remind a client of other difficult or rejecting situations in their lives, and they may react from that place. Responding to these situations requires assessment to determine the best course of action.

Assessment

While we can never fully predict when someone may behave in an abusive manner, we can minimize those times when a medical case manager might be surprised by an abusive or dangerous behavior. The key to prevention of abusive situations is thorough and ongoing assessment. Assessment in our service delivery system includes a comprehensive initial assessment and an ongoing assessment.

Initial Assessment: In Module 3 the Initial/Needs Assessment process was reviewed. The questions from the Needs Assessment most connected to assessing risk around abuse are the mental health and substance abuse questions. It is important to know how the client handles anger, disappointment, frustration, and other difficult feelings. It is also important to know if they have ever injured or been accused of injuring someone. It is helpful to know if they are being or have been treated for mental illness, since some illnesses can be connected with abusive behavior. These questions will give you some idea about their propensity for being abusive. It is also important to know if they are actively using substances and, if so, which ones. Their use/abuse may alter their disposition, resulting in an abusive situation related to their level of intoxication. A past history of violence or abusive behavior prior to seeking case management will not necessarily disqualify the client from case management services. However, such a history will influence how you will work with the client (e.g. meeting at the office when others are present, making referrals to substance abuse treatment or mental health services, assessing social supports, etc.).

Assessing Client's Potential for Violence

Indicators of potential violence are illustrated below.

Indicators of Potential Violence

- Prior history of violence
- Low frustration tolerance
- Having a history of perpetrating violence on others or being the victim of violence
- History of serving time in jail or prison for a violent offense
- High level of agitation
- History of threatening others in a violent manner
- Mental illness related to acts of violence: A diagnosis of Borderline Personality Disorder, Anti-Social Personality Disorder, Conduct Disorder in youth, etc.
- No demonstrated understanding between cause and effect
- Active chemical dependency, detox, or early sobriety
- Possession of weapons

In dealing with potentially violent clients, it is critical for the medical case manager to trust their instincts. If the situation seems uncomfortable, leave, and make other

arrangements. In such instances, medical case managers should record assessment information in the case notes and consult with their supervisor. It is important to develop a plan of how this client will be served to *prevent client abandonment*. Use of cooling-off periods, boundaries regarding when and where services are rendered are tools to consider using in these situations.

Ongoing Assessment: As the medical case manager continues to work with clients, he or she will need to continually watch for and assess changes in attitude or disposition that may lead to a client behaving in an abusive manner. By identifying the issues early, the MCM may be able to de-escalate the situation or make a referral for additional support that may prevent an abusive episode. Sometimes clients surprise us despite our best efforts to identify and intervene in potentially abusive situations. There are a number of situations that may present themselves in the moment when meeting with clients.

Possible Triggers for Client Abusive Behavior towards the Case Manager

Medical case managers serve as the center of many of the services within the system of care. Some clients are very new to the system of care and others have been a part of the system for some time. MCMs may need to set limits with clients. It is important that MCMs remain consistent and clear in their limit setting and use of the guidelines and protocols. Clear and consistent communication and follow-through can be helpful for the client and the MCM. Case managers can also get support from one another through case conferencing, strategizing in medical rounds or from supervisors as these situations present themselves.

Abusive situations can arise from the following actions:

Limit Setting: Case managers experience potentially abusive situations most often when setting limits. These limits might be related to the denial or limitation of food vouchers or other Emergency Financial Assistance (EFA) services.

Creating the Care Plan: Case managers work with clients to develop a Care Plan that will guide the client's use of the service delivery system. When discussing social problems such as substance abuse, non-compliance with medical care or other service system protocols, or mental health issues, clients can become agitated, defensive and potentially abusive.

Saying "No": Case managers experience potentially abusive situations often when saying "no" to clients. Clients may cuss, yell, threaten, or otherwise behave in an abusive manner. Sticking with the "no' if it is appropriate, will be key for the case manager's relationship with the client.

