	Violence-Free Workplace		
Chapter:	Board Services and Program Administration	**Policy #**	2-12-12
Section:	Safety and Therapeutic Environment	**Revision #**	4

I. **PURPOSE**: WMCMH recognizes the need to provide for the safety and security of all staff members, independent contractors, vendors, customers, and visitors. Therefore, WMCMH will take steps to prevent and appropriately respond to threats, threatening behavior, or acts of violence by or against staff members, independent contractors, vendors, customers, and visitors on WMCMH property and service locations. This includes physical attacks, verbal or physical threats, destruction of property, intimidation, or abusive language.

II. **APPLICATION**: All staff members, independent contracted providers, vendors, customers, and visitors of WMCMH.

III. **REQUIRED BY**: Section 5(a), Federal Occupational Safety and Health Act of 1970 (OSHA) and accrediting bodies.

IV. **DEFINITIONS**:

Staff members – All employees, students, interns, and volunteers at WMCMH.

Independent Contractors – Those people hired to perform work at WMCMH facilities, but who are not considered employees of the Agency. Examples of independent contractors include but are not limited to a carpenter making repairs to the building or a mental health clinician hired under a time-limited grant to deliver specific skills or complete a specific project.

Contracted Provider – An employee of an agency or business who is under contract with WMCMH for the purpose of providing a consumer direct service. Examples of contracted providers would be a residential staff person or community living supports service provider.

Vendors – Those on the premises of WMCMH for the purpose of selling a product or service. Examples of vendors include but are not limited to the following: a prescription drug company representative or Federal Express delivery person.

Consumer – Those persons seeking the services of WMCMH.

Visitors – All other persons who come onto the premises of WMCMH for any other reason not related to employment, service, or product delivery, or to seek services.

WMCMH Property – This includes all WMCMH owned or leased buildings and properties, as well as motor vehicles.

Service locations – Any location where staff members are engaged in providing services to a consumer.

Threat – The expression of intent to cause physical or mental harm. An expression constitutes a threat without regard as to whether the party communicating the threat has the present ability to carry it out and without regard as to whether the expression

is contingent, conditional or future. Threats can be transmitted in written form, verbally, or electronically.

Workplace Violence – Any threat, physical attack or property damage that occurs on WMCMH property or service location.

Physical Attack – An unwanted or hostile physical contact such as hitting, fighting, pushing, shoving, biting, spitting, and throwing objects.

Emergency Physical Intervention – An approved MDHHS curriculum technique used by trained staff to restrict the movement of an individual by direct physical contact in spite of the individual's resistance in order to prevent the individual from physically harming himself, herself, or others. Physical interventions may only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. The term "physical intervention" does not include briefly holding an individual in order to comfort him or her or to demonstrate affection or holding his/her hand.

Property Damage – The intentional damage to property, which includes property owned or leased by WMCMH, its staff members, independent contractors, vendors, customers, or visitors.

CIR (Critical Incident Report) – A WMCMH critical incident report.

Debriefing – A debriefing with all involved staff is required after the use of an emergency physical intervention. The debriefing is documented in R3 routing notes and is routed to the appropriate Director after the debriefing meeting.

V. **POLICY**: WMCMH will take appropriate action, including legal action, to eliminate threats, threatening behavior, or acts of violence by or against staff members, independent contractors, vendors, consumers, and visitors on WMCMH property.

This policy shall not be construed to create any duty or obligation on the part of WMCMH to take any actions beyond those required of an employer by existing law.

VI. **PROCEDURES**:

A. Staff Member Education: During the orientation process with their supervisor, all new staff members are to read this policy and are provided with an explanation of its implementation procedures, such as how to report incidents of violence, what to do if the staff member is threatened and/or if an incident of violence takes place. In addition, all staff members are required to complete the WMCMH Intranet-based course entitled "Interacting with People" within thirty (30) days of their hire and every three years thereafter. The Facilities/Safety staff shall review the course on a scheduled basis to ensure that it meets the training requirements for staff. WMCMH offers Mandt training as the preferred method for non-physical and emergency physical intervention training. Mandt has three components: relational, conceptual and technical. WMCMH developed a matrix

that outlined which internal staff required the different components of Mandt training, depending on the job description and assigned work duties.

