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

Preventing Conflict, Violence and the use of Seclusion/Restraint

November 8, 2010

Kevin Ann Huckshorn RN, MSN, CADC, ICRC

DE Director, Division of Substance Abuse and Mental Health (DSAMH)

Objectives

Attendees will:

1) Receive an overview of the National Initiative to prevent violence and SR use,

2) Understand the rationale and philosophy underlying this work,

3) Be introduced to the Six Core Strategies© that have proven effective in preventing violence and seclusion/restraint use in MH and other settings

Brief Historical Overview
National S/R Reduction Initiative (2000-2010)

- Hartford Courant newspaper Series (1998)
- GAO Report for Congress (1999)
- NASMHPD S/R Reports (1999-01)
- National SR Rule changes (1999, 2000)
- NASMHPD Training Curriculum created (2002)

Brief Historical Overview
National S/R Reduction Initiative (2000-2010)

- **National SR Reduction Project**
  - FY 2004: 8 State Incentive Grants to identify alternatives to reduce use (HI, IL, KY, LA, MA, MD, MO, WA)
  - 3 year grant on best practice applications
  - Data analyzed by HSRI (MA Evaluation Center) and a group of consumer expert researchers
  - **Results support Six Core Strategies as new Evidence-based Practice**

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.

Preliminary Results

Data Collected (continued)

Table 2: ISRRI Dimensions (Domains & Sub-domains)

Domain	Sub-domain (n= number of items in the sub-domain)
I. Leadership	1. State Policy (n=6)
	2. Facility Policy (n=6)
	3. Facility Action Plan (n=4)
	4. Recovery Oriented Care (n=7)
	5. Trauma Informed Care (n=6)
	6. CEO (n=3)
	7. Medical Director (n=5)
	8. Non-Coercive Environment (n=4)
	9. Kickoff Celebration (n=2)
	10. Staff Recognition (n=1)
II. Debriefing	1. Immediate Post-Event Analysis (n=7)
	2. Formal Debriefing (n=19)
III. Use of data	1. Data Collected (n=14)
	2. Goal Setting (n=3)
IV. Workforce Development	1. Structure (n=3)
	2. Training (n=8)
	3. Supervision & Performance Review (n=5)
	4. Staff Empowerment (n=6)
V. Tools for Reduction	1. Implementation (n=4)
	2. Emergency Interventions (n=2)
	3. Environment (n=6)
VI. Consumer/Family/Advocate Involvement	1. Consumer Roles (n=4)
	2. Family Member Roles (n=5)
	3. Advocate Roles (n=4)
VII. Oversight/Witnessing	1. Elevating Oversight/Witnessing (n=4)

Preliminary Results

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

Preliminary Results

Figure 4: Example of a facility in the before implementation, implementing, and stable phase.

Facility 935: ISRRI Score
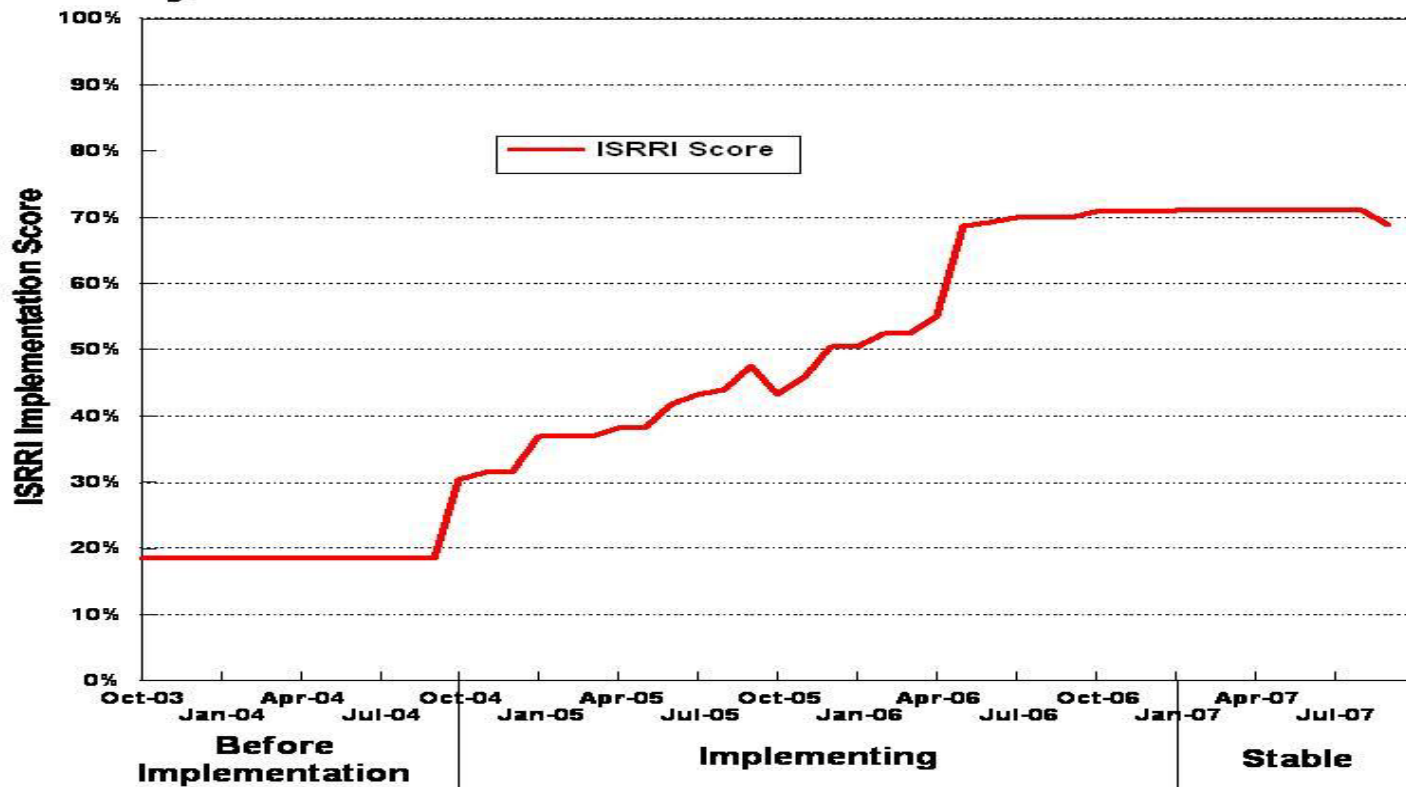
Preliminary Results

Summary

- Six Core Strategy© Interventions for the reduction of the use of S/R *were successful*

- Of the 28 facilities that reached stable implementation:

  - 20 facilities reduced seclusion hours (19%) and reduced the percent of consumers secluded (17%)

  - 15 facilities reduced restraint hours by 55% hours

  - 16 facilities reduced the percent of consumers restrained by 30%;

What this means?

- The significant success of this first study produced enough evidence to apply for an evidence-based practice for reducing SR use

- This research is a step in changing the threshold for what is called "usual or customary" practice that is used to measure minimum acceptable practices regarding SR

Lessons Learned

- 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 U.S. have reduced use considerably without additional resources

- We know that this effort ***takes*** tremendous leadership, commitment, and motivation

- Best practice core strategies have been identified

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 risk factors (e.g. hand washing, vaccinations, condoms)

- Secondary Prevention (Selected Interventions)
  - Early interventions to minimize and resolve conflicts 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 is a Key

- 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; 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 *(NETI, 2005)*

Consumer/Staff self-reports help change staff beliefs about SR

"The first time that I helped with a restraint, a four-point restraint, I walked out of the room in tears because it was one of the most horrible things I had ever seen."

(*female direct care staff*)

"The seclusion made me feel even more angry because it hurt me and made me worse. I would like staff to respond in a different way such as give you more options during the step before they act too quickly."

(Samantha Jones, age 14)

First step in prevention? Develop a Plan!

- TO START: Facility leaders must develop *a S/R Prevention/Reduction Action Plan*

Action Plan Framework

- ✓Prevention-Based Approach
- ✓Continuous Quality Improvement Principles
- ✓Individualized for the Facility or Agency
- ✓Adopt/adapt Six Core Strategies ©

The Six Core Strategies© to Prevent Violence and S/R

1) *Leadership* Toward Organizational Change

2) Use *Data* To Inform Practices

3) Develop Your *Workforce*

4) Implement *S/R Prevention Tools*

5) Actively recruit and include *service users and families in all activities*

6) Make *Debriefing* rigorous

Core Strategy #1
Leadership in Organizational Change

- The ***most important*** component in successful prevention and culture change projects.

