Creating Environments that Help and Support Individuals: *Moving from Theory to Practice*

Dr. Janice LeBel, ABPP

CT R/S Prevention Initiative Partnership Conference

September 11, 2015

Outline

- How We Got Here
- Restraint & Seclusion: Uniqueness & Universality
- Painful Practice Truths
- Pragmatic Steps to Move from Theory to Practice
- The Six Core Strategies© - Gone Viral
- Final Caveats

How Did I Get Here?

- Early curiosity & sensitivity
- Personal assault experience
- Moral imperative & urgency
- Fear

Danvers State Hospital

Kirkbride Building 1878 -1992

"I am aware that many persons regard non-restraint in lunatic hospitals as a fad of enthusiasts. I often hear this subject discussed with such indifference that it is proper to explain why restraint is abolished at Danvers."

Dr. Charles W. Page, Superintendent (1907)

How Did You Get Here?

CT's Legacy of Extraordinary Leadership & Mobilization

- Hartford Courant

  "punctuated equilibrium"
- Legislator Actions: Senators Dodd & Lieberman compel GAO report & file new federal legislation for psychiatric facilities
- Senator Christopher Murphy files amendment to reauthorization to Elem. & Sec. Ed. Act (05/15)
- Office of Child Advocate; P&A
- Scream Rooms & new School Regulations

R/S: Uniqueness & Universality

- **Unique**
  - populations
  - ages served
  - mandates / requirements / regulations
  - language / verbiage
  - definitions for restraint & seclusion
  - service cultures
  - service expectations
  - funding streams/amounts

R/S: Uniqueness & Universality

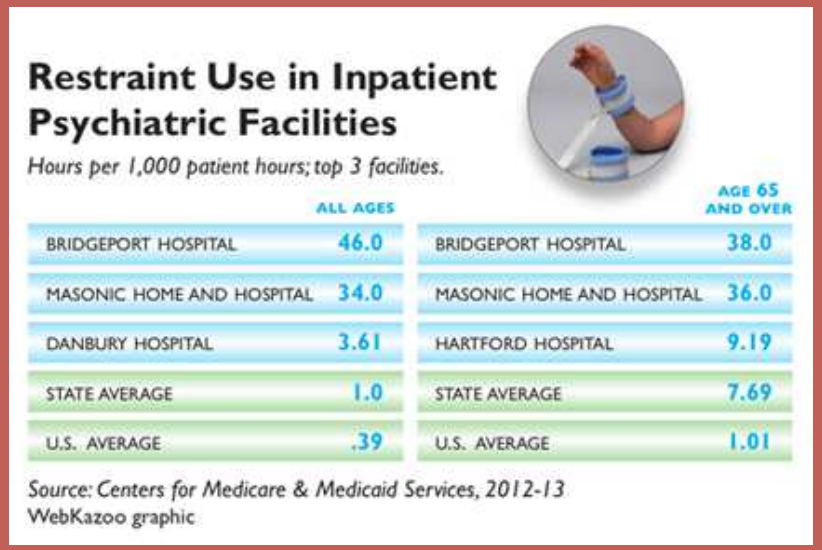
- **Universal**
  - charge: *effectively serve people*
  - challenges: *effectively manage difficult behavior & dyscontrol*
  - expectation: *improve condition, positive outcome*
  - imperative: *accountable to constituents*
  - belief: *our population is 'special' and a barrier to R/S prevention*
  - methods: *humane*

Current Public Scorn & Scrutiny

- **Pittsburgh Post-Gazette – July 2015**
  "'Physical restraint' cited in Allegheny County Jail inmate's death"
- **NPR – May 2015** *"3 Ex-Guards Indicted In Inmate Restraint Death At Bridgewater Prison"*
- **Wall St Journal – August 2014** *"Second NYPD Restraint Death Being Investigated"*

Current Public Scorn & Scrutiny

- **Huffington Post – April 2015** *"Outrage of the Month: Misprescribing of Antipsychotic Drugs to Elderly Dementia Patients"*
- **CT Health I Team - May 2014** *"State Restrains Psychiatric Patients At High Rate"*



Restraint Use in Inpatient Psychiatric Facilities

Hours per 1,000 patient hours; top 3 facilities.

	ALL AGES		AGE 65 AND OVER
BRIDGEPORT HOSPITAL	46.0	BRIDGEPORT HOSPITAL	38.0
MASONIC HOME AND HOSPITAL	34.0	MASONIC HOME AND HOSPITAL	36.0
DANBURY HOSPITAL	3.61	HARTFORD HOSPITAL	9.19
STATE AVERAGE	1.0	STATE AVERAGE	7.69
U.S. AVERAGE	.39	U.S. AVERAGE	1.01

Source: Centers for Medicare & Medicaid Services, 2012-13
WebKazoo graphic

http://c-hit.org/2014/05/31/state-restrains-psychiatric-patients-at-high-rate/

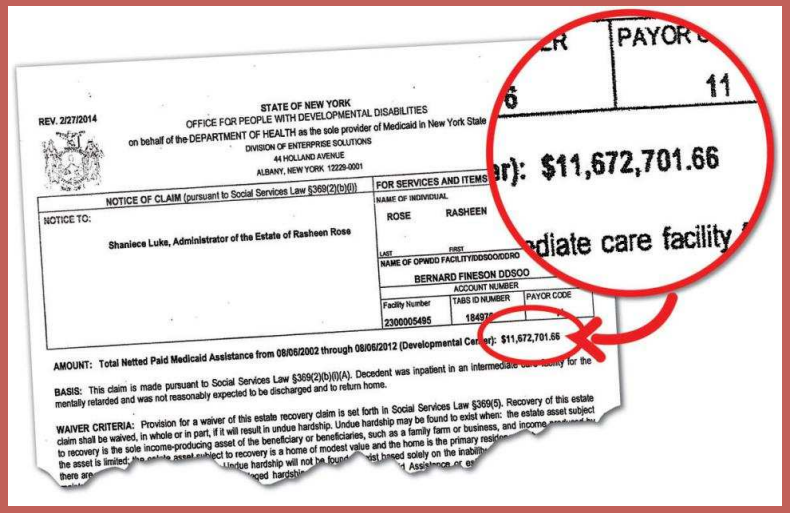
Current Public Scorn & Scrutiny

- **PoliceState USA – October 2014** *"Juvenile detainees locked in controversial device 'when verbal deescalation is not working'"*
- WRAP restraint used in Ark. juvenile detention facilities - *"It is torture and should not be used with kids"*

http://www.policestateusa.com/2014/juvenile-detainees-locked-in-controversial-device/

Current Public Scorn & Scrutiny

- **NY Daily News – May 2014** *"Family of mentally disabled man who was 'crushed to death' at Queens care center sent $11M bill"*
- **LeerHiggins - 2015** *"No one gets prosecuted when developmentally disabled people are killed during restraints"*


REV. 2/27/2014

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES
on behalf of the DEPARTMENT OF HEALTH as the sole provider of Medicaid in New York State
DIVISION OF ENTERPRISE SOLUTIONS
44 HOLLAND AVENUE
ALBANY, NEW YORK 12229-0001

NOTICE OF CLAIM (pursuant to Social Services Law §369(2)(b)(i))

FOR SERVICES AND ITEMS

NOTICE TO:
Shaniece Luke, Administrator of the Estate of Rasheen Rose

NAME OF INDIVIDUAL
ROSE (LAST) RASHEEN (FIRST)

NAME OF OPWDD FACILITY/DDSO/DDRO
BERNARD FINESON DDSO

ACCOUNT NUMBER

Facility Number	TABS ID NUMBER	PAYOR CODE
2300005495	184970	

AMOUNT: Total Netted Paid Medicaid Assistance from 08/06/2002 through 08/06/2012 (Developmental Center): $11,672,701.66

BASIS: This claim is made pursuant to Social Services Law §369(2)(b)(i)(A). Decedent was inpatient in an intermediate care facility for the mentally retarded and was not reasonably expected to be discharged and to return home.

WAIVER CRITERIA: Provision for a waiver of this estate recovery claim is set forth in Social Services Law §369(5). Recovery of this estate claim shall be waived, in whole or in part, if it will result in undue hardship. Undue hardship may be found to exist when: the estate asset subject to recovery is the sole income-producing asset of the beneficiary or beneficiaries, such as a family farm or business, and income produced by the asset is limited; the estate asset subject to recovery is a home of modest value and the home is the primary residence of there are

PAYOR
11
): $11,672,701.66
diate care facility

http://www.nydailynews.com/new-york/queens/family-killed-disabled-man-11m-bill-article-1.1808713

Current Public Scorn & Scrutiny

SUNDAY EDITION | Video of Kentucky inmate death highlights controversy over restraints

Posted: Aug 21, 2015 12:41 PM EDT
Updated: Aug 23, 2015 10:04 AM EDT

By Jason Riley **CONNECT**

LOUISVILLE, Ky. (WDRB) -- He was strapped face down on a mattress in a Kentucky State Reformatory cell by four prison officers, his hands cuffed behind his back and ankles shackled to a bed frame.

Within an hour Steven Lee McStoots was dead.

The 30-year-old's final moments in the La Grange prison on Jan. 16, 2013, were captured on video and became the focus of multiple investigations and lawsuits, as well as a debate on whether Kentucky prisons should employ the controversial "five-point restraints" used on McStoots.

The restraints, according to prison staffers, were for his own good -- to protect the mentally ill man from hurting himself.

http://www.wdrb.com/story/29851660/sunday-edition-death-at-kentucky-prison-renews-debate-over-restraints

Current Public Scorn & Scrutiny

Child being restrained by Kentucky Sheriff Deputy - CNN.COM Screen Shot
Read more at http://www.commdiginews.com/featured/the-legal-handcuffing-of-disabled-students-by-kentucky-sheriff-deputy-46396/#LVIvWjYBxUvsOGZk.99

Current Public Scorn & Scrutiny

- **ProPublica – February 2015** *"Connecticut Schools Pin Down and Restrain 'Staggering' Number of Kids"*
- **Fresno Bee - Nov 2014:** *"Claim: Special Education Student 'Caged' In Class"*

http://www.disabilityscoop.com/2014/11/11/claim-sped-caged/19840/

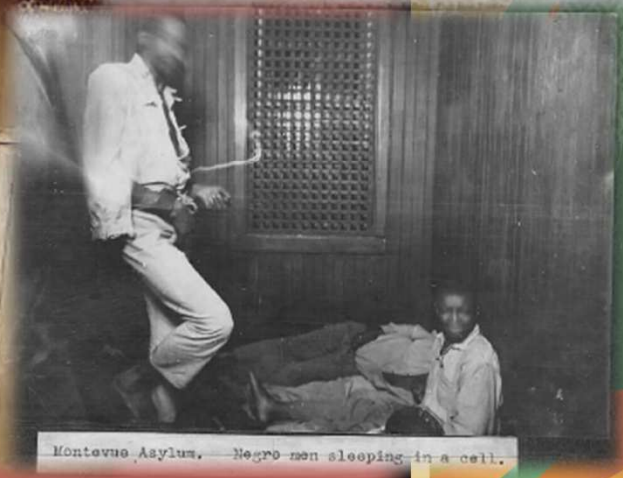
Current Public Scorn & Scrutiny

- **Fort Worth, TX – June 2014**

  "Day Care Restrained Children With Duct Tape"

http://www.nbcdfw.com/news/local/Mother-Daycare-Restrained-Children-With-Duct-Tape-263917191.html

Common History & Approaches
Punish, Isolate, Confine



A Common History - But We Part Ways ...

