

# Crisis De-escalation Training in a Jail Setting

DSHS Office of Forensic Mental Health Services

# Training Overview

- The OFMHS provides training to jails regarding best-practices in managing people incarcerated with mental illness. This training focuses on best-practices for psychiatric de-escalation in jails.
- Jail staff need to know their role and responsibilities in crisis de-escalation, as well as have knowledge of initiating factors, effective use of verbal and non-verbal communication techniques, and know how to implement de-escalation strategies that are oriented toward recovery and resilience.

# Learning Objectives

1. Know the general concepts/definitions pertaining to aggression and why crisis de-escalation training is essential
2. Understand how trauma and emotional triggers are associated with aggression and escalation
3. Be able to apply the use of verbal and non-verbal communication strategies to interactions
4. Differentiate between escalating and de-escalating verbal exchanges
5. Be able to utilize levels of validation during difficult situations

This presentation focuses on the de-escalation requirements of CIT training and its content is considered Advanced CIT training within the State of WA and other regions within the Pacific Northwest

# Definitions & Essential Concepts

A **Psychiatric Crisis** is when a person has any or all of the following:

- *Thoughts/actions of self-directed violence (suicide) or physical harm to others*
- *Acute psychotic symptoms*
- *Deterioration in mental status*

Any or all of which result in the person's behaviors putting them at risk of harming themselves or others.

# Definitions & Essential Concepts

*Continued*

- **De-escalation** - Reduction of the intensity of a conflict or potentially violent situation.
- **Crisis Intervention** - An immediate and short-term psychological care aimed at assisting individuals in a crisis situation to restore self-control.

# System Responses

- Federal Agencies (OSHA, NIOSH) prioritizing Workplace Violence Prevention Plan Development and Implementation
- Growing trend in “De-escalation” trainings and expectations in nearly all human services organizations
- Media coverage uptrend in “Use-Of-Force” vs. De-Escalation events driving agency initiatives

# The Importance of Crisis De-escalation Training & Skills: Statistics

- Health care workers are 4 times more likely to be victims of workplace violence than those in non-healthcare fields
- Violence rates for psychiatric aides are 69 times higher than the national rate of violence in the workplace
- Violence rates for psychiatric technicians are 38 times higher than the national rate of violence in the workplace
- Police officers and sheriff's patrol officers experience 151.3 incidence rate per 10,000 full-time, equivalent workers, with Corrections Officers presented with an ever larger rate.



# Trauma & Suicide Risk: Statistics

*Suicide is particularly high among correctional officers and law enforcement...*

- Continued exposure to those directly experiencing or witnessing trauma and violence impacts suicidal ideation and risk
- More police die by suicide than in the line of duty. In 2017, there were an estimated 140 law enforcement deaths by suicide.
- 1 in 4 police officers has thoughts of suicide at some point in their life.
- Higher in working police officers vs. separated/retired officers.

# What is Trauma?

*The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism and disasters*

# The Importance of Crisis De-escalation Training & Skills: Trauma Exposure

- Direct Experience of violence and witnessing violence
- Injuries and witnessing injuries
- Vicarious trauma
- Post Traumatic Stress Disorder and Depression for both police and firefighters is approximately five-times higher than the civilian population

# Prevalence of Trauma within Mental Health Population

- 90% of public mental health clients have been exposed
- Most have multiple experiences of trauma
- 34-53% report childhood sexual or physical abuse
- 43-81% report some type of victimization

## Trauma Informed Care:

Mental Health Treatment that is directed by a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual.

***“Many providers may assume that abuse experiences are additional problems for the person, rather than the central problem...”***

# Managing Personal Reactions

Remember, how behavior and reaction can make all the difference in a crisis de-escalation scenario. You have the power to escalate or de-escalate a situation. Your behavior may even trigger a person's pre-existing traumas.

**DEMANDING STATEMENTS**

**POSTURES THAT IMPLY DOMINANCE OR PHYSICALITY**

**SARCASTIC OR DEMEANING ATTITUDES**

**INVADING PERSONAL SPACE AND TOUCH**

# Aggression

Aggressive behavior may occur when a person lacks the chance or the ability to express feelings and meet needs.

