The Patient Safety
Education Program™
CANADA

PSEP

Module 13c: Mental Health Care:
Diminishing Violence and
Aggressive Behaviour

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Module 13c Mental Health Diminishing Violence and Aggressive Behaviour

PSEP – Canada Objectives	Related CPSI Safety Competencies
The knowledge elements include an understanding of: • the difference between violence and aggressive behaviour; • how environmental factors contribute to risk of violence and aggressive behaviour; • the role of the mental health team in assessing and preventing violence and aggressive behaviour; • strategies for preventing violence and aggressive behaviour; and • processes for reviewing incidents of violence and aggressive behaviour. The performance elements include the ability to: • identify person- level risk	**Domain: Contribute to a Culture of Patient Safety** *1. Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:* 1.1. Are able to articulate their role as individuals, as professionals, and as health care system employees in providing safe patient care 1.3. Recognize personal limitations and ask for assistance when required 1.4. Demonstrate knowledge of policies and procedures as they relate to patient and provider safety, including disclosure 1.6. Participate actively in event and close call reporting, event analyses and process improvement initiatives 1.9. Recognize clinical situations that may be unsafe and support the empowerment of all staff to resolve unsafe situations 1.10. Demonstrate a commitment to a just culture, promoting fair approaches to dealing with adverse events 1.11. Advocate for improvements in system processes to support professional practice standards and the best patient care *2. Health care professionals who are able to describe the fundamental elements of patient safety, understand:* 2.1. Core theories and terminology of patient safety and the epidemiology of unsafe practices 2.2. The characteristics and capacities of organizations with respect to patient safety, namely: 2.2.1. A commitment to patient safety as a major organizational or institutional goal demonstrated at the most senior levels 2.2.2. The establishment and maintenance of a just culture 2.2.3. The implementation of patient safety best practices

factors for violence and aggressive behaviour; and • utilize techniques for dealing with current incidents of violence or aggressive behaviours (behavioural emergencies).	2.2.4. The conduct of adverse event and incident (e.g., close call) analysis 2.2.5. The involvement of patients and their families as key players in patient safety 2.2.6. The provision of an environment of support and safety for health care professionals 2.3. The use of evaluative strategies to promote safety 2.4. The risks posed by personal and professional limitations 2.5. Principles, practices and processes that have been demonstrated to promote patient safety 2.6. The nature of systems and latent failures in the trajectory of adverse events 2.9. The elements of a just culture for patient safety, and the role of professional and organizational Accountabilities 2.10. The concept that health care is a complex adaptive system with many vulnerabilities, (e.g., space or workplace design, staffing, technology) *3. Health care professionals who maintain and enhance patient safety practices through ongoing learning:* 3.1. Identify opportunities for continuous learning and improvement for patient safety 3.3. Analyze a patient safety event and give examples on how future events can be avoided 3.5. Share information on adaptations to practices and procedures that increase safety for specific individuals or situations 3.7. Participate in self- and peer assessments reflecting on practice and patient outcomes *4. Health care professionals who demonstrate a questioning attitude as a fundamental aspect of safe professional practice and patient care:* 4.1. Recognize that continuous improvement in patient care may require them to challenge existing methods 4.2. Identify existing procedures or policies that may be unsafe or are inconsistent with best practices and take action to address those concerns 4.3. Re-examine simplistic explanations for adverse events to facilitate optimal changes to care

4.4. Demonstrate openness to change

Domain: Work in Teams for Patient Safety

*1. Health care professionals who participate effectively and appropriately in an interprofessional health
   care team to optimize patient safety are able to:*

  1.2. Describe individual and team roles and responsibilities in the context of practice and in the
       health care system

  1.4. Work to develop a shared set of individual and team values, rights and responsibilities

  1.5. Identify and act on safety issues, priorities and adverse events in the context of team practice

*2. Health care professionals who meaningfully engage patients as the central participants in their
health*

  care teams:

  2.1. Ensure that patients are at the centre of care

  2.2. Engage patients in decision-making and the management of their own health

  2.3. Provide appropriate, sufficient and clear information, and teaching to patients to support
       informed decision-making

  2.5. Respond to individual patient needs and respect cultural and personal health beliefs and
       practices

*3. Health care professionals who appropriately share authority, leadership, and decision-making for
safer care:*

  3.2. Collaboratively consult with, delegate tasks to, supervise and support team members

  3.4. Ask for support when appropriate

  3.6. Demonstrate leadership techniques appropriate to clinical situations

Domain: Communicate Effectively for Patient Safety

1. Health care professionals who demonstrate effective verbal and non-verbal communication abilities to prevent adverse events:

    1.1. Show respect and empathy in communication

    1.2. Explain investigations, treatments and protocols clearly and adequately to patients

    1.3. Convey information with clarity appropriate to each patient (e.g., by using the Calgary-Cambridge model)

    1.4. Convey information in structured communications to team members to promote understanding (e.g. ARC, CHAT, CUS, DESCscript, I'M SAFE, I PASS THE BATON, STAR)

    1.5. Communicate in a manner that is sensitive to health literacy needs

    1.6. Employ active listening techniques to understand the needs of others

    1.7. Communicate in a manner that is respectful of cultural diversity

    1.8. Respect privacy and confidentiality

    1.9. Use a variety of communication tools and techniques to enhance and assess understanding on the part of patients and their families

2. Health care professionals who communicate effectively in special high-risk situations to ensure the safety of patients:

    2.1. Engage patients or substitute decision-makers in a discussion of risks and benefits of investigations and treatments to obtain informed consent

    2.2. Provide informed discharge so that patients know when and where to seek care

    2.2. The characteristics and capacities of organizations with respect to patient safety, namely:

        2.2.1. A commitment to patient safety as a major organizational or institutional goal demonstrated at the most senior levels

        2.2.2. The establishment and maintenance of a just culture

        2.2.3. The implementation of patient safety best practices

2.2.4. The conduct of adverse event and incident (e.g., close call) analysis

2.2.5. The involvement of patients and their families as key players in patient safety

2.2.6. The provision of an environment of support and safety for health care professionals

2.3. Communicate to others the urgency of a clinical situation

2.4. Employ communication techniques to escalate concerns across authority gradients to match the seriousness of the clinical situation