- Only Leadership has the authority to make the changes that are necessary for success:
  - To *make violence prevention* a high priority
  - To *assure* for Reduction Plan Development
  - To *reduce/eliminate* organizational barriers
  - To *provide or re-allocate* the necessary resources, and
  - To hold people accountable for their actions

Core Strategy #1
Principles of Effective Leadership

- Create the Vision

- Live Key Values

- Develop your Human Technology

- Monitor Staff Performance

- Elevate Oversight of Untoward Events

- Assure Violence/S/R Prevention Plan Development *(Anthony & Huckshorn, 2008)*

Core Strategy #2
Using Data to Inform Practice

- Leaders and staff use information to drive change
  - Identify your definitions of violent events, S/R, imminent danger, reportable injuries, stat med use
  - Gather historical data by event/hours (6 months to 1 year) to use as baseline
  - Set realistic goals or 100% reduction
  - Post reports on units monthly
  - **Mandate data collection on S/R events, hours, stat meds, and consumer and staff injuries**

Core Strategy #3
Workforce Development

- Integrate S/R Reduction & Violence Prevention in Human Resource & Staff Development Activities
  - New Hire procedures
  - Job Descriptions and Competencies
  - Performance Evaluations
  - New Employee Orientation
  - Annual Reviews

New Findings on Violence Causality: Related to Strategy #3 Workforce

- 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)

Violence Causality

- Difficult problems require complex answers (even though we constantly search for simple ones…)

- Conflict and violence in inpatient MH settings is complicated and multi-factorial. "Human behavior does not occur in a vacuum…" *(Johnstone & Cooke, 2007, p. 9).*

- Many professionals now believe that most conflict in inpatient settings occurs as a direct result of staff to client interactions and staff attitudes

    (NETI, 2006)

Core Strategy #3
Workforce Development

- Leaders and staff will require education on key concepts:
  - Public Health Prevention Approach
  - Common Assumptions about S/R
  - Experiences of staff and adults/kids with S/R
  - The Neurobiological/psychological effects of Trauma
  - Roles of Consumers, Families and Advocates
  - *Basic Customer Service Skills*

Staff Education and Training

- – Creating Trauma-Informed Systems and Services
- – Principles of Recovery/Building Resiliency
- – Matching Interventions with Behaviors
- – Use of Prevention Tools (violence, death/injury, trauma, de-escalation, safety plans, environmental changes, language)
- – Roles in rigorous debriefing

Staff Education and Training

- Once Staff are trained in new knowledge the work does not stop

- Practice changes do not occur from training but from supervision and mentoring by supervisors

- Care must be based on respect, dignity, provision of choices, individual needs, personal attention, the development of a meaningful relationship, HOPE for a better life/outcomes

Core Strategy #4
Use Violence Prevention Tools

- Choose and Implement Violence and S/R Prevention Tools
  - Assess risk factors for violence and S/R use
  - Assess risk factors for death and injury
  - Implement a Universal Trauma Assessment
  - Use Safety Plans/Crisis Plans/Advance Directives to identify triggers/preferences

    (NETI, 2005)

Core Strategy #4
Use Violence/S/R Prevention Tools

- – Use of comfort rooms
- – Implement sensory rooms and sensory interventions
- – Incorporate Person First Language
- – Monitor Training Guidelines (De-escalation models)
- – Effective Treatment Activities*

(NETI, 2005)

Person First Language must be used in our settings…

- Many staff use 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

  – Emotional disturbed, schizophrenics, the mentally ill, borderlines, non-compliant, manipulative, attention seeking, cases, juvee

Person First Language

- Chosen language to use for recovery/resiliency oriented systems of care

- A major change/shift from usual language

- Is culturally competent, respectful and person-centered

- Based on linguistic philosophy i.e. "How we speak about something is indicative of how we value and treat it"

(IAPSRS, 2003)

Core Strategy #5
Full Customer/Advocate Inclusion

- Hire people in recovery, family members/community advocates as staff members, use volunteers

- Make information available

- Use to interview service user post-event

- Attend meetings - all levels

- Empower and support participation

Core Strategy #6
Make Debriefing Rigorous

- Definition of Debriefing

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

(Scholtes et al, 1998)

Debriefing Questions

- Rigorous debriefing answers these questions:
  - Who was involved?
  - What happened?
  - Where did it happen?
  - ***Why did it happen?***
  - ***What contributed to it happening***
  - ***What did we learn?***

(Cook et al, 2002; Hardenstine, 2001)

Debriefing Specifics

- Requires new policy & procedures

- Implement two types of Debriefing Activities
  - ✓ Acute - immediate post event response to gather info, manage milieu, assure safety

  - ✓ Formal - rigorous problem solving event with treatment team and consumer input, usually 24 hours later

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

Real Reduction Experiences
What Worked?

Examples of Individual Success Stories

Delaware Psychiatric Center

- Implemented the Six Core Strategy Model in 2008-09

- Focus was on reducing allowable hours for MD orders, eliminating restrictive rules, adding Peers, Debriefing, holding nurse managers accountable for unit behaviors, increasing documentation, removing security staff from process, replacing restraint use training model, and mandatory communication with administrator when use occurred.

Incidents of Seclusion and Restraint

	Restraint	Seclusion
2008	106	43
2009	26	39
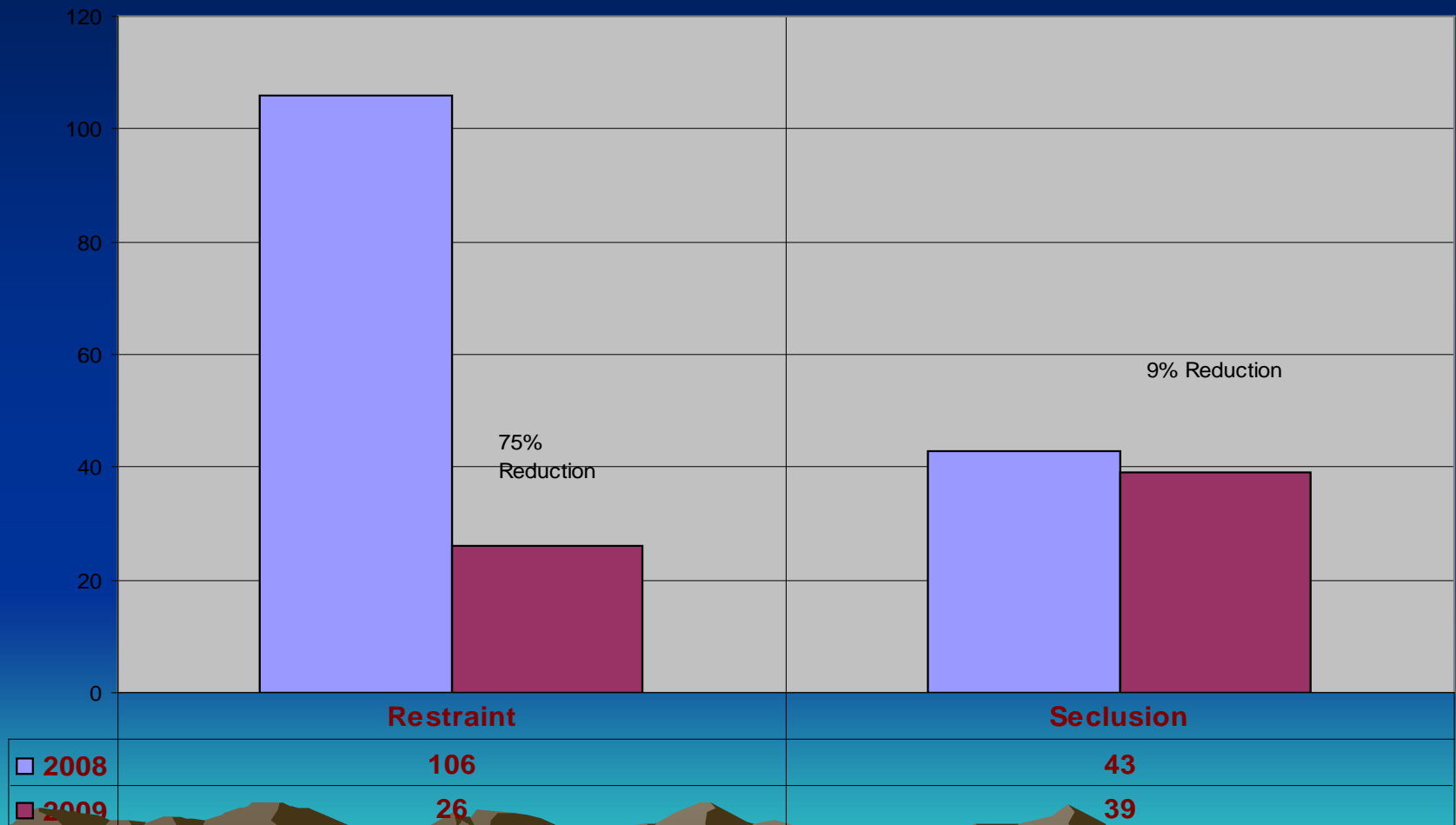
South Florida State Hospital
Essential Components

- Debriefing including root cause analysis and daily reports to Executive Management Group; non-punitive environment. Change in staff roles in crisis response (security, nursing, direct care staff).

- Supervisors responding to every incident; on call EMG member involved for oversight 24/7.

- Use of persons-served throughout project:
  - to interview residents and staff post-event
  - to make recommendations
  - to develop comfort rooms
  - to develop treatment activities

