

MODULE TWELVE

Appendix

Professional Responses To Abusive Behavior and Difficult Situations

The following appendix will provide descriptions of how some professionals handle abusive behaviors or difficult situations. The Appendix is ***not*** a how-to manual, but rather ***a list of suggestions that others have used when faced with the behaviors that follow.*** Each Medical Case Manager is reminded to ***consult with their clinical and program supervisors*** when addressing abusive and difficult situations. Each section corresponds with the definitions and assessment sections detailed in Module 12. ***Agencies are also expected to have specific protocols, training and responses to these situations to ensure the safety of staff and clients.***

Responding to Abusive and Threatening Behaviors

Responding in the following manner is helpful when medical case managers (MCMs) find themselves in the midst of an abusive situation:

1. Have an **understanding of your agency's emergency procedures** and policies for dealing with abusive or threatening behavior. The process may involve calling 911 for situations requiring police intervention or assessment for an involuntary hospitalization for a client (P.C. 5150).
2. **Remain calm** and get yourself and others to safety. Assess whether or not you are in imminent danger. If yes, attempt to get to safety as soon as possible and call 911. Remember to breathe as oxygen to the brain helps with decision-making.
3. As part of **assessment**, medical case managers pay attention to what is happening in every situation. For example if the client is cursing, identify if they are cursing because it is the language they use or if they are more agitated and directing the cursing at the medical case manager or others. Is the client invading the case manager's personal space? If the client is invading space, the case manager should ask himself or herself, what might this be about (inability to understand social cues, developmental disability, or attempt to threaten and intimidate)? Where is the case manager? Is the case manager alone in an office, in public, or with other staff available in the office? How is the client responding to the case manager? If the client is de-escalating then the situation may be workable, requiring no intervention at this time. If the situation is not de-escalating, the case manager will use their safety plans. Case managers may ask other staff to assist with a crisis situation, use an office code word or need to take one of the actions listed earlier (e.g. call 911, etc.).
4. **De-escalate the situation.** How de-escalation occurs will vary based on the situation and style of the case manager. If appropriate, the case manager may use their relationship with the client to begin to talk the client down from their agitated or abusive state. Sometimes the situation will demand that the case manager set a clear limit with the client, telling them that they will need to leave the facility immediately given their abusive behavior. Remind them that you do want to talk with them and assist them when they are calmer or no longer

behaving in an abusive or threatening manner. Use your judgment in terms of how long you believe they need to cool down or experience a cool-out period from your program. Forbidding clients from getting services in your facility should be a last resort and discussed with the clinical supervisor prior to implementation. For some clients, it is effective to become calmer and quieter as they become more agitated. For other clients using this method will make the situation worse. Some clients want to yell and shout and then return to a rather calm or workable state, and for others their typical tone is loud and/or agitated. It is important for the case manager to know what works for the client. It is also important to note if the client's behavior has changed from the typical tone the client uses everyday. Using active listening skills (listening attentively and repeating/summarizing what was heard in order to be clear on the issue) can be helpful. Slowing down the process and giving the client the opportunity to be heard can often de-escalate the situation.

5. Dealing with Abusive or Threatening Behavior may require:

- Knowing the EFA protocols and following them consistently.
- Knowing the EFA appeals process and being able to refer clients to it.
- Communicating clearly what is okay and not okay in the interaction.
 1. Remind the client about the client responsibility agreement, which details how they are to interact with case managers and others.
 2. Respond clearly with "I will not be able to talk with you further if you continue..."
- Assessing when to bring your supervisor into the situation.
 1. The case manager may give the client their supervisor's number and encourage them to call the supervisor directly. It may be helpful to brief the supervisor before they receive the phone call.
 2. Build a good rapport with your supervisor so that you can debrief difficult situations and receive support.
- Understanding chemical dependency so that you can respond to situations when a client may be intoxicated.
 1. Know how to make a referral to the substance abuse counselor. Telling clients to come back when they are not intoxicated may not be feasible. Using a harm reduction approach, decide what would be best for each client situation.
 2. Set a limit with the client that lets them know that you will not be able to meet with them if they are under the influence and behaving in an inappropriate way. You or they may need to leave and meet another time.
 3. In some settings, the client can be referred to the quiet room to calm down and return to the session after this "time-out".

