TEAM®
TECHNIQUES FOR EFFECTIVE AGGRESSION MANAGEMENT

A WHITE PAPER

AGGRESSION MANAGEMENT: VERBAL DE-ESCALATION STRATEGIES FOR PEOPLE UNDER THE INFLUENCE OF STIMULANTS AND HALLUCINOGENS

By Jeff Puttkammer, M.Ed. and Keri Fitzpatrick, M.S.

FORWARD

This paper is part of a series of papers presented by HSS Inc. and the TEAM® (Techniques for Effective Aggression Management) educational program. These resources are designed to provide analysis and to share research, guidelines, tips and techniques for action in the fields of education and training. Our goal is to provide credible sources of information that provide evidence-based solutions to best provide individuals and organizations with the tools and resources they need to effectively manage aggression in the healthcare setting.

We are committed to developing and delivering the highest quality educational programs and materials for healthcare professionals. Violence in healthcare continues to increase at an alarming rate – a noticeable 37% spike in the past three years alone! Effective de-escalation skills are as much an 'art' as 'science' when it comes to managing someone who is under the influence of stimulants or hallucinogens. This paper was created as a resource for those who are on the frontlines of healthcare in this growing challenge.

The TEAM® (Techniques for Effective Aggression Management) and ED-Safe™ programs are healthcare-specific violence intervention trainings that take a proactive, multi-tiered approach in managing the environment as well as de-escalating the aggressive and violent individual. Both of these proven programs are designed to help create a culture of safety through prevention and mitigation strategies for all sizes and all trauma levels of healthcare organizations.

TEAM®
HSS TECHNIQUES FOR EFFECTIVE AGGRESSION MANAGEMENT

Visit our website at www.hss-us.com for additional information

ISBN-

RECOGNITION OF THE ISSUE

The increasing need for verbal de-escalation skills has long since been recognized across many healthcare and allied human services fields as a training gap. A brief conversation with any medical staff, security officer, nurse educator, provider of patient care, or a review of almost any local news source will attest to the prevalence of substance-fueled violence and problematic behavior by persons who enter healthcare facilities.

Persons under the influence of stimulants present different communication challenges than those using hallucinogens. This credible resource will provide guidance on identifying the presenting behavior with associated de-escalation strategies, a brief "analysis" of what type of drug the individual may be using, and some tips and techniques which can be used in helping a person regain control of their own behavior.

THE CHALLENGE

Workplace safety is a growing concern for healthcare providers as workplace violence continues to escalate. The emotional state of a person under the influence of a substance is an additive factor to an already tense or fear-inducing setting for that person. Expectations of access to a professional healthcare providercan then exceed realistic response capacity which may, in turn, trigger loss of behavioral control resulting in an incident where de-escalation is necessary. Understanding the dynamics between the person's state of mind, substance abuse, and potential for violence is the key to successful de-escalation.

UNDERSTANDING THE WEAVE BETWEEN THE PERSON'S STATE OF MIND, SUBSTANCE USE, AND POTENTIAL FOR ACTING OUT OR VIOLENCE IS THE KEY TO SUCCESSFUL DE-ESCALATION.

To illuminate the differences between those under the influence of stimulants and those who have used hallucinogens, consider the agenda the person may have; in other words what it is that they want. Someone using stimulants may be trying to acquire a feeling of hyperproductivity - of driving faster and more intense results than they would without the drug. This misleading perception that anything not on their agenda is a barrier someone else has purposely put in their way can also lead to paranoia that someone is trying to prevent them from their goal, or is watching them and "messing" with them. At this point, what they wantis to continue what they were doing before they came to the facility for treatment. An injury, an appointment, or a directive by a care provider could potentially lead to agitation.. Anger and rage can be common in such a situation, the trigger may be something as routine as being asked to fill out a form. Signs of unreasonable

SIGNS OF UNREASONABLE AGITATION ARE EARLY INDICATORS THAT SOMEONE MAY BE UNDER THE INFLUENCE.

agitation are early indicators that someone may be under the influence. Other signs are fast, pressured speech, restless movement, tense body positioning, and fidgeting to the point of encroaching on other people's sense of space and safety.