SFSH SR RESULTS
January 1999 - March 2004

TOTAL SECLUSIONS AND RESTRAINTS EVENTS (January 1999 - March 2004
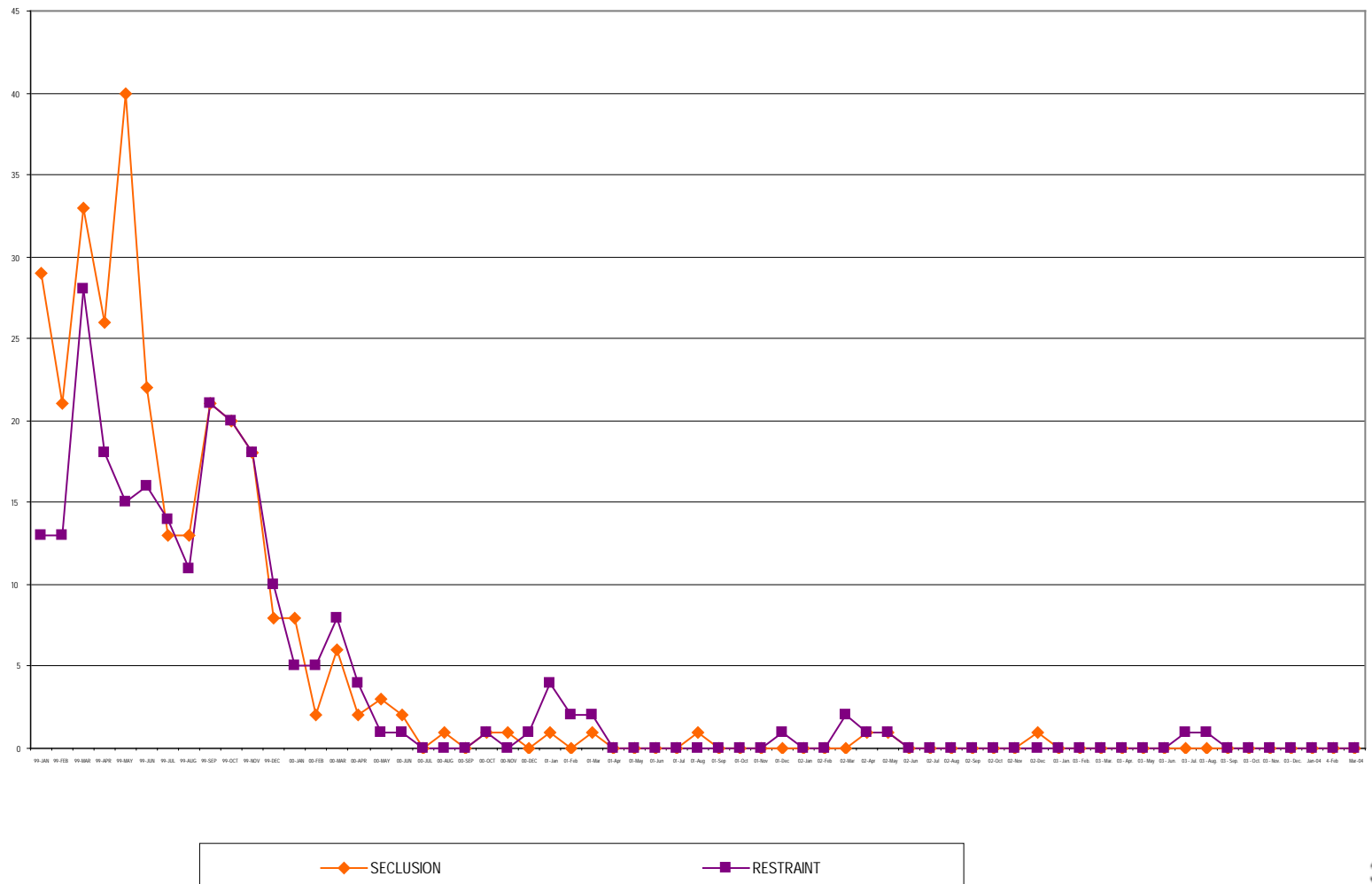
GEO/SFSH SR Summary
March 06 – February 07

- Geo Care/SFSH had an average of 7 restraint and seclusion events per year since March 02 and February 08. 96 % overall reduction/baseline

- Some of these events are duplicated.

- Injury rates related to S/R are almost flat, other injury rates have been reduced

Elgin Mental Health Services, Chicago Adult Hospital: Civil & Forensic NETI Training 2003; SIG 6/05

Essential Components:

- Development of formal plan
- Trauma-informed care, revision of unit rules
- Consumer council/full involvement
- Facility kick-off, staff training on prevention model, soothing rooms
- New policy/reduced hours
- Use of data/graphed & posted
- Staff Heart Awards/storytelling

Percent Client Restrained
*Percent of clients restrained at least once

2000 to 2005

41
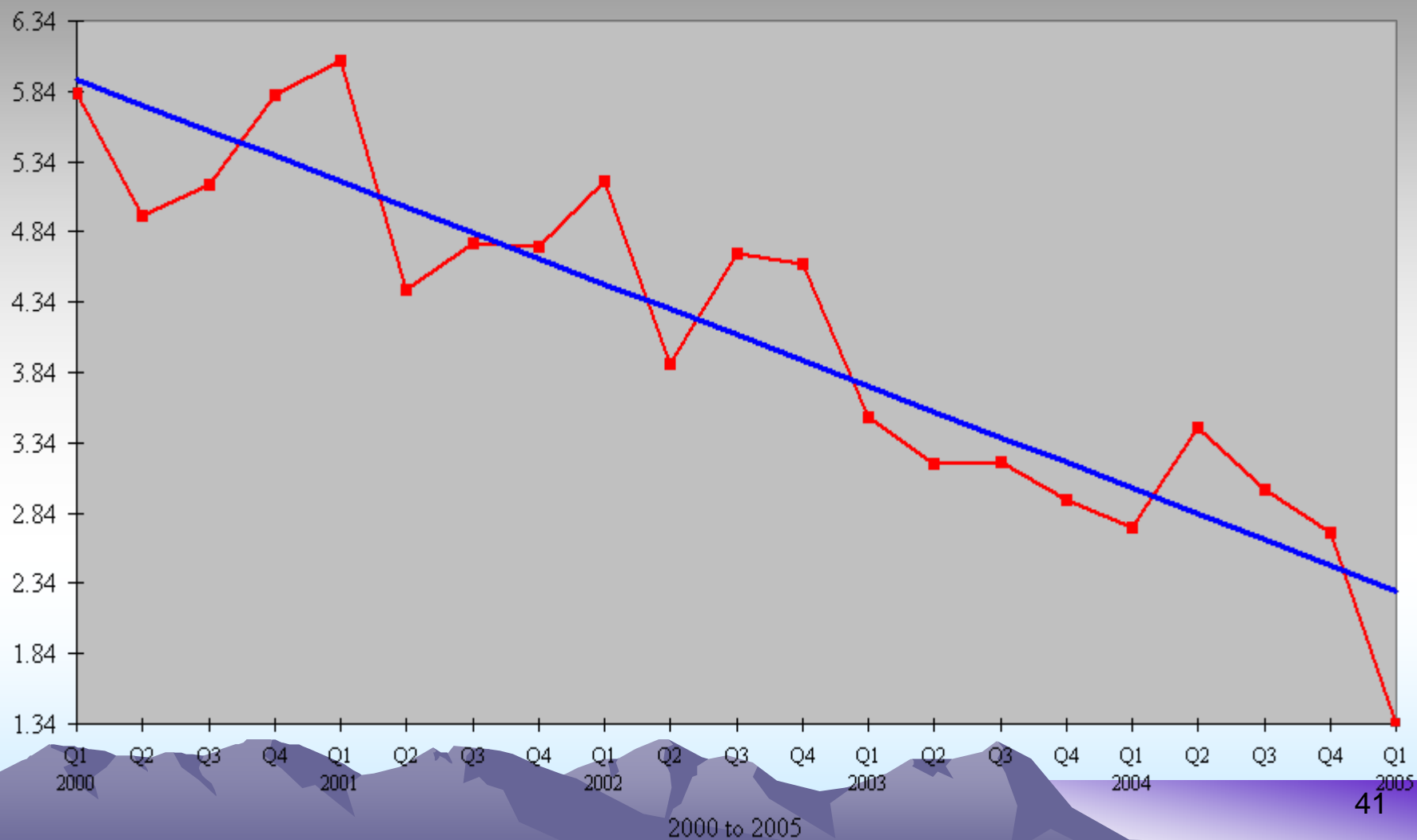
Percent of Clients Secluded
*Percent of clients secluded at least once