B. Staff Member Resources: WMCMH offers the services of an Employee Assistance Program (EAP) to all members of its staff. Any staff member who displays a tendency or propensity to engage in violent, abusive, or threatening behavior may be referred to the EAP by the employer for assessment, counseling, or other appropriate treatment. Any staff member that is referred to the EAP because he/she displays a tendency or propensity to engage in violent, abusive, or threatening behavior must comply with the referral as a condition of continued employment.

C. Staff Member Responsibilities:
   1. All WMCMH staff members must review and be familiar with the "Emergency Intervention for Consumer Disturbance / Disruptive Behavior" Plan for adults and children document (Appendix 2-12-12B and C).
   2. Any WMCMH staff member who becomes aware of an individual who poses a threat to himself, others, or WMCMH property shall report the matter based on the Reporting Incidents in section D below. Exception: This policy does not apply to the Pre-Admission Screening process for individuals requesting, or identified to need, inpatient psychiatric hospitalization unless they are making threats against a WMCMH staff or property.
   3. Any WMCMH staff member who has knowledge of workplace violence involving another staff member (as victim or perpetrator) must report the information based on the Reporting Incidents in section D below.
   4. Any WMCMH staff member who applies for or obtains a protective or restraining order that identifies WMCMH facilities as being protected areas, must provide this information to their supervisor; in turn, the supervisor will notify their Chief Officer, the Chief Executive Officer and Human Resources immediately. WMCMH understands the sensitivity and confidentiality of the information requested and will respect the privacy of the reporting staff member(s) to the extent authorized by law.
   5. Managing a Potentially Violent Situation: Staff members are expected to assist all persons and fellow staff members, but not subject themselves to abusive conduct. Please see Appendix 2-12-12B and C for more specific information.
   6. Emergency physical interventions may only be used by a staff member in an emergency situation as a last resort when other attempts to keep persons safe using less restrictive techniques have failed.
   7. Only staff who are trained and competent in the use of emergency physical interventions may use physical management techniques.
   8. If a WMCMH staff member uses an emergency physical intervention with a consumer, the staff person will participate in a debriefing with his/her supervisor, documenting the process In R3 routing notes. The debriefing notes are reviewed by the clinical team leader for review and follow up if needed.

D. Reporting Incidents:
   1. For critical incidents, in which serious threat or injury occurs, emergency responders such as law enforcement and/or ambulance personnel should be notified immediately by dialing 9-911.
   2. Any WMCMH staff member who identifies an individual who poses a threat to himself, others, or WMCMH property, has knowledge of workplace violence involving another staff member (as victim or perpetrator), must report the information to their supervisor, a member of Senior Management, or to the Chief Executive Officer immediately and complete a CIR.
   3. Any WMCMH staff member who utilizes an emergency physical intervention with a consumer must report the incident via Critical Incident Report in accordance with policy 2-12-8.

Following a Critical Incident involving a consumer, debriefing shall be conducted in accordance with policy 2-12-8.

E. Incident Investigation:
   1. Investigation Team: The Workplace Violence Investigation Team is responsible to investigate incidents of workplace violence. The investigation team will be asked to convene at the request of a Chief Officer, or the Chief Executive Officer should the incident require it. Typical members of the Team are:
      a. Director of Human Resources
      b. Facilities/Safety Staff
      c. Clinical team representative if appropriate to the incident
   2. Format: The Team uses the Violence Assessment Checklist to assist in identifying the violence risk and factors associated with the incident.
   3. Time Frame: The Investigation Team shall convene a meeting and make recommendations to the Chief Operations Officer, the Chief Executive Officer, and the insurance carrier, if necessary, within a reasonable amount of time (usually one week).
   4. Action Plan: A written plan shall be developed identifying the safety precautions that need to take place to include notification of impacted staff, security instructions, identified warning signs and reporting instructions.

G. Sanctions: WMCMH will initiate an appropriate response as a result of the completion of an investigation. If an allegation of the violation of this policy has been made against a staff member and the allegation is substantiated, sanctions will be applied, which may include reassignment of job duties, suspension without pay, termination of association with WMCMH, and criminal prosecution, if appropriate.

