Preventing Violence, Trauma and the Use of Seclusion and Restraint in Mental Health Settings

U.S. Initiative to Reduce Conflict, Coercion and S/R in Mental Health Settings:

Setting the Stage for Change

Kevin Ann Huckshorn PhD, RN, CADC

State Director: Delaware

Past Director: National Technical Assistance Center, NASMHPD

Brief Historical Overview National S/R Reduction Initiative

- 1998: Hartford Courant Series
- 1999: US Congress and Government Accountability Report
- 2001: HCFA Federal Rules Change
- 2001: States ask for help…
- 2007: CMS Final Rule
- 2002: NASMHPD Training Model created
- 2003: New Freedom Commission supports work
- 2005-2013: Research Supports Effectiveness
- 2012: Six Core Strategies© approved by NREPP=EBP

(NAPHS Success Stories 2003; Murphy/Davis, 2005; Sullivan et al., 2005; Barton et al., 2009; Lewis et al., 2009; Barton et al., 2009; Hardy et al., 2011; Azeem, 2011; Ashcraft et al, 2012; Huckshorn, 2013)

Brief Historical Overview
Largest US S/R Reduction Study (2000-Present)

- **1st federal SR SIG Research Project**
  - 2004: 8 State Incentive Grants to identify alternatives to reduce use (HI*, IL, KY*, LA*, MA*, MD*, MO, WA)
  - Data analyzed by a Cambridge Univ. Evaluation Center and a group of consumer expert researchers
  - **Results support Six Core Strategies as effective evidence-based practices**

Background of Study (continued)

- Facilities started at different levels of implementing alternatives to seclusion and restraint.
- Facilities' readiness/willingness or ability to adopt alternatives to seclusion and restraint was not investigated.
- Only facilities that implemented the 6 Core Strategies and reached stabilization were included in final data

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Data Collected

Table 1: Outcomes variables included in the analysis

Outcome Variable		Definition
Seclusion	1. Seclusion hours per 1,000 treatment hours	Hours of seclusion as a proportion of all treatment hours in the pre and stable phase.
	2. Percent of consumers secluded	Proportion of all individuals in the facility during the pre and stable phase who had a seclusion event.
Restraint	3. Restraint hours per 1,000 treatment hours	Hours of restraint as a proportion of all treatment hours in the pre and stable phase.
	4. Percent of consumers restrained	Proportion of all individuals in the facility during the pre and stable phase who had a restraint event.

Analysis/Statistical Strategy (continued)

Table 3: Number and percent of facilities by implementation phase at the end of the grant period (n=43).

	a. Implementation Phase	b. # of Facilities	c. % of Facilities
1.	Never Implemented	2	4.7%
2.	Implementing, Did not Stabilize	7	16.3%
3.	Stable Implementation	28	65.1%
4.	Implementation followed by a Decreased	5	11.6%
5.	Implementation followed by Discontinuation	1	2.3

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Summary

- Interventions for the reduction of the use of S/R ***were successful*** in reducing the use of S/R.
- Of the 28 facilities that reached stable implementation:
  - 71.4% (n=20) reduced seclusion hours per 1,000 treatment hours;
    - On average, seclusion hours per 1,000 treatment hours were reduced by 19%.
  - 71.3% (n=20) reduced the percent of consumers secluded;
    - On average, the percent of consumers secluded was reduced by 17%.

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SUMMARY (CONTINUED)

- Of the 28 facilities that reached stable implementation:
  - 53.6% (n=15) reduced restraint hours per 1,000 treatment hours;
    - On average, restraint hours per 1,000 treatment hours were reduced by 55%.
  - 57.1% (n=16) reduced the percent of consumers restrained;
    - On average, the percent of consumers restrained was reduced by 30%.