- In mental health:
  - R/S is synonymous with treatment failure
  - R/S cannot be included in a treatment plan
  - R/S resulting in injury/death is a '*never event*' and can result in defunding/$ clawback
  - Staff who have used R/S resulting in injury/death have been incarcerated
  - The federal government (CMS) has national R/S standards of practice in healthcare

What Have we Learned? Painful Practice Truths

- R/S are not evidenced based practices: Cochrane Review 2012
- Injury rate in health care & law enforcement > non-human service, high risk industries
- People restrained are injured more often than staff
- Prone restraint is more lethal
- Injury & death rate for children and adolescents subjected to R/S is higher than that of adults subjected to R/S
- Staff have been harmed & died from R/S, too

(LeBel , Huckshorn & Caldwell, 2014)

What Have we Learned? Painful Practice Truths

- Fundamental Practice Bias
  - Children are subjected to R/S more than adolescents
  - Adolescents are subjected to R/S more than adults
  - Minorities are subjected to R/S more than non-minorities
  - People with disabilities are subjected to R/S more than those without disabilities

(LeBel , Huckshorn & Caldwell, 2014)

What Have we Learned? Painful Practice Truths

- Traumatizing to all involved
- No universal, accepted set of definitions
- No standardized reporting system / data system
- No therapeutic or educational benefit
- Limited public accountability

(LeBel , Huckshorn & Caldwell, 2014)

Compelling Change

Punctuated Equilibrium Compels Momentum

- 1998: Hartford Courant exposé
- 1999: Congressional Hearings, GAO Reports; Trade reports
- 2000: Children's Health Act
- 2001: CMS Rule (1-hr. rule) & Joint Commission changes
- 2002: NASMHPD Experts Mtgs. > Six Core Strategies©
- 2003: SAMHSA $; National Call to Action to Eliminate R/S
  Curie calls R/S "disgraceful" – SIG 2004 & 2007
  New Freedom Commission
- 2009: NDRN & ACLU/HRW Reports re: R/S
  abuse/deaths in public schools

(NASMHPD, 2011)

Compelling Change

- 2009 /10: GAO Investigation; Rep. Miller files bipartisan bill for national R/S school standards

  SAMHSA Issue Briefs
- 2011/12: Federal education bill refiled

  Six Core Strategies© recognized on NREPP

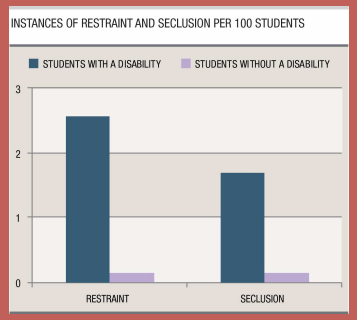
  NDRN report updated

  DOE R&S Resource Document

  DOE Secretary Duncan reported national survey findings (72K schools, 85% of student pop.):
  - **70% of pop. restrained are students with disabilities;**
  - 21% of students with disabilities are **African American,** but = **44% of AA students mechanically restrained**

Compelling Change

- 2013 / 14: HR1893, *Keeping All Students Safe Act*, re-filed by Rep. George Miller; dies in committee

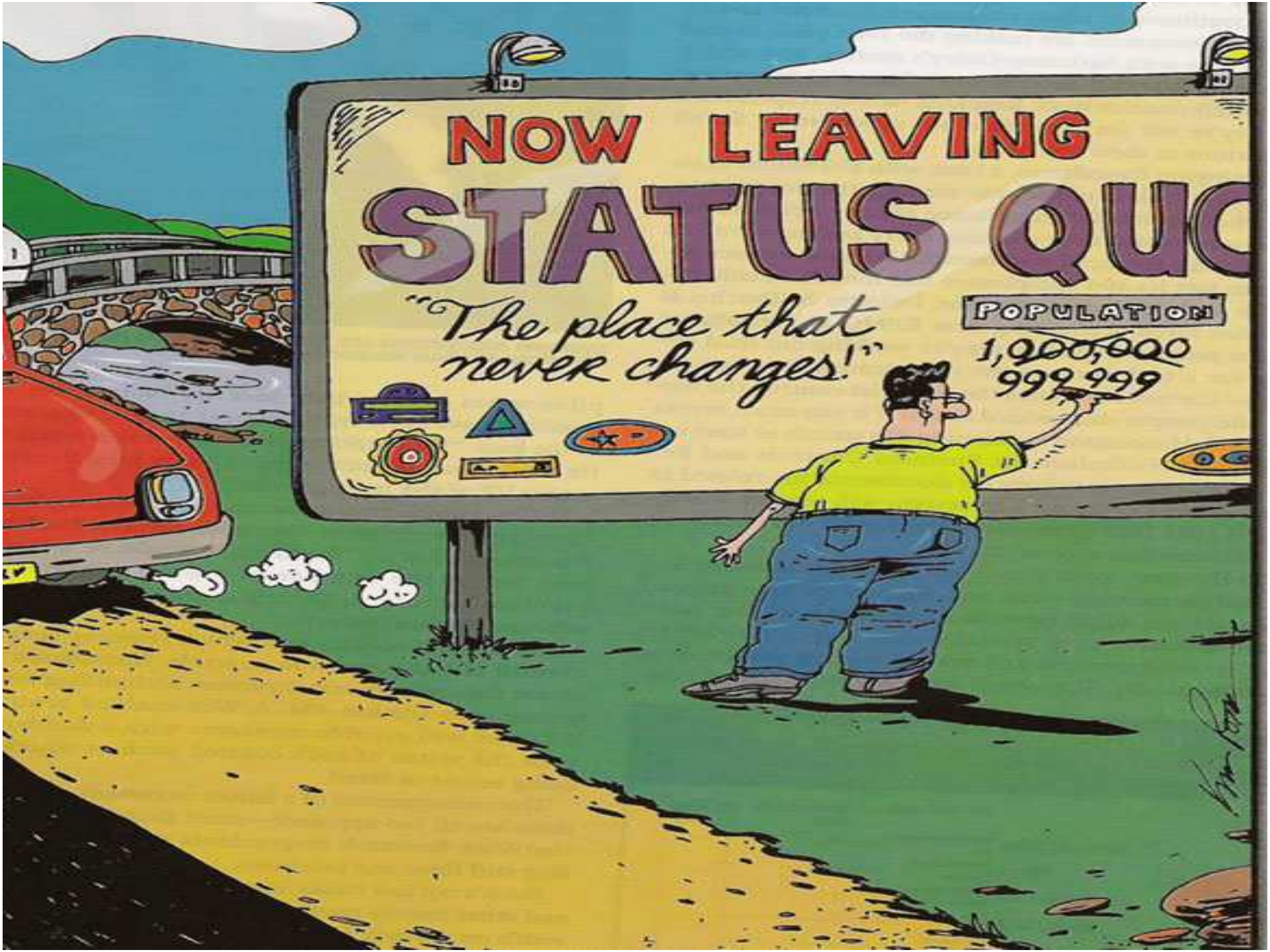


UNH study affirms persistent national pattern of higher R/S with students with disabilities & under-reporting

- 2015 / 16: HR 927, *Keeping All Students Safe Act*, re-filed by Rep. Beyer and related bill HR 2268 filed: *Ending Corporal Punishment in Schools Act of 2015;* Bills referred on to committee/subcommittee

  Sen. C. Murphy files amendment to authorization of ESE Act for states to have policies to limit R/S in schools

Retrieved on 12/17/13 from http://www.unh.edu/news/releases/2013/12/lw17carsey.cfm


NOW LEAVING
STATUS QUO
"The place that never changes!"
POPULATION
1,000,000
999,999

Steps to Create Positive Environments and Move from Theory to Practice

Step 1:
Stop Admiring the Problem: ***Study it!***

- Restraint and seclusion are toxic, violent episodes for persons-served and staff
- Pay attention to what you want to change: Hawthorne vs. Heisenberg Effect
- Study & Analyze

Violence in Human Service

- A global problem
- The U.S. health sector reports:
  - > 50% of workplace aggression claims

    (ILO, 2002)
  - the highest share of lost work time

    (Llewellyn, 2001)
  - the cost of violence alone > $35 billion

    (di Martino, 2003)

Violence in Mental Health

- Violence considered endemic & staff at higher risk (Nijman, Bjørkly, Palmstierna, & Almvik, 2006; Whittington & Richter, 2006)
- The closer the role to direct care, the higher the injury rate (DOJ, 2001)
- Nursing: 1 : 10 chance of injury/year (Foster, Bowers, & Nijman, 2006)

Violence & R/S:
The Chicken or the Egg?

- Violence is contextual, proximal to R/S, the portal to R/S use (Kaltiala-Heino, Korkeila, & Lehtinen, 2003; Steinert et al., 2008)
- R/S contributes to and precipitates violence (GAO, 1999)
- Staff actions are often antecedents to violence resulting in R/S (Natta et al., 1990, Garrison, et al., 1990; Goren, Singh, & Best, 1993)
- R/S may cause, reinforce, and maintain aggression and violence on the ward (Daffern, Howells, & Ogloff, 2007)

Analyze the Restraint Process

- LeBel & Goldstein (2005) analyzed restraint with time/motion/task & cost analysis

Study the Process: Use ***Taylorism***

To increase performance & production, first observe and analyze the work process then determine the best method for each phase of the activity.

Frederick Taylor (1880s)

Identify Discrete Steps: Count the ***Therbligs***

To maximize efficiency, break down an observable task into a more specific individual unit of motion or a "therblig"

Frank Gilbreth (1908)

Analysis of Restraint Tasks/Functions

- **Analyze each type of Intervention & Duration**
- **Specific Analysis of Mechanical Restraint**

  <u>11.9 hrs. staff time</u>
- **Three (3) Phases of Restraint Episode:**

1. Initial Crisis Management — 1.65 hrs. staff time

   11 tasks & 13 staff - Event, Contact, Deployment, Nurse/MHC, Unit Management, Assessment, Consult MD

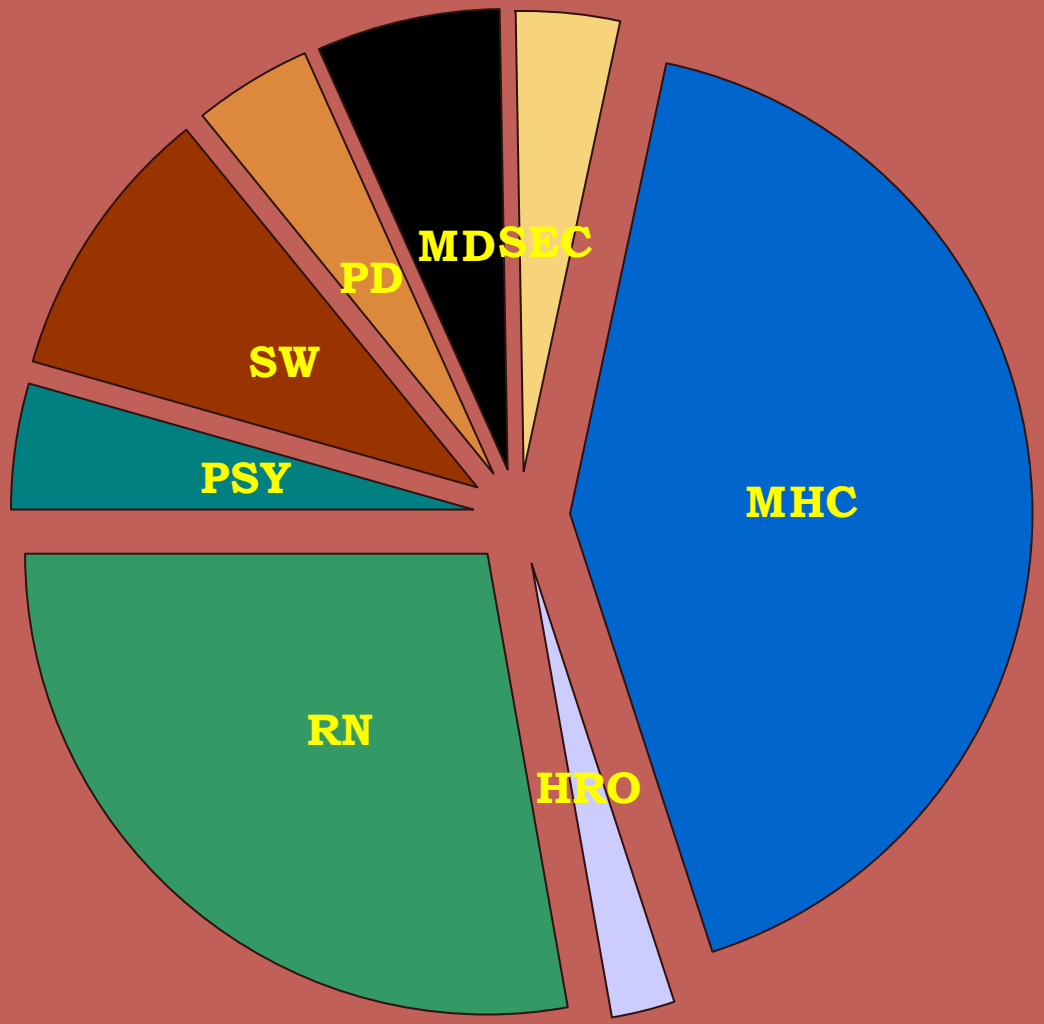
2. Application - Removal of Restraint — 4.42 hrs. staff time