A person under the influence of stimulants typically wants to have his/her needs met as s/he perceives them and in the manner they determine best fits them. Therefore, a staff member may be doing everything right, but the person may still find fault due to their own substanceaffected perception. In general, people want to either gain something (attention to an issue, a tangible item, etc.) or avoid losing something (losing drugs, being slowed down on their task, being confronted, etc.).

Now to contrast the stimulant user to an individual under the influence of a hallucinogen and you will see a difference in information processing speed, and likely comprehension. Generally speaking, someone using a hallucinogen will not come to a facility unless there is an emergency or they are having a "bad trip" and are frightened. Conversation may seem heady with someone using hallucinogens as they may feel they are extraordinarily aware of their own thoughts and possibly those of other people. They may describe seeing words, language, or music. Colorful hallucinations are common and seem to engage with the person. People have reportedly experienced hallucinations as part of their environment and a union within them. Someone hallucinating will be difficult to redirect and to gain clear information from as they are often not directly seeking help and have come to the attention of medical staff due to an injury, self-harm, suicidal behavior or aimless wandering. Safety of the person will be the primary objective for the caregiver, but if the person is able to communicate, they typically will want to finish their trip as well. The agenda, then, for someone using hallucinogens is to have the thoughts and feelings they had

THE DIFFERENCES BETWEEN THOSE UNDER THE INFLUENCE OF STIMULANTS AND HALLUCINOGENS

CONSIDER THEIR AGENDA- WHAT DO THEY WANT AND WHY?

STIMULANTS

- May self-admit for treatment in order to meet their need(s)
- Trying to continue the feeling of excitement or 'the high'
- Wants to have their needs meet as they perceive them
- They are attempting to gain something or avoid losing something
- The provider may be seen as necessary, but an obstacle if unable to fulfill their needs

HALLUCINOGENS

- Typically does not self-admit for treatment. Usually arrive at facility due to crisis or emergency due to a 'bad trip'
- Hallucinations may 'colorful'. May describe seeing words, language or music
- Person may be difficult to communicate with and difficult to re-direct
- Their 'agenda' may be to finish their trip

hoped for by using the drug by being in a particular environment to enhance the feeling—concerts and religious rituals are most common. Bad trips create nightmare sensations, and in that case, creating a safe environment is key.

STIMULANTS

The limbic reward system within the brain is the area affected by stimulant and depressant drug use. STIMULANTS such as "bath salts," cocaine, and methamphetamine affect the arousal mechanism as well as the feelings of pleasure triggered by the release of dopamine - the primary neurotransmitter involved in feelings of well-being, satisfaction, and euphoria. Dopamine production and release cycles are interrupted when a person uses drugs that trigger the release, thus tricking the brain into both over-releasing and diminishing the new production of the neurotransmitter. When the brain is flooded with dopamine, feelings of euphoria, perceptions of profound thought, and extreme confidence with less concern for risk are common. Hallucinations or delusions may be present, but are not as frequently reported. On the low-end of the release cycle, they may feel nervous, irritable, aggressive, and possibly paranoid. Interestingly, then, the presenting behavior can be confounding to a professional because both sides of the pleasure/agitation cycle can be exhibited in one person depending on how much of the substance was used and the time that has lapsed between use and contact at the facility.

HALLUCINOGENS

HALLUCINOGENS such as LSD and Psilocybin mushrooms produce a cognitive effect that is often called mind-expanding, rather than a general sense of well-being or euphoria. The neurotransmitter serotonin is primarily affected. Users typically have visual and other sensory hallucinations, often producing what seems to be at the time, very profound thoughts. A difference between those under the influence and people who have hallucinations due to mental illness is that those using drugs know the hallucinations are not real. This knowledge provides an opening for de-escalation that may not be present for persons who cannot distinguish reality from delusions and/or hallucinations.

Risk perception is reduced when someone uses hallucinogens and physical safety is a real concern as people may seek to deepen their experience by acting on impulses that put them directly in harm's way. Raves, concerts and other events are common settings for the use of hallucinogens and "bad trips" can be made worse by over stimulation. Research shows that higher cognitive functioning is impaired by the use of hallucinogens, thus, linear and rational thought tends to be difficult for someone who is high. Verbal de-escalation approaches need to be tailored to the person's ability to function – safety and reduced external stimulation will be key elements.