Confronting a Client: Case managers are often the key person to confront a client. These confrontations may be about guidelines for participation, the protocols for Emergency Financial Assistance (EFA) or other services, following through on referrals, adhering to medication plans, going to a health care provider, attending meetings with the case manager, or talking about substance abuse issues.

Intoxication: Occasionally clients will attempt to work with case managers when they are under the influence of alcohol or other drugs. Use of these chemicals makes it difficult to provide case management services. Case managers need to be clear about how they plan to handle these situations, as they do come up. Clients can benefit from a harm reduction approach.

Additional suggestions for dealing with or responding to these abusive situations can be found in the appendix of this module.

Threatening Behavior

From time to time clients may be agitated or upset in a manner that leads them to behave in a threatening manner. These threats are to be taken seriously and discussed with the clinical supervisor. Discussing threatening situations with other collaborating service providers involved with the client is important for developing and supporting a joint plan to provide services to the client and ensure the safety of the staff member and client. Barring a client from service should be used as a last resort depending on the type and nature of the threat. Other tools that have been successful include using cooling off periods, developing behavior contracts, linkage to other support services (mental health/substance abuse services), and strategic case coordination. The system of care goal is to support the clinical treatment plan. In some instances clients who are difficult to work with, who have active substance abuse or mental health issues, are those most in need of medical case management. See the appendix for additional suggestions for addressing these situations.

Suicidal Behavior

Medical Case Managers conduct assessments and observe client behaviors as part of each session. Recognizing the warning signs of possible suicidal behavior can provide opportunities for linkage to mental health support to prevent the self-destructive behavior. The goal is to intervene until the immediate danger or threat of suicide has passed or until additional assistance and resources can be accessed.

Suicide Assessment

Common Warning Signs: Most people communicate some sort of warning about their suicidal intentions before they engage in the actual self-destructive behavior. The method of communication varies and can include blatant behavior (suicide note, off-hand comment, openly declared plan, or an action such as standing on a ledge), or extremely subtle (a gesture, a posture, a roundabout comment, a tone of voice, a change in usual behavior). Either way the message is, "suicide is on my mind." Warning signs are a way of saying, "Notice me, I'm in trouble." See Appendix for an expanded list of common warning signs. It is very important to keep in mind that clients are individuals and that their history, as well as the personal meaning they attach to their life crisis, will impact the seriousness of the warning sign. Working with the clinical supervisor is very important.

Some people respond to having a life-threatening illness by making a plan for some point, far in the future, when they feel they can no longer cope with the effects of their illness. For many of these individuals, the idea that they could commit suicide at a later time is a coping strategy, and a way to maintain some feeling of control over the course of their life, but is not an immediate threat. When exploring this issue with a client, it is especially important to discuss whether or not the plans to commit suicide are:

1. Immediate (for now or in the near future).
2. Specific (how and when, and how well thought out is their plan).
3. Lethal (how likely would their plan be to result in their death).

For more information about assessing these situations and examples of how professionals handle suicidal clients, refer to the appendix at the end of this module.

Child Abuse

Many medical case managers find themselves working with or in the presence of clients' families. During the course of the work, MCMs may hear about, witness, or suspect that child abuse has occurred. Child abuse is defined as an injury inflicted on a child by other than accidental means. It includes physical abuse, sexual abuse, emotional maltreatment, and neglect.

Case managers in the service delivery system work under the direction of a variety of agencies. The agency will inform MCMs of their duty and procedures as mandated child abuse reporters. If an agency wants specific training about recognizing child abuse or about mandated reporting, the Child Abuse Prevention Council of Contra

Costa County will provide free training at your agency through their volunteer community education program. They can be contacted at (925) 798-0546.