2.5. Employ appropriate communication approaches in high-risk situations, such as in clinical crises, emotional or distressing situations, and conflict

2.6. Use appropriate communication approaches to provide safe transfers, transitions of care and consultations among providers, including between institutions, and on discharge to community care

2.7. Demonstrate insight into their own communication styles with patients and team members in ordinary, crisis and stressful situations and adjust these styles appropriately to provide safe care

3. Health care professionals who use effective written communications for patient safety:

3.1. Provide appropriately detailed and clear written or electronic entries to the patient health record

3.2. Provide sufficient documentation to facilitate team members' comprehension of the patient's history, physical findings, diagnosis and rationale for the diagnosis, treatment and care plan at any time

3.4. Write patient care orders and prescriptions to convey the appropriate degree of urgency

3.5. Use appropriate, safe written communication approaches in consultation requests and responses, investigative, operative and other reports, and other correspondence

4. Health care professionals who apply communication technologies appropriately and effectively to provide safe patient care:

4.2. Employ critical thinking tools and structured approaches to communications (e.g., Situation-Background-Assessment-Recommendation [SBAR] and read-back of orders on the telephone)

when using technology

Domain: Manage Safety Risks

1. Health care professionals who recognize routine situations and settings in which safety problems may arise:

    1.1. Demonstrate situational awareness by continually observing the whole environment, thinking ahead and reviewing potential options and consequences

    1.2. Recognize safety problems in real-time and respond to correct them, preventing them from reaching the patient

    1.3. Employ, as appropriate, techniques such as diligent information-gathering, cross-checking of information using checklists, and investigating mismatches between the current situation and the expected state

2. Health care professionals who systematically identify, implement, and evaluate context-specific safety solutions:

    2.4. Reflect on the impact of an individual intervention, including the potentially harmful or unintended consequences of a safety intervention

    2.5. Evaluate the ongoing success of a safety intervention by incorporating lessons learned

    2.6. Adjust policies and procedures to reflect established guidelines, if applicable

3. Health care professionals who anticipate, identify and manage high-risk situations:

    3.1. Recognize health care settings that may lead to high-risk situations

    3.2. Respond effectively by means of efficient task and process management, crisis team functioning, and dynamic decision-making

Domain: Optimize Human and Environmental Factors

1. Health care professionals who are able to describe the individual and environmental factors that can affect human performance understand:

    1.2. The role of attitude and professional culture in clinical practice

1.5. How to evaluate the impact of organizational resource allocation, policies and procedures and culture

2. Health care professionals who apply techniques in critical thinking to make decisions safely are able to:

2.1. Describe the common types of cognitive biases

2.2. Model the behavioural characteristics that demonstrate situational awareness

2.3. Demonstrate a process of sound decision-making, understanding where the process can be challenged and corrected

Domain: Recognize, Respond to and Disclose Adverse Events

2. Health care professionals who mitigate harm and address immediate risks for patients and others affected by adverse events and close calls:

2.1. Assess the immediate safety and care needs for the physical and emotional well-being of patients and their families, and provide interventions as appropriate

2.2. Reduce or manage the risk of further harm to patients affected by adverse events and close calls

2.3. Provide appropriate support for individual health care professionals and teams involved in adverse events and close calls

3. Health care professionals who disclose the occurrence of an adverse event to patients and/or their families as appropriate and in keeping with relevant legislation:

3.1. Understand what information should be disclosed at the initial disclosure stage, the time frame for disclosure, and the relevant documentation, reporting, and analyses

3.2. Recognize the ethical, professional and legal obligation to disclose and report adverse events

3.3. Differentiate between disclosure and reporting and the inherent processes associated with each concept

3.4. Are aware of existing policies and procedures associated with disclosure and the extent to which these foster a culture of patient safety

	3.5. Engage in honest communication and empathic dialogue with respect to disclosure
	3.6. Recognize that there are situations that constitute special consideration regarding disclosure, for example, patients in vulnerable situations, patients who have a substitute decision-maker, patients with special communication requirements (e.g., those who are hearing impaired), and patients whose cultural perspective on disclosure differs from the provider's
	3.10. Document unexpected outcomes, adverse events and the disclosure discussions
	3.11. Provide ongoing follow-up as needed
	3.12. Recognize the need for a just culture of safety in supporting disclosure and reporting
	3.13. Appreciate the legal implications arising from disclosure
	4. Health care professionals who effectively report the occurrence of an adverse event or close call:
	4.1. Recognize that the reporting of adverse events takes place across the continuum of care and includes primary, secondary and tertiary care centres
	5. Health care professionals who participate in timely event analysis, reflective practice, and planning for the prevention of recurrence:
	5.1. Engage in personal and professional reflection regarding the adverse event
	5.2. Recognize the importance of monitoring the outcome of event analysis
	5.3. Apply lessons learned from the event analysis
	5.4. Advocate for system change as warranted

Abstract

Mental health patients are vulnerable to the risks associated with violence and aggressive behavior as both victims and perpetrators. In inpatient environments in particular, violence and aggressive behaviour create a significant safety risk not only for staff and other persons, but for the person exhibiting the behavior. This module focuses on the person and environmental factors that may contribute to the risk of violence and aggressive behaviours among persons with mental illness and proposes that least restraint approaches should be the framework within which intervention and treatment should be developed. Risk factors for violence and agression can be identified using risk assessment tools and the information used to inform treatment planning and intervention. Any interventions should first ensure the personal safety of staff and the person, followed by attempts to de-escalate the behaviour using calm, talk-down approaches with the person. In all instances prevention includes environment of care considerations, proper training for all staff, and an empathetic and understanding care culture.

Keywords

Physical abuse, verbal abuse, physical violence, violence ideation, intimidation, threats, responsive behaviour, distress, agitation, de-escalation, stigma, least restraint

Teaching methods

Didactic presentation, case-based small group discussion

Objectives

The objective of this module is to provide information about risk and management of violence and aggressive behavior.