VII. SUPPORTING DOCUMENTS:

2-12-12A: Physical Management Reduction Plan
2-12-12B: Emergency Intervention for Disruptive Behavior of Adults
2-12-12C: Emergency Intervention for Disruptive Behavior of Children

Emergency Operations Plan and Emergency Response Guides

VIII. **POLICY/PROCEDURE REVIEW:**

REV#	APPROVED BY	Policy/Procedure	DATE
			04/2018
			10/2019
			11/2020
2	Corp Comm	Procedure	03/2022
3	Safety Comm	Procedure	04/2023
4	Safety Comm	Procedure	06/2024
***Board Approval Date**: 01/18/2005*			

IX. **CHIEF EXECUTIVE OFFICER ENDORSEMENT:**

I have reviewed and approved of policy # 2-12-12 Revision # 4.

CEO: Lisa A. Williams Approval Signature:_____

Appendix 2-12-12A

WEST MICHIGAN COMMUNITY MENTAL HEALTH

Emergency Physical Intervention Reduction Plan
Revised February 2022

Purpose
To minimize or eliminate the use of emergency physical interventions during the provision of WMCMH directly provided services and contractual services.

Oversight
This plan will be reviewed by the Chief Clinical Officer and the Behavior Treatment Committee on an annual basis. The Behavior Treatment Committee reviews all emergency physical management data and 911 calls on a monthly basis.

Goal
The goal of this plan is to reduce the number of emergency physical interventions in the current fiscal year from the previous fiscal year.

Interventions
Workforce attitudes: WMCMH continues to support a Culture of Recovery. WMCMH supports a Culture of Recovery via its clinical processes, use of evidence-based practices, trauma informed care, culture of gentleness, and foundational materials including policies and procedures and mission, vision, and value statements. WMCMH creates an environment where all persons feel safe and valued.

Staff Education: In 2015, the Lakeshore Regional Entity (PIHP) adopted the use of Mandt as the preferred method for non-physical and emergency physical intervention training. Mandt has three components: relational, conceptual, and technical. WMCMH developed a matrix that outlined which internal staff required the different components of Mandt training depending on the job description and assigned work duties. The desired outcome is that staff will increase their skills to foster positive and peaceful relationships. WMCMH Policy 2-12-12 requires that all staff complete the "Interacting with People" training module every two years. Training will be documented along with other mandatory staff trainings by Human Resources.

All staff are required to review and be familiar with Policy 2-12-12 "Violence Free Workplace," which describes specific strategies to prevent crisis, including:

- staff responsibilities in the event of violence or the threat of violence
- guidelines for managing potentially violent situations
- requirement that all staff review and are familiar with "Emergency Intervention for Consumer Disturbance / Disruptive Behavior" Plan document (Appendix 2-12-12) and "Emergency Intervention for Disruptive Behavior of Children and Adolescents" (Appendix 2-12-12).

Debriefing: Following an incident of emergency physical intervention involving WMCMH employees, supervisors of staff involved will initiate a timely debriefing with staff and others as appropriate. The debriefing is documented in writing in R3 routing notes and is routed to the appropriate clinical team leader.

Contract Providers: Contract providers are required to report incidents of emergency physical interventions via Critical Incident Report. Contract providers are asked to submit documentation of debriefing along with any Critical Incident Report which reports the use of an emergency physical intervention.

Monitoring

All incidents of emergency physical interventions are reported via Critical Incident Report according to WMCMH policy 2-12-8 for both internal and contractual providers.

The Network, Quality and Compliance Team maintains a database of emergency physical interventions and 911 law enforcement contacts.

A full report of emergency physical management interventions by consumer name is reviewed by the Behavior Treatment Committee on a monthly, quarterly, and annual basis. The Quality Improvement Oversight Committee (QISCC) reviews an aggregate report of the use of emergency physical management and 911 calls on a quarterly basis.

A year-end status report on this plan will be prepared annually by the Network, Quality and Compliance Team and will be reviewed by the Behavior Treatment Committee. The Behavior Treatment Committee makes recommendations for the next year.