4. In rare situations, depending on the level of intoxication and the behavior displayed by the client, the case manager may need to call 911.
 5. Occasionally, other clients will set limits with the client who is behaving abusively.
- During home visit situations, it is critical for case managers to follow their gut (instinctive) reactions to a client's situation. The following are guides that may assist with specific situations that may come up when doing home visits.
 1. Call the client before going to their home. This will let the case manager hear how the client is doing prior to arriving and gain a sense of whether or not the client is intoxicated.
 2. Recognize that case managers can leave a home at any time if it seems unsafe for them.
 3. Case managers may want to partner with another case manager or other staff member for certain home visits.
 4. Schedule the meeting in another site that seems safer for the case manager and client.

Responding to Suicidal Behaviors

It is important for Medical Case Managers to consult with clinical and program supervisors and to understand the agency protocols and policies regarding responding to clients who may be suicidal. When in the situation, consultation and support in making decisions is critical.

Thoughts of suicide are common among HIV positive individuals with few people actually planning suicide or taking the action to end their life according to a 2007 study (Carrico AW et al, 2007). Typical risk factors that put anyone at risk for suicide: include depression, recent loss, substance abuse, age, gender, life stressors, a prior suicide attempt, a current plan for suicide, and the absence of resources and support, (Goldblum, 1987). Some specific situations that can put people with HIV at greater risk for attempting suicide include:

Specific Risk Factors for People Living with HIV/AIDS:

- Emotional stress over and above the physiological aspects of the disease.
- Exhaustion of physical and emotional resources (including a feeling of lack of family and medical staff support).
- Significantly more complaints of pain and discomfort.
- Near death physical condition.
- Alcohol use and drug use may contribute.
- Issues regarding sexual orientation and/or gender identity.
- Multiple losses related to AIDS--either deaths or illnesses of friends or lovers; or other losses, such as employment or housing.
- Intimate involvement with another person who has died of AIDS (this past experience often has a decided impact on people as they enter the later stages of their own illness).
- Different stages of the disease may pose different risks of suicide and personal needs may change as the illness progresses (recently diagnosed, mid-stage, late stage).
- Great anxiety for people living with HIV who are uncertain of their health status and their future, find their life planning disrupted, experience a loss of physical stamina, etc.
- Recent notification of a positive result from the HIV test, prompting confusion about the meaning of the test result and its implications for future health status and life stages.
- Experiencing discrimination, insults, or injury by others due to fear of AIDS or homophobia.
- Personal histories of losses related to homophobia (family history of rejection, history of employment or legal problems related to being gay/bisexual or transgender).
- Discrimination and/or violence related to HIV status, gender, race, sexual orientation, etc.
- Hiding sexual or drug using behavior and experiencing guilt, personal conflict or other emotions.
- Lack of social and financial support system that is adequate for coping with the AIDS epidemic, (this can be exacerbated for some gay/bisexual/transgender people who recently moved to a large urban area as a haven from discrimination in other parts of the country).
- Immigration issues that may impact access to care and support.

Suicide Assessment

As part of the intake, assessment and needs assessment process, some of the stressors listed above will be discovered by the Medical Case Manager. Exploring these more fully will assist with understanding what is going on with the client. In addition, it is important to have an understanding of what those experiences *mean* to the client. If the changes a client is going through produce stress and a sense of loss, suicide is more likely. Even so, many of our clients experience multiple losses and stressful life events, and the vast majority does not commit suicide. Medical Case managers must ask directly for personal feelings about the losses clients' experience, which can come in many forms. The losses could include medication failure, terrible side effects, the loss of a driver's license, the loss of freedom and choices. The more a client shows overall feelings of hopelessness and helplessness, the more likely it is that they are at risk for suicide. Some of the most stressful life events include:

- Suicide of parent, spouse, or loved one
- Death of a parent
- Divorce or separation of parents
- Sexual abuse or assault
- Physical abuse
- Serious illness in family
- Death of friend
- Substance abuse by parent
- Remarriage of parent
- Dependency on drugs or alcohol
- Legal involvement
- Running away from home
- Moving to new school, job or community
- Witnessing violent event
- Failing grades or work performance
- College rejections
- First sexual experience
- Inability to refuse sex
- Mother returning to work

To find out if the client is considering suicide, ask them directly. Some people are concerned that if they ask a person directly if they are thinking of committing suicide, they will “put ideas into their head.” This is not the case. Usually a simple question, like “John, when you talk about how ‘life is not worth living anymore’, I’m wondering, are you thinking of killing yourself?” or “Do you ever think about suicide?” or “What do you mean when you say, ‘I don’t think I’ll be around much longer anyway?’” Some clients will be surprised by the question but are usually impressed by your concern for them. It is also important that clients understand the consequences of telling you that they have an immediate plan to kill themselves. (For example: Many providers have an exception to the limits of confidentiality, which will require the service provider to break confidentiality to ensure the client's safety). Consult with your supervisor regarding your agency policy and procedure.

The above information will give the case manager information about whether the client has thought of suicide. The next critical step is to assess the likelihood that an actual attempt of suicide might occur.

Five factors serve as valuable predictors of the immediate risk of suicide. Their predictive power, although not guaranteed, has been supported by research. The presence of these factors identifies those who are at much greater risk of suicide.

A person's suicide risk has to do with their risk factors and the level of stress those factors create. Listed below are other examples of life events that often bring about high stress levels and sometimes serve as the precipitating factors for later suicidal behaviors, especially among young people.

When conducting the assessment, it is critical to ask about and listen for the predictors of suicide.

Five predictors of immediate risk for suicide:

- Current suicide plan
- Method
- Means to carry it out (preparation, time set, etc.)
- Prior suicidal behavior
- Resources

Current Suicide Plan

A passing thought of suicide in times of emotional pain and loss is not uncommon. Case managers are concerned about intervening in those situations where a person seriously considers suicide as an option. Asking the client if they are serious about suicide may not get the case manager the information they need, since the client may not be clear about their own seriousness. To get at this question, it is helpful to ask about the plan. The more clear and detailed they are tells us how close the act is to actually happening. It is also important to recognize that plans sometimes take on a life of their own. Once someone has made a plan, the obligation to finish what has been started becomes strong. When asking about plans, case managers want to know: How the client plans to do it, how prepared are they to do it, and how soon will it happen.

Method

Does the client know how he or she is going to do it? Do they have the means to carry out their plan? The greater the specificity, the greater the risk. Other questions include how lethal is the method? The more lethal, the greater the risk of death. Consider the finality or potential for reversibility of the act. Firearms or hanging as methods are less reversible, and therefore more dangerous, than most self-poisoning or overdose attempts. It is important to consider that sometimes the intent has nothing to do with the method.

Preparations

Has the client made preparations to commit suicide? Have the means been acquired or is it easily available? Has a suicide note been written? Completed preparations and easy access to the means increase the risk considerably.

Time

Has the client settled on a specific time? How close at hand is it? The sooner the intended act, the greater the risk. Persons who indicate that suicide is imminent should not be left alone. In California, specified mental health professionals are empowered by law to detain a person at imminent risk of suicide for his own protection through a 5150 assessment conducted by local law enforcement or a psychiatric emergency response team. Other questions include, how long will it take to die from the chosen method? The more immediate the result, the greater the risk. How long would it take for someone to discover the suicide attempt and try to help the individual? The greater the distance from those who could help in an emergency, the greater the risk.

Prior Suicidal Behavior

According to the California Helper's Handbook for Suicide Prevention, the rates of suicide among people who have previously attempted suicide are 45-50 times greater than general population rates. Although the ratio of those who attempt to those who eventually commit suicide is still quite small, those who do kill themselves are more likely to do it within two years of their attempt. The more recent the attempt, the more acceptable suicide remains as a solution.

The risk of suicide can also increase for those whose parents or some other significant figure died by suicide. Past suicidal behavior by the person at-risk also indicates that self-destructive actions are more acceptable to the individual. The more frequently a person resorts to suicide attempts as a means of coping with stressful life events, the more likely it is that he will eventually die by suicide.