Knowledge requirements

The knowledge elements include an understanding of:

- the difference between violence and aggressive behaviour;
- how environmental factors contribute to risk of violence and aggressive behaviour;
- the role of the mental health team in assessing and preventing violence and aggressive behaviour;
- strategies for preventing violence and aggressive behaviour; and
- processes for reviewing incidents of violence and aggressive behaviour.

Performance requirements

The performance elements include the ability to:

- identify person-level risk factors for violence and aggressive behaviour; and
- utilize techniques for dealing with current incidents of violence or aggressive behaviours.

Defining violence and aggressive behaviour

Aggression is broadly defined as any verbal, non-verbal or physical behviour that is threatening or does harm to others (Morrison). *Aggressive behaviour* and *violence* are two forms of aggression, and can be used to describe behaviours that are <u>similar in form but differ based on intent</u>.

Violence

This module uses the World Health Organization (WHO) definition of violence which defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community.

Descriptively, the progression toward violence typically begins with violent ideation including thoughts of committing a violent act and the formulation of a plan. The behaviour may then progress into verbal threats of violence which may include intimidation directed at others. In the final stage, the person may act out, becoming physically violent towards others either using physical force or weapons or fire setting. Not all persons follow this progression. Some proceed from ideation to violent acts without engaging in verbal threats or intimidation. For example, persons with schizophrenia may experience auditory command hallucinations that progress from ideation and planning straight to the commission of violent actions.

Aggressive behaviour

Aggressive behavior can be defined as any behaviour which causes harm to others but where there is no intent to harm. Unlike violence, aggressive behaviour does not begin with ideation and progress to action. Instead, these behaviours are sometimes referred to as *responsive behaviour* because the behaviour is said to reflect the response to a situation causing distress to the person and where the person is unable to express this distress in any other way. Aggressive behavior may not be malicious or purposeful and may be indicative of the presence of a medical, psychological, or social problem.

Aggressive behaviour can include:

- verbal abuse,
- threatening behavior, and
- damage to property.

Physical abuse toward objects (e.g. throwing things) or persons (e.g., family, persons, health care staff, etc.).

Introduction

The majority of mental health patients neither display aggressive behaviour nor are violent. While the rates of incidents of violence or aggressive behaviours are higher in mental health settings compared to non-mental health settings, incidents often reflect a select number of persons who have a higher level of risk than most, for example in a forensic mental health settings. In inpatient care settings, there may be a greater likelihood for violence or aggressive behaviour among persons admitted as compared to the community, simply due to the fact that persons admitted to inpatient care are in a more acute stage of illness and experiencing greater distress. Despite the relatively low rates in all mental health settings, it is the risks of property damage, physical injury, psychological trauma to staff and persons in care including the one exhibiting the behavior that drive the focus on these kinds of patient safety events.

A second and equally compelling reason for the focus on identifying and addressing the root causes of violence and aggressive behaviours is that violence contributes to the continued stigmatization of persons recovering from mental illness and addiction. This stigma, stemming from the perception that all persons with mental illness are violent, can lead to the exclusion of persons with mental illness from community, housing, and employment. These persons may experience isolation and loneliness, and may be at higher risk of incarceration. Additionally, persons with a history of violence and aggressive behaviour are at risk for future such incidents as well as other patient safety issues such as restraint, absconding, suicide and self-harm, and substance abuse. For these reasons, understanding how to prevent persons with mental illness displaying behaviours that may be harmful may reduce negative stigma and improve opportunities for community integration and recovery.

Contributing factors

There are two categories of factors that contribute to increased risk and therefore incidents of violence and aggressive behavior. The first category is factors related to the person i.e. intrinsic factors. The second is factors that are external to the person i.e. extrinsic factors, including treatment and environmental. However, depending on one's perspective, views may differ on the exact cause. For example, persons in care and staff may have a different understanding of the triggers for aggressive and violent behaviour.

- Persons in care in inpatient settings have identified that environmental conditions such as unit structure (e.g., crowding) and poor communication from staff in the provision of care were precursors to aggressive behaviour.

- Healthcare providers, on the other hand, have identified symptoms of mental illness in combination with negative environmental conditions as underlying factors of behaviour.

Despite the conflicting views, what is known is that there is *no single cause of aggressive behaviour or violence*. These differing perspectives speak to the importance of understanding violence and aggressive behaviour as a series of interactions between persons, staff, other care recipients, and environmental characteristics. As such, a systems view of incidents of violence and aggressive behaviour should be kept in mind as the risk factors identified below are discussed.

Factors related to the person

It is important to avoid equating risk of violence or aggressive behavior as a personal feature; rather it should be clear that it is a feature of the condition. Instead of referring to a person in care as a "violent or aggressive person" refer to the person as "someone whose condition may increase the risk of harm to him/herself or others". This change in language moves away from labeling the person and helps highlight the fact that it is the condition or conditions that are driving the risk. The following are factors related to the person that may increase the risk of violence or aggressive behaviour.

Prior violence or aggressive behaviour

In both mental health and the general populations, prior expressions of violence or aggressive behaviour are the strongest predictors of future violence or aggressive behaviour. This behaviour will most often occur where the person feels threatened and fearful, particularly when the person has poor coping skills and strategies for managing ongoing distress. This can be exacerbated by trait characteristics of the person that may not change over time.

Demographic factors

Research on the relationship between age as well as gender and aggressive behavior or violence is somewhat inconclusive. To the extent that these factors are taken into account during a risk assessment, they are more likely to play a role in identifying the *type* of violence or aggressive behaviour that will occur as opposed to the *likelihood* that it that it will happen. Men often express physically abusive behaviour while women more commonly express verbally abusive behaviour. A similar issue exists for the relationship between age and violence. Overall, it is likely that any relationship between age and harm to others represents a proxy association for other factors such as impulsivity or unrecognized distress.

Mental illness

Some persons with mental illness may experience symptoms (for example, paranoia, command hallucinations, mania, anger, impulsivity) that affect his or her ability to assess and react rationally to changes in the environment (for example, hospitalization, interactions with new or unfamiliar people). Here are some factors found to be associated with risk of violence or aggressive behaviour.