   9 tasks & 12 staff - Application and Removal of Restraint, Assessment, Documentation, 1:1, Vitals, Release

3. Post Restraint Activities — 5.83 hrs. staff time

   17 tasks & 20 staff - Debriefing, Follow-Up, Maintenance, HRO Review, Documentation, Family Contact, Revise treatment plan

Staff Time per Episode of Mechanical Restraint



Staff	Hrs/Episode	%
MHC	4.97	41.9%
RN	3.31	27.9%
SW	1.17	9.9%
MD	0.75	6.3%
PSY	0.50	4.2%
PD	0.50	4.2%
SEC	0.42	3.5%
HRO	0.25	2.1%
Total	11.9	

The Business Case Made Loud & Clear

- Restraint use on an adolescent inpatient service claimed:
  - > 23% of staff time
  - > $1.4 million in staff-related costs
  - 40% of operating budget

Restraint Type	# Tasks	Staff Time	Cost / Event / (2015 $)
Medication	26	11.07 hours	$287 / **$348**
Physical	25	11.57 hours	$302 / **$367**
Mechanical	25	11.90 hours	$309 / **$375**
Combination	29	13.40 hours	$355 / **$431**

Value Added by Restraint Reduction

Staff Impact

- Staff turnover -84%
- New hires -78%
- Sick time -53%
- Replacement staff -78%
- Cost to replace staff -98%
- Missed days due to R/S injury -98%
- Worker's Comp -98%
- WC medical costs -98%
- Hiring costs -68%

Consumer Impact

- Restraint reduction -92%
- Length of stay/Tx -59%
- Injuries -60%
- Higher functional assessment at D/C +27%
- Reduced medication
- Community success @ 6 months +92%
- Community success @ 12 months +88%

UK Study of R/S Cost

- Flood, Bowers & Parkin (2008) studied conflict and containment using an interview schedule with key staff and event data from 136 wards & costs from 15 wards and determined:
  - Cost of a single episode of manual restraint = £145.27 and seclusion = £200.07 (approximately $240.24 and $330.88)
  - Total cost of all containment in UK inpatient wards was estimated at > £106,157,997 (approximately $156 million)
  - **50% of all UK nursing resources were expended to manage conflict & implement containment procedures**

The Business Case for Preventing and Reducing Restraint and Seclusion Use

MAY 2010

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

http://store.samhsa.gov/shin/content/SMA11-4632/SMA11-4632.pdf

Step 2: Don’t Hope for Improvement - Create Solutions

- Physical Environment
- Social Environment
- Knowledge Environment

Improve the Physical Environment

Common Sense says:

- Look at the physical environment
  - Scan it
  - Clean it
  - De-clutter
  - Use a checklist

Improve the Physical Environment

The Literature says:

- Borckardt et al (2011) Used a multifaceted approach to R/S reduction:
  - TIC
  - Rules & language
  - Therapeutic environment
  - Patient involvement in treatment planning
- Found that only changes to the physical environment were associated with R/S reduction
  - Painting walls with warm colors
  - Decorative throw rugs and plants
  - Arranging furniture

Improve the Physical Environment

The Literature says:

- McCurdy et al (2015) made a design change in their psychiatric emergency department in a general university hospital. They installed a door to change patient flow in the ED and reduce the ‘openness’. This resulted in a 62% reduction in seclusion and restraint use. This finding was replicated over a similar period of time.

Improve the Physical Environment

The Literature says:

- Lee et al. (2011) environmental psychology research indicates that **posting encouraging signage** increases the positive action being prompted
- Valtchanov & Ellard (2015) research indicates people prefer **images /views of nature**
- Werner, Linting & Vermeer (2015) – noise is a major aspect of environmental chaos, has adverse outcomes on wellbeing and behavior in group settings

Improve the Physical Environment

The Literature says:

- Pause on painting ***Baker-Miller Pink***
  - Contradictory findings
- Calkins (2010) reports:
  - Blue calms & lowers BP
  - Red increases brain wave activity and can stimulate adrenalin
  - Green reduces CNS activity and helps calm

Improve the Physical Environment

The Literature says:

- Use Evidence-based Aromatherapy
- Stop and smell the ... *lavender!*
  - **Lavender** is calming and increases interpersonal trust
  - **Citrus** reduces perceived stress & anxiety and enhances mood (Drummond, 2012 – Mayo Clinic)
- **Sweet fragrances** such as cookies baking and roasting coffee results in significantly improved prosocial behavior (Baron, 1997)

Improve the Physical Environment

Dr. Richard Wener (NYU) describes stressors in facilities that raise the individual's trauma response and negatively impact behavior:

1. **Crowding:** density of shared space increases stress, claustrophobia and behavior incidents
2. **Lack of Natural Light:** the lack of natural daylight and views to nature also increases stress. Even a simulated view of nature reduces heart rate and lowers stress
3. **Noise:** Wener defines noise as "unwanted sound". An increase in 3 decibels translates to a doubling of the power of sound. When it is quieter, stress is reduced, it is easier to communicate and sleep patterns improve

Improve the Physical Environment

4. **Lack of Privacy:** People who live in shared living arrangement where there is no privacy often become irritated. Private places allow people to retreat when anger is escalating
5. **Isolation:** Isolation has been found to lead to sensory deprivation and extreme boredom, and to produce high levels of psychological trauma and psychopathology
6. **Confinement** leads to overwhelming feelings of sadness and depression, paranoia, fear of people and deterioration both cognitively and emotionally leading to self-mutilation

Improve the Physical Environment

Create a Trauma-Informed Environment

(Huskey, 2015)

1. No physical barriers between staff and persons-served
2. Abundant sunlight throughout, views to the outside and to nature
3. Courtyards with benches, gardens, & recreation space
4. Carpet to reduce noise (= reduction in BP). Noise level less than 60 decibels
5. Non-institutional furnishings
6. Inviting and welcoming messages to encourage visitation

http://www.aia.org/akr/Resources/Documents/AIAB105792

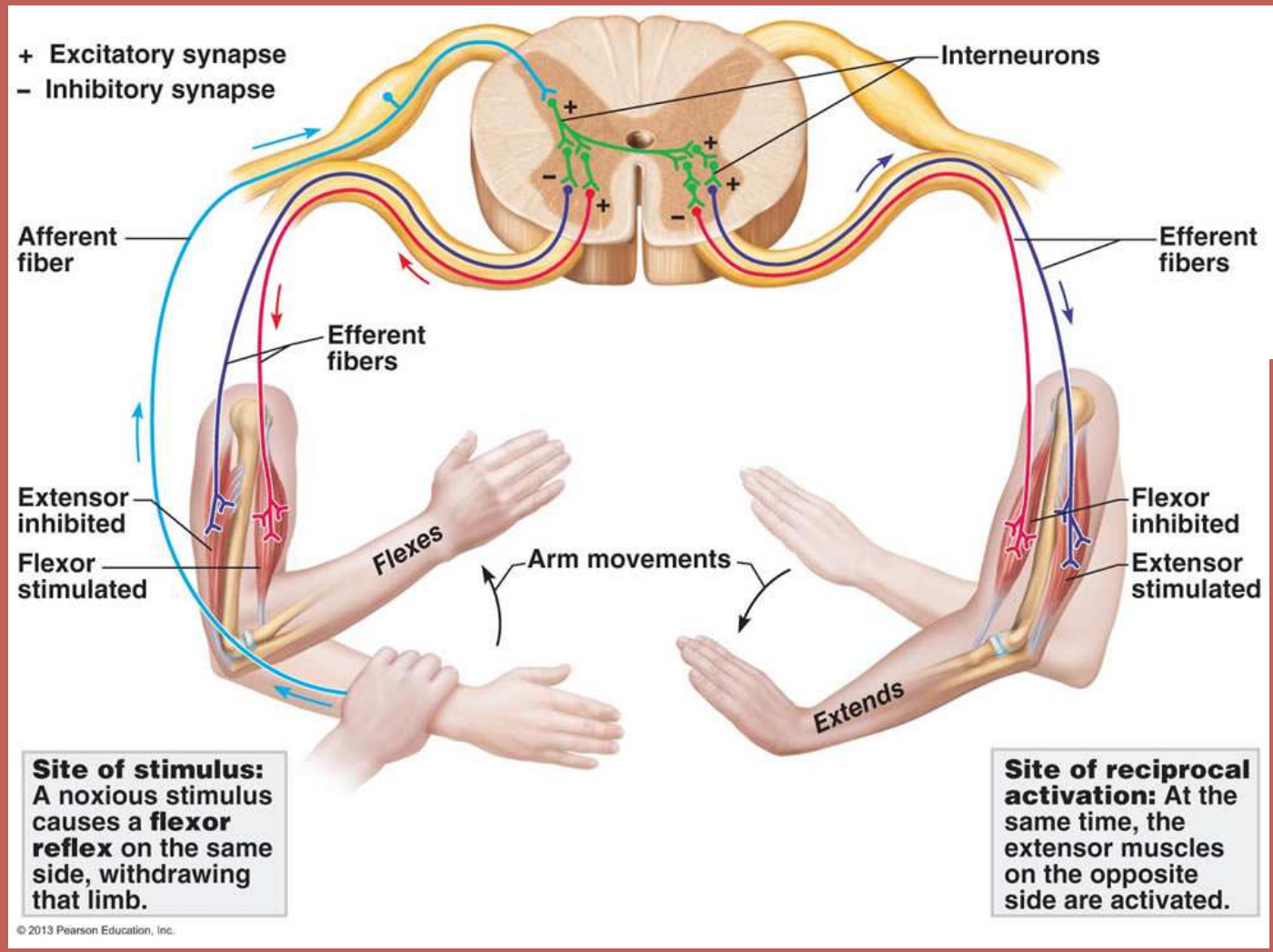
Improve the Physical Environment

- Convert R/S Rooms / Quiet Rooms
- Create sensory focus / Rooms
- Consider service dogs
- Martin & Suane (2012)
- Champagne & Sayer (2005)
  - 75% reduction in R/S

Improve the Social Environment

- **Director of First Impressions –** Fisher Paykel
- McAleer (2014): **The Jerry McGuire Effect**, *"You had me at Hello"* – in less than 1 second we judge the sound of a voice and whether we will approach or avoid
- Willis & Todorov (2006): 100-ms exposure to a face correlated highly with judgments on attractiveness, likeability, trustworthiness, competence, and aggressiveness
- Warm Welcome
- Touch assessment
- Don't touch without permission

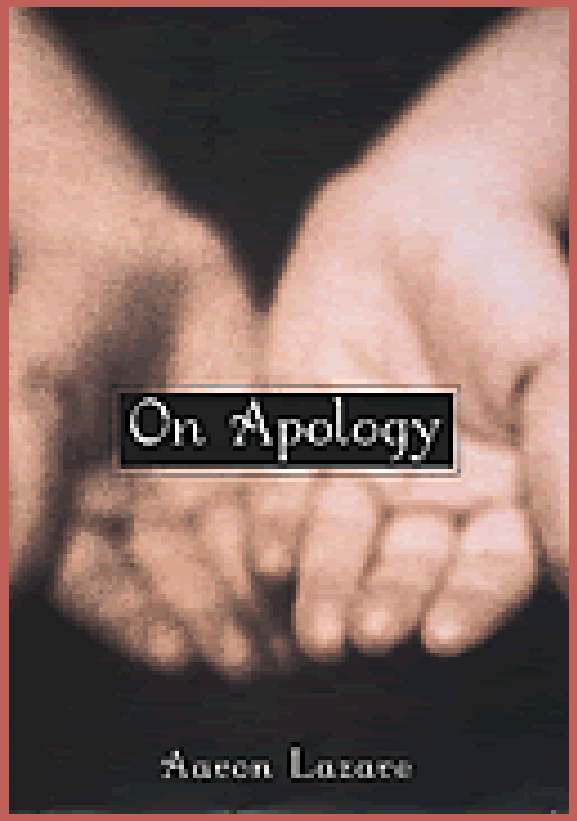
Improve the Social Environment: Remember the Withdrawal Reflex!



