

SUPPORT Act Grant 101: Crisis De-Escalation Techniques & Tele- Behavioral Health

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- The information contained in this material can change as we learn more about the brain and the ways it is impacted by the environment, trauma, medications, substances of misuse, and other things
- Always follow the guidelines of your agency, ethical and legal standards of your certifying Board, evidence-based practice methods; local, state and Federal laws as well as your judgement and commonsense when working with clients

Questions?

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If you have any questions, please do not hesitate to contact the author at paul.brasler@dmas.Virginia.gov

Program Outline

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- I. Introduction: *Tele-Behavioral Health Basics*
- II. Overview of the Crisis Cycle
- III. Aggression Cycle & De-escalation Techniques
- IV. Assessing Threats of Future Violence or Homicide
- V. SUD: Areas of Concern for Tele-Behavioral Health

I. Introduction: *Tele-Behavioral Health Basics*

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Tele-Behavioral Health

We first need to admit that most of us do not enjoy “connecting” with clients this way; “I didn’t go to school for this!”

We also need to acknowledge that not all clients have access to technology to participate in tele-behavioral health and so we have to improvise

Therefore practitioners and clients are using phones, Skype and FaceTime to conduct sessions; and getting creative in other ways

Clinicians do not have to use HIPAA-compliant video conferencing technology during the current National Emergency; Health & Human Services will waive any penalties for HIPAA violations related to the platform used during this emergency

Tele-Behavioral Health: Clinician

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- Have a space set up where you can connect with your client without being disturbed
- Your work-space should provide some privacy for your client
- Internet connectivity and/or phone signal strength should be tested prior to engaging in tele-behavioral health
- If conducting a group therapy session, educate clients on muting themselves unless they are speaking
- I recommend against using your personal phone, but sometimes this cannot be avoided
 - If using a personal device, I would set firm boundaries with clients regarding when they can and cannot contact you



You'll likely notice that the flow of clinical sessions will be slower than in-person



Be aware that you will likely need to speak slower than in person



Try to express empathy with your voice, especially when not connecting via video

Tele- Behavioral Health: Clinician

Tele-Behavioral Health: Client

- Try to have a private space where you can connect with your counselor that is also free from interruptions and distractions
- Test out your communications system (connectivity) prior to meeting with your counselor
- Most of us (counselors especially) don't like meeting this way, so remember this is temporary and we (like you) look forward to meeting face-to-face again

Creative Ways Clinicians are Connecting with Clients

Some clients do not have access to remote technology at all

What are some ways that people are connecting during this time?

Informed Consent to Treatment

Informed consent should be obtained prior to the start of tele-mental health

I recommend that the clinician review all aspects of the Consent to Treatment form with the client prior to the start of treatment to ensure that the client understands what is expected in treatment and the limits of what the clinician can and cannot disclose without the client's permission

The National Association of Social Workers has developed an example of a Telemental Health Informed Consent you can find at:

<https://www.socialworkers.org/LinkClick.aspx?fileticket=fN67-dWQReM%3d&portalid=0>

Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

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- A statement explaining what tele-behavioral health will look like for you and the client (methods to be utilized: FaceTime, phone, etc.)
- A statement discussing the risks of tele-behavioral health (technology limitations and failures; possible/unintentional breaches of confidentiality)
- A statement agreeing that the sessions will not be recorded by either party
- A statement emphasizing that the content of the session is confidential and that a written release is required from the client to release information
- A statement noting the limits of confidentiality, including having to report suspected child abuse, vulnerable adult abuse, danger to self or others

Informed Consent to Tele-Behavioral Health Treatment—Essential Elements

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- A statement explaining what steps must be taken should the clinician believe that the client is a danger to themselves, a danger to others or is unable to care for themselves
 - This could include a statement that participation in tele-behavioral health may not be appropriate and a higher level of care could be required
- A statement describing how you will handle technical problems should they arise
- A statement explaining that the client must disclose their physical location during the session and an individual the clinician can contact in case of an emergency
- A statement that you are continuing to maintain treatment records during this time

Documentation

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- **If you don't write it down, it never happened**
- Record, in detail, all aspects of client interactions, including any known precipitating events, interventions, outcomes, staff members involved and all contacts with outside agencies
- Record where the client says they are contacting you from
- Do this as quickly as possible following the session
- **Stick to the facts**; do not presuppose or assume anything
- See documentation as a necessary means to protect yourself, the people you serve, and your organization

II. Overview of the Crisis Cycle

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What Is A Crisis?