- **Insight:** A person who lacks insight into his or her mental health problem may react aggressively to the provision of treatment.
- **Trauma:** A person who has experienced a psychological trauma, often unrecognized or untreated, may have an induced agitated state due to triggers related to his or her trauma (for example, sounds, smells, physical environment, and conversations).
- **Bipolar disorder:** Persons with bipolar disorder who are in a manic state may have a pervasive fear of loss of control and may respond with aggressive behaviour in instances where control is perceived to be lost.
- **Psychotic symptoms or disorders:** Persons with psychotic symptoms or disorders may be at risk of harming others due command hallucinations or delusions. Risk may increase with concurrent alcohol or substance abuse, antisocial personality, or neurological impairment.
- **Antisocial personality disorder:** Persons with antisocial personality disorder may express aggressive or violent behaviors as a result of negative emotional states as well as in reaction to interventions or care environments, particularly if expectations about treatment and rules of the care setting are unclear. Be aware that some persons may engage in "limit testing" and "splitting." In both of these events, the person may engage in verbal threats or physically violent or aggressive acts. These aggressive behaviours usually have an instrumental purpose, with the person having a goal or an objective served by the behaviour.
- **Dementia or recent cognitive loss:** Examples include Alzheimer's disease, a stroke, an intellectual disability, and a decline in cognitive function. A person with such conditions may have difficulty communicating needs or may lack inhibition, which can lead to aggression.

General medical conditions

Medical conditions such as delirium, brain lesions, and other neurological syndromes may increase the risk of violence or aggressive behaviour due to factors related to the condition such as agitation, stress or disorientation. As well, persons who have conditions that cause physical pain or discomfort such as oral health problems or arthritis may express aggressive behaviour especially if they are unable to express their distress, perhaps due to language barriers, poor communication skills, or cognitive impairments.

Substance abuse

Persons who are intoxicated or experiencing withdrawal symptoms may be at an increased risk of aggressive behaviours and violence due to anxiety, irritability, agitation, impaired impulse control, disinhibition, decreased pain sensitivity, and impaired reality testing. Specific substances that may contribute to increased risk include alcohol, cocaine, methamphetamine, PCP, anabolic steroids, hallucinogens, cannabis, or combinations such as alcohol and psychostimulants or benzodiazapines. Persons who use tobacco, particularly on a daily basis, may also be at heighted risk of violence or aggressive behaviour when they are not allowed to smoke in settings where smoking is prohibited. Nicotine replacement therapies may curb this risk in these settings.

Perceived threat, fear, and loss of personal control

Perceived threats and feelings of fear and loss of personal control may increase the risk of aggressive behaviour and violence. Feeling threatened or fearful may be the result of symptoms, such as command hallucinations. Additionally, environmental factors can also influence threat or fear responses. As an example, the institutionalization process can invoke fear or paranoia, particularly without a strong therapeutic rapport between the person and care providers.

Social marginalization

Marginalization, as experienced through poverty, transient lifestyle, and substance use, may increase the risk of violence or aggressive behaviour. Any of these experiences may expose persons, and especially those with mental illness, to an increased likelihood of being the victim or perpetrator of violence or aggressive behaviour.

Factors related to treatment and the environment

The following factors related to treatment and the environment may increase the risk of violence or aggressive behaviour.

Medication issues

Adverse reactions from medications, such as medication side effects and adverse medication combinations, may affect risk of aggressive behaviour or violence. For instance, behaviours may arise from an adverse medication effect such as akathisia which is a restlessness in the body and may be associated with reduced regulation of aggression. As well, complications between medications and lifestyle factors may reduce the efficacy of medications (for example, effectiveness of certain antipsychotic medications can be affected by changes in smoking patterns) thus leaving the person vulnerable to an increased risk of violence and aggressive behaviour.

The care environment

Characteristics of a mental health care environment, such as the physical, organizational, and treatment factors, can be related to increased risk of aggressive behaviour and violence. In the physical environment, for example, the following characteristics can engender fear and paranoia and therefore increase the risk of violence and aggressive behaviour:

- overcrowding;
- the concentration of severely ill persons on an inpatient unit;
- lack of privacy;
- perceived risks to personal safety; and
- the existence of objects that could be used as weapons.

More broadly, treatment settings with confusing structures (i.e. the layout of the hospital is confusing causing people to get lost and frustrated), inconsistent or unclear procedures, inconsistently applied rules, and fragmented leadership may have higher rates of violence and aggressive behaviour. This is especially true where persons in care may perceive inconsistencies as injustices. Environments of care that have cultures of strict enforcement may also experience higher rates of violence compared to one where the cultures is more understanding, open, and respectful.

Characteristics of the care team

Negative attitudes, perceived power imbalances between staff and persons in care, stigma, and poor communication are potential triggers for aggressive behaviour and violence. Inconsistencies in staff communication and non-empathetic attitudes towards care recipients may be viewed as provocative and lead to feelings of frustration or injustice by some persons. On the other hand, there are communication skills that may reduce triggering of aggressive behaviour, particularly for persons with cognitive impairment or those experiencing acute delirium or confusion. These include calm speech and body language and clear descriptions and explanations of all procedures.

Risk assessment

Appropriate and effective risk assessment is a process that is underpinned by certain key principles. Screening for risk of violence and aggressive behaviours should be standard procedure for all persons with mental illness who are seen in mental healthcare environments. With the involvement of the person and their family, where possible, the risk assessment is the first step in designing a treatment or intervention plan that recognizes the person's unique condition, triggers and care needs which is also mindful of the safety of the person, staff, and others. All of this should be done without labeling the person as being violent or aggressive.

The risk assessment process should be based on a combination of quantitative risk assessment and clinical observation of the person's status. Whenever possible, risk screening and assessment should be combined with the overall assessment of the person's needs.

