Outreach and Personal Safety

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand outreach principles and best practices for working with clients
- Protect personal safety when doing field work and working at the agency

INSTRUCTIONS

1. Prior to the session, review the PowerPoint slides and notes. Using the construction paper, cut out two shapes, such as a circle and star. One shape is for things participants should do to protect their safety and the other is for things participants should not do. Post two flip chart sheets with the words "Do" and "Don't."
2. Welcome participants and review the objectives for the session.
3. Review slides about safety and outreach (slides 1–10).
4. Think, pair, share activity (slide 11)
   - Tell participants, "We are going to use the think, pair, and share technique to increase our awareness about safety tactics."
   - Pair off participants and hand out shapes, markers, and tape. Each pair will receive two shapes. Ask the participants to write on their shapes some things CHWs should do and not do to protect their safety when doing fieldwork depending on their community/culture.
   - Ask participants to tape their shapes on the corresponding flip chart sheets (Do/Don't)
   - Read the responses aloud.
   - Ask, "Should any of the shapes be moved to the other side? Why? Any additional questions or comments?"
5. Wrap up. Share the handouts Outreach Tips and Personal Safety, Safety in the Outreach Setting, and Steps to Develop an Outreach Plan. These are resources to share with your agency especially if the agency is developing a policy on outreach. Whether you are providing services within the agency or in the field, safety should always be considered first. Have a safety plan for emergencies and dangerous situations. Let your supervisor know where you are at all times (location and time of appointment) and work with a partner at every opportunity.

Related C3 Roles

Conducting outreach

Related C3 Skills

Professional skills and conduct, outreach skills

Method(s) of Instruction

Think, pair, and share

Estimated time

30 minutes

Key Concepts

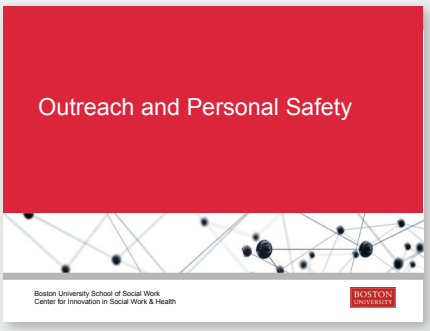
Personal safety, outreach, best practices

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart (divided into two halves)
- Markers
- Shapes made out of colored construction paper
- Tape to post shapes

Handouts

- Safety in the Outreach Setting: Community and Home Visit—Sample Work Policy
- Outreach Tips and Personal Safety
- Steps to Develop an Outreach Plan



SLIDE 1

Ensuring that you have a safe working environment regardless of the setting is paramount. Fieldwork is sometimes conducted in areas that can be unsafe; therefore we need ways to protect our personal safety when doing home visits or individual outreach in the community.

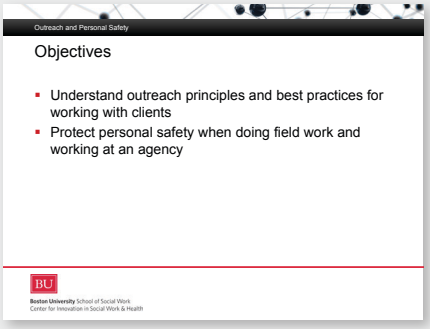
Make sure you have established your own personal boundaries before conducting outreach.

You may anticipate dangerous situations that may come up when doing fieldwork and ways to handle them in advance. In this session we will review some best practices for outreach and personal safety.

Before going on home visits or conducting field work-check in with your supervisor about any agency policy.

Ask, "How many know your agency's policy about conducting field work?"