Improve the Social Environment: It's OK to say *I'm Sorry*

On Apology

- Aaron Lazare, M.D.



Improve the Social Environment: Engage Those you Serve

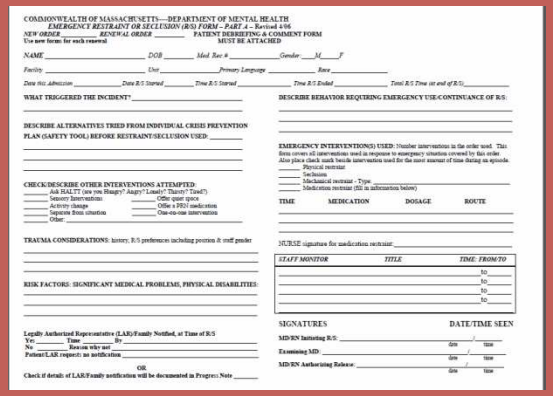
Improve the Knowledge Environment

- Transfer the R/S prevention knowledge – key to sustainability
- Write it down!
- Raise standards, practice, expectations
- Repeat, repeat, repeat
- Watch for effort fatigue

Improve the Knowledge Environment

Create Tangible Legacies

- Standards / Regulations
- R/S Forms
- Resource Guides
- Licensing expectations
- Contract language & Performance Indicators
- Y & F Position Statements & Real Danger DVD


COMMONWEALTH OF MASSACHUSETTS—DEPARTMENT OF MENTAL HEALTH
EMERGENCY RESTRAINT OR SECLUSION (R/S) FORM – PART A – Revised 4/06
NEW ORDER _____ RENEWAL ORDER _____ PATIENT DEBRIEFING & COMMENT FORM
Use new forms for each renewal — MUST BE ATTACHED

NAME _____ DOB _____ Med. Rec. # _____ Gender: ___M ___F

Facility _____ Unit _____ Primary Language _____ Race _____

Date this Admission _____ Date R/S Started _____ Time R/S Started _____ Time R/S Ended _____ Total R/S Time (at end of R/S) _____

WHAT TRIGGERED THE INCIDENT? _____

DESCRIBE ALTERNATIVES TRIED FROM INDIVIDUAL CRISIS PREVENTION PLAN (SAFETY TOOL) BEFORE RESTRAINT/SECLUSION USED: _____

CHECK/DESCRIBE OTHER INTERVENTIONS ATTEMPTED:
_____ Ask HALT? (are you Hungry? Angry? Lonely? Tired?)
_____ Sensory Intervention _____ Offer quiet space
_____ Activity change _____ Offer a PRN medication
_____ Separate from situation _____ One-on-one intervention
_____ Other: _____

TRAUMA CONSIDERATIONS: history, R/S preferences including position & staff gender

RISK FACTORS: SIGNIFICANT MEDICAL PROBLEMS, PHYSICAL DISABILITIES:

Legally Authorized Representative (LAR)/Family Notified, at Time of R/S
Yes: _____ Time _____ By _____
No: _____ Reason why not _____
Patient/LAR request: no notification _____
OR
Check if details of LAR/Family notification will be documented in Progress Note _____

DESCRIBE BEHAVIOR REQUIRING EMERGENCY USE/CONTINUANCE OF R/S:

EMERGENCY INTERVENTION(S) USED: Number interventions in the order used. This form covers all interventions used in response to emergency situation covered by this order. Also place check mark beside intervention used for the most amount of time during an episode.
___ Physical restraint
___ Seclusion
___ Mechanical restraint - Type _____
___ Medication restraint (fill in information below)

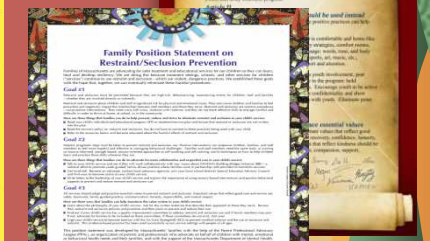
TIME	MEDICATION	DOSAGE	ROUTE

NURSE signature for medication restraint: _____

STAFF MONITOR	TITLE	TIME: FROM/TO
		___ to ___
		___ to ___
		___ to ___
		___ to ___

SIGNATURES — DATE/TIME SEEN

MD/RN Initiating R/S: _____ date _____ time _____
Examining MD: _____ date _____ time _____
MD/RN Authorizing Release: _____ date _____ time _____



Step 3: Use the Six Core Strategies©

The Core Strategies:

- **Are Not**:
  - Defunct 60's Rock Band
  - Rocket Science
  - Magic
- **Are:**
  - Framework for organizational change
  - Template for changing culture & practice
  - Recognized evidenced-based practice
  - Curriculum to prevent violence, coercion & R/S

Six Core Strategies©

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

(NASMHPD, 2011)

Constructs Underpinning the Six Core Strategies© Model

- **Leadership** principles for effective change
- The **Public Health Prevention** approach
- Use of **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)

(NASMHPHD, 2011)

1st Core Strategy: Leadership

I. Key Leadership Activities

- Create the vision & plan
- Organize & mobilize the R/S Team
- Create infrastructure to support R/S Team
- Elevate oversight of all R/S events
- Ensure viability, accountability & sustainability

(NASMHPD, 2011)

2nd Core Strategy: Use of Data

II. Key Data Use Activities

- Gather baseline data of events & hours (6 mos - 1 yr)
- Set realistic goals
- Gather data by unit, day, shift, duration, age, dx, gender, race, staff involved
- Monitor & post data regularly for training needs / best practices
- Create healthy competition

(NASMHPD, 2011)

3rd Core Strategy: Workforce Development

III. Key Workforce Development Activities

- Know what staff are currently taught in aggression prevention and control
- Integrate R/S Reduction in HRD activities (hire, supervise, evaluate)
- Provide new training/education

(NASMHPD, 2011)

4th Core Strategy: R/S Tools

IV. Key R/S Prevention Tools & Activities

- Conduct assessments: violence/aggression, trauma, medical/physical
- Use Safety Plans: identify triggers, warning signs, strategies / preferences
- Implement alternatives: Comfort & Sensory Rooms, sensory integration, meaningful activities, exercise, relationship building, de-escalation, person-first language

(Bluebird, 2005; LeBel, 2011; NASMHPD, 2014)

5th Core Strategy: Debriefing

V. Key Debriefing Activities

- Define what debriefing is and is not
- Implement 3 types of debriefing:
  - ✓ Pre-event: Pre-Witnessing
  - ✓ Acute- immediate post event
  - ✓ Formal- rigorous problem solving
  - ✓ **New Approaches**: Consumer 'Debriefer' / resident support team / apology

(NASMHPD, 2011).

6th Core Strategy: Full Consumer / Family Inclusion

VI. Key Inclusion Activities

- Hire persons-served, family members/ community advocates as staff members, appoint volunteers
- Allow access to information
- Use to interview people post-event
- Attend meetings at all levels
- Empower participation and abilities

(NASMHPD, 2011)

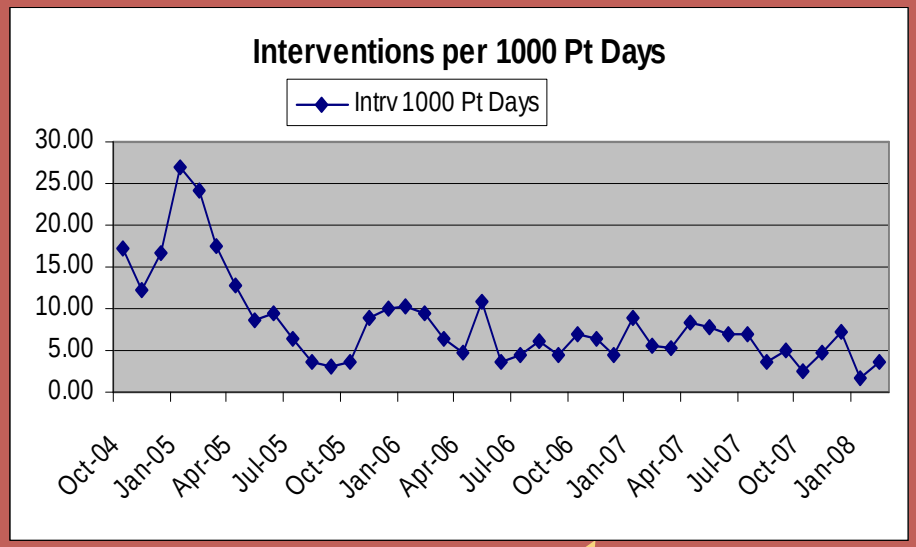
The Six Core Strategies©
Gone Viral

MA 6CS Implementation Outcomes

- ***MA: DMH Statewide Initiative***
  - R/S reduction involved all psychiatric inpatient services
  - Post SIG Grant: DMH Adult services decreased R/S 65%
  - Post SIG Grant: C/A services decreased R/S 86%
  - Currently: DMH C/A services decreased R/S 97%