- Clinical observation, consultation and communication should take place between care team members as well as others who may be familiar with the person's status or history (e.g., family, primary care, first responders). Similarly, assessment based on clinical observation can also consider the experience of the care staff in preventing risk, the specific care environment, and the rapid changes that may occur in risk once treatment is implemented.
- Quantitative risk assessment tools for violence and aggressive behaviour used predominately in forensic mental health settings but are now used in the majority of mental health service settings. Many of these tools are designed to predict a person's risk of expressing violent or aggressive behavior but can also be used for initial screening and ongoing monitoring of the person. (refer to the Toolkits & outcome measures of this module for references).

Documentation

Documentation is another key principle that frames the risk assessment process. Ongoing documentation of the risk assessment process is essential. Documentation should include:

- the overall level of risk of harm to others that was identified and the factors contributing to this risk, including the tools used to inform risk assessment, the factors that contribute to risk, prior history of violence or aggressive behaviours, presence of personal factors that may contribute to risk such as specific symptoms or conditions, and care environment considerations;
- evidence of an escalation in nature, frequency, and intensity of behaviours;
- similarity of person's current circumstances to those surrounding previous expressions of violent or aggressive behaviour; and
- history of violence or aggressive behaviour among family or friends, including the types of behaviours, intended target of behaviours, and consequences.

Communication

Communication about risk, including sharing of documentation, is a must within and between care teams. This is especially true during transitions in care where risk of violence or aggression may be heightened because of the instability in observation, introduction of new triggers, or changes to daily structure. Organizations should develop processes to ensure that risk is communicated to the necessary stakeholders.

One way that some organizations have developed to communicate risk status is the adoption of "flags" that alert the clinical team that the person may be or has recently

displayed violence or aggressive behaviour. These flags can be a demarcation or text in a different colour in the chart of an at-risk person. However, flagging should be used cautiously since the use of these flags may raise questions about stigma. There should be clear criteria for determining when a "flag" should be removed from the chart.

The mental health team

The mental health team plays a crucial role in the assessment, prevention and incident management of violence and aggressive behaviours.

The prevention of violence and aggressive behaviour requires the participation of all persons involved in the care of the person. To the extent that the mental health team can consult with and elicit information on the person from family, teachers, co-workers, first responders (i.e. fire, ambulance and police), the better an appropriate care plan can be developed to avert these behaviours.

In order to prevent incidents of violence and aggressive behaviours, the mental health team needs to take into consideration the person's perspectives and goals. Specific prevention goals for healthcare team members might include:

- awareness and identification of risk factors;
- identification and implementation of the most efficient intervention, avoiding restraints, to manage current harmful incidents;
- communicating with empathy to the person so as to facilitate a better understanding of his or her current needs and distress;
- implementation of therapeutic interventions that are specific to the person and address their unique risk factors;
- development of strategies with the person to reduce the risk of harm to others in the future;
- increasing perceived sense of safety, predictability, control, and choice; and
- decreasing sense of fear and vulnerability.

The behavior response team is a subset of the mental health team that is uniquely associated with incidents of violence and aggressive behaviour. This team is also sometimes called a "code white team" and is composed of clinicians who work on the unit where the person receives care as well as security personnel. Security personnel play a key role in the management and de-escalation of violent incents. Behavior response team members should be trained and certified in:

- procedures for early detection of violence or aggressive behavior;
- identification of potential environmental hazards (e.g., objects that could be used as weapons);
- techniques for de-escalation;
- processes for calling an emergency code white;
- physical response techniques (e.g. hand placement stance); and

- how the care team can support each other and maintain awareness of their own need for support (e.g. how can the team members manage stress).

Incident prevention

Prevention is a process that begins with knowledge of risk factors. Understanding these factors directly influences how the care team approaches and interacts with the person. For example, persons new to the care environment, including those experiencing difficulties with cognitive functioning, may experience and express fear as aggressive behaviour during the provision of personal care. Care team members who are able to recognize that the person may be fearful, could adjust their communication style, perhaps by using a calming voice. Or, understanding that a person with dementia might be easily distracted, the care provider could ask the person about his or life as a means of distraction while providing care (e.g., ADL). The added benefit being that the care provider would also gather helpful background information about the person.

At the individual level, prevention is about understanding the specific circumstances that may contribute to or mitigate risk. At a more macro level, prevention is about understanding the organizational processes and structures that can similarly contribute to or mitigate risk. These processes and structures can include the physical structure of care environments, personnel attitudes and training, and organizational policies.

Prevention at the person level

Interventions and education are key components of a prevention strategy. These should be focused on the person as a way to introduce methods for recognizing and coping with potential triggers for violence and aggression. For example:

- anger management training can help persons cope with stress, or
- relaxation training is also effective to reducing stress and anger.

While it is important to not label (e.g. stigmatize) persons as violent or aggressive, care providers should be aware of the persons who are high-risk and more likely to engage in these behaviours. Thus it is important to understand the specific causes or triggers for such behaviour with each person.

Prevention at the clinical and organizational level

The structure, policies, and delivery of care all play important roles in preventing incidents of violence and aggressive behaviour. In particular, models of care that emphasize person-centred approaches to care, such as the Recovery Model (**which is discussed in more detail in *PSEP-Canada Module 13: Introduction***), can be effective in reducing risk of violence or aggressive behaviour since they promote:

- hope;
- a secure sense of self;

- supportive relationships;
- social inclusion; and
- coping skills, and meaning.

These models are based on respecting the person's preferences and own goals for care while providing guidance and support. Shifting to such models of care can break down power dynamics that may exist between persons and clinical staff and which trigger fear, agitation and other emotions that can escalate into violence and aggressive behaviour.

While policies in organizations should be flexible enough to accommodate personal choice in recovery and the person's specific goals, they should nevertheless ensure consistency in the structure and delivery of care. (For example, the unit has consistent guidelines such that all person's need to bathe every day). For all persons at risk, and particularly persons who may have antisocial personality disorders, it is important that treatment and delivery of care is structured around clearly stated expectations about treatment participation, rules, and consequences resulting in stable care environment.