Important Observations:

- States where the state Department of Mental Health were involved achieved most significant successes:
  - **MA – 11 hospitals**: 65% ↓ episodes; 48% ↓ patients restrained;
  - **IL – 9 hospitals:** 48% ↓ duration; 28% ↓ persons restrained; 50% < seclusions)
- Hospitals receiving on-site consultation at least 3 x over 3 yrs reduced most:
  - **MA – 2 hospitals**: 93.5% & 96.9%;
  - **IL – 1 hospital**: from 10 episodes R/S per 1,000/pt days to 2.79)

Other Data

- There were 0 reports of increased injuries from any site.
- The significant success of this first study provided more than enough evidence to apply for an evidence-based practice for reducing SR use
- A big step in changing the US threshold for what is called “usual or customary” practice; used to measure minimum acceptable practices, and
- Successful hospitals all demonstrated significant changes in core beliefs and values that directed fundamental practice changes

We *know* what works to prevent and reduce S/R

- We know that the prevention of conflict and reduction of S/R **is *possible in all mental health settings***
- We know that facilities throughout the US have reduced use considerably without additional resources
- We know that this effort ***takes*** tremendous leadership, commitment, and motivation by all involved

Framing the Issue

- A change such as reducing SR use requires a **CULTURE CHANGE** in mental health treatment settings that results in far more than just reducing S/R *(Huckshorn, 2006; 2013)*

- This 'Culture Change' includes taking a look at how you [staff] interact with clients, what skills your staff have, and recovery, resiliency and transformation principles

- Best practice core strategies have been identified

- However, system wide change is slow and difficult… for many reasons…

A Vision of Mental Health: The Future in the U.S…?

- Families and former clients are employed in every setting and up to 50% of staff
- Treatment planning is directed by the customer (adult, child, adolescent and family), whenever possible, and when not possible chosen surrogates serve to assist
- Conflict/Violence has been reduced by 90%
- Staff language is always “person-centered and non-discriminatory”
- Treatment settings are “sanctuaries”
- Evidence-based practices (EBP) are the norm, including non-coercion, standards for use of meds, cons/family education, and a treatment focus on illness self-management

Development of the 6CS Curriculum to Reduce the Use of S/R

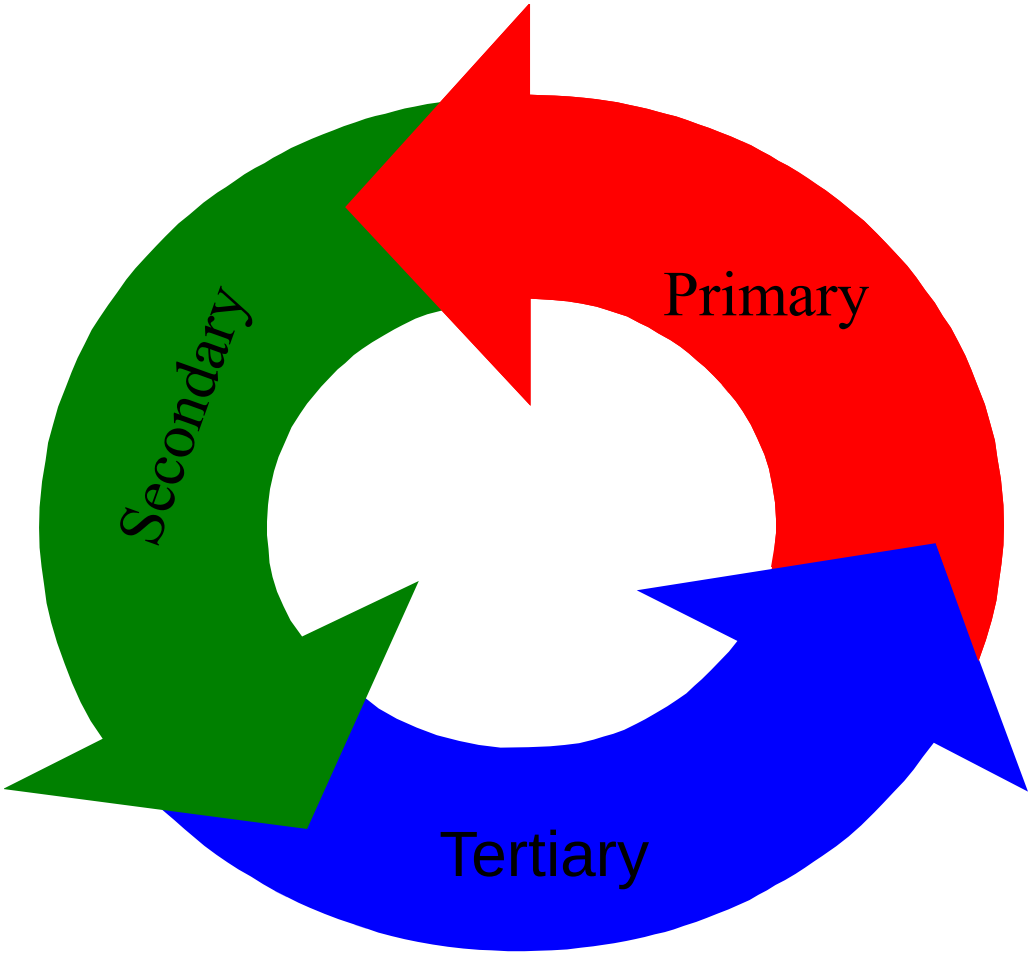
- Ongoing Review of Literature
- Faculty: Best practice information emerged from personal and direct experiences in successful reduction projects across the country
- Service Users/Staff: Personal experiences describe what these events feel like, both *to be restrained* or participate as staff in these events
- Focus Groups held in 2001-2002 plus literature
- Core strategies emerged in themes over time