2000 to 2005
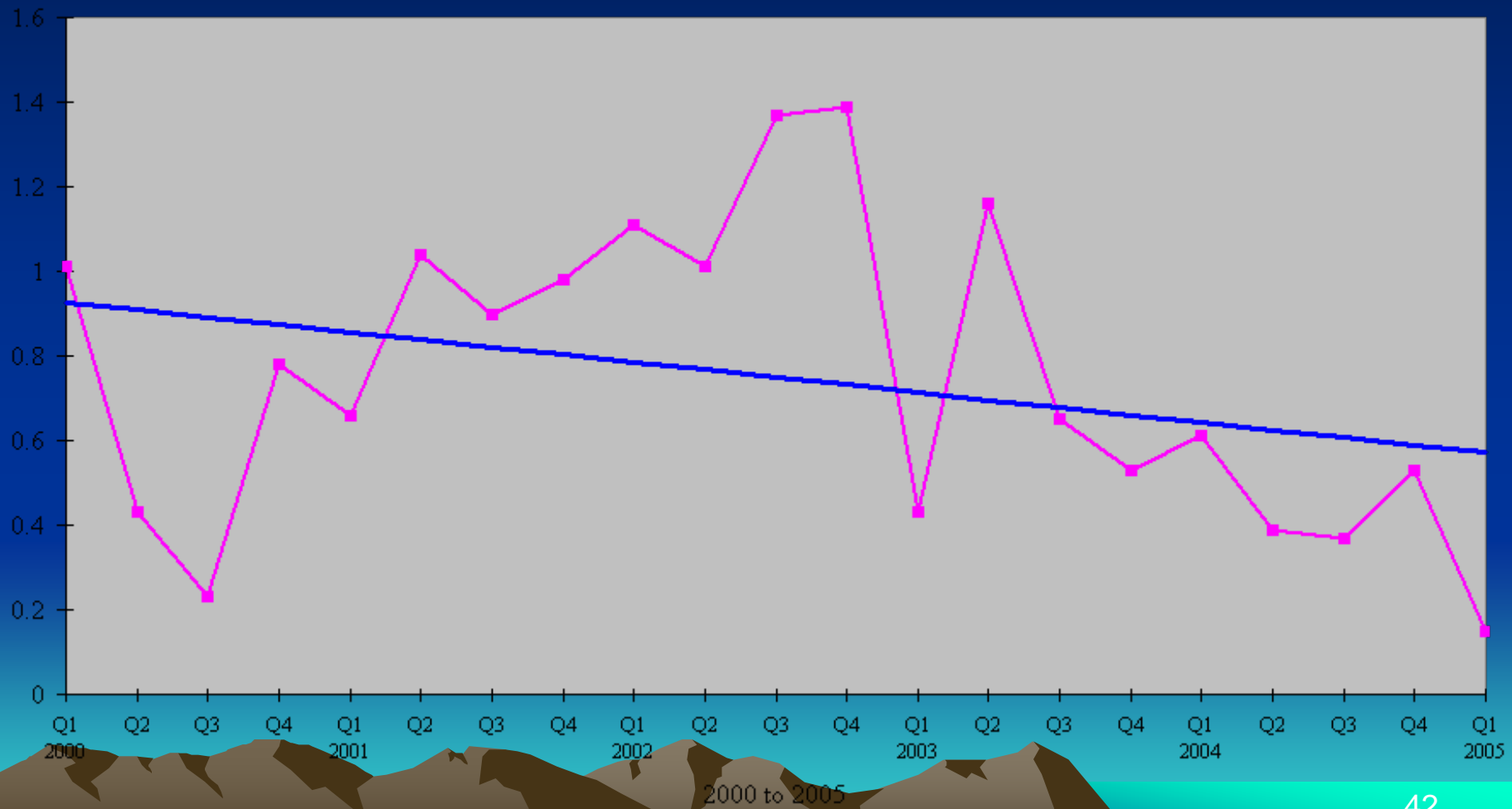
Restraint Hours
***Number of hours client spent in restraints per 1000 inpatient hours**
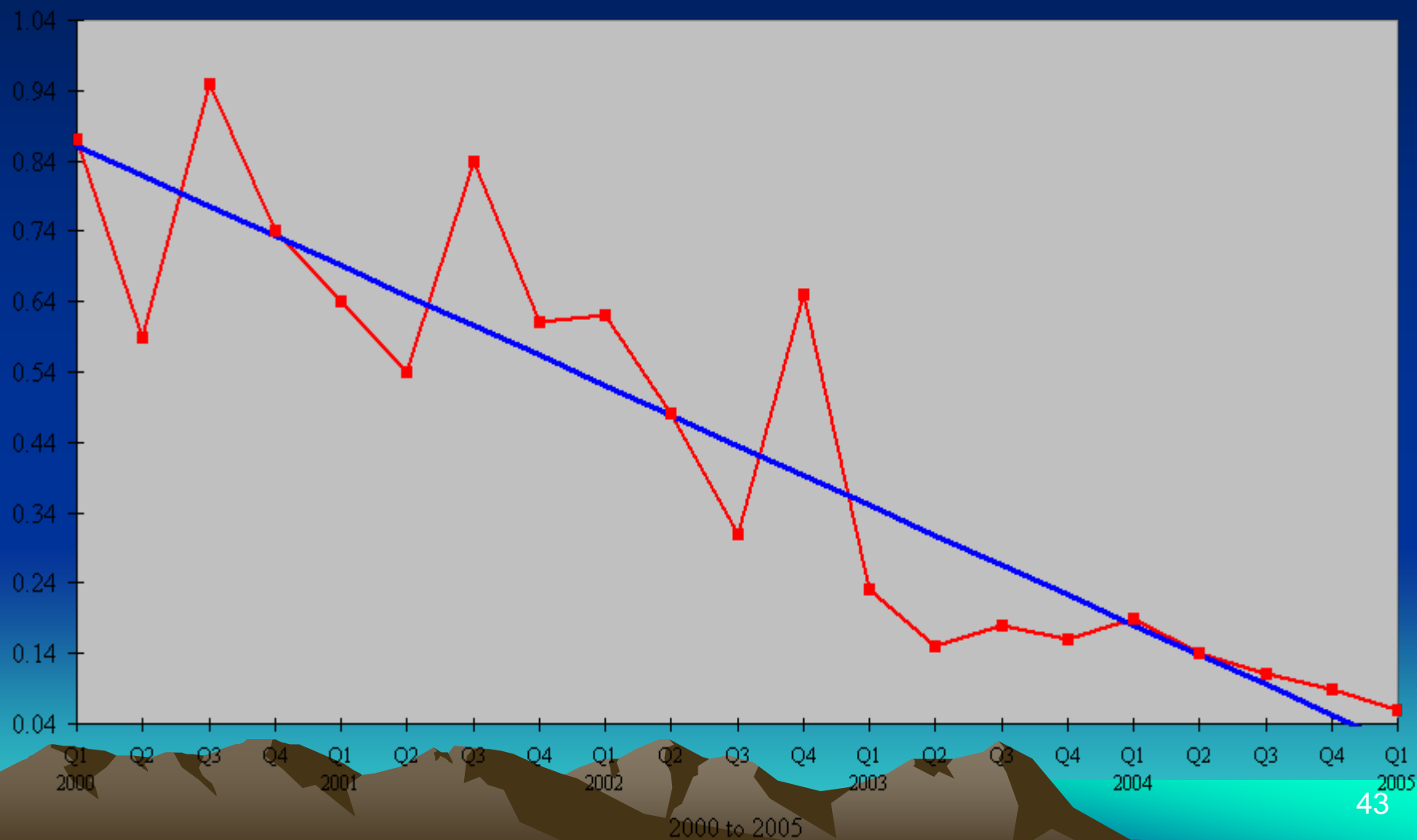
Seclusion Hours
*Number of hours spent in seclusion per 1000 inpatient hours

2000 to 2005

44
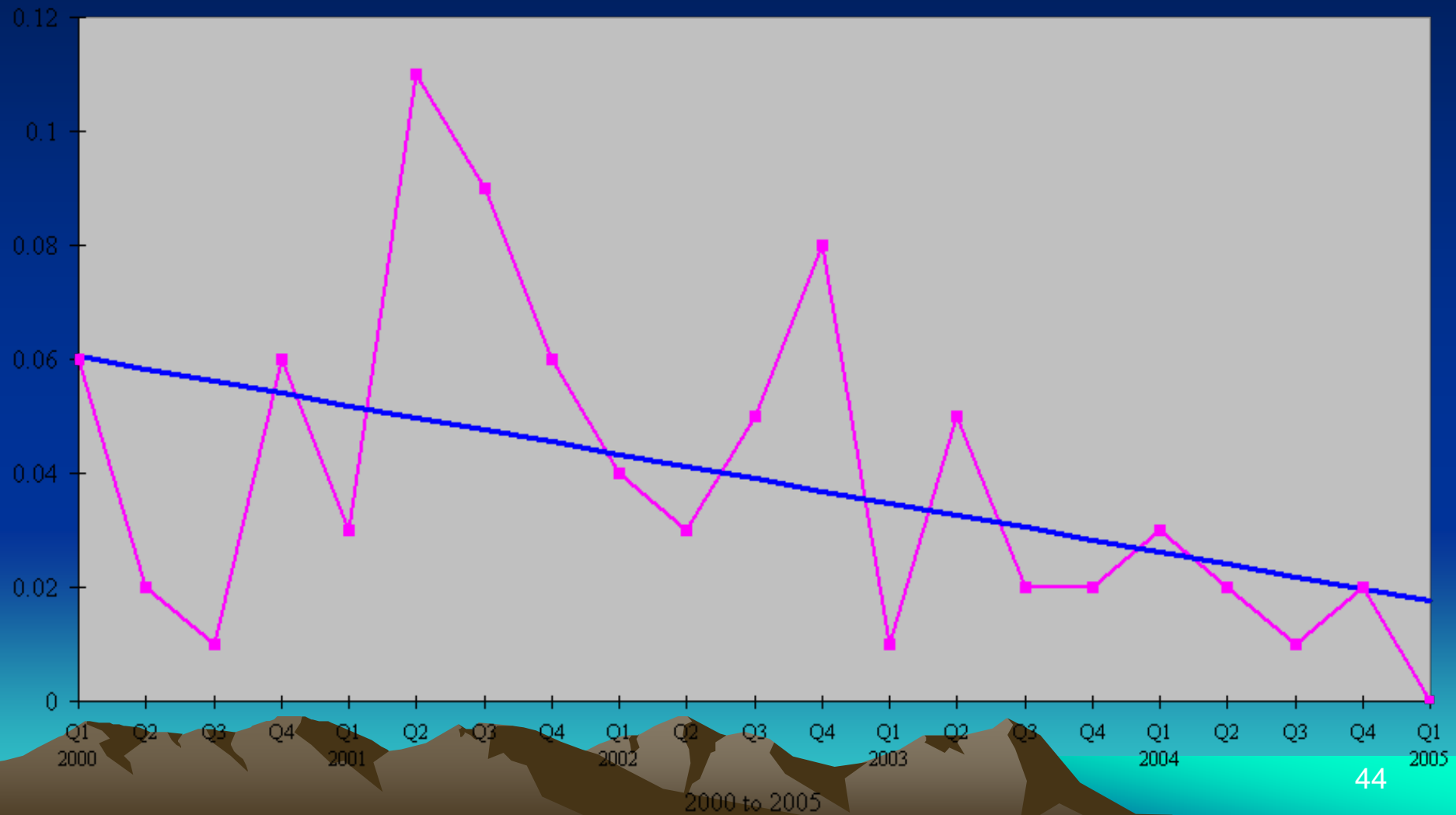
Client Injury Rate
*Number of Injuries per 1000 Patient Days