Within inpatient mental health settings, consistency is also important with respect to staff. All staff should be trained on the same set of care rules and procedures. Moreover, those rules or procedures should be consistently applied to all persons in care. For the person and family, in all settings, procedures that are applicable to them should be clearly outlined and reinforced throughout treatment and introduced at the point of admission. For the person in care, this introduction to procedures may take place at a later point when s/he is able to understand the information.

In inpatient and day treatment settings, the importance of maintaining a physical environment that is safe should not be forgotten. For example, discussions about care should be carried out in private interview rooms that are free of objects that could be used as weapons. Another example would be deciding on the appropriate level of staff participation when in discussions with the person given the risk status of the person. In this example, persons at high risk of violence and aggressive behaviour might require a multiple staff to participate when conductive interviews or discussions. That being said, the interaction should take place in a manner that is neither threatening nor intimidating to the person. A clear and calm explanation to the person as to why multiple team members are present at the meeting and their specific roles may help alleviate any perceptions of threat.

Incident management

Incident management involves the following steps:

- ensure in a goal and a step safety of all persons;
- interventions to prevent or de-escalate immediate threats or acts of violence;
- interventions to halt actions of violence or aggressive behaviour (if needed);
- documentation and reporting; and

- incident review.

Step 1: Ensure in a goal and a step the safety of all persons

First and foremost, if a person becomes violent or aggressive in the care environment it is essential to ensure the safety of:

- the person involved in the incident;
- the other persons in care on the unit; and
- the staff.

Optimally, one staff member who has received formal training, has had experience in dealing with these kinds of behavioural emergencies, and is familiar with the person in question should take the lead in attempting to de-escalate the situation. Other staff should remain in proximity until advised otherwise in case the incident escalates.

Ensuring the safety of all persons means making sure that any risks to the person or others involved in or around the incident are minimized. This would include taking action to:

- produce a quiet and calm environment;
- ensure a safe space free of objects that could be potentially used as weapons; and
- prepare a space that is away from areas of heavy traffic or gatherings of other staff or care recipients.

If possible, the person involved in the incident should be moved to a quieter room or an open space and should be kept in this space until the incident de-escalates. If the person cannot be moved, other staff and care recipients should be moved to another area away from the person in question. If environmental changes cannot occur, attempt to remove any objects that could cause harm to the person or potential victims (for example, chairs, tables, glass, pens or pencils, syringes).

Step 2: Interventions to prevent or de-escalate immediate threats or actions of violence

Once immediate precautions are taken, interventions to prevent or de-escalate immediate threats or actions of violence should be implemented in the least coercive and least aggressive way possible. Below are some examples of de-escalation techniques.

- Verbal approaches, such as "talk-down" interventions, are intended to make the person feel understood in terms of his or her negative emotions and feelings.
- Expressions of sympathy and understanding will often shift the person's attention away from his or her anger and distress. With this shift in attention and resulting relaxation, the motor component of the violent or aggressive behaviour becomes less severe.

- Noncoercive behavioural approaches emphasizing calm and non-threatening speech and body language (for example, keeping distance, talking with calm voice, avoiding crossing arms or putting hands on hips) can also be used.
- Attempting to establish a therapeutic alliance i.e. acknowledging his or her distress and reminding him or her that staff are there to help. With this approach, it is often helpful to bring the clinician who knows the person best into the interaction. This clinician who has already established a therapeutic relationship with the person may be better able to de-escalate the situation.

Step 3: Interventions to halt actions of violence or aggressive behaviour

If the behaviour continues to escalate and de-escalation is ineffective, interventions to halt actions of violence or aggressive behaviour may be needed. Staff that has been involved in attempting to de-escalate the situation must immediately withdraw from the vicinity and an emergency code should be called.

An emergency code (for example, "code white") is usually called over the loudspeaker system in the facility, summoning security staff and personnel from adjacent services to attend the unit or place where the person is located. Until extra personnel have arrived, the person should be contained in the particular space with exits blocked. When the summoned staff has arrived at the scene, a team leader must be identified. Who is chosen as team leader will vary from facility to facility and may depend on circumstances, knowledge of the person, or organizational policy. Usually, if security staff has ultimate responsibility for these kinds of incidents, the team leader will be selected from among the security staff in attendance. The team leader's role is to gather as much information as possible about the events including event triggers and background information on the person and, with the team, develop a plan for managing the situation including assignment of roles to the team.

According to least restraint principles, the first option the assembled team would consider would be continued attempts at de-escalation. However, at the team's discretion, some procedure (for example, chemical restraint/acute control medication, physical restraint, seclusion) may be used. These kinds of acute control procedures should only be considered and deployed if all other strategies, such as de-escalation, have been attempted and failed. Please refer to Safety in the Use of Restraints section of *PSEP-Canada Module 13d: Mental Health Care: Seclusion and Restraint: When All Else Fails* for more information.

Step 4: Incident documentation

If an organization has not already done so, reporting tools including standardized report forms for violence and aggressive behaviour incidents should be developed (could be called a Patient Safety Reporting Form: Violent or Aggressive Behaviour). The form

should be completed by a staff member overseeing the care of the person who may have witnessed or been involved in the incident. If no immediate staff members caring for the person were involved in or witnessed the incident then documentation should be completed in consultation with persons involved in or who witnessed the incident. If no standardized form exists, then documentation should be made directly in the person's clinical record. The account of the incident should be narrative and include as much detail as possible. The narrative may be organized into headings such as the following:

- the date, time, and location of the incident;
- all persons involved in the incident:
  - the person,
  - victims or intended targets of the behaviour (if any), and
  - persons involved in the incident response or management (those involved in escalation or control interventions);
- the person's activity prior to the onset of the behaviour (e.g., conversation with someone, watching TV, in an organized group);
- issues that were perceived to trigger the event (from the person's account as well as witnesses);
- methods of behaviour expression (e.g., physical abuse, verbal abuse);
- degree of intent (did the person express an interest in harming other people or objects?);
- interventions attempted and implemented to manage the behaviour (including those that may have been unsuccessful);
- outcome of each behaviour management intervention (behaviour decreased, escalated, or no change to behaviour); and
- details about the consequences of the behaviour, such as:
  - no consequences, behaviour abated,
  - person was restrained,
  - injury to the person or others, and
  - property damage.