Resources

Support systems can sustain an individual during stressful periods in life. They afford protection from being totally alone and in this way effectively lower the risk of suicidal behavior. There are both internal resources (self-esteem, self-confidence, a positive outlook, hopes for the future, etc.) and external resources (family, friends, financial security, a satisfying job, a place to live, access to professional help and medical care, positive role models, membership in church or other organizations, etc.). The 2007 study cited above states that regardless of ethnicity or sexuality, being in a romantic relationship was seen as a protective factor against suicidal thoughts (Carrico, AW, et al, 2007). A person without supportive resources is vulnerable. He or she has no one with whom they can share their ideas or test their perceptions. Resources lessen feelings of hopelessness and helplessness. Their support makes it less likely that suicide will occur. If you want to determine whether the absence of resources is predictive of suicide, ask directly about feelings of being alone. Find out if there are resources that would be acceptable if connections could be made with them.

Intervention with a Suicidal Client

There are five tasks that the case manager should work towards with clinical or programmatic supervision. Keeping in mind that each person is an individual and what works with one client may not necessarily work with another. The five tasks are:

1. **Engage:** Explore the person's situation by encouraging the open expression of his/her personal concerns. Show the client that you are concerned about

understanding their feelings. The client may focus at first on events but try to draw out the feelings and meaning the client attaches to the event. By helping a client connect feelings to an event, the distance between the case manager and the client will quickly narrow.

The objectives for this task are:

1. To give the individual a sense of acceptance and support **and**
2. To look for signs that suicidal intentions might be connected to the feelings and events happening in his/her life.

2. **Identify:** The second task is to find out if the person is thinking right now about suicide. As the case manager establishes and maintains the relationship and learns more about the client's thoughts and feelings, the case manager may find that the client is considering suicide. The case manager will need to steer the conversation towards suicide. Finding out from the client how they plan to deal with their situation is important. Be sensitive and clear in your questions about suicide. Being indirect or roundabout will get the same fuzziness in response. Examples of questions are:

"Are you thinking about suicide?"

"Are you thinking about killing yourself?"

Being direct and to the point will give the client permission to talk about his/her suicidal thoughts and possible plans. It makes suicide an issue that can be talked about rather than a private, hidden problem. If the client answers "no", then you can return to discussing what's going on for them. If the answer was abrupt or the case manager believes it may not be truthful, the case manager should return and ask about suicide again when the discussion reinforces or confirms concern.

3. **Inquire:** If the client is indeed considering suicide, the case manager will then inquire about the reasons why these events and feelings are leading to thoughts of suicide at this point in time. The goal is to help the case manager and client develop an understanding of why suicide is being considered. The mutual understanding creates a base from which the case manager and client can work together towards finding other ways out of the immediate situation besides suicide. The focus is still on the events and the client's reaction to them, but approached from a different perspective. The emphasis has shifted to learning as much as possible about the client's struggles and attempts to deal with suicide. Additional questions the case manager may consider are:

"What other stress or loss has occurred?"

"How is this loss connected to suicide in his/her mind?"

“Is he/she showing symptoms of hopelessness in his/her thoughts and feelings?”

How alone does the client feel?”

“How acceptable is suicide as a solution to his/her pain?” (Have they known anyone who has attempted and /or completed a suicide? This may increase their risk for attempting suicide.)

The time needed for this task is highly variable and depends on the willingness of the client to trust and share with the case manager. The case manager should not expect the understanding the client shares to be clear and specific. The case manager must be willing to let the client vent whatever feelings he/she has about the immediate problems and to talk openly about his/her thoughts about death. This is an important part of understanding the events and feelings that are leading to suicide. The case manager’s ability to open up and to accept the discussion of suicide provides a release for the client. It also helps the client recognize that there are other ways of looking at the situation. As a result of the closeness and sharing the case manager accomplishes during this task, the client may begin to move away from the focus on suicide. You may begin to sense that some part of the client is ambivalent about the decision to commit suicide. Working with the client at this undecided state requires that the case manager remain sensitive to both parts (the ambivalent/undecided part and the part that wants to commit suicide). Case managers may find themselves having their own feelings about the back and forth struggle with life and death feelings. The case manager’s willingness to share in the struggle can provide the key for a renewed commitment to life. Just as the case manager openly accepted thoughts of death, the case manager can help the client focus on living and on problem solving.