2000 to 2005

45
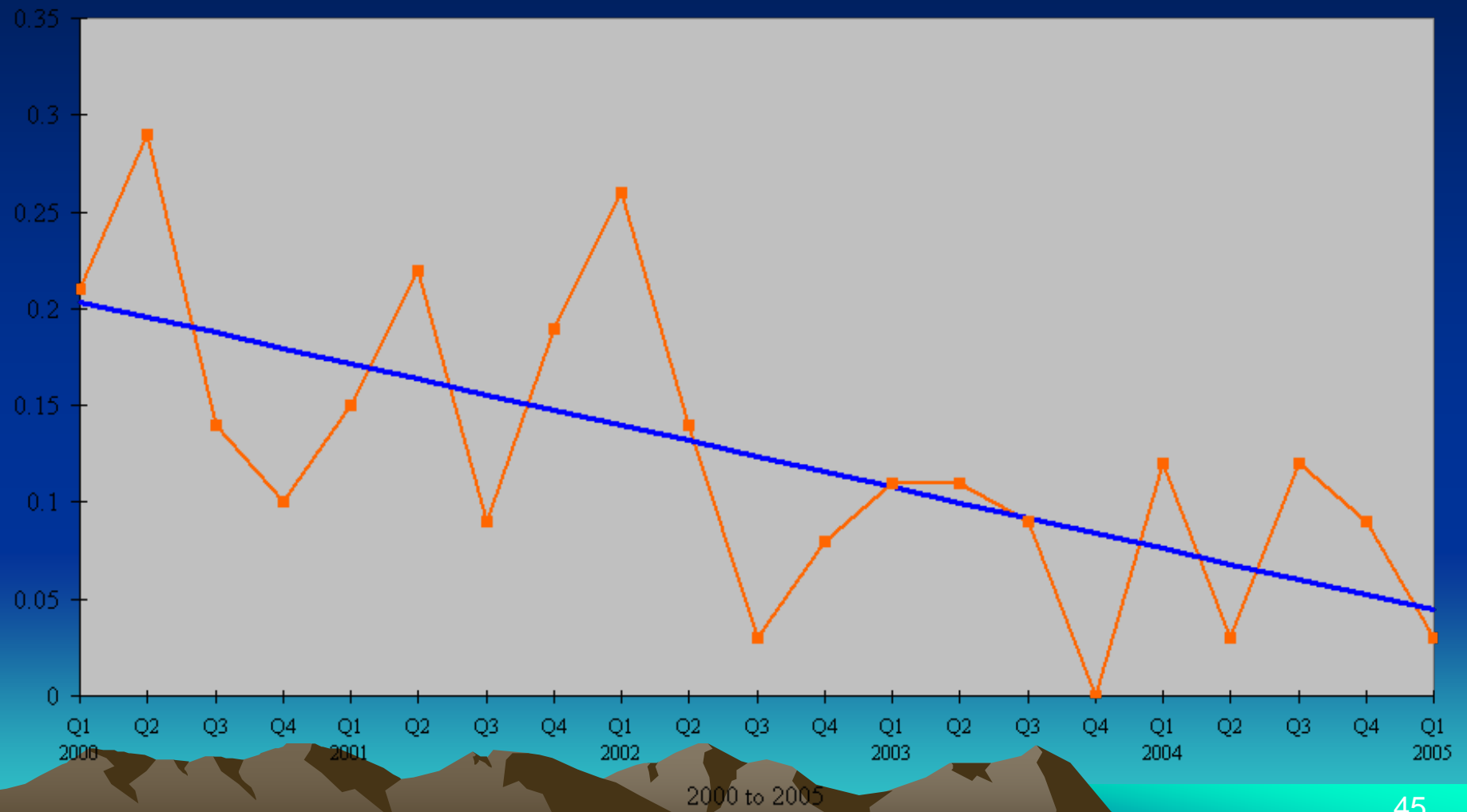
Madden Mental Health Center: Executive Leadership used Witnessing after EVERY event

- Madden is an **acute care** state operated facility.

- In FY08, Madden had 138 budgeted beds. The number of budgeted bed has been increased to 150 for FY09.

- <u>Average length of stay for patients is 11 days.</u>

- In FY08, <u>Madden had 4133 admissions</u>.

Madden Mental Health Center
Rates of Hours, Patients and Episodes of Restraint*

- Anita Hour Rate   Combined Hour Rate

R&S	Baseline 10/01/03-9/30/04	Witnessing initiated 10/01/04-9/30/05	10/01/05-10/1/06	7/01/06-6/30/07	Witnessing cont'd 7/01/07-6/30/08
Episodes *Per 1000 pt days	**10**	5.66	4.51	3.88	**2.79**
Patients *undup pts restrained /pts served)	**7%**	6.1%	3.95%	2.92%	**3.4%**
Hours *Per 1000 pt hours	**.82**	.43	.23	.16	**.11**

Episodes: **72% reduction**

Pts: **51% reduction**

Hours: **86% reduction**

47

Restraint and Seclusion Patient Rate (Combined)
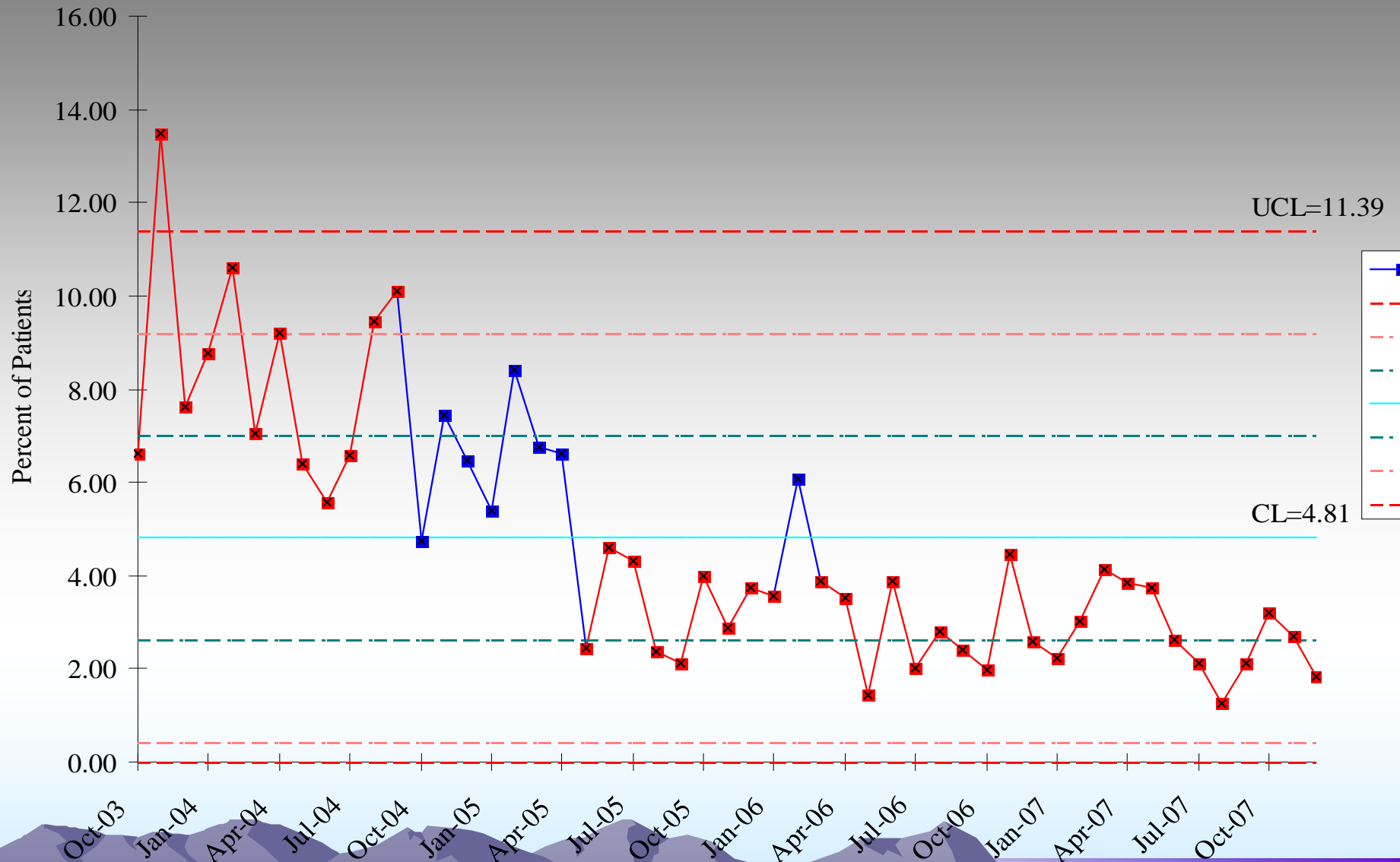
Andrus Children's Center (Residential and School) Yonkers, New York   1999 - 2008

Essential Components (Note: Never used Seclusion):

- Leadership commitment (leadership turnover in school directly correlated to > in restraints at 2 points in time)