In addition to being recorded in the person's clinical record, a copy should also be shared with the quality and risk management or review team.

Step 5 – Incident review

A thorough review of any incident of violence or aggressive behaviour should occur following the de-escalation of the beahviour. The review should be carried out by an incident or quality review team established within the organization and should take place in collaboration with the care team and, whenever possible, the person.

The incident review process enables an exploration of:

- what happened;
- why it occurred; and

- what can be done to prevent it from happening again.

For incidents of aggressive behaviour or violence, the incident review process evaluates a number of factors to try to determine which contributed to the behaviour in order to make recommendations for prevention or improvement. The evaluation process includes the steps below.

- **Determination of the type and nature of violence or aggressive behaviour.** The type of behaviour that was exhibited by the person provides initial insights into the underlying factors contributing to the onset of the incident.
- **Talking to the victim of harm, if any.** The victim is not to blame in these situations. Instead, this person may be able to identify specific triggers that precipitated the event. This information can be used in future care planning with the person and for education with others.
- **Talking to the person about what he or she feels triggered the behaviour.** This discussion should maintain an empathetic approach towards understanding distress rather than a blaming or punitive tone.
- **Talking to other witnesses to the behaviour.** Others may be able to provide an objective observation of events leading up to the behaviour.
- **Review if the behaviour was related to symptoms of mental or physical illness.** It may be that the person is experiencing new or unrecognized symptoms that are causing distress and agitation.
- **Review the behaviour response process.** A review of the process to ensure safety, de-escalate, manage, and halt the behaviour is needed to ensure that all policies and procedures were followed and that the safety, rights, and dignity of the person and others was considered throughout the process.

Quality improvement

As outlined in the Introduction module, quality improvement is a multi-step process. However, specific to violence and aggressive behavior, quality improvement begins by aligning organizational policies with recommended best practice and care standards. Existing policies should be reviewed for currency and relevance. The review should include an examination of how the policy addresses risk assessment for violence or aggressive behaviour (i.e., the nature and timing of assessment), care for persons at risk, and procedures for management of violence or aggressive behaviour.

A number of indicators can also be monitored against which of the impact of quality improvement initiatives can be measured. For example, at the unit and organizational levels, the aggregate prevalence, incidence, and improvement rates of violence and aggressive behaviour can be monitored over standard intervals (e.g., monthly, quarterly). These indicators can help healthcare providers establish the magnitude of violence or aggressive behaviour within the service setting as well as patterns of behaviours over different periods of time. Identified patterns can then be used to develop targeted quality

improvement initiatives as well as to evaluate outcomes following improvement initiatives.

Another indicator that could be monitored is the rates of restraint and seclusion room use. High rates of restraint use may indicate that a review of organizational policy or an increase in staff education in the management of violence or aggressive behaviour is necessary.

Summary

Violence and aggressive behaviour occur in persons with mental illness for a variety of reasons. The challenge for organizations dealing with this patient safety issue is the identification of individual triggers keeping in mind that culture and previous trauma may influence how care may be received. Trained staff is key to prevention and quality improvement processes. Training should provide detailed de-escalation interventions, least-restraint behaviour management techniques and behaviour emergency response protocols, all of which should emphasize the importance of maintaining dignity and respect for the person.

Potential pitfalls

- Failing to perform a thorough assessment of person level and environmental factors, due to staff training, that may contribute to risk of violence or aggressive behaviour.
- Not recognizing the person and his/her family as part of the care team when plans to mitigate and prevent risk are being developed.
- Failing to adopt least restraint procedures in managing behaviours.

Pearls

- Leveraging approaches to care such as recovery oriented care and trauma informed care, that are based on respect, empathy and non-judgment, is the norm in the organization.
- Thorough risk screening that identifies potential triggers is an essential element of a global mental health assessment.
- Behaviourial emergencies should be managed using least restrictive approaches with all other interventions being attempted before restraints are implemented.

Toolkits & outcome measures

Risk Assessments for Acute Violence to Third Parties: A Review of the Literature: Ferris, L.E., Sandercock, J., Hoffman, B., Silverman, M., Barkun, H., Carlisle, J., Katz, C., (1997). *Canadian Journal of Psychiatry*, 42, 1051–1060

interRAI Risk of Harm to Others Scale and Clinical Assessment Protocol: Hirdes JP, Curtin-Telegdi N, Mathias K, Perlman C, et al.. interRAI Mental Health Clinical Assessment Protocols (CAPs) for use with community and hospital-based mental health assessment instruments. Version 9.1. Washington, DC: interRAI, 2011. http://catalog.interrai.org/

Predicting Inpatient Assaults using the interRAI-MH Risk of Harm to Others Clinical Assessment Protocol: A Tool for Risk Assessment and Care Planning: Neufeld, E., Perlman, C.P., & Hirdes, J.P., *Journal of Behavioural Health Services and Research*, (2012) 39, (4): 472 - 480

The Overt Aggression Scale for the objective rating of verbal and physical aggression: Yudofsky SC, Silver JM, Jackson W, Endicott J, Williams D.. *Am J Psychiatry*. 1986 Jan;143(1):35-9.

Short Term Assessment of Risk and Treatability (START): Webser, C.D., Martin, M.L., Brink, J., Nicholls, T., Desmarais, S. (2009). Manual for the Short-Term Assessment of Risk and Treatability (START) (Version 1.1). Port Coquitlam, Canada: B.C. Mental Health & Addiction Services. www.bcmhas.ca/Research/Research_START.htm

The Violence Risk Appraisal Guide: Harris, G.T., Rice, M.E., & Camilleri, J.A. (2004). Applying a forensic actuarial assessment (the Violence Risk Appraisal Guide) to nonforensic patients. .*Journal of Interpersonal Violence*, 19, 1063-1074.