*In other words...*

When you are looking at a person who is upset, you are looking at a person with an unmet need, expressed through an aggression type

# Aggression Types

**Reactive or Impulsive** – anchored in abrupt emotional deviation...generally most common encountered by staff and easiest to de-escalate.

**Instrumental/Intentional** – pre-planned, learned over-time...less frequent overall, but more common in Criminal Justice System...harder to de-escalate.

**Psychotic** – biologically rooted...generally requires chemical intervention as part of the intervention modality.



## Environmental Factors

The environment in which the person is in can contribute to agitation and crisis.

- *The overall unit, or entry of new person(s) may agitate*
- *Lack of personal space or being in a crowded room*
- *A new incarcerated person or staff member that reminds person of traumatic experience*
- *Noise, such as a loud TV set, intercoms, or slamming doors*

# Interactions & Aggression

## Cause of Aggression

Feeling at the mercy of an uncaring system or staff member, such as aversive staff interactions.

## Preventing Aggression

- ✓ Increasing frequency therapeutic interactions
- ✓ Decreasing frequency non-therapeutic interactions

# Types of Interpersonal Interactions

*Overall interactions predict consumer outcomes but particular interactions can be therapeutic and non-therapeutic*

## Therapeutic:

Positive verbal and non-verbal communication in response to appropriate behavior; prompting to failure behavior; ignore/no response to bizarre behavior or repeated requests that cannot be met; setting boundaries, deflecting, and maintaining boundaries

## Non-Therapeutic:

Negative verbal communication; should statements; taking something away; reinforcing undesirable or dangerous behaviors

Positive Verbal and Non-Verbal  
communication to appropriate behavior  
*Therapeutic*

Positive appraisal of an appropriate behavior

*Verbal*

*Non-verbal*

# Understanding Crisis

## *Application:*

The techniques within this training are enacted within these sequenced Crisis Intervention Procedures, known as INSERT.

- **Identify Escalating Behavior**
- **Needs Assessment**
- **Safely Approach**
- **Engage the incarcerated person**
- **Reinforce incarcerated person self-management and self-control**
- **Teaching moment for patient, staff, and team**

# Prompting to Failure Behavior – Therapeutic

Explaining the consequences of behaviors:

*Negative Prompt describes undesired consequence(s)*

*Positive Prompt describes desired consequence(s)*

*Always follow negative prompt with positive prompt*

# No Response to Bizarre Behavior or Repeated Requests that Cannot be Met - Therapeutic

- Incarcerated person walks up to staff and says, “I have a microchip in my tooth” and then staff does not make eye contact and safely walks away.
- Staff informed the Incarcerated person that he does not have time to make phone calls. In response, staff break eye contact with the consumer and tends to another task. Once the Incarcerated person behaves appropriately, staff resumes eye contact and responds.
- When breaking eye contact, do not turn away or lose sight of the Incarcerated person peripherally, for safety.

# Negative Verbal Communication

## *Non-Therapeutic*

- Negative verbal to appropriate behavior
  - An incarcerated person is appropriately using a mop to clean their cell then staff says, “you're doing that wrong.”
- Negative verbal to a failure
  - An incarcerated person is struggling with writing a kite to medical and then staff says, “You really suck at writing.”
- Negative verbal to request
  - An incarcerated person hands staff an empty food tray and asks to return to his cell, and then staff says, “I don't want your frickin' empty tray and you're not going anywhere.”



# Dealing with Bizarre Behavior Non-Therapeutic

- Arguing with incarcerated person
- Challenging their delusions (unless done with an established therapy protocol)
- Reinforcing delusions
- Reinforcing bizarre behavior

# Reinforcing Undesirable Behavior

## Non-Therapeutic

- Incarcerated person calls his cell-mate a “stupid idiot” and staff nods and laughs at the statement.
- Incarcerated person is in restraints and then staff says, “I’m so sorry you were placed in restraints. Let me see if I can get you that snack you were asking for.”
- Incarcerated person deliberately ignores facility instructions to clean off dayroom table and cell-in within 5 minutes, and staff does nothing.
- Incarcerated person is talking to unseen others and then a staff member says, “I like how you do that crazy stuff.”