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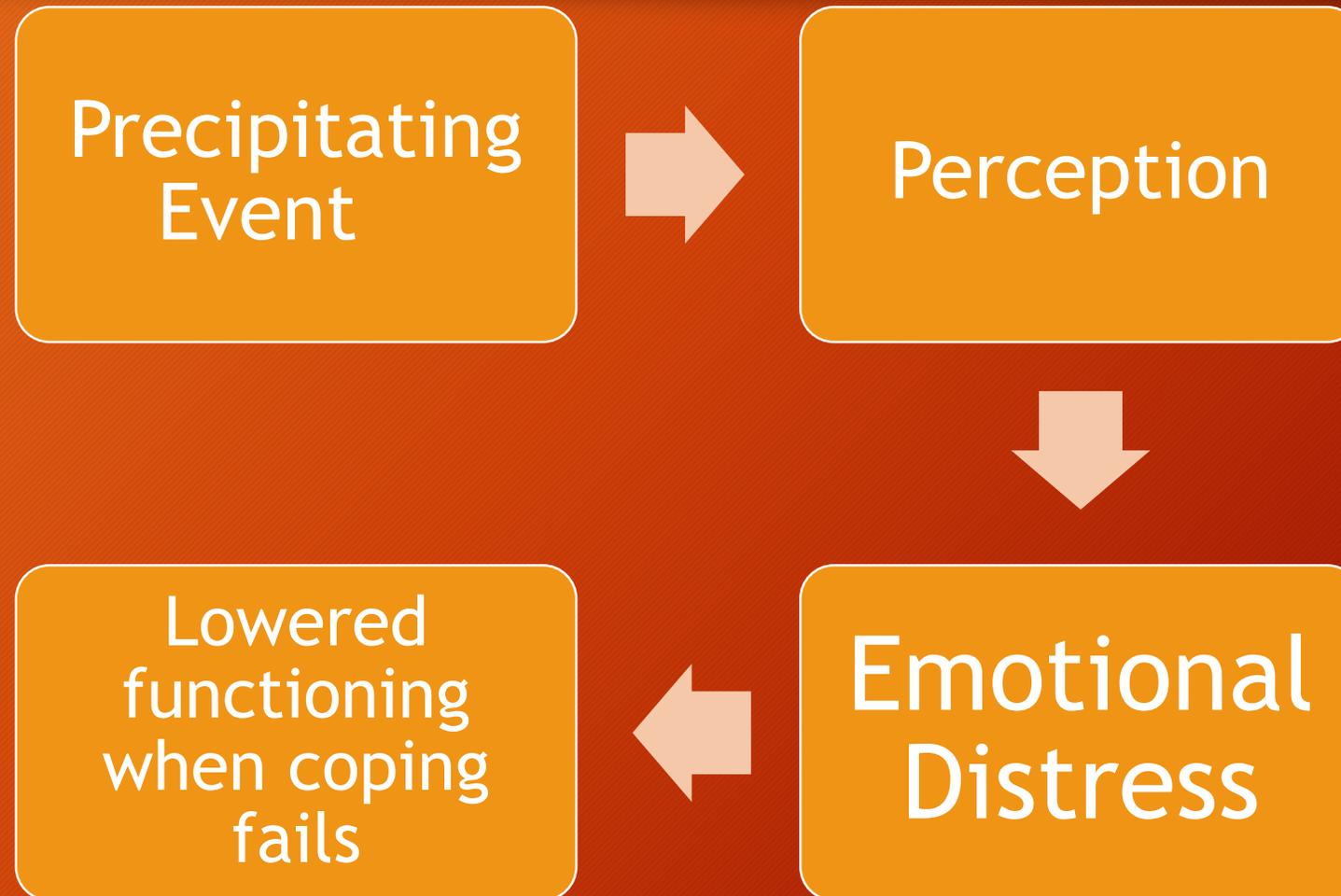


