

Reducing the Use of Seclusion and Restraint:

A National Initiative toward Culture Change and Transformation

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Reducing the Use of Seclusion and Restraint:

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Outline

- Historical Overview
- Current Knowledge/Theories
- Understanding the S/R Process
- *Six Core Strategies for S/R Reduction*©
- Developing a S/R Reduction Plan
- Closing Comments

NTAC S/R Training Pre/Post Data (NRI, 2003)

- 5 of 8 hospitals reduced hours of restraint,
- 5 of 7 reduced hours of seclusion,
- 7 of 8 had fewer consumers restrained,
- 6 of 7 had fewer clients secluded,
- 5 of 7 had fewer restraint events,
- 6 of 6 had fewer seclusion events.

(HSRI Fast Facts, 2004)

NTAC S/R Training Pre/Post Data (NRI, 2003)

- The data also showed that S/R hours were reduced by as much as 79%, the proportion of consumers in S/R was reduced by as much as 62%, and the incidents of S/R events in a month were reduced by as much as 68%.

(HSRI Fast Facts, 2004)

Current Knowledge

- The reduction and elimination of S/R is *possible*
- MH Facilities through country have reduced use considerably without additional resources or increase injuries (MH, DD, CO, DOJ, SA (kid))
- This effort **does *take*** tremendous leadership, commitment, and motivation

Current Knowledge

- Reducing S/R requires a ***different way*** of looking at the people we serve and the staff who serve them
- Although there is no ***one way*** to do this, best practice core strategies have been identified

Current Know

- The reduction of seclusion and restraint requires and can result in a **CULTURE CHANGE** that will transform our mental health systems.
- For this to happen we need to “change the way we do business”

Facilitating Culture Change in MH

The New Freedom Commission

- A Call for System Transformation
- System Goal=Recovery for everyone
- Services/supports are consumer, child/family centered
- Focus of care must increase consumer's ability self manage illness and build resiliency
- Individualized Plans of Care critical
- Consumers and Children/Families are full partners

(NF Commission, 2003)

Reducing S/R is a cornerstone to creating recovery oriented SOC

- Changes our worldview and language
- Improves safety for staff and customers
- Teaches respect and negotiation skills
- Moves from focus on control to one of partnership and empowerment
- Creates warm environments
- Facilitates trust in treatment
- Avoids re-traumatization

What are the Culture Change Constructs for Reducing S/R?

- Public Health Prevention Approach
- Principles Facilitating Recovery
- Trauma Informed Care
- Consumers (adults, children/families) and staff self-reports valued
- Leadership theory

The Public Health Prevention Model

Brief Overview

- The Public Health Approach is a model of disease prevention and health promotion and is a logical fit with a practice issue such as S/R
- This approach I.D.'s contributing factors and creates remedies to prevent, minimize and remedy the problem if it occurs
- It reconciles our focus on “safer use” to preventing use in the first place

The Public Health Prevention Model

- Primary Prevention (Universal Precautions)
 - Interventions that create environments that avoid conflict by anticipating risk factors
- Secondary Prevention
 - Interventions designed to immediately respond to and resolve conflicts when they occur
- Tertiary Prevention
 - Interventions used post S/R designed to mitigate effects, analyze the event and take corrective action

Recovery Principles

Brief Overview

- Goal of the NF Commission:
Transformation to Recovery Based SOC
 - Individuals can recover and have a meaningful life in their communities
 - Focused on adults to date but concepts apply to kids (resiliency)
 - Primary concepts include the avoidance of labeling, offer hope and promote a highly individualized, inclusive treatment process
 - **SOC that facilitate recovery avoid coercion**

Principles of Trauma Informed Systems of Care Brief Overview

- Definition: Behavioral Health Care that is grounded in and directed by:
 - a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and
 - knowledge of the prevalence of these experiences in children and adults who receive public BH services. *(NASMHPD, 2005; Jennings, 2004)*

Exposure to Trauma

Mental Health Population

- 90% of public mental health clients have been exposed

(Muesar et al., in press; Muesar et al., 1998)

- Most have multiple experiences of trauma

(Ibid)