Data provided by RRO, December 2016. Reviewed KH Oct 2019, Reviewed February 2022, Reviewed April 2023

EMERGENCY INTERVENTION
FOR DISRUPTIVE BEHAVIOR OF ADULTS
Revised February 2022

I. Purpose: To provide guidance to CMH staff in the event an adult being seen by CMH staff on the building or grounds of CMH or involved in CMH sponsored activity is agitated, making verbal or physical threats appears to be under the influence of intoxicating substance, destroying property, etc.

II. Prevention:

1. Always keep clinical offices and public areas of the building free of items that could be easily used as weapons.
2. Always keep decorations, office supplies and activity materials that could be used as weapons out of easy reach of consumers.
3. Always have enough staff to adequately supervise or lead groups.
4. Always have enough room for the activity planned.
5. Always be mindful of the environment, maintain an orderly and calm setting.
6. Always have a predetermined emergency plan for those persons likely to become disruption or assaultive.
7. Follow CMH procedures when providing transportation.
8. Never permit consumers to be between you and your means of escape.
9. Never go into a closed room with a person who is agitated to the degree that he/she may become assaultive.
10. Never corner either physically, verbally, or emotionally an agitated person.

III. Cautions:

1. When you touch a person who is agitated, you may risk that the gesture will be interpreted as intrusive or an assault by that person, YOU now have become the aggressor.
2. The use of an emergency physical intervention is a strenuous activity for both the consumer and staff member (s). Always be aware of the person's physical and medical condition especially chronic respiratory and cardiac conditions and skeletal-muscular conditions that increase the potential of injury. An emergency physical Intervention can lead to serious injury or death when applied improperly or without consideration given to a person's health status. To reduce this risk, do the interventions with two trained persons whenever possible.
3. Only persons who have current competency in emergency physical intervention (Mandt or an approved MDHHS curriculum) and therapeutic holds may intervene and only if there is an immediate risk of harm to any person(s) and/or significant property damage; after applicable less restrictive measures are attempted. Only approved come-alongs and holds and those considered least intrusive for the situation are to be used.
4. WMCMH policies do not permit the use of Seclusion.

IV. Procedures:

In the event that a consumer becomes unruly, assaultive, or agitated and attempts to calm the person using de-escalating techniques has been ineffective, emergency physical intervention may be necessary to protect the consumer, the clinician and others in the area against harm and/or significant property damage. In circumstances as described above, the following procedures are to be implemented:

1. Intervention
    a. If the consumer is accompanied by a caregiver, the caregiver is the lead in helping to calm the individual.
    b. If possible, the individual is moved to a location where the behavior will not disturb other persons.
    c. If the caregiver is trained to use emergency physical intervention, he/she is the lead person in the intervention.
    d. If the caregiver is not in the vicinity or requests assistance, the CMH staff person in the intervention may direct other CMH staff to do any of the following;
        i. Get assistance from other staff members, including notification of guardians or caregivers.
        ii. Have other persons in the area move to another area for safety if necessary.
        iii. Contact a staff member related to the consumer or situation
        iv. Inform available management staff.
        v. Contact 911.

    e. Only persons who have current competency in emergency physical intervention and therapeutic holds may use these techniques with a consumer.

    f. Only approved Mandt (other MDHHS approved curriculum) techniques considered least intrusive for the situation are to be used. To ensure the safety of each consumer and staff each agency shall designate emergency physical techniques to be utilized during emergency situations.

    g. If an emergency physical intervention is used, it is to be time-limited and ONLY until the individual is no longer a risk to others or until appropriate law enforcement, safety, or other emergency service providers arrive.

        i. The intervention is not to exceed 10 minutes.
        ii. At least every 2 minutes a review for continued need for the emergency intervention is completed and is documented in the CIR.
        iii. A second trained staff member is to observe for any signs of physical/medical duress and provide relief for the staff intervening with the consumer.
        iv. If there are signs of physical/medical duress the consumer is to be immediately released.

    h. Uninvolved staff members are to continue normal operations if feasible.

    i. Staff may call 911 and request law enforcement assistance if a consumer's aggressive behavior place him/her or others at risk of physical harm. Guidelines for calling 911 are:
        i. Caregivers are unable to remove other individuals from the hazardous situation.
        ii. Safe implementation of emergency physical intervention is impractical and/or approved emergency physical interventions have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

2. Communication: Team leaders/supervisors shall alert other staff members in the building to the situation, if necessary.