Gerald Caplan (“The Father of Modern Crisis Intervention”):

“An obstacle that is, for a time, insurmountable by the use of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at a solution are made” (1961, cited in James & Gilliland, 2013, p. 18)

Crisis Formation: The Trilogy Definition (Kanel, 2012)

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 Presence of Danger & Opportunity

 Seeds of Growth and Change

 No Quick Fixes

 The Necessity of Choice

 Perception

 Complicated Symptomology

 Resiliency

Characteristics of a Crisis

III. Aggression Cycle & De-escalation Techniques

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Violence: Risk Factors

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- Identification of potentially violent patients can be difficult, but there are some common characteristics:
 - Male
 - History of violence
 - Drug or alcohol abuse
 - Psychosocial stressors
 - Poor social support
 - Housing instability
 - Employment instability
 - **But, ethnicity, age, marital status, and education do not reliably identify such behaviors overall**

Violence: Risk Factors

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- A known psychiatric illness is a risk factor for violent behavior:
 - Psychosis
 - Schizophrenia
 - Depression with psychotic features
 - Command hallucinations
 - Delusions involving violence
 - Personality disorders
 - Antisocial Personality Disorder
 - Borderline Personality Disorder
 - Even in the absences of these, be aware of a history of fire setting or cruelty to animals as a child (e.g., Conduct Disorder)

Violence: Risk Factors

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- A known psychiatric illness is a risk factor for violent behavior:
 - Cognitive disorders
 - Intellectual or Developmental Disability
 - Neurologic impairment
 - Traumatic Brain Injury
 - Autism Spectrum Disorder
 - Impulse control disorders
 - Substance Use Disorder
 - Drug intoxication/withdrawal syndromes
 - Mania

Aggression Cycle

Violence

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Escalation

De-
Escalation

Resting

Aggression Cycle: Escalation

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- This is the build-up phase to aggression; many people fail to recognize this until it is too late
- It is easier to intervene now than when the client is aggressive
- **Signs of escalation include:**
 - Provocative behavior; prolonged staring at providers
 - Angry demeanor
 - Loud, aggressive, rude, sarcastic or caustic speech
 - Tense posturing (e.g., gripping arm rails tightly, clenching fists)
 - Frequently changing body position/pacing
 - Aggressive acts (e.g., pounding walls, throwing objects, hitting oneself)

Escalation Interventions

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- Clients who are agitated but cooperative may be amenable to verbal de-escalation techniques
- Nearly all people who present with agitation or violent behavior deserve the chance to calm down in response to **verbal techniques**
- The staff should adopt an honest and straightforward manner
- Friendly gestures can be helpful:
 - Offer a soft chair or something to eat or drink (not a hot liquid, which may be used as a weapon) to establish trust
 - Many clients will decompress at this point, as offering food or drink appeals to their most basic human needs and builds trust

Escalation Interventions

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- A non-confrontational, but attentive and receptive manner without conveying weakness or vulnerability is optimal
- Some people become angry because they feel they are not being taken seriously or treated with respect and their anger abates when these concerns are addressed
- It is important to avoid approaching the person from behind or moving suddenly, and to stand at least one arm's length away
- In some cases, an agitated person may be aware of their impulse control problem and may welcome **limit-setting** by the staff (e.g., "I can help you with your problem, but I cannot allow you to continue threatening me or the ED staff")

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Escalation Interventions

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- Some common approaches to the combative person are counterproductive and can lead to escalation:
 - Arguing with, condescending to, or commanding the person to calm down can have disastrous consequences
 - Clients often interpret such approaches as a challenge to "prove themselves." A threat to call security personnel also invites aggression
- Other potential mistakes include criticizing or interrupting the client, responding defensively or taking the client's ire personally, and not clarifying what the client wants before responding