- 34-53% report childhood sexual or physical abuse

(Kessler et al., 1995; MHA NY & NYOMH 1995)

(Ibid)

Exposure to Trauma

Substance Abuse Population

- 97 % of homeless women with SMI/SA have experienced severe physical and sexual abuse - 87% experience this abuse both as children and as adults *(Goodman et al., 1997)*
- Up to 2/3 of people in SA treatment report childhood abuse or neglect *(CSAT, 2001)*
- 90% of female ETOH addicts were sexually and/or physically abused as children *(Miller, 1994)*

Trauma in American Children

- 3.9 million adolescents have been victims of serious physical assault, and almost 9 million have witnessed an act of serious violence

- *(Kilpatrick et al., 2001)*

- In 1998, 92% of incarcerated girls reported sexual, physical or severe emotional abuse in childhood

- (DOC, 1998)*



Key Principles

Trauma Informed Care Systems

- Integrate philosophies of care that guide all clinical interventions
- Are inclusive of the survivor's perspective
- Are informed by research and evidence of effective practice
- Recognize that coercive interventions cause traumatization and re-traumatization and are to be avoided

(Fallot & Harris, 2002; Ford, 2003; Najavits, 2003)

Key Features

Trauma Informed Care Systems

- Recognition that the majority of mental health staff are uninformed about trauma and its sequelae, and do not recognize its significance in their daily work

(Fallot & Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al.; Jennings, 1998; Prescott, 2000)

Staff Experiences of Seclusion and Restraint

Male direct care staff:

I've been injured from time to time. Nothing severe. Yeah, sometimes I get headaches. I get shaky.

Staff Experiences of Seclusion and Restraint

“One of the things that doesn’t get talked about very much is the trauma of the staff. We talk about the trauma paradigm for our clients or people in recovery. But not very often in my 20 years of work in the field of mental health have I heard much about what happens to us, the workers and I think that’s an area where we need to do some work. I’ve seen some pretty traumatic things from when I first started 20 years ago. Some of those things still haunt me that I’ve seen.”

- female direct care staff

(Jorgenson, in press)

See how we speak...

- De-humanizing labeling and language of conflict:
 - Target populations, line staff, “in the trenches”, “take downs”, aggression control
 - Units, wards, lock ups, lock downs, “in the field”, surveillance, strip search, curfews
 - Schizophrenics, the mentally ill, borderlines, non-compliant, manipulative, attention seeking, patients, cases,

Staff need to know *Why* they are reducing S/R?

- To be consistent with our mission to promote dignity, autonomy, respect and recovery
- To improve the safety of our persons served and our staff
- To avoid causing trauma or re-enacting traumatic experiences
- To instill a culture of caring, collaboration and partnership vs. one of coercion and control

Know why you are reducing Seclusion & Restraint?

To at least

- *Do No Harm...*

How do we reduce S/R use?

- TO START: *Develop a S/R Reduction Action Plan*

Action Plan Essential Framework

- ✓ Prevention-Based Approach
- ✓ Continuous Quality Improvement Principles
- ✓ Individualized for the Facility or Agency
- ✓ **Know the culture you wish to create**

Adopt *Six Core Strategies* ©

- ***Leadership*** Toward Organizational Change
- Use ***Data*** To Inform Practices
- Develop Your ***Workforce***
- Implement ***S/R Prevention Tools***
- Actively recruit and include ***consumers, children and families***
- Make ***Debriefing*** rigorous

1st Core Strategy: Leadership

I. Leadership Toward Organizational Change

- Mandatory Component ***
- Create the Vision/Philosophy
- Clarify Values
- Develop the Plan
- Develop Champions
- Reward Excellent Practice

1st Core Strategy: Leadership Key Strategy

Elevate oversight of all S/R Events

- Called “Witnessing”
- Refers to 24-7 off site executive level on call response (by phone) to each event
- Demonstrates importance of event
- Executive role is to ask “ Why” questions
- Assigns new responsibilities to all staff