CORE BELIEFS PROVIDED A FOUNDATION FOR THE 6CS CURRICULUM (THEORETICAL MODEL)

- **Leadership** Principles for effective change
- The **Public Health Prevention** approach
- **Recovery/Resiliency** Principles
- Valuing **Consumer/Staff Self Reports**
- **Trauma Knowledge** operationalized
- Staying true to **CQI Principles** (the ability of staff to be honest and take risks to assure that we learn from our mistakes)

(Anthony & Huckshorn, 2008; IOM, 2005; New Freedom Report, 2003; NASMHPD Med Directors SR Report, 1999)

Public Health Prevention Model



The Public Health Prevention Model

- The Public Health approach is a model of disease prevention and health promotion and is a logical fit with a practice issue such as reducing use of S/R/using TIC in practice

- This approach identifies contributing factors and creates remedies to prevent, minimize and/or mitigate the problem if it occurs

- It refocused us on prevention while maintaining safe use

(NASMHPD Medical Directors S/R Series (1), 1999)

The Public Health Prevention Model applied to S/R Reduction

- Primary Prevention (Universal Precautions)
  - Interventions designed to prevent conflict from occurring at all by anticipating pop risk factors (e.g. hand washing, vaccinations, condoms)
- Secondary Prevention (Selected Interventions)
  - Early interventions to minimize and resolve more specific risk factors when they occur to prevent S/R use (e.g. clean needle exchanges, osteoporosis prevention)
- Tertiary Prevention (Indicated Interventions)
  - Post S/R interventions designed to mitigate effects, analyze events, take corrective actions, and avoid reoccurrences (e.g. meds for diabetes, hypertension, cancer)

Trauma-Informed Care

- Emerging science based on high prevalence of traumatic life experiences in people we serve

  (Muesar et al, 1998)

- Says that traumatic life experiences cause mental health or other problems or seriously complicate these, including treatment resistance

  (NETI, 2005; IOM, 2005; Felitti et al, 1998)

- Systems of care that are trauma-informed recognize that coercive or violent interventions cause trauma and are to be avoided
- Universal precautions required *(NASMHPD Med Dir, 1999)*

Trauma-Informed Care

- TIC is both a philosophy and includes specific activities
- TIC is the umbrella over everything we do going forward IF you want to adopt this approach
- Concepts are not complicated; Implementation is as it runs directly into most everything we have been trained to do
- TIC is provided in a transdisciplinary model when no team member is higher then anyone else and the customers voice is the MOST IMPT!
- Hospitals cannot function in silos anymore.

Moving On… The Six Core Strategies© to Prevent Violence and S/R (NREPP, 2013)

1) ***Leadership*** Toward Organizational Change
2) Use ***Data*** To Inform Practices
3) Develop Your ***Workforce***
4) Implement ***S/R Prevention Tools***
5) Full inclusion of ***service users (Peers)and families in all activities***
6) Make ***Debriefing*** rigorous

New Research on Violence Causality and Role of the Environment

- Violence in mental health settings has been blamed on the "patient" for years
- Hundreds of studies done on patient demographics and characteristics
- Findings are variable and inconclusive
- More recently, studies have looked at the role of the environment in violence, including staff interaction patterns

(Duxbury, 2002; Richter & Whittington, 2006; Johnstone & Cooke, 2007; Huckshorn, 2013)

Snapshot of 6CS©

- What follows is attempt to distill a two day training into a one + hour presentation
- This work is in the public sector and is free to read
- We strongly encourage you to not try and train this work if you do not have trainers that have done this work first hand
- Considering that many research studies have demonstrated effectiveness, many of us are hoping that CMS will again revise their Conditions of Participation, on SR use, to include these findings
- However, with Healthcare Reform "looming" and the expectation that services and supports are mostly evidenced based we also hope that the customer service drivers will also continued change

6CS #1: Leadership Sets Clear Goals Based on a Vision or Policy Goals

- These Goals:
  - Are clear and unambiguous
  - Specifies S/R use only for “safety in response to imminent danger to self or others, time limited, and all events analyzed to prevent use in future” (Performance Improvement)
  - Includes statement of agency’s expressed goal to reduce/eliminate and why
  - Links reduction with agency philosophy of care and expressed values
  - Includes significant staff training on new way of viewing conflict and violence

6CS # 1: The Power of Leadership

- The power of Leadership in creating change is mostly within the leaders **control**
- **But leaders need to use their power…**
- Used ineffectively, or not at all, it becomes the **major barrier** in any effective organizational change
- Leadership (on all levels) is considered the most important and fundamental resource in any project that seeks organizational change

(Anthony, 2004; Anthony & Huckshorn, 2008; Huckshorn, 2013)

6 CS #1: Fundamental Principle for Leaders: *Creating A Vision*

1) **The essence of Effective Leadership is the ability to motivate one's staff to action around a shared vision. In this case:**

- Toward "preventing" conflict, coercion and violence that results in the use of seclusion/restraint
- Creating non-violent and non-coercive treatment cultures
- Implementing a trauma-informed systems of care that feel safe and warm to customers

(Anthony & Huckshorn, 2008; Huckshorn, 2013)

6CS #1: Principles of Leaders
Valuing Exemplary Performance

Effective Leaders build their organization around exemplary performers:

- Best practices are recognized and rewarded
- Efforts are made to encourage reports of near misses and what worked
- Knowledge is transferred and sustained in policy, procedures, and practices
- Staff are involved in Performance Improvement around these issues

(Anthony & Huckshorn, 2008; Huckshorn, 2013)

6 CS #1: Effective Leaders develop a formal plan and approach to reducing S/R

- This work needs to start with a clear and documented "**Prevention of Conflict "Goal"**
- Needs to include Performance Improvement Principles (CQI) where constant work is occurring to analyze events and attempt to eliminate these triggers
- Needs to create a Facility/Unit Accountable Team
- Needs to be inclusive of person served

The harm that is still being perpetrated on people in inpatient mental health facilities is still widely pervasive

(Anthony & Huckshorn, 2008; NASMHPD, 2012)

6 CS #2: Using data to Inform Practice

- Providers need Data To Identify & Analyze Events by:
  - Unit/Day/Shift/Time of day, Average Duration
  - Age/Gender/Race
  - Date of admission/Diagnosis
  - Attending Physician
  - Pattern of individual staff involved in events
  - Number of Grievances, by provider
  - Precipitating Events, by event
  - Safety issues justifying seclusion/restraint was the only response and why

6 CS #2: Using data to Inform Practice

- Provider Leaders must use data to:
  - Monitor Hospital or Agency Progress
  - Discover new best practices in-house
  - Identify emerging staff S/R champions
  - Target certain units/staff for training
  - Create healthy competition (e.g.PA, MA)
  - Assure that everyone knows what is going on

(NASMHPD, 2012)

6 CS # 3: Workforce Development

- Staff need to get training on the following high risk issues that is evidence based.
- **Aggression & Violence Risk**

  Identify risks for aggression or violence in order to prevent the use of seclusion or restraint (S/R)
  - Individual, environmental, & situational risk factors
- **Medical/Physical Risk**

  Assess and understand medical risks when S/R is used to reduce the possibility of serious injury and/or death
- Prone restraint restrictions
- Knowledge of known medical issues (asthma, obesity…) We can never know all the risks in S/R use.

6 CS # 3: Workforce Development

Staff need to be informed about the three models on violence:

1) Patient characteristics (blame the patient…)
2) Environmental factors e.g. “triggers”
3) Situational: a combination of the above

- The situational model has been the most useful in understanding the violence that leads to S/R use
- Attention to only the “patient” or only the “setting” ignores this multi-dimensional relationship and the variables that inter-relate to lead to conflict

6 CS # 3: Workforce Development

- Situational risk factors are those negative or sometimes neutral features of a healthcare (or other setting) where the violence takes place
- These factors include the setting's violence levels, organizational and management structures, leadership styles, policies, the physical environment, quality and skills of staff, quality of life factors, and treatment interventions *(Megargee, 1982; Mohr, 2000; NASMHPD, 2012, Huckshorn, 2013))*

Promoting Risk Interventions by Situational Management *(Johnstone & Cooke , 2007)*

- The *key goal* here is to prevent the risk of conflict and violence, as without that, neither seclusion or restraint are likely to occur.
- As leaders in this effort it is going to be your challenge to investigate these issues and come up with strategies to help your staff to do this prevention work.

6 CS # 3: Workforce Development

- I do not have time to present all these studies that hold important info for staff. Suffice to say this research should drive what we do in inpatient settings for person's with mental illnesses.
- In fact, the lack of knowledge of this research puts everyone at risk.

(Johnstone & Cooke, 2007; Folger et al, 1995; Megargee, 1982; Rosenhan, 1973; Morrison, 1989; Okin, 1985; *Fisher, 1994; Petti, Mohr, & Somers, 2001*; *Duxbury, 2002; Ryan, Hart, Messick, Aaron, & Burnette, 2004; Robins, Sauvageot, Suffoleta-Maierle, & Frueh, 2005; O'Brian & Cole*, 2004; *National Executive Training Institutes, 2005; May, Grubbs, & Binder, 2000; Stefan, 2006; Morrison, 2001, 1998, 1992, & 1989; Lanza et al, 1994; Hodas, 2004; Chou, Lu, & Mao, 2002; Nijman & Rector, 1999; Lanza et al, 1994; Lalemond, 2004; Mohr, Petti, & Mohr, 2003; Paterson et al, 2003; Tracy, Donnelly, & Stultz, 2002; Morrison, 2002; Mohr, Petti, & Mohr, 2003; Parkes, 2000; Mohr & Mohr, 2000; NAPHS, 2003, Huckshorn, 2013.*

6 CS # 4: Specific Prevention Strategies

Why Are They Used?

- To help consumers during the earliest stages of escalation before a crisis erupts
- To help consumers identify coping strategies before they are needed
- To help staff plan ahead and know what to do with each person if a problem arises
- To help staff use interventions that reduce risk and trauma to individuals

6CS #4 Prevention Tools

Essential Crisis Plan Components:

- Triggers [A=Antecedents]
- Early Warning Signs [B=Behaviors]
- Strategies [C=Calming Interventions]

Simple Right? The ABCs of Conflict Resolution!

No, not *that* Trigger …

Trigger, Roy Rogers' Horse

6CS #4 Prevention Tools

These Triggers

- A trigger is something that sets off an action, process, or series of events (such as fear, panic, upset, agitation)
- Also referred to as a “threat cue” such as:
  - Bedtime
  - Feeling shamed
  - room checks
  - large men
  - yelling
  - people too close

More Triggers: *What makes you feel scared or upset or angry and could cause you to go into crisis?*

- Being told NO!
- Not being listened to
- Lack of privacy
- Feeling lonely
- Darkness
- Being teased or picked on
- Feeling pressured
- People yelling
- Arguments
- Being isolated
- Being touched
- Loud noises
- Not having control
- Being stared at
- Room checks
- Contact w/family

6CS #4: Prevention Tools

Second, Identify *Early Warning Signs*

Early Warning Signs

What might you or others notice or what you might feel just before losing control?

- Clenching teeth
- Wringing hands
- Bouncing legs
- Shaking
- Crying
- Giggling
- Heart Pounding
- Singing inappropriately
- Pacing
- Eating more
- Breathing hard
- Shortness of breath
- Clenching fists
- Loud voice
- Rocking
- Can’t sit still
- Swearing
- Restlessness
- Other _____

6CS #4: Prevention Tools

Third, Identify ***Strategies*

6CS #4: Prevention Tools
Calming Strategies

- Strategies are individually-specific calming mechanisms to manage and minimize stress, such as:
  - time away from a stressful situation
  - going for a walk
  - talking to someone who will listen
  - working out
  - lying down
  - listening to peaceful music

Calming Strategies

What are some things that help you calm down when you start to get upset?

- Reading a book
- Pacing
- Coloring
- Hugging a stuffed animal
- Taking a hot shower
- Deep breathing
- Being left alone
- Talking to peers
- Therapeutic Touch, describe _____
- Exercising
- Eating
- Writing in a journal
- Taking a cold shower
- Listening to music
- Molding clay
- Calling friends or family (who?)

If a person is getting agitated – don't forget to use **HALT**

ARE THEY…

H ungry?

A ngry?

L onely?

T ired?

If it prevents
just one
restraint or seclusion,
it is worth it!

Noble Hospital, Westfield, Ma
Screensaver – staff reminder

Common Attributes of Each Prevention Plan

- Reflects the person's trauma history
- Uses available environmental resources
- Encourages staff & client creativity
- Incorporates sensory interventions
- ***Needs of the individual supercede the rules of the institution***

Sensing A Change

- Understand sensory experience, modulation & integration
  - Incorporate knowledge of sensory input and expertise of Occupational Therapy
  - Assess the ***sensory diet*** of each person-served
  - Identify *sensory-seeking* & *sensory-avoiding* behaviors
- Adapt the physical environment & develop sensory rooms/spaces to respond to differing sensory needs

(Champagne, 2003)

Sensory Input

The 5 well-known senses & 2 "*hidden*" senses

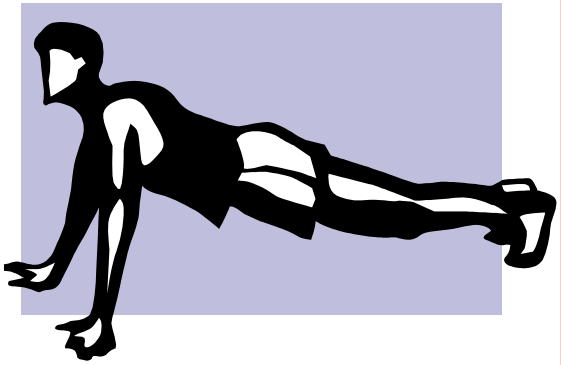
- How we ***feel*** is directly impacted by information received through the different senses:

1. Sight
2. Sound
3. Smell
4. Touch
5. Taste
6. Proprioception
7. Vestibular input

6CS #4: Prevention Tools

Sensory-based Approaches

- **Grounding physical activities**:
  - holding
  - weighted blankets – vests, blankets
  - arm & hand massages
  - push-ups
  - “tunnels”/ body socks
  - walk with joint compression
  - wrist/ankle weights
  - aerobic exercise
  - sour/fireball candies



6CS #4: Prevention Tools
Sensory-based Approaches

- **Calming self-soothing activities:**
  - hot shower/bath
  - wrapping in a heavy quilt
  - decaf tea
  - rocking in a rocking chair
  - beanbag tapping
  - yoga
  - drumming
  - meditation

Calming & Grounding Alternatives

A converted seclusion room now offers:

- a cuddle swing
- rock climbing wall
- Velcro wall &
- mini-trampoline

Everett House, Boston, MA

Fort Lauderdale Hospital ~ “The Fishbowl”
Children’s Unit

Western State Hospital

Tacoma, WA

6 CS # 5: Full Inclusion of Peers and Families in change processes

New Freedom Commission

The New Freedom Commission… "called for the complete inclusion of consumers and family members as providers, advocates, policymakers, and full partners in creating their own plans of care."

So did the SG report (1999) and IOM report (2002/2005) and the lit since mid 1990's)

(*The President's New Freedom Commission on Mental Health*, 2003)

DEFERRING TO BB WHEN I AM DONE. For 5th Core Strategy. She is the expert here.

6 CS # 6: Rigorous Debriefing
Definition of Debriefing

- A stepwise tool designed to rigorously analyze a critical event, to examine what occurred and to facilitate an improved outcome next time (manage events better or avoid event).

(Scholtes et al, 1998)

Debriefing Questions

- Debriefing will answer these questions:
  - Who was involved?
  - What happened?
  - Where did it happen?
  - ***Why did it happen?***
  - ***What did we learn?***

(Cook et al, 2002; Hardenstine, 2001)

Debriefing Goals

1) To reverse or minimize the negative effects of the use of seclusion and restraint.

- Evaluate the physical and emotional impact on all involved individuals

- Identify need for (and provide) counseling or support for the individuals (and staff) involved for any trauma that may have resulted (or emerged) from the incident.

(Massachusetts DMH, 2001; Huckshorn, 2001; Cook et al, 2002; Hardenstine, 2001; Goetz, 2000)

Debriefing Goals

2) To prevent the future use of seclusion and restraint.

- Assist the individual and staff in identifying what led to the incident and what could have been done differently.

- Determine if all alternatives to seclusion and restraint were considered.

(Massachusetts DMH, 2001; Huckshorn, 2001; Cook et al, 2002; Hardenstine, 2001; Goetz, 2000)

Debriefing Goals

3) To address organizational problems and make appropriate changes.

- Determine what organizational barriers may exist to avoiding seclusion and restraint in the future.

- Recommend changes to the organization's philosophy, policies and procedures, environments of care, treatment approaches, staff education and training.

(Massachusetts DMH, 2001; Huckshorn, 2001; Cook et al, 2002; Hardenstine, 2001;Goetz, 2000)

Formal Debriefing

- Include a broader group of people
  - Mandatory attendance by clinical lead, other treatment members, executive staff representative (champion), consumer advocates
  - Encourage adult, child, family involvement (independent session or formal meeting)
  - Peers now serve in “debriefer roles” in many facilities *(Huckshorn, 2013; NASMHPD, 2012)*

And Finally…

Blame, guilt, second-guessing… Staff need to understand…

- We have all used S/R as we were trained and as we understood
- I do not much differentiate between use of SR and involuntary med administration that often includes use of restraint
- All I ask is that you have an “open mind” and accept that **research drives knowledge that changes practices**
- I ask you to have the courage to “change” because our field will not survive health care reform if we do not…And in terms of ***coercive practices*** it is the right thing to do for the people we serve

Martin Luther King, Jr. said:

"Violence is the language of the unheard…"

The people we serve are the "unheard"

The "attention seeking" 12 year old and the "manipulative" 37 year old

I think this profound statement fits into this work.

Last

- Destiny is not a matter of chance; it is a matter of choice. It is not a thing to be waited for, it is a thing to be achieved.”
  — William Jennings Bryan

THANK YOU VERY MUCH!

Contact Information

Kevin Ann Huckshorn PhD, RN, CADC

302-255-9398 (Office)

Kevinurse@gmail.com