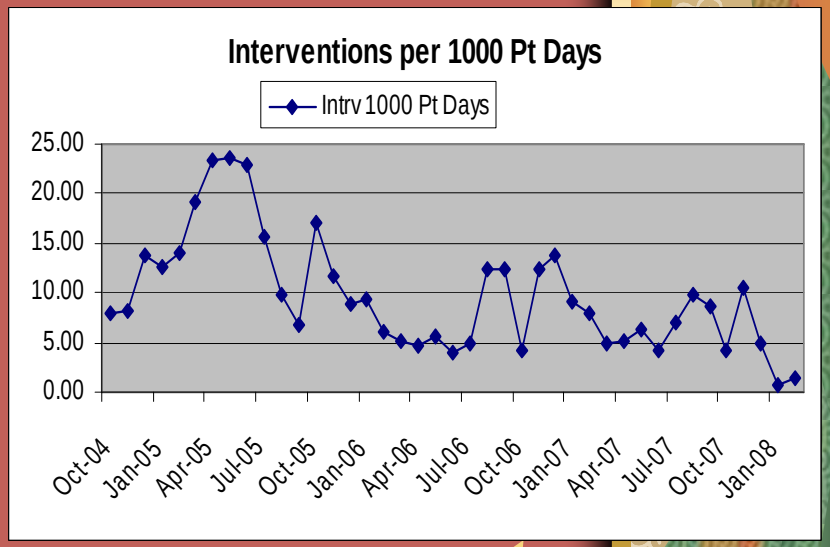
MA SIG Pilot Facilities

Taunton State Hospital
10 adult units, 1 adolescent unit



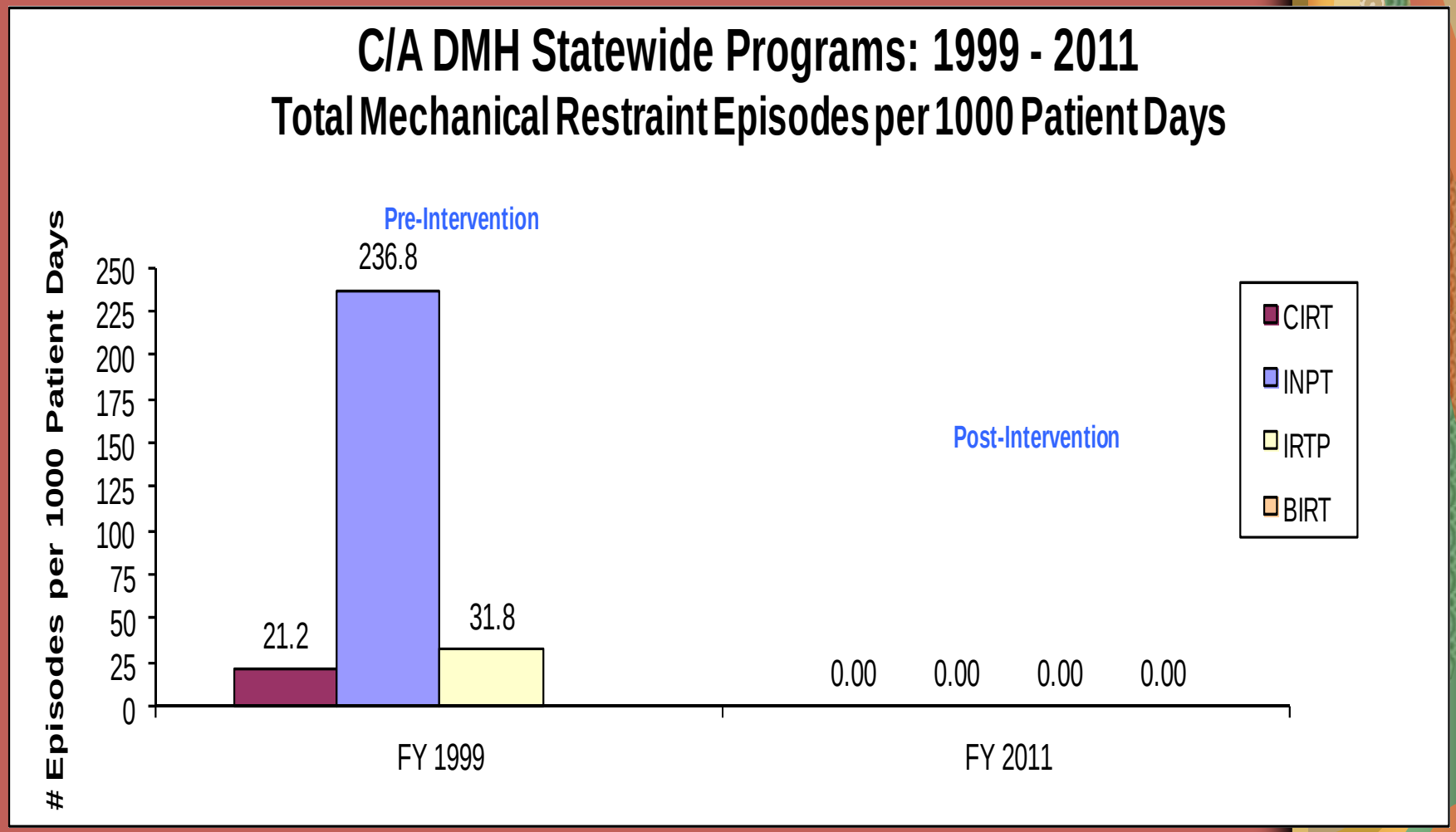
- 93.5%

Westborough State Hospital
5 adult units, 2 adolescent units

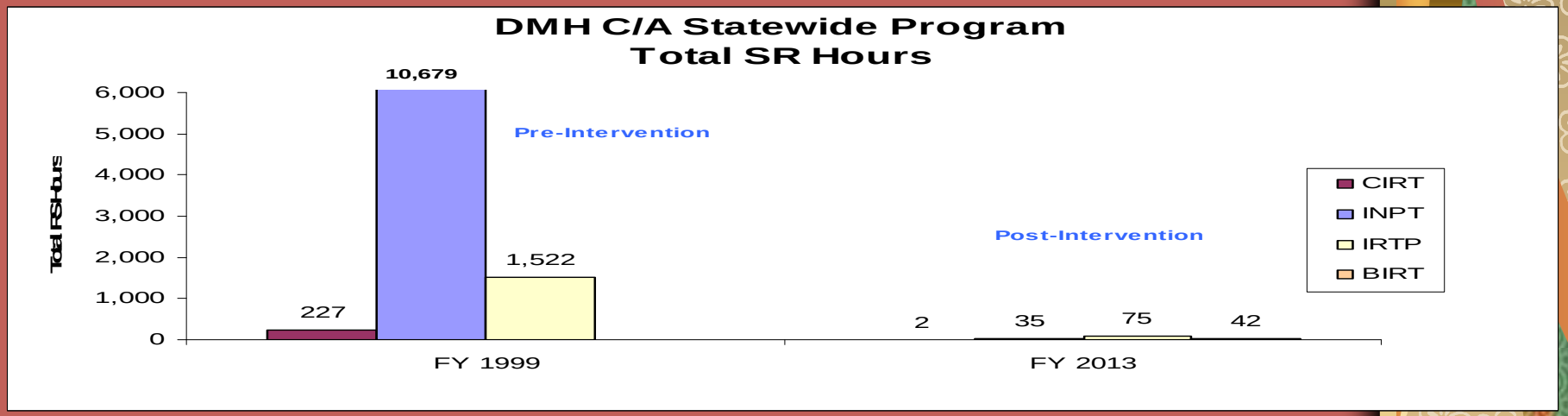


- 96.9%

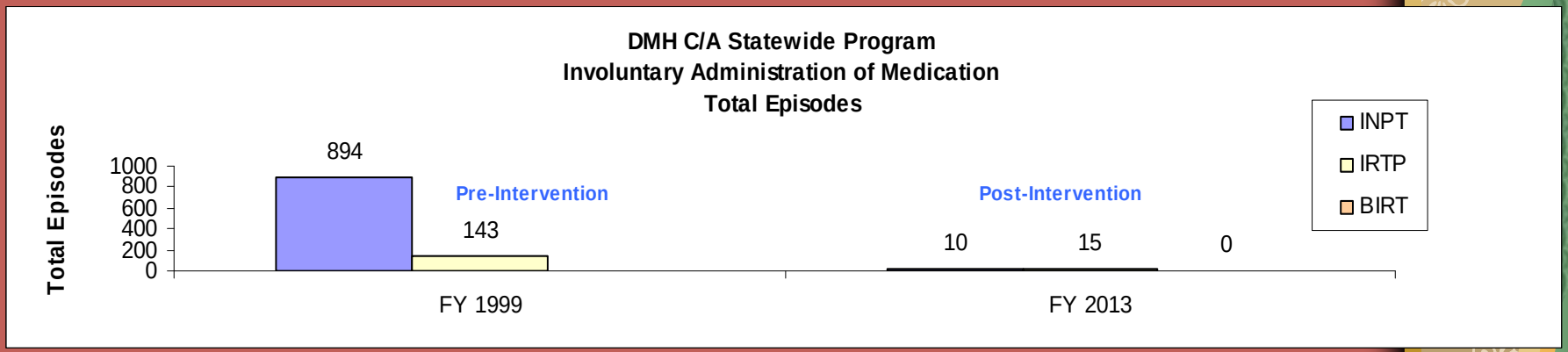
Child / Adolescent Mechanical Restraint Reduced - 100%



Duration Reduced - 99%



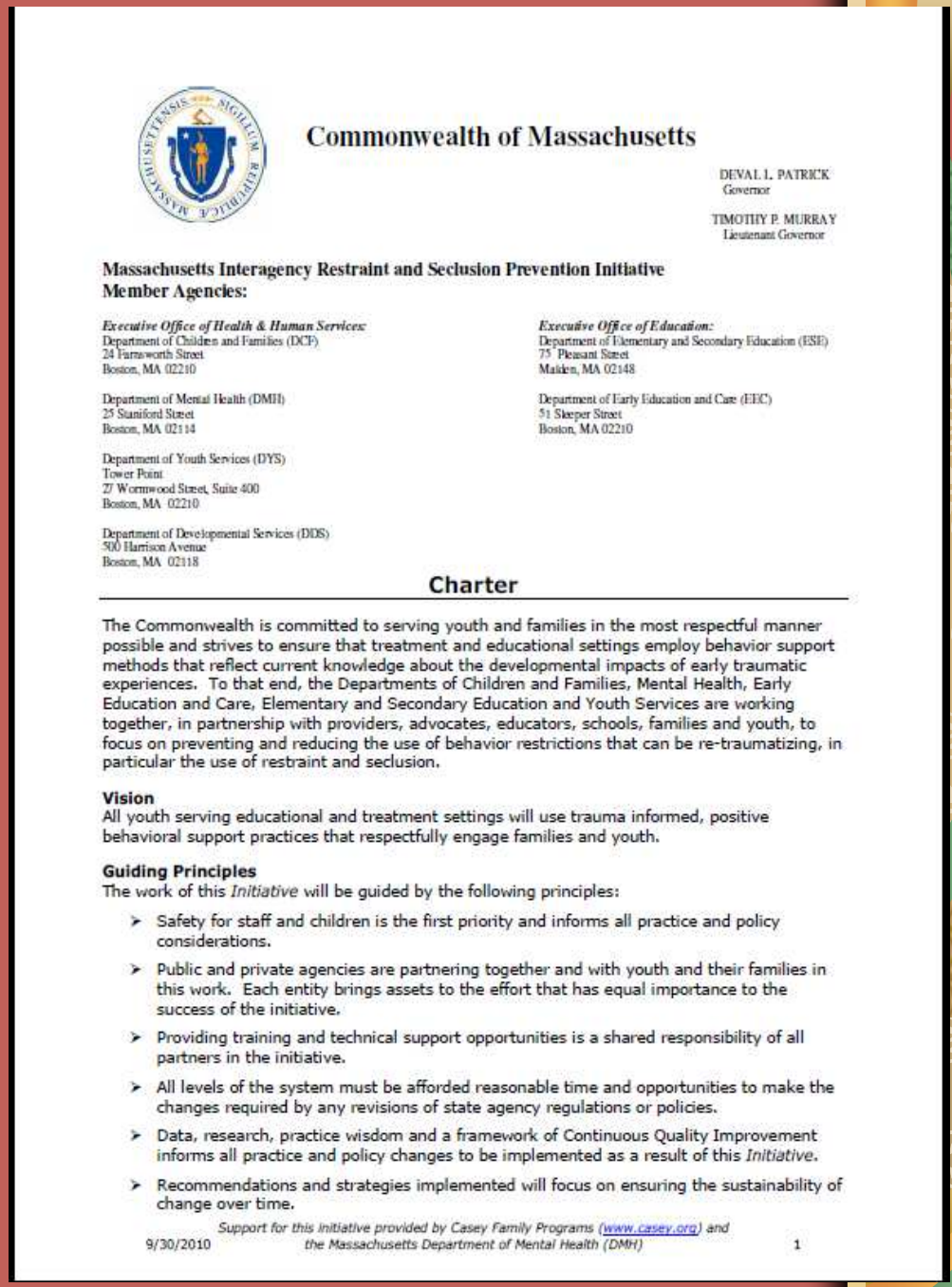
Medication Restraint Reduced - 98%



MA R/S Initiative Interagency Charter:

DMH, DCF, DYS, DDS, ESE, EEC, DPH

All C/A residential providers adopt 6CS



Commonwealth of Massachusetts

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

Massachusetts Interagency Restraint and Seclusion Prevention Initiative
Member Agencies:

Executive Office of Health & Human Services:
Department of Children and Families (DCF)
24 Farnsworth Street
Boston, MA 02210

Department of Mental Health (DMH)
25 Staniford Street
Boston, MA 02114

Department of Youth Services (DYS)
Tower Point
27 Wormwood Street, Suite 400
Boston, MA 02210

Department of Developmental Services (DDS)
500 Harrison Avenue
Boston, MA 02118

Executive Office of Education:
Department of Elementary and Secondary Education (ESE)
75 Pleasant Street
Malden, MA 02148

Department of Early Education and Care (EEC)
51 Sleeper Street
Boston, MA 02210

Charter

The Commonwealth is committed to serving youth and families in the most respectful manner possible and strives to ensure that treatment and educational settings employ behavior support methods that reflect current knowledge about the developmental impacts of early traumatic experiences. To that end, the Departments of Children and Families, Mental Health, Early Education and Care, Elementary and Secondary Education and Youth Services are working together, in partnership with providers, advocates, educators, schools, families and youth, to focus on preventing and reducing the use of behavior restrictions that can be re-traumatizing, in particular the use of restraint and seclusion.