2nd Core Strategy: Use of Data

II. Use Data To Reduce Use

- Gather baseline data by event/hours (6 m to 1 yr)
- Set realistic goals
- Gather other core data by unit/day/shift/time/age/dx/gender/race/individuals involved/MD/DOA
- Post on units monthly

2nd Core Strategy: Use of Data

Use Data To Reduce Use

- Monitor Progress
- Discover new best practices
- Identify emerging S/R champions
- Target certain units/staff for training
- Create healthy competition
- Assure that everyone knows what is going on

3rd Core Strategy: Workforce Development

III. Determine Workforce Development Activities

❖ Integrate S/R Reduction in HRD Activities

- New Hire procedures
- Job Descriptions and Competencies
- Performance Evaluations
- New Employee Orientation
- Annual Reviews

3rd Core Strategy: Workforce Development

❖ Staff will require education on key concepts:

- Common Assumptions about S/R
- Experiences of Staff and Consumers with S/R
- The Neurobiological/Psych Effects of Trauma
- Creating Trauma Informed Systems and Services
- Principles of Recovery
- Building non-coercive relationships
- Use of S/R Reduction Tools (violence, death/injury, de-escalation, trauma etc)

4th Core Strategy: S/R Tools

IV. Review and Implement S/R Prevention Tools

- Risk for Violence and S/R Use
- Trauma Assessment – Risk history
- Risk for Death and Injury
- Use of Safety Plans- identify triggers/preferences

4th Core Strategy: S/R Tools

Review and Implement S/R Prevention Tools

- Use of comfort/sensory rooms
- Use of Language
- Building Relationships
- Training Guidelines (De-escalation models)
- Effective Treatment Activities

5th Core Strategy: Full Consumer Inclusion

V. Consumer/Family Inclusion

- Inclusion-MAKE IT HAPPEN!
- Clarify Roles for All
- Value Information Transparency
- “Nothing about us without us”

5th Core Strategy: Full Consumer Inclusion

Child/Family and Consumer Inclusion in S/R Action Plan, at all levels

- Hire ex-consumers/family members as staff members, appoint volunteers
- Allow access to information
- Use to interview people post-event
- Attend meetings-all levels
- Empower participation (age dependant)

6th Core Strategy: Debriefing

VI. Debriefing Specifics

- Define What Debriefing Is and What it is Not
- Implement both types of Debriefing
 - ✓ Acute- immediate post event response
gather info, manage milieu
 - ✓ Formal- rigorous problem solving

6th Core Strategy: Debriefing

- Debriefing is not a small meeting of staff involved that is designed to reassure staff that they did everything they could
- It is a rigorous problem analysis of why something happened
- Requires courage, honesty, an ability to objectively look at self and others behavior
- And a safe environment in which to talk

Understanding The S/R Process

(can be used to guide debriefing)

Step 1: Has a treatment environment been created where conflict is minimized (or not)?

Step 2: Could the trigger for conflict (disease, personal, environmental) have been prevented (or not)?

Step 3: Did staff notice and respond to events (or not)?

The S/R Process

Step 5: Did Staff choose an effective intervention (or not)?

Step 6: If the Intervention was unsuccessful was another chosen (or not)?

Step 7: Did Staff order S/R only in response to imminent danger (or not)?

Step 8: Was S/R is applied safely (or not)?

The S/R Process

Step 9 : Was the Individual monitored safely (or not)?

Step 10: Was Individual released ASAP (or not)?

Step 11: Did Post-event activities occur (or not)?

Step 12: Did Learning occur and was it integrated into the tx plan and practice (or not)?

Seclusion/Restraint Reduction Final Comments

- Lowering the risk of S/R use can occur at almost every step
- Focus on Prevention and Improved Safety
- The strategies outlined here are designed to assist in implementing a culture change that reduces use, mitigates harm and promotes safety for all.
- An important cornerstone toward changing to recovery based SOC

Seclusion/Restraint Reduction Final Comments

- S/R Reduction is a **Leadership responsibility**
- Develop a facility specific **Action Plan**
- **Learn and revise plan** as you implement
- **Change is challenging** and takes time
- Consumers, children, families and advocates know a lot, **learn from them**
- **Need to share lessons learned-other SOC**

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