According to the law, a mandated reporter is anyone who is required by law to report suspected child abuse. Those professionals required to report, according to Penal Code Section 11165 include a number of professions including a large category of "health practitioners". The law states that "… any …health practitioner, … who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment who he or she knows or reasonably suspects has been the victim of child abuse, shall report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof within 36 hours of receiving the information concerning the incident…" Reasonable suspicion means that, after examining all of the facts in a particular situation, most people with similar training and experience would also suspect abuse. It is important to report the suspicion of abuse to your agency supervisor for direction in addressing the situation.

There are time limits for reporting. Suspected child abuse must be reported immediately. The written report must be filed within 36 hours after reporting suspected child abuse. Reports are to be made to any police department, the sheriff's department, the county probation department, or the county welfare department. It does not include a school district police or security department. Fines or other consequences may be given for failing to report.

How to make a referral when you have a suspicion of child abuse

You can call 24-hours, seven days a week:
(925) 646-1680
Or Toll Free at 1-(877) 881-1116

The following information is helpful when making a referral

Identifying information about the child and the parents or person having custody.

- Name and birthdate of child
- Your relationship to child
- Current location of child
- Where the incident occurred
- Address and telephone number where the child is.
- Name and address of child's school or daycare, if applicable.

Written reports are to be done on the SS 8572 Suspected Child Abuse Report Form. An example is in the appendix of this module. Blank forms may be requested through

the Child and Family Services Division of Employment and Human Services in Contra Costa County.

Elder or Dependant Adult Abuse

An elder is defined as any person residing in California who is 65 years of age or older. Dependent adult is defined as any person residing in California, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. Dependent adults include any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in the Health and Safety Code (1250,1250.2, and 1250.3). Elder or dependant adult abuse is defined as seven specific types of abuse. These are described below:

Physical Abuse: Includes slapping, hitting, bruising, beating or other intentional act that causes someone physical pain, injury or suffering, including excessive forms of restraint used to confine someone against their will. Sexual abuse is also considered physical abuse and includes any sexual activity to which the older or dependent adult does not consent or is incapable of consenting and includes the range between exhibitionism to sexual intercourse.

Financial Abuse: Any theft or misuse of money or property, by a person in a position of trust with an elder/dependant adult.

Neglect: The failure of any person having the care or custody of an elder or dependent adult intentionally or unintentionally fails to support the physical, emotional and social needs of the elder or dependent adult. Neglect can include denying food or medication, health services or contact with friends and family. This is the most common form of elder/dependent adult mistreatment in domestic settings.

Self-Neglect: Failure of elder or dependent adult to meet their own physical, psychological or social needs or they threaten their health or safety in any way. Often times, physical or mental illness, isolation or substance abuse prevent elderly or dependent adults from being able to take care of their own basic needs.

Isolation: Social isolation of family, or isolation or restriction of activity of the elder or dependent adult within the family unit by the caregiver. Can include preventing an elder or dependant adult from receiving his or her mail, phone calls or visitors, false imprisonment as defined in section 236 of the Penal Code, and physical restraint to prevent meeting with visitors.

Abandonment: Abandonment constitutes the desertion or willful forsaking of an elder/dependent adult by any person having the care and custody of that elder/dependant adult.

Abduction: To take an elder or dependent adult away by force.

Agencies providing Medical Case Management should be instructed by their supervisors regarding their duties as mandated reporters of Elder or Dependent Abuse. California law specifies that mandated reporters who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse, (as defined above) shall report the known or suspected instance of abuse by telephone immediately or as soon as practically possible, and by written report (SOC 341), within two working days, to the appropriate agency.

Suspected cases of elder abuse or dependent adult abuse should be reported to the county adult protective services agency or local law enforcement agency. If the abuse occurred in a long-term care facility (i.e. nursing home, community care facility for the elderly, adult day health care center) reports should be made to the local long-term care ombudsman or local law enforcement agency. Failure to report may result in fines or other consequences.

- Adult Protective Services: Elder/Dependent Adult Abuse Reporting
  Contra Costa County 877-839-4347 Toll Free

- Long Term Care Ombudsman 925-685-2070

References

The following references were used to develop this module.

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