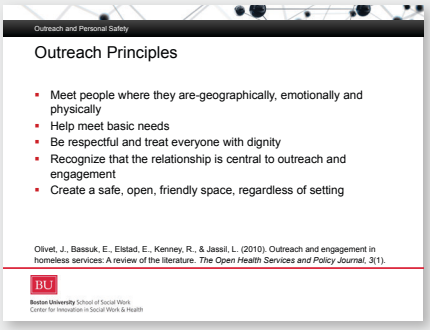
Acknowledge that that this session is designed to complement that policy and provide additional tips for being safe when conducting field work



SLIDE 2

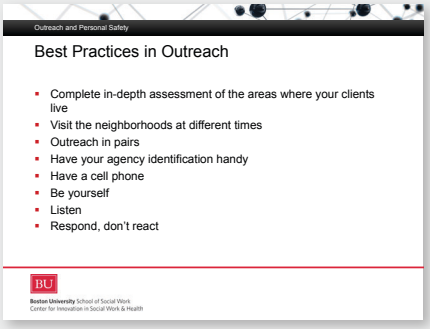
Review the objectives.

Acknowledge that that this session is designed to complement agency policies and provide additional tips for being safe when conducting field work



SLIDE 3

Review the slide.



SLIDE 4

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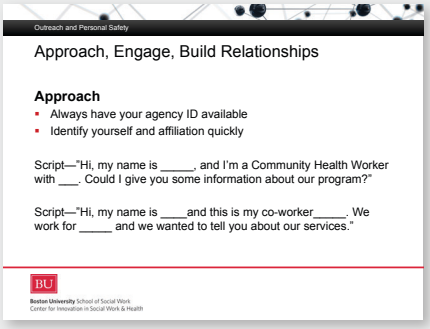
Ask, "How many know your agency's policy about conducting field work?"

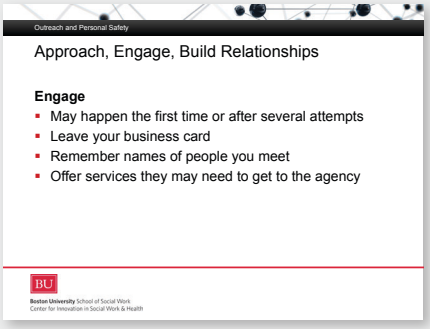
Review the points on the slide.



SLIDE 5

Review the slide.

Ask participants if they have any examples they would like to share on how they approach a client.

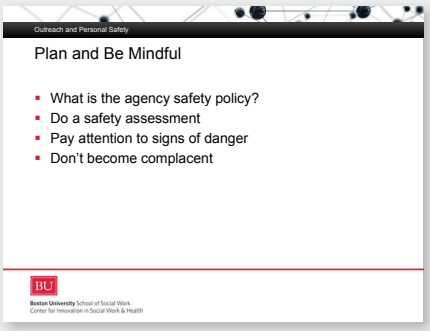


SLIDE 6

Ask a volunteer to read the slide.

SLIDE 7

Review the slide.



SLIDE 8

The first step in addressing personal safety is to plan and be mindful. Planning and being mindful is your best defense against workplace violence.

For example, the human service employees with the highest rates of work place victimization include those with very little experience and those with extensive experience. Newer employees may not have not gained the experience necessary to assess violence among clients and may be trying to remember all of the aspects of their job and its requirements, leading them to forget to pay attention to even the most obvious signs of client aggression. And when that aggression occurs, they have no idea how to respond.

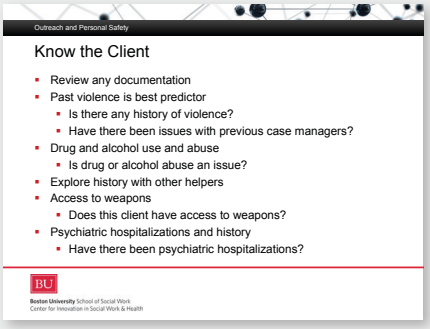
On the opposite end of the spectrum, longer-term employees may begin to feel complacent and ignore potential dangers around them. Many have never been the victim of work-related violence and therefore do not see it as a threat in the future.

Planning and being mindful are separate skills that work together to prepare you to stay safe in an event of violence. These skills should be applied to how you set up your office, completing a safety assessment, paying attention to signs of danger, and avoiding complacency. We will explore these areas as we move through this session.

SLIDE 9

There are three things which need to be managed before, during, and after an episode of aggression. First is your client, second is yourself, and third is your environment.