- Debriefing after every incident

- Used data to inform practice

- Strong Workforce Development: staff training/staff empowerment

- Moved to Trauma model

Restraint Incidents
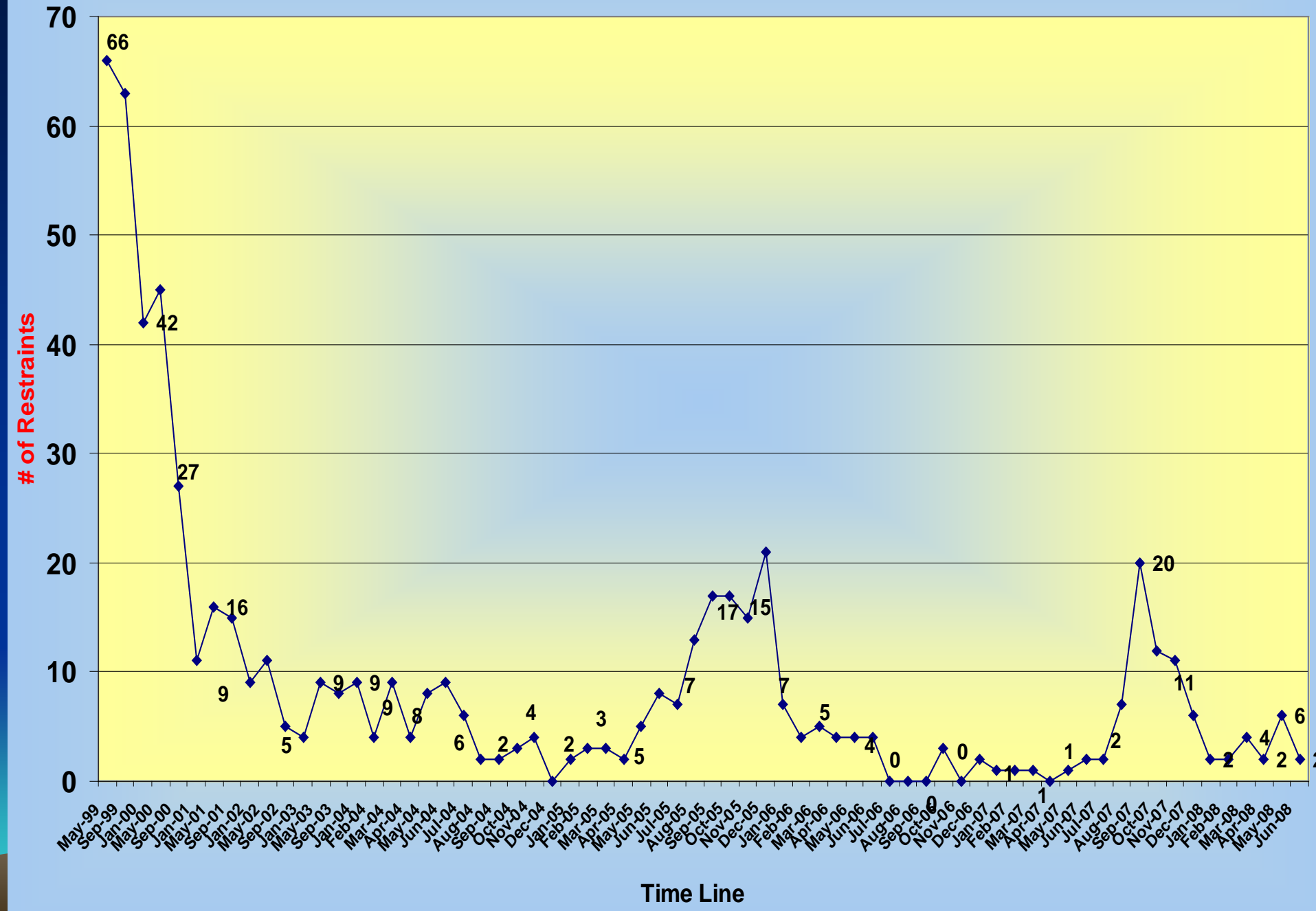
Worcester State Hospital
# 156 beds/Civil
(NETI training 2003)

Essential Components:

- Set up taskforce, developed formal plan

- Effective strategies included new policy, kick-off, staff training, 24-7 response by CEO, COO, CNO

- Use of data, distributed to staff

- Regular meetings - all staff & unions; performance recognition

- Early intervention, sensory approaches, DBT, consult team

- Consumer involvement, Debriefing

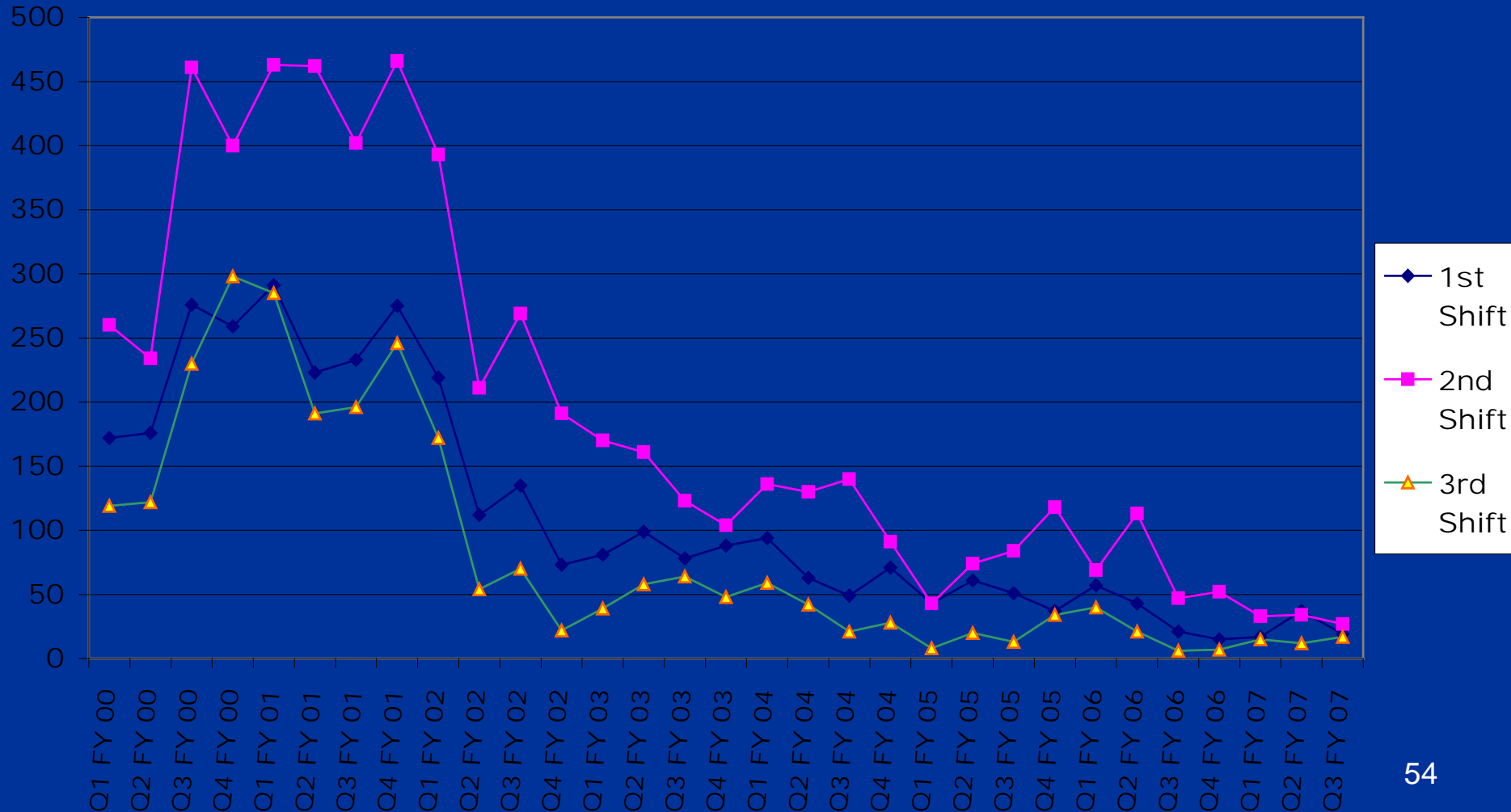Seclusion and Restraint Orders
per 1000 Inpatient Days