# Levels of Validation

*Validation* is the recognition and acceptance of another person's thoughts, feelings, sensations, and behaviors as understandable, while still maintaining a different opinion to the person's belief or behavior.

# Levels of Validation

Continued

## **Level One Validation – Listening & Observing:**

This level of validation allows the staff to understand where the incarcerated person is in the moment through listening to and observing the person's words, feelings, and actions. The staff is interested in the person and actively attending to the person's verbal and non-verbal output.

## **Level Two Validation – Accurate reflection of what is stated:**

This level of validation is accurate reflection using a nonjudgmental stance. This allows the incarcerated person to know that he or she has been understood in a meaningful way.

# Levels of Validation

Continued

## **Level Three Validation – Articulating the un-verbalized**

At this level of validation, the staff “reads” the incarcerated person’s behavior and articulates emotions and meanings that the person has not expressed. This does not mean that the staff uses consequences of behavior as proof of intent. This allows the person to know that his or her responses to events are justifiable and for the person to know him- or herself better than before.

# Levels of Validation

Continued

## **Level Four Validation – Validating in Terms of Sufficient (but Not Necessarily Valid) Causes**

This level of validation is viewing the incarcerated person's feelings, thoughts, and actions as justified and understandable in light of the following:

- 1) historical antecedents,
- 2) invalid current antecedents, and
- 3) disordered antecedents due to biological factors. Validating means highlighting and reinforcing the adaptive aspects of the person's behavior, without emphasizing the inherent dysfunction of the behavior. This allows the person to make sense of his or her behavior.

# Levels of Validation

Continued

## **Level Five Validation – Validating as Reasonable in the Moment**

At this level of validation, the staff communicates that behavior is justifiable, reasonable, well-grounded, meaningful, or efficacious in terms of current events, normative biological functioning, and the incarcerated person's ultimate life goals.

## **Level Six Validation – Radical Genuineness**

At this level of validation, the incarcerated persons is responded to as a person of equal status, due equal respect. This requires the staff to be genuine, and to respond spontaneously and completely in the moment. At this level, the staff communicates that the person is valid.

# Frequent Situations

- Limit-Setting
  - Getting someone to stop doing something they want to keep doing
- Activity Demand
  - Getting someone to do something they don't want to do
- Denial of Request
  - Situations goods or privileges cannot or should not be approved



# V.D.S.P.

## Validate:

I see you, I hear you, I want to understand you

## Defer:

Defer to a procedure, policy or expectation. “Shared value system.”

## Suggest Alternative:

Provide an alternate way and/or setting to go address the issue

## Positive Prompt:

Describe a desirable outcome

# Effective Limit Setting

Strategies:

Validate, Defer, Suggest Alternative, Positive Prompt

# Effective Activity Demand

## Strategies

Validate, Defer, Suggest Alternative, Positive Prompt

# Effective Denial of Request

## Strategies

Validate, Defer, Suggest Alternative, Positive Prompt

## What to include in Policy

- All jails, regardless of their size and location, should have written policy and defined procedures for initial and ongoing training for staff on the use of de-escalation strategies.
- Jails should consider developing these policies and defined procedures using evidence-based models to ensure all jail staff are prepared to effectively identify and manage escalating behavior.

# Resources

- [Washington State legal System Guide to Forensic Mental Health Services](#)
- [Jail Technical Assistance Program](#)
- Jail Technical Assistance Guidebook
- SAMHSA's article "Practice Guidelines: Core Elements In Responding To Mental Health Crises"  
<https://store.samhsa.gov/system/files/sma09-4427.pdf>

# References

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# Thank you!

Please don't forget to complete our training evaluation survey at <https://www.research.net/r/KRD8QY8>

A downloadable PDF version of this training and video is available at our website:

<https://www.dshs.wa.gov/bha/office-forensic-mental-health-services/jail-technical-assistance-program>