Who or what will the person miss the most if he or she is gone? What is the best part of his or her life? How did he or she solve serious problems previously? Be ready to speak for the life side, but don’t overdo it. Pulling hard to the life side can backfire and trigger resentment. The case manager’s persistence and flexibility will serve the client well.

4. **Assess:** The inquiry phase ends when the case manager and the client have reached a shared understanding of the client’s here-and-now situation. Next, the case manager must assess what the client’s level of risk for suicide is right now. The task of assessing the immediate risk was presented in the assessment section. Now, assessing the risk summarizes the case manager’s present understanding and provides direction for the case manager’s action plan. The information needed for this assessment is very specific and includes the following:
 - a. **Current plan:** How does the client plan to commit suicide, how prepared is the client, and how soon will it happen?

- b. **Lethality:** Have there been prior suicidal behaviors? Ask directly about them, when they happened and how the situation was handled, and what their thoughts are currently about suicide as an option.

In addition to the indicators and predictors of suicide risk, the assessment process also includes a combination of gut feelings and a more objective assessment. ***If you have any doubt about the level of danger, err on the side of caution and consider the risk to be on the higher side. In a situation where a person's life could be at stake, it is better to do too much than not enough. Consult with the supervisor.***

5. **Take Action:** The goal here is to create and carry out a plan that prevents the immediate risk of suicide. At this point the case manager has identified the problem and worked with the client to gain a full understanding of it from a number of viewpoints. The case manager has decided how much risk of suicide there is at this time and is prepared to do something about it. Case managers need to determine if the client is ready to begin to take action. It is important for the case manager to share their assessment of the degree of risk with the client (e.g. "Because you said you can't go on like this and because of the setback you have had with the medication, and because I take you seriously, I'm concerned that you are at high risk for suicide right now.") Ask if they are ready to consider other solutions besides suicide.

Most plans that are made must have the agreement and active cooperation of the client. To solidify the plan and increase commitment, the case manager can write out the action plan and both the client and case manager can sign it. If the client hesitates or seems in any way unsure of the next step, the case manager should return to the inquiry task and reopen the issue of the client's ambivalence. If the client is ready to consider alternatives to suicide but wants the freedom to continue looking at suicide as an option, it is unrealistic to expect that the case manager's understanding and support would entirely resolve the client's ambivalence. Some part of the client is still not wanting to live. It is important to remember that case managers must follow policies and procedures of their agency in working with suicidal clients. Case managers should consult with the clinical supervisor to develop the plan. Elements of plan typically include:

- a. **Specificity.** Include details about the things to be done.
- b. **Limited Objectives.** Remember the job is to intervene until the immediate danger or threat of suicide has passed or until additional assistance and resources can be accessed. The action plan is not meant to be a total solution for all the person's problems. Be realistic.
- c. **Mutuality.** Both the case manager and client have some things to do.
- d. **Crisis Contact.** Confirm some arrangement for emergency support if the steps of your plan for action cannot be carried out or if the commitment cannot be maintained until follow-up.
- e. **Follow-up.** Set the date and time for another meeting between the case manager and the client or between the client and whatever follow-up resources have been agreed to.

- f. **Contracting**. Write out the plan and have the client sign that they agree to follow the plan. It should be in the client's language and written in a simple straightforward manner.

The following is an example of what the components might look like combined and how the contracting process is done verbally:

"I can understand that things must seem terrible to you and that it seems like the pain won't ever stop, but help is available. It'll take some work on your part, but it can happen. I want your agreement that you will not do anything to hurt yourself between now and our appointment tomorrow when we can talk some more. If thoughts of suicide really build up, I still want your promise not to do anything until you talk to me. That means talking to me... not calling me and finding I wasn't there. We are also agreeing to meet at the office tomorrow at 10:00 a.m. Is that a plan that fits your view? Can you give me your promise on it? Can you repeat it in your own words to see what it feels like? I'm also going to give you a phone number for the crisis line. They have staff available 24-hours per day that can talk with you if you are unable to talk with me. Let's write this down so we both know exactly what the plan involves."