52
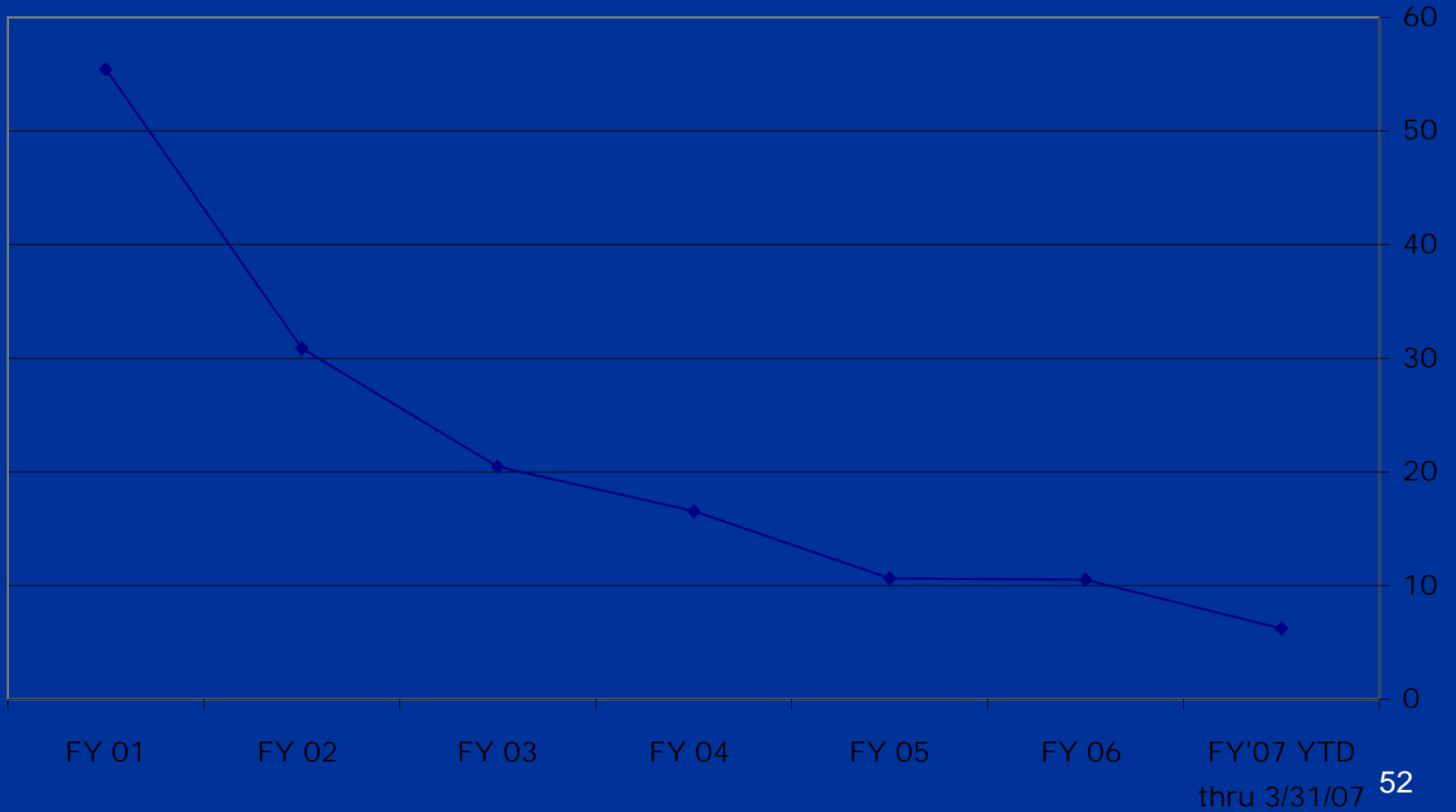
Seclusion and Restraint Hours
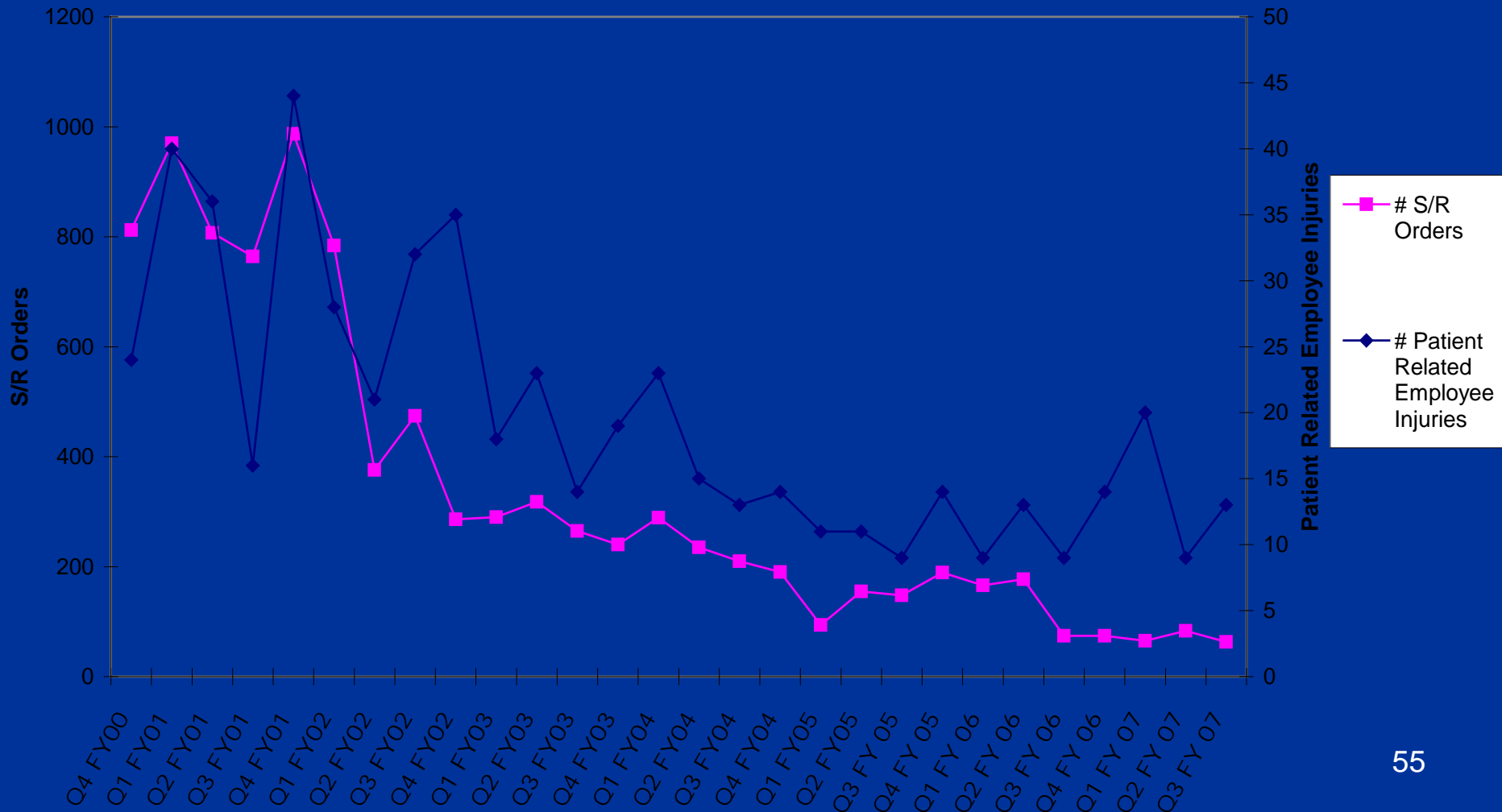**Worcester State Hospital**

53
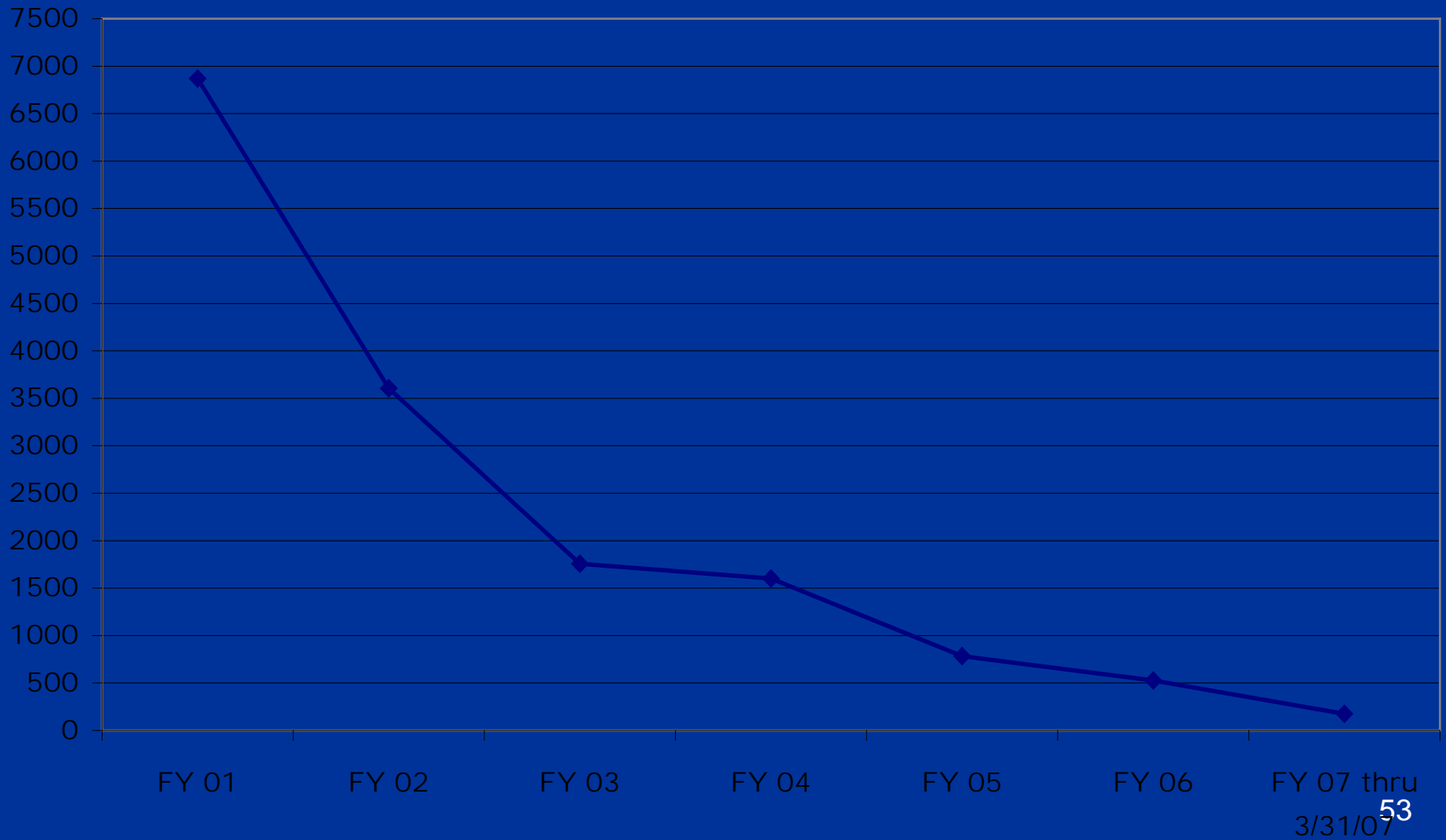
Seclusion and Restraint Orders by Shift
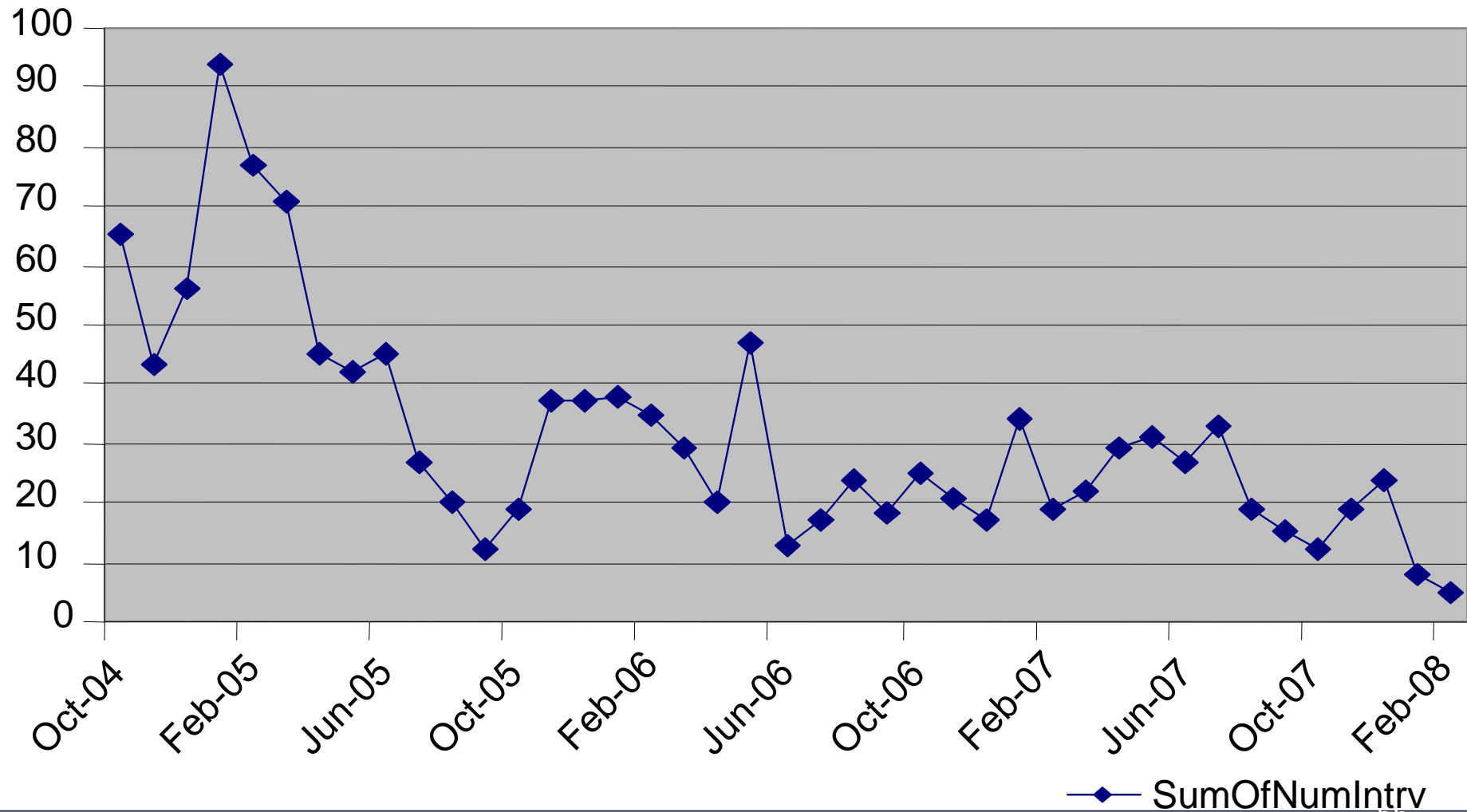Worcester State Hospital
Q1 FY 00 - Q3 FY 07