3. Building Evacuation

    a. If the disturbance is such that staff members, consumers and visitors need to evacuate the building, the Safety Officer shall be informed or the Incident Commander or his/her designee in the absence of the Safety Officer.

    b. The Safety Officer or Incident Commnader shall inform the Chief Executive Officer or his/her designee of the situation.

    c. In the event of a building evacuation, the previously appointed building sweepers shall assure that the occupants of the section/building evacuate to a safe area outside the building.

    d. No staff member or consumer shall re-enter the building until the Safety Officer and/or Incident Commander have given an “all clear” signal.

    e. After the “all clear” signal has been given by the Incident Commander and/or the Safety Officer, the Incident Commander shall decide whether or not to resume normal operations. In addition, if normal operations are not resumed, the following shall be implemented:

        i. Clinical Supervisors/Coordinators or their designee are responsible for ensuring all consumers have adequate transportation home and that the care providers are home.
        ii. Clinical Supervisors/Coordinators or their designee shall remain at their program site until all consumers and program staff has safety evacuated.

4. Debriefing: Immediately following the incident, the direct supervisor of the affected staff shall meet with the staff to review the incident and to assure that the involved staff are afforded medical attention if necessary and are sufficiently calm to resume duties. If medical attention is required another staff is to accompany the staff to the appropriate health clinic.

    Before the end of the next business day following the incident, the involved staff and the supervisor of the involved staff or another appropriate supervisor will meet to conduct a full debriefing of the incident. To prepare for the full debriefing, additional information should be gathered from the consumer involved, witnesses, and other individuals as appropriate. Full debriefing must be documented in R3 routing notes

5. Reporting: The staff member who is first aware of the situation is to complete a Critical Incident Report within 24 hours and submit it to the Quality Assurance Specialist.

EMERGENCY INTERVENTION
FOR DISRUPTIVE BEHAVIOR OF CHILDREN AND ADOLESCENTS
Revised February 2022

I. Purpose:

To provide guidance to CMH staff in the event a child or adolescent that is being seen by CMH staff on the building or grounds of CMH or involved in CMH sponsored activity is agitated, making verbal or physical threats appears to be under the influence of intoxicating substance, destroying property, etc.

II. Prevention:

1. Always keep clinical offices and public areas of the building free of items that could be easily used as weapons.
2. Always keep decorations, office supplies and activity materials that could be used as weapons out of easy reach of consumers
3. Always have enough staff to adequately supervise or lead groups
4. Always have enough room for the activity planned
5. Always be mindful of the environment, maintain an orderly and calm setting
6. Always have a predetermined emergency plan for those persons likely to become disruption or assaultive
7. Follow CMH procedures when providing transportation
8. Never permit consumers to be between you and your means of escape.
9. Never go into a closed room with a person who is agitated to the degree that he/she may become assaultive
10. Never corner either physically, verbally, or emotionally an agitated person

III. Cautions:

1. When you touch a person who is agitated, you may risk that the gesture will be interpreted as intrusive or an assault by that person, YOU now have become the aggressor.
2. The use of an emergency physical intervention is a strenuous activity for both the consumer and staff member (s). Always be aware of the person's physical and medical condition especially chronic respiratory and cardiac conditions and skeletal-muscular conditions that increase the potential of injury. An emergency physical Intervention can lead to serious injury or death when applied improperly or without consideration given to a person's health status. To reduce this risk, do the interventions with two trained persons whenever possible.
3. Only persons who have current competency in emergency physical intervention (Mandt or an approved MDHHS curriculum) and therapeutic holds may intervene and only if there is an immediate risk of harm to any person(s) and/or significant property damage; after applicable less restrictive measures are attempted. Only approved come-alongs and holds and those considered least intrusive for the situation are to be used.
4. WMCMH policies do not permit the use of Seclusion.