A DIFFERENCE BETWEEN THOSE UNDER THE INFLUENCE AND PEOPLE WHO HAVE HALLUCINATIONS DUE TO MENTAL ILLNESS IS THAT THOSE USING DRUGS KNOW THE HALLUCINATIONS ARE NOT REAL. THIS KNOWLEDGE PROVIDES AN OPENING FOR DE-ESCALATION THAT MAY NOT BE PRESENT FOR PERSONS WHO CANNOT DISTINGUISH REALITY FROM DELUSIONS AND/OR HALLUCINATIONS.

RESPONSE SKILLS

Verbal de-escalation will be most effective if the caregiver knows what substance is "on-board" and can respond to the person's level of excitability with calm, clear direction. Note the term respond has been purposely used here rather than react. For de-escalation to be initiated and successful, the caregiver will be thoughtful in their approach and employ a strategy to manage the situation including directing the person toward self-control.

Active Listening Skills (ALS) are very useful in de-escalation. While there are several ALS, four that are particularly useful are: 1) open ended questions; 2) affirmations; 3) reflections; and 4) summaries. In the scenario below several opportunities are provided for the use of ALS.

SCENARIO 1: *A male walks into a waiting room in a small clinic and demands to be seen immediately. He willingly gives his name and fills out the necessary intake paperwork. He is becoming increasingly agitated in his seat, looking around and down the hallway toward the examination rooms. He moves from tapping his toes loudly on the floor to stomping his feet which clearly disrupts others in the waiting room.*

When approached by a staff member he states that he arrived on time, he wishes to be seen on time and that he is in a hurry today. He doesn't want to be kept waiting and his time is just as important as the medical staff's time. He adds that doctors and other people think their time is more important than his and he is tired of being treated that way.

While the example above may seem simplistic, the approach works well particularly if initiated before the person is pacing the room and further escalating. The physical presence and approach by the staff member is also a key element. Non-verbal communication conveys the intent of the staff member and may be seen as threatening by the person. Being aware of the potential to escalate rather than de-escalate is a foundational element in this skill set.

FOUR DE-ESCALATION ACTIVE LISTENING SKILLS

- Open-ended questions
- Reflections
- Affirmations
- Summaries

The core de-escalation skills taught in TEAM® for first responders start with verbal and non-verbal behavior on the part of the caregiver. Other models, such as Mental Health First Aid also use a similar outline. Below is a list of the core de-escalation skills compiled from various sources (further reading is recommended for a comprehensive listing that delves into secondary techniques):

- Voice Tone and Modulation
- Non-verbal Approach and Presence
- Speech and ALS
- Time and Rapport Building
- Problem Solving
- Medical Information Gathering (includes gaining information re: current substance use, prescription use, medical or mental status)

WHAT WORKS? The combination of ALS and the list above have proven to work in a myriad of settings and situations. While patterns of human behavior are well known, predictability is affected by substance use. De-escalation skills follow a low-to-high need continuum similar to any other type of threat assessment. The following graph provides verbal alternatives and accompanying non-verbal approaches when contacting people who are likely using or have been using stimulants. Hallucinogens may cause similar concerns to stimulants within each communication area, however, there are differences which have been noted in the far right column.

The skills are aggregated, that is, each builds on the one before.

OPEN ENDED QUESTION: What's is happening that seems to be upsetting you?
AFFIRMATION: You've arrived on time for your appointment and you've done all you can do to make the appointment happen from your end.
REFLECTION: You're in a hurry today, waiting for your appointment is making you feel upset.
SUMMARY: You've done all you can do to get to your appointment, it seems to be taking a longer to meet with the doctor than anticipated, and your time is important, too.