Contracting is not foolproof. If the case manager thinks a person is at immediate risk of killing himself or herself, they should still work on getting them increased crisis assistance. Contracting does give you more information about steps the client is willing to take to protect his or her own life. It works best when you have a trusting, established relationship with a client.

The following is a list of some actions that may be taken during the action phase of the plan and are listed in order of increasing involvement of external supports and directive actions.

Some Action Suggestions for Low Assessed Risk for Suicide

1. **Understand the negative personal feelings**: Consideration of suicide is often linked to symptoms of low self-esteem. These are sometimes so painful that the suicidal person will push them from his mind and report feeling little or no emotion. Only through putting them out into the open can they be addressed.
2. **Identify positive personal traits**: Have the person list or express the good things about himself/herself and their life. These are the inner resources upon which a renewed commitment to life will be built. Becoming aware of them may require energy and focus by the client.
3. **Reduce stressors**: Sometimes a decision to avoid or withdraw from a stressful situation, even if only temporarily, is enough to permit inner resources and coping abilities to begin functioning effectively again.
4. **Strengthen coping abilities**: Inner resources to handle stress often exist but are not being used. Work with the client to identify how they handled difficulties like this in the past without turning towards suicide.
5. **Identify supports and community resources**. Have the client consider how many family members and friends both at work and in the neighborhood are people

whom he regards as supportive and caring. Have the client explore and learn more about some of the specific professional helping resources for his difficulties.

6. Get supervision or consultation. The support might include consultation with the supervisor or contact with a licensed mental health professional who can support your action agreement. Tell the client you will bring these suggestions back to him or her for their consideration.

Some Action Suggestions for High Assessed Risk for Suicide

1. Mobilize Support System. Contact family or friends and share your concerns with them. Seek professional help by setting up treatment contacts with trained mental health professionals. Case manager may agree to make the appointment together.
2. Suicide-proof the environment. The most well meant agreements not to harm oneself are sometimes impossible to keep. Removing dangerous items from the environment around the person-at-risk may lessen the chance of an impulsive attempt at suicide. Most obvious is making sure that firearms are locked up or surrendered and that drugs and medicines are safely out of reach.
3. Maintain one-to-one supervision. If the urgency for suicide cannot be resolved or lessened, even temporarily, the client cannot be left alone. It may be necessary for the case manager to remain with the client until other helping resources can be involved. It may be necessary to set up a “suicide watch” with family and friends to make sure that the client does not harm himself. This is an action useful for only a limited period of time, usually until some institutional care can be arranged. If it must continue for more than one day, the level of risk should be reassessed at least once each day and professional consultation and support should be sought.
4. Request hospitalization or legal commitment. Each county has facilities for the assessment, care and treatment of persons-at-risk of suicide. Hospital mental health or psychiatric units are acceptable “safe” places for most persons-at-risk. State laws and regulations mandate the involuntary detention of persons-at-risk that are dangerous to themselves. All emergency resources in the state (911, police, paramedics) are aware of and can put you in contact with the caregivers in your community who are responsible for enforcing these laws. In Contra Costa, hospitalization can occur on a voluntary or involuntary basis. Facilities exist at Contra Costa Regional Medical Center Psychiatric Emergency Services 24-hour assistance (925-646-2800). If the client is not willing to go voluntarily, then the client can be placed on an involuntary hospitalization by calling 911. A law enforcement officer will conduct an assessment and determine if they are in fact a danger to themselves or others and refer them to the county or other facility for an evaluation and observation.

No guarantee is ever possible, but getting agreement from the client on the plan and on his or her responsibility for some of the actions to be taken will increase the chances for success.

Accomplishing these five tasks may resolve the issue of suicide altogether or it may continue to be an ongoing issue for the client. The client has been able to make use of the case manager as an external support or resource at a time when they were feeling overwhelmed. The Medical Case Manager's involvement is clear evidence that the client is not alone.