IV. Procedures:

In the event that a consumer becomes unruly, assaultive, or agitated and attempts to calm the person using de-escalating techniques has been ineffective, emergency physical

intervention may be necessary to protect the consumer, the clinician, and others in the area against harm and/or significant property damage. In circumstances as described above, the following procedures are to be implemented:

1. Intervention
    a. If the parent or guardian is present, he/she is the leader in helping to calm the child.

    b. If possible, move the child to a location where the behavior will not disturb other persons.

    c. If the parent or guardian is not in the vicinity or requests assistance, the lead CMH staff person in the intervention may direct other staff to do any of the following;

        i. Get assistance from other staff members, including contacting the parent or guardian.
        ii. Have other persons in the area move to another area for safety if necessary.
        iii. Contact a staff member related to the consumer or situation.
        iv. Inform available management staff.
        v. Contact 911.

    d. Only persons who have current competency in emergency physical intervention and therapeutic holds may use these techniques with a child.

    e. Only approved Mandt (or other MDHHS approved curriculum) techniques considered least intrusive for the situation are to be used. To ensure the safety of the child and CMH staff member, each agency shall designate emergency physical management techniques to be utilized during emergency situations.

    f. If an emergency physical intervention is used, it is to be time-limited and ONLY until the individual is no longer a risk to others or until appropriate law enforcement, safety, or other emergency service providers arrive.

        i. The intervention is not to exceed 10 minutes.
        ii. At least every 2 minutes a review for continued need for the emergency intervention is completed and documented in the CIR.
        iii. A second trained staff member is to observe for any signs of physical/medical duress and provide relief for the staff intervening with the child.
        iv. If there are signs of physical/medical duress the child is to be immediately released.

    g. Uninvolved staff members are to continue normal operations if feasible.

    h. Staff may call 911 and request law enforcement assistance if a child's aggressive behavior place him/her or others at risk of physical harm. Guidelines for calling 911 are:
        i. Staff are unable to remove other individuals from the hazardous situation.
        ii. Safe implementation of emergency physical intervention is impractical and/or approved emergency physical interventions have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others.

2. Communication: Team leaders/supervisors shall alert other staff members in the building to the situation, if necessary.

3. Building Evacuation:

    a. If the disturbance is such that staff members, consumers and visitors need to evacuate the building, the Safety Officer shall be informed or the Chief Operations Officer or his/her designee in the absence of the Safety Officer.

    b. The Safety Officer or Chief Operations Officer shall inform the Chief Executive Officer or his/her designee of the situation.

    c. In the event of a building evacuation, the previously appointed building sweepers shall assure that the occupants of the section/building are evacuated to a safe area outside the building.

    d. No staff member or consumer shall re-enter the building until the Safety Officer and/or Chief Operations Officer have given an “all clear” signal.

    e. After the “all clear” signal has been given by the Chief Operations Officer and/or the Safety Officer, the Chief Executive Officer shall decide whether or not to resume normal operations. In addition, if normal operations are not resumed, the following shall be implemented:

        i. Clinical Team Leaders or their designee are responsible for ensuring all consumers have adequate transportation home and that the care providers are home.
        ii. Clinical Team Leaders or their designee shall remain at their program site until all consumers and program staff has safety evacuated.

4. Debriefing:

    Immediately following the incident, the Director/direct supervisor of the affected staff shall meet with the staff to review the incident and to assure that the involved staff are afforded medical attention if necessary and are sufficiently calm to resume duties. If medical attention is required another staff is to accompany the staff to the appropriate health clinic.

    Before the end of the next business day following the incident, the involved staff and the supervisor of the involved staff or another appropriate supervisor will meet to conduct a full debriefing of the incident. To prepare for the full debriefing, additional information should be gathered from the consumer involved, witnesses, and other individuals as appropriate. Full debriefing must be documented in R3 routing notes.

5. Reporting:

    The staff member who is first aware of the situation is to complete a Critical Incident Report within 24 hours and submit it to the Network, Quality and Compliance Team.

Name	Date
Title	Phone #