Each area may include not only the reason for client aggression, but also things which exacerbate violent behavior. Therefore, effectively managing these three areas will help to prevent and diffuse violence. We will be taking a closer look at just how to manage each of these areas in the following set of slides.



SLIDE 10

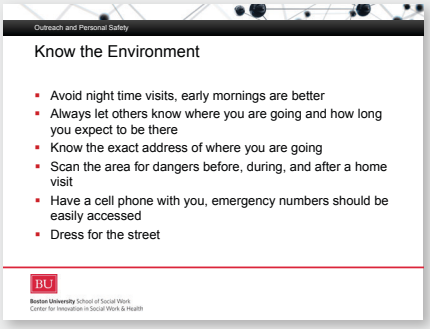
A thorough assessment of your client's potential for violent behavior begins with a review of any documentation available to you. Since the best predictor of future violent behavior is a history of past violent behavior, any available records should be reviewed for incidents of past violent behavior.

Since drugs and alcohol use can lead to erratic and sometimes violent behavior, it is important to review for a history of substance abuse. Even the most timid client can become threatening and violent while under the influence, so it is important not to assume that since a client's usual personality is timid and shy that he or she will always be so.

It's also a good idea to check with other colleagues about the client's history and reputation. Asking colleagues about their experiences with that client may produce much needed and valuable information on individual idiosyncrasies and behavior.

Since weapons are often used by clients during violent behavior and aggression, it is important to assess your client's access to them. Review their record for any information which indicates the client's past access to and use of weapons. It is important to remember that in violent episodes almost anything can be used as a weapon. A pen, for example, in the hands of a calm client may be a great for instrument for writing reports and signing forms, but in the hands of a violent client that same pen may become a weapon. So it is important not to exclude ordinary items in your assessment of weapon access and use.

Finally, it is important to review the record for a history of crises which precipitate any medical or psychiatric hospitalizations. Although a history of psychiatric hospitalization does not in and of itself indicate whether the client is likely to become violent in the future, the information on how the client responded to the crisis will provide powerful insight into how that client may attempt to cope with future crises. And if the client has a history of attempting to cope through violent behavior you will be more prepared in the future to address that behavior.



SLIDE 11

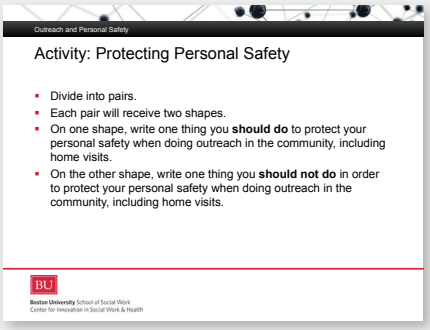
For most case managers, community and home visits are an essential part of the job. Sometimes this means going into a neighborhood that is unfamiliar or dangerous. Therefore, it is important that they pay close attention to and continually assess their surroundings.

Attending home visits early in the morning may increase safety since most crimes are committed in the evening. Criminals are less likely to be awake and "on the job" early in the morning than late at night.

Never leave the office without telling other staff where you are going. Informing others where you are going and the address will help to ensure that emergency services and/or other staff will be able to come to your aid.

Even if there appears to be no imminent aggressive behavior from your client, the environment is constantly changing. Dangers from other sources could appear at any time. Scanning the environment throughout the entire visit will help to ensure that if something changes for the worse you will be ready.

Lastly, carry a cell phone and use GPS. Some of us will remember the days of having to run to find a pay phone and some change to make an emergency call. Thankfully those days are over. Having a cell phone on you at all times will increase the response time of emergency services and will help keep open communication between you and your colleagues.



SLIDE 12

Review the slide.

Safety in the Outreach Setting: Community and Home Visits—Sample Work Policy

Purpose:
The need to promote worker safety in the outreach setting is clear. Safety guidelines are critical to the effective provision of services. To create a climate of safety, Boston Health Care for the Homeless Population (BHCHP) aims to assure that outreach workers are well informed about risks of danger and that they consistently exercise safe practices to minimize risks.