Aggression Cycle: Violence

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- Violence can occur in several ways: For our purposes here, we are referring to physical violence
- At this point, it is imperative that you get help and **GET AWAY!**
- The time for talk is over

Violence Interventions

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- If de-escalation techniques have failed and the client is threatening violence OR the individual has already engaged in violence, call the police
- Once the police arrive, they are in charge of the situation
- If the individual has been violent, and there is not a compelling mental health reason for their behaviors, consider pressing charges or taking legal action
- Clients who are violent due to a mental illness should be assessed at a local emergency department for hospitalization
- ***Please do not allow a client to be hospitalized to avoid jail when there is not a clinical reason for them to be hospitalized***

Aggression Cycle: De-Escalation

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- Once the client is no longer violent, they will enter a period of calming down
- It is possible for people to “flare” back into violence or aggression, and this may be fueled by guilt, self-loathing, or embarrassment from their aggressive actions or violence
- Many of the techniques used to diffuse and re-direct a person who is escalating can be utilized at this stage too
- **Some clinicians make the mistake of trying to process the client’s aggression when the client is not ready (or able) to do this**

Aggression Cycle: Resting

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- This is the phase when the person is least engaged in the aggression cycle
- It is important that the client be allowed to calm down and rest following a period of escalation and/or aggression
- For some clients, especially those who have experienced severe trauma, they may remain hypervigilant and “on edge” all or most of the time, thus they are never truly at the resting phase
- Some clients can “jump” from the resting phase to acts of violence with no warning

IV. Assessing Threats of Future Violence or Homicide

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Obligatory Safety Warning!!!!



Assessing Threats of Future Violence or Homicide

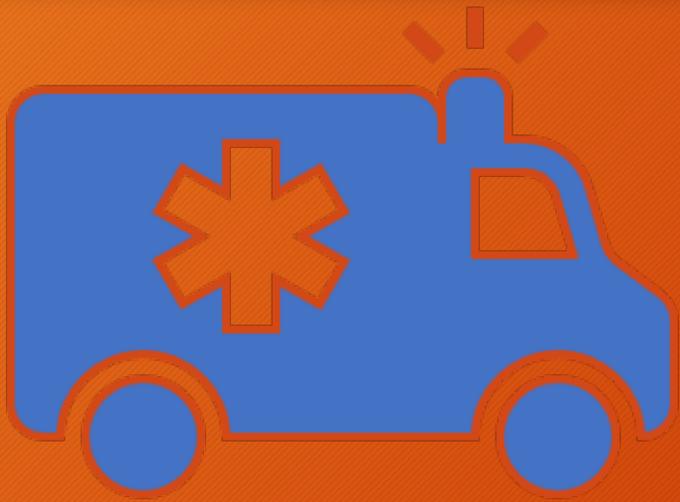
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- While we cannot completely predict if/when a client may become violent in the future, we always need to assess for possible future violence:
 - What is the person's **attitude** regarding future violence?
 - Does the person have the **capacity** to carry out any threat of violence?
 - What is the person's **history** of violence?
 - What are the person's **plans** for future violence?
 - Does **anyone else** know of this plan?

Duty to Protect

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- As noted in the 1976 California State Supreme Court ruling; *Tarasoff vs. Regents of the University of California*, mental health professionals have a duty to protect individuals who have been specifically threatened with death or bodily harm by their clients
 - If the patient makes a threat of violence or homicidal ideation toward a specific individual, then the clinician is required to make every reasonable effort to contact the threatened individual and warn them of the client's threat. I also contact the police
 - Care must be taken to divulge the minimal amount of information necessary to the threatened person, to protect the rights of the client. No diagnostic, medical, substance abuse, or any other patient information, other than the name of the individual who made the threat, should be divulged to the intended victim and law enforcement
 - The counselor should then document this contact in the client's medical record