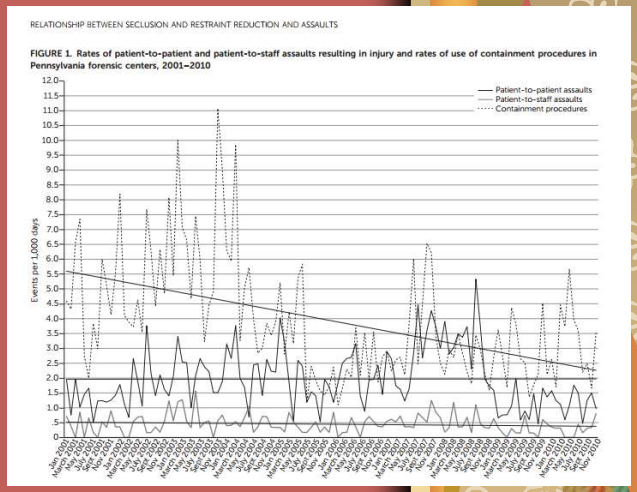
Vision
All youth serving educational and treatment settings will use trauma informed, positive behavioral support practices that respectfully engage families and youth.

Guiding Principles
The work of this *Initiative* will be guided by the following principles:

- Safety for staff and children is the first priority and informs all practice and policy considerations.
- Public and private agencies are partnering together and with youth and their families in this work. Each entity brings assets to the effort that has equal importance to the success of the initiative.
- Providing training and technical support opportunities is a shared responsibility of all partners in the initiative.
- All levels of the system must be afforded reasonable time and opportunities to make the changes required by any revisions of state agency regulations or policies.
- Data, research, practice wisdom and a framework of Continuous Quality Improvement informs all practice and policy changes to be implemented as a result of this *Initiative*.
- Recommendations and strategies implemented will focus on ensuring the sustainability of change over time.

Support for this initiative provided by Casey Family Programs (www.casey.org) and the Massachusetts Department of Mental Health (DMH)

Findings from Other 6CS Implementation Efforts



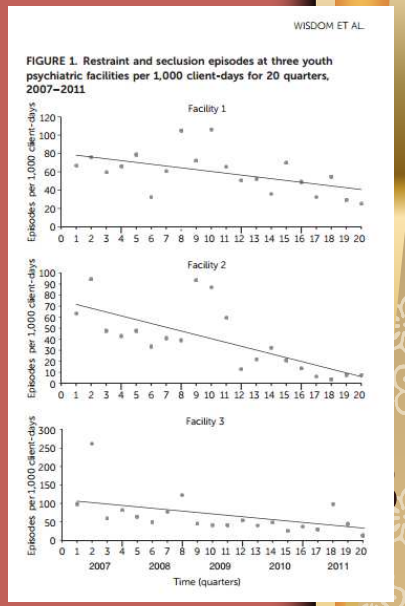
- ***PA: Forensic Services Centers***
  - 10 year retrospective review of 3 centers use of R/S
  - Significant reduction in restraint use
  - Significant reduction in seclusion use
  - Significant reduction in assaults to staff
  - No change in patient-to-patient assault
  - Discontinued use of PRN orders for psychiatric medications

(Smith et al, 2015)

Findings from Other 6CS Implementation Efforts

- ***NY: Child/Adolescent Facilities***
  - 4 year retrospective review of facilities' use R/S
  - Significant reduction in R/S use 62 – 86% use
  - Continued reduction / changes made post implementation period
  - Shifted focus from early intervention to problematic behavior to addressing unmet needs
  - Made environmental / practice changes too

(Wisdom et al, 2015)



Findings from Other 6CS Implementation Efforts

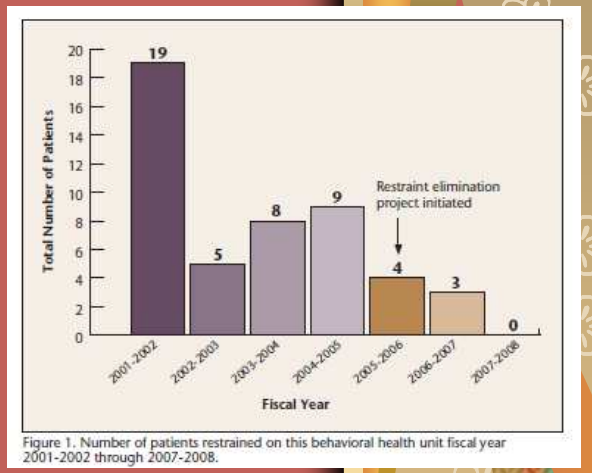


Figure 1. Number of patients restrained on this behavioral health unit fiscal year 2001-2002 through 2007-2008.

- ***PA: Chambersburg Hospital***
  - 26 bed unit in 248 bed general hospital
  - Two nurses attended 6 CS training in 2005
  - Ceased R/S use in 2007
  - Converted seclusion room to Comfort Room
  - Corresponding decrease in use of PRNs & sedative/hypnotic agents
  - Original goal R/S reduction became elimination

(Barton et al, 2009)[71]

Findings from Other 6CS Implementation Efforts

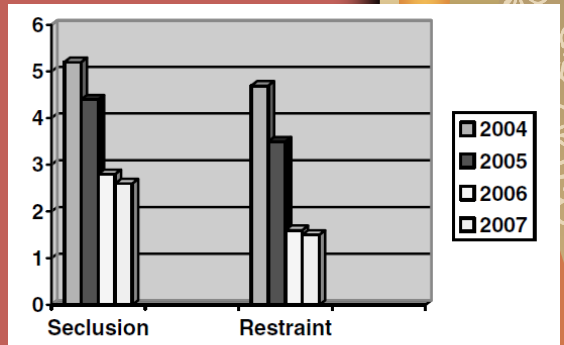


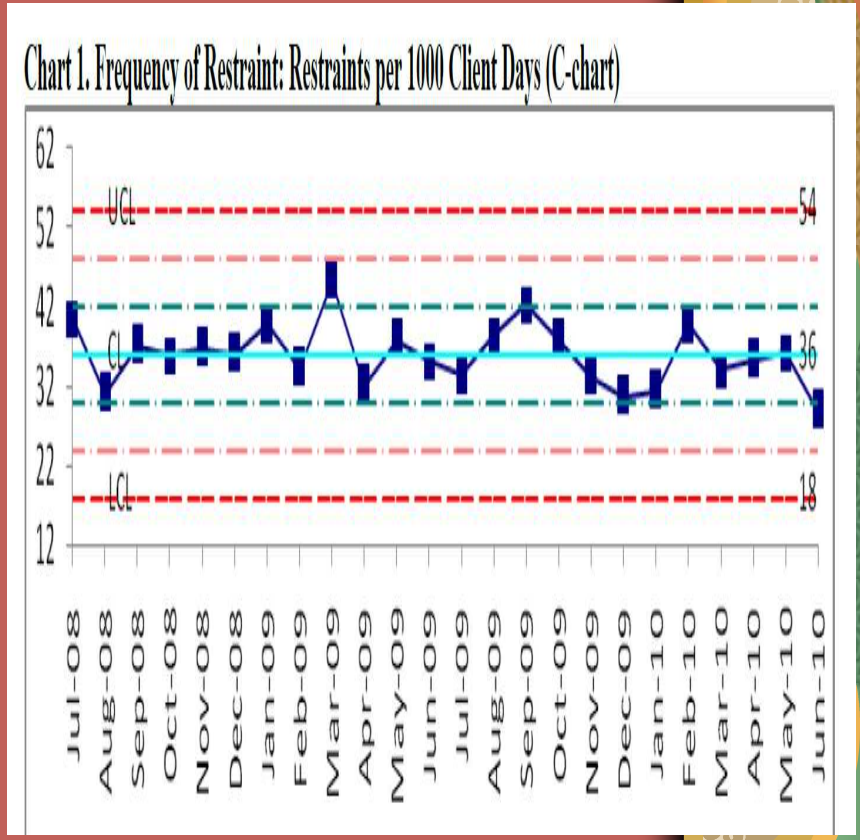
FIG. 2. Seclusion and restraint per 1000 patient hours a year.

- ***MD: Johns Hopkins***
  - 88 beds in 5 units in 900 bed tertiary care facility
  - Nurses attended same 6CS training as Barton
  - Reduced R/S 75%
  - No increase in R/S-related injuries
  - Implemented: aggression assessment, safety plans, Comfort Cart, family-style dining & witnessing

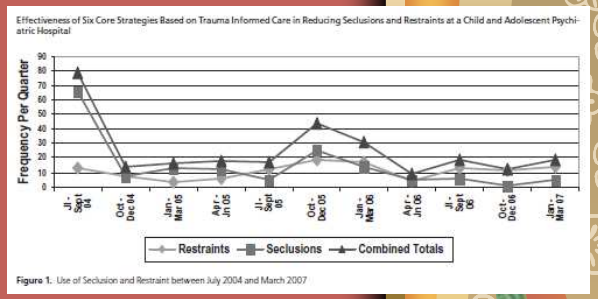
(Lewis et al, 2009)

Findings from Other 6CS Implementation Efforts

- ***OH: OACCA Learning Collaborative***
  - C/A residential &inpatient services
  - 20 facilities (>700 beds)
  - Kick-off training 2008
  - Shared: data, problems, learning
  - >36% R/S reduction within past year



Findings from Other 6CS Implementation Efforts



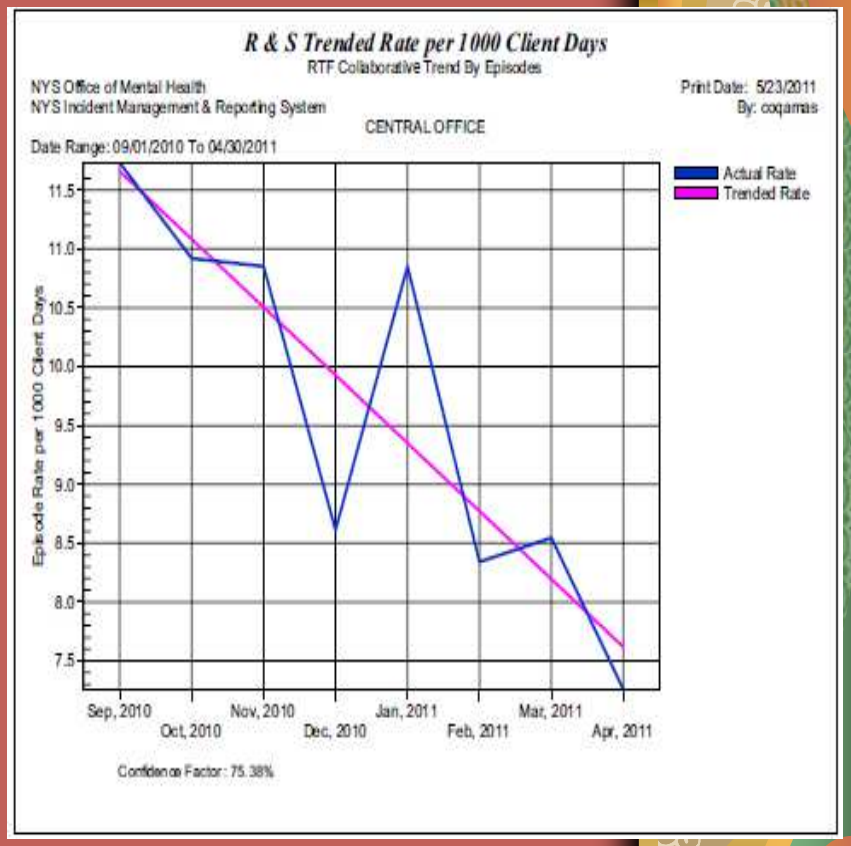
- ***MN: State Operated C/A Behavioral Health Services***
  - Attended 6CS training in 2005
  - Implemented in 3 youth units (26 beds)
  - Data analysis of R/S use pre- and post-training (2004-2007; 458 admissions)
  - 66% reduced R/S use
  - Replication at Riverview Hospital