SUSPECTED RECENT OR CURRENT STIMULANT OR HALLUCINOGEN USE

LOW AGITATION WITH IMPATIENCE, FIDGETING	MODERATE AGITATION, DEMANDING STATEMENTS, PHYSICAL MOVEMENT THAT IS STILL CONTAINED	ESCALATING VERBALIZATIONS, PHYSICAL MOVEMENT AROUND A ROOM OR AREA, CONTACTING OTHERS IN AREA TO "INCITE" THEM	MANIC, SEEMINGLY OUT-OF-CONTROL VERBALIZATIONS AND INABILITY TO SIT DOWN OR MOVE AWAY FROM THOSE S/HE IS CONTACTING	HALLUCINATING AND/OR ERRATIC AND POTENTIALLY HARMFUL BEHAVIOR DUE TO INABILITY TO FOLLOW DIRECTIONS FOR ANY LENGTH OF TIME OR TO SUSTAIN SELF-CONTROL
VOICE TONE AND MODULATION				
Using the person's name, begin the contact with a calm voice with even tone, ask questions for information gathering, model calm presence.	Add "energy" to voice with volume while maintaining a calm tone	Add clear directives while using calm tone, modulation shifts from conversational to directive, e.g. "Mr. Brown, please sit back down so that we can continue to talk about what is bothering you."	Using directives in clear, short sentences, one directive at a time followed by a request to comply and reinforcement of compliance on the part of the person. Maintain calm presence.	In a calm, yet firm tone, use the person's name to check for orientation to reality and ability to respond to direction. Give short directives, conversation will not be useful at this juncture. Positively reinforce compliance with same calm, engaged tone.
SPEECH AND STATEMENTS				
Clear, concise, ask questions, reflect emotion statements, ask what they have done/can do to resolve immediate situation, what resources can they access? Offer assistance within your resources on-scene. Expect normal ability for discussion infused with intense emotion.	Clear, concise, listen for emotion statements and reflect those back for clarity and rapport	Clear, concise re: FACTS you can observe and ascertain from person. Avoid getting into content: blaming, awfulizing. They may present an unsolvable problem, ask about resources and what they've done in the past to resolve problems.	Maintain focus on facts and what can be done at this point in the here and now.	Speak slowly, ask one question at a time and allow ample time for response. Ask the same question in a different way if not getting through. Do not use leading questions. Ask the person to repeat what was said or agreed to (to be certain of clarity). Draw a verbal picture of what you want them to do. Keep questions separate from general conversation. Explain action plan in simple terms.
PROBLEM SOLVING				
Ask what they want to have happen, reflect their emotions, consider with them realistic options within the setting.	Ask what they want to do to help them feel as though the situation is improving. Use any of their strengths (and assess their ability to access own strengths) to problem-solve: "Mr. Brown, I can see that you are doing what you need to do to make this appointment happen on time. You feel upset about the wait, what would help you feel calmer as you wait?" What resources are available? Maintain here and now, as well as realistic options.	Be directive in plan and taking immediate action. Ask for their ideas to solve the problem, build off of realistic options (empower them). They may feel overwhelmed at being asked to solve the problem, offer ideas in a simple and clear manner with the plan a step at a time. State behavioral expectations of the client in each step. Note: each step or change could re-escalate the person, be ready to start over.	Be directive as you will be the one offering options. Give simple choices. Be clear and concise with what will happen, explain in simple terms what will happen next and your expectations of the person. Tell them who will be entering the scene and what you will do to maintain safety for both of you.	Assess "where they are at" in terms of ability to understand their problem. Cognitive functioning is likely to be impaired due to hallucinogens. You will likely be making the plan and providing simple directives while getting medical attention lined up that includes addressing the presenting problem as well as the issue of being under the influence.