V. SUD: Areas of Concern for Tele-Behavioral Health

Substance Intoxication & Withdrawal Syndromes

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- While substance dependence/addiction is a chronic condition, **substance intoxication syndromes** and **substance withdrawal syndromes** have their own symptom sets and sometimes require immediate attention
- Some forms of intoxication require immediate medical treatment
- Likewise, some forms of substance withdrawal require immediate and ongoing medical attention to prevent further illness or death

Depressant Intoxication Symptoms

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ALCOHOL

- Lowered inhibitions
- Mild euphoria
- Depression, sedation and relaxation
- Memory loss
- Drowsiness, sleep induction
- Reduced coordination and speech
- Decreased respiration

BENZODIAZEPINES

- Lowered inhibitions
- Mild euphoria
- Used to treat anxiety disorders
- Depression, sedation and relaxation
- Memory loss
- Drowsiness, sleep induction
- Reduced coordination and speech
- Also used to help detoxify people from alcohol and to control seizures

Alcohol/Depressant Withdrawal Symptoms

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- Nausea/vomiting
- Cravings
- Malaise & weakness
- Tachycardia
- Delirium, including hallucinations
- Anxiety rebound and agitation
- Sweating
- Irritability
- Orthostatic Hypotension
- Tremors
- Insomnia
- Seizures possible
- Depersonalization
- High fever
- Depression

Alcohol Withdrawal Course

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- Begins within 4 - 24 hours after the last drink
- In mild forms of withdrawal, the symptoms resolve after 48 hours
- Most clients with severe AUD require medically-supervised detoxification
- Tremulousness is the earliest symptom and many people with AUD know that this indicates a need to drink again to avoid more pronounced symptoms
 - This appears within hours after drinking stops and peaks in 1 - 2 days but can persist for weeks
 - In more severe forms, visual hallucinations can occur within 24 hours of cessation—to the patient these are real

Alcohol Withdrawal Course

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- Between 6 - 48 hours after stopping ETOH use, 3 - 4% of untreated patients will have a seizure
- 30 - 40% of patients who have a seizure will progress into Delirium-Tremens if they are left untreated
- Delirium-Tremens are fatal in up to 25% of people who are not treated
- D-Ts can precede or follow a seizure
- Repeated withdrawal episodes seem to “kindle” more serious withdrawal episodes

Opiate Abuse

Physical signs someone you know is abusing opiates.

Nodding

This is when a person temporarily falls asleep at an unusual time like during a conversation or while standing.

Constricted Pupils

Heroin or other opiates will cause the user to have constricted pupils which will appear as pinpoints or a small dot.

Covering their Arms

A person may wear long sleeve shirts, and keep their arms covered, even if it is hot outside.

Needle Marks

Also known as track marks, if someone is shooting the drugs, they may have needle marks on the arms, behind their knees, or ankles

Bad coordination

If someone is high on opiates, their balance may be off, and they might stumble and trip while walking.

Scratching

Another clue is that someone on opiates will usually itch and scratch frequently.

Are you concerned someone you love has an opiate addiction? Visit newroadstreatment.com and see what you can do to help.



- Sedation
- Nausea
- Constipation
- Pinpoint Pupils
- Slowed Breathing
- Coma & Death

Opioid Withdrawal Symptoms

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- Cravings
- Irritability, depression, anxiety
- Nausea, vomiting, stomach cramps, diarrhea
- Muscle (and possibly bone) aches and pains
- Lacrimation, Rhinorrhea, Piloerection
- Hot and cold flashes; uncontrolled sweating
- Yawning
- Anorexia
- Insomnia
- Fever
- Dilated pupils

Opioid Withdrawal Course

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- Symptoms appear within 6 - 8 hours of last dose
- Medically-supervised detoxification (inpatient) is usually not necessary
- Symptoms peak on the 2nd or 3rd day
- Symptoms usually disappear within 7 - 10 days
- Duration is much longer with Methadone (about twice as long as heroin takes)
 - Methadone withdrawal can last at least three weeks after the last use if the patient was using a large amount of Methadone
- **Post-acute withdrawal symptoms continue for many months afterward**

References

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References

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