54

Seclusion and Restraint Orders and Patient Related Employee Injuries*
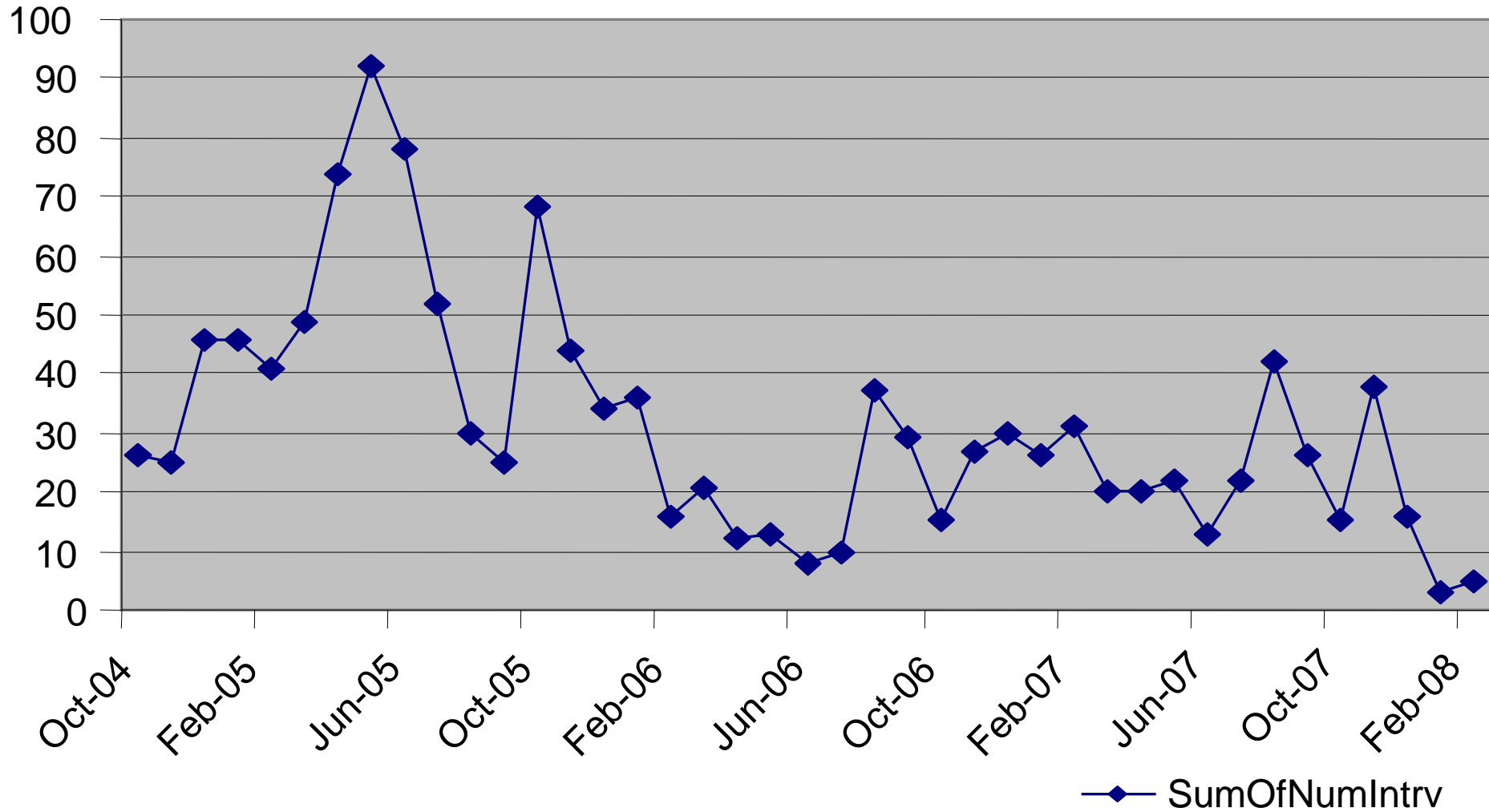Worcester State Hospital
Q4 FY '00 - Q3 FY '07

Taunton State Hospital
Number of Episodes of R-S

Westborough State Hospital
Number of Episodes of R-S
Data

Uta Halee Girls Village & Cooper Village for Boys

Restraints 2005 - 2008

	2005	2006	2007	2008
	418	426	293	170

(Y-axis: 0, 200, 400, 600)

60% decrease from 2005 to-date

Alegent Health Mental Health Services

Omaha NE & Council Bluffs IA

❑ In the first quarter of 2001 (January through March), there were 167 Seclusion/Restraint events. In the last quarter of 2007 (October through December), there were only 42 events

❑ The Alegent Health Mental Health **has experienced a 56.23% reduction in the number of Seclusion/Restraint events** since presenting Trauma Informed Care to staff throughout the service line in July 2005

Over 6,300 patients served in the 2008 Fiscal Year

Acute Geriatric 7%

Acute C/A Residential Partial/School 33%

Acute Adult Special Care 60%
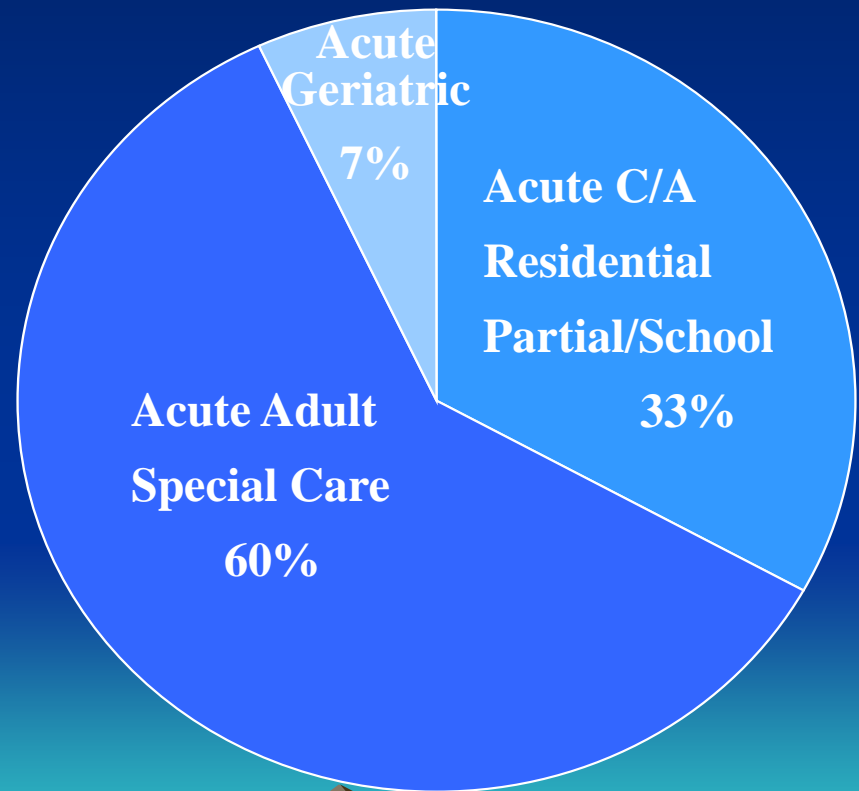
Experts Contributing to Findings

- Kevin Huckshorn: kevin.huckshorn@state.de.us
- Joan Gillece: joan.gillece@nasmhpd.org
- Gayle Bluebird: gaylebluebird@aol.com
- Janice LeBel: Jlebel@comcast.net
- Beth Caldwell: Bethcaldwell@roadrunner.net

Remember what Margaret Mead said:

"Never doubt that a small group of committed citizens can change the world. Indeed, it is the only thing that every has."

Mental health care is our world. Please be a change agent.