SUSPECTED RECENT OR CURRENT STIMULANT OR HALLUCINOGEN USE				
LOW AGITATION WITH IMPATIENCE, FIDGETING	MODERATE AGITATION, DEMANDING STATE-MENTS, PHYSICAL MOVEMENT THAT IS STILL CONTAINED	ESCALATING VERBALIZATIONS, PHYSICAL MOVEMENT AROUND A ROOM OR AREA, CONTACTING OTHERS IN AREA TO "INCITE" THEM	MANIC, SEEMINGLY OUT-OF-CONTROL VERBALIZATIONS AND INABILITY TO SIT DOWN OR MOVE AWAY FROM THOSE S/HE IS CONTACTING	HALLUCINATING AND/OR ERRATIC AND POTENTIALLY HARMFUL BEHAVIOR DUE TO INABILITY TO FOLLOW DIRECTIONS FOR ANY LENGTH OF TIME OR TO SUSTAIN SELF-CONTROL
MEDICATION INFORMATION				
Ask if taking any medication? What they are for? Do they have them with them? Have they taken any today? When was the last time taken? Ask about the possibility of other non-prescribed medication or substances that may be causing some issues. Be direct, without accusing when asking about taking any street drugs.	Ask if taking any medication? What they are for? Do they have them with them? Have they taken any today? When was the last time taken? Ask about the possibility of other non-prescribed medication or substances that may be causing some issues. Be direct, without accusing when asking about taking any street drugs.	Ask if taking any medication? What they are for? Do they have them with them? Have they taken any today? When was the last time taken? Ask about the possibility of other non-prescribed medication or substances that may be causing some issues. Be direct, without accusing when asking about taking any street drugs.	Ask if taking any medication? What they are for? Do they have them with them? Have they taken any today? When was the last time taken? Ask about the possibility of other non-prescribed medication or substances that may be causing some issues. Be direct, without accusing when asking about taking any street drugs.	Ask if taking any medication? What they are for? Do they have them with them? Have they taken any today? When was the last time taken? Ask about the possibility of other non-prescribed medication or substances that may be causing some issues. Be direct, without accusing when asking about taking any street drugs.

SUMMARY

Verbal de-escalation skills are a common communication skill-set designed to manage a situation and help empower an individual to regain control of their situation, enabling them to see itas manageable and moving towards a solution. The individual needs to be confident that their needs will be met and that they are being heard. Cooperation is a key element, therefore, the caregiver employs a grouping of techniques to gain a cooperative agreement - sometimes stated as such, to bring the person and the situation back under control in order to move everyone's goals forward.

When a person enters an office or facility under the influence of either a stimulant or hallucinogen, their coping skills will be impacted by the substance. A caregiver who understands the effect of the substance on the brain, and thus the person's ability to think clearly, will have better success with the approaches outlined in the skills graph.

Caregivers who practice verbal de-escalation skills will create their own personal approach and gain not only comfort, but mastery of the skills with frequency of use.

ABOUT THE AUTHOR'S

JEFF PUTTKAMMER, M.ED.

Jeff is the Director of Learning and Development for HSS Inc., the nation's leading specialized services outsourcing firms, specializing in healthcare security solutions. With more than 18 years as security professional, Jeff previously served as the Director of security for a large Level 1 Trauma center in Denver, CO and spent more than 13 years as a commissioned law enforcement officer. He has worked closely with community leaders, private industry business partners, and with multiple municipal and federal government agencies, to include the Depart→ment of Defense, the Federal Bureau of Investigations, and the Departments of State, Justice, Energy, and Homeland Security on developing safety and security initiatives and he has lectured on crime prevention, workplace violence and drug diversion efforts to healthcare and protection professionals throughout the U.S. and across the globe. He has published several articles related to training and development, security concepts and emergency preparedness. He served as the past Treasurer for the Colorado chapter of the International Association for Healthcare Security and Safety (IAHSS).

Jeff earned his M.Ed. from Colorado State University and his B.S. from MSU of Denver.

Jeff also serves as the Administrator for the HSS suite of violence mitigation programs which are designed to help healthcare facilities prevent and mitigate violence and aggression. The TEAM® (Techniques for Effective Aggression Management Training Program) is a healthcare-specific workplace violence intervention training program and the ED-Safe™ program, which takes a proactive, multi-tiered approach in managing the physical space as well as managing the aggressive and violent person. Both of these proven programs are designed to help create a culture of safety through prevention and mitigation strategies for all sizes of healthcare organizations or trauma level.

KERI FITZPATRICK, M.S.

Keri currently serves as the Director of Training and Consultancy Services for NorthPointe, Inc. With more than 18+ years as professional mental health therapist, Keri has counseled clients with addiction and behavioral health issues in a variety of settings and is considered a certified expert witness in abuse cases.

Keri has served as a Crisis Intervention Manager, Probation Officer and Juvenile Standards Coordinator for the State of Colorado, Department of Public Safety and Division of Criminal Justice. Keri earned her B.A. degree from the University of Kansas in Psychology and her M.S. from the University of Nebraska, Omaha. Keri is one of the original founding Board members for Crisis Intervention Teams of Colorado and still serves as a Board member.

TEAM®
HSS TECHNIQUES FOR EFFECTIVE AGGRESSION MANAGEMENT