Resources

- Allen MH, Currier GW, Hughes DH, Reyes-Harde M, & Docherty JP. (2001). *The Expert Consensus Guideline™: Treatment of Behavioral Emergencies. A Postgraduate Medicine Special Report.* The MGraw-Hill Companies, Inc. www.psychguides.com/Behavioral%20Emergencies.pdf
- National Institute for Clinical Excellence (2005). *Violence: The short-term management of disturbed/violent behavior on psychiatric in-patient setting and emergency departments: Nice guideline.* http://www.nice.org.uk/Guidance/CG25
- National Institute of Mental Health in England. *Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings.* http://www.teamteach-tutors.co.uk/guidance/documents/NIMHE%20guidance%20feb04.pdf
- Nijman HL. A model of aggression in psychiatric hospitals. *Acta Psychiatr Scand Suppl.* 2002;(412):142-3.

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Duxbury J, Whittington R. Causes and management of patient aggression and violence: staff and patient perspectives. *J Adv Nurs*. 2005 Jun;50(5):469-78.

Ferris LE, Barkun H, Carlisle J, Hoffman B, Katz C, Silverman M. Defining the physician's duty to warn: consensus statement of Ontario's Medical Expert Panel on Duty to Inform. *CMAJ*. 1998 Jun 2;158(11):1473-9.

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Linaker OM, Busch-Iversen H. Predictors of imminent violence in psychiatric inpatients. *Acta Psychiatr Scand*. 1995 Oct;92(4):250-4.

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Owen C, Tarantello C, Jones M, Tennant C. Violence and aggression in psychiatric units. *Psychiatr Serv*. 1998 Nov;49(11):1452-7.

Rocca P, Villari V, Bogetto F. Managing the aggressive and violent patient in the psychiatric emergency. *Prog Neuropsychopharmacol Biol Psychiatry*. 2006 Jun;30(4):586-98.

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Soliman AE, Reza H. Risk factors and correlates of violence among acutely ill adult psychiatric inpatients. *Psychiatr Serv*. 2001 Jan;52(1):75-80.

Steadman HJ, Mulvey EP, Monahan J, et al. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Arch Gen Psychiatry*. 1998 May;55(5):393-401.

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World Health Organization. *World report on violence and health: Summary*. Geneva: World Health Organization; 2002.

Principal message

The single most important message your audience should come away with is the various factors that impact a person's risk for violent and aggressive behavior and that the mental health team should be trained in assessment and prevention of this risk. As a part of this insight, the participant should come away with key elements of a strategy that can be implemented by a unit or organization to promote a safe care environment.

Module overview

Mental health patients are vulnerable to the risks associated with violence and aggressive behavior as both victims and perpetrators. In inpatient environments in particular, violence and aggressive behaviour create a significant safety risk not only for staff and other persons, but for the person exhibiting the behavior. This module focuses on the person and environmental factors that may contribute to the risk of violence and aggressive behaviours among persons with mental illness and proposes that least restraint approaches should be the framework within which intervention and treatment should be developed. Risk factors for violence and agression can be identified using risk assessment tools and the information used to inform treatment planning and intervention. Any interventions should first ensure the personal safety of staff and the person, followed by attempts to de-escalate the behaviour using calm, talk-down approaches with the person. In all instances prevention includes environment of care considerations, proper training for all staff, and an empathetic and understanding care culture.

This module reviews best practices related to risk assessment and prevention of violent and aggressive behaviour with an emphasis on de-escalation and a culture of least restraint.   Specifically, this module will discuss the difference between violence and aggressive behaviour as well as how environmental factors contribute to risk of violence and aggressive behaviour. In addition, the role of the mental health team and the processes for reviewing incidents of violence and aggressive behaviour are also discussed. Lastly, strategies to identify person-level risk factors for violence and aggressive behaviour, considerations for preventing violence and aggressive behaviour, and techniques for dealing with current incidents of violence or aggressive behaviours are covered by this module.

This module is designed to be taught in tandem with *PSEP-Canada Module 13d: Mental Health Care: Seclusion and Restraint: When All Else Fails*.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

Allow sufficient time to collect participants' demographic data and complete the pre-test.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Presentation	35 minutes
Debrief about teaching methods	5 minutes
Summary	2-3 minutes
Post-test & Evaluation	5 minutes
Total	49-51 minutes

3. Number of slides: 15

4. Preparing your presentation

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The syllabus text and slides in the **Participant's Handbook** were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be

used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- **PSEP - Canada Front Cover Page**;
- **PSEP - Canada Acknowledgment Pages** (to acknowledge the source of the material);
- syllabus and slides for **your topic**; and
- appendix material as relevant.

6. Equipment needs

- Projector and screen
- Computer and monitor
- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your video segments to assess which trigger tapes or portions you would like to use.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the video fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, you can refer to the hand out slides; and
- if flipcharts and markers are not available, you can have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience, yet cover your chosen material within the time. You can use as your interactive components the trigger tape stimulated discussion and an interactive exercise. To foster discussion, ask participants for examples from their institutions or experiences. Ideally, the examples could be linked to one of the major teaching points.

Alternative style: case-based teaching

Use a case you are familiar with to include some case-based teaching. To help participants feel involved and invested, you may invite them to give you a case from their institution or experience. However, it is usually best to return to the case you know to draw out analytic points for teaching since you do not need to 'think on your feet' too much.

5. Key take-home points

1. The majority of mental health patients neither display aggressive behavior nor are violent.
2. It is important to avoid equating risk of violence or aggressive behavior as a personal feature; rather it should be clear that it is a feature of the condition.
3. There are two categories of factors that contribute to increased risk and therefore incidents of violence and aggressive behavior namely; person level risk factors and external to the person factors.
4. It is critical to recognize the person and his/her family as part of the care team when plans to mitigate and prevent risk are being developed.
5. It is important to leverage client centred approaches to care such as recovery oriented care and trauma informed care, which are based on respect, empathy and non-judgment.
6. Behaviourial emergencies should be managed using least restrictive approaches with all other interventions being attempted before restraints are implemented.

6. Summarize the discussion

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

7. Debrief about the teaching method

Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods

would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

8. Post-test/evaluation

Ask the participants to complete the post-test questions for this module and evaluate the session.