Reports of violence against social service employees during the past decade are notable.[1] An Act to Promote the Public Health through Workplace Safety for Social Workers, H3864, was signed into Massachusetts law in February 2013 in response to recommendations of the National Association of Social Workers Safety Task Force, which convened after the 2008 death of a social worker on a home visit.

Policy:
All workers who participate in outreach work, defined as home visits, street visits, or any encounter with a patient that occurs in a non-clinic setting, must consistently exercise safe practices by following the procedures listed below.

Procedure:

Training: All workers who participate in outreach work must complete a safety training determined by BHCHP at least every other year. This training will include personal safety techniques, de-escalation techniques, risk assessment, and non-violent crisis intervention.

Safety Planning and Visit Preparation

- **Track whereabouts**: Workers are required to report all planned patient encounters on their BHCHP Outlook calendar and to make their calendar accessible to the supervisor. Any deviation from the schedule while workers are out of the office must be reported to the supervisor immediately by the method determined by the supervisor (either via phone call, text, email, or a change in their Outlook calendar). Workers are expected to start and end the day in the office, with exceptions only as approved by the supervisor. If a worker doesn't check in when expected, the supervisor should contact the worker's emergency contact.
- **Risk assessment**: Note there is a procedure in place to communicate violent history to staff in the EMR when danger is known to exist (see policy called "Communication of Known Patient Safety Risks"). A risk assessment is ideally conducted in a clinic setting prior to initiating outreach or home visits. It must include consideration of both potential safety issues with the particular patient and safety issues ascribed to the particular setting in which the visit will take place. What is the potential for violence with this particular patient or this particular environment? The following categories assist in determining factors that may be associated with risk of violence:[2]

[1] Creating a Climate of Safety. National Association of Social Workers, Massachusetts Chapter, 2013. www.naswma.org
[2] Adapted conservatively from Family Continuity Safety Assessment Scale (Assessing Risk to Staff), 2009. http://www.naswma.org/displaycommon.cfm?an=1&subarticlenbr=51

- **Level I Risk Factors**
  - Family history of suicide or homicide
  - Past history of impulsivity or disinhibition
  - Past history of intimate partner violence
  - Past history of drug activity in the home or outreach setting
  - Past history of self-mutilation
- **Level II Risk Factors: Moderate Risk** (must trigger a safety plan review with supervisor and visitation only in teams of two, with exceptions only at the discretion of the supervisor)
  - Active drug/gang activity in the family or neighborhood
  - History of restraining orders in the distant past (either obtained by the patient or placed upon the patient)
  - Known person in the home with history of criminal violent offense, including sex offense
  - History of suicide attempt or violence directed against others in the distant past (>2 years ago) or history of suicidal or homicidal gestures
  - Unexpected or unreported strangers in the home
- **Level III Risk Factors: High Risk** (must trigger a safety plan review with supervisor, which could include decision to hold encounters at alternative setting, visitation in teams of two to include a clinician, or prohibition of home/outreach visits)
  - No cell phone reception at the place of the outreach/home visit
  - Past history of suicide attempt or current suicidal preoccupation with plan or intent but able to contract for safety (exception in the case of Behavioral Health clinicians, who are not required to review safety plan with supervisors)
  - History of violence directed against others or property within the past year or current homicidal preoccupation
  - Persistent self-destructive or aggressive behavior
  - Unable or unwilling to contract for safety
  - Hallucinations instructing harm to self or others
  - Active or recent intimate partner violence
  - Active or recent restraining orders (either obtained by the patient or placed upon the patient)
  - Active drug activity in the home
  - Patient is under the influence of drugs
  - Patient states worker is not welcome in the home

- **Level IV Risk Factors: Highest Risk** (absolutely no home visits should occur)
  - Unsecured weapons in the home or on the person
  - Past threats to a worker