    AKA: **“Solnit Ctr” (CT)** underway

(Azeem et al, 2011)

Findings from Other 6CS Implementation Efforts

- ***NY: OMH RTFs***
  - 13 facilities (>550 beds)
  - Kick-off training 2008
  - Site visits 2009/2010
  - Bi-monthly conference calls (2010/2011)
  - Shared: data, problems, learning
  - >60% R/S reduction overall, + 14% this FY



Findings from Other 6CS Implementation Efforts

- ***New York City: Health & Hospital Corporation (11 sites)***
  - Largest municipal health care system in the US > 1,117 psychiatric inpatient beds
  - Avg. LOS = 22 days
  - 01/07 began initiative: 6CS training & site visits
  - Statistically significant reduction in R/S:
    - Episodes, duration, & injuries to patients

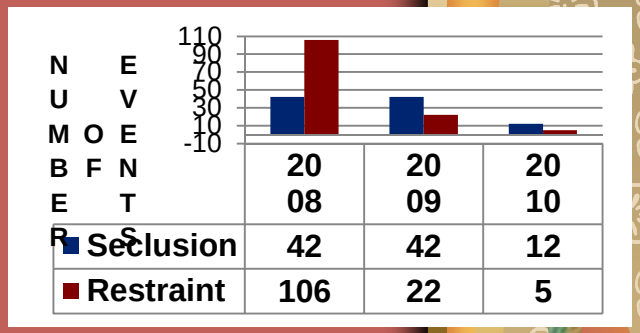
(Wale et al., 2011)

Findings from Other 6CS Implementation Efforts

- ***IL: Elgin Mental Health Center***
  - Psychiatric facility with 315 bed medium security forensic beds and 75 civil beds
  - Implemented 6CS
  - Decreased maximum R/S order to 1 hour
  - Created Comfort Rooms/kits; Consumer Council; Consumer trainers; Training staff in de-escalation & relaxation techniques
  - Reduced R/S use >95%

(Hardy & Patel, 2011)

Findings from Other 6CS Implementation Efforts



	2008	2009	2010
Seclusion	42	42	12
Restraint	106	22	5

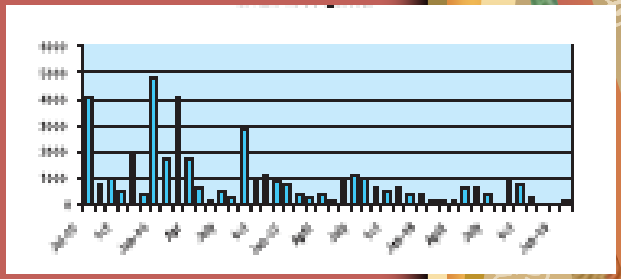
- ***DE: Psychiatric Treatment Center***
  - Psychiatric facility with 250 - 160 beds, 6 units including forensic service; acute & cont. care admissions; LOS 30 days-15 yrs.
  - Implemented 6CS
  - Decreased maximum R/S order to 2 hours
  - Hired 8 Peer Specialists, removed Security from R/S response, created Comfort Rooms
  - Reduced R/S use >93% x 4 years (NASMHPD, 2013)

Lancashire, UK

- ***Two Current NHS Studies, Lancashire, UK***
  - Duxbury et al., (2012): Planned comparative case study of implementing 6CS in a medium secure mental health unit
  - Duxbury et al., (2013): Restraint Reduction in a Forensic Setting: Testing an Organisational Model for Implementation in the UK (Six Core Strategies UK)(SCORES-UK)

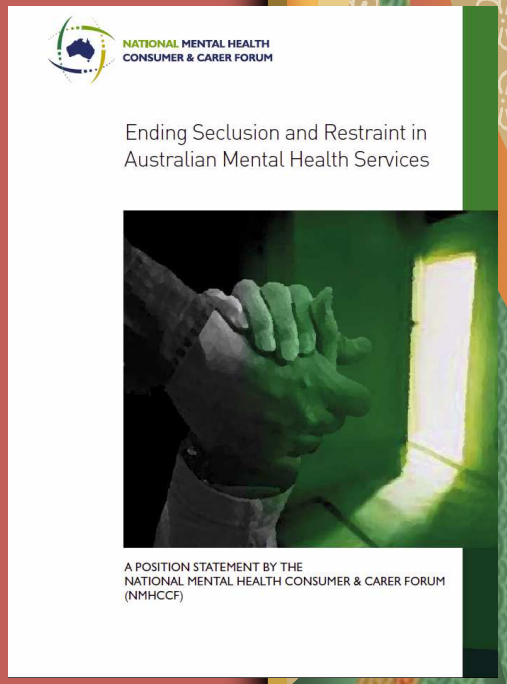
Australia ~ National Project

- ***AU Gov't: National MH R/S Project Beacon Project (11 sites)***
  - 2 National Forums
  - One site: T. Embling Hosp. (7 forensic units, 118 beds); attended 6CS training in 2007; Implemented: Consumer consultant, Safe/Calming Rooms, massage chair, calming sprays, debriefing, aggression assessment . "*At the completion of the project in June 2009 the* ***outcomes were positive, with significant changes achieved at all participating sites; not just in the rates of seclusion, but in the culture, knowledge and attitude of staff as well as increased consumer and carer involvement."*** (Martin, 2010)



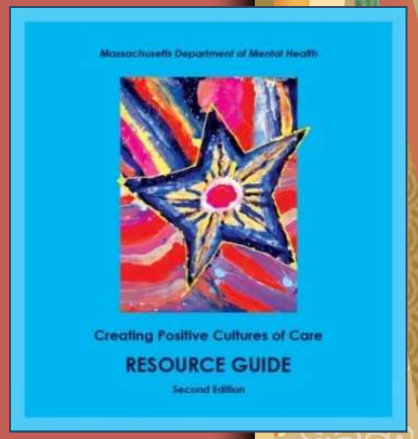
Australia ~ Victoria

- ***AU: Creating Safety: Addressing R&S Practices Project (6 sites)***
  - State of Victoria
  - Training in 6CS
  - Site visits to USA 2007/2008
  - Project duration 01/08 – 08/08
  - Short duration and lack of control group made it impossible to discern clear trends



Australia ~ New South Wales

- ***AU: MH-Kids! Statewide Initiative Creating Positive Cultures of Care (all C/A inpatient services)***
  - State of New South Wales
  - Site visit to USA 2011
  - Training in 6CS in 2012
  - Awards in 2013:
    - Shell Harbor no R/S



New Zealand

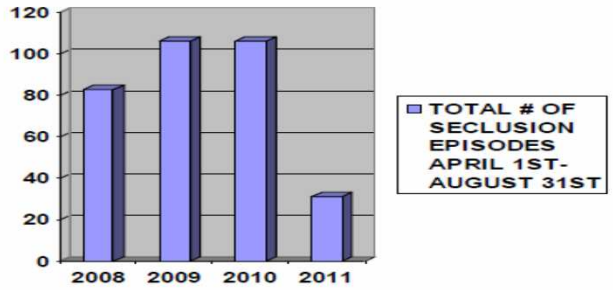
- ***NZ : Seclusion: Time for Change Project*** ***(phase 2 & 3 of national plan)***
- Two reports guide National Action Plan development:
  - Best Practice Review (O'Hagan, Divis & Long, 2008)
  - DHB Survey of Initiatives
  - ***Sensory Trolleys*** implemented
- Trained in 6CS; National Plan includes 6CS
- Several important goals – including reducing R/S with Maori people www.tepou.co.nz

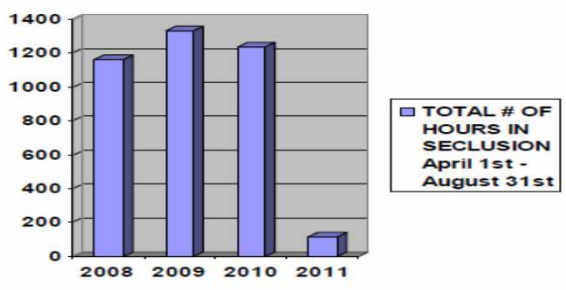
Canada

- ***Canadian Facilities Trained in 6CS***

  2008 – 2014

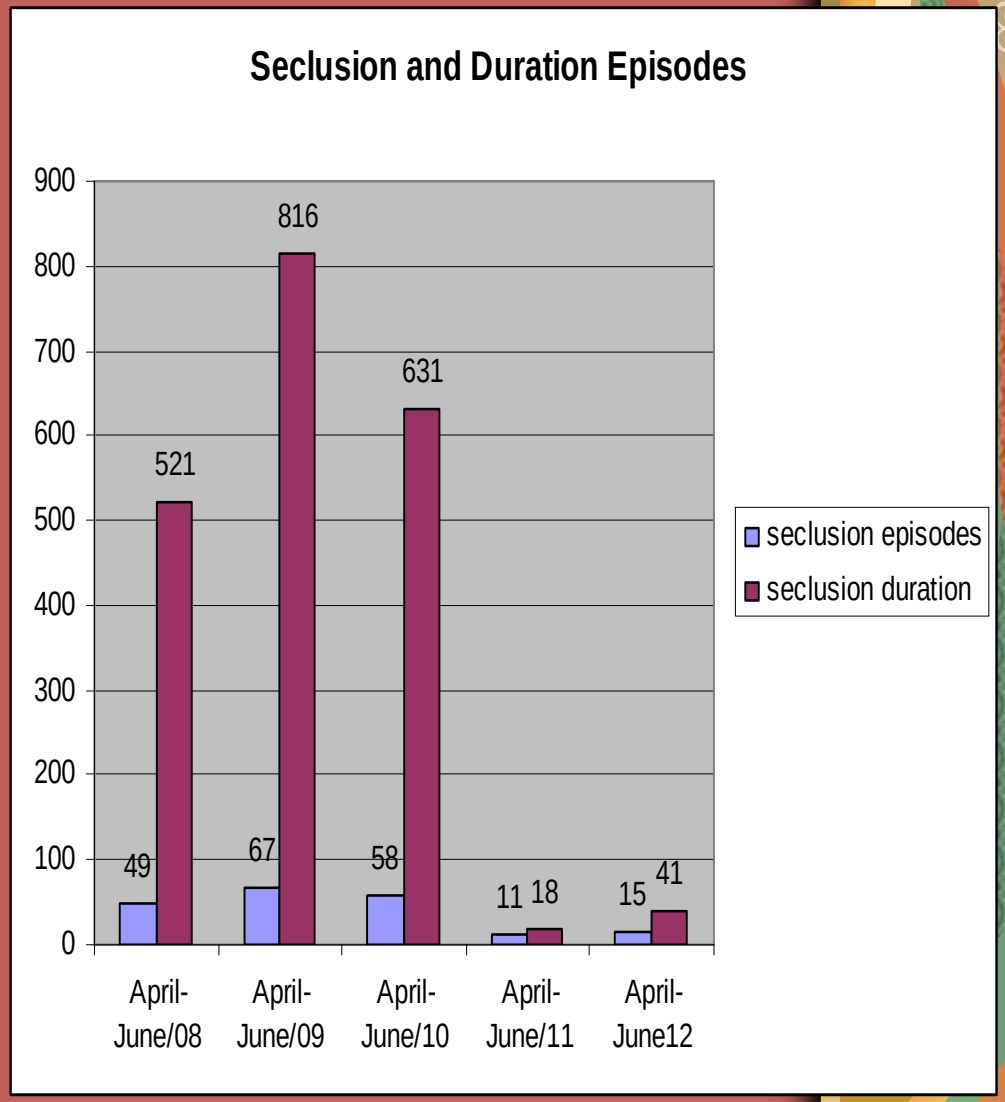
  - CAMH – Toronto, ON
  - NE MH Centre - North Bay, ON
  - St. Joseph's Health Care – Hamilton, ON
  - Ontario Shores MH Services– Whitby, ON
  - Halton Healthcare – Oakville, ON
  - PsycHealth – Winnipeg, MB: *(data below)*





PsychHealth – Winnipeg, MB

- Started seclusion reduction 02/11
- In 1 year decreased episodes: 84%
- Decreased duration: 87%



12 months later in Manitoba ...