- **Dress and valuables**: Consider avoiding items around the neck like scarves, jewelry, which can pose a choking risk; leave valuable bags and jewelry at home; leave vehicles locked at all times and keep valuables out of sight; use of headphones can diminish the ability to hear and may increase vulnerability; BHCHP IDs should be worn at all times (if a lanyard is used, it should be breakaway).
- **Teams of two**:[3] Outreach workers can ask for accompaniment for *any* outreach visit in which there is a safety concern and that request will be honored by their supervisor. For situations involving moderate or high-risk factors, upon review with supervisors, outreach visits will be made *only* in teams of two, with exceptions only at the discretion of the supervisor. Workers may consider meeting a patient in a public setting or in the office if they are unable to find a partner for a home visit.
  - Teamwork requires trust and cooperation. In teams of two, both staff members leave when the either staff person indicates the need to leave a potentially unsafe situation. No one stays behind. Because it may be difficult to leave a potentially dangerous situation without escalating tension, and because one staff person may perceive a threat that the other is entirely unaware of, it is important that both agree to leave at any sign the other is ready.
- **Safety equipment** will be provided to staff:
  - Breakaway ID lanyards
  - Personal safety alarms (for example, www.streetdefender.com/MC-231.htm)
- **Plan of action** should be developed prior to visit, to be initiated at the first signs of agitation. This includes consideration of how to immediately end a potentially dangerous situation and when to evacuate a facility.
- **General safety tips**:[4]
  - Use “universal precautions,” meaning that every person and every environment is considered potentially dangerous.
  - It is important during visits to be friendly and kind but to stay focused on the working relationship and help the patient reach their goals. Remember, this is a professional relationship, not a friendship.
  - Trust your instincts. Leave when you sense potential danger.

[3] Adapted from Pine Street Inn’s Low Threshold Housing Safety Policy from April 2013
[4] Adapted from Pine Street Inn’s Low Threshold Housing Safety Policy from April 2013

- Stay alert.
- Know what behaviors provoke you, and ways to respond to those behaviors without placing yourself in danger.
- Keep your hands free.
- Keep car keys in your pocket or hand.
- When indicated, consider developing a contract with patients to outline appropriate and inappropriate behaviors, establishing clear boundaries.
- It is important that patients either manage their own money or work with a formal payee service. Staff may not ever borrow, save, give, use, or exchange money or other valuables, including ATM or EB cards, with patients. This helps to avoid any possible misunderstandings about financial transactions.

- **Safety before the visit**
  - As stated above, a safety risk assessment is conducted in a clinic setting prior to initiating outreach or home visits.
  - Call ahead of arriving to a patient's home to remind them of the visit. It may be helpful to explain expectations to the patient, including that the visit won't be made in the presence of others who are unknown to the worker.
  - Schedule home visits early in the day when possible.
  - Scan the environment before getting out of the car/bus to be aware of any potentially dangerous activity. Do not talk on the phone, which is distracting, while walking.
  - Have an excuse to leave prepared in advance, just in case. For example, press the ringer of your cell phone and pretend to take the call and excuse yourself; excuse yourself to retrieve something out of your car.
- **Safety during the visit**
  - Remember you are a guest in the patient's home.
  - Never enter a home if there is yelling, screaming, or other noises coming from within.
  - Immediately leave the scene if there are weapons on site.
  - Be aware of exits in case of emergency and maintain clear access to an exit at all times.
  - If there are unexpected or unapproved visitors present when you arrive, assess the situation and consider rescheduling the appointment and leaving immediately.
  - If you perceive the presence of drugs or paraphernalia, leave immediately. Staff must never touch or discard any drugs or paraphernalia.
  - Be aware of personal space – keep at least an arm's length between you and the patient.
  - Avoid sitting on the patient's bed.

- **Safety after the visit**
    - Be aware of surroundings as you exit the home or outreach setting.
    - Do not make phone calls until you are out of view of the home.
    - Lock your car doors as soon as you get in.

Extreme Weather Conditions: Note that some weather conditions can affect the safety of an outreach environment. For example, when parking is limited in a neighborhood due to significant snowfall, this can result in parking further away from the site of a planned encounter. When weather emergencies affect workers' ability to reasonably park, this may result in increased potential for danger and workers should discuss the feasibility of the outreach visit with their supervisors in this situation.