20 months later in Manitoba ...

From: Larry Stratton [mailto:LStratton@exchange.hsc.mb.ca]
Sent: Friday, December 14, 2012 11:58 AM
To: Janice LeBel [jlebel@comcast.net]
Subject: hello from the great white north

Hi Janice, hope all is well. We are looking at **extending our pilot project** that wrapped up in August on our unit PY3-S to the entire inpatient department. The nice part about it all is that the **Workers Compensation Board of Manitoba** actually **approached us to see if we would like them to partner further with them on this initiative!** I suppose given the fact that **we haven't had a compensable injury in 17 months bodes well for given this is by far a historic record for our Unit.**

Finland

- ***Niuvanniemi Hospital***

  Kuopio, FI

  - First controlled trial implementation of 6CS (national high-security forensic hospital)
  - R/S episodes & duration decreased >50% without an increase in violence or injury to staff or consumers

Cluster-Randomized Controlled Trial of Reducing Seclusion and Restraint in Secured Care of Men With Schizophrenia

Anu Putkonen, M.D., Ph.D.
Satu Kuivalainen, R.N., M.Sc.
Olavi Louheranta, Th.M., Ph.D.
Eila Repo-Tiihonen, M.D., Ph.D.
Olli-Pekka Ryynänen, M.D., Ph.D.
Hannu Kautiainen, B.A.
Jari Tiihonen, M.D., Ph.D.

Objective: This randomized controlled trial studied whether seclusion and restraint could be prevented in the psychiatric care of persons with schizophrenia without an increase of violence. *Methods:* Over the course of a year, 13 wards of a secured national psychiatric hospital in Finland received information about seclusion and restraint prevention. Four high-security wards (N=88 beds) for men with psychotic illness were then stratified by coercion rates and randomly assigned to two equal groups. In the intervention wards, staff, patients, and doctors were trained for six months in applying six core strategies to prevent seclusion-restraint; six months of supervised intervention followed. Poisson's regression analyses compared monthly incidence rate ratios (IRRs) of coercion and violence (per 100 patient-days). *Results:* The proportion of patient-days with seclusion, restraint, or room observation declined from 30% to 15% for intervention wards (IRR=.88, 95% confidence interval [CI]=.86–.90, p<.001) versus from 25% to 19% for control wards (IRR=.97, CI=.93–1.01, p=.056). Seclusion-restraint time decreased from 110 to 56 hours per 100 patient-days for intervention wards (IRR=.85, CI=.78–.92, p<.001) but increased from 133 to 150 hours for control wards (IRR=1.09, CI=.94–1.25, p=.24). Incidence of violence decreased from 1.1% to .4% for the intervention wards and from .1% to .0% for control wards. Between-groups differences were significant for seclusion-restraint-observation days (p=.001) and seclusion-restraint time (p=.001) but not for violence (p=.91). *Conclusions:* Seclusion and restraint were prevented without an increase of violence in wards for men with schizophrenia and violent behavior. A similar reduction may also be feasible under less extreme circumstances. (*Psychiatric Services in Advance*, June 17, 2013; doi: 10.1176/appi.ps.201200393)

Dr. Putkonen, Ms. Kuivalainen, Dr Louheranta, and Dr. Repo-Tiihonen are affiliated with the Department of Forensic Psychiatry, University of Eastern Finland (UEF), Kuopio, where Dr. Tiihonen is affiliated, and with Niuvanniemi Hospital, Kuopio. Dr. Tiihonen is also with the Department of Clinical Neuroscience, Karolinska Institutet, Stockholm. Dr. Ryynänen is with the Department of Public Health and Clinical Nutrition, Primary Health Care, UEF. Mr. Kautiainen is with the Unit of Primary Health Care, Helsinki University Central Hospital, and with the Department of General Practice, University of Helsinki in Finland. Send correspondence to Dr. Putkonen, Niuvanniemen sairaala, Niuvankuja 65, 70240 Kuopio, Finland (e-mail: putkonen@niuva.fi).

Restraint has been defined as "any manual method or physical or mechanical device, material or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body or head freely," whereas seclusion is "the involuntary confinement of a person alone in a locked room or an area where the person is physically prevented from leaving" (1). Although the use of seclusion or restraint may minimize harm in psychiatric emergencies, the risks and costs of these procedures to both patients and staff have resulted in several national and international recommendations to restrict their use (2–5). In theory, seclusion-restraint could be discontinued by decree, if patient violence is not a consideration.

According to the literature, the highest seclusion-restraint reduction rates have been achieved by simultaneously improving several elements of care to prevent crises that lead to seclusion or restraint. Such elements include improved leadership, staff development, use of data, consumer involvement, use of seclusion-restraint reduction tools, and postevent analyses (6–10). Decreases in seclusion-restraint rates have ranged from 47% to 92% in 70 U.S. institutions that applied these six core strategies under the State Mental Health Authority (10–15). Violence considerably decreased in some

Japan

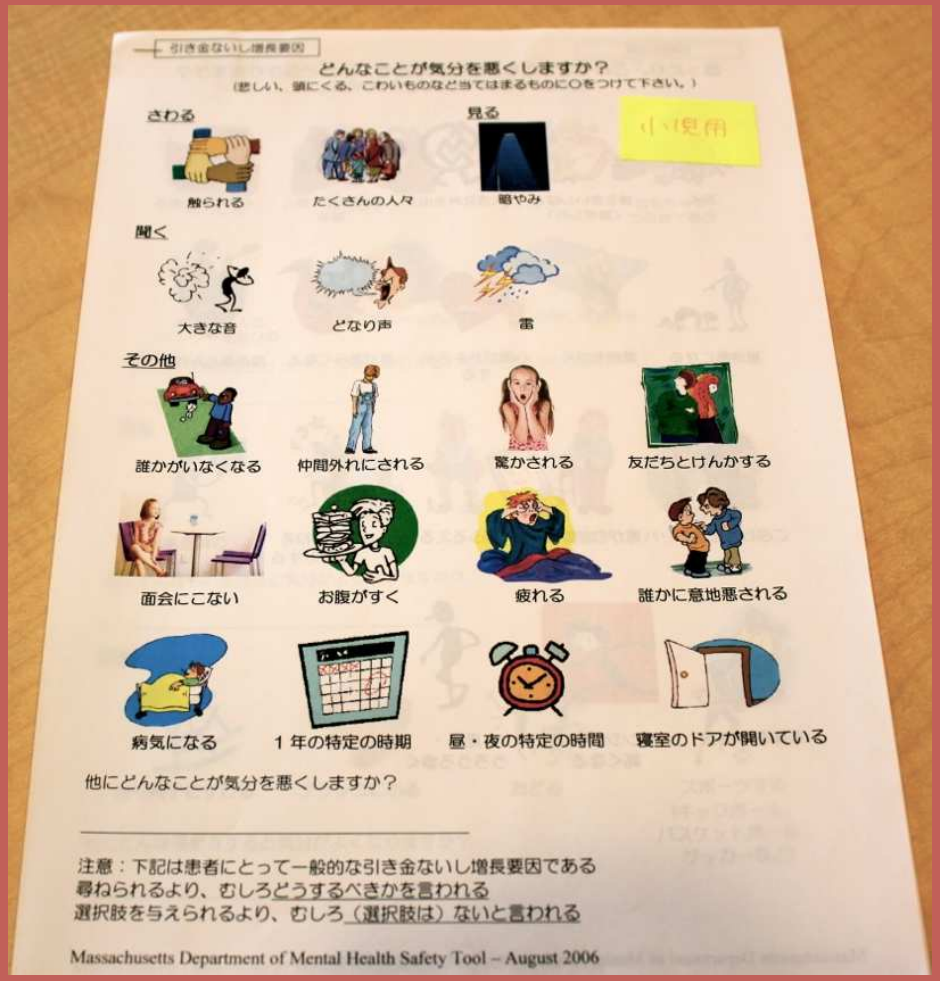
- First International Visitors to WRCH – Oct. 2012
- Translated 6CS into Japanese & disseminated
- Study Title: ***Study of minimizing seclusion and restraint use in Japan***

  "In this study, we are going to measure amount of seclusion and restraint use, and to assess consumer satisfaction to patients with mentally disabled in Japanese psychiatric hospitals."
- Purpose: To measure the amount of seclusion and restraint (S/R) and the perceptions of S/R use among nursing staff and patients through interventions using the Six Core Strategies, developed in the United States.
- Term of study: March 30, 2012~March 31, 2014

  We would like to use the Safety Tool as one of intervention methods during the study.
- Investigators: 'naoyasug'; '吉浜 文洋'; 'Toshie Noda'; 'Hiroto ITO'; '末安民生'; '三宅美智'; '石井美緒'; '早川 幸男'; '窪田 澄夫'; 'Orika Egashira'Makiko Sato

精神保健領域における隔離・身体拘束最小化

—使用防止のためのコア戦略



【原題】

Reducing Seclusion & Restraint Use in Mental Health Settings

Core Strategies for Prevention

text by Kevin Ann Huckshorn

【邦題】

精神保健領域における隔離・身体拘束最小化

—使用防止のためのコア戦略

【訳】 吉浜文洋[1)]　杉山直也[2)]　野田寿恵[3)]

神奈川県立保健福祉大学 看護学科 教授[1)]
財団法人復康会 沼津中央病院 院長[2)]
国立精神・神経医療研究センター 精神保健研究所 社会精神保健研究部[3)]

精神保健医療福祉の専門出版社
精神看護出版

The training was very beneficial for us … We learned how much your state is advanced. ***Especially, we were amazed about peer role, safety tools, comfort rooms.*** *Although Japan is still way behind compared with the U.S, I am sure that this two-day training will be definitely useful to reduce coercive methods in Japanese psychiatric settings.*

Also, hospital touring was good opportunity to know the differences of hospital roles between the U.S and Japan. ***We are impressed by the staff's efforts and work to help clients with mental illness. We learned how important patient-centered-care is.***

Makiko Sato, MS

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

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

We also *know* the pitfalls

- Mission drift / practice creep
- R/S prevention fatigue
- Intervention substitution
  - Increase in medication
  - Translocation of problem = speed dial to police / ambulance
  - Hands off = do nothing = injury & environmental damage = *"See, we can't do this. It's too dangerous!"*
  - *"We need more staff" & "We need more money"*

What can you do about it?

- Take a longer view
- Expect challenge, pushback & resistance
- Monitor backsliding/intervention substitution, use pre-post data, supervise to it
- Solicit the involvement of those most concerned and those you serve
- Be prepared to draw the line, help those who can make the change, and help the others *"find their gifts and grace in other places"*

Remember:

"Good ideas are not adopted automatically. They must be driven into practice with courageous patience."

Hyman G. Rickover

Contact Information

Janice LeBel
Director of System Transformation
Dept. of Mental Health
25 Staniford Street
Boston, MA 02114
Janice.lebel@state.ma.us
617-626-8085