Expectations of Supervisors

- Keep a list of emergency contacts for each worker who does outreach.
- Develop a safety plan with staff, especially for outreach visits involving moderate or high risk factors. This plan should be re-evaluated as factors change, according to the need for safety and staff should be supported in order to implement the safety plan.
- If a worker asks to be accompanied during an outreach or home visit due to safety concerns, every attempt should be made to honor this request. If it is not possible for a team of two to make the visit together, an alternative plan may include arranging for a clinic visit instead or postponing the visit until a team of two is available.
- Address the threat of violence or the aftermath of violence by attending to the needs of the worker, co-workers, and affected patients. Present an open environment for discussion.
    - Provide ample opportunity for debriefing with all involved and offer trauma counseling.
    - Provide option of escorts to cars, or other measures that might help a worker feel more secure.
- Document details of any incident in a written record kept by the supervisor.
- Immediately communicate with the Chief Operating Officer to report any serious incident and consider if, and when, legal action should be taken.
- Communicate to other staff instances of work-related violence or significant threats of violence, as per our protocol (see policy called "Communication of Known Patient Safety Risks").

Steps to Develop an Outreach Plan

Outreach Plans: Structure Outreach Activities
The process of developing an outreach plan involves setting goals, action steps, timelines, and evaluation measures; it helps structure outreach activities in a logical way and targets them to where they are most needed. The outreach plan creates a means to look at what has been done, celebrate accomplishments, assess miscalculations, and revise strategies as needed to make progress in the future. Such evaluation may be more difficult when outreach is conducted without an outreach plan.

1. **Identify and Prioritize Needs and Assess Resources Available**
   What do you need to do? To increase caseload? To increase your organization's referrals? To maintain a caseload? What are the particular underserved areas or unmet needs in your community (for example, pregnant teens, specific ethnic groups, geographical areas)? What staff and program resources do you have to implement outreach activities?

2. **Identify your Audience(s) – Community of Focus**
   Whom do you want to reach? Potentially eligible people? The general public? Specific cultural communities? Health or social service providers who refer community members?

3. **Define Goals and Objectives**
   What is it you would like your audience to do once they have heard your message? Who will do what, how, where, and by when?

4. **Identify Outreach Strategies**
   What outreach methods and tools will you use? Will outreach be one-time, short term, or ongoing or a combination? At a minimum, your outreach plan should include ongoing outreach activities.

5. **Implement Plan**
   Put your plan into action. Monitor to make sure that implementation is going as planned. Make adjustments as needed.

6. **Evaluate Plan**
   Before you implement your plan, identify how you will evaluate it. How will you know if your plan is working? What baseline information will you obtain before you implement the plan? What outcomes will you be measuring? What feedback will you gather from participants, potential participants, providers, etc.? What can you learn that may help you be more successful in the future?

Source: Adapted from Villie M. Appoo, MA, MSW. Outreach to Residents of Public Housing: A Resource Tool Kit for Health Centers. National Center for Health in Public Housing.

Outreach Tips and Personal Safety

- Do conduct a strengths and needs assessment and evaluate areas where your community of focus spends time
- Be flexible with scheduling
- Accommodate the community of focus
- Establish contacts with police precincts in all areas where you conduct outreach
- Carry identification at all times
- Let someone know where you are at all times
- Work with a partner and be aware of your surroundings
- Be aware of how you are feeling and how your partner is feeling
- Have a safety plan for emergencies and dangerous situations
- Find a hook or way to engage people in conversation on the streets
- Know when it is appropriate to engage with a client and when it's not appropriate
- Behave respectfully to all people (people who use drugs, dealers, pimps, sex workers, etc.) in order to win personal trust and confidence
- Have good listening skills; hear people out
- Be ready to direct community members to social, health, school, and justice system services
- Assure community members that you will maintain confidentiality
- Provide follow up and deliver on promises
- Tell community members when you will be back and how to reach you

Acknowlegements

This curricula draws from and is adapted from other training curricula for peer educators and community health workers, such as the Building Blocks to Peer Success (https://ciswh.org/resources/HIV-peer-training-toolkit) and the Community Capacitation Center, Multnomah County Health Department (https://multco.us/health/community-health/